NHS SCOTLAND

Co-ordinated, integrated and fit for purpose

A Delivery Framework for Adult Rehabilitation in Scotland

Scottish Executive, February 2007

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Joint foreword by the Deputy Minister for Health and Community Care and the Deputy Minister for Education and Young People

Rehabilitation underpins many of the deliverables arising from the Scottish Executive's health and social care policies, and is central to ensuring that the vision set out in *Delivering for Health and Changing Lives* is achieved.

Without integrated, co-ordinated and fit-for-purpose rehabilitation services, the benefits to people's lives these policies are designed to achieve will not be fully realised.

That is why we welcome this Delivery Framework for Adult Rehabilitation in Scotland. It reflects the importance of rehabilitation in health and social care and recognises, acknowledges and respects people's potential to overcome barriers to independent living.

The framework focuses on three key groups – older people, adults with long-term conditions and people returning from work absence and/or wishing to stay in employment – with the aims of maximising individuals' participation in their communities and improving quality of life for them, their family and carers.

Rehabilitation services should be easily accessible and, wherever possible, delivered locally where people need them. This requires a shift in how health and social care professionals work and think. It also requires a review of skill mix and pathways of service provision to ensure they meet changing demands and deliver the right services from the right people, in the right place, at the right time.

Service users and carers truly value the support they receive from rehabilitation professionals and support staff. Making their journey as straightforward and smooth as possible is an opportunity within our grasp and builds on the enthusiasm and commitment of generic and specialist rehabilitation teams.

Professionals will require strong support and leadership from NHS Boards and local authorities to make this happen. In particular, we look to community health partnerships (CHPs) to play a leading role in planning and providing services for people requiring rehabilitation in local communities.

It is clear from the models the framework presents that strategic and local co-ordination of rehabilitation services is required to achieve maximum impact and benefits for the people who use them. We are fully committed to the establishment of Rehabilitation Co-ordinators, on a local basis, who will provide leadership, vision and impetus across health, social care and voluntary sectors. They will promote the cultural change required at strategic level to ensure truly integrated services and help meet the aspirations of a number of Scottish Executive polices, including *Delivering for Health* and the *Changing Lives* programme for social work services. And they will work with key agencies to provide staff support and development opportunities through spreading good practice.

It is vital that this proposal and the other recommendations set out in the framework are considered, absorbed and actioned locally and nationally. That is why we are setting up a National Rehabilitation Implementation Group to oversee progress across the country.

The framework builds from a strong tradition in Scotland of developing innovative, integrated rehabilitation services. NHSScotland, local authorities and voluntary groups are delivering effective programmes designed to maintain the population's health and well-being. These need to become the norm across the whole of Scotland, with access being extended to all communities. We believe this Delivery Framework for Adult Rehabilitation provides the necessary infrastructure to make this happen.

Lewis Macdonald, MSP

Deputy Minster for Health
and Community Care

Robert Brown, MSP

Deputy Minister for
Education and Young People

Foreword by Olivia Giles

I was asked to chair the steering group for this framework because I have fairly wide, first-hand experience of NHSScotland's rehabilitation services. In February 2002 I contracted the blood-poisoning form of meningitis and, as a result, my lower arms and lower legs had to be amputated. After the acute phase of my care, I spent six months in a specialised rehabilitation hospital and now my rehabilitation is ongoing in the community. Overall, my experience has been resoundingly positive. Almost every individual rehabilitation service delivered a gold standard of care. But I wonder - could the whole have been greater than the sum of the parts?

In hospital, when my team of professionals pulled together, I felt securely held in a closely woven net. But when communication with an off-site discipline or between two hospitals was poor, I instantly lost confidence in the whole system.

On discharge, I was still using physiotherapy, occupational therapy, psychology, prosthetic and nursing services. Only some of the personnel changed but the team approach, which I had taken for granted in hospital, vanished overnight. It felt like free fall!

Returning home was the most testing hurdle of my rehabilitation. Lack of co-ordination of services was only part of the challenge. From being used to having everything arranged for me, I suddenly had to work out for myself how physically (with limited mobility) and economically to get to each rehabilitation location. I also had to take instant responsibility for deciding the extent to which I would access each service. If I stopped attending, I wouldn't be able to return without going through a referral procedure. So, just at the time when I was having to plumb the depths of my inner resources to cope with the physical demands of being at home alone, the psychological challenge of creating a new life and the emotional low of coming to terms with the contrast between what I had been pre-illness and what I was now - the very time when I could have done with extra support - supervision and co-ordination simply stopped. I was ready for a two-wheeler bike, but I needed a temporary set of stabilisers.

For some of my older fellow patients (especially those with social problems), there was an added dimension to the natural pain of transition. Going home meant increased isolation and consequently reduced motivation to be active. Were psycho-social considerations adequately taken into account in structuring a rehabilitation package for a meaningful life in the community? Even if you can physically pedal the bike, you still need the confidence to go out on it, somewhere to ride it and a reason for the trip.

This framework for the future delivery of rehabilitation services in Scotland tackles all of these issues boldly and head on. Its recommendations aim to break down the traditional boundaries between health professions and professionals, between phases of care, between locations of

care and between the conventional preserves of health care and social work. The driver is recognition that meeting the patient's needs as a human being in our society and managing his or her journey through the *whole* system has to be the primary consideration of every professional involved in rehabilitation. If this responsibility is accepted and put into practice, patients will automatically be placed at the centre of an integrated, sensitive, flexible, intelligent and multi-disciplinary network - and the potential of its excellent workforce and first-rate individual services will be maximised instead of undermined.

The new model for rehabilitation in Scotland illustrates this vision of a seamless patient journey. It also demonstrates how patients should be able to access the streamlined multi-disciplinary system easily at different points and, in particular, from the community. Genuinely facilitated access will also involve delivering services closer to people's homes, simplifying referral procedures (including self referral where appropriate) and, very importantly, providing user-friendly information to the public with constructive guidance about what is available in their locality. These features of the framework will be key to making *pre-emptive* health and social measures effective.

The framework's recommendations spell a huge cultural shift for health and social services and demand commitment and effort from professionals. But patients too will have to respond positively to the changes in ethos *'from care to enablement'* and *'hospital to community'* advocated by *Delivering for Health.*

This does not mean that rehabilitation professionals will be any less kind to patients or that patients will be discharged from hospital prematurely! Maximum physical, psychological, emotional and social autonomy is the goal of rehabilitation. So, in the context of rehabilitation, 'care' means 'enablement'. Old fashioned care alone will not stimulate progress. And institutionalisation is a capability-draining, mind-numbing condition to which human beings are very susceptible. Encouraging independence at home as soon as possible is the only way to counter it. It's not so much a case of being cruel to be kind as recognising that motivation is the key to tapping into patients' own restorative inner resources and natural inclination to achieve their full potential, whatever the limitations of their circumstances. If you want to ride a two-wheeler, being kept on a tricycle will never get you where you want to be.

I have been heartened by the quality of contribution from professionals and users throughout the consultation process. I am delighted to see the Scottish Executive respond to their clear messages and in particular by the commitment to a true integration of health and social care at ministerial level with the joint launch of this policy, underlined by joint funding of Rehabilitation Co-ordinators for each board area.

Olivia Giles
Steering Group Chair

1. Introduction by the Chief Health Professions Officer

Rehabilitation is a core element in the delivery of the Scottish Executive's plans to improve the health and well-being of the population of Scotland and will be instrumental in achieving some of the key national outcomes and targets that have been set for the NHS and local authorities.

When individuals face challenges to their physical or mental well-being, they experience an impact on their quality of life. Rehabilitation is fundamentally about enabling and supporting individuals to recover or adjust during this time, achieve their full potential and – where possible – to live full and active lives. Improving community-based rehabilitation services is integral to the rehabilitative approach, as is the prevention of dependency on 'care' and support services through the promotion of independent living.

While much has already been done to develop rehabilitation services that promote safe and effective discharge from hospital and to expand evidence-based rehabilitation in a number of specialties, challenges remain in areas such as meeting the needs of older people or those with multiple long-term conditions who wish to live independently in their own homes. Improving access, availability and transitions between services provided in hospital and community settings were recurring themes identified by service users involved in the development of the delivery framework. Their views and those of rehabilitation professionals and their multi-agency colleagues are core to the actions set out in this document.

Process

The delivery framework has been developed by the Scottish Executive in partnership with a wide range of stakeholders, including individuals who use services, unpaid carers and rehabilitation providers in health and social care. A National Steering Group and three Action Groups were established (Appendix 1), each chaired by a service user. The Steering Group and Action Groups worked in support of the National Project Officer during the engagement process and the production of successive drafts.

The process of developing the framework involved:

- a thematic analysis of the evidence by the Scottish School of Primary Care;
- a series of consultation events with those who use services;
- a consensus event with health and social care professionals;
- a three-month national consultation on a draft framework document.

Purpose and vision

The purpose of this delivery framework for adult rehabilitation is to give strategic direction and support to all health and social care services and practitioners who deliver rehabilitation services to individuals and communities. The document focuses on core principles of rehabilitation specifically as they relate to older people, adults with long-term conditions and people returning from work absence and/or aiming to stay in employment.

The framework:

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

The vision underpinning the framework is the creation of a modern, effective, multi-disciplinary, multi-agency approach to rehabilitation services that are flexible and responsive in meeting the needs of individuals and communities in Scotland. These services will be facilitated by dedicated Rehabilitation Co-ordinators who will play a key role in:

- mapping existing rehabilitation services in health and social care;
- re-designing services with the support of a rehabilitation improvement network;
- integrating health and social care rehabilitation services;
- promoting case management in the rehabilitation team.

