SCOTTISH EXECUTIVE
Health Department

Moving From Care to Enablement

Framework for Rehabilitation

(DRAFT DOCUMENT FOR CONSULTATION)

Scottish Executive
August 2006

Contents

Key messages

The following are some themes that are central to the delivery of this framework. They will be explained further and possibly expanded during the consultation process.

- Rehabilitation is central to ensuring that the vision set out in ***Delivering for Health*** is achieved.
- The rehabilitation process aims to maximise the participation of the patient in his or her social setting; and minimise the distress of, and stress on, the patient's family and carers.
- Rehabilitation services should be delivered locally to where the people who need them live. This requires a shift in how health and social care services and professionals work.
- Strategic and local co-ordination of rehabilitation services is required to achieve maximum impact and benefits for people who use them during transition phases and throughout their ongoing rehabilitation.
- Community health partnerships (CHPs) will play a significant role in planning and providing NHS and related services for people requiring rehabilitation in local communities.
- Allied health professionals (AHPs), working in partnership with other health and social care professionals, should drive changes to rehabilitation services and take lead roles in their re-design. They will require strong support and leadership from NHS Boards, CHPs and local authorities to make this happen.
- Health and social care providers involved in delivering or developing rehabilitation should critically review their service provision and skill mix to ensure they meet the changing demands of health care and provide services from the right people, in the right place, at the right time.
- The immediate focus should be on how transitions between hospital and community services and subsequent follow up are managed to ensure a seamless patient journey.
- Rehabilitation professionals should provide patients and their carers with better information and support to manage their condition(s), consequently helping to reduce avoidable admissions to hospital.
- Health and social care professionals should be actively engaged in promoting the public health agenda, reducing health inequalities and improving NHS efficiency.
- Communication and information sharing between health and social care professionals should be enhanced to improve the patient/service user journey.

Introduction by the Chief Health Professions Officer

The purpose of this draft Framework for Rehabilitation is to give strategic direction and support to all health and social care services and practitioners who deliver rehabilitation. It presents recommendations for action that have been developed following a process of consultation with relevant stakeholders and are offered for comment and approval.

The draft framework focuses on core principles of rehabilitation specifically as they relate to older people, people with long-term conditions and people returning from work absence and aiming to stay in employment.

The framework:

- concentrates explicitly on the added value offered by rehabilitation through earlier anticipatory interventions and the prevention of unnecessary admissions to hospital
- explores how rehabilitation can produce health gains for individuals and communities through enabling return to productive activity and employment
- provides guidance to underpin the development of rehabilitation in a multi-agency context
- offers a clear vision for health and social care practitioners in delivering this agenda.

The vision underpinning the framework is the creation of a modern, effective, multi-agency approach to rehabilitation services which are flexible and responsive in meeting the needs of individuals and communities in Scotland.

The framework has been taken forward by the Scottish Executive in partnership with a wide range of stakeholders representing individuals who use the service, carers and rehabilitation services in health and social care. A National Steering Group and three Action Groups were established, each chaired by a service user. The Steering Group and Action Groups worked in support of the National Project Officer during the engagement process and the production of the draft.

We wanted to ensure that adults who use rehabilitation services were at the heart of the development of the framework. The focus of consultation was therefore engagement with individuals, carers and organisations representing older people, people with long term-conditions and those receiving vocational rehabilitation. Further work will be undertaken during the formal consultation process to engage with services and adults with additional support needs and communication difficulties.

The process of developing the draft framework involved:

- a thematic analysis of the evidence by the Scottish School of Primary Care
- a series of consultation events with those who use services
- a consensus event with health and social care professionals.

The work has shown us that people want rehabilitation services delivered close to their homes by professionals who are competent and have the requisite skills to support individuals through the rehabilitation journey. More important, users of the service want professionals to engage fully with them and treat them as equal partners in the management of their condition(s).

There was a strong call for better co-ordination of rehabilitation services, and a need to explore the potential benefits of rehabilitation co-ordinator / key worker roles.

Providing effective rehabilitation services that meet the challenges set out in ***Delivering for Health*** and ***Changing Lives (Scottish Executive 2006)*** requires transformational change. Health and social care professionals have already shown real commitment to integrated working and service improvement. We now call on them to build on what has been achieved, look beyond traditional methods of providing services, and grasp opportunities for joint learning with health and social care colleagues.

