A. Title of Rehabilitation Service Improvement

Working with researchers to improve neuropsychological rehabilitation for people with multiple sclerosis	**B. Status:**	
	Planning Stage	X
	In progress	
	Business ready	

C. Summary of Objectives

1. To develop a research study to investigate memory rehabilitation strategies for people with Multiple Sclerosis
2. To evaluate the benefit of existing memory rehabilitation intervention called NeuroPage
3. To improve understanding of the presentation of neuropsychological problems in MS.

D. Name of Lead Contact	Dr Andrew Bateman	**E. Role and organisation**	Clinical Lead for NeuroRehabilitation
F. email address	Andrew.bateman@ozc.nhs.uk	**G. Phone number**	01353652169
H. Website or url	http://www.ozc.nhs.uk		

I. Other participants in this service improvement

Organisation/service/name *(if applicable)*	Provider/commissioner/ service user/other
1. University of Nottingham	University
2. Multiple Sclerosis Society	Charity

J. Description of patient group	People living with MS who are experiencing cognitive problems
K. County or Counties covered	Cambs and Notts

L. Key outcomes	**M. If you are unable to share your data** (eg cost savings that are seen as business sensitive), are you willing to be approached directly to discuss?
1. Evidence of efficacy of treatment	**Due academic process will have to be followed before data can be released**
	YES / NO
	YES / NO
	YES / NO

N. Any unintended outcomes	**Study only in planning stages**
O. Key learning points	We have previously shown that text messaging or paging people with memory problems is cost-effective, it reduces carer strain, increases independence and can be delivered as a sustainable service (www.neuropage.nhs.uk)
P. Next planned steps	
Q. Consent to share content of this summary	**I am** willing for the content of this summary to be shared across the Clinical Commissioning Community Improving Adult Rehabilitation Community of Practice and to be summarised in any final report provided by the Clinical Commissioning Community on the outcomes of the Community of Practice **I do** agree to be the named contact for any future enquiries about this service improvement Signed ……………(by email) andrew bateman…………… Date……14/2/13…

A. Title of Rehabilitation Service Improvement		
Redesign of non-elective(LTC with comorbidity) services to match services to patients and integrate care with practices	**B. Status:**	
	Planning Stage	
	In progress	X
	Business ready	

C. Summary of Objectives

1. Provide services in an environment that meets the definition of primary care
   - Primary care as first point of contact for each new need
   - Person (not disease) centred care
   - Comprehensive care
   - Coordinated care when it cannot be provided
2. Improving the IT support to create one system.
   - Single system for practice TEAM
   - Separate but visible teams for discrete services inc hospital
   - Bringing outpatient department and casualty into the primary care system
   - Making the break to hospital systems happen for the specialist inpatient departments
3. Using Criteria and standards to produce change
   - Coordinated CQUIN and primary care trust
   - Introducing requirement to produce the data wanted and IT system
   - Requesting disease registers and criteria and standards for specialist services
   - Creating formative criteria for use of investigations, over diagnosis and over treatment
4. Use of external academic resources to observe and embed the change
   - Use of design school to think differently about design
   - Use of generalist expertise to think through the changes requires for GPs, nurses and consultants to make them more generalist
5. Building teams of generalists based on practice, intermediate service and hospital to link between sectors

D. Name of Lead Contact	Dr A Spooner	**E. Role and organisation**	Lead Commissioner CCG
F. email address	andrewspooner@btinternet.com	**G. Phone number**	Practice 01270 256340
H. Website or url	http://		

I. Other participants in this service improvement

Organisation/service/name *(if applicable)*	**Provider/commissioner/ service user/other**
1. South and Vale Royal CCGs	Commissioner
2. Mid Cheshire Trust	Provider
3. East Cheshire Trust Community Business Unit	Provider
4. Cheshire and Wirral Partnership Trust (Mental Health)	Provider
5. GP practices	Provider

J. Description of patient group	Various stakeholder groups at CCG and provider level
K. County or Counties covered	Cheshire (part)

L. Key outcomes *[if applicable]*	**M. If you are unable to share your data** (eg cost savings that are seen as business sensitive), are you willing to be approached directly to discuss?
1. This is so transformational this isn't going to work in the way the NHS wants. The QIPP is global. The funding to the acute provider is held or reduces. Other parts of the system increase. GP providers understand they need to refrain from referrals and the system cannot cope with that as a measurement. The provider can only hold to the levels required because other changes are happening.	**YES / NO**
	YES / NO
	YES / NO

N. Any unintended outcomes *(if applicable)*	**The path is not smooth. Many of the outcomes are being achieved slowly by persuasion and system leadership. There is a vision that is being slowly implemented across the whole system as resources and opportunities occur. We haven't got the criteria and standards up and running yet. A nursing home scheme to capture patient wishes and make the service goal centred has worked and reduced them to negligible levels. There was pressure on the 4hr wait and numbers in casualty but investment in casualty has turned that around with reduced admissions when patients are sorted in casualty. The IT is work in progress and national data requirements and KPIs have made it more difficult.**
O. Key learning points	Developing and disseminating a vision across managers and clinicians separately allows cohesive development. A holistic QIPP is beneficial. You don't then have to make community investment dependent on specific cost savings in hospitals and can remove the incentive to capture patients in those areas.
P. Next planned steps	Further work on the vision to engage the new group of managers and leaders coming in to the organisation all the time. Working with a Monitor review that suggests the hospital has to change and change fast. We have a readymade vision to work with.
Q. Consent to share content of this summary	**I am** willing for the content of this summary to be shared across the Clinical Commissioning Community Improving Adult Rehabilitation Community of Practice and to be summarised in any final report provided by the Clinical Commissioning Community on the outcomes of the Community of Practice **I do** agree to be the named contact for any future enquiries about this service improvement Signed …………………A Spooner……………………………………………………. Date……………15/2/13……………………………… However the time to do this is severely limited

A. Title of Rehabilitation Service Improvement

	B. Status:	
Redesigning electronic systems and processes in order to best manage waiting lists and caseloads for Intermediate care teams in Leeds using SystmOne with smartboards and mobile devices.	Planning Stage	X
	In progress	
	Business ready	

C. Summary of Objectives

1. Saving time in admin processes of collecting and reporting paper-based waiting lists and expected visits on a daily basis.

2. Enabling staff of any grade to access up to date information re: visits due on a daily basis from remote locations via System one

3. Improved audit trail in relation to patients waiting for assessment and timely reviews.

4. Streamlined process to be used across 6 teams in Leeds. Enabling staff to move across teams in the city and pick up work easily. Allows managers to make decisions about staffing requirements on a daily basis with clear, up to date information.

D. Name of Lead Contact	Ann-Marie Holliday	**E. Role and organisation**	Professional Lead Physiotherapist Out of Hospital Care (OOHC) Leeds Community Healthcare (LCH)
F. email address	Ann.holliday@nhs.net	**G. Phone number**	0113 8430123
H. Website or url	http://		

I. Other participants in this service improvement

Organisation/service/name *(if applicable)*	**Provider/commissioner/ service user/other**
1. LCH/Service Improvement/Jo Davy	Provider
2. LCH/OOHC/Chris Day	Provider
3. LCH/OOHC/Fiona Shackleton	Provider

J. Description of patient group	Intermediate Care (Community population over 60s in general)
K. County or Counties covered	Leeds

L. Key outcomes *[if applicable]*	**M. If you are unable to share your data** (eg cost savings that are seen as business sensitive), are you willing to be approached directly to discuss?
1. Will reduce approx 6 x 30 mins per day of admin data inputting re: "patient contacts planned today"	**YES / NO**
2. Once staff have mobile devices, they will be able to access visits due from remote locations. They can also update visits completed from remote locations. Prior to mobile devices, staff will be able to input and view this information from any of the health centre in Leeds via Systm one not just their own base as currently.	**YES / NO**
3. Electronic audit trail will be available immediately via systm one which saves any changes made by staff and can be accessed by anyone running reports.	**YES / NO**
4. Resources can be fairly allocated citywide on a daily/weekly basis to meet patient need in an objective and timely manner.	**YES / NO**

N. Any unintended outcomes *(if applicable)*	**In planning stage currently**
O. Key learning points	
P. Next planned steps	Working with System one team and service improvement to set up the electronic processes and templates Testing it out in one of the 6 teams and evaluating Awaiting timescale for mobile devices for staff
Q. Consent to share content of this summary	**I am** willing for the content of this summary to be shared across the Clinical Commissioning Community Improving Adult Rehabilitation Community of Practice and to be summarised in any final report provided by the Clinical Commissioning Community on the outcomes of the Community of Practice **I do** agree to be the named contact for any future enquiries about this service improvement Signed ……AM Holliday…………………………………. Date………27th February 2013………………………

A. Title of Rehabilitation Service Improvement

	B. Status:	
Continued enhancement of the Multidisciplinary support of overweight or obese patients. To facilitate pleasurable eating experiences at the same time as aiming to motivate patients to opt for healthy eating choices and to self monitor portion size in order to achieve and maintain a healthy body weight (BMI within the range 18.5-25.)	Planning Stage	
	In progress	X
	Business ready	

C. Summary of Objectives

1.To further develop assessment tools for wheelchair users and appropriate visual aids for education sessions and displays

2 To 'brand' healthy lifestyle and weight management initiatives(e.g. Why WAITT we're all in this together)as a *big team* goal encompassing the patients, their family and carers, all MDT members of hospital and community staff

3. To develop the Club 600 12 week programme run by the Community Neuro Rehabilitation Team in 2010 into a ward based programme. (summary of project below)