Findings

Work on developing the framework has shown us that existing rehabilitation services are highly valued and that people want rehabilitation services delivered close to their homes (although not necessarily always in their homes) by professionals and teams who are competent and have the requisite skills to support them through the rehabilitation journey. When in-patient rehabilitation services are required, they want rapid admission, effective intervention and appropriate early discharge. Most important, individuals and their carers want professionals to engage fully with them and treat them as equal partners in managing their condition(s) and making decisions about services.

There was a strong call for better co-ordination of rehabilitation services, particularly when the individual is not in hospital, and a need to explore the potential benefits of key worker/ rehabilitation co-ordinator roles was highlighted. This was reinforced during the three-month consultation process.

Impacts

Health and social care organisations across Scotland have a common purpose in addressing rehabilitation issues in the context of sustainable community services. There are clearly practical and economic benefits associated with the development of the integrated approach promoted by this framework.

Services should strive to support people in managing their own health conditions and remaining independent in their own home rather than being admitted to hospital. Current evidence would indicate that many admissions to hospital or institutional care could be avoided if anticipatory and

rehabilitation services were in place. Other potential areas of impact include reducing dependency on care and support services (with decreases in associated costs), reductions in delayed discharge and avoidance of readmissions or repeated (unnecessary) admissions to hospital.

This rehabilitation framework links into ongoing work in relation to anticipatory care/early interventions, long-term condition management and unscheduled care. Effective implementation of the framework with better co-ordination of resources will help reduce emergency admissions, length of stay and delayed discharges. This will be made possible through better access to rehabilitation professionals and the wider primary care team, which in turn will support better identification and management of the at-risk population and those with complex needs. It will also ensure better engagement of service users and their carers in decision making and enable people, wherever possible, to remain in their own homes.

Integrated service redesign and role development are key to putting the rehabilitation journey at the heart of systematically planned services. They will enable multi-disciplinary, multi-agency teams to maximise the benefits of existing models of service and create approaches that focus on the shift from 'care' provision to 'enablement' and rehabilitation, using the expertise of these professions and of the whole team to work with individuals and carers to best effect.

Providing effective rehabilitation services that meet the challenges set out in ***Delivering for Health***[1] and ***Changing Lives***[2] and which comply with guidance provided by the Department for Work and Pensions (DWP), such as ***Building Capacity for Work: A UK Framework for Vocational Rehabilitation***,[3] requires transformational change. Health and social care professionals have already shown real commitment to integrated working and service improvement. They will need to work across organisational and professional boundaries which have previously caused disruptions to the rehabilitation journey, with Rehabilitation Co-ordinators playing a key role in facilitating this process.

I now call on health and social care professionals to build on what has been achieved, look beyond traditional methods of providing services and grasp opportunities for joint learning with health and social care colleagues.

Jacqui Lunday
Chief Health Professions Officer

2. Policy context and background

This delivery framework for adult rehabilitation explores the principles of rehabilitation in line with the new health and social care agendas in Scotland.

Policy context

Delivering for Health[1] signals transformational change in the NHS from a service that is primarily focused on providing care in hospitals to one where care is planned, delivered and evaluated close to people's homes, when this is the most appropriate option. It sets out the Scottish Executive's priorities for NHSScotland over the next decade (see Box 2.1), presenting a new vision for the NHS based on:

- delivering services close to where people live;
- offering people timely access to services;
- promoting a strong emphasis on anticipatory care;
- supporting individuals and carers in self-managing long-term conditions.

Box 2.1 *Delivering for Health*[1]

Delivering for Health[1] calls for:

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

Delivering for Health[1] set out a specific action to develop:

> *… a rehabilitation framework to support services for older people, people with long-term conditions and people returning to work after a period of ill health. The framework will promote a co-ordinated approach to delivering integrated care in community settings…*

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

Various initiatives have been launched by the Scottish Executive in response to specific needs identified in ***Delivering for Health***,[1] including those that support services for:

- people with long-term conditions and their carers;
- older people;
- people with specific conditions, such as stroke.

Rehabilitation is seen as being central to all of these initiatives.

The shift in policy direction in the health service that ***Delivering for Health***[1] represents is mirrored in the social care sector by ***Changing Lives***.[2] The review of social work in Scotland sets out a vision for social care services for the 21st century. The report outlines 13 recommendations based on the premise that 'more of the same won't work', highlighting the need for change to ensure services respond to future demographic changes, public expectations, workforce availability and financial allocations (Box 2.2).

Box 2.2 Recommendations from *Changing Lives*[2]

1. Social work services must be designed and delivered around the needs of people who use services, their carers and communities.
2. Social work services must build individual, family and community capacity to meet their own needs.
3. Social work services must play a full and active part in a public sector-wide approach to prevention and earlier intervention.
4. Social work services must become an integral part of a whole public sector approach to supporting vulnerable people and promoting social well-being.
5. Social work services must recognise and effectively manage the mixed economy of care in the delivery of services.
6. Social work services must develop a new organisational approach to managing risk which ensures the delivery of safe, effective, innovative practice.
7. Employers must make sure that social workers are enabled and supported to practice accountably and exercise their professional autonomy.
8. Social work services must develop a learning culture that commits all individuals and organisations to lifelong learning and development.
9. Social work services should be delivered by effective teams designed to incorporate the appropriate mix of skills and expertise and operating the delegated authority and responsibilities.
10. Social work services must develop enabling leadership and effective management at all levels and across the system.
11. Social work services must be monitored and evaluated on the delivery of improved outcomes for people who use services, their carers and communities.
12. Social work services should develop the capacity and capability for transformational change, both focusing on redesigning services and organisational development.
13. The Scottish Executive should consolidate in legislation the new direction of Scottish social work services.

Changing Lives[2] places the emphasis on service redesign, workforce training and leadership and a shift towards early intervention and prevention. It focuses on building the capacity of the workforce to deliver personalised services and create sustainable change.

Rehabilitation can therefore be seen as being pivotal to the principles of ***Delivering for Health***[1] and ***Changing Lives***,[2] many of which are shared (see Box 2.3).

Box 2.3 Shared principles of *Delivering for Health*[1] and *Changing Lives*[2]

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

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

Other key policy statements relevant to rehabilitation services include:

- ***Delivering for Mental Health***[4]
- ***The Scottish Executive Response to The Future of Unpaid Care in Scotland***[5]
- ***The Diabetes Action Plan***[6]
- ***Cancer in Scotland***[7]
- ***Coronary Heart Disease and Stroke Strategy for Scotland***[8]
- ***Workforce Plus – An Employability Framework for Scotland***[9]
- ***More Choices, More Chances: A Strategy to Reduce the Proportion of Young People not in Education, Employment or Training in Scotland***[10]
- ***Healthy Working Lives: A Plan for Action***[11]
- ***Pathways to Work: Helping People into Employment***[12]
- ***The Department for Work and Pensions Cities Strategy***[13]
- ***The Strategy for Community Hospitals in Scotland.***[14]

These UK and Scottish initiatives, and many more like them, indicate a significant shift in policy towards community-based services, with rehabilitation firmly defined as a central component.

Health and social care professionals now need to build on existing skills in the management of long-term conditions and co-morbidities, health improvement and anticipatory care/early intervention. The Community Health Partnership (CHP) Long-Term Conditions Toolkit will be a useful resource in taking this forward. By focusing on rehabilitation and enablement, professionals will be in a strong position to contribute their expertise to the delivery of the new health and social care agenda, working with individuals, carers, communities and voluntary organisations.

Rehabilitation services in Scotland

Hard data on the numbers of people accessing rehabilitation services in Scotland are difficult to establish due to the diverse nature of service provision. An indication of the extent of demand, however, can be gained from the National Allied Health Professions (AHP) Census, which took place in September 2005, and which showed that across Scotland, 59 997 people were seen by an AHP on Census Day – on average, 1:89 people in Scotland.[15] The Census covered only AHPs working in the NHS, so the actual numbers will be greater when account is taken of people accessing rehabilitation services through social services, independent and voluntary organisations.

Rehabilitation services currently are delivered in a variety of settings, often by diverse groups that cross health, local authority and voluntary sectors and which include individuals and carers, equipment and adaptation services and employers. Around 600 000 unpaid carers support individuals throughout Scotland and play a crucial role in successful self management.

3. A new approach to rehabilitation

Rehabilitation

Rehabilitation interventions are designed to make positive impacts on individuals and carers, enabling them to live their lives to their fullest potential. Rehabilitation is a concept that has broad applicability across health and social care professions and agencies. It can be defined in different ways within different contexts and means different things for different client groups.

There is no universally accepted definition or theoretical model to describe rehabilitation. The King's Fund, however, has produced a working definition which describes rehabilitation as:

> *A process aiming to restore personal autonomy to those aspects of daily life considered most relevant by patients or service users, and their family carers.*[16]

This definition reflects the fact that the needs of individuals and carers are at the heart of rehabilitation. Developing enablement approaches will allow services to work in partnership with individuals and carers to provide professional support or interventions when required and to ensure best use of resources and best outcomes for individuals and carers.

A more detailed analysis of rehabilitation, which relates more to specialist roles and focuses on structure, process and outcomes, is provided by Wade *et al.*[17] (Box 3.1).

Box 3.1 Rehabilitation[17]

Structure

A rehabilitation service consists of a multi-disciplinary team of people who:

- work together towards common goals for each patient;
- involve and educate the patient and family;
- have relevant knowledge and skills;
- can resolve most of the common problems faced by their patients.

Process

Rehabilitation is a reiterative, active, educational, problem-solving process focused on a patient's behaviour (disability), with the following components:

- assessment – the identification of the nature and extent of the patient's problems and the factors relevant to their resolution;
- goal setting;
- intervention, which may include either or both of (a) treatments, which affect the process of change, and (b) support, which maintains the patient's quality of life and his or her safety;
- evaluation – to check on the effects of any intervention.

Outcome

The rehabilitation process aims to:

- maximise the participation of the patient in his or her social setting;
- minimise the pain and distress experienced by the patient;
- minimise the distress of, and stress on, the patient's family and carers.