Integrated service redesign and role development will be key to putting the patient/service user journey at the heart of systematically planned services. This will enable multi-agency teams to maximise the benefits of existing models and create new models of service that focus on the shift from 'care' to 'enablement and rehabilitation, using the expertise of these professions and of the whole team to best effect.

Jacqui Lunday
Chief Health Professions Officer

1. Context and background

Delivering for Health (SEHD, 2005) signals a transformational change in the NHS from a service that is primarily focused on providing care in hospitals to one where care is planned, delivered and evaluated close to people's homes. This draft Framework for Rehabilitation explores the principles of rehabilitation in line with this new health agenda.

Delivering for Health sets out the Executive's priorities for NHS Scotland over the next decade (see Box 1.1). It presents a new vision for NHS Scotland, a vision based on:

- delivering care close to where people live
- offering people timely access to services
- promoting a strong emphasis on anticipatory care
- supporting patient self-management of long-term conditions.

Box 1.1 *Delivering for Health*

Delivering for Health calls for:

- a fundamental shift in the way the NHS works, from an acute, hospital-driven service to one that is embedded within the community, is patient focused and is based on a philosophy which moves from 'care' to enablement and rehabilitation.
- a focus on meeting the twin challenges of an ageing population and the rising incidence of long-term conditions
- a concentration on preventing ill-health and treating people faster and closer to home
- a determination to develop responses that are proactive, modern, safe and embedded in communities
- support for health care professionals, patients and their carers to deliver sustainable, quality services.

It emphasises the need for a decisive shift in the balance of care within the NHS to meet the challenges of an ageing population, which will result in a growing number of people living with long-term conditions.

The importance of applying a more systematic approach to care for people with long-term conditions is emphasised in the new policy. This calls for services to identify individuals in their local population who have long-term conditions and to tailor health and social care services to meet their requirements. Proactive, systematic approaches to patient management, underpinned by good prevention, need to be adopted to further this agenda.

The shift in policy direction in the health service that ***Delivering for Health*** represents is mirrored in the social care sector by ***Changing Lives*** **(**SEHD, 2006). This review of social work in Scotland sets out a vision for social care

services for the 21st Century. The report outlines 13 recommendations based on the premise that 'more of the same won't work', highlighting the need for change to make sure services respond to future demographic changes, public expectations, workforce availability and financial allocations.

Changing Lives places the emphasis on service redesign, workforce training and leadership and a shift towards early intervention and prevention. It focuses on building the capacity of the workforce to deliver personalised services and create sustainable change.

Rehabilitation is therefore pivotal to the principles of ***Delivering for Health*** and ***Changing Lives*** (see Box 1.2).

Box 1.2 Shared principles of *Delivering for Health* and *Changing Lives.*

Each document focuses on different aspects of transformation within the respective services, but share common principles of:

- community capacity building
- whole-systems approaches
- focus on prevention and early intervention
- user involvement
- carers as partners
- self management of care
- systematic approach to long-term conditions management
- a competent workforce.

Health and social care professionals now need to build on existing skills in the management of long-term conditions and co-morbidities, health improvement and anticipatory care/early intervention. The CHP Long-Term Conditions Toolkit will be a useful resource in taking this forward. By focusing on rehabilitation and enablement, professionals will be in a strong position to contribute their expertise to the delivery of the new health and social care agenda, working with service users/patients to ensure they receive the support they need.

2. Rehabilitation

Rehabilitation is a concept that has broad applicability across health and social care professions and agencies. It can be defined in different ways within different contexts, and means different things for different client groups.

The King's Fund has produced a working definition of rehabilitation. Rehabilitation is:

> *A process aiming to restore personal autonomy to those aspects of daily life considered most relevant by patients or service users, and their family carers. (King's Fund, 1998)*

A more detailed analysis, which relates more to specialist roles in rehabilitation and focuses on structure, process and outcomes, is provided by Wade et al (Box 2.1).

Box 2.1 Rehabilitation (Wade et al, 2000)

Structure
A rehabilitation service comprises a multidisciplinary team of people who:
- work together towards common goals for each patient
- involve and educate the patient and family
- have relevant knowledge and skills
- can resolve most of the common problems faced by their patients.

Process
Rehabilitation is a reiterative, active, educational, problem-solving process focused on a patient's behaviour (disability), with the following components:
- assessment—the identification of the nature and extent of the patient's problems and the factors relevant to their resolution
- goal setting
- intervention, which may include either or both of *(a)* treatments, which affect the process of change, and *(b)*support, which maintains the patient's quality of life and his or her safety
- evaluation—to check on the effects of any intervention.