Club 600

4.To take steps to create a hospital environment that will promote healthy eating messages by appropriate art work, provision of a self selection salad bar on the ward and in the staff restaurant, promotion of healthy eating choices on the League of Friends patient trolley/cafe

D. Name of Lead Contact	Catherine Wickens	**E. Role and organisation**	Senior Specialist Dietitian
F. email address	Catherine.wickens@swft.nhs.uk	**G. Phone number**	01926 317742
H. Website or url	http://		

I. Other participants in this service improvement

Organisation/service/name *(if applicable)*	**Provider/commissioner/ service user/other**
1. The ABI team, Campion Ward. Royal Leamington Spa Rehabilitation Hospital	SWFT
2. The Community Neuro Rehabilitation Team of South Warwickshire Foundation Trust (SWFT)	SWFT
3. The Dietetic and Catering Departments of SWFT at the Royal Leamington Spa Rehabilitation Hospital	SWFT
4. The League of Friends of the Royal Leamington Spa Rehabilitation Hospital	SWFT

J. Description of patient group	People with long term neurological conditions including Acquired brain injury and Multiple Sclerosis
K. County or Counties covered	Warwickshire and those counties who commission services from RLSRH e.g. Leicester, Northamptonshire, Kettering, Worcester and Coventry

L. Key outcomes *[if applicable]*		**M. If you are unable to share your data** (e.g. cost savings that are seen as business sensitive), are you willing to be approached directly to discuss?
1. A weight management advice booklet for those with low mobility together with cookbook designed for those who may have functional deficits will be completed within the next 6 months. Best practice will be shared with other Dietetic services to ABI units		**YES / NO**
2. Members of the Multi Disciplinary team of Campion Wards and the Community Neuro Rehabilitation Team will be aware of their own role in promoting healthy eating and in giving consistent messages on the positive impact of a healthy weight on achievement of rehabilitation potential		**YES / NO**
3. Structured weight management support will be available for people with long term neurological conditions living in South Warwickshire who have unique needs due to low mobility and functional and cognitive deficits.		**YES / NO**
4.The hospital environment will promote a focus on health for patients, relatives and staff through provision of self selection salad bar, wall art depicting fruit and vegetables, outside activity areas and a grow and eat garden.		**YES / NO**
N. Any unintended outcomes *(if applicable)*	Entrenched views of patients, carer, family member's hospital staff and hospital volunteers can result in inconsistent support with weight management goals. The issue of 'walking the talk' of healthy weight for NHS staff has recently been highlighted in the national press and does incite some vehement reactions.	
O. Key learning points	Weight management is a complex and emotive area and the Mental Capacity Act stipulates freedom of choice on consumption of food and drink. A debate is needed on the issue that could best be summed up as 'Derogation of care in favour of freedom of choice' as outcome measures for rehabilitation goals and future vocational opportunities can be significantly impacted by obesity	
P. Next planned steps	Ongoing debate and education with ward team –to promote the Why WAITT idea Completion of client specific resources Regular activity based evening education sessions to provide information on appropriate portion size Development of a Grow and Eat garden and outdoor sensory garden with measured circuit for wheel chair propulsion or walking Further consideration of a Mindfulness with eating session run jointly with the Psychology Department Timetable review and funding discussion re staffing for 12 week weight management programme.	
Q. Consent to share content of this summary	**I am** willing for the content of this summary to be shared across the Clinical Commissioning Community Improving Adult Rehabilitation Community of Practice and to be summarised in any final report provided by the Clinical Commissioning Community on the outcomes of the Community of Practice **I do** agree to be the named contact for any future enquiries about this service improvement Signed…………CatherineWickens……………. Date…………28/2/13………………	

A. Title of Rehabilitation Service Improvement

Title	B. Status:	
Macmillan On Target Programme: 3 year service development programme addressing aftercare needs of teenagers and young adults with cancer (TYA) in SW England. To support TYAs in the achievement of life as it would have been lived without the intrusion of cancer, or as the patient decides to recreate it after experiencing/assessing the impact of the diagnosis of cancer/treatment.	Planning Stage	X
	In progress	
	Business ready	

C. Summary of Objectives

1. Listen to the opinions of TYAs, their supporters, and health / education/ social care professionals with regard to identifying their needs

2. Co-create pilot interventions to address these needs through a variety of media within community or hospital settings, as required throughout the South West (e.g. psychosocial support for TYAs and their supporters, education, work-life, physical wellbeing, self-management, rehabilitation, finance, productivity etc and to include training for staff in the specific needs of TYAs as required)

3. Review and redesign and repilot.

4. Identify recommendations. Present to relevant bodies.

D. Name of Lead Contact	Charlie Ewer-Smith	**E. Role and organisation**	Macmillan TYA Aftercare Specialist, University Hospitals Bristol
F. email address	Charlie.ewer-smith@UHBristol.nhs.uk	**G. Phone number**	0117 3421394
H. Website or url	http://		

I. Other participants in this service improvement

Organisation/service/name *(if applicable)*	Provider/commissioner/ service user/other
1. Macmillan Cancer Support	Charity
2. University Hospitals Bristol (host organisation)	Provider

J. Description of patient group	Teenagers and young adults with cancer throughout the south west of England
K. County or Counties covered	Wiltshire, Avon, Somerset, Devon and Cornwall

L. Key outcomes *[if applicable]* No outcomes as yet	**M. If you are unable to share your data** (eg cost savings that are seen as business sensitive), are you willing to be approached directly to discuss?
	YES / NO
	YES / NO
	YES / NO
	YES / NO

N. Any unintended outcomes *(if applicable)*	
O. Key learning points	
P. Next planned steps	
Q. Consent to share content of this summary	**I am** willing for the content of this summary to be shared across the Clinical Commissioning Community Improving Adult Rehabilitation Community of Practice and to be summarised in any final report provided by the Clinical Commissioning Community on the outcomes of the Community of Practice **I do** agree to be the named contact for any future enquiries about this service improvement Signed Charlie Ewer-Smith Date 19/02/2013

A. Title of Rehabilitation Service Improvement			
Developing Integrated Therapy Teams in a Community Locality Setting		**B. Status:**	
		Planning Stage	
		In progress	X
		Business ready	

C. Summary of Objectives

1. Improving the patients' journey by developing a smooth pathway across sectors and professional groups

2.Improve communication between all providers by developing multidisciplinary pathways that promote the sharing of skills, experience and training.

3.Improve access to the service with the ability to respond to urgent need

4.Improve the efficiency and productivity of the service by eliminating duplication of work. This will also increase capacity to improve access to the service and reduce waiting times.

D. Name of Lead Contact	Freya Sledding	**E. Role and organisation**	Occupational therapy Service Manager
F. email address	Freya.sledding@elht.nhs.uk	**G. Phone number**	01282 731143
H. Website or url	http://		

I. Other participants in this service improvement

Organisation/service/name *(if applicable)*	**Provider/commissioner/ service user/other**
1. Lancashire County Council	Commissioners and Providers
2. Physiotherapy East Lancs Hospitals Trust	Providers
3. Speech and Language Therapists East Lancs Hospitals Trust	Providers
4. Dieticians East Lancs Hospitals Trust	Providers
5. Virtuals Ward East Lancs Hospitals Trust	

J. Description of patient group	Adults over 18 years old with long-term conditions
K. County or Counties covered	East Lancashire

<table>
<tr><td colspan="2">L. Key outcomes [if applicable]</td><td>M. If you are unable to share your data (eg cost savings that are seen as business sensitive), are you willing to be approached directly to discuss?</td></tr>
<tr><td colspan="2"></td><td>YES / NO</td></tr>
<tr><td colspan="2"></td><td>YES / NO</td></tr>
<tr><td colspan="2"></td><td>YES / NO</td></tr>
<tr><td colspan="2"></td><td>YES / NO</td></tr>
<tr><td>N. Any unintended outcomes
(if applicable)</td><td colspan="2"></td></tr>
<tr><td>O. Key learning points</td><td colspan="2"></td></tr>
<tr><td>P. Next planned steps</td><td colspan="2"></td></tr>
<tr><td>Q. Consent to share content of this summary</td><td colspan="2">I am willing for the content of this summary to be shared across the Clinical Commissioning Community Improving Adult Rehabilitation Community of Practice and to be summarised in any final report provided by the Clinical Commissioning Community on the outcomes of the Community of Practice
I do agree to be the named contact for any future enquiries about this service improvement

