Community Rehabilitation Alliance (CRA)

Rehabilitation
fit for the future

Submission to the NHS England consultation on its 10 Year Plan

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Introduction

The Community Rehabilitation Alliance (CRA) comprises more than 60 charities and professional bodies who are all committed to improving the commissioning, planning and delivery of rehabilitation. This document comprises our submission to the government under its 10 Year Plan consultation on the future of NHS England.

Our vision for an NHS fit for the future

The CRA would like NHS England's 10 Year Plan to acknowledge that universal access to rehabilitation is as important to outcomes as medicines and surgery and fully utilise its potential.

Any plan to make the NHS fit for the future needs to include:

- Full integration of outside-hospital provision, joining up health and social care with voluntary, community, local authority, and social enterprise organisations, communities, unpaid carers, and private providers.
- Tackling the causes of ill-health through increasing rehabilitation expertise in primary care teams and improving access to community rehabilitation from primary care.
- Improving access to quality rehabilitation through better use of data and technology, supporting this with education and training, fit-for-purpose systems and infrastructure and leadership.

Rehabilitation is not only an enabler of the two major healthcare shifts, but could, if done well, underpin the sustainability of the NHS.

Rehabilitation advice, support and care optimises function (physical, mental, sensory, and/or cognitive) and reduces disability in individuals with health conditions, in interactions with their environment and daily lives. All rehabilitation is focused on empowering individuals to get back, keep, or slow the loss of functional abilities to meet their goals.

This is as essential to improving health outcomes as medicines and surgery. It reduces the need for hospital admissions, surgery, and medication through supporting people to successfully manage long-term physical and mental conditions, enabling more people to stay in or return to work. It also unlocks the value of high tech and expensive interventi\ons (scans, surgery, pharmacology), making them more productive.

With the UK's population projected to increase significantly and older adults living with multiple conditions, improving rehabilitation services is critical. People, the NHS and the country cannot afford access to rehabilitation to continue being so uneven that half of people who need it go without. Without universal access to rehabilitation, we cannot reduce persistent inequalities nor close the gaps in healthy and disability-free life expectancy.

How to rebalance the healthcare system

The challenge of ensuring people's health does not 'fall off a cliff' after hospital discharge means ensuring population need is met by community-based rehabilitation teams. When community rehabilitation supports people to get as well as they are able in a timely way, it reduces hospital admissions and shortens bed stays, easing demand on acute and secondary services. But capacity cannot be sustained unless the centre ensures funding is protected from cuts at a local level.

Enablers:

- **Fund community rehabilitation teams through designated (ring-fenced) resources,** with resulting system savings reinvested to further expand community capacity.
- **Grow community-based rehabilitation teams by using the whole available rehabilitation workforce** including allied health professionals, mental health experts, rehabilitation nurses, support and care workers, social workers, health coaches and social prescribers, exercise professionals, volunteers, and students.
- **Provide training and development for support and care workers as rehabilitation assistants** to strengthen community rehabilitation teams. Create advanced practice roles to provide clinical leadership outside hospitals and enhance skills across the health and care workforce in public coaching and supported self-management.
- **Establish a full-cost recovery funding model for voluntary sector providers,** acknowledging their unique contributions to service user outcomes. This will enable them to complement NHS community rehabilitation efforts effectively.

The challenge of ensuring a seamless care experience across sectors for service users can only be met at a system level. This will improve outcomes, particularly those with diverse health needs.

Enablers:

- **Establish accountability within Integrated Care Boards (ICBs):** Ensure all ICBs designate a senior officer accountable for overseeing rehabilitation across all sectors and health condition pathways. This officer should facilitate a cohesive rehabilitation strategy that involves input from all sectors. This has been achieved in NHS Sussex ICB with a Sussex Rehabilitation Mandate.

- **Enhance partnerships between NHS community services and primary care through integrated neighbourhood teams.** Share specialised roles between community and primary care teams to elevate rehabilitation expertise and add mutual value.
- **Provide rehab through those integrated neighbourhood teams.** Rehab MDTs in neighbourhood teams would provide a comprehensive rehab assessment of an individual's needs, working with individuals to co-produce a rehab prescription based on what matters to them.
- **Expand innovative approaches to service design:** Scale up progressive approaches to community-based rehabilitation service design – including an integrated rehabilitation offer for people with long term conditions, an approach for both mental and physical health, and investment in public and former service users to provide peer support.

The challenge of an ageing population and growing numbers of people with long-term conditions must be met unless the NHS is to be overwhelmed. Currently people with long-term conditions risk developing co-morbidities, often associated with loss of mobility, chronic pain, anxiety, depression, and social isolation.