The definition of Wade *et al.* outlines the ***structure*** necessary for rehabilitation. The emphasis is on the existence of a multi-disciplinary, multi-agency team who can assess and treat most of the problems commonly faced by individuals.

The ***process*** of rehabilitation is one of assessing (collecting and interpreting data), setting goals, intervening to provide support, enabling self-management potential and treating, then re-assessing to compare the situation after intervention. At some point, the individual should exit this cycle and manage his or her own condition, but there will continue to be times when interventions from the multi-disciplinary, multi-agency team will be required.

The intended primary ***outcomes*** of rehabilitation are related to maximising individuals' participation in society.

Elements of the King's Fund and Wade *et al.* definitions have informed the development of the delivery framework, which has pursued a patient-focused approach to the rehabilitation journey.

Levels of management in the rehabilitation process

Three levels of management have been identified in the rehabilitation process.

- For the majority of people, ***self management*** has been shown to be effective in improving quality of life and promoting appropriate use of services.
- People with less-complex needs and their carers are offered ***condition management*** support through ***multi-disciplinary primary care teams***, with specialist rehabilitation as appropriate.
- For the small number of people with the most complex needs and their carers, the aim is to offer ***case management***, often in the form of ***community or specialist nursing***, but also capable of being provided by a variety of multi-disciplinary, multi-agency team members. Individuals with complex needs are most likely to be at risk of admission to hospital and may become ill unless their needs are anticipated and addressed. The case management approach should be utilised for individuals in all three of the target groups identified in Chapter 4 who have complex rehabilitation needs.

These levels of management are described in more detail in Box 3.2

Box 3.2 Levels of management in the rehabilitation process

Self management relates to individuals taking responsibility for their own physical and emotional health and well-being and includes staying fit and healthy, taking action to prevent illness and accidents, using medicines appropriately, seeking prompt treatment for minor physical and emotional ailments and self managing long-term conditions appropriately.

Condition (sometimes referred to as 'disease') **management** has been defined as: *a system of co-ordinated health care interventions and communications for populations with conditions in which patient self-management efforts are significant.*[18]

Case management has been defined as: *a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes.*[19]

Care management is the process of tailoring services to individual needs. Assessment is an integral part of **care management**, but it is only one of a number of core tasks that make up the whole process. Care management is a cyclical process in which needs are assessed, services are delivered in response and needs are then re-assessed, leading to a changed service response.[20]

Case management is the term most often used by health care professionals, and care management is commonly used by social work professionals. As the definitions show, however, they both in essence *describe the same service*. For the purposes of this document, **case management** is adopted as the preferred term to reflect the focus on enablement (as distinct from the provision of 'care' services) that is central to this delivery framework.

Creating the vision

A major transformation in health and social care services is now needed to place rehabilitation at the heart of service delivery and ensure that the challenges of the inevitable transitions in the rehabilitation journey are acknowledged and well handled. This means challenging current organisational structures and staff roles.

To do this, we need to move away from a *reactive, unplanned* and *episodic* approach to service provision, particularly for individuals and carers with complex conditions and high-intensity and/or ongoing needs. Services are in place to help people and their carers during times of crisis, but the ongoing co-ordinated support and rehabilitation necessary to prevent crises may be less easily accessible.

Evidence shows that intensive, ongoing and personalised case management can improve quality of life and outcomes for individuals with complex or ongoing needs and their carers. This dramatically reduces emergency hospital admissions and enables patients who are admitted to return home more quickly with a co-ordinated support package that will allow them to remain at home as long as possible. The model for rehabilitation which follows aims to ensure planned, continuous rehabilitation support is available within community settings to maximise self-management potential and minimise the risk of hospital admission and readmission.

Developing a model for future rehabilitation services

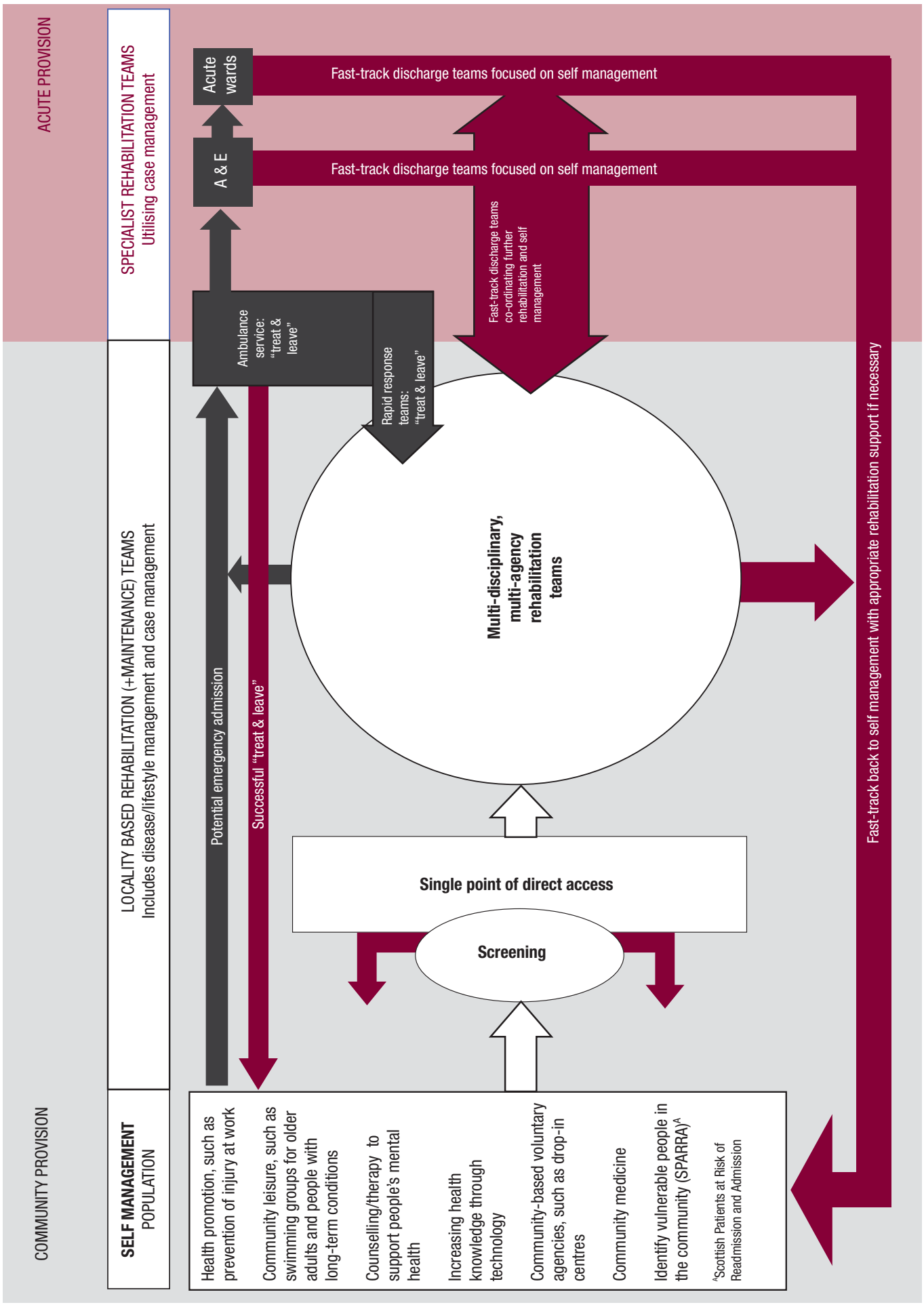
The model reflects closely the main messages transmitted by individuals and carers during the consultation. These highlight the need to:

- develop person and carer-centred rehabilitation services;
- create direct access to rehabilitation services, where appropriate;
- create a single point of access to rehabilitation services, where appropriate;
- promote a focus on maximising individuals' autonomy and enablement;
- provide rehabilitation services closer to individuals' homes, when appropriate;
- encourage multi-disciplinary, multi-agency teams genuinely to work together in whole-systems approaches;
- adopt a holistic model of rehabilitation encompassing physical, psychological, emotional and social needs;
- strengthen the Single Shared Assessment system on accessing services;
- provide the same quality of treatment for all, regardless of class, age, culture or geographical location;
- review and analyse outcomes on an ongoing basis, with a particular focus on feedback from individuals and carers.

Figure 3.1 identifies the components of a future model of rehabilitation. It is a generic model intended to be relevant for all three target groups identified by ***Delivering for Health***[1] and discussed in Chapter 4.

The future model for rehabilitation identifies, first, opportunities for **early intervention for the self-management group**, where the emphasis is on self management and health promotion utilising community culture and leisure centres, lifelong learning opportunities and voluntary agencies' services. This phase of the rehabilitation journey could be called 'prehabilitation', or even 'habilitation', and has strong links with anticipatory care.

Figure 3.1 Future model for rehabilitation



The next phase is the **condition management phase**, into which an individual can self refer when appropriate to a rehabilitation team via a single point of access to enable specific needs, either social or health, to be addressed. It is anticipated that more appropriate and better co-ordinated management in this phase will lead to reduced hospital admissions. If hospital admission is necessary, rehabilitation teams with case managers in place in hospital and community will facilitate safe and effective discharge. Individuals requiring uni-professional interventions should be able to access them within multi-disciplinary, multi-agency rehabilitation teams, ensuring individuals and carers receive the services they require and are not excluded due to restrictive referral criteria.

The model then addresses the need for acute, transitional and long-term rehabilitation services with the aim of ensuring that individuals can access the service at any point, whether through the acute service or by direct access through a community rehabilitation team.

In the **acute phase**, vital specialist interventions are undertaken by hospital rehabilitation teams with the aim of stabilising the patient and ensuring a timely, seamless discharge process. There will be a continuing need for specialist acute rehabilitation services across Scotland.

