Neurorehabilitation Workshop

NNAG event write up

March 2018

Document control

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Date	March 2018

Contents

The Strategy Unit, hosted by Midlands and Lancashire CSU, has been employed by the Neurological Alliance to provide programme management for the National Neuro Advisory Group. This document has been produced as part of this package of work. Please direct any queries to Lucy Hawkins, Senior Consultant, lucy.hawkins4@nhs.net. More examples of The Strategy Unit's work can be found at strategyunitwm.nhs.uk/ .

1. Event description

The National Neuro Advisory Group (NNAG) exists to seek alignment between programmes in NHS England, the Department of Health's Arm's Length Bodies and system partners, such as charities relevant to people with neurological conditions, and to guide the strategic development of work to improve outcomes for people living with neurological conditions. One of the aims of NNAG is to bring together all the different professionals that need to work together to achieve improvement in neurology services including clinicians, patients, commissioners and academics.

As part of the NNAG's wider scheme of work several condition specific groups have been identified to lead the development of pathways to complement the revised neurosciences specification.

These groups have been identified by conditions that share similar challenges in ensuring access and equity of care, as well as where pathways between services could be improved. The groups are as follows:

- Neuromuscular
- Headache and Migraine
- Epilepsy
- Neurorehabilitation
- Parkinson's, Dementia and Psychiatry

A number of workshops have been established by these groups in order to facilitate the improvement of services nationally through the sharing of good practice and identification of areas where more work is needed. Different models of care will work in different parts of the country but equity in the standard of care is the goal.

This report concerns itself with the second of these workshops that focused on Neurorehabilitation and was held on the 13th March 2018. It summarises each of the presentations, including the challenges identified and solutions already in place, as well as analysis of feedback given during the working groups and via feedback forms, identifying the key actions to be taken forward.

The Presentations have been kindly made available by the speakers and may be used support the further exploration of the themes and outcomes of the day.

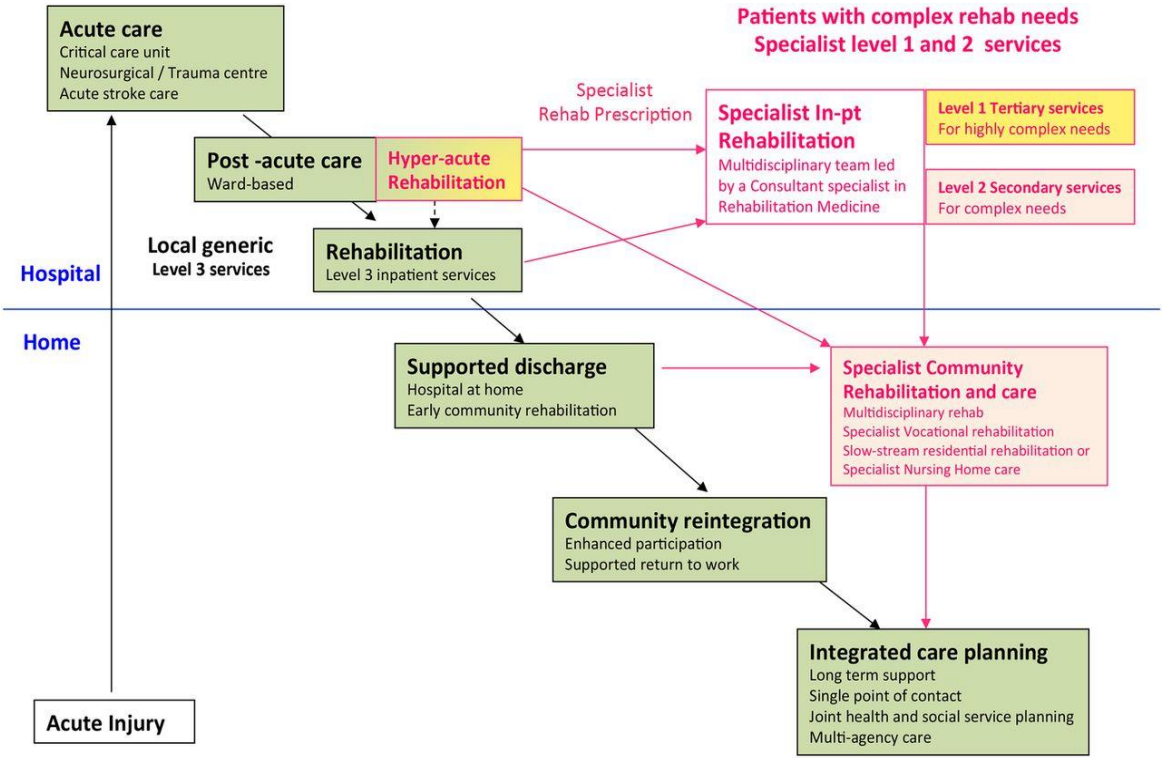
2. What is Rehabilitation?

The NHS England (2016, p.5.)[1] Commissioning Guidance for Rehabilitation describes rehabilitation as *"a philosophy of care that helps to ensure people are included in their communities, employment and education rather than being isolated from the mainstream and pushed through a system with ever-dwindling hopes of leading a fulfilling life."* The aim of rehabilitation is to equip people to live their lives to their maximum potential.

The NHSE Standard Contract for Specialist Rehabilitation defines 3 different levels (1-3) of rehabilitation services and four categories of patient needs (A-D)[2]:

- Level 1 – Tertiary specialised services, hold a regional role serving category A patients (most complex) requiring specialist rehabilitation facilities.
- Level 2 – Local specialist services, led by rehabilitation medicine consultants at a district level serving category B patients.
- Level 3 – Non-specialist services, serving category C and D patients (least complex) providing local general rehabilitation.

The rehabilitation pathway following major illness or injury is shown below[3].



[1] https://www.england.nhs.uk/wp-content/uploads/2016/04/rehabilitation-comms-guid-16-17.pdf
[2] https://www.england.nhs.uk/wp-content/uploads/2014/04/d02-rehab-pat-high-needs-0414.pdf
[3] http://bmjopen.bmj.com/content/6/9/e012112?utm_source=trendmd&utm_medium=cpc&utm_campaign=bmjopen&trendmd-shared=1&utm_content=Journalcontent&utm_term=TrendMDPhase4

Within neurology the remit of rehabilitation services covers both long term neurological conditions such as; stroke, epilepsy, Parkinson's disease, MS, and cerebral palsy. As well as conditions that result from disease, injury or damage to the body's nervous system, that will affect the individual and their family for the rest of their life.

3. Summary of presentations

This section summarises the presentations from the day and key discussions following each. Please read the following summaries in conjunction with the corresponding slide pack.

3.1 A brief history of rehabilitation in the NHS *Dr Derrick Wade*

Dr Wade began the day by suggesting that in planning the future of rehabilitation services we need an understanding of the past. He described how the story of rehabilitation in the NHS has been one of disintegration. How when the NHS was created, rehabilitation, apart from spinal cord injury, was fully integrated into services and known as convalescence.

Then in 1988 rehabilitation was created as its own specialty, this is believed to have led to a perception amongst the medical profession of super-specialisation, a service only for the few and one that was unrelated to other services. The result of this is that the current state of rehabilitation is one of fragmentation, with services being accessed in series rather than as part of a whole care package.

Dr Wade suggested that the reason for this perception is that the health system still works in a model that is over 350 years old, the biomedical (surgical) model, which focuses on treating disease but doesn't consider the person and their wider context. He illustrated this in that NHS funding is based on single disease diagnosis and the assumption that there is a single appropriate treatment, which is conducted by a single consultant or team.

He went on to emphasise that in rehabilitation it is important to look at illness as a whole, rather than just the disease. And, that rehabilitation should address the subjective experience of being unwell in addition to the underlying condition.