Signed …Freya Sledding…………………… Date…26.02.13……</td></tr>
</table>

<table>
<tr><td colspan="4">A. Title of Rehabilitation Service Improvement
</td></tr>
<tr><td colspan="3">Standing Start UK C.I.C (due to be renamed)
Delivery of intensive, innovative activity-based rehabilitation programmes to individuals with all levels of spinal cord injury (traumatic and non-traumatic) to allow patients to maximise their neurological, physiological and psychological potential within a Community setting.</td><td>B. Status:
Planning Stage:
In progress:
Business ready: X</td></tr>
<tr><td colspan="4">C. Summary of Objectives</td></tr>
<tr><td colspan="4">1. Physiological Outcomes: Intensive activity-based rehabilitation designed to target the levels above and below the injury to improve cardiovascular health, weight management, bone health, skin health and muscle quality. Improving physiological outcomes improves overall long-term health of individuals with spinal cord injury and reduces the probability of re-admittance to National Spinal Injuries Centres for common secondary complications such as pressure sores, bone fractures and obesity.</td></tr>
<tr><td colspan="4">2. Psycho-social Outcomes: Physical activity through intensive activity-based rehabilitation can result in a drastic reduction in medicinal intake for pain, depressants, spasticity and bowel and bladder regulation. Reduction in drug consumption results in a myriad of benefits from improved sleeping patterns to increased energy levels and appetite. In addition, the results of physical activity can improve self-esteem, body image issues and confidence for individuals with spinal cord injury which can have a knock-on effect in their family, career and social lives.</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>D. Name of Lead Contact</td><td>Harvey Sihota</td><td>E. Role and organisation</td><td>Director
Standing Start UK C.I.C</td></tr>
<tr><td>F. email address</td><td>harvey@standingstart.org</td><td>G. Phone number</td><td>+447939248401</td></tr>
<tr><td>H. Website or url</td><td colspan="3">http://www.standingstart.org</td></tr>
<tr><td colspan="4">I. Other participants in this service improvement</td></tr>
<tr><td colspan="3">Organisation/service/name
(if applicable)</td><td>Provider/commissioner/ service user/other</td></tr>
<tr><td colspan="3">1. Spinal Cord Injury Coalition (Spinal Injuries Association, Backup Trust, Aspire) have gained Neurological Commissioning Support (NCS) for spinal cord injuries.</td><td>Service User</td></tr>
<tr><td colspan="3"></td><td></td></tr>
<tr><td colspan="3"></td><td></td></tr>
<tr><td colspan="3"></td><td></td></tr>
<tr><td colspan="3"></td><td></td></tr>
<tr><td>J. Description of patient group</td><td colspan="3">Spinal Cord Injury (Traumatic and Non-Traumatic)</td></tr>
<tr><td>K. County or Counties covered</td><td colspan="3">Hertfordshire, Essex, Berkshire, Buckinghamshire, Middlesex, Cambridgeshire, Bedfordshire, Northamptonshire, Leicestershire, East and West Sussex, Kent, Surrey</td></tr>
<tr><td colspan="3">L. Key outcomes [if applicable]</td><td>M. If you are unable to share your data are you willing to be approached directly to discuss?</td></tr>
</table>

1. As an outcome of objective C1, patients are generally healthier. For example, the improvement of immune-system, blood circulation, muscle and skin quality on lower limbs reduces the probability of pressure sores for patients that take part in the programmes. Increased physical activity also results in improved cardiovascular health, results in better weight management and reduces the probability of a myriad of diseases related to non-activity. Finally, increased weight-bearing activities improve bone health reducing the probability of bone fractures which are common amongst individuals with spinal cord injury. Occurrences of pressure sores, bone fractures, body weight, bone density scores (DEXA) and heart rate/blood pressure is regularly monitored/recorded. Studies by an academic research partner into the immunological benefits of our programme have been submitted for peer review. Additional studies into bone health, skin health and cardiovascular health are being planned.	**YES**
2. As an outcome of objective C2, patients experience a better quality of life and sense of wellbeing. The reduction of anti-depressants through increased physical activity can considerably improve an individual's wellbeing. A reduction in anti-spasticity drugs can also have marked differences in the lives of individuals in the shape of increased energy levels and improved focus. Improved self-esteem/body image, sleep patterns and appetite also contribute to a better quality of life for individuals that take part in activity-based rehabilitation programmes. Medicinal intake is monitored regularly and psycho-social studies are being conducted by an academic research partner.	**YES**

N. Any unintended outcomes *(if applicable)*	
O. Key learning points	Key learning points are that physical activity in the form of intensive activity-based rehabilitation offers a myriad of benefits – some of which is quantitative and a lot is qualitative. Therefore it is difficult to quantify all of the benefits into simple cash-based cost savings. The programmes offer a personalised one-to-one and sometimes two-to-one therapist-patient service. Active-rehabilitation programmes are common place in Australia and North America. They are relatively new to Europe.
P. Next planned steps	Launch of new larger facility in Watford, Herts with additional therapists and assistants. Launch the new brand name and image (no longer Standing Start – still being finalised). Diversify to include supplementary services. Strengthen relationships with national spinal units and serious injury law firms. Kick-off additional studies with our academic research partners. Plan for additional facilities in other regions (Midlands, North West and Scotland).
Q. Consent to share content of this summary	**I am** willing for the content of this summary to be shared across the Clinical Commissioning Community Improving Adult Rehabilitation Community of Practice and to be summarised in any final report provided by the Clinical Commissioning Community on the outcomes of the Community of Practice **I do** agree to be the named contact for any future enquiries about this service improvement Signed …Harvey Sihota………………. Date…4th March 2013…………………

<table>
<tr><td colspan="4">A. Title of Rehabilitation Service Improvement </td></tr>
<tr><td colspan="2" rowspan="4">Improving uptake and access to pulmonary rehabilitation for patients discharged from hospital with an exacerbation of COPD</td><td colspan="2">B. Status:</td></tr>
<tr><td>Planning Stage</td><td>X</td></tr>
<tr><td>In progress</td><td></td></tr>
<tr><td>Business ready</td><td></td></tr>
<tr><td colspan="4">C. Summary of Objectives</td></tr>
<tr><td colspan="4">1. We have identified that only a small number of patients admitted to hospital with an exacerbation of COPD are either deemed suitable to attend a structured rehabilitation class or accept the offer of rehab. We aim to visit patients in their home to eliminate the difficulty of getting to a venue and to discuss the role of Pulm Rehab in the context of self management</td></tr>
<tr><td colspan="4">2. Start simple home exercise programme, along with breathlessness management and energy conservation. This will be delivered whilst also assessing the patients ability to self management. They will work closely with the Respiratory nurses, Early supported discharge and hospital avoidance teams to reinforce strategies put in place to manage further exacerbations.</td></tr>
<tr><td colspan="4">3. Reduce readmissions by assessing and commencing a programme within 30 days of discharge</td></tr>
<tr><td colspan="4">4. Triage appropriate patients to the structured 8 week pulmonary rehab programme or the local council exercise scheme</td></tr>
<tr><td>D. Name of Lead Contact</td><td>Heather Moffat</td><td>E. Role and organisation</td><td>Respiratory Physiotherapist Calderdale and Huddersfield NHS Foundation Trust</td></tr>
<tr><td>F. email address</td><td>Heather.Moffat@cht.nhs.uk</td><td>G. Phone number</td><td>01484 342432
07798 854582</td></tr>
<tr><td>H. Website or url</td><td colspan="3">http://</td></tr>
</table>

I. Other participants in this service improvement	
Organisation/service/name *(if applicable)*	**Provider/commissioner/ service user/other**
1. I am in the business case stage for this service and have only just verbally discussed this with our commissioners so I haven't included them as other parties involved but hopefully they will be soon!	

J. Description of patient group	COPD post exacerbation and hospital admission
K. County or Counties covered	Greater Huddersfield and Calderdale

L. Key outcomes *[if applicable]*	**M. If you are unable to share your data** (eg cost savings that are seen as business sensitive), are you willing to be approached directly to discuss?
1. Increased uptake of pulmonary rehab in admitted population	**YES /**
2. Reduced hospital admissions	**YES /**
3. Improved confidence to exert themselves with improved exercise tolerance within 30 days post admission	**YES /**
4. Increased uptake of the evidence based structured 8 week pulmonary rehabilitation programme	**YES /**

N. Any unintended outcomes *(if applicable)*	Unsure as yet
O. Key learning points	Unsure as yet
P. Next planned steps	Unsure as yet
Q. Consent to share content of this summary	**I am** willing for the content of this summary to be shared across the Clinical Commissioning Community Improving Adult Rehabilitation Community of Practice and to be summarised in any final report provided by the Clinical Commissioning Community on the outcomes of the Community of Practice **I do** agree to be the named contact for any future enquiries about this service improvement Signed ………Heather Moffat……………………………………… Date……14.2.13……………………………

<table>
<tr><td colspan="4">A. Title of Rehabilitation Service Improvement
</td></tr>
<tr><td colspan="3">To improve the rehabilitation pathway for vascular amputees in NE London</td><td>B. Status:
Planning Stage: X
In progress:
Business ready:</td></tr>
<tr><td colspan="4">C. Summary of Objectives</td></tr>
<tr><td colspan="4">1. To ensure vascular amputees receive rehabilitation of an appropriate intensity at the right time in the right setting (ie hospital or community)</td></tr>
<tr><td colspan="4">2. To work with local clinicians to develop a description of an ideal pathway</td></tr>
<tr><td colspan="4">3. To develop inreach working from the limb fitting centre to the vascular centre</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>D. Name of Lead Contact</td><td>Helen Cutting
(Successor needs to be confirmed)</td><td>E. Role and organisation</td><td>Stroke project lead North East London cardiovascular and stroke network</td></tr>
<tr><td>F. email address</td><td>hcutting@nhs.net</td><td>G. Phone number</td><td>020 8822 3078</td></tr>
<tr><td>H. Website or url</td><td colspan="3">http://</td></tr>
</table>

I. Other participants in this service improvement

Organisation/service/name *(if applicable)*	**Provider/commissioner/ service user/other**
1. Anna Rose	Provider
2. Helena Train	Provider
3. Deborah Redknapp	Provider
4. Gabriel Sayer	Provider
5. Tara- Lee Baohm	Commissioner
6. Lindsey Harris	Provider

J. Description of patient group	Vascular amputees
K. County or Counties covered	North East London

L. Key outcomes *[if applicable]*	**M. If you are unable to share your data** (eg cost savings that are seen as business sensitive), are you willing to be approached directly to discuss?
1. Specific bad base is identified where rehab can be provided by therapists with appropriate skill set and community teams are developed	**YES / NO**
2. Pathway is developed and agreed by local clinicians and commissioners	**YES / NO**
3. Prosthetists are visiting 2 vascular centres to review vascular amputees on a fortnightly basis	**YES / NO**
	YES / NO

N. Any unintended outcomes *(if applicable)*	
O. Key learning points	Even without an increase in resources a service can be improved by linking clinicians to share good practice and novel ideas.
P. Next planned steps	Visit CCG leads with the proposal Raise the issue at Trust board level
Q. Consent to share content of this summary	**I am** willing for the content of this summary to be shared across the Clinical Commissioning Community Improving Adult Rehabilitation Community of Practice and to be summarised in any final report provided by the Clinical Commissioning Community on the outcomes of the Community of Practice **I do** agree to be the named contact for any future enquiries about this service improvement Signed ……Helen Cutting………………………………………………………………. Date……28/02/13………………………………………

A. Title of Rehabilitation Service Improvement		
National Spinal Cord Injury Strategy Board (all eight recognised SCI Centres in England, plus specialised commissioners, service users and other stakeholders). Has worked over the last 3 years. Covers not just rehab but the entire patient pathway from point of injury, through acute care, rehab, reintegration and life-long follow-up. Note: the NSCISB has recently been wound up and the work programme has handed over to the new NHS Commissioning Board structure.	**B. Status:**	
	Planning Stage	
	In progress	**X**
	Business ready	

C. Summary of Objectives
1. To agree a co-ordinated and common approach across England to the delivery and commissioning of services for people with a spinal cord injury.
2. To ensure improved health outcomes for people with spinal cord injury in England by effective commissioning of appropriate high quality and cost effective services.