The model reflects the need for smooth, planned **transitions** from hospital rehabilitation to the community, emphasising the importance of working with carers. The aim is to have a flexible service that facilitates seamless transitions across primary and secondary care and encourages joint working. There is good evidence that outreach services following discharge should follow the case management ethos (see Box 3.2, above). There is also scope for developing inreach[A] services to ensure transitions are managed effectively, consequently preventing delayed discharge.

The **longer-term rehabilitation phase** calls for community rehabilitation teams to work in partnership not only with acute rehabilitation teams, but also across all health, local authority,[B] independent and voluntary sectors and, crucially, with individuals, carers and communities.

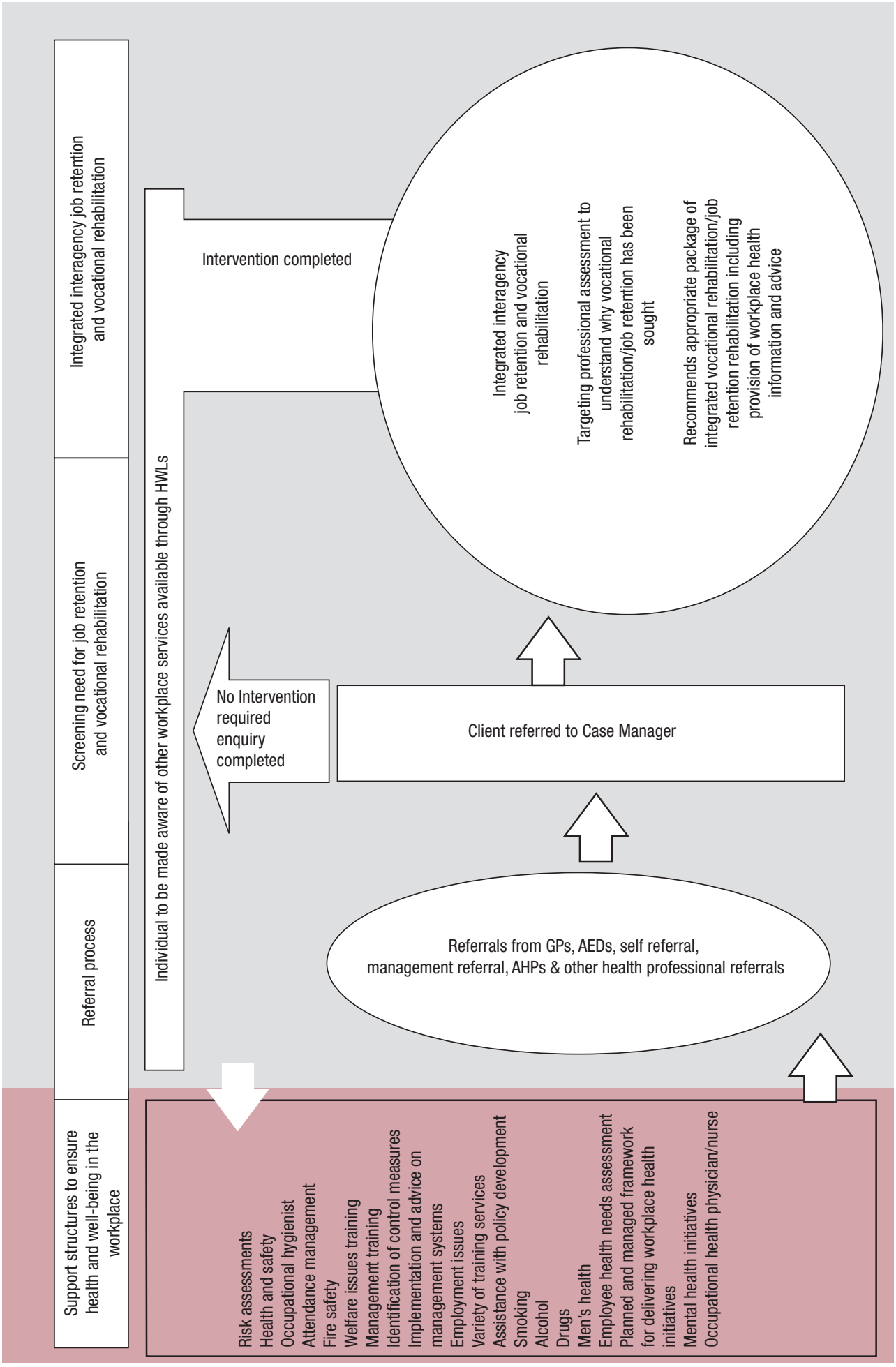
The overall aim for rehabilitation services should be to build on the strengths of existing services in these phases to develop a network of rehabilitation teams. Some of these teams will specialise in specific conditions or interventions and others in longer-term involvement with individuals and carers in the community, enabling return to work or education where appropriate and promoting increased social participation.

A separate model specifically relating to vocational rehabilitation is shown in Figure 3.2. Vocational rehabilitation has particular characteristics which justify an alternative approach by services. The aims of vocational rehabilitation are set out in Chapter 4.

A 'Outreach' refers to acute rehabilitation teams delivering services within the community, and 'inreach' to community rehabilitation teams delivering services within acute settings.

B Local authority services include social care, some care home provision, housing, equipment provision and leisure services.

Figure 3.2 Future model for vocational rehabilitation



The model for vocational rehabilitation outlines the **support structures** that should be available to individuals in workplaces to promote health and well-being at work. It then identifies a rapid-access **referral process** through which individuals should be able to secure support and specialist advice from a dedicated vocational rehabilitation team consisting of a range of professionals (including those shown in Box 3.3) using case management approaches (for a discussion of case management approaches, see Box 3.2, page 16).

Box 3.3 Vocational rehabilitation teams

Teams are likely to consist of a range of professionals, including:

- case manager (any discipline)
- counsellor
- manual handling trainer
- occupational health adviser
- occupational health physician
- occupational therapist
- physiotherapist
- psychologist
- support worker.

The list is not exhaustive.

Supporting the future model for rehabilitation

The model will require the development of multi-disciplinary, multi-agency rehabilitation teams with a suitably trained and skilled workforce to deliver services that are locally based and patient focused and which adopt an integrated, seamless approach to delivery.

The ethos of the rehabilitation model is about enabling maximum physical, psychological, emotional, social and occupational potential of the individual and improving quality of life. Individuals and carers told us that quality of life is about more than the ability to perform basic activities of daily living, commonly a central focus of rehabilitation, especially in the early phase. The ability to perform basic activities is, of course, important, but is secondary to the need to enable social engagement and purposeful occupation, which are key to encouraging a sense of self worth and well-being and which have been particularly prominent in rehabilitation offered within mental health services. More effective linking between specialist rehabilitation, vocational rehabilitation and community-based social and leisure services is therefore a prerequisite to enhancing the model's effectiveness in practice.

During the process of developing the delivery framework, strong support for the inclusion of individuals and carers in rehabilitation teams was expressed. The intention in developing their contributions in this way is to enhance, and not diminish, the professional rehabilitation services provided to individuals. The aim is to reduce the burden on carers through strategic developments and service delivery that acknowledge and support carers' central role.

Professionals should continue to provide key services, education and support at all stages of the rehabilitation process, resulting in individuals and carers being better supported and equipped to play their part in contributing to the design of their own support.

Rehabilitation teams should therefore foster an inclusive, partnership approach with individuals and carers and should include a wide range of health and social care professionals and the voluntary sector (including those shown in Figure 3.3 – the list is not exhaustive). Rehabilitation teams will be working within a diverse range of settings, including those shown in Figure 3.4 – again, the list is not exhaustive. The range and diversity of agencies, teams, individuals and settings involved in rehabilitation services will provide an enormous source of strength and expertise from which patient-centred services can be developed.

Figure 3.3 Personnel within rehabilitation teams

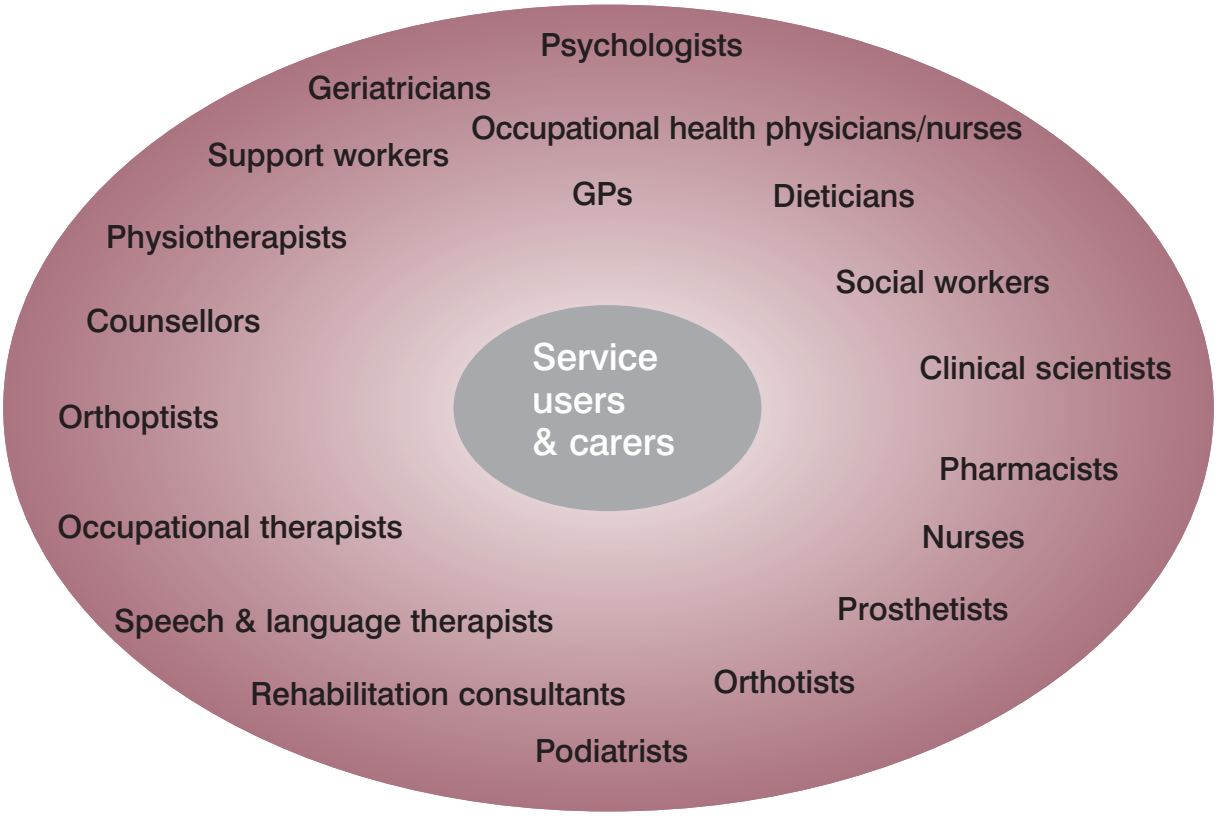


Figure 3.4 Settings in which rehabilitation teams work

Joint induction and training programmes among agencies, which involve individuals and carers, will be needed to develop this team approach. Information and training for individuals and carers about how to contribute to managing their conditions will also be vitally important for successful outcomes.