Expert advice on how to manage long-term conditions is difficult to access from primary care until individuals have deteriorated, often to a point of crisis and often years after the original diagnosis.

Primary care teams do not always have a First Contact Practitioner, or other expertise to advise on and understand self-management and rehabilitation as part of treatment. As a result, people with long-term conditions often are not referred for the rehabilitation services they need.

Universal and timely access to NHS community-based rehabilitation and voluntary sector support can help halt a downward health spiral and keep people well for longer.

Enablers:

- **Improve early access to self-management resources** and community support groups.
- **Equip primary care teams for community rehabilitation referrals:** Provide training to ensure that primary care professionals are equipped to advise on self-management and rehabilitation options.
- **Establish Community Advanced Practice Clinicians for Long-Term Conditions:** Introduce advanced practice clinicians within Integrated Neighbourhood Teams. These clinicians would work across primary and community care, offering people with long-term conditions expert advice on self-management, facilitating referral to voluntary services for support from the moment of diagnosis, and connecting the public to NHS community rehabilitation services where needed. They will also prepare service users on the importance of rehabilitation as part of treatment.
- **Enhance secondary prevention through community-based rehabilitation:** Prompt access to community-based rehabilitation is key to secondary prevention by helping people maintain mobility, functionality, cognition, and independence. Existing community rehabilitation services such as pulmonary, musculoskeletal (MSK), stroke, cardiac and cancer rehabilitation providing therapeutic exercise, education and peer support are leading the way in focusing on secondary prevention, including through incorporating psychological support.

Fixing the foundations of the NHS

Technology is an enabler for the shift from hospital to community and sickness to prevention. The Sudlow Review (2024) highlighted the critical role that robust, multi-source **data** plays in underpinning all healthcare planning and delivery, referring to it as the "critical national infrastructure that can underpin the health of the nation". It also recognised the need for digital transformation to be enabled by a **"strategy, leadership** and **investment** to match." Alongside this, "a fundamental shift in the balance of skills in the **workforce"** is needed, as recommended by the Topol Review (2019) .

Yet community rehabilitation organisations are lacking service level data for multiple purposes including clinical delivery, research, quality improvement, benchmarking, showcasing best practice, making business cases and workforce planning.

We would like to see the 10 Year Plan support the move from hospital to community with an integrated community rehabilitation database that covers the full breadth of health and social care (i.e. linked across acute, intermediate, community and primary settings), which reduces current issues with interoperability, data flow and access.

It should be co-designed with stakeholders to help map population need against public access to services and outcomes; support audit and service evaluation; and improve integration of community services (including partnership working between NHS, statutory and non-statutory bodies).

Importantly, this would include person-reported outcomes and experience of NHS rehabilitation and recovery services in the community, to help drive quality improvements and resources into the community.

When it comes to patient-facing data and tech, high quality digital rehabilitation provision should remain a choice alongside face-to-face provision, with the intention to widen access, and funding for local implementation.

Community rehabilitation providers should be supported to integrate seamlessly new technologies into services to reduce administrative burden (eg ambient note taking technologies, scheduling assistants), support clinician workflows (eg service user facing apps, decision support tools) or support delivery of rehabilitation for service users in their own home (eg self-management support apps, augmented reality exercise programmes).

Access to digital is not universal. Solutions must consider that 7% of households don't have access to the internet, 1 million people cancelled their broadband services during the cost-of-living crisis, 10 million adults lack foundation-level digital skills, and 30% of people who are offline feel that the NHS is one of the most difficult organisations to interface with . It is, therefore, critical that future services provide in-person and technology-enabled rehabilitation to ensure every person is seen when and how they would like, and that existing inequities are not maintained or widened further.

Health inequalities exist across the UK, and these are entrenched in poor representation of marginalised groups in health data sets, and these same groups are more likely to experience digital exclusion . In that context, we believe the 10 Year Plan needs to address:

1. **Data**
2. **Education and training**
3. **Systems and infrastructure**
4. **Leadership**

This response has been structured so that the enablers for each challenge are listed in priority order (i.e. 1.1 is higher priority than 1.2), and that key activities under each enabler (e.g. 1.1.1 – 1.1.9) are listed in chronological order, with activities that should be completed first appearing highest on the list.

1. **Challenge One is** to provide the quantity and quality of workforce, organisational, service, and individual level data required to support the rehabilitation workforce to plan, deliver, measure, and improve the key services they provide across health and social care. These issues have been highlighted and explored in the CRA report, Making Community Rehabilitation Data Count (2022) .