Outcome
The rehabilitation process aims to:
- maximize the participation of the patient in his or her social setting
- minimize the pain and distress experienced by the patient
- minimize the distress of and stress on the patient's, families and carers

Both definitions have been used to guide work on this framework.

3. The three target groups

This section identifies the background and specific issues around rehabilitation provision for:

- older people
- people with long-term conditions
- people returning from work absence and aiming to stay in employment.

There are a number of areas of overlap among the groups, but also specific challenges that require focused attention.

Older people

Scotland's population is growing older. More than one million people are over the age of sixty years, approximately one fifth of the total population.

Old age is not an illness, and many older people are fit and well. Older people nevertheless tend to have higher levels of ill health than those who are under 65. The Scottish Executive Information and Statistics Division reported in 2001 that rates of limiting long-standing illnesses increase considerably with age. Fifty percent of men and 60% of women in the 75 and over age group at that time had a disability, compared to only 14% of the general adult population (aged 16 and over).

Care of older people accounts for 40% of the health service budget in Scotland and 40% of the social work budget (Scottish Executive, 2000). The numbers of older people (aged 65 and over) is expected to increase from 787 000 to 1.2 million between 2000 and 2031; those aged over 85 are expected to increase from 84 000 to 150 000 (Expert Group on Healthcare of Older People, 2002).

Care of older people is consequently a key priority for the Scottish Executive (see Box 3.1).

Box 3.1 Health and social care policy for older people in Scotland.

The Scottish Executive Health Department has published a series of policy documents identifying the health of older people as a priority for NHS Scotland:

- *The Future Care of Older People in Scotland* (2006)
- *National Framework for Service Change in the NHS in Scotland - Care of Older People* (2005)
- *Adding Life to Years* (2002)
- *Age and Experience – Developing the Strategy for a Scotland with an Ageing Population'*, to be published later in 2006.

In addition, NHS Quality Improvement Scotland has produced several recommendations for older people's services, including:

- *Healthcare Services Used by Older People in NHSScotland* (2005)
- *National Overview: Older People in Acute Care* (2004).

The focus of policy is to identify the growing need for integrated older people's services. ***Better Outcomes for Older People,*** published in 2005, provides a lead on how to set up joint services and sets out the requirements, actions and timescales local partnerships should meet in developing joint services. It also emphasises that progress will be monitored by a national partnership involving the Scottish Executive, Convention of Scottish Local Authorities (COSLA) and NHS Scotland.

The key messages from ***Better Outcomes for Older People*** are about:

- pro-actively supporting people living at home so they are not inappropriately admitted to a care home or hospital
- providing intensive rehabilitation prior to returning home
- ensuring a seamless transition from hospital to home
- actively supporting older people on returning home
- facilitating provision of appropriate rehabilitation support to people in care homes.

Specialist rehabilitation, including comprehensive assessment and rehabilitation for frail older people, has made significant progress in demonstrating better outcomes for patients, particularly in stroke and orthopaedic rehabilitation. Stroke and hip fractures are the two most common causes of disability among older people and pose significant challenges for rehabilitation and community services.

Specialist rehabilitation services, often situated within secondary care, are highly valued by patients and service users. They must continue to play a key role in the future development of the rehabilitation/enablement continuum within health and social care services. It is important to reinforce the need for comprehensive in-patient assessment and rehabilitation in specialist units for frail older people. There is evidence to support that comprehensive care in

such settings can improve the probability of return to independent living. The transition from these settings to the community needs to be seamless for patients and service users to gain maximum benefits.

Reviews of older people's services carried out by several NHS Boards have reinforced this need for a coherent, integrated system of community based rehabilitation. The reviews have recognised that flexible service delivery involving hospital discharge teams, community older people's teams, social services, day hospitals and day centres is essential in addressing gaps for patients who do not meet current service criteria, preventing unnecessary admission to hospital and supporting hospital discharge.

Better Outcomes for Older People outlined the principles and values of joint service provision, which relate to their:

- flexibility
- responsiveness to local needs
- ability to deliver better outcomes for individuals.

It also called for a stronger focus on integrated care services to provide a range of enabling, rehabilitative and treatment services in community settings.

Intermediate care services have not featured as a key policy driver in Scotland to date, but local partnerships are currently exploring the potential benefits they offer in bringing ongoing rehabilitative and enabling services closer to communities.