D. Name of Lead Contact	Helen Goodship Lead Commissioner for the CRG (and formerly for the NSCISB)	**E. Role and organisation**	Policy Lead, National Spinal Cord Injury, South of England Specialised commissioning Group
F. email address	Helen.Goodship@nhs.net	**G. Phone number**	01323 831775
H. Website or url	http://		

I. Other participants in this service improvement	
Organisation/service/name *(if applicable)*	**Provider/commissioner/ service user/other**

J. Description of patient group	People with spinal cord injury - traumatic and non-traumatic (as defined in the Service Specification)
K. County or Counties covered	All England

L. Key outcomes *[if applicable]*	**M. If you are unable to share your data** (eg cost savings that are seen as business sensitive), are you willing to be approached directly to discuss?
1. Development of the National Care Pathways for SCI	**YES**
2. Development of a set of Commissioning Classifications (currencies) to be used for national SCI tariff structure	**YES**
3. National Service Specification, CQUINS, QIPPs, outcome measures etc.	**YES**
4. National SCI Database – to go live April 2013	**YES**

N. Any unintended outcomes *(if applicable)*	
O. Key learning points	
P. Next planned steps	Will continue as part of the NHS Commissioning Board work programme
Q. Consent to share content of this summary	I **am** willing for the content of this summary to be shared across the Clinical Commissioning Community Improving Adult Rehabilitation Community of Practice and to be summarised in any final report provided by the Clinical Commissioning Community on the outcomes of the Community of Practice I **do** agree to be the named contact for any future enquiries about this service improvement I will be retiring shortly, but should be able to give you a contact before then. Signed Helen Goodship Date15th February 2013

A. Title of Rehabilitation Service Improvement		
Patient held document for patients with primary brain tumour	**B. Status:**	
	Planning Stage	
	In progress	X
	Business ready	

C. Summary of Objectives
1. to implement a document in line with NICE guidance
2. Assess staff attitudes to the idea of a patient held document (research indicates this can be one of the barriers to change) Dissertation for MSc
3. Need to then ask patients opinions and involve in development of a document
4.introduce and review effectiveness / use

D. Name of Lead Contact	Julie Emerson	**E. Role and organisation**	Specialist AHP brain and CNS tumour rehabilitation The Christie Hospital NHS Trust
F. email address	Julie.emerson@christie.nhs.uk	**G. Phone number**	0161 918 7400 07827 955 048
H. Website or url	http://		

I. Other participants in this service improvement	
Organisation/service/name *(if applicable)*	**Provider/commissioner/ service user/other**
1. staff within The Christie Hospital NHS Trust and Salford Royal NHS Foundation Trust	

J. Description of patient group	Brain tumour, low grade, high grade, cancer, non-cancer
K. County or Counties covered	Greater Manchester & Cheshire

L. Key outcomes *[if applicable]*		**M. If you are unable to share your data** (eg cost savings that are seen as business sensitive), are you willing to be approached directly to discuss?
1. all patients with a diagnosis of a primary brain tumour receive a patient held document		**YES**
2. identify barriers to implementing patient held document and address in change process		**YES**
3. 10-20% increase in patients saying they received written information on the national patient survey		**YES**
		YES / NO
N. Any unintended outcomes *(if applicable)*	**Delay in introducing a 'document' but hopefully the learning will support better engagement with the product**	
O. Key learning points	It all takes time! especially because it is part of a MSc with ethics approval etc	
P. Next planned steps	Questionnaire and analysis	
Q. Consent to share content of this summary	I **am** willing for the content of this summary to be shared across the Clinical Commissioning Community Improving Adult Rehabilitation Community of Practice and to be summarised in any final report provided by the Clinical Commissioning Community on the outcomes of the Community of Practice I **do** agree to be the named contact for any future enquiries about this service improvement Signed ……………………………………Julie Emerson…………… Date…19th Feb 2013………………………	

A. Title of Rehabilitation Service Improvement		
Remodelling Community Neurology Services, Leeds, West Yorkshire. **CNS comprises Stroke Early Supported Discharge Service, Community Inpatient Rehab Unit AND Community Neurology Team.**	**B. Status:**	
	Planning Stage	
	In progress	X
	Business ready	

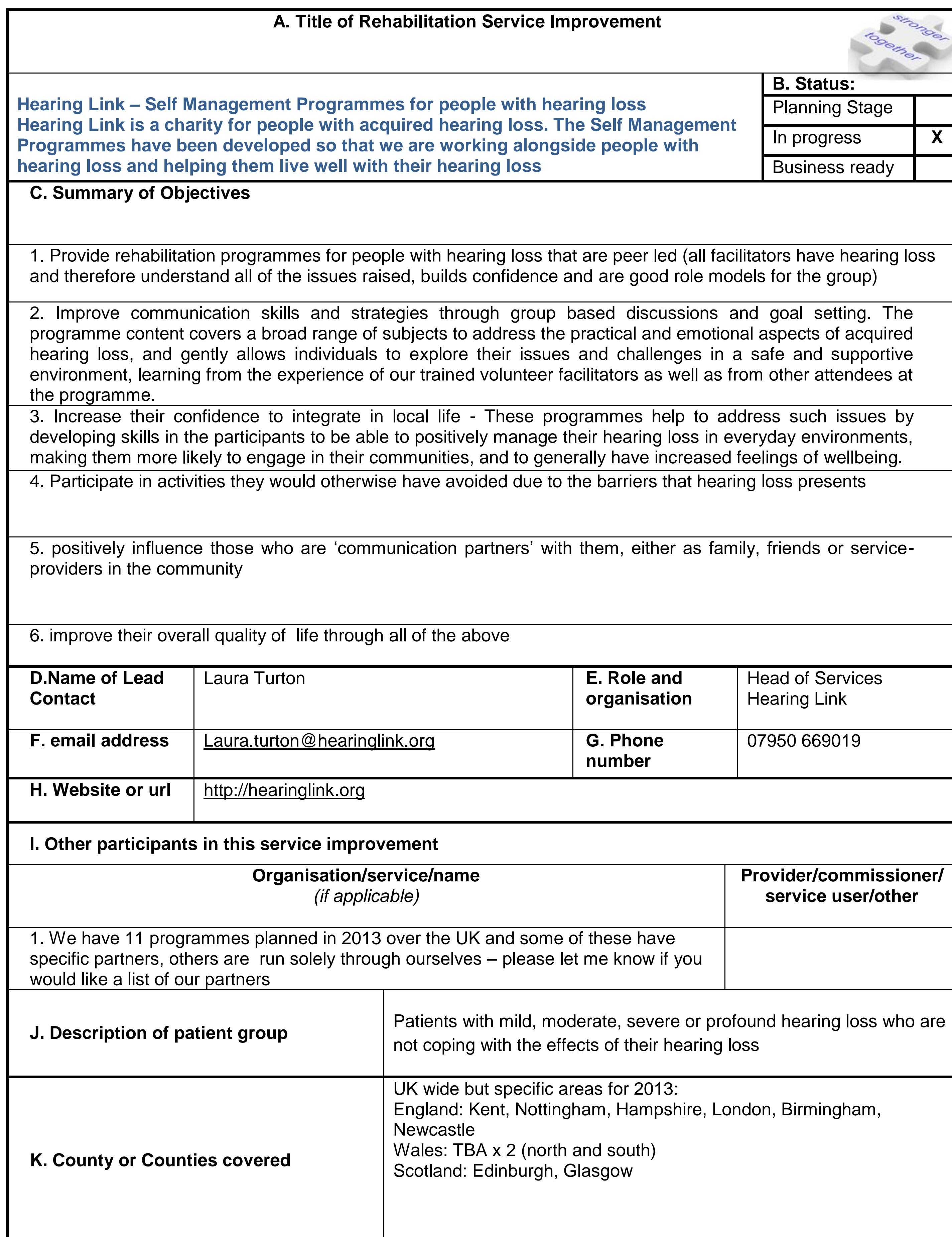
C. Summary of Objectives
1. To determine capacity and demand for specific interventions and need for different treatment settings (home v inpatient v outpatient)
2. To propose a new staffing structure/skill mix to use resources most effectively.
3. To liaise with partners and other stakeholders to identify strengths, weaknesses and opportunities to inform a new service model.
4. To develop most efficient operational processes.