The role of community health partnerships in supporting the model

In developing the future model for rehabilitation, the model for vocational rehabilitation and the delivery framework recommendations (see Chapter 5), it was important to consider the role of community health partnerships (CHPs), bearing in mind that CHPs will continue to develop services according to local need and priority. CHPs play a key role in planning and providing NHS and related services for people requiring rehabilitation in local communities. They are local service-delivery mechanisms through which health improvement and shifts in the balance of care are being delivered by the NHS, local authorities and the voluntary sector, with greater involvement of individuals, carers, staff and independent contractors.

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

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

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

The role of community hospitals in supporting the model

Community hospitals are an important element of health service provision for many communities across Scotland, particularly, but not exclusively, in remote and rural areas. They also have a key role to play in integrated care provision. ***Delivering for Health***[1] cites rehabilitation as one of the elements of practice to which community hospitals can make a significant contribution, and ***The Strategy for Community Hospitals in Scotland***[14] calls on NHS Boards to create the structures necessary to ensure community hospitals remain central to local health care systems. Community hospital services should be maximised to support step-down care from acute hospitals and offer locally based access to services.

The role of intermediate care services in supporting the model

Intermediate care services, which are those that do not require the resources of an acute hospital but are beyond the scope of traditional primary and social care services, have not featured as a key policy driver in Scotland to date. Local partnerships involving health and social services are, however, currently exploring the potential benefits they offer in bringing ongoing rehabilitative and enabling services closer to communities. The Joint Improvement Team is supporting a national Intermediate Care Learning Network which aims to facilitate sharing of good practice and to support evaluation and development programmes with local health and social care partnerships (www.jitscotland.org.uk).

The role of technology in supporting the model

The national eHealth programme has been launched with the aim of supporting:

- faster access to services through electronic referral and discharge systems;
- enhanced user involvement, with better access to information;
- development of the electronic health record with appropriate security controls;
- sharing of information among professionals;
- development of standardised referral and assessment protocols to support evidence-based care.

Equipment, adaptations, assistive or 'SMART' technology and telehealth will play a significant role in future rehabilitation services. In addition, information technology (IT) developments are continually extending the range of devices available to support rehabilitation. These offer enormous scope for telecare and telehealth services to support people with health and social care needs to remain in their own homes and to optimise their independence and quality of life.

The National Telecare Development Programme (Box 3.4) was launched in 2006 to lead initiatives in this field. The Scottish Centre for Telehealth was also launched in 2006, fulfilling a Scottish Executive commitment to set up the Aberdeen-based centre to help NHS Boards to make the most of technologies designed to improve health care services. The centre is harnessing the skills and expertise of key groups across Scotland from medicine, operational management and industry to provide advice and support for all parts of the NHS.

Telecare and telehealth could each be pivotal in bringing equality of care to rural areas, preserving, maximising and spreading the benefit of centralised expertise.

Box 3.4 National Telecare Development Programme

The programme makes funds for telecare developments available to health and social care partnerships across Scotland. Partnerships' proposals for funding must:

- be endorsed by community planning partners;
- present a strategic approach that demonstrates how telecare will complement the range of other local health and social care services;
- indicate the scope and range of services to be introduced, with explicit targets relating to impact;
- provide evidence of how services will be sustained and further developed through the partnership's own resources;
- provide evidence of the efficiency savings to be gained as a result of the introduction of a range of telecare services.

Source: http://www.jitscotland.org.uk/action-areas/themes/telecare.html

4. The three target groups

There is clearly a need to build on the significant range of policy and service developments already in place that reflect the needs of our key target groups. This chapter explores this underpinning work and specific issues relating to rehabilitation service provision for:

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

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

Older people

Scotland's population is growing older. The numbers of older people (aged 65 and over) is expected to increase from 830 000 in 2004 to 1.31 million in 2031. The number aged 75 and over is projected to rise from 370 000 to 650 000 over the same period.[21] The carer population is also growing as a consequence of increasing demand for support.

Old age is not an illness. Many older people are fit and well, functioning capably in their communities without professional support. The service emphasis for these people is 'habilitation' – maintaining their physical, psychological and social health and well-being and anticipating and pre-empting any decline before it becomes acute.

Older people nevertheless tend to have higher levels of ill health than those who are under 65. The Scottish Executive Information and Statistics Division reported in 2001 that rates of occurrence of limiting long-standing illnesses increased considerably with age. Fifty percent of men and 60% of women in the 75 and over age group at that time had a disability, compared to only 14% of the general adult population (aged 16 and over).[22] Care of older people accounts for 40% of the health service budget in Scotland and 60% of the social work budget[23] and is consequently a key priority for the Scottish Executive (see Box 4.1).

Box 4.1 Health and social care policy for older people in Scotland

The Scottish Executive has published a series of policy documents identifying the health and well-being of older people as a priority for Scotland, including:

- ***The Future Care of Older People in Scotland***[24]
- ***The Scottish Executive Response to The Future of Unpaid Care in Scotland***[5]
- ***Better Outcomes for Older People***[25]
- ***National Framework for Service Change in the NHS in Scotland - Care of Older People***[23]
- ***National Care Standards – Care Homes for People with Physical and Sensory Impairment***[26]
- ***National Care Standards – Care Homes for Older People***[27]
- ***Effective Social Work with Older People***[28]
- ***Adding Life to Years***[29]
- ***The Strategy for a Scotland with an Ageing Population***.[30]

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

- ***Healthcare Services Used by Older People in NHSScotland***[31]
- ***Working with Dependent Older People Towards Promoting Movement and Physical Activity***[32]
- ***National Overview: Older People in Acute Care***[33]
- ***Working with Older People Towards Prevention and Early Detection of Depression.***[34]

The focus of policy is to identify the growing need for integrated older people's services. ***Better Outcomes for Older People***[25] provides a lead on how to set up joint services and sets out the requirements, actions and timescales local partnerships should meet in developing joint services. It also emphasises that progress will be monitored by a national partnership involving the Scottish Executive, the Convention of Scottish Local Authorities (CoSLA) and NHSScotland.

The key messages from ***Better Outcomes for Older People***[25] are about:

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

Reviews of older people's services carried out by several NHS Boards have reinforced the need for a coherent, integrated system of community-based rehabilitation. The reviews have recognised that flexible service delivery involving hospital discharge teams, community older people's teams, social services, day hospitals and day centres is essential in preventing unnecessary admission to hospital and supporting hospital discharge.

Better Outcomes for Older People[25] outlined the principles and values of joint service provision, which relate to their:

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

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

Joint Future is the headline policy on joint working in community care. It initially focused on systems and structures, but now adopts an outcomes-based approach, promoting whole-systems working and partnerships.

Single Shared Assessment (SSA) is central to the Joint Future initiative and is already resulting in real improvements for older people and their carers (and others) through facilitating quicker and more effective decision making. SSA aims to:

- provide direct access to services and resources across agency boundaries;
- eliminate duplication in assessment;
- ensure that information is shared across agencies with the consent of the person being assessed;
- speed up the delivery of appropriate services.

Stroke and hip fractures are particularly common causes of disability among older people and pose significant challenges for rehabilitation and community services. Specialist rehabilitation services, including comprehensive assessment and rehabilitation for frail older people, has made significant progress in demonstrating better outcomes for patients, particularly in stroke and orthopaedic rehabilitation. These services, often situated within secondary care settings, are highly valued by patients and their carers and must continue to play a key role in the future development of the rehabilitation/enablement continuum within health and social care services.[C]

It is also known that older people have a higher incidence of dementia, which can be misdiagnosed as depression. It is important that older people are assessed appropriately at the point of contact with health and social care services and that appropriate services are available. ***Delivering for Mental Health***[4] has committed to funding a pilot improvement programme involving NHS Forth Valley and the Dementia Services Development Centre which will look at better ways of identifying dementia early and providing services focused on supporting the person at home as long as possible. The programme will be evaluated in 2008.

C Advice on falls prevention will be issued to NHS Boards concurrently with this rehabilitation framework (HDL *Prevention of falls in older people*, February 2007).

It is important to reinforce the need for comprehensive in-patient assessment and rehabilitation in specialist units for frail older people. There is evidence to suggest that comprehensive care in such settings can improve the probability of return to independent living. The transition to the community thereafter needs to be seamless for older people and carers to gain maximum benefits.