He suggested that to improve services, rehabilitation services should apply the biopsychosocial model[4]. Applied in a healthcare setting, the biopsychosocial model would mean an individual at any time is able to access;

1) someone to look at their disease,
2) a team looking at their emotion and beliefs,
3) a team looking at activities and rehabilitation.

[4] Wade DT and Halligan PW, the biopsychosocial model of illness: a model whose time has come. Clinical Rehabilitation 2017; 31: 995-1004. https://doi.org/10.1177/0269215517709890

An individual would access services in parallel rather than series which prevents long waits between. Dr Wade demonstrated how this model puts the patient at the centre and ensures understanding of all factors influencing recovery, hence avoiding treatment of the wrong factors.

He concluded by saying that this solution would need to be driven by the funding organisation and, as many factors are outside the control of the NHS, collaboration is essential to make it work.

3.2 Does rehabilitation work and do we do it properly in the UK? *Professor Lynne Turner-Stokes*

Professor Turner-Stokes began by giving an overview of rehabilitation pathways and levels of service as defined by the NHSE Standard Contract for Specialist Rehabilitation, this has been included in Section 2.

She sought to address three key myths around rehabilitation:

1) That there is no evidence rehabilitation works
2) That rehabilitation is done better elsewhere e.g. the US and Australia
3) That the NHS can't afford to offer rehabilitation services

By focusing on specialist inpatient services, she demonstrated that there is a strong body of evidence for the benefits of rehabilitation, including Cochrane systematic reviews of randomised trials and real-life evidence from long term cohort studies. She explained how the evidence shows that specialist rehabilitation improves functional independence and hence reduces the burden on carers, as well as improving rates of return to work and productivity for those who are able. In addition to this she demonstrated the cost effectiveness of rehabilitation in both the US and UK.

The evidence base used was the UK Rehabilitation Outcomes Collaborative (UKROC). UKROC holds the national clinical database for specialist rehabilitation, including data on rehabilitation needs, nursing, therapy and medical hours, as well as patient outcomes. UKROC is also the national commissioning database for NHS England, enabling benchmarking on quality, outcomes and cost-efficiency.

Professor Turner-Stokes explained how, as the primary aim for rehabilitation programmes is to restore independence, success is measured through the functional independence measure (FIM) and the functional assessment measure (FAM). She illustrated how measures of cost efficiency in rehabilitation are calculated by measuring change in FIM over length of stay. And that, due to the 'floor and ceiling' effects of this method, other tools such as changes in FAM are also used, particularly to compare outcomes for patients with complex physical disabilities and those in cognitive behavioural programmes.

She concluded by showing that data held by UKROC demonstrates significant savings and cost efficiency across all groups of patients, but particularly those with high dependency. She demonstrated how the costs of rehabilitation are offset by the reduction in on-going care costs and can therefore provide significant benefits to both health and social care.

Discussions following the presentation centred around the impact on the cohort of patients if there is no rehabilitation intervention or if intervention is delayed. Professor Turner-Stokes explained that in the case of complex patients if there is no intervention the data shows that they deteriorate further hence increasing care costs.

3.3 A father's story
Mr Andy Dunnett

The next presentation was from Andy Dunnett, Andy is the father and carer of MJ and he explained their experience of rehabilitation services. MJ is 32 and suffers from Walker Warburg syndrome, he is blind, suffers from seizures and has no body control, he is on CPAP and is wheelchair bound. He is cared for by his family and a small community of people around him.

Andy explained how the family's experience of transition from paediatric to adult services felt like falling off a cliff, they felt that the levels of support changed over-night and he said that it was a constant battle to establish the basics. The family felt that they were caught up in inter-agency debates and had no access to key support. He described how they knew what MJ needed but had to push for it and were often asking the question "Why does it feel like the least qualified person is leading the debate?"

He went on to say that they have now come through that and there are positives. MJ is in good health and is not regressing. He said that access to services is still a challenge, but they know who to call to help, and professionals they are supported by have also been flexible in the timing of appointments which has helped the family immensely.

Despite this, they feel that challenges remain. Particularly constant review activity and resulting tensions between agencies and providers. He said that MJ has had 8 reviews in 12 months and each review involves a debate about what is needed and who is paying. There are also debates around medication and supply and reasonable access to the support and services needed.

Andy explained that he could see similarities between his area of work and the NHS, he said that both were large organisations with dedicated staff but were trapped by years of continuous repeat behaviour which were considered as inefficient, expensive and wasteful processes.

He concluded with some key questions from a father to professionals and policy makers:

- Does the patient remain at the heart of the decision-making process?
- Due to social and economic pressure have we moved away from the patient centric model?
- Could more be done to co-ordinate between agencies and departments?

3.4 GIRFT Methodology – Will it work in Rehab?

Professor Tim Briggs

Professor Briggs described how Getting It Right First Time (GIRFT) started life at the Royal National Orthopaedic Hospital and the successes and developments seen by the programme so far.

GIRFT was piloted as a peer to peer review of orthopaedic surgery services with supporting datasets creating a report that put patients at the front of the queue to improve quality and outcomes. The pilot highlighted huge areas of variation but also a lot of scope to tackle this variation.

He went on to show that the successes so far in Orthopaedics have been a reduction in inappropriate surgery, a reduction in total knee replacement outliers and a reduction in legal claims. These have totalled £150 million in cost benefits nationally.

Due to these successes GIRFT has since received wider investment and is now undertaking 29 workstreams with a further 6 due to kick off by the end of March 2018. Its core elements are a data warehouse, which enables trusts to compare data, and a team of clinicians who are committed to driving changes forward.

Professor Briggs explained that GIRFT is breaking down barriers, it is identifying cross cutting themes and facilitating people working together. This is done by implementation teams operating across 7 regional hubs which provide a management structure to facilitate changes and support clinicians to working together in teams. There are currently 46 clinical leads across the workstreams driving forward changes.

He believes that the GIRFT methodology could be applied to rehabilitation, however, it would need clinical leads to be identified. If implemented in rehabilitation GIRFT could enable improvement across the board, demonstrate cost effectiveness, and aid in breaking down the barriers between specialised commissioning and CCG's.

3.5 The Rehabilitation Prescription – Where are we going? *Colonel Alan Mistlin*

Col. Mistlin presented on work currently being done on the Rehabilitation prescription which will form part of the best practice tariff for Major Trauma from April 2019, the Major Trauma CRG commissioned a working group to drive this work forward.

He explained that the aim of the rehabilitation prescription is to improve communication along the patient pathway and ensure that patients are accessing the services that they need. Inclusion in the best practice tariff will also mandate data collection which will be held by the Trauma Audit and Research Network. Analysis of this data will be used to highlight deficiencies in rehab services, and data collected will also be linked into UKROC.

The minimum information that will need to be included on the rehabilitation prescription includes employment pre-accident and a rehabilitation needs checklist.

Discussion on the rehabilitation prescription focused on the patient perspective, there was concern that the prescription would still be very clinical and therefore miss the patient view. A suggestion to resolve this was to add a comment box for patients to add their thoughts regarding the care they need.

Discussions also recognised that as it is not always clear what rehab services a patient will need at the start of their pathway the prescription should be flexible and adapted as and when required.

It should be noted that the use of the rehabilitation prescription will only be mandated for patients on the trauma pathway, however use for patients on other pathways is encouraged.

3.6 The obstacles therapists face *Michelle Kudhail*

Michelle Kudhail is a physiotherapist with 25 years of experience working in neurological rehabilitation and is currently Director of Clinical Services at Badby Park Care Home in Daventry. She presented a therapists' view to the challenges in neurorehabilitation developed through discussion with therapy colleagues from across the country and throughout the rehab pathway.

Therapists work in Neurorehabilitation along all parts of the pathway including acute rehabilitation, critical care, community rehabilitation, long term care, specialised rehabilitation and neurotrauma. The challenges that therapists face can vary, but exist, at each stage along the pathway.