The Joint Improvement Team (JIT) (www.jitscotland.org.uk) was established in late 2004 to work directly with local health and social care partnerships across Scotland, sharing and disseminating good practice, providing information and facilitating closer working between agencies. The team works under the direction of the Joint Future Unit, which heads up the lead policy on joint working between local authorities and the NHS in community care. The unit's main aim is to provide faster access to better and more joined-up services, including rehabilitation services, through improved joint working, and it looks to local partnerships to take holistic decisions on the management, financing and delivery of community care services for all care groups.

Single Shared Assessment (SSA) is central to the Joint Future initiative and is already resulting in real improvements for older people - and their carers - through quicker and more effective decision making. SSA aims to eliminate duplication in assessment, ensure that information is shared across agencies with the consent of the person being assessed, and speed up the delivery of appropriate services.

Community hospitals are an important element of health service provision for many communities across Scotland, particularly in remote and rural areas. They also have a key role to play in integrated/intermediate care provision. ***Delivering for Health*** cites rehabilitation as one of the elements of practice to

which community hospitals can make a significant contribution, and the strategy for community hospitals in Scotland, due to be published later in 2006, calls on NHS Boards to set the structures that are necessary to ensure community hospitals can make the transitional shift required by the new health care policy and work to sustain them at the heart of local health care. Community hospital services should be maximised to support step-down care from acute hospitals and offer locally based access to services.

While it is important to focus on the needs of the most frail older people in our communities, it is also important to promote independence for older people who are well. Local authorities and health professionals working with older adults should encourage physical activity programmes specifically targeting older people. The links between physical and mental health are well known, and older people who are physically active are more likely to remain physically and mentally healthy.

People with long-term conditions

Long-term conditions are those that require ongoing health care, limit what people can do and are likely to last longer than one year. They include physical and mental illnesses, learning disabilities and other conditions.

Long-term conditions place a huge burden on NHS resources. People with long-term conditions are more likely to visit their GP and outpatient departments, be admitted to hospital and to remain in hospital longer (Royal College of Surgeons, 2004). The World Health Organisation has acknowledged that by the year 2020, long-term conditions will be the leading cause of disability and the most expensive problem for health care systems, if not successfully managed.

Incidence increases with age, and many older people are likely to be living with more than one long-term condition. Usually there is no cure for the condition, but much can be done to maintain and improve quality of life. A key aim of rehabilitation for people with long-term conditions is to equip them with skills, knowledge and support to self manage wherever possible in a way that enables them to participate fully in their communities, with timely access to appropriate professional interventions when required. This is an important element in the Scottish Executive's strategy to manage long-term conditions.

Enabling people who have long-term conditions to take greater control of their treatment with support from health care professionals in the community improves their quality and length of life, reduces emergency admissions to hospital and releases inpatient capacity (King's Fund, 2004).

Three levels of care have been identified in the management of long-term conditions.

- For the small number of people with the most complex needs, the aim is to offer ***case management,*** often in the form of ***community or specialist nursing,*** but also capable of being provided by a variety of multi-disciplinary team members. These patients are most likely to be admitted to hospital or become ill unless their needs are anticipated and addressed.
- People with less complex needs are offered ***disease management*** support through ***multi-disciplinary primary care teams*** with specialist intervention as appropriate.
- For the majority of people with long-term conditions, ***self-care*** has been shown to be effective in improving quality of life and promoting appropriate use of services.

People returning from work absence and aiming to stay in employment (vocational rehabilitation)

Vocational rehabilitation is a therapy-led process designed to enable people with functional, psychological, developmental, cognitive and emotional impairments or other health conditions to overcome barriers to accessing, maintaining or returning to employment or other useful occupation. It is usually delivered by occupational therapists and physiotherapists working with multi-disciplinary colleagues.

While vocational rehabilitation is relatively new to the UK, it has been extensively developed and evaluated in countries such as Australia, Canada and the US, and is now beginning to emerge as a priority for service development in Scotland and the rest of the UK.

It is estimated that the working-age population in the UK will decrease by around 8% between 2002 and 2027. This will have major implications for the productivity of the Scottish economy (both public and private sectors).

The Health and Safety Executive (HSE) reports that over two million workers in the UK are suffering from an illness believed to be caused or exacerbated by their current or previous work. Around 40 million working days are lost each year due to occupational ill health and injury. The CBI estimates that sickness/absence costs the UK economy around £12 billion each year; this equates to £1 billion for Scotland, or around £800 per worker per year.

UK data from the Department for Work and Pensions show that:

- one million people report sick each week
- 2.6 million people are on incapacity benefit (IB)
- nearly 40% of IB claimants report mental health problems
- 30% report musculo-skeletal problems.