There is evidence to suggest that a multidisciplinary Comprehensive Geriatric Assessment (CGA) (Table 4.1) has significant benefits in identifying and planning rehabilitation needs.[35] Older people, whether being managed in the community or presenting to the acute hospital, should have appropriate access to CGA.

Table 4.1 Components of Comprehensive Geriatric Assessment

Components	Elements
Medical assessment	Problem list Co-morbid conditions and disease severity Medication review Nutritional status
Assessment of functioning	Basic activities of daily living Instrumental activities of daily living Activity/exercise status Gait and balance
Psychological assessment	Mental status (cognitive) testing Mood/depression testing
Social assessment	Informal support needs and assets Care resource eligibility/financial assessment
Environmental assessment	Home safety Transportation and tele-health

Source:
http://www.bgs.org.uk/Publications/Publication Downloads/Compend_3-5 Comp Assessment hospital.doc

While it is important to focus on the needs of the frailest older people in our communities, it is also vital to promote independence for older people who are well. Local authorities, voluntary groups and health services, working with NHS Health Scotland and using the Scottish diet action plan[36] and the national physical activity strategy,[37] are developing innovative, effective programmes designed to maintain the population's health and well-being. Programmes such as these need to become the norm across the whole of Scotland, allowing access by all communities. In addition, the links between physical and mental health are well known: older people who are physically active are more likely to remain physically and mentally healthy.

People with long-term conditions

A long-term condition is defined by the Long-Term Conditions Alliance Scotland as one that requires ongoing care, limits what the person with the condition can do and is likely to last longer than one year. As incidence increases with age, many older people are likely to be living with more than one long-term condition.

Long-term conditions have been the focus of a raft of health and social care policy from the Scottish Executive and others (Box 4.2).

Box 4.2 Health and social care policy for people with long-term conditions

The Scottish Executive has launched a series of policy initiatives identifying the health of people with long-term conditions as a priority for health and social care providers, including:

- CHP Long-term Conditions Toolkit
- the Long-term Conditions Alliance Scotland, launched in May 2006
- ***Promoting Active Lifestyles: Good Ideas For Transport and Health Practitioners***[38]

The Department of Health in England has also published useful documents on the management of long-term conditions, including:

- ***Supporting People with Long-term Conditions to Self Care***[39]
- ***The National Service Framework for Long-term Conditions***[40]
- ***Supporting People with Long-term Conditions***[41]
- ***Promoting Optimal Self Care***.[42]

Long-term conditions can place huge physical, social, emotional and financial pressure on individuals, families and carers. They also create significant challenges for NHS and other services and resources. People with long-term conditions are more likely to visit their GP and outpatient departments, be admitted to hospital and to remain in hospital longer. Currently, long-term conditions comprise eight of the top 11 causes of hospital admissions.

The World Health Organization has acknowledged that if not successfully managed, long-term conditions will be the leading cause of disability and the most expensive problem for health care systems by the year 2020, with depression being the number one cause of disability.[43] ***Delivering for Mental Health***[4] has focused heavily on the need to reduce the incidence of depression through better assessment, early intervention and the use of a range of evidence-based psychological therapies. Work is being done to take this forward, as is work around better

management of individuals who have long-term physical conditions such as coronary heart disease and diabetes with depression and anxiety.

Initiatives aimed at ensuring people with severe and enduring mental health problems have access to better health interventions such as smoking cessation services and dental and eye checks will be progressed. The evidence to support interventions in this area is very strong: we know that people with a chronic mental illness may die up to 10 years earlier than their peers in the general population due to higher incidences of coronary heart disease, diabetes and asthma, and that they tend to consume more alcohol and misuse other substances. Much work needs to be done by services in primary and community care around this agenda.

A key aim of rehabilitation for people with long-term conditions, which was reinforced strongly in the consultation process, is to equip individuals and their carers with skills, knowledge and support to self manage wherever possible in a way that enables them to participate fully in their communities, with timely access to appropriate professional interventions when required. Enabling people who have long-term conditions to take greater control of their treatment in the community, with access to appropriate support from health and social care professionals, improves their quality and length of life, reduces emergency admissions to hospital and releases inpatient capacity.[44]

It is recognised that the central component in enabling people with long-term conditions to live their lives as independently as possible in their homes is the support provided by families, carers and communities. People with long-term conditions and their carers are experts in how their condition affects them and their lives. Individuals and carers must be acknowledged as partners in their management and as central members of rehabilitation teams, deciding what support they need, when they need it and how it is delivered.

Another key message from the consultation was that self-management support options should be based on comprehensive assessment of need and should include access to:

- self-monitoring devices, assistive technologies, equipment and adaptations;
- rehabilitation services as an effective alternative to traditional home care services;
- information about services in other sectors such as the voluntary sector and local authorities.

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

Vocational rehabilitation has been defined as a process that enables people with functional, psychological, developmental, cognitive and emotional impairments or health conditions to overcome barriers to accessing, maintaining or returning to employment or other useful occupation. The emphasis is on restoration of functional capacity for work or other useful occupation rather than treatment of a clinical condition *per se*.

While vocational rehabilitation is relatively new to the UK, it has been extensively developed and evaluated in countries such as Australia, Canada and the US and is now beginning to emerge as a priority for policy and service development in Scotland and the rest of the UK (Box 4.3).

Box 4.3 Health and social care policy for people returning from work absence and/or aiming to stay in employment (vocational rehabilitation)

The Scottish Executive and the Department for Work and Pensions have published a series of policy documents in this field, including:

- ***Workforce Plus: An Employability Framework for Scotland***[9]
- ***A New Deal for Welfare: Empowering People to Work***[45]
- ***Healthy Working Lives: a Plan for Action***[46]
- ***Building Capacity for Work: A UK framework for Vocational Rehabilitation.***[3]

Workforce Plus: An Employability Framework for Scotland,[9] for example, sets out how a large number of agencies need to work together to help individuals who often face a complex combination of factors that keep them from finding and sustaining employment. It clearly identifies the role of NHSScotland as an employer and as a provider of rehabilitation services, working in partnership with other employment-related services through CHPs and local *Workforce Plus* partnerships. Partnership working involving NHS health care professionals and employment-related services has already been demonstrated in Scotland with the Department for Work and Pensions' innovative Pathways to Work programme.

Some policy activity has focused on education, training and economic development, while other initiatives have specifically targeted social exclusion, directly addressing the disadvantage implicated in disability. Vocational rehabilitation draws all of these strands together in a holistic and systematic manner. It requires a joined-up approach to provision of treatment and other interventions.

A recent review of 400 pieces of scientific evidence[47] concludes that being in work is good for people's physical and mental health, boosting self esteem and quality of life. The adverse effects of unemployment (higher rates of mental health problems and increased likelihood of suicide, disability and obesity) can be reversed: when people return to work from unemployment, their health improves to the same degree by which it was damaged by unemployment.

Delivering for Mental Health[4] has identified that employment can be key to recovery for many people suffering from mental illness. Programmes to maintain employment or facilitate re-entry into the labour pool can be very effective in supporting social inclusion. Pilot work in primary care and in labour markets will be evaluated and, where appropriate, lessons will be applied. Learning from work being taken forward by the Scottish Development Centre for Mental Health on behalf of the European Commission will also be reflected in future action.

In Scotland, the *Healthy Working Lives* initiative has been launched to support and enable individuals to maximise their functional capacity throughout their working lives through a 'one-stop-shop' approach to accessing information, specialist advice and practical support. The

Scottish Executive commissioned a working group in 2003 to look at 'fast-track' rehabilitation programmes in the NHS in Scotland. The working group produced a paper describing a scheme (OHS Xtra) which advocated an approach to tackling long-term sickness absence in NHS staff by providing rapid access to a vocational rehabilitation programme (Box 4.4).

Box 4.4 OHS Xtra

OHS Xtra is a pilot project based in NHS Fife and NHS Lanarkshire. The aim of the project is to reduce work-related difficulties and absences for NHS employees who may be experiencing health and welfare problems.

NHS staff in the two NHS Board areas have rapid access to a dedicated health support service consisting of physiotherapy, occupational therapy and mental health support. The provision of heath support services has had a positive impact on the health, welfare and well-being of the NHS workforce, which in turn will benefit the

In addition, services such as those provided by Employee Assistance Programmes that provide early intervention for mental health conditions have been in place for 25 years in the UK, but have fallen within the remit of social policy. Usually provided by private enterprise, these services can play a critical role in job retention for employees at risk. The important contribution of the voluntary sector in promoting vocational rehabilitation is also significant.

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

The Health and Safety Executive (HSE) reports that over 2 million workers in the UK are suffering from an illness believed to be caused or exacerbated by their current or previous work. Around 40 million working days are lost each year due to occupational ill health and injury. The Confederation of British Industry (CBI) estimates that sickness/absence costs the UK economy around £12 billion each year; this equates to £1 billion for Scotland, or around £800 per worker per year.

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

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

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

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

Innovations such as the ***New Deal for Disabled People***[48] and ***Pathways to Work***[12] show that, with the right help, support and vocational rehabilitation, many people on incapacity benefits can move back into the workplace. Early results from the Pathways to Work pilot programmes, for instance, show off-flows from incapacity benefit at six months of about 48%, compared with 40% nationally. Benefits data for the UK reveal that the number of people on incapacity benefits has fallen by 54 000 in the year to May 2006 and is now below 2.7 million for the first time in six years.[49]

Research has identified features of vocational rehabilitation that are valued by people. They include:

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

Studies also support initiatives that:

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

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

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

Key elements of vocational rehabilitation include:

- assessment of functional, physical, psychological and cognitive work capacity;
- vocational assessment and counselling to determine suitable job options;
- counselling to support adjustment to disability;
- supervised on-the-job training and/or a short vocational course;
- fitness and work conditioning programmes;
- confidence building/self-esteem groups or individual sessions;
- assessment of workplace suitability;
- development of skills for job seeking;
- brokerage and case management;
- linkage with community-based agencies.