She explained that key challenges and variations regionally are linked to: access to services, which vary based on location and professional relationships; variability of community provision and

access; differing waiting times according to facilities and the teams available; as well as access to inpatient beds and specialised rehabilitation.

She went on to say that common themes for therapists nationally are the increased amount of time spent with 'issue management' such as financial, social, family, and safeguarding concerns. The provision of equipment out of hospital and who is paying for that equipment. The sharing or passing on of information between teams coupled with a bumpy transition for patients along the pathway. Long waits for inpatient beds or community packages, and a shortage of suitable discharge destinations.

These challenges are coupled with a changing professional structure among therapists with the development of advanced clinical practitioner roles, senior staff undertaking more advisory roles and the downgrading of positions when senior staff leave. She explained that there is also a change in the demographics of students in training, due to the need for students to fund their own degrees there are fewer mature students coming through the system and students are coming through with higher expectations in their degree and job prospects which is having an impact on recruitment and retention.

She concluded by suggesting some considerations to address these challenges moving forward. Suggestions included: the building of an evidence base for therapeutic effectiveness, increasing the knowledge base of therapists outside of specialist services, and the diversification of the skills amongst therapists including respiratory, mental capacity act decisions and family liaison.

3.7 Changing the face of Rehabilitation – is there political will? *Lord Philip Hunt*

Lord Hunt began by presenting the current state of the NHS. He demonstrated how the NHS is under increasing pressure, the proportion of older people is increasing, and we have seen a growth in emergency admissions particularly in the older population as well as a rise in avoidable admissions. Despite this the UK health spending per head is markedly lower than France, Germany and Sweden.

He went on to further illustrate how funding in real terms and proportion of GDP spending on healthcare has decreased. This leads to questions as to whether the Health Service is sustainable, long term.

In the short term this picture will not change, funding will continue to be tight and service pressures will continue to be relentless. We see that key NHS performance targets are being missed and therefore service redesign is imperative.

However, Lord Hunt suggested that this may provide an opportunity for rehabilitation as prevention and reduction in demand for health services is high on the agenda. He highlighted the

point that there are economic benefits of commissioning rehabilitation services. These include employment benefits, reduced cost of nursing, reduction in need to residential and nursing care, reduction in risk of falls, reduction in costs by integrating physical and mental health care, reduction in length of stay costs.

Referring to the key themes of the Sustainability and Transformation Partnerships around redesigning primary care and community services, strengthening prevention and early intervention, creating centralisation of acute services and improving mental health, he suggested that rehabilitation can indeed make a major contribution. In order to do so, however, the profile of rehabilitation needs raising both nationally and locally.

He concluded by suggesting that alliances need to be built between organisations to lobby STP's, local authorities, NHS England, Ministers and parliament. And that a plan needs to be built around a business case that demonstrates the need for upfront funding but will enable downstream improvements. He finished by saying that the evidence is there but the case needs to be properly compiled and promoted.

3.8 Neurorehabilitation the Greater Manchester experience *Dr Krystyna Walton*

Dr Walton presented the developments in Neurorehabilitation services in Greater Manchester. She began by explaining that these changes have been 20 years in the making and have been driven by variation in service eligibility criteria, variation in provision, lack of access to hyper acute/acute services from DGH beds outside of Salford, and long waits to access all services.

She explained that the case for change was inadequate, inequitable and disjointed patient flow, with particular issues for patients with tracheostomy, prolonged disorders of consciousness, severe challenging behaviour, and patients with slow stream rehabilitation needs. In addition to the impact on patients and their families which was long waits in the wrong bed with a lot of uncertainty.

She went on to say that since 2015 there has been significant progress. There is wide clinical engagement across the Neurorehab operational delivery network (ODN), patients and carers have also been involved in service design standards and they have been consulted and agreed on the proposed model of care and patient information standards, there has been a reduction in length of stay in post-acute units and standards have been agreed for assessment/admission, goal planning and setting estimated discharge dates.

Greater Manchester Neurosciences Centre now have co-ordinated triage for rehabilitation complexity and need by a Neurorehab SpN. Referrals can be received from any healthcare professional and assessment is usually within 2 days, and if suitable patients are listed immediately.

Hyper acute and acute neurorehabilitation is on site and there is co-ordination of rehabilitation pathways with post-acute and community services.

There are also specialist outreach MDT's specifically for tracheostomy, spasticity and neuro-oncology rehabilitation, as well as weekly Neurorehab and Major Trauma Rehab patient flow meetings.

All major trauma patients are assessed for rehabilitation needs, all have a rehab prescription and no patients requiring specialist rehabilitation are repatriated to non-specialist rehab beds.

Despite these successes Dr Walton explained that there is still need for:

- Agreement for and implementation of a model that includes the reduction of beds
- A single point of access for Neurorehab referrals and assessments
- Agreement from CCG's to commission community Neurorehab.
- Network wide clinical governance, shared learning and higher quality consistent care.
- Improvement of the experience and care of patients with spinal cord injury who do not access the Spinal Intensive Care Unit in Southport.
- Evaluation of the enhanced outpatient rehabilitation for MSK major trauma patients (project has been funded for Manchester arena bomb patients)

She concluded by posing a key question for consideration:

"Shouldn't we be replicating Major Trauma rehabilitation processes for Neuroscience and Critical Care patients?"

This would cover managed pathways of care; pro-active assessments of rehabilitation need and use of the rehabilitation prescription.

3.9 What can the independent sector offer?

Professor Mike Barnes

Professor Barnes began his presentation by demonstrating the need for inpatient rehabilitation beds and the role that the independent sector plays in meeting this demand.

He showed that there are approximately 300,000 Acquired Brain Injury (ABI) admissions annually. To meet this demand for inpatient rehabilitation 14,600 beds are needed, however there are currently only 4,600 beds hence only meeting 31% of demand. He also showed that the supply gap is greater for level 2a, 2b and level 3 rehabilitation.

He then went on to illustrate that the NHS provides 1,400 of these beds and the independent sector provides the remaining 3.200. Of those 3,200 independent sector beds 1,800 are dedicated rehab beds and 1,400 are non-dedicated beds.

In addition to this the NHS has lost approximately 100 Neurorehab beds since 2013, in comparison the number of beds in the independent sector has increased by approximately 700.

He suggested that with increasing survival rates, and population increase, the demand for beds will continue to grow and the independent sector will continue to provide a proportion of those beds.

However, Professor Barnes also issued a plea to not sent people to nursing homes that are claiming to offer rehabilitation but really aren't. He introduced the Independent Neurorehabilitation Providers Alliance that has developed a set of criteria to ensure that centres are delivering at least the same standard of care as the NHS. They review centres based on the rehabilitation ethos of discharge planning, goal planning, outcome measurement, and an MDT of at least for different disciplines.

He concluded by suggesting that the independent sector offers flexibility and growth potential, it offers better integration and community step down, and it offers reduced costs in the medium and long term. He believes that it will continue to grow and continue to increase in proportion to the NHS and will be key in meeting future demand for beds.

Discussion following the presentation centred around the training of different professions and the independent sectors involvement, there was agreement that training of staff in the independent sector and integration of training between the independent sector and the NHS should be improved.

3.10 What do patients want?

Joe Korner

Joe Korner discussed how a systematic review of patient experience of community rehabilitation, and support services for patients with long term neurological conditions, reveals that patients want to be part of the decision-making process for their care and want to be able to self-manage their condition.

He suggested that patient experience data shows that patients want a diagnosis, they want to know what their condition means for them and they want to get better. They want to slow deterioration in their condition, they want to remain as independent as possible for as long as possible, they want to know what services and support they will need and they want those services to kick in at the right time, they want their care to be co-ordinated, and they want their carers to be supported.

