



Response to

**Moving from Care to Enablement
Framework for Rehabilitation
(DRAFT DOCUMENT FOR CONSULTATION)**

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response please contact;
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1. Introduction and structure of response

RCSLT welcomes the opportunity to respond to the **Framework for Rehabilitation**.

RCSLT members consider the Framework to be a seminal document given SLT core competences and their relevance to the field of rehabilitation.

SLT competences add value to the care pathways of the following relevant client groups;

- o **Stroke**
- o **Traumatic brain injury**
- o **Progressive neurological conditions** e.g. MS, MND, Parkinson's.
- o **Autistic Spectrum Disorder**
- o **Dementia and Alzheimer's**
- o **Mental illness including depression**
- o **Learning disability**
- o **Cancers – oral and laryngeal cancers, brain tumours.**
- o **Cerebral Palsy and other physical disabilities**

The RCSLT response to the framework was compiled following consultation with SLT managers and clinicians working in relevant fields. RCSLT members were briefed on the framework and asked to comment on key ideas and recommendations.

The RCSLT response which follows is in three sections;

1. RCSLT Executive Summary of response to Framework for Rehabilitation
2. RCSLT Framework for Rehabilitation Survey Report
3. RCSLT response to recommendations - including examples of good practice.

2. RCSLT Executive Summary of response to Framework for Rehabilitation

The Framework for Rehabilitation says it aims to give strategic direction and support to practitioners who deliver rehabilitation and this aim is laudable.

RCSLT members welcome the direction of travel laid down in the framework particularly as in many respects it reflects current evidence based best practice.

RCSLT members are however very concerned that the document is in significant danger of not achieving its aims because most recommendations are too “light touch” to be effective in leveraging real commitment from agencies to act to improve and invest in local services.

There is a significant lack of measurable objectives within the framework or any commitment to actually invest any new resource in improvements in these vital services.

In the words of one SLT who reflects the views of many;

“...There is a great deal of goodwill towards this kind of thinking in SLT and a willingness to make changes.

The challenge is persuading our service users that this is a good thing and we have not underestimated the task ahead of us in educating and communicating with our colleagues, clients and carers.

I feel very strongly that it needs proper commitment from on high to invest in the process, providing resources to enable the changes to be planned and coordinated properly and that this support should be maintained.”

A Scotland wide survey of SLTs working with relevant groups generated responses from eight rural, urban and mixed health boards and SLT leads and clinicians working with all relevant group.

The survey revealed strong majority support for the key aims of the framework.

However the majority of SLTs do not believe key goals in the framework can be delivered within current resources as the table over reveals.

Key Aim of Framework	% who did / did not believe aim could be delivered within current resources	
	Did believe...	Did not believe...
1. Rehabilitation being focus of future health services	30%	70%
2. Shift of focus of services from care to enablement	72%	38%
3. Local, community based delivery of service	0%	100%
4. Systematic, continuous care approach to management of older people, long term conditions and vocational rehabilitation.	12%	88%
5. Better co-ordination of multi-disciplinary and multi-agency rehabilitation services at strategic and local level.	60%	40%
6. CHPs and, within them, AHPs to act as leaders in service re-design.	17%	83%
7. Self-management of long-term conditions.	17%	83%
8. Quality transitions between services	unclear	unclear
9. Strong emphasis on pro-active, preventative care, anticipatory interventions and early intervention to reduce avoidable admissions to hospital	40%	60%
10. Patients and carers as partners in care.	100%	0%
11. Better information and support for patients and carers	80%	20%
12. Service redesign and role development	0%	100%

3. RCSLT Framework for Rehabilitation Survey Report

An e-mail questionnaire was sent out to all RCSLT members in Scotland.

Responses were received from clinicians and service leads representing views of rehabilitation SLTs in;

- eight out of the fifteen health boards including
- four rural, two urban and three mixed rural / urban localities
- adult community and acute care settings – covering all care groups listed in the introduction.

SLTs were asked for their response to 12 “key aims” of the Framework. They were asked

- a) if they thought the aim was “good” or “challenging” and if so why and
- b) if they thought they could deliver the aim within current resources.