D. Name of Lead Contact	Kirsty Forrester Jane Savage (second)	**E. Role and organisation**	Clinical Manager Leeds Community Neurology Services
F. email address	Kirsty.forrester@nhs.net Jane.savage@nhs.net (second)	**G. Phone number**	0113 3055082
H. Website or url	http://leedscommunityhealthcare.nhs.uk		

I. Other participants in this service improvement	
Organisation/service/name *(if applicable)*	**Provider/commissioner/ service user/other**

J. Description of patient group	Community Neurology including stroke
K. County or Counties covered	West Yorkshire – Leeds

L. Key outcomes *[if applicable]*		**M. If you are unable to share your data** (eg cost savings that are seen as business sensitive), are you willing to be approached directly to discuss?
1.		**YES / NO**
2.		**YES / NO**
3.		**YES / NO**
4.		**YES / NO**
N. Any unintended outcomes *(if applicable)*		
O. Key learning points		
P. Next planned steps		
Q. Consent to share content of this summary	**I am** willing for the content of this summary to be shared across the Clinical Commissioning Community Improving Adult Rehabilitation Community of Practice and to be summarised in any final report provided by the Clinical Commissioning Community on the outcomes of the Community of Practice **I do** agree to be the named contact for any future enquiries about this service improvement Signed ……Kirsty Forrester (electronic) Date 19 March 2013	



A. Title of Rehabilitation Service Improvement

Title	B. Status:	
Hearing Link – Self Management Programmes for people with hearing loss **Hearing Link is a charity for people with acquired hearing loss. The Self Management Programmes have been developed so that we are working alongside people with hearing loss and helping them live well with their hearing loss**	Planning Stage	
	In progress	X
	Business ready	

C. Summary of Objectives

1. Provide rehabilitation programmes for people with hearing loss that are peer led (all facilitators have hearing loss and therefore understand all of the issues raised, builds confidence and are good role models for the group)

2. Improve communication skills and strategies through group based discussions and goal setting. The programme content covers a broad range of subjects to address the practical and emotional aspects of acquired hearing loss, and gently allows individuals to explore their issues and challenges in a safe and supportive environment, learning from the experience of our trained volunteer facilitators as well as from other attendees at the programme.

3. Increase their confidence to integrate in local life - These programmes help to address such issues by developing skills in the participants to be able to positively manage their hearing loss in everyday environments, making them more likely to engage in their communities, and to generally have increased feelings of wellbeing.

4. Participate in activities they would otherwise have avoided due to the barriers that hearing loss presents

5. positively influence those who are 'communication partners' with them, either as family, friends or service-providers in the community

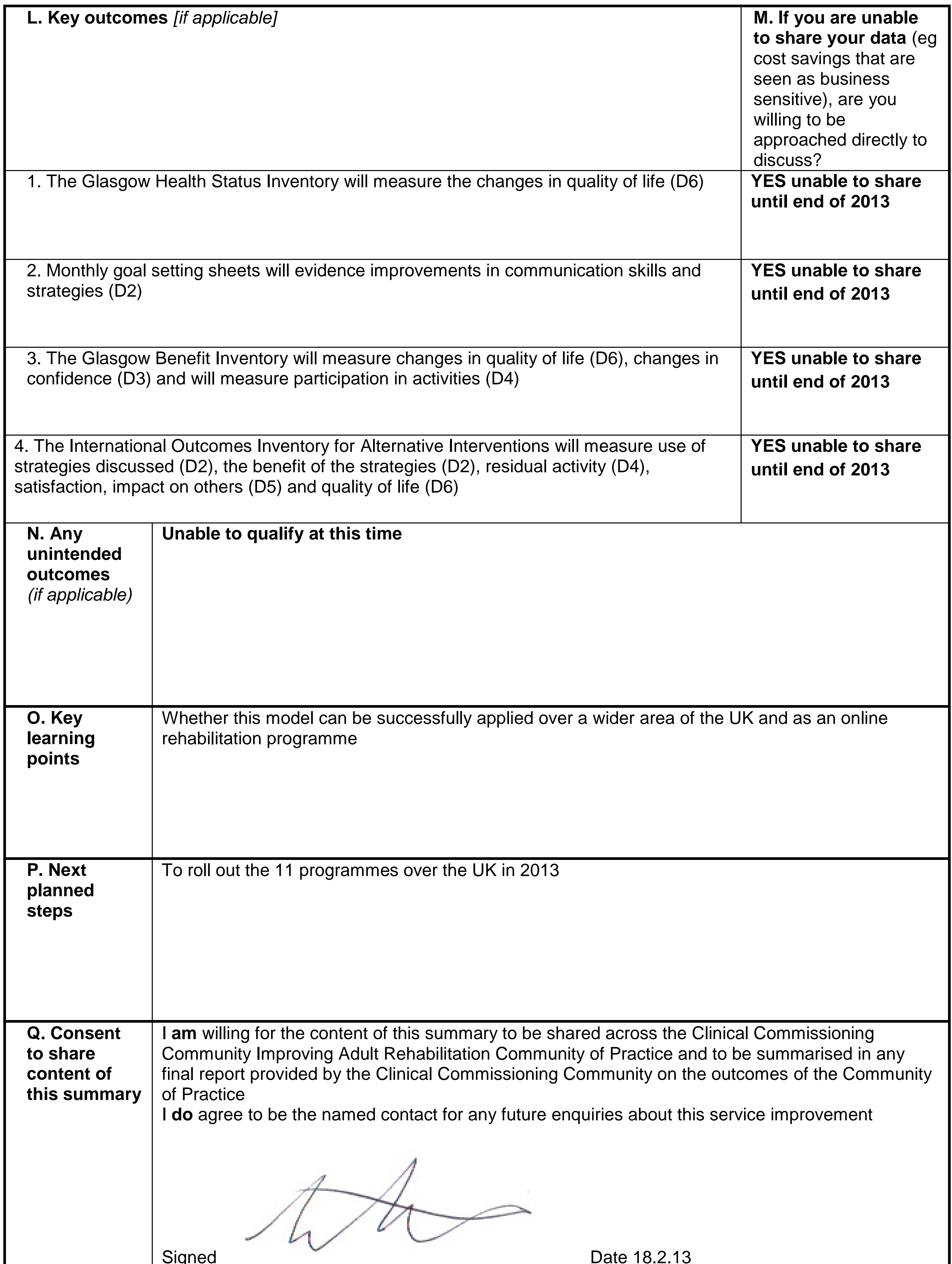
6. improve their overall quality of life through all of the above

D.Name of Lead Contact	Laura Turton	**E. Role and organisation**	Head of Services Hearing Link
F. email address	Laura.turton@hearinglink.org	**G. Phone number**	07950 669019
H. Website or url	http://hearinglink.org		

I. Other participants in this service improvement

Organisation/service/name *(if applicable)*	**Provider/commissioner/ service user/other**
1. We have 11 programmes planned in 2013 over the UK and some of these have specific partners, others are run solely through ourselves – please let me know if you would like a list of our partners	

J. Description of patient group	Patients with mild, moderate, severe or profound hearing loss who are not coping with the effects of their hearing loss
K. County or Counties covered	UK wide but specific areas for 2013: England: Kent, Nottingham, Hampshire, London, Birmingham, Newcastle Wales: TBA x 2 (north and south) Scotland: Edinburgh, Glasgow



L. Key outcomes *[if applicable]*	**M. If you are unable to share your data** (eg cost savings that are seen as business sensitive), are you willing to be approached directly to discuss?
1. The Glasgow Health Status Inventory will measure the changes in quality of life (D6)	**YES unable to share until end of 2013**
2. Monthly goal setting sheets will evidence improvements in communication skills and strategies (D2)	**YES unable to share until end of 2013**
3. The Glasgow Benefit Inventory will measure changes in quality of life (D6), changes in confidence (D3) and will measure participation in activities (D4)	**YES unable to share until end of 2013**
4. The International Outcomes Inventory for Alternative Interventions will measure use of strategies discussed (D2), the benefit of the strategies (D2), residual activity (D4), satisfaction, impact on others (D5) and quality of life (D6)	**YES unable to share until end of 2013**

N. Any unintended outcomes *(if applicable)*	**Unable to qualify at this time**
O. Key learning points	Whether this model can be successfully applied over a wider area of the UK and as an online rehabilitation programme
P. Next planned steps	To roll out the 11 programmes over the UK in 2013
Q. Consent to share content of this summary	**I am** willing for the content of this summary to be shared across the Clinical Commissioning Community Improving Adult Rehabilitation Community of Practice and to be summarised in any final report provided by the Clinical Commissioning Community on the outcomes of the Community of Practice **I do** agree to be the named contact for any future enquiries about this service improvement Signed Date 18.2.13

A. Title of Rehabilitation Service Improvement

	B. Status:	
Providing regular exercise in a safe and supportive environment for people with an acquired brain injury	Planning Stage	X
	In progress	
	Business ready	

C. Summary of Objectives

1. To train our gym facilitator in the Later Life training which is accredited by The Stroke association to ensure he has the skills required to provide specialist exercise groups for people with acquired brain injury

2. To provide regular specialist exercise groups for people with an acquired brain injury in an environment where people with brain injury feel safe, supported and are not seen as "different"

3. To ensure all clients referred to the exercise group receive an initial assessment by the neuro-physiotherapist to ensure they can participate in the exercise programme safely and their individual exercise goals are identified

4. To ensure ongoing supervision of the gym facilitator by the neuro-physiotherapist to ensure safe practice and an effective service

D. Name of Lead Contact	Michele Fleming	**E. Role and organisation**	Chief Executive, Headway Hurstwood Park
F. email address	Michele.fleming@headway-hp.co.uk	**G. Phone number**	01825 724363
H. Website or url	http://www.headway-hp.org.uk		