He went on to say that after a stroke or major trauma, the rehabilitation pathway is relatively clear, however, that is not the same for other conditions. He explained that to access Neurorehab services after they have been discharged from hospital patients need a care plan, the National Audit Office (2015) report into services for people with neurological conditions and the

Neurological Alliance patient survey highlight that this is still an area where neurological services fall short.

He concluded by suggesting that further work needs to be done to ensure that patients know which services they need and are entitled to and at what stage they are going to get them.

3.11 What works in community based and vocational rehab? *Professor Diane Playford*

Professor Playford concluded the day by reviewing the remit and purpose of rehabilitation. She demonstrated that rehabilitation is about restoring social integration, and the components of social and community integration include: independence, sense of belonging, adjustment, having a place to live, being involved in a meaningful occupational activity and being socially connected into the community.

She went on to say that figures show that approximately 75% of people with acquired brain injury are of working age, however there is large variation in the number of people who return to work. She suggested that in a lot of cases there appears to be a reservation amongst healthcare professionals in talking about work and the benefits of it.

She then demonstrated that there is a significant cluster of vocational rehabilitation services in the south east with far fewer services available in the south west and northern regions of the country. In addition to this most vocational rehabilitation services treat an average of 10-20 patients each year, which is less than 10% of people with long term conditions. Service reviews show that VR teams are under resourced in terms of staff numbers, the range of disciplines and expertise, there is no consensus on how outcome data should be collected, and most VR is not provided by VR specialists but rather forms a component of existing services.

Professor Playford illustrated a 3-level model of vocational rehab support:

1) All patients who work or have potential to work
2) People with straightforward problems
3) People with complex problems

As well as guidance relating to joined up working between healthcare and social services, and provision of specialist community rehabilitation services for people with long term conditions, both emphasising social integration and that an adequate range of services should be offered by appropriately skilled staff. Despite these there is remarkably little written about different models of care and very little data collection.

She concluded by suggesting that there is still a lot of work to be done in vocational rehabilitation, core generic services need to be developed with specialist routes in and specialist routes out, there

needs to be agreement on what services look like and the staffing levels required to deliver these. And that in order to facilitate this work status needs to be recognised as a health outcome and a marker of comprehensive neurorehabilitation services.

4. Summary of feedback

During the day event attendees participated in focus group discussion in order to identify the top challenges for rehabilitation services (see Appendix 4). In addition to this, delegates were asked to individually feedback on what they believed the challenges and solutions to be (see Appendix 5). This section summarises the feedback received by common themes.

4.1 Focus Groups

Six different focus groups were convened to identify the top 5 challenges in rehab care today. Feedback from the facilitators identifies the following as the key challenges and therefore priorities for improvement in rehab services:

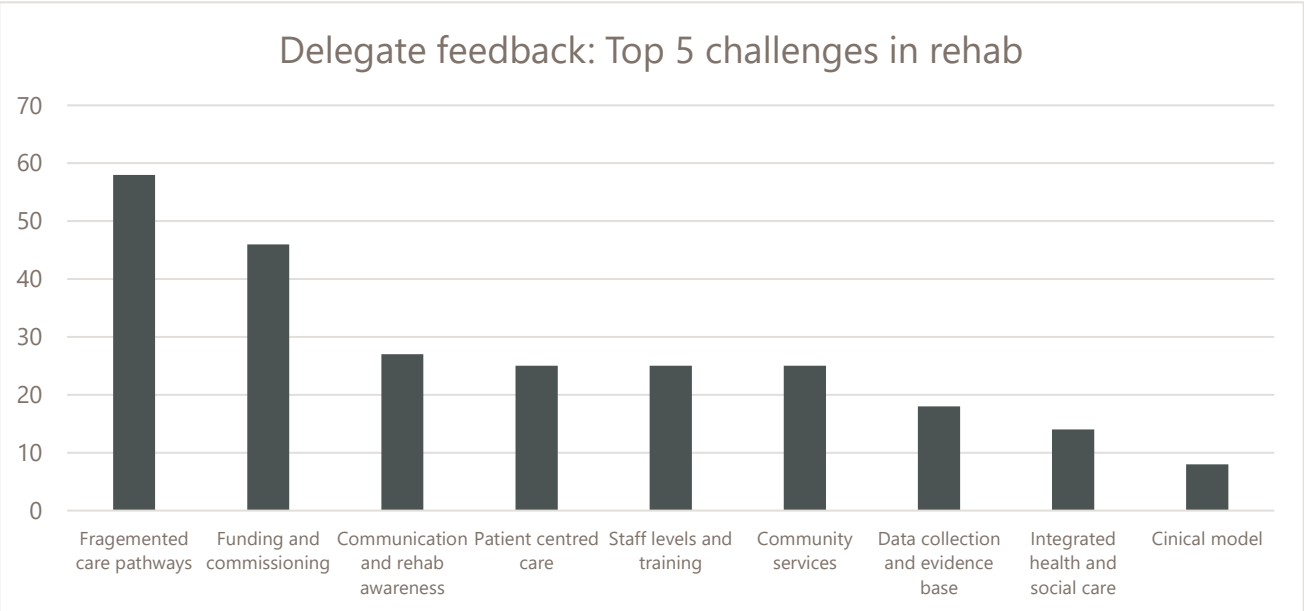
1) Fragmented care pathways
2) National variation in access to services
3) Lack of understanding of what rehabilitation is at both a national and local level
4) Workforce and resourcing challenges, particularly in training pathways
5) Absence of data providing evidence on service outcomes and costs

4.2 Delegate feedback

Each delegate was also given a feedback sheet which asked them what they believed the top 5 challenges in rehab care to be as well as the top 5 solutions.

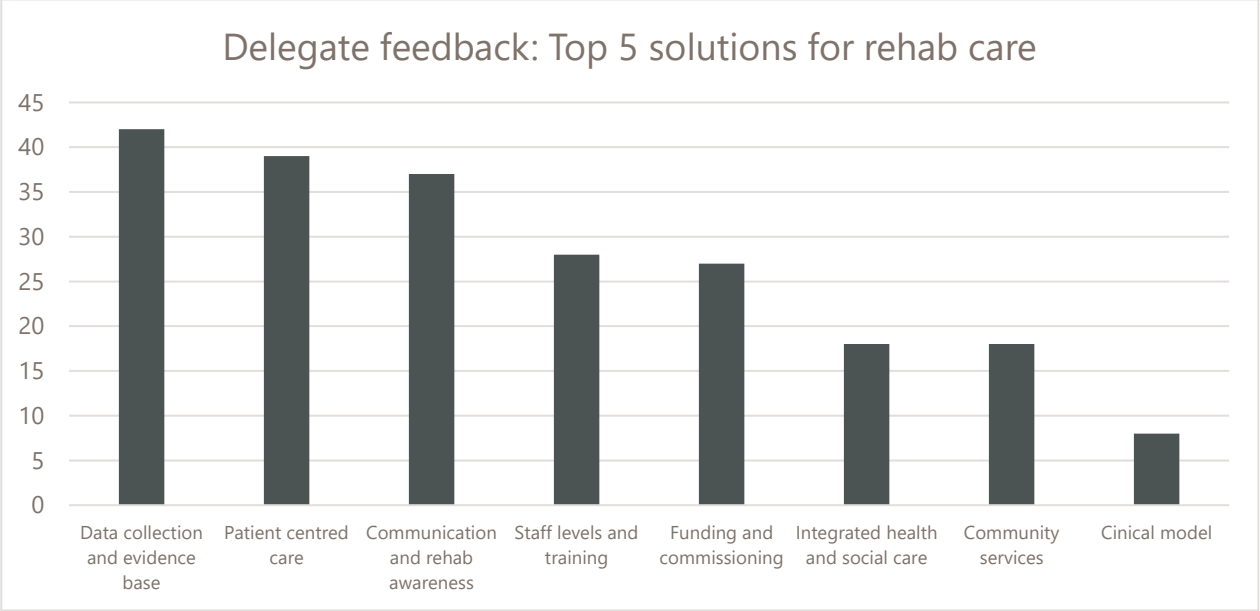
Results from the delegate feedback highlighted the top 5 challenges as:

1) Fragmented pathways and poor co-ordination
2) Funding and disjointed commissioning
3) Communication and awareness of rehab services
4) Patient centred care / Staff levels and training / Community services (all equally scored)



Results from delegate feedback highlighted the top 5 solutions as:

1) Data collection and an evidence base across the whole pathway
2) Patient centred care
3) Increasing communication and rehab awareness
4) Staffing levels and training
5) Increased funding and commissioning for the whole pathway



5. Recommendations

The following recommendations were proposed with general consensus on the day. They have not yet been agreed or commissioned but are included in this report and proposed for review by the National Neuro Advisory Group, the Rehabilitation and Disability CRG and the Neurosciences CRG:

1) Commission GIRFT to undertake an analysis of rehabilitation services to produce a national map of the services available and variation in outcomes.
2) Undertake a gap analysis to identify key areas for intervention.
3) Form a National Rehabilitation advisory group drawing together relevant parties to create a national voice for rehabilitation services.
4) Develop a Rehabilitation specification demonstrating clear care pathways and the resources required to deliver services.
5) Review workforce models across all professional groups identifying how there can be increased awareness of rehabilitation throughout training programmes and review roles and responsibilities including opportunities for advanced practice.

6. Appendices

Appendix 1 –Event agenda

Neuroscience and Rehabilitation Medicine Summit

"Urgent Priorities in Planning and Commissioning Rehab Care – How Can we do Better?"

Tuesday 13th March University Hospital Birmingham

Programme

0930-1000 Meet Greet and coffee

Session 1 So what's the Problem? 1000-1145 – Chair: Prof Diane Playford, British Society of Rehab Medicine

1000-1010	Why a Summit, Now? – Introduction and Welcome	Col.Alan Mistlin, Chair Rehab Medicine CRG &Prof Adrian Williams, Chair Neurosciences CRG
1010-1025	Rehabilitation in the NHS – How did we get here?	Prof Derick Wade, Oxford
1025-1045	Does Rehab work and do we do it properly in the NHS?	Prof Lynne Turner-Stokes, Northwick Park
1045-1100	What do patients and PROMS Tell Us?	Mr Andy Dunnett & Neurological Alliance
1100-1115	GIRFT Methodology – will it work in rehab?	Prof Tim Briggs, National Director of Quality and Efficiency DoH
1115-1130	The Rehab Prescription – where are we going?	Col Alan Mistlin, Chair Rehab Medicine CRG
1130-1145	The obstacles therapists face	Ms Michelle Kurdhail, UKABIF

Focus Groups and Coffee 1145-1230

What are the top 5 challenges in rehab care in the UK today?

Dr Richard Greenwood, London	Board Room
Prof Lynne Turner-Stokes, London	Seminar Room 1
Dr Krystyna Walton, Manchester	Seminar Room 2
Prof Diane Playford. Warwick	Seminar Room 4
Prof Derick Wade, Oxford	Seminar Room 6
Prof Mike Barnes, UKABIF	Lecture Theatre

Lunch and Networking 1230-1310

Session 2 Solutions – What can we do? 1310- 1430 – Chair Col Alan Mistlin DMRC, Headley Court

Key Note lecture: 1310

Changing the face of Rehabilitation – is there the political will? **The Rt Hon Lord Phillip Hunt**

1330-1345	Joined up care: the Manchester Experience	Dr Krystyna Walton, Manchester
1345-1400	What can the private sector offer?	Prof Mike Barnes
1400-1415	What do patients want?	Mr Joe Korner, Neurological Alliance
1415-1430	What works in Community based and Vocational Rehab?	Prof Diane Playford, Warwick

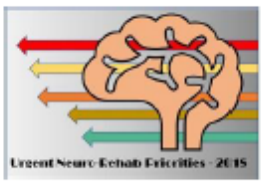
Focus Groups 2 1430-1500

What 5 things should commissioning and political leaders do to address the challenges? – venues and facilitators as above

Tea 1500-1515

Interactive Panel Discussion and Focus Group Feedback 1515-1600

Audience led Voting to rank key themes from the day



There is no Registration Fee for this event but Spaces are limited so Pre-Registration Essential.

Book via Eventbrite:

https://www.eventbrite.co.uk/e/national-summit-urgent-priorities-in-planning-and-commissioning-rehab-care-tickets-42841427864

Appendix 3 – Presentations

Please see attached presentation documents

Appendix 4 – Focus group feedback

Group	Top 5 challenges
Room 6	Lack of resources
	Demonstrating cost efficiency
	Patient flow - lack of stepdown beds / services results in DOTC and inappropriate use of specialist beds
	Earlier specialist rehab in acute rehab
	Quality of independent sector - not to forget it and to improve integration with the NHS
Room 4	Commissioning issues - commissioning whole pathway, money following the patient, NHSE vs CCG's
	Fragmented pathways - no strategic vision, no networks, no communication systems, a lack of understanding of service dependencies
	Equity of access - postcode lottery, shared admission criteria, timing of access, community provision
	Staffing - recruitment for nurses and rehabilitation medicine, retention of nurses, ensuring skillset, training across pathways
	Know what really happens on the ground - mapping costs, activity and outcomes
Room 1	Joined up pathways covering the whole of the patient journey
	Linking data and tracking through the whole pathway in order to identify blockages
	Understanding of what rehabilitation is, mapping services, knowing what they are, care co-ordinators to direct people to the right places
	Managing expectations particularly conflicting expectations between patients, trusts and commissioners
	We need needs lead decision making - patient at the centre and ability to move to the next stage when they are ready
Room 2	Commissioning the whole of the pathway
	Postcode provision
	Developing a networked approach to providing rehabilitation so that we get the right care at the right time
	Resources (money) and cost efficiency
	Discharge process - continuing healthcare and inequities due to lack of expertise of continuing healthcare co-ordinators
	Staffing / Workforce - recruitment, retention, career progression and specialisms
Lecture theatre	Fragmentation - fragmentation leads to holes and people drop through services, people are excluded rather than included, people don't have problems recognised, inequity of care
	Culture -we don't do that here, that's not what we do it's far too difficult, we'll think about it, we'll think about it later, it's another service dealing with this not us

	Loss of staff - experienced staff go to independent sector and there is a drive to replace them with lower graded staff
Board room	Fragmentation - at micro level e.g. case management and at macro level e.g. health and social care
	Ignorance - education needed around what rehab is
	Establish role of medical input into MDT
	Problem of managers not being allowed to take financial risk and therefore not being able to set up innovative services
	The time over which someone should be supported in the community (years)