The number of incapacity benefits claimants more than trebled between the late 1970s and the mid-1990s. Although most people coming onto benefit expect to get back to work, a very large number never do; an individual is very unlikely to return to the workplace after two years on incapacity benefit.

It is important to prevent the flow of people onto benefits as a result of illness or injury while in employment. By raising awareness of the advantages of rehabilitation among health professionals, employers and employees, many more people can be assisted to remain in work while recovering from or coming to terms with their condition.

Innovations such as the New Deal for Disabled People and Pathways to Work show that, with the right help, support and vocational rehabilitation, many people on incapacity benefits can move back into the workplace. Research has identified features of vocational rehabilitation that are valued by people, including:

- active case management, which empowers clients to take action
- early intervention
- operation across professional and multi-agency boundaries
- interventions such as psychological therapies, referrals to specialists, surgical interventions and complementary therapies, which act to boost strength, mobility, cognition, confidence and mental and emotional well-being.

Studies also support initiatives that:

- enhance the vocational rehabilitation advice available to employers
- encourage health professionals to focus on and manage returns to work
- enhance vocational rehabilitation training for health professionals
- develop vocational rehabilitation services within the NHS.

Vocational rehabilitation is well placed to help meet the stipulations of the Welfare Reform Bill published on 4 July 2006. Some of the key messages in the Bill relate to the need to:

- reduce the number of people who leave the workplace due to illness
- increase the number of individuals leaving benefits
- better address the needs of those who remain on benefits, with additional payments to the most severely disabled people.

This section and the one that preceded it have outlined the key messages from* Delivering For Health *and* Changing Lives *and the important role rehabilitation plays in the delivery of the new health and social care agenda for all three client groups identified. The next two sections develop and present recommendations for future rehabilitation models.

4. Moving to action

The key messages emerging from our consultation in relation to older people, people with long-term conditions and those who access vocational rehabilitation services consistently focused on the need for:

- easy and quick access to rehabilitation services
- local service provision
- effective communication, engagement and emotional support
- supportive partnerships between service users and professionals
- opportunities to participate, awareness their choices and options and involvement in decision making
- clear, comprehensive information about local services
- support to enable self care
- involvement of, and support for, family and carers
- continuity of care and smooth transitions.

These key points subsequently underpinned a set of six statements developed by the Chief Health Professions Officer and National Project Officer which were endorsed as important themes to take forward at a consensus event with health and social care practitioners. The statements are set out below.

1. Rehabilitation services should be more accessible to those who use services, including direct access when essential.
2. Rehabilitation services need to be provided locally, with a strong community focus.
3. A systematic approach to delivering rehabilitation to individuals is required, promoting independence and self management.
4. Rehabilitation services should be comprehensive and evidence based, should reflect patient needs at distinct phases of care, and should identify models to ensure seamless transitions.
5. Practitioners and providers in health and social care need to be better informed about current and evolving roles and expertise within rehabilitation teams.
6. Health and social care professionals need to critically review staff resource deployment through service re-design and skill-mix review.

Service users and health and social care professionals also recognised the need for strategic co-ordination of rehabilitation services to drive necessary changes across boundaries.

The next section addresses the six themes listed above, outlining recommendations for action. Many are relevant for all three identified groups, but specific issues relating to particular groups are listed separately.

5. Recommendations for action

The recommendations have been devised following a process of consultation which involved:

- a thematic analysis of the evidence by the Scottish School of Primary Care
- a series of consultation events with those who use services
- a consensus event with health and social care professionals.

They are presented here for comment and approval.

In developing the recommendations, it was important to consider the role of community health partnerships (CHPs), bearing in mind that CHPs will continue to ***develop services according to local need and priority***.

In the 'key messages' section at the beginning of this document, CHPs are highlighted as playing a key role in planning and providing NHS and related services for people requiring rehabilitation in local communities . CHPs are a central focus of the vision set out in ***Delivering for Health***. They are local service delivery mechanisms through which health improvement and shifts in the balance of care will be delivered by the NHS, local authorities and the voluntary sector, with greater involvement of service users, carers, staff and independent contractors.

CHPs are fully involved in local NHS strategic planning, priority setting, decision making and resource allocation and play a lead role in wider community planning processes led by local authorities. They have delegated responsibility for all primary and community based services, including joint health and social care services, community hospitals and resource centres.