5. Recommendations for action

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

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

Six statements

A set of six statements was developed by the Chief Health Professions Officer and National Project Officer following the process of consultation detailed above. These were endorsed at the consensus event with health and social care practitioners and are set out below.

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

In addition to endorsing these statements, individuals, carers and health and social care professionals also highlighted the need for strategic co-ordination of rehabilitation services to drive necessary changes across the boundaries between stages of care, between disciplines within the health sector and between health and social services.

The following sections address the six themes listed above, outlining recommendations for action. Many are relevant for all three target groups identified in Chapter 4, but specific issues relating to particular groups are listed separately.

The process of implementing the recommendations will be facilitated through five key actions supported by the Scottish Executive.

Five key actions

1. A **National Rehabilitation Implementation Group** will be formed to oversee the introduction of the rehabilitation models and other recommendations from the delivery framework. The group will report jointly to the Scottish Executive Health Department and the Social Work Services Policy Division, Scottish Executive Education Department.

2. Local **Rehabilitation Co-ordinator Posts** will be established and funded through the Scottish Executive Health Department and Scottish Executive Education Department. Post holders, working with the rehabilitation models, will provide leadership, direction and strategic co-ordination at local level and will work with the National Rehabilitation Implementation Group to ensure the rehabilitation models and framework recommendations are delivered locally. The co-ordinators will work closely with key stakeholders to facilitate the required organisational changes.

3. The Chief Health Professions Officer will work with the Improvement and Support Team, the Joint Improvement Team and the Joint Future Unit to explore the development of a **Rehabilitation Improvement Programme** to shape delivery of rehabilitation services nationally, based on the rehabilitation models. The programme will work with the relevant agencies to ensure alignment with existing education and improvement initiatives.

4. The Scottish Executive Health Department will work in partnership with NHS Education for Scotland, NHS Quality Improvement Scotland and the regional research consortia to develop a **Managed Knowledge Network** (MKN). This MKN will facilitate effective access to the knowledge and evidence base for rehabilitation and the sharing and generation of new knowledge.

5. The Scottish Executive will bring together national and international rehabilitation research experts for a **Rehabilitation Research Consensus Event** that will explore gaps in the current research literature and make recommendations for future research bids.

Four priorities for NHS Boards and local authorities

The priority for NHS Boards and local authorities will be to:

- transform their rehabilitation services to put rehabilitation at the heart of service delivery;
- adopt a whole-systems approach to rehabilitation services;
- give greater priority to rehabilitation services;
- reflect evolving outcomes measures for community care (and any consequent targets) that impact on rehabilitation services.

1. Access

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

Improving access to physical or mental health services requires the incorporation of innovative and novel systems into practice. Many rehabilitation and specialist services are already looking at referral criteria and access issues, building on existing good practice.

Views of users of the service

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

Access – recommendations

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

ACCESS			
Recommendation	**Lead responsibility**	**Working with**	**Timescale: by end of**
1.1 NHS Boards, particularly CHPs, working in partnership with local authorities, should enhance access to services, information and sources of support for individuals requiring uni-professional and multi-professional rehabilitation, including developing a single point of access to services.	NHS Boards Local authorities	Rehabilitation co-ordinators SEHD SEED	2008
1.2 Access to NHS and local authority rehabilitation advice and services should be explored for individuals living in community-based care settings, such as care homes.	NHS Boards Local authorities	Rehabilitation co-ordinators Independent sector	2009
1.3 NHS Boards and local authorities should work to ensure Single Shared Assessment is available and identifies all individuals with potential rehabilitation needs.	NHS Boards Local authorities	Rehabilitation co-ordinators	2008
1.4 NHS 24's functions as a resource for rehabilitation advice and triage should be explored, as should opportunities for 'interfaced services'.	SEHD SEED NHS 24	NHS Boards Local authorities	2008
1.5 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.	NHS Boards Local authorities	Rehabilitation co-ordinators	2008
1.6 NHS Boards and local authorities should consider the introduction of direct access to rehabilitation services provided by individual AHP and social work professionals as part of an integrated care pathway.	NHS Boards Local authorities	Rehabilitation co-ordinators	2008
1.7 NHS Boards and local authorities should maximise developments in eHealth, Telehealth and new technologies to ensure equitable access and service provision, especially for those in remote and rural areas.	NHS Boards Local authorities	Rehabilitation co-ordinators	2008

Recommendation	Lead responsibility	Working with	Timescale: by end of
1.8 NHS Boards and local authorities should work in partnership to facilitate the development of suitable local transport for rehabilitation purposes.	SEHD NHS Boards Local authorities	Rehabilitation co-ordinators	2008
1.9 NHS Boards and local authorities should build on existing innovations and developments to enhance opportunities for the population to keep fit and active. They should recognise the health gain and social engagement benefits of using mainstream leisure facilities for health promotion and rehabilitation and the impact this may have in avoiding future health and social care challenges.	NHS Boards NHS Health Scotland Local authorities	Rehabilitation co-ordinators	2007
1.10 Scottish Executive and the Department for Work and Pensions should work to establish the role of vocational rehabilitation and rehabilitation co-ordinators in local employability partnerships, seeking to expand existing models and develop new models of vocational rehabilitation and condition management programmes.	NHS Boards SEETTLD Local authorities	Voluntary sector Jobcentre Plus Healthy Working Lives Rehabilitation co-ordinators	2009
1.11 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.	SEHD	Local authorities Voluntary sector Jobcentre Plus, Healthy Working Lives Rehabilitation co-ordinators	2008
1.12 NHS Boards should ensure that older people, whether being supported in the community or presenting to the acute hospital, have appropriate access to a Comprehensive Geriatric Assessment (CGA) (see Table 4.1, page 30).	NHS Boards	Rehabilitation co-ordinators	2008

2. Local service provision

One of the key aims of ***Delivering for Health***[1] is to bring services closer to communities and for individuals to have more choice and input into where they are treated. ***Changing Lives***[2] also recognises that services should be organised around the needs of individuals, families and carers through a whole public sector approach. A clear message from the consensus events was the desire of individuals and carers to be able to utilise local amenities to better effect.

This has been tested out in a number of areas across Scotland, with health and social care providers looking to make use of existing mainstream facilities to enhance access to rehabilitation and expand service provision for these key groups. One example is increasing utilisation of state-of-the-art equipment and other resources located in many local sports and leisure facilities for rehabilitation purposes.

Views of users of the service

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

Local service provision – recommendations

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

LOCAL SERVICE PROVISION			
Recommendation	**Lead responsibility**	**Working with**	**Timescale: by end of**
2.1 NHS Boards, particularly CHPs, and local authorities should use community planning processes to identify how rehabilitation and integrated care services can be developed to meet the needs of the growing proportion of older people in the population, people with long-term conditions and those with specialist rehabilitation needs.	NHS Boards Local authorities	Rehabilitation co-ordinators	2008
2.2 NHS Boards, particularly CHPs, and local authorities should identify 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.[D]	NHS Boards Local authorities	Rehabilitation co-ordinators	2008
2.3 NHS Boards, particularly CHPs, and local authorities should work in partnership to identify the provision of rehabilitation and self-management/enablement services in non-traditional local settings such as community centres and leisure services accommodation.	NHS Boards Local authorities	Rehabilitation co-ordinators	2008
2.4 NHS Boards, local authorities and voluntary services should ensure rehabilitation teams are co-located where possible to enhance accessibility and facilitate multi-agency team working and ensure effective joint learning, communication and skill mix. Agreed assessment and intervention pathways should be developed according to the needs of the local population.	NHS Boards Local authorities	Rehabilitation co-ordinators	2009

D Actions in this area should complement those already being taken forward from *The WHO Europe Family Health Nursing Pilot in Scotland*[50] and *Visible, Accessible, Integrated Care: The Report of the Review of Nursing in the Community in Scotland*.[51]

3. Enablement and self-managed care

Delivering for Health[1] recognises the need for a more systematic approach to care for people with long-term conditions. Individuals and carers also identified the key role they play as active participants in their own rehabilitation and overall progress.

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

Views of users of the service

- Good communication channels are needed to ensure individuals and carers are included in the management of their care.
- Volunteer and special interest/support groups should have greater involvement in designing, delivering and evaluating services.
- Professionals need greater awareness of individuals' knowledge of their own condition and how it should best be managed.
- The benefits of 'buddy systems' for those with long-term conditions should be explored.
- More flexible systems should be in place to support people to get back to work following illness or injury
- The particular needs of children moving from young people's rehabilitation services to adult services must be addressed.