Results of survey

1. Key aim: Rehabilitation being focus of future health services

Deliverable within current resources: 70% of respondents **did not** believe they could achieve this shift within current resources, 30% did.

Summary of positive comments on aim:

- Positive shift in thinking, aims should be to help people regain as much independence as possible.
- Rehabilitation is already the focus of much of our service. The challenge is to maintain progress made to ensure quality of life is as good as possible.

Challenges associated with this aim and what needs to happen to overcome these:

- Need to improving team working
- Would require better integrated, inclusive workforce planning and more SLTs.
- Re-direction of therapy resources alone is unlikely to be enough to achieve the full definition of rehabilitation given in framework.
- Need to shift focus in culture which is still based largely on crisis response.
- Think the word “rehabilitation” is likely to be misinterpreted – concern that target groups have more people within them who need ongoing support or have progressive conditions than those who need rehabilitation to “restore” skills.
- Some suspicion this is a political move to get people off Incapacity Benefit rather than being based on best clinical evidence.

2. Key aim: Shift of focus of services from care to enablement

Deliverable within current resources: 62% did believe and 38% did not believe they could deliver shift within current resources.

Summary of positive comments on aim:

- Good - fits in with the philosophy of SLTs (care aims) and philosophy of participation and hopefully accessibility; would be in line with our approach to multi-disciplinary and multi-agency management of children and young people.
- Good to hear enablement acknowledged as important.
- Learning Disability services and AHPs will have a role in helping to demonstrate what enablement means.
- Essential for the future.

Challenges associated with this aim and what needs to happen to overcome these:

- Needs shift in NHS culture - requires services to address embedded medical model attitudes and attitude towards enablement - seen within some services as less legitimate
- Needs shift in public perceptions - wider society needs to understand that not all problems can be fixed with exercises issued by a health professional.
- Need for acute services to relinquish funds and doubt that this will be forthcoming.
- Danger of over-emphasising “coping with disability and self –care”. There is also a need to promote the role in facilitating recovery (i.e. care) – especially in SLT where

3. Key aim: Local, community based delivery of service

Deliverable within current resources: 100% of respondents did not believe aim could be achieved within current resources.

Summary of positive comments on aim:

- Excellent idea to focus more on this,
- Already deliver a high proportion of our service in people’s homes and community
- Good in principle
- Would support this
- Important shift has to be away from purely domiciliary care in community and move back to the rehab centres with efficient transport services to support. This could then promote the enablement and self help focus allowing group interventions etc.
- Essential.
- More choice needs to be available for patients - acute hospital, domiciliary, OP clinics in the community.

Challenges associated with this aim and what needs to happen to overcome these:

- SLT services are already struggling to cope with increased referrals and to attend all appropriate MDT meetings (where MDT exists) at local centres.
- Need to increase SLT team (full range of skill mix) in communities to meet current demand particularly as community based input generally takes up more resource. This problem increases further in rural settings.

- Need development of new rehab. dedicated SLT services in rural communities. Currently SLTs have predominantly paediatric caseloads, adults are an ‘add on’. There is often no ring fenced adult time. Safely managing Dysphagia (eating, drinking and swallowing difficulties) presents problems because it’s difficult to justify the expense of CPD if adults make up 9 – 10% of the caseload. Turnover of staff often means we have no post grad. dysphagia trained therapist available. Extensive travel for staff also needs to be factored in to planning of local based services in rural areas.
- Need to retain specialist staff, units and equipment e.g. stroke rehab., as well as developing more “generalist” services.
- Relocation to new premises will need significant funding.
- Significant, carefully planned skill development for community therapy and medical staff and infrastructure development is required.
- Day hospital/ rehab centre opening times may need extended.
- There is a risk of unwelcome disaggregation of small services such as SLT. We have consistently promoted the view that we do best with an area wide service, e.g. current SLT Older People’s Service = 2.2 equivalent.

4. Key aim: Systematic, continuous care approach to management of older people, long term conditions and vocational rehabilitation.

Deliverable within current resources: 88% of respondents did not believe this goal could be achieved within current resources.

Summary of positive comments on aim:

- Good. Development of new, integrated care pathways is essential.
- Already exists. There are examples of proactive services such as the Parkinsons assessment clinic but again these are supported by voluntary agency and do have limited resources.
- Again, very much the way that we wish to go,
- This seems very positive but seems a very ambitious aim.