I. Other participants in this service improvement

Organisation/service/name *(if applicable)*	**Provider/commissioner/ service user/other**

J. Description of patient group	Anyone over the age of 18 years who has an acquired brain injury
K. County or Counties covered	East Sussex; West Sussex border

L. Key outcomes *[if applicable]*	**M. If you are unable to share your data** (eg cost savings that are seen as business sensitive), are you willing to be approached directly to discuss?
1. Our gym facilitator will be fully trained in the Later Life programme and competent to deliver specialist exercise programmes	**YES / ~~NO~~**
2. We will have regular specialist exercise groups running for people with an acquired brain injury which are fully evaluated and meet the individual needs of the participants	**YES / ~~NO~~**
3. All clients referred to the exercise group receive an initial assessment by the neuro-physiotherapist and any specific exercise requirements are incorporated into the programme	**YES / ~~NO~~**
4. The gym facilitator receives regular supervision from the neuro-physiotherapist so his practice is safe and clients are able to achieve optimum benefit form the exercise group	**YES / ~~NO~~**

N. Any unintended outcomes *(if applicable)*	• It is anticipated that we will further develop our working relationships with other organisations involved in the rehabilitation of people with acquired brain injury • By marketing this service we hope to raise awareness of the impact of brain injury to the general public • Our services will be promoted and clients with brain injury may identify other resources to support them
O. Key learning points	• Need to work in partnership with other relevant organisations e.g. the Stroke Association • Need to market and promote the service to ensure it is widely accessible • Need to cost service appropriately to ensure it is a financially viable project
P. Next planned steps	To run the first programme of exercise groups and evaluate them. A regular programme of exercise groups is planned and the evaluations from the initial programme will inform future programmes
Q. Consent to share content of this summary	I **am/~~am not~~** willing for the content of this summary to be shared across the Clinical Commissioning Community Improving Adult Rehabilitation Community of Practice and to be summarised in any final report provided by the Clinical Commissioning Community on the outcomes of the Community of Practice I **do/~~do not~~** agree to be the named contact for any future enquiries about this service improvement Signed: Electronic Date: 01.03.13

<table>
<tr><td colspan="4">**A. Title of Rehabilitation Service Improvement** </td></tr>
<tr><td colspan="3" rowspan="4">**Developing Counselling Services for people affected by Acquired Brain Injury to widen access for survivors and their families and to increase the knowledge and awareness of the volunteer/trainee counsellors**</td><td>**B. Status:**</td></tr>
<tr><td>Planning Stage | </td></tr>
<tr><td>In progress | X</td></tr>
<tr><td>Business ready | </td></tr>
<tr><td colspan="4">**C. Summary of Objectives**</td></tr>
<tr><td colspan="4">1. To improve access to counselling for people affected by acquired brain injury in the Eastbourne area</td></tr>
<tr><td colspan="4">2. To provide training opportunities which will develop specialist knowledge in Acquired Brain Injury for our volunteer counsellors</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>**D. Name of Lead Contact**</td><td>Michele Fleming</td><td>**E. Role and organisation**</td><td>Chief Executive, Headway Hurstwood Park</td></tr>
<tr><td>**F. email address**</td><td>Michele.fleming@headway-hp.co.uk</td><td>**G. Phone number**</td><td>01825 724363</td></tr>
<tr><td>**H. Website or url**</td><td colspan="3">http://www.headway-hp.org.uk</td></tr>
<tr><td colspan="4">**I. Other participants in this service improvement**</td></tr>
<tr><td colspan="3">**Organisation/service/name**
(if applicable)</td><td>**Provider/commissioner/ service user/other**</td></tr>
<tr><td colspan="3"></td><td></td></tr>
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<tr><td colspan="3"></td><td></td></tr>
<tr><td colspan="3"></td><td></td></tr>
<tr><td>**J. Description of patient group**</td><td colspan="3">• Anyone over the age of 18 years who has an acquired brain injury
• Relatives of carers of someone with an acquired brain injury</td></tr>
<tr><td>**K. County or Counties covered**</td><td colspan="3">East Sussex; West Sussex border</td></tr>
</table>

L. Key outcomes *[if applicable]*	**M. If you are unable to share your data** (eg cost savings that are seen as business sensitive), are you willing to be approached directly to discuss?
1. To reduce the waiting list for access to our counselling service	**YES / ~~NO~~**
2. To provide a service in the Eastbourne area to avoid the need for clients/carers in that area to travel to Newick or Brighton (where the service is currently provided)	**YES / ~~NO~~**
3. To develop and deliver workshops to ensure that our volunteer and trainee counsellors develop a knowledge and awareness of acquired brain injury and the impact it may have on the life of an individual and his/her family	**YES / ~~NO~~**

N. Any unintended outcomes *(if applicable)*	To deliver this service we are renting a room at The Chaseley Trust in Eastbourne. This will enable us to build a relationship with the staff at Chaseley and look at potential opportunities to work together to support adults with acquired brain injury
O. Key learning points	The Eastbourne counselling service has just started for one morning per week and will be evaluated after 12 weeks. Feedback from the clients will be used to develop the service further. We have sought feedback from our existing staff team regarding the type of information they would have liked to have received before commencing work in the field of acquired brain injury. We have used this feedback to develop a training programme for our trainee and volunteer counsellors.
P. Next planned steps	To run the first workshop and evaluate it. A regular programme of workshops is planned and the evaluations from the initial one will inform future programmes
Q. Consent to share content of this summary	I **am/~~am not~~** willing for the content of this summary to be shared across the Clinical Commissioning Community Improving Adult Rehabilitation Community of Practice and to be summarised in any final report provided by the Clinical Commissioning Community on the outcomes of the Community of Practice I **do/~~do not~~** agree to be the named contact for any future enquiries about this service improvement Signed: Electronic Date01.03.13

A. Title of Rehabilitation Service Improvement		
Use of X box Kinect to continue neuro rehabilitation therapy for patients with acquired brain injury in their homes following discharge	**B. Status:**	
	Planning Stage	
	In progress	X
	Business ready	

C. Summary of Objectives
1. Maintain and continue to improve physical abilities on discharge
2. support people with acquired brain injury to manage their long term condition and remain fit and well at home
3. provide a motivating leisure experience during the day
4.A smooth transition to community services with no decline in function

D. Name of Lead Contact	Moyra Pugh	**E. Role and organisation**	Professional Lead Occupational Therapist Royal Berkshire Hospital Foundation Trust
F. email address	moyra.pugh@royalberkshire.nhs.uk	**G. Phone number**	0118 322 5215
H. Website or url	http://		

I. Other participants in this service improvement

Organisation/service/name *(if applicable)*	**Provider/commissioner/ service user/other**
1. Professor Malcolm Sperrin. Lead for Clinical Engineering at Royal Berkshire Hospital Foundation Trust	
2. Erica Key, Lead Neuro Rehabilitation Occupational Therapist	
3. Bo Lamperd, Occupational Therapist at Berkshire Headway	

J. Description of patient group	**Acquired brain injury**
K. County or Counties covered	**West Berkshire**

L. Key outcomes *[if applicable]*	**M. If you are unable to share your data** (eg cost savings that are seen as business sensitive), are you willing to be approached directly to discuss?
1. Maintain function	**YES / NO**
2. Improve function - balance, coordination, ROM, reaction speed – measurable on XBox Kinect game improvement	**YES / NO**
3. to develop games for use in Therapy – with Reading University	**YES / NO**
4. to provide an enjoyable activity in the home to promote health and well being long term	**YES / NO**

N. Any unintended outcomes *(if applicable)*	**Improved socialisation – patients use the games with their grandchildren, children etc. common activity**
O. Key learning points	**Manufacture games are too fast – not always appropriate. Working with Reading university to develop appropriate games**
P. Next planned steps	**2 trials carried out.** **Another trial with developed games.** **Working with Headway to continue to develop use, feedback and outcomes.**
Q. Consent to share content of this summary	**I am** willing for the content of this summary to be shared across the Clinical Commissioning Community Improving Adult Rehabilitation Community of Practice and to be summarised in any final report provided by the Clinical Commissioning Community on the outcomes of the Community of Practice **I do** agree to be the named contact for any future enquiries about this service improvement Signed ……..electronic………………………………………………. Date 1 March 2013

A. Title of Rehabilitation Service Improvement	**B. Status:**	
The development of an innovative three week hotel based multi-disciplinary pain management programme for people with chronic pain and specialist rehabilitation programmes for conditions such as Joint Hypermobility Syndrome and Ehlers Danlos Syndrome. **The change in the setting of the programmes from a hospital to a hotel environment moves away from a medicalised approach to managing pain focusing instead on self-management through education sessions, tailored exercises, psychological support and practical coping and problem-solving strategies using a cognitive behavioural approach.**	Planning Stage	
	In progress	**X**
	Business ready	

C. Summary of Objectives
1. To de-medicalise the management of chronic pain by transferring the programme from a hospital to a hotel setting which prevents patients behaving passively in the patient role and instead becomes actively engaged and responsible for the management of their condition.
2. To reduce patients' pain related disability To improve self efficacy and to empower patients to effectively manage their own condition To improve physical function To improve quality of life.
3. To improve the patient experience by providing an environment more conducive to rehabilitation
4. To provide a cost saving to the organisation & improved access into the service by increasing the number of programmes

D. Name of Lead Contact	Sapna Ramani	**E. Role and organisation**	Therapy Lead in Pain Management & Rehabilitation at the Royal National Orthopaedic Hospital NHS Trust
F. email address	sapna.ramani@rnoh.nhs.uk	**G. Phone number**	0208 909 5820
H. Website or url	http://www.rnoh.nhs.uk		