Synergies with the broader work being taken forward by CHPs to improve health and care services and health outcomes locally should be taken into account when considering the proposed recommendations. It should be noted that CHPs are already identifying specific and measurable service improvements, ***according to local needs***, in the following areas:

- easing access to primary care services
- taking a systematic approach to long-term conditions
- providing anticipatory care
- supporting people at home
- avoiding hospital admissions
- identifying opportunities for more local diagnosis and treatment
- enabling appropriate discharge and rehabilitation
- improving health and tackling inequalities
- improving specific health outcomes.

1. Access

Service users consistently highlighted the importance of rehabilitation support received in specialist/hospital-based services. Challenges were perceived to relate to accessing rehabilitation services in the community or accessing specialist services once discharged, and service users felt uncomfortable about the time-limited nature of some services.

Improving access to services requires innovative and novel systems being incorporated into practice. Many rehabilitation and specialist services are already looking at referral criteria and access issues, building on existing good practice.

Views of users of the service

- Individuals should have better access to rehabilitation without always having to use the GP as gatekeeper to services.
- There should be one point of contact in the community – a key worker/rehabilitation co-ordinator.
- Services should be flexible to the needs of the individual, rather than being time limited by the needs of services.
- Better hospital and public transport is needed in community settings to enable people to access rehabilitation services.
- Better information and support should be offered following diagnosis.
- Better communication and referral processes are needed among professionals.
- Services should be better advertised and relevant information should be available.
- More drop-in services are required.
- An NHS 24-type telephone helpline service should be set up to support people requiring rehabilitation advice and support.
- Transitions of care between primary and secondary care services and social care need to be managed better, breaking down historic boundaries that stifle innovative, co-ordinated approaches to care delivery.

Access - recommendations

Rehabilitation services should be more accessible to those who use services, including direct access when essential.

1.1 NHS systems, particularly CHPs, working in partnership with local authorities, should enhance access for individuals requiring uni-professional and multi-professional rehabilitation, including exploring a single point of access to services.

1.2 NHS 24's functions as a resource for rehabilitation advice and triage should be explored, as should 'interfaced services'.

1.3 Health and social care providers should address transitions of care for older people and those with long-term conditions, particularly in relation to discharge from hospital or specialist rehabilitation services.

1.4 NHS systems should consider the introduction of direct access to rehabilitation services provided by individual AHP professionals, building on the success achieved in Scotland-wide initiatives in physiotherapy and as part of an integrated care pathway.

1.5 NHS systems and local authorities providing services in remote and rural areas should consider how specialised and general rehabilitation services can be provided equitably, taking into consideration the development of new and existing roles and the use of technology.

1.6 NHS systems and local authorities should work in partnership to facilitate the development of suitable local transport and local facilities to reflect the needs of a community focused approach to rehabilitation and self help/enablement services.

1.7 NHS systems and local authorities need to work in partnership, building on existing innovations and developments to enhance opportunities for older people to keep fit and active. They should recognise the health gain and social engagement benefits of using mainstream leisure facilities and voluntary services and the impact this may have in avoiding future health and social care challenges.

1.8 NHS systems and local authorities need to work in partnership to become exemplar employers, building on existing achievements in the creation of healthy workplaces and expanding vocational/rehabilitation services linked to occupational health services to support employees to return to work after ill health or injury.

1.9 Scottish Executive and the Department for Work and Pensions should work to expand existing models and develop new models of vocational rehabilitation and condition management programmes for those receiving incapacity benefit.

1.10 The Scottish Executive Health Department should develop guidance on the establishment of models of early intervention for individuals with long-term conditions which result in absence from work, building on existing achievements through the successful ‘Pathways to Work’ pilots.

Models of good practice

We are aware of services currently providing direct and single point of access for users of the service. There are also services providing web-based access and information to services. We are keen to have further examples for this Framework.
Further examples of good practice in your areas should be sent to us using the 'contact us' section on: www.rehabilitationframework.scot.nhs.uk.

2. Local service provision

One of the key messages from ***Delivering for Health*** is to bring services closer to communities and for individuals to have more choice and input into where they are treated. A clear message from the consensus events was the desire of users of the service to be able to utilise local amenities to better effect. This has been tested out in a number of areas across Scotland, with health and social care providers looking to make use of existing mainstream facilities to enhance access and expand service provision for these key groups.

Views of users of the service

- Services should be provided locally, but not necessarily at home.
- Local amenities should be used – there should be engagement with local authorities.
- Therapy-led rehabilitation centres should be established in communities.
- The provision of multi-disciplinary teams providing rehabilitation for patients at home should be expanded.
- Better links are required between specialist rehabilitation services and community services.