Appendix 5 – Delegate feedback

Role	Years in role	In light of what you have heard today what are the top 5 challenges in rehab care in the UK currently?	In light of what you have heard today what are the top 5 solutions to the challenges faced in rehab?
Academic	30	Service integration / pathways	Providing clearer justification for increased rehab care to commissioners
		Resources	Re-visit/Re-design the rehab care model
		Addressing inequalities	Gathering better data to inform service development
		Understanding patient needs, especially due to issues around complexity and demographic ageing	GIRFT
		Impact of private sector	Developing improved communication between community and acute
AHP	20	Postcode lottery	Collaborative working across the pathway
		Lack of integrated health and social care and mental health	Increased profile to STP's / Government
		Money (lack of) vs demand (increasing)	Data and evidence of what works
		Health / social care / independent / 3rd sector splits	Sharing what works across the country - best practice
		Deluging rehab to include everything rehab	Look at things differently that started outside of neuro e.g. GIRFT
AHP	36	Communication	A national driving force
		Commissioning the pathway and the understanding of where the money is being spent	Try and resolve communication
		National direction for rehabilitation to get consistency	Regional mapping of services
		Ensuring skills of the whole MDT are available	Publicity / awareness / education on training in rehabilitation
		Ensuring collaboration amongst independent providers and the NHS	Get NHSE and Commissioners to work together over funding and resource allocation
AHP	10	Having the right data across the whole pathway from day 1 (i.e. not just UKROC data of those accepted to certain units)	Know what the vision is - what exactly do we need?
		Services running in series not parallel - do we know / have evidence on what is best when	Ensure unified voice understands this, voices and champions
		Does rehab movement champion all rehab or focus on specialist rehab - what will be best to push our cause?	
		Address competing pressures e.g. LOS vs patient improvement	
		Need patient function pathways based on need not diagnosis / reason for symptoms	
NHS England / RightCare Clinician	1	Not having a standardised data set	Have a standardised data set
		There is a lot of unwarranted variation	Commissioners need influencing at ICS level
		Care co-ordination does not happen	Enable the system to know what looks or is good in terms of rehab

		Integration of local and specialised commissioning doesn't occur	Have co-ordinated influencing / representation of rehab
		Staffing levels	Integrated health and social care
		Integrating social care and healthcare and showing savings where service improvement takes place	
AHP	19	Lack of community services	National group to map NHS and private rehab services and related costs
		Lack of national mapping of services to highlight needs and disparities	Forming a dedicated group to review evidence base and cost effectiveness
		Lack of resources at practical level	Redesign rehab services to support those who need community rehab but don't get it
		Defining what rehab is	Developing good practice to demonstrate it works
		Lack of resources in the NHS for neurorehabilitation and consequent high costs of private sector to provide these	Cost of patients in Neurorehab if services cut and impact on length of stay
Consultant, Rehab Medicine	4	Poor understanding of rehab - politicians, commissioners, stakeholders	Share experiences - good practice, challenges, successes in service developments
		Not all services have pathways across acute, inpatient and community rehab services	Raise profile of rehabilitation
		Deficiencies in community rehab	Needs related services rather than disease specific
		Waits for admission and delayed discharges	Improved links between specialist rehab and spinal injuries / stroke services
		Inequity of services postcode dependent	
AHP - OT	10	Variability in funding between CCG's	Increased collaboration across services in pathway (acute to community)
		Delays in patient flow between services as a result of limited resources, disagreements in eligibility and funding	Increased research and data collection in order to drive increased funding in rehabilitation directed at the areas that need it
		Funding seems to prioritise short term fixes rather than investing in the long-term cost savings and improved quality of life	Consideration of employers investing in vocational rehabilitation (works in MOD, has been used in other companies)
		Government doesn't recognise the financial savings across other areas as a result of increased investment in inpatient provision (e.g. decrease in social care provision and unemployment)	Eligibility for rehab based on need not diagnosis
Specialty Trainee in Rehab Medicine	3	Awareness of services available in rehabilitation	Increase availability of community services
		Disjointed pathways	Provide smooth pathways for inpatients and outpatients into rehabilitation services
		Poor access to community services in some regions	
		Rehabilitation input in long term conditions	

Commissioner (NHSE)		Equity of access within existing bed base	Shared learning of existing pathways
		Unknown financial footprint	Equity of access
		Lack of CCG engagement	Single managed coordinated pathways
		Lack of community provision	CCG engagement
		Lack of shared learning	
NHS Manager Rehab Service	2.5	Inequity of services	Replicability of good rehab services
		Discharge destinations	Education / Understanding of what complex means
		Variation of services	Patient focussed not financial focussed
		Decrease in health funding	Long term thinking re health economics
		Decrease in social funding	Sustainability
AHP - OT	10.5	Postcode lottery, variable services that patients can be referred to and funding streams	Encouragement for clinicians / therapists to engage in research, collect data to demonstrate outcomes and cost effectiveness
		Lack of vocational rehab (few therapists of clinicians are talking about work or using this as an outcome in inpatient/community neuro rehab	Increased investment in vocational rehab due to long term cost benefits i.e. health benefits of work
		Goals for rehab looks at the basics, very little provision of specialist cognitive rehab for example	Trying to reduce variability of service provision across the country
		Rehab timeframes are not goal / patient need focused - instead limited by timeframes or finances	
Consultant AHP Specialist	32	Disintegration of the integration of the pathway of rehab	Integrate agencies budgets and clarify responsibility
		Disincentives of commissioning: cheaper to pay fines	Stop diagnosis led funding and make needs led
		Accessibility to rehabilitation with specialists	Ensure standards capture quality of provision of rehab for better outcomes
		Ignorance / lack of knowledge of those managing finances: governing commissioning decisions, STP's / CCG's	An individual in each CCG or social care funding panel to understand rehab
		Fear of who provides rehabilitation: so long as they have same skills and standards and costs who cares?	
		Lack of succession planning	
AHP - OT	8	Segregation of funding. Differences across different locations and delays in patients moving through their journey.	Simplify funding - remove segregation between areas. Do not rely on GP or postcode on ability to access rehab
		Access to vocational rehabilitation and focus on work / vocation	Have a national standard and framework for rehab with clear contacts and processes for all to view
		Time - time patients have in rehab, time therapists have to treat (not enough), time taken to get to the correct centre / facility (too long)	Bring in a strong vocational focus with work vocation as a driving force behind the entire rehab process
		Focus on discharge home, not the holistic recovery of the patient resulting in high level patients missing out on rehab and	Increase awareness of difficulties faced by high level patients so they are not missed and receive support

		struggling (e.g. executive function impairments)	
		No consistent approach and provision for rehab across the UK - difficult for people to know what they should expect and where to get support / information	Use data on cost saving of rehab to try and increase rehab beds and therapy levels to maximise benefits and functional outcomes
Clinical Neuropsychologist	10	Rehab culture in acute settings - being able to start and continue rehab in a timely way	Co-ordinated collaboration to lobby STP's, NHS England, ministers and parliament to prioritise rehab
		Appropriate outcome measures	Utilise the evidence we have to persuade CCG's to fund services
		Variability in services	Increase focus on patient needs, include patients in service development
		Lack of services for "walking wounded"	Develop services based on rehab of function not rehab of conditions
		Need to actually implement bio-physical-social model which challenges traditional medical model	
Consultant	26	Mismatch between trust priority and patient / rehab MDT experience	Assessment of timescales outcomes between all stakeholders and accessibility of community rehab
		Fragmentation of case	Transformation of services
		Lack of joined up working	Joined up care
		Lack of resources	Upfront funding
		Patient / Carer involvement in what matters to them	Patient / family consultation / involvement in service redesign and selection of outcomes
Consultant in Rehab Medicine	7	Linking patient outcomes from acute care through to community	Measure what matters to patients - function after intervention and reintegration into society - return to work, maintaining abilities
		Reducing false barriers of level 1, 2a, 2b etc and making patient central to process	Support effective networked solutions for rehab needs across sectors with effective clinical leadership
		Accessing rehab early related to need not diagnostic label, therefore not just trauma or stroke but based on patient need	Closer links with 3rd sector, community, vocational services to support patients back to work
		Lack of understanding in CCG's about what rehab is	Clinicians involved in all aspects of strategic planning for rehab services, not devolved to commissioner / manager level
		Lack of provision for patients with progressive conditions- we know we can keep people out of hospital with strategic management and provision of community services	Empower and resource patient groups to have a real impact with clinicians on improving patient focused services
			keep staff well and engaged, look after their health in a meaningful way
AHP	26	Rehabilitation profile	GIRFT opportunities
		Communication between professionals and between professionals and patients	Get 'Rehabilitation' as a government focus theme rather than just as an aspect of others e.g. cancer or stroke
		Staff recruitment and training	Money! But then use it in a monitored and evidenced way