Challenges associated with this aim and what needs to happen to overcome these:

- “Systematic” provision can be challenging in a rural setting because of the potential for a breakdown in communication where there is less chance of meeting regularly. This would be particularly the case where the SLT also had a paediatric caseload. Good collaborative working is also difficult if SLTs work across multiple teams.
- Need for special consideration of in rural areas
- Difficulty will be achieving an adequate speed of response to avoid hospital admissions - current community services does not allow this – more often patients are admitted prior to community team reaching the patient when there is a crisis.
- Need for more SLT staff working across or between acute and community services.
- Need for much improved multi-disciplinary partnership working between Health and Social Work.

- Need big improvement in IT support to achieve as services are still very limited in databases/ patient records e.g systematic recall of patients for review.
- Need for CPD for all involved.
- Services need to develop in parallel not individually to avoid different services for patients in living in the same locality but at a different CHP.
- In respect of vocational rehabilitation – many people will not ever have had a job or would not be able to sustain one.
- There is a significant role for AHPs and SLTs in particular in supporting people in employment – again would need resources

5. Key aim: Better co-ordination of multi-disciplinary and multi-agency rehabilitation services at strategic and local level.

Deliverable within current resources: 40% did and 60% did not believe this goal could be delivered within current resources.

Summary of positive comments on aim:

- Community SLTs are already well used to multi-disciplinary working across a variety of agencies. Community SLT Managers are already multi agency networking, linking, developing policy with Education partners for paediatrics so this would be an extension of what we already do.
- Good. Works well already for LD services
- Should already be done. This is just good practice.
- I think this is what we all strive towards, particularly in the community.
- Development of new, integrated care pathways is essential.

Challenges associated with this aim and what needs to happen to overcome these:

- Need for increased SLT staffing at clinical and strategic levels.
- In one service, for example, SLTs can only visit the community once a week, so very few opportunities to liaise with other disciplines and/or agencies. In another a very good, major coordinated and radical development took place when an MCN for stroke was properly funded and managed. The momentum was impossible to maintain after dedicated management was withdrawn.
- Need for better supported and more consistent AHP representation at CHP and Board planning levels.
- Need for particular development activities in areas where “health” has been only focus, eg, acquired brain injury teams.
- Planning, development and implementation (including budgeting) of better integrated and co-ordinated rehabilitation services must be more inclusive of those disciplines delivering patient services and take account of the full range of patient and carer needs.
- SLTs have had a poor experience of previous initiatives, e.g. Joint Futures, E-Access. Often the SLT is not included at any or at the appropriate level of planning.

- Current care packages for long-term care of people living on their own barely covers basic requirements. People who have needs for maintenance of mobility, communication skills etc are not enabled to do this because services for ongoing care do not exist. In a very short time progress made in rehabilitation is lost.
- Private sector carers and the local authorities have had lengthy disputes about who should pay for the time for carers to attend basic awareness training on the communication needs of new clients being discharged from hospital to their care.
- The inconsistent progress across Scotland with the Joint Futures Agenda suggests a need for local authorities to be “geared up” to work with health as the framework suggests.
- Clear pathways need to be established with strong leadership and coordination

6. Key aim: CHPs and, within them, AHPs to act as leaders in service re-design.

Deliverable within current resources: 83% of respondents did not believe this could be delivered within current resources.

Summary of positive comments on aim:

- This is welcomed and AHPs would be well equipped to act as leaders in service re-design.

Challenges associated with this aim and what needs to happen to overcome these:

- Need to consider integrated service redesign with secondary and tertiary services as well as other CHPs.
- Time and money needed to do the redesign and to pay those responsible adequately. Need specific leadership / redesign posts
- Need to change perceptions of AHPs. Still massive issues/barriers in relation to perceptions of the NHS – definite feeling that Drs and Nurses are most important.
- Need training in how to effectively plan and implement redesign.

7. Key aim: Self-management of long-term conditions.

Deliverable within current resources: 83% of respondents did not believe this goal could be delivered within current resources.