Local service provision - recommendations

Rehabilitation services need to be provided locally with a strong community focus.

2.1 NHS systems, particularly CHPs, and local authorities should use community planning processes to explore how rehabilitation and integrated/intermediate care services can be developed to meet the needs of the growing proportion of older people in the population and those with specialist rehabilitation needs.

2.2 NHS systems, particularly CHPs, and local authorities should explore how anticipatory care and rehabilitation services can be focused on 'at-risk' individuals to provide early interventions, prevent unnecessary admissions to hospital or care facilities and facilitate smooth transitions from hospital or specialist services.

2.3 NHS systems, particularly CHPs, and local authorities should work in partnership to explore the provision of rehabilitation and self-care/enablement services in non-traditional local settings such as community centres and leisure services accommodation.

2.4 NHS systems and local authorities should work in partnership to explore the co-locations of health, local authority and voluntary services to enhance accessibility and facilitate multi-agency team working.

Models of good practice

We are aware of services working in a multi-agency environment, co-locating premises and providing rehabilitation close to communities. We are keen to have further examples.

Further examples of good practice in your areas should be sent to us using the 'contact us' section on: www.rehabilitationframework.scot.nhs.uk.

3. Enablement and self-managed care

Delivering for Health recognises the need for a more systematic approach to care for people with long-term conditions. Service users also identified the key role they play as active participants in their own rehabilitation and overall progress.

Individuals and health and social care practitioners within rehabilitation teams should therefore work to enable people who have long-term conditions to take greater control of their own condition management with focused rehabilitation goals.

Views of users of the service

- Good communication channels are needed to ensure the patient feels included in the management of their care.
- Volunteer and special interest/support groups should have greater involvement in designing, delivering and evaluating services.
- Professionals need greater awareness of service users' knowledge of their own condition and how it should best be managed.
- The benefits of 'buddy systems' for those with long-term conditions should be explored.
- More flexible systems should be in place to support people to get back to work following illness or injury.

Enablement and self-managed care - recommendations

A systematic approach to delivering rehabilitation to individuals is required, promoting independence and self management.

3.1 The Scottish Executive Health Department should work with NHS Scotland and the Long-Term Conditions Alliance for Scotland to support the development of new models of self-managed care using the CHP Long-Term Conditions (LTC) Toolkit as a vehicle for local implementation.

3.2 NHS systems and local authorities need to explore how communication and information sharing can be improved to enhance the patient/service user journey within legislative constraints such as the Data Protection Act, Human Rights Act and the Common Law of Confidentiality. This should include the use of shared assessment and, where possible, computerised records.

3.3 All staff working with people with long-term conditions and rehabilitation needs should strive to enhance and support their ability to self care avoiding unnecessary professional interventions.

3.4 NHS systems and local authorities should work in partnership to build on existing achievements in physical activity and diet for all target groups – especially children and young people.

3.5 NHS systems and local authorities should build on existing good partnership working with the voluntary sector to develop accessible information for users on self-care support and rehabilitation services available in local areas.

Models of good practice
We are aware of innovative developments that have focused on empowering service users to support their own health and well-being through using mainstream leisure services. We are keen to have further examples.

Further examples of good practice in your areas should be sent to us using the 'contact us' section on: www.rehabilitationframework.scot.nhs.uk.

4. Comprehensive and evidence-based services

Throughout the consultation, there was a clear message from service users and professionals that comprehensive specialist rehabilitation, often hospital based, played an important role in helping individuals attain their immediate rehabilitation goals. Challenges often became apparent following discharge, when access to previous rehabilitation expertise was less likely to be available.

Transitions between hospital and home and between services were highlighted as being stressful and were often difficult for individuals to navigate. There was a strong feeling that a rehabilitation key worker/co-ordinator could ensure seamless transitions and facilitate ongoing rehabilitation requirements.

Views of users of the service

- Ongoing rehabilitation needs should be met following discharge from hospital.
- The potential benefits of a key worker/rehabilitation co-ordinator role in facilitating transitions and ongoing rehabilitation should be explored.
- Services provided should be evidence based and consistent with best practice, where possible.
- Good communication among professionals is necessary to achieve comprehensive services.

Comprehensive and evidence-based services - recommendations

A comprehensive evidence based rehabilitation service needs to cater for the distinct phases of care and identify models to enable seamless transitions.