		True patient focus to the pathways	Vocational rehab service development
		Life quality outcomes not just medical stability	All regions map their services and identify gaps, public access to this
Third sector / charity	12	Lack of integration	Robust collection of data
		Too focused on acute services	Meaningful patient engagement / feedback
		Lack of resources	Better evidence
		Not enough robust data	Rehab - not just about recovery!
		Staffing, recruitment, retention, succession planning	Sharing of good practice tools and resources
AHP	40	Ensure the patient is at the centre	Communication links with patient groups and independent sector
		Ensure we collect data appropriately and use it effectively	Engage with CCG's - get lead therapists on them
		Getting CCG's to commission Neurorehab (not just acute)	Provision of training opportunities
		Funding on a political level (NHS England etc)	Joining social care and acute care at decision making levels (all levels)
		Staffing - recruitment and skills / down banding of staff	Promote good practice where it is happening
Doctor	21	Need to engage with current demands to improve patient flows and demonstrate how rehabilitation can help (STP level)	Employ interventions like GIRFT to allow comparisons between services or CCG's to drive up standards and reduce costs
		Rehabilitation needs to be delivered in acute care setting	Engage with STP's and acute care providers to show how rehabilitation services can improve patient flow and reduce bed usage.
		Address the wide variation in community and inpatient rehabilitation	Develop consistent, effective, community rehabilitation services
		Need better contract management of private providers	Better promoting of rehabilitation to politicians, DOH, NHSE etc
		Need more resources but current climate makes this challenging	Make clear pathways for people with newly acquired disability and LTC
AHP	10	Discharging complex patients - CHC funding / social care decreasing	Integration of services from acute to community
		Patients waiting long periods of time in acute care for specialist rehab	Skilled teams with expertise in Neurorehab not generalist skills
		Reduction of community	Increase access to level 2 rehab beds
		Difficulty accessing specialist equipment - wheelchairs, FES, orthotics, Botox spasticity	Improves access to skilled social care
		Postcode lottery	Coordinated data collection not just UKROC but outcome measure that help demonstrate that rehab is effective across the whole pathway - quality measures, impairment outcomes, ADL outcomes, to demonstrate improvement over years
Children's Physio / Neurorehab Physio Lead (paeds)	12	Communicating to politicians what rehab can do to help the NHS	Communication communication communication
		Equitable provision across paeds to adults and geographically	Raising awareness and political support
		Re-accessing specialist services later in rehab journey	Abolish boundaries/silos/inequity

		Fragmentation of pathway / lack of staffing across pathways	Funding is needed to invest in services and decrease costs in long term
		Not patient centred, need to focus on need and funding to follow patient and address needs	Harnessing patient / carer support
Non-medical support specialist (Brains trust)	0.25	Money / Funding	Focus on patient centred services - listen to patients and let them have input and level of control over their own care
		Processes don't seem to be standard	Pressure to put on government / funders
		Lack of consistency in geographical areas	Simplify processes and create as standard across all areas.
		Lack of transparency of care pathway - barriers in terms of having to have reviews of care plans extends timescales	Important to have a pathway but not one size fits all.
		Lack of patient voice / input into their own care	Be transparent about the care services that are available
			Ability to treat each patient as an individual.
AHP - OT	19	Adequate staffing levels	Need to build alliances - become one voice - currently too many professional bodies for government to deal with
		Fragmented pathway - unclear vision	Raise profile of rehabilitation and its evidence-based benefits
		Equity of access to services	Build stronger business plans / case - a national business case
		Bust the myths - rehab does work and is effective	
		Resources - lack of them	
Commissioner	3	Funding - provision and variation	Increase funding and be able to utilise other budgets e.g. social care (or pool budgets)
		Integration of services	Collect more data
		Transition periods	Invest in training and consider mechanisms for staff retention
		Staffing - opportunities and retention	Identify transition periods early and plan
		Showing the evidence (to inform business cases)	Truly personalised care plans
AHP - Physio	33	Recognising that the financial gain is sometimes now in year	Creative use of roles - AHP's can relieve the burden on neurologists
		Supported research into efficacy	Stop working in medicalised diagnostic silos - work on need
		Pressure to commission whole pathways	Longer term access as point of expertise
		Raising the profile of Neurorehab	Recognise specialisms but creatively use lower grades
		No co-ordination when people need to cross boundaries	Tighter specs meaning money must be spent by providers when CCG's invest not hived off to support savings
		Medical hierarchy need to accept change	
AHP - Major Trauma Practitioner	6	Communicating the message that rehab saves money (return to work, brings down care costs) to government, CCG's, trust boards	Prioritise supporting therapists into CCG posts

		Overcoming the difficulties caused by separate budgets (trusts vs CCG's, DWP v Healthcare) to get up front funding / investment in current financial climate	Produce and publicise a clear message on why rehab works
		Data for whole patient journey to show we can show effects of early intervention, timely community rehab	Transfer the minimum data set RP to all patients as standard not just MT
		Redesigning pathways to bring down waits and decrease impact of postcode lottery	Publicise more widely successes like Manchester to save us all writing business cases from scratch
		Communicating effectively with patients	Do GIRFT for rehab
			Use of joined up systems e.g. patients know best to communicate with other professionals, patients and collect data
Director of Nursing and AHP for Circle Health	3.5	Fragmented pathways	Define the offer and how it is funded - be clear who is responsible / accountable for what
		Fragmented commissioning	Define and mandate where this is delivered
		The postcode lottery - variability of services across UK	Work with the independent sector to ensure access to appropriate services - we can do this together
		Recruitment, training and retention of nurses and AHP's	Work with HEE to ensuring appropriate training programmes for nurses / AHP's and to make rehab an attractive service to work in and encourage and support recruitment and retention.
		Right bed in right place at right time	
AHP	8	Culture change to focus on patient rehabilitation from day one	Make changes locally
		Ringfenced funding dedicated to rehab teams	Make your voice heard
		Waiting for rehab from hyper-acute settings	
Doctor	18	Resource - despite clear evidence for cost benefit the separate health / social care funding stops common sense investment to address unmet need	Single budget to fund rehab from health and social care
		Prevention - address lifestyle of people to prevent the preventable neurological disabilities / TBI	Nationally agreed consensus on the composition of community rehab teams
		Inter-agency differences / competition and barriers in pathways	Clearly agreed criteria across NHSE / CCG for rapid decisions on funding along agreed pathways - end the IFR debacle
		Capacity - fewer beds / staff / teams over time	Rehab prescription for all - extend beyond trauma
		Knowledge of what rehab is by non-specialists e.g. terms like 'potential for rehabilitation' on social care assessment forms without any consensus / definition	Mandate rehab training in medical schools / for undergraduate nursing / AHP students
Clinical Nurse Specialist / Neurorehab case manager	11	Flow in and out of the specialised rehab units	One funding stream / pathway for ongoing care
		Funding of non NHA rehab / specialised placements	Case managers within each CCG to monitor need v provision