Summary of positive comments on aim:

- Excellent vision - SLTs welcome and already gear therapy to encourage this.
- AHPs are well placed to take forward the self care agenda.

Challenges associated with this aim and what needs to happen to overcome these:

- Staffing levels do not always permit e.g. group work on psychological adjustment to long term conditions. Need increased SLT staff resource to do this.
- Need to emphasise many LTCs also need periods of rehabilitation where the focus is on promoting recovery.

- Self care is not appropriate for some clients for any number of reasons – cognitive impairment (permanent or transitory), communication needs, socioeconomic etc. There is a need to carefully and consistently assess and monitor a person’s capacity to self care. The framework as to indicate how people will safely move from one “category of care” to another if and when circumstances change.
- Communication competences (i.e. ability to understand and express self) are significant when considering a persons capacity to self manage not least because communication competence generally reduces when a person is anxious, ill, tired or communicating with unfamiliar people or in an unfamiliar place. Target groups for the framework present additional communication challenges for services.
- Overcoming communication challenges effectively will place significant resource demands on SLT services. There is a need to increase SLT services to develop “Total Communication” approaches to care throughout the MDT care pathway.
- Confidence to self care stems from correct medical and therapy support in the early stages. This is currently not in place.
- The population will require a lot of education and convincing to cope with this shift.

8. Key aim: Quality transitions between services

Deliverable within current resources: 100% of those who responded to the question thought this could be delivered within current resources – although see comments on investment below and on local community rehabilitation services above.

Summary of positive comments on aim:

- Welcomed, essential, saves time, money and confusion, “good practice”.
- Electronic patient records will help this process.
- SLTs have a particular role in supporting communication with patient and between patient and new environment during transitions.

Challenges associated with this aim and what needs to happen to overcome these:

- Need for clear indicators of what makes a “quality” transition.
- Need for special consideration of mechanisms in bigger the organization.
- Needs investment in multi-disciplinary/multi-agency teams.
- Need to recognise significant amount of time required to liaise with sometimes numerous agencies, e.g. when trying to ensure that continuation of good communication strategies set up in hospital are followed through in community.
- Need for clear understandings of duty of care and risk management required at all levels.
- Significant training needs particularly in community based services receiving people with for example, communication support needs and / or eating, dinking and swallowing difficulties.

9. Key aim: Strong emphasis on pro-active, preventative care, anticipatory interventions and early intervention to reduce avoidable admissions to hospital

Deliverable within current resources: 60% of respondents did not believe they could deliver this within current resources

Summary of positive comments on aim:

- Excellent vision. Focus on health promotion can only bring long-term benefits, saves time and money, saves stress on patient and family, so long as the illness/condition can be reasonably managed at home.
- AHPs see this as a core activity although we have no preventative role at present.

Challenges associated with this aim and what needs to happen to overcome these:

- Need for increase in SLT resource if we are to do this - as not managing to currently meet need of those presenting with existing problems in an equitable way as evidenced by reduce waiting times. Don't currently have 52 weeks cover for AHPs.
- Culture change needed to recognise value of such work.
- Need for training and education of AHPs.
- Addressing anticipatory or preventative care should be role of same team dealing with "rehab" and enablement. Where remit boundaries have been introduced it has led to confusion and restricted access to services.
- Need to make sure all actual and potential users can access information and support including patients and carers with communication support needs.
- Will need a whole new design of service to achieve speed of response to indicators of deterioration – e.g untrained carers adept at recognizing and responding effectively to nursing home resident developing swallowing difficulty with any onset of sepsis.

10. Key aim: Patients and carers as partners in care.

Deliverable within current resources: 100% of respondents believed they could deliver this shift within current resources.

Summary of positive comments on aim:

- Patients and carers as partners is already an integral part of the way SLTs work and the requirement to do so is laid down in RCSLT evidence based clinical guidelines and service standards (Communicating Quality 3). SLTs recognize "therapy partners" allow the delivery of intensive and effective care packages.
- Recognition of the importance involving patients and carers in decision making is welcome.

Challenges associated with this aim and what needs to happen to overcome these:

- There is a need to consider partnership roles of patients and carers in consultation with them. Consideration must be given to the capacity of patients, paid and unpaid carers to fulfill partnership roles.