I. Other participants in this service improvement	
Organisation/service/name *(if applicable)*	**Provider/commissioner/ service user/other**
1. Professor Rodney Grahame at UCLH refers patients with Hypermobility/Ehlers Danlos Syndrome into the programmes	Referrer
2. Royal National Orthopaedic Hospital Patient Focus Group	On behalf of service uses
3. The Mercure Hotel, Watford	Other
4. The Pain Management & Rehabilitation team at the Royal National Orthopaedic Hospital including medical consultants, physiotherapists, occupational therapists, nurses, therapy technicians, a horticultural therapists and health and clinical psychologists.	Provider

J. Description of patient group	Patients with complex chronic pain and associated disabilities & Patients with rheumatological conditions e.g. Joint Hypermobility Syndrome(JHS) & Ehlers Danlos Syndrome (EDS)
K. County or Counties covered	From all over the UK as the Royal National Orthopaedic Hospital is a national orthopaedic specialist centre

L. Key outcomes *[if applicable]*	**M. If you are unable to share your data** (eg cost savings that are seen as business sensitive), are you willing to be approached directly to discuss?
1. Improved patient experience by providing a more suitable environment in which to deliver pain management and specialist rehabilitation programmes as demonstrated by patient feedback.	**YES / NO**
2. To reduce the negative psychological effects of chronic pain, improve self efficacy, physical function and quality of life as measured on a range of outcome measures.	**YES / NO**
3. To deliver cost savings to the organisation	**YES / NO**
4. To reduce impact on waiting list and to improve access to service by running additional hotel based programmes.	**YES / NO**

N. Any unintended outcomes *(if applicable)*	There has been an opportunity to set up a horticultural service for patients attending the programme at the hotel. There are also plans to covert one of the guest bedrooms in the hotel into a kitchen for use by participants on the programme. Participants report an improved night sleep and fewer distractions staying in a hotel environment (compared to a hospital stay) and therefore they are better able to engage and participate in the programmes. Positive patient feedback including reports of being treated in more holistically as a person rather than a just medical condition.
O. Key learning points	To consider the skill mix of clinical staff to ensure cost effectiveness of service without compromising quality of care.
P. Next planned steps	1. To maintain service delivery & effectiveness 2. To improve access by increasing numbers of patients attending each programme from eight to twelve 3. To develop links with local community based services and patient organisations to ensure continuity of care and ongoing long term support following discharge from the programme. 4. Research and publication of outcomes
Consent to share content of this summary	**I am** willing for the content of this summary to be shared across the Clinical Commissioning Community Improving Adult Rehabilitation Community of Practice and to be summarised in any final report provided by the Clinical Commissioning Community on the outcomes of the Community of Practice **I do** agree to be the named contact for any future enquiries about this service improvement Signed ………Sapna Ramani………………………………………………………………. Date………………28/02/2013……………………………

A. Title of Rehabilitation Service Improvement		
Developing a rapid response dysphagia (swallowing) service for adults in the community.	**B. Status:**	
	Planning Stage	X
	In progress	
	Business ready	

C. Summary of Objectives
1. to implement use of a prioritisation matrix to identify patients presenting with high risk from dysphagia, with the aim of maximising health and well being, reducing hospital admission for dysphagia and its complications and facilitating seamless and timely hospital discharge and community follow up.
2. to assess all high risk community referrals on the day of referral or next day – service to be delivered across the 5 localities of East Lancashire, including people in their own home, in intermediate care services, and in care homes.
3. to evaluate the need for seven day working for community dysphagia and to determine the most efficient and safe way to deliver seven day services.
4. to introduce this service as part of a redesign of integrated community therapies across East Lancashire, including improved pathways for dietetic/SLT joint working.

D. Name of Lead Contact	Sian Davies	**E. Role and organisation**	Manager – Speech & Language Therapy East Lancashire Hospitals Trust
F. email address	Sian.davies@elht.nhs.uk	**G. Phone number**	01282 804075
H. Website or url	http://		

I. Other participants in this service improvement	
Organisation/service/name *(if applicable)*	**Provider/commissioner/ service user/other**
1. Community therapy and intermediate care services, East Lancashire Hospitals Trust & Lancashire County Council	NHS East Lancashire/CCG

J. Description of patient group	Adults in the community of East Lancashire presenting with acquired dysphagia (swallowing difficulties)
K. County or Counties covered	East Lancashire – Burnley, Pendle, Rossendale, Hyndburn, Ribble Valley

L. Key outcomes *[if applicable]*	**M. If you are unable to share your data** (eg cost savings that are seen as business sensitive), are you willing to be approached directly to discuss?
1. % of referrals scoring as high risk on the matrix seen within one working day	**YES**
2. Impact recording sheet developed in conjunction with physiotherapy, occupational therapy, dietetics to evaluate the impact of reorganised therapy services in the community – includes data collection on hospital admission/readmission and facilitating discharge, use of TOMs as outcome measure	**YES**
	YES / NO
	YES / NO

N. Any unintended outcomes *(if applicable)*	
O. Key learning points	
P. Next planned steps	Staff recruitment underway; service model under development. Plan to deliver from April 2013
Q. Consent to share content of this summary	**I am** willing for the content of this summary to be shared across the Clinical Commissioning Community Improving Adult Rehabilitation Community of Practice and to be summarised in any final report provided by the Clinical Commissioning Community on the outcomes of the Community of Practice **I do** agree to be the named contact for any future enquiries about this service improvement Signed Sian Davies Date 22.02.13…

A. Title of Rehabilitation Service Improvement

	B. Status:	
Early Supported Discharge Service for patients who have suffered a stroke	Planning Stage	
	In progress	
	Business ready	X

C. Summary of Objectives

1. To work closely with the multi-disciplinary-team (MDT) on the stroke unit and facilitate the safe discharge of St Helens and Widnes stroke patients (at the earliest appropriate opportunity) to a place that meets their needs ie home or nursing/residential/sheltered home.

2. To provide specialised stroke rehabilitation to patients in the safe environment they are discharged to and to aim to facilitate their potential recovery from stroke for a specified period, before being either discharged from the service or referred on to other community services to continue their rehabilitation.

2. To meet KPI set out in the service specification ie
   - 100% of patients to be contacted by a team member within 24 hours of discharge
   - 80% of patients demonstrate some functional improvement
   - 100% of patients are screened for mood disturbance and cognitive impairment
   - Annual patient and carer satisfaction survey demonstrates 90% satisfaction with the service
   - A maximum of 6 weeks input post discharge is achieved by 95% of patients

D.Name of Lead Contact	Sue Grumley	**E. Role and organisation**	Therapy Manager – Cluster 1, Secondary Care AHP Services, 5 Boroughs Partnership Trust.
F. email address	susan.grumley@5bp.nhs.uk	**G. Phone number**	0151 430 1014
H. Website or url	http://		

I. Other participants in this service improvement

Organisation/service/name *(if applicable)*	**Provider/commissioner/ service user/other**
1. St Helens and Knowsley Hospital Trust / stroke service / Dr Sanjeev	St Helens CCG's
2. Halton - Jackie Johnson	Halton Intermediate Care Manager

J. Description of patient group	Patients who have suffered from a stroke, are medically stable but require further rehab. They must be able to transfer with the assistance of just one other person or independently.
K. County or Counties covered	St Helens Borough and Widnes area

<table>
<tr><td colspan="2">L. Key outcomes [if applicable]</td><td>M. If you are unable to share your data (eg cost savings that are seen as business sensitive), are you willing to be approached directly to discuss?</td></tr>
<tr><td colspan="2"></td><td>YES</td></tr>
<tr><td colspan="2"></td><td>YES</td></tr>
<tr><td colspan="2"></td><td>YES</td></tr>
<tr><td colspan="2"></td><td>YES / NO</td></tr>
<tr><td>N. Any unintended outcomes
(if applicable)</td><td colspan="2">Previous team set up affected service delivery</td></tr>
<tr><td>O. Key learning points</td><td colspan="2">Team has changed from being in-reach to being an out-reach team and has had staffing changes. These changes have brought an improvement in the service provided, in the form of reduced duplication, improved communication, quicker response time, continuity of care for patients and has brought greater user satisfaction.</td></tr>
<tr><td>P. Next planned steps</td><td colspan="2">To integrate the documentation between the stroke unit and the Early Stroke Discharge team
To formulate a business case for additional staffing, additional staffing would allow more dependant patients to be taken home earlier
To work with the commissioners to develop a more equitable service between the St Helens and Halton areas
To develop patient focus groups to inform change within the team</td></tr>
<tr><td>Q. Consent to share content of this summary</td><td colspan="2">I am willing for the content of this summary to be shared across the Clinical Commissioning Community Improving Adult Rehabilitation Community of Practice and to be summarised in any final report provided by the Clinical Commissioning Community on the outcomes of the Community of Practice
I do agree to be the named contact for any future enquiries about this service improvement

Signed Sue Grumley Date 25/2/13</td></tr>
</table>

A. Title of Rehabilitation Service Improvement		
Proactive and assertive rehabilitation for patients in community settings, and wherever possible in their own homes. To provide a "step up" service to prevent acute admission, or "step down" to facilitate timely discharge and reduce lengths of stay.	**B. Status:**	
	Planning Stage	X
	In progress	X
	Business ready	

C. Summary of Objectives
1. The aim of the service is to maintain people at home when safe and appropriate to do so and thereby reducing admissions to hospital, reducing inpatient lengths of stay and reducing readmissions.
2. To adopt a client centred approach in which the individual takes on an active role to achieve maximum independence and quality of life, with the Intermediate Care team supporting the individual to set achievable objectives to help them attain their long term goals.
3. To provide a zone-led intermediate care service and medical input to enable the client to remain in their own home, wherever possible; where this is not possible in a short-term nursing or residential home placement with regular therapeutic & nursing interventions.