Enablement and self-managed care – recommendations

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

ENABLEMENT AND SELF-MANAGED CARE			
Recommendation	**Lead responsibility**	**Working with**	**Timescale: by end of**
3.1 The Scottish Executive Health Department and the Scottish Executive Education Department should work with NHSScotland, local authorities and the Long Term Conditions Alliance Scotland to support the development of models of self-managed care using the CHP Long-Term Conditions (LTC) Toolkit as a vehicle for local implementation.	SEHD SEED	NHS Boards Local authorities Rehabilitation co-ordinators LTCAS	2008
3.2 NHS Boards and local authorities need to explore how communication and information sharing can be improved to enhance individuals' and carers' rehabilitation 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, electronic information sharing.	NHS Boards Local authorities	Rehabilitation co-ordinators	2008
3.3 All staff working with people with long-term conditions and rehabilitation needs should strive to enhance and support their capacity and that of their carers to self manage to the best of their ability, with appropriate access to appropriate professional interventions when required.	All relevant staff	Rehabilitation co-ordinators	2008
3.4 People with long-term conditions and rehabilitation needs should have access to psychological expertise to ensure that individuals receive appropriate assessment and intervention to overcome emotional, cognitive or behavioural barriers to their participation in rehabilitation and to maximise their progress.	All relevant staff	Rehabilitation co-ordinators	2009
3.5 NHS Boards and local authorities should work in partnership with the voluntary sector to build on existing achievements in physical activity, smoking cessation, alcohol misbuse and healthy eating target groups.	NHS Boards Local authorities	Voluntary sector Rehabilitation co-ordinators	2008
3.6 NHS Boards and local authorities should build on existing good partnership, working with the voluntary sector to develop accessible information for users and carers on self-management support and rehabilitation services available in local areas	NHS Boards Local authorities	Voluntary sector Rehabilitation co-ordinators	2008
3.7 NHS Boards and local authorities must engage effectively with individuals and carers to ensure seamless transitions from child to adult rehabilitation services and also from adult to older people's services.	NHS Boards Local authorities	Rehabilitation co-ordinators	2008

4. Comprehensive and evidence-based services

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

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

Views of users of the service

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

Comprehensive and evidence-based services – recommendations

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

COMPREHENSIVE AND EVIDENCE-BASED SERVICES			
Recommendation	**Lead responsibility**	**Working with**	**Timescale: by end of**
4.1 NHS Boards, particularly CHPs, and local authorities need to apply 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 care to provide seamless transitions of care.	NHS Boards Local authorities	Rehabilitation co-ordinators	2009
4.2 Rehabilitation and integrated care services should evaluate the impact of service provision from individuals' and carers' perspectives and make better use of information gathered using standardised assessment tools to enhance the evidence base.	Rehabilitation co-ordinators	Individuals and carers	2008
4.3 Scottish Executive Health Department and the Scottish Executive Education Department, in partnership with NHS Education for Scotland, NHS Quality Improvement Scotland, the Scottish Social Services Council, the Scottish Institute for Social Work Excellence and the Social Work Inspection Agency, will work with the Improvement Programme to ensure education and quality improvement programme support to underpin the rehabilitation framework.	SEHD NHSQIS NES SWIA SSCC SISWE	Rehabilitation co-ordinators	2009
4.4 Scottish Executive Health Department and the Scottish Executive Education Department should work with the research community in Scotland to explore how best to develop further research in the field of rehabilitation.	SEHD SEED	Research community in Scotland	2008

5. Sustainable multi-professional teams

The success of service redesign and the ***Delivering for Health***[1] agenda will to a large extent be determined by how effectively health care workers work together in teams – communicating with each other, planning jointly and adopting a teamwork ethos that places patients, families and carers at the centre of service planning, delivery and evaluation.

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

Views of users of the service

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

Sustainable multi-professional teams – recommendations

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

SUSTAINABLE MULTI-PROFESSIONAL TEAMS			
Recommendation	**Lead responsibility**	**Working with**	**Timescale: by end of**
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 core competencies; b. work flexibly to meet the needs of individuals and carers; 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; e. maximise the contributions of individuals and carers, lay workers and informal support networks.	Health and social care practitioners	Rehabilitation co-ordinators NES	2008
5.2 NES, in partnership with NHS Boards, 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 and for support workers to underpin effective multi-professional team working and facilitate self management/enablement approaches within health and social care.[E]	NES	NHS Boards Local authorities Higher education institutions	2008

E This issue is being addressed for the nursing, midwifery and allied health professions workforce through the *Delivering Care, Enabling Health*[52] action plan

6. Capacity

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

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

Views of users of the service

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

Capacity – recommendations

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

CAPACITY			
Recommendation	**Lead responsibility**	**Working with**	**Timescale: by end of**
6.1 NHS Boards 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 Boards Local authorities	Rehabilitation co-ordinators	2008
6.2 AHPs with rehabilitation expertise should work in partnership with medical, nursing and social work colleagues and individuals, families and carers to expand on new ways of team working, including therapist/nurse and social worker leadership and case manager/ co-ordinator roles where this will enhance outcomes.	Rehabilitation co-ordinators	NHS Boards Local authorities	2008
6.3 Rehabilitation teams should consider how they could improve continuity of care, eliminate duplication of work and enhance individuals' and carers experience of transitions through, for example, in-reach/outreach rehabilitation across community hospitals and early intervention/ discharge teams.	Rehabilitation co-ordinators	Rehabilitation teams	2008

6. Delivering the vision

The rehabilitation models set out in Chapter 3 and the recommendations outlined above build on the direction of travel set out in ***Delivering for Health***,[1] ***Changing Lives***[2] and other key Scottish and UK policies to describe a vision of rehabilitation services that:

- reflect individuals' and carers' needs and wants;
- maximise individuals' self-management potential;
- are delivered by competent, effective practitioners working in multi-disciplinary, multi-agency teams which include individuals and carers;
- make best use of the skills of the whole team;
- provide development and career opportunities for professionals;
- maximise community resources for rehabilitation;
- are co-ordinated, integrated and fit for purpose.

The recommendations in this delivery framework and the accompanying models fulfil a specific action from ***Delivering for Health***[1] in focusing on the rehabilitation needs of three target groups:

- older people;
- adults with long-term conditions;
- people returning from an absence from work and/or wishing to stay in employment.

The principles underpinning the delivery framework and models, however, have applicability for rehabilitation services offered to all individuals, carers and communities.

The effective implementation of the models will call on members of multi-disciplinary, multi-agency rehabilitation teams – including individuals and carers and the voluntary sector – to grasp the potential the models present to improve services across all phases of rehabilitation. Professionals, in particular, will need to look anew at the way they design, deliver and evaluate services.

A successful, comprehensive rehabilitation service will require the integration of the acute, transitional and longer-term rehabilitation phases. The ***National Rehabilitation Implementation Group*** and the ***Rehabilitation Improvement Programme*** will support this approach at national level and ***Local Rehabilitation Co-ordinators*** will develop local leadership of integrated rehabilitation services. These key elements of service, as described in the delivery framework, will provide the impetus necessary to secure the transformational change required to deliver the rehabilitation services individuals, families, communities and professionals want and demand.

Appendix 1

National Steering Group and three Action Groups

STEERING GROUP MEMBERSHIP

NAME	ROLE	ORGANISATION
Dr Penny Bridger	Consultant in Public Health Medicine	Information Services Division, NHS National Services Scotland
Helen Cadden	Voluntary Worker	
Peter Cameron	Client Involvement Organiser	NHS Glasgow & Clyde
Kath Fairgrieve	AHP Lead	NHS Tayside
Anne Galbraith	AHP Lead	Rehabilitation and Assessment Directorate, NHS Glasgow & Clyde
Olivia Giles	Chair	
Sonya Lam	Director of Allied Health Professionals	NHS Education for Scotland
Jane Leask	Lead Professional for Social Work Occupational Therapists	The Scottish Executive – Social Work Services Policy Division
Jacqui Lunday	Chief Health Professions Officer	The Scottish Executive - Directorate of Nursing, Midwifery and Allied Health Professionals
Dr Sarah L Mitchell	Project Manager – Framework for Adult Rehabilitation	The Scottish Executive - Directorate of Nursing, Midwifery and Allied Health Professionals
Helen Morrison	Project Officer – Review of Nursing in the Community	The Scottish Executive – Directorate of Primary Care and Community Care
Dr Bhupinder Panesar	President	Scottish Society of Rehabilitation
Catherine Paterson	Carer	The Dochas Fund
Will Scott	Branch Head, Long-term Conditions	The Scottish Executive – Directorate of Healthcare Policy and Strategy

NAME	ROLE	ORGANISATION
Professor David Stott	Professor of Geriatric Medicine	NHS Glasgow & Clyde
Helen Tyrrell	Director	Voluntary Health Scotland
Jane Walker	Nursing Officer	The Scottish Executive – Directorate of Primary Care and Community Care
Margaret Whoriskey	Assistant Director, Joint Improvement Team	The Scottish Executive – Directorate of Primary Care and Community Care
June Wylie	AHP Professional Practice Development Officer	NHS QIS

OLDER PEOPLE ACTION GROUP MEMBERSHIP

NAME	ROLE	ORGANISATION
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Sheena Borthwick	AHP Lead	NHS Lothian
Joanne Boyle	Social Work Occupational Therapist	NHS Lothian
Colin Brown	Project Manager	NHS QIS
Alex Davidson	Director of SW/Head of Service	ADSW
Senga Gaughan	Service Manager	Dart Team – NHS Glasgow & Clyde
Dr Lesley Holdsworth	Clinical Effectiveness Co-ordinator	NHS Forth Valley
Violet Laidlaw	Chair	
Jane Leask	Lead Professional for Social Work Occupational Therapists	The Scottish Executive – Social Work Services Policy Division
Jacqui Lunday	Chief Health Professions Officer	The Scottish Executive – Directorate of Nursing, Midwifery and Allied Health Professionals
Anna Marie McGregor	Pharmacist Prescribing Co-ordinator	NHS National Services Scotland

NAME	ROLE	ORGANISATION
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Nicki McNaney	Programme Manager – Unsheduled Care	The Scottish Executive – Directorate of Delivery (Health)
Winona Samet	Nursing Officer	The Scottish Executive – Directorate of Primary Care and Community Care
Frances Smith	Director	Scottish Association of Community Hospitals
Rhona Smyth	Assistant Manager, Community Rehabilitation Service	NHS Lothian
John Storey	Branch Head, Older People's Unit	The Scottish Executive – Directorate of Primary Care and Community Care
Sally Westwick	AHP Lead	NHS Lothian
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LONG-TERM CONDITIONS ACTION GROUP MEMBERSHIP

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Janette Barrie	Project Co-ordinator	NHS QIS Practice Development Unit
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Helen Cadden	Chair	
Morag Dorward	Modernisation & Development Consultant	NHS Tayside
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Frances Wood	Policy Analyst	The Scottish Executive – Health Improvement Team
Sarah Wormwell	Employability Manager	Scottish Business in the Community/the Scottish Centre for Health Working Lives

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