- A shift in expectations of the public is needed to fully maximise the potential of this resource. For example members of the public be enlightened to the concept of patients and carers as partners so they have reasonable expectations.

11. Key aim: Better information and support for patients and carers

Deliverable within current resources: 80% said they could deliver within current resources.

Summary of positive comments on aim:

- Strongly agree - if improved, would make a huge difference to many patients and carers, aid prevention and promote compliance.
- Accessibility of information is important to highlight
- SLT could be involved to ensure information is accessible to those with communication impairment.
- This is already a core approach in SLT care.
- SLTs have an essential role

Challenges associated with this aim and what needs to happen to overcome these:

- Need improvement of quality and consistency of information at national and local level.
- Need more time to improve support to patients and carers e.g. to initiate/facilitate support group.
- Need to develop and use available evidence from SLT and voluntary sector to develop best practice in relation to best ways to support people with LT Disability.

12. Key aim: Service redesign and role development

Deliverable within current resources: 100% did not believe they could deliver changes within current resources.

Summary of positive comments on aim:

- Recognition of the need for service re-design and role development is welcomed.
- Experienced staff can have a positive effect on redesign. New staff may too look at things through 'fresh eyes'.

Challenges associated with this aim and what needs to happen to overcome these:

- Huge investment in all grades of staff will be essential for any re-design to take place. For example one rural service has no assistants working in adult teams; in another rural area the posts for adults, say in Stroke Units, are often part-time and this is a real challenge in terms of recruitment and many areas are simply under resourced to start with and so options for redesign are limited (eg one area reports only having 4 sessions for non Head & Neck cancer patients).
- Shift of resources from acute to community care will be needed to facilitate service redesign.

- Service redesign across agencies must include meaningful involvement of patients and carers including those with communication support needs.
- Role development can be positive but need to be aware of asking too few people to do too much, they may not have time to do any more or have anything they can safely, legally, professionally or ethically delegate or stop doing.
- Staff need to be rewarded for increased role if redesigns are to be sustainable.
- Re-design should follow the patient pathway. These pathways should be more radically thought through. Current patient pathways are to some extent fitted around historical services and lack the flexibility that is needed with the broader definition of rehab.
- Approach needs to be supported by the alignments of strategic direction between NHS systems and local authorities.

4. RCSLT response to recommendations - including examples of good practice

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

See RCSLT Rehabilitation Framework Survey Report in particular comments on;

- Rehabilitation being focus of future health services
- Local, community based delivery of service
- Systematic, continuous care approach to management of older people, long term conditions and vocational rehabilitation.
- Quality transitions between services
- Service redesign and role development

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.

a) Recommendation welcomed although it would be more powerful if meaning of “enhancement” was elaborated on. Does it for example mean expanding services to reducing waiting times. Access should also cover communication access to services, as well as physical access.

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

a) Recommendation broadly welcomed although SLTs have a number of concerns.

b) NHS 24 and “interface services” should be urged to invest in developing capacity to cater for people and carers with communication support needs to ensure equitable access. For many with communication support needs telephone help lines will not improve access.

c) Increasing referral to services, although potentially helpful in exposing unmet need, will not increase amount of service actually available. Any increase in referral needs to be matched by increases in capacity to deliver services.

d) For the NHS 24 route to work staff at NHS 24 would need detailed local information. NHS 24 would struggle to give board differentials between different 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.

a) This recommendation is broadly welcomed although it would be stronger if it was more specific about who should lead developments and how partners “should

address” transitions. The recommendation should take cognizance of the needs identified by RCSLT survey in respect of quality transitions.

Good Practice in Transitions

Highland SLTs are involved in strategies to address the ongoing needs of people with long term conditions e.g. how to enable nursing homes to manage ongoing communication and swallowing problems and collaborating with CHSS to train Conversation Partners for people with aphasia.

In Lothian SLTs secured funding for a liaison SLT to follow up stroke patients immediately on their discharge home, prior to being seen by the community SLT team.

In Ayrshire and Arran SLTs have been working on a year long pilot supported by MCN Stroke to provide rapid outreach support , information and therapy to patients with communication and /or swallowing problems discharged home from stroke service .Early indications show this has been a valued and effective resource supporting early discharge. The project will end in Sept.06 and outreach work cannot be continued due to lack of funding. A similar project involving multi-disciplinary team is ongoing in south Ayrshire.