D. Name of Lead Contact	Solveig Sansom	**E. Role and organisation**	Senior Commissioning Manager for Integration, South Devon & Torbay CCG
F. Email address	Solveig.sansom@nhs.net	**G. Phone number**	01803 652 511
H. Website or url	http://		

I. Other participants in this service improvement	
Organisation/service/name *(if applicable)*	**Provider/commissioner/ service user/other**
1. Torbay & Southern Devon Health & Care NHS Trust: Lesley Wade	Provider

J. Description of patient group	Patients over the age of 18 with a medical condition assessed as manageable in a community setting who would benefit from the input of a multi-professional team to meet their health and/or social care needs in the short term. Typically, although not exclusively, patients are complex and elderly.
K. County or Counties covered	Southern Devon and Torbay

L. Key outcomes *[if applicable]*	**M. If you are unable to share your data** (eg cost savings that are seen as business sensitive), are you willing to be approached directly to discuss?
1. Process & activity measures: 1. Numbers of urgent & non-urgent referrals 2. Sources of referral 3. Average length of stay in placement 4. No of bed days purchased 5. Cost of bed days 6. Average duration on caseload 7. Average cost of intermediate care episode	**YES**
2. Numbers of Intermediate Care patients attending &/or being admitted to acute care a. During the IC episode b. Within 7/14/28 days of end of IC episode Numbers of patients referred to IC by the acute Trust & subsequently readmitted within 7/14/28 days	**YES**
3. Service outcomes • Documented achievement of individual goals *(in next 12-18 months)* ***and/or*** • Change in functional capacity before and after intervention *(in next 12-18 months)* • Patient Experience	**YES**
4. The following measures would be subject to periodic audit: • Case mix of referrals • Timeliness of responses • Numbers of admissions to acute care prevented	**YES**

N. Any unintended outcomes *(if applicable)*	
O. Key learning points	Primary Care capacity to take on the extra responsibility of medical cover for these often complex patients is limited. An alternative, additional medical cover is being investigated.
P. Next planned steps	As above.
Q. Consent to share content of this summary	**I am** willing for the content of this summary to be shared across the Clinical Commissioning Community Improving Adult Rehabilitation Community of Practice and to be summarised in any final report provided by the Clinical Commissioning Community on the outcomes of the Community of Practice **I do** agree to be the named contact for any future enquiries about this service improvement Signed elecronic………………. Date……………………………………………

A. Title of Rehabilitation Service Improvement

Title	B. Status:	
Supporting young people with rehabilitation needs as they transition from paediatric to adult health care services.	Planning Stage	X
	In progress	
	Business ready	

C. Summary of Objectives

1. **To develop a pathway for children with neurodisability transitioning to adult services**. The purpose of this pathway would be to ensure that the rehabilitation needs of young people with neurodisability, withinin a developmental context, are better communicated to adult service providers in preparation for transition and to serve as a starting point for communication between services in anticipation of transitions taking place.

2. **To bring together adult and paediatric rehabilitation service providers across community, hospital and specialist settings to a) establish networks b) share knowledge around models of delivery, definition of terms, referral processes and c) clarify terminology and assumptions of very differently organised and delivered services.** Communication and collaboration to establish practice guidance will support provision of interventions in a timely manner to minimise long-term disability for young people with changing needs through the life span are needed.

3. **Through the above, to develop a guidance strategy around transitions specifically for young people requiring rehabilitation for local/regional piloting with the potential for national distribution**. National guidance documents e.g. DoH 'A Transition Guide for All Services', the RCN 'Adolescent Transition Care' and the Transition Information Network 'TransMap – From Theory Into Practice' all provide guidance regarding preparing for need to access health care (e.g. consultation with medical and nursing professionals as required). None however refer to rehabilitation provision – how to anticipate, locate or obtain it.

4. **To increase awareness of adult rehabilitation providers of the particular needs of young people with regard to** rehabilitation (sometimes in targeted bursts) in the context of ongoing development of the individual in the face of rapidly changing and increasing demands of transitions in education, social, vocational and independent living related to a key stage of life.

D. Name of Lead Contact	Dr Anne Gordon	**E. Role and organisation**	Consultant Occupational Therapist & Clinical Lead – Paediatric Occupational Therapy; Evelina Children's Hospital, Guy's & St Thomas' Hospital NHS Foundation Trust
F. Eail address	anne.gordon@gstt.nhs.uk	**G. Phone number**	020 7188 7188 x 53281
H. Website or url			

I. Other participants in this service improvement

Organisation/service/name (*if applicable)*	**Provider/commissioner/ service user/other**
1. Regional community services providers in child development centres in the SE London and SE England	
2. Specialist rehabilitation providers for adults and children in SE England	

J. Description of patient group	Children and young people with neurological disabilities.
K. County or Counties covered	South London and SE England

L. Key outcomes *[if applicable]*	**M. If you are unable to share your data** (eg cost savings that are seen as business sensitive), are you willing to be approached directly to discuss?
1. To have developed a SE London pathway for young people with acquired neurodisability in the first instance for pilot over a 12 month period. Feedback would be sought qualitatively from service providers and recipients and through standardised measures of processes of care.	**YES / NO**
2. To identify key individuals in paediatric and adult rehabilitation community (both service providers and recipients) to meet and discuss areas of concern and share knowledge of service provision. Data to be collected through focus groups targeting both strengths and weakness of current system, and identification of exemplars of good practice.	**YES / NO**
3. Through the above to identify key individuals in paediatric and adult rehabilitation community across disciplines for development of a strategy document specifically targeting rehabilitation transitions.	**YES / NO**
4. To develop education and information resources for young people, their families and service providers to be able to locate services providing intervention in their area. This may include for example the identification of rehabilitation 'champions' or key workers in regions, or online based directories/resources.	**YES / NO**

N. Any unintended outcomes *(if applicable)*	
O. Key learning points	
P. Next planned steps	
Q. Consent to share content of this summary	**I am** willing for the content of this summary to be shared across the Clinical Commissioning Community Improving Adult Rehabilitation Community of Practice and to be summarised in any final report provided by the Clinical Commissioning Community on the outcomes of the Community of Practice **I do** agree to be the named contact for any future enquiries about this service improvement Signed … 12th March 2013 Date……………………………………

A. Title of Rehabilitation Service Improvement

Improve rehabilitation services working together (namely intermediate care / reablement / prevention services) to create a more joined up, flexible and accessible rehabilitation experience for people living in Cumbria	**B. Status:**	
	Planning Stage	
	In progress	X
	Business ready	

C. Summary of Objectives

1. Develop protocol for rehabilitation model/pathway across services namely intermediate care, reablement and prevention services) in discussion with stakeholders
2. Overcome professional barriers and systems variances between services in localities placing 'the person' at the centre of any rehabilitation model/pathway
3.
4.

D. Name of Lead Contact	Anne Phillips	**E. Role and organisation**	Development Manager (Adult Social Care, Cumbria County Council)
F. Email address	anne.phillips@cumbria.gov.uk	**G. Phone number**	07837 113472
H. Website or url	http://		

I. Other participants in this service improvement

	Organisation/service/name *(if applicable)*	**Provider/commissioner/ service user/other**
1.	Intermediate care services in Cumbria	Provider
2.	Adult Social Care District Teams	Operational / commissioner
3.	Reablement Service (Cumbria Care)	Provider
4.	General Commissioning Team	Commissioner
5.	Prevention services via Neighbourhood Care Programme	Provider
6.	Health commissioners	Commissioner

J. Description of patient group	Patient / service user being discharged home from hospital and/or living within their community
K. County or Counties covered	Cumbria

<table>
<tr><td colspan="2">L. Key outcomes [if applicable]</td><td>M. If you are unable to share your data (eg cost savings that are seen as business sensitive), are you willing to be approached directly to discuss?</td></tr>
<tr><td colspan="2">8. Outcomes to be determined as part of developing protocol for rehabilitation model/pathway</td><td>YES / NO</td></tr>
<tr><td colspan="2">2. Direct outcomes for people are:

• I can remain in my own home
• I can look after myself as much as possible
• I have improved my independence
• I can get outside my front door again
• I feel safe again
• My family are re-assured and worry less about me
• I am more confident
• I am more in control of my own life
• I understand how to take better care of myself
• I have more choice about my life</td><td>YES / NO</td></tr>
<tr><td colspan="2"></td><td>YES / NO</td></tr>
<tr><td>N. Any unintended outcomes</td><td colspan="2">• keeping the person at the centre of the rehabilitation pathway
• joining up of services will provide a better 'individual' experience
• better use of skill and resources will be more cost effective, reduce duplication and improve communication
• overcoming systems variances will help to reduce the same questions being asked several times of patients/service users
• improving support on discharge from hospital and in a change of circumstances at home will enable patients/service users to stay well for longer living in their communities</td></tr>
<tr><td>O. Key learning points</td><td colspan="2"></td></tr>
<tr><td>P. Next planned steps</td><td colspan="2">As detailed above</td></tr>
<tr><td>Q. Consent to share content of this summary</td><td colspan="2">I am willing for the content of this summary to be shared across the Clinical Commissioning Community Improving Adult Rehabilitation Community of Practice and to be summarised in any final report provided by the Clinical Commissioning Community on the outcomes of the Community of Practice
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Signed …………………Anne Phillips (electronic)…… Date……12/3/13………………………….</td></tr>
</table>