		Lack of community neuro rehab / follow up	Development of community teams to provide equitable care - not postcode dependent
		Staffing, training, competencies and equality across the services	Rehab prescription for all - extend beyond trauma
		Understanding the levels of rehab, the rehab process and patient's needs (all non-specialised teams)	Defined pathways for patients with cognitive / behavioural needs who can no longer be managed in SR unit
AHP	23	Resources / Commissioning	Investing in staff (particularly AHP's)
		Patient flow from acute into long term care	Looking at moving money between agencies
		Reducing barriers between organisations (health and social care)	Lobbying MP's
		Having the right mix of professionals	Developing networks
		Managing the patient's needs (complex co-morbidities)	Technology development
Service development manager, Post stroke rehab	6	Disjointed funding for services, budgets in silos	Commissioning whole pathway of care
		Reducing variation in access to services	Standardisation of rehab pathways, gold standard care
		Lack of signposting for patients to return to care	Open access and flexible follow up for patients after discharge
		Lack of local audit data to evidence patient needs	Standardised audit tools for rehab
		Demonstrating cost efficiency of rehabilitation	Produce clear business case to support rehab services
Consultant rehabilitation medicine	10	Minimal knowledge / interest on non-level 1 or 2 units and community non-neurological patients	Increase rehab staffing levels
		Poor community rehab provision	More rehab doctors, leads of rehab MDT's
		Insufficient rehab beds	Adequate mapping of disabilities
		Insufficient number of rehabilitation doctors	Define clear pathways
		Narrow rehabilitation attitude of rehab doctors	
AHP	35	Lack of adequate community-based services	NHSE/CCG collaborate on expectation that STP's have rehab as a priority agenda item
		Fragmentation of services and working in silos	Redesign bottom up to ensure patients are pulled through
		CCG's do not have a focus on Neurorehab	Register of specialist community services, self-evaluation framework
		Focus on acute need has made LTC management / rehab access more difficult	Ditto specialist nursing homes and framework
		Very limited access to vocational rehabilitation	Recognise role of AHP's and develop specialist roles. AHP rehab ingrained into everything these professionals do for many years
		2016 guidelines have widely been ignored	GIRFT may be able to be used as a lever for change
AHP	18	Poor recognition of the need for early acute based rehabilitation	Investment in resources e.g. AHP's / equipment / co-ordinators
		Poor patient flow due to barriers in communication and bureaucracy referrals / fragmented services	Perception of rehab can start at day 1 for ALL patient groups (holistic care)

		Lack of community services (rehab and social)	Better retention of staff through training
		Lack of resources - staffing, equipment etc	Increase understanding at CCG / GP and government levels that early rehab and long-term rehab can reduce LOS, reduce readmissions and reduce strain on social care
		Idea that staff and equipment may be needed more than beds - unable to be innovative	Communication between acute and community to aid seamless joined up care and access to agency
AHP	7	Commissioning resources to follow the clinical need (whole pathway) i.e. community complex rehab following level 1/2a/2b	Increase neurorehabilitation on the public and political agenda
		Joint funding POC -long term CHC/ASC, social health integrated plan and transitional beds in community	Unbundled tariffs to follow patient journey / need
		Recruitment, retention and succession planning for longevity and sustainability of NHS (skills/knowledge specialisation)	Linked accessible data / IT systems - patient plan transparent
		Vocational rehab and long-term rehabilitation access	Standardisation of outcomes - priority linked
		pathways across rehabilitation equitable, and to include mental health, alcohol/drug/substance misuse	Increase AHP roles as leads in rehabilitation delivery and authority / accountability - MDT clinics increase cost efficiency and goal / outcome performance
Unknown	Unknown	Lack of integration across acute / community / social care	Peer review is useful to progress standards especially when combined with useful data like GIRFT
		No network model for non-traumatic conditions requiring rehab	Training rehab professionals to straddle adult/paediatric, acute/long term to minimise problems with transition
		Variation in commissioners understanding of rehab	Roll out rehab prescription for non-traumatic conditions and develop networking
		Transition from paediatric to adult rehab services	Be able to educate commissioners so they can understand what data means and the cost effectiveness of rehab
		Training for rehabilitation professionals (e.g. RM doctors) to certain standards and retention of skills	
Unknown	Unknown	Lack of adequate funding	Rational use of available resources
		Poor model of service pathway design	Reorganisation
		Lack of understanding from CCG's and policy makers	Collaboration
		Managing comorbidities in isolated units and community	Better integration with acute hospital
		Limited scope of rehabilitation service in VR (just neuro, spinal, MSK and amputee)	Reviewing training and service structure
Unknown	Unknown	Rehab prescription - applications to all	Funds
		Data collection	Community based approach
		Community functional rehab	More integrated / incorporating community
		Integration	Simpler pathways

		Commissioning pathway	Training and skills towards community / carers
Doctor	3	Fragmentation of services both in rehabilitation medicine and across the pathway	Integration of services - defined pathways
		Geographic variability	Seamless transition of care across the pathway
		Lack of recognition and awareness of rehabilitation	Improved awareness of rehabilitation medicine and its effectiveness
		Loss of experienced staff and reduced uptake	Capture of data and patient outcomes
		Lack of utilisation of technological advances	Education and increased staffing
Doctor	7	Funding	
		Resources	
		Fragmentation	
		Commissioning	
		Collaboration	
Rehab Consultant	10	Resources being cut gradually	Coordinated approach (avoiding a diagnosis based or professional based approach) to form business case to NHSE
		Integration - not planned and being driven by resources	Collaborative care approach
		Pathway orientated rehab rather than person focused care	Co-ordinated teaching across boundaries
		Lack of communication from acute to rehab to community	Investing in rehab for cost efficiency
		Fragmented care	Review of funding for conditions due to limited resources and reinvesting elsewhere appropriately
Unknown	Unknown	Lack of efficiency	Service to be provided by one organisation / commissioned by one commissioner
		Fragmented services and multiple commissioners	Self-management
		Poor involvement of service user in planning services	
		Reliance on state	
		Lack of resources	
Doctor	17	Need to raise the profile	Lobbying MP's
		Resources	Whole system review
		Improve integration	Collaboration across sectors
		Whole pathway commissioning	
		Training the workforce	
Unknown	Unknown		Break barriers of commissioning
			Have a bigger society to include AHP's etc
Unknown	Unknown	Care coordinators/rehab navigator from hyper acute to MT units	
		Mapped pathway	
	4	Fragmentation	

Doctor Rehabilitation Medicine		Culture	
Consultant rehabilitation medicine	10	Fragmented services within a system that has rules that prevent flexibility	Collaboration between rehab organisations to have one voice
		Barriers - inpatient to community, funding (CCG or NHSE), diagnosis specific services excluding others, geography of services, age, time allocated for rehabilitation input	Lobby government with an agreed business case containing data and evidence that rehab works for acquired conditions and long-term conditions. Business case to be proposed to all STP's and CCG's to facilitate equity.
Unknown	Unknown	Budget	Networked patient forums
		Fragmentation	Resources
		Education - ignorance over what is rehab	Discharge process - CHC
		Staffing	Workforce
		Money led decision making, managers cannot take financial risk	Whole pathway commissioning
Service redesign specialist	1	Fragmented pathways along the whole journey	More money needed
		Inequity - postcode	Right person, right place, right time
		Workforce	Innovative commissioning, invest to save
		Commissioning	Integrated working
		Follow patient through NHS number / data collection	Resourcing / workforce improvements (upskilling etc)
		Lack of knowledge re services available	

Appendix 6 – Event attendees

There were 106 attendees at the event, a breakdown of attendees by profession (where provided) is detailed in the table below.

Role	Count
Academic	1
AHP	12
AHP - Major Trauma Practitioner	1
AHP - OT	4
AHP - Physio	1
Children's Physio / Neurorehab Physio Lead (paeds)	1
Clinical Neuropsychologist	1
Clinical Nurse Specialist / Neurorehab case manager	1
Commissioner	1
Commissioner (NHSE)	1
Consultant	1
Consultant AHP Specialist	1
Consultant, Rehab Medicine	5
NHS England / RightCare Clinician	1
NHS Manager Rehab Service	1
Service development manager, Post stroke rehab	1
Service redesign specialist	1
Specialty Trainee in Rehab Medicine	2
Third sector / charity	2
Unknown	7
Junior Doctor	5
Director of Nursing and AHP	1

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