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.

- b) Recommendation broadly welcomed however it would be improved if it reflected current practice across AHPs.*
- c) Most SLT service users have always enjoyed direct access although in some cases this is not considered clinical best practice e.g. ENT.*
- d) This recommendation would be improved if it also included promotion of direct access to AHP services already set up to accept direct referral.*
- e) Promotion and development of direct referral mechanisms must reflect best practice in relation to multi-disciplinary team (MDT) clinical decision-making processes. In a number of MDTs referral is to a team and not an individual.*
- f) NHS systems should be urged to go beyond “considering” introduction (and promotion) of direct access.*

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.

- a) NHS systems should be urged to go beyond “considering” equitable service delivery. See comments below in respect of theme 4.*

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.

- a) *Scottish Executive also needs to address funding to develop appropriate local transport and local facilities to reflect needs of each community within remote and rural communities.*
- b) *Local transport and facilities must also meet needs of people with communication support needs as well as physical disability – in line with public Disability Equality Duty.*

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.

- a) *Firstly there will be a need to establish leisure and fitness opportunities within remote and rural communities requiring investment from national and local agencies.*
- b) *This recommendation would be improved if it alluded to the need to ensure physical and communication accessible facilities particularly given disproportionately high incidence of sensory impairment and literacy difficulties in older generation.*
- c) *It would also be further improved were it to encourage activity by all “at risk” groups.*

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.

- a) *Recommendation welcomed although increased resources required to provide equitable, quality vocational rehabilitation service to all staff groups who acquire communication disability, for example, following a stroke or with a progressive neurological condition.*

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.

- a) *Recommendation welcomed. SLTs endorse the need for a focus on rehabilitation services for people returning to work although concerns incapacity benefit recipients could be inappropriately “hounded” back to employment.*

b) This recommendation would be improved if it specified engagement with the Scottish Executive Health and Community Care Department, professionals delivering vocational rehabilitation and organizations representing interests of users of vocational rehabilitation.

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.

a) Accept the thrust of this recommendation although guidance is more likely to drive change if resources are there to implement it.

b) An additional recommendation identifying responsibility to implement guidance is essential if the goal of early intervention is to be achieved.

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

See RCSLT Rehabilitation Framework Survey Report in particular comments on;

- Local, community based delivery of service
- Strong emphasis on pro-active, preventative care, anticipatory interventions and early intervention to reduce avoidable admissions to hospital
- Self-management of long-term conditions.

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.

a) This recommendation must urge community planning partners to go beyond “exploring” how services can be developed.

b) The recommendation should stress “exploration” at least involves meaningful, direct representation of all key professions involved in rehabilitation etc. as too often team development for established community teams has not factored in any or adequate SLT services.

c) The recommendation should also require relevant partners to consider funding of increased staff resources (including possible extension of working hours), relocation of staff and equipment, infrastructure development, relationship between different tiers of service (community versus specialist hospital services) and skill development for community therapy and medical staff.

- d) *Community planning partners operating in rural areas should be urged to develop new rehabilitation dedicated SLT services.*

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.

- a) *This recommendation must urge NHS systems, CHPs, and local authorities to go beyond “exploring” how services can be developed.*
- b) *The recommendation should stress “exploration” at least involves meaningful, direct representation of all relevant professions.*

Communication impairment- including literacy difficulties and sensory impairments – are disproportionately high among “hard to reach” communities, low employment communities and people with long term conditions and older people.

It is important that presence of “Communication Support Needs” (CSN) is seen as a risk factor not least because CSN creates significant barriers to accessing help (like NHS 24) or benefiting from self care advice.

SLTs can uniquely contribute to development of risk assessment tools in respect of people with CSN as well as eating, drinking and swallowing disorders.

- c) *The population “at risk” is not a static group. Risk management of communities requires ongoing monitoring of the whole community to keep the “at risk” register up to date. Partners should be urged to consider ongoing monitoring of the whole community as part of risk management.*
- d) *One respondent reported the “Fair Access to Care” policy that provides the strategic direction for local authority services will limit the NHS ability to deliver care in partnership. The recommendation must take cognizance of this.*

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.