4.1 NHS systems, particularly through CHPs, and local authorities need to work towards a whole-systems approach to the provision of rehabilitation services, linking together early intervention/rapid response services with community rehabilitation teams, specialist rehabilitation and nurse/therapist-led units, community hospitals and integrated/intermediate care to provide seamless transitions of care.

4.1b Consideration should be given to the co-ordination of rehabilitation for individuals who use services and the introduction of key workers/rehabilitation coordinators to underpin this approach and improve the patient/service users experience of transition.

4.2 Rehabilitation and integrated/intermediate care services should explore the impact of service provision from the patient/service user's perspective and make better use of information gathered using standardised assessment tools to enhance the evidence base.

4.3 Scottish Executive Health Department, in partnership with NHS Education for Scotland, NHS Quality Improvement Scotland and the Social Work Inspection Agency, should explore the potential for a Managed Knowledge Network for Rehabilitation.

4.4 Health and social care professionals should work in clinical collaboration with the Research Consortia and other stakeholders to build upon the growing body of evidence.

Models of good practice
We have a range of examples of comprehensive, evidence-based services.

Further examples of good practice in your areas should be sent to us using the 'contact us' section on: www.rehabilitationframework.scot.nhs.uk.

5. Sustainable multi-professional teams

The success of service redesign and the ***Delivering for Health*** agenda will to a large extent be determined by how effectively health care workers work together in teams - communicating with each other, planning jointly and adopting a teamwork ethos that places patients, families and carers at the centre of service planning, delivery and evaluation.

There is a clear need for team members to have a better understanding of each others' professional roles, which will lead to better sharing of information and reduced instances of contradictory advice being offered to service users. The message was clear that professionals and support staff need to enhance service continuity across boundaries in partnership with service users and carers.

Views of users of the service

- More joint training is required to improve knowledge of what professionals within the team can offer and where services can be offered.
- Improved skill mix is needed within teams.

Sustainable multi-professional teams - recommendations

Practitioners and providers in health and social care need to be better informed about current and evolving roles and expertise within rehabilitation services.

5.1 Health and social care practitioners involved in the development and delivery of rehabilitation need to work with colleagues to: (a) clarify roles and care competencies; (b) work flexibly to meet the needs of service users; (c) share skills with team members to enhance team efficiency; (d) develop capable and confident support staff to work across boundaries and release capacity of professionals.

5.2 NES, in partnership with NHS systems, local authorities and higher education/further education institutions, needs to support the development of undergraduate and postgraduate education and training for health and social care practitioners to underpin effective multi-professional team working and facilitate self care/enablement approaches within health and social care.

Models of good practice
We have examples of role developments within multi-disciplinary teams.

Further examples of good practice in your areas should be sent to us using the 'contact us' section on: www.rehabilitationframework.scot.nhs.uk.

6. Capacity

The growing demand for rehabilitation services requires health and social care professionals to look at new and innovative ways of utilising their expertise. Users of services are open to a variety of models, including new roles and, in particular, ideas for better co-ordination and support to enable them to navigate and access services that are already available – including self-help and voluntary/support groups.

All health and social care professionals involved in developing or delivering rehabilitation services should therefore look beyond traditional methods of providing services and engage in service redesign and role development in partnership with users of the service. This will enable them to create new models of service that reach across historical professional and service boundaries.

Views of users of the service

- The role of the key worker/rehabilitation co-ordinator should be utilised.
- More local community workers are needed.
- More imaginative use of resources is required.

Capacity - recommendations

Health and social care professionals need to critically review the use of the current staff resource through service re-design and skill mix review

6.1 NHS systems and local authorities should build upon existing achievements through Joint Future and Joint Funding to explore flexible use of staff and resources. They should also look to enhance outcomes for patients and their carers through redesign of services underpinned by the patient pathway, promoting best practice in integrated services across health and social care.

6.2 AHPs with rehabilitation expertise should work in partnership with medical, nursing and social work colleagues to expand on new ways of working, including therapist/nurse and social worker leadership and key worker/co-ordinator roles where this will enhance patient/service user outcomes and experience and team working.

6.3 Rehabilitation teams with crossover functions should consider how they could improve continuity of care, eliminate duplication of work and enhance the patient's experience of transitions through, for example, in-reach/outreach rehabilitation across community hospitals and early intervention/discharge teams.

Models of good practice
We have good examples of how role development initiatives are increasing capacity in rehabilitation services.

Further examples of good practice in your areas should be sent to us using the 'contact us' section on: www.rehabilitationframework.scot.nhs.uk.