- a) *This recommendation must urge community planning partners to go beyond “exploring” how services can be developed.*
- b) *The recommendation should stress “exploration” at least involves meaningful, direct representation of all key professions involved in rehabilitation etc. to ensure non-traditional facilities that are fit for purpose and meet professional standards.*

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.

- a) *This recommendation must urge NHS systems and local authorities to go beyond “exploring” how services can be developed.*
- c) *The recommendation should stress “exploration” at least involves meaningful, direct representation of all key professions involved in rehabilitation etc. so appropriately costed account can be taken of various client and professional needs in term of space, access issues, equipment etc.*
- b) *Partners should be encouraged to view co-location as only a small element better team working or access.*

Team working is improved by evidence based integrated care pathways and team organizational development along this spine – not simply though players being in same building.

Co-location can mean centralisation of previously neighbourhood services.

3. Enablement and self-managed care : A systematic approach to delivering rehabilitation to individuals is required, promoting independence and self management.

See RCSLT Rehabilitation Framework Survey Report in particular comments on;

- self-management of long-term conditions
- better information and support for patients and carers
- patients and carers as partners

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.

- a) *This recommendation should stress the need to involve meaningful, direct representation of all key professions groups engaged in patient self management at a strategic level.*
- b) *The recommendation should stress the importance of models of self care accessible to all, including those with communication support needs.*

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.

- a) *Electronic mechanisms to enable sharing of information between key agencies should be explored and developed at a national level (as part of E-Health) so that;*
- *patients can move across boundaries without need for new records etc.,*
 - *professionals can move across boundaries without the need to learn different systems and*
 - *local, regional and national management information can be easily compared.*

Development of different systems in each local area would appear inefficient and uneconomical.

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

- a) *AHPs are already doing this as much as possible as a matter of good practice.*
- b) *This recommendation must clarify who is to lead this work locally and where the resources to implement more relevant work might come from.*
- c) *Further a multidisciplinary rehabilitation model of self-care needs to operate within a competency. This needs to be underpinned by education.*

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.

- a) *It is important that this recommendation alludes to the need to include all children, young people and adults e.g. those with communication support needs and / or eating, drinking and swallowing difficulties.*

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.

- a) *This recommendation overlooks the significant amount of work SLTs do in relation to communication accessible information and services generally.*

SLTs provide advice and training as well as communication resource development services for a wide range of public and third sector agencies.

It is a significant feature of many SLT provision in learning disability, stroke services, mental health, primary care, ASD services, progressive conditions etc.

This recommendation must be altered to include reference to the primary and unique role of SLTs in this respect.

- b) *This recommendation also unfortunately overlooks the need for people to not just get information from but to give information to services.*

An additional recommendation should urge NHS systems to work in partnership with SLT services and voluntary sector to develop services responsive to the full spectrum of people expressive language methods.

Good Practice in Better information

Forth Valley SLTs have been instrumental in two relevant projects;

- Lottery Fund project seeking the views of people with aphasia and a
- Aphasia Friendly Goal Setting Process within the Stroke Ward at Falkirk & District Royal Infirmary

They have also worked with independent organization “Connect” to develop a vision for improvement in communication for aphasic adults.

SLTs in Mid and East Lothian are leading several similar “Total Communication” projects

- improving access to Roodlands (Community) Hospital,
- in GP practices across the area (Better Health through Better Communication Project) which mirrors learning from a similar project by Lothian SLTs,
- Communication links – aimed at developing “communication friendly sports centres”

Regional and national SLT initiatives in this field include establishment of the RCSLT Inclusive Communication Network (which is working to share and develop good practice) and the Learning Disability MCN Accessible Information Group.

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

See RCSLT Rehabilitation Framework Survey Report in particular comments on;

- Systematic, continuous care approach to management of older people, long term conditions and vocational rehabilitation.
- Better co-ordination of multi-disciplinary and multi-agency rehabilitation services at strategic and local level
- CHPs and, within them, AHPs to act as leaders in service re-design.

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.

- a) *NHS systems, particularly through CHPs, and local authorities work must take account of the challenges and needs identified by SLTs in the CSLT Survey.*
- b) *The recommendation should stress “working towards” involves meaningful, direct representation of all key professions involved in rehabilitation etc. as too often team development for established community teams has not factored in adequate SLT services.*
- c) *RCST would hope the “Toolkit” standards (and quality indicators) dictate the requirement for meaningful, direct representation of all key professions involved in rehabilitation etc.*
- d) *One respondent reported “Fair Access” criteria may undermine the NHS ability to work as closely with local authorities as this approach requires.*

Good practice in Co-ordinated, integrated services

A good example of co-ordination is the out patient dysphagia referral system at the Royal Infirmary in Edinburgh where SLT, GI and ENT work together to make the right assessments.

In Highland SLTs have an integrated service and communication between SLT acute and community services has always been good.

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.

- a) *This recommendation should urge partners to go beyond “considering” if and how key workers systems should be developed. It should urge them to develop and implement an inclusive and viable system.*

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.

- a) *This is happening already in many services.*
- b) *Services should be urged to seek the views of all actual and potential service users (NB; Disability Equality Duty). In particular they should be urged to ensure people with communication support needs are given equal opportunity to influence service planning, implementation and evaluation as they currently do not (or cannot) either access or gain equal benefit from services.*

c) *Impact assessment, evaluation of data and action (regardless of measuring tool) requires time, skills and technical capacities over and above those needed for clinical provision to service users.*

a) *An additional recommendation should urge partners to recognize the importance of impact assessment and to adequately resource teams so they have capacity to do it.*

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.

a) *RCSLT welcomes this recommendation but believe it must urge partners to go beyond “exploring” how an MKN can be developed. Partners should be urged to fund and support development of an inclusive and sustainable MKN.*

b) *Further SLTs queried why the focus of a Managed Knowledge Network would be on rehabilitation i.e. a model and not a population per se. We would suggest the focus should be on three target groups – older people LTC and vocational 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.

a) *Some RCSLT members are already doing this however the majority of SLTs, all of whom are extremely keen to grow the evidence base, experience significant barriers to doing so. Barriers include lack protected time in job descriptions and lack of financial or other support locally.*

b) *An additional recommendation should urge NHS systems to support AHPs to overcome barriers including adding a “growing evidence base” role to job descriptions for AHP staff (proportion perhaps determined by AfC banding).*

5. Sustainable multi-professional teams : 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.

a) *This recommendation reflects work that is already being done and has been ongoing for many years in many services. Barriers to success of local efforts include time and other resources available for professional development of individuals and teams and*

service redesign including skill mix initiatives (see comments on service redesign under theme 6). RCSLT have already reported challenges of delivering proposed HNC for SLT support workers to NHS Education Scotland.

- b) This recommendation would be more progressive were it complimented by an additional recommendation committing specified lead agencies to realistically supporting professional development and service redesign including skill mix initiatives.*
- c) Efficiencies and economies of scale could be gained by agencies if points (a) and (c) for example were approached at a national level.*

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.

- a) This recommendation reflects good practice which is already going on in HEIs and elsewhere. The recommendation would be significantly strengthened were it to describe “how” agencies were to support developments given already very busy undergraduate curriculums, clinical placement opportunities and severely restricted capacity (financial and staff) to develop and deliver new CPD “products”.*

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

See RCSLT Rehabilitation Framework Survey Report in particular comments on;

- Service redesign and role development.

Good Practice in Redesign.

In Highland Health Board an SLT is leading a Redesign Project looking at changing the culture in which AHPs work and shifting the focus very much along the lines of the framework.

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.

NHS systems and local authorities should be urged to actively address the needs identified by SLTs in respect of redesign and role development.

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.

AHPs have been trying to do this for sometime. However barriers, including resources, attitude, skills and knowledge and decision making structures and systems across all agencies can frequently get in the way of progress.

An additional recommendation should be included committing the SEHD to provision of strategic leadership and support to enable AHPs at a local level to overcome these barriers.

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 team.

a) *A recommendation in addition to that above should urge those partners with funding responsibility for integrated rehabilitation teams to act on the recommendations in respect of the development of sustainable smooth transition services – as described by rehabilitation teams.*