Enablers:

1.1. Improve the Quality and Quantity of data that reflects the rehabilitation workforce, their key activities, and the outcomes of the rehabilitation they provide.

1.1.1. Promote the crucial role data plays in supporting and developing rehabilitation services for service users across all sectors, identifying marginalised groups.

1.1.2. Consult with the rehab workforce to identify and explore the requirements for data items that help describe the activities, outcomes, and impact of rehabilitation.

1.1.3. Co-develop and deliver data audits and mapping exercises with members of the rehabilitation workforce, upskilling where required, and with sufficient staffing to allow time for practice improvement (see 1.2). This will allow services and systems to understand what rehabilitation data they currently have and what data they are lacking. This process should explore existing, and missing data linkages that either support or hinder rehabilitation services in their day-to-day activities.

1.1.4. Deliver programmes of work that support the rehabilitation workforce to change the data and digital culture across the rehabilitation workforce, and their places of work.

1.1.5. Work with the rehabilitation workforce to create standardised data items for rehabilitation. These will be used to provide intelligence that describes the activity, outcome, and impact of rehabilitation across the system.

1.1.6. Deliver robust data flows. These should include automated extraction from rehabilitation services by central and system agencies, with robust, mandated reporting back to rehab services. This should also include appropriate bench marking of service data.

1.1.7. Deliver a complete and robust dataset to implement population health approaches and support embedded predictive analytics. These may be used for population profiling, exploring inequalities, risk stratification, and case identification for refining rehabilitation pathways or interventions, and for developing new interventions.

1.1.8. Deliver integrated datasets to allow for monitoring of continuous improvement projects and their impacts across the system using local health data insights.

1.1.9. Real time, inclusive data to be used by the rehabilitation workforce to help identify, design, and deliver new preventative approaches. These approaches will improve health and wellbeing and help to reduce their rate of decline in the local population.

1.2. Improve the competence, confidence, knowledge, and skills of the entire rehab workforce in data and digital.

1.2.1. The central and local promotion of good data behaviours by NHSE and partners to be clearly visible to the entire rehabilitation workforce from day one. This must promote the data best practice of collect well, use well, share well. It should also promote the collection of robust health inequalities data.

1.2.2. Provide guidance on how data flows within our systems, and the key role the rehab workforce has in getting the inputting of the data right.

1.2.3. Embed data knowledge and skills into rehabilitation workforce job descriptions at all levels.

1.2.4. Assign a data leader in every rehabilitation team and support them to foster a data culture across their rehabilitation workforce.

1.3. Ensure visible, safe, easy to access and easy to use data linkages for rehabilitation service planning, monitoring, improvement, and research.

1.3.1. Explore linkages across health and social care datasets, and requirements for integrations with datasets outside of health such as ONS or public health.

1.3.2. Develop and pilot benchmarking tools for existing data to demonstrate process and outputs.

1.3.3. Deliver linked data across workforce, individual, and organisational levels.

1.3.4. Facilitate rehabilitation data flows through the Federated Data Platform.

1.3.5. Make national-level benchmarked rehabilitation data accessible to the workforce, and service users as appropriate. This will provide interactive data dashboards with appropriate benchmarking and comparisons.

1.3.6. Use robust rehab workforce, individual and organisational data for rehab service monitoring, planning and improvement.

1.3.7. Make federated and linked datasets accessible and available for research or other secondary uses (as appropriate). This may be through secure data environments or alternative provision. These will provide federated analytics to ensure researchers have safe and

secure access to health and social care data whilst ensuring service user anonymity, enhancing population health planning.

1.3.8. Integrate health wearables and internet of things platforms to the EHR and national data flows to improve data richness.

1.4. Create a data environment where central and local systems and rehabilitation services can utilise in-built dashboards and federated analytics to automate reporting and business intelligence.

1.4.1. Interactive dashboards, federated analytics and automated reporting should be optimised for use by rehabilitation service providers.

1.4.2. Optimise data processes so there is minimal or no duplication of data entry, data manipulation or analysis by rehabilitation staff (eg using AI to extract structured data from unstructured submissions).

2. **Challenge Two** is to deliver the digital and data skills required to support the transition from an analogue rehab workforce to a digitally enabled one.

Enablers

2.1. Deliver ways to improve the digital and data competency of the entire rehabilitation workforce

2.1.1. Roll out the NHSE / CSP Introduction to Health Informatics education programme to the NHSE workforce for them to gain foundation knowledge and skills in data and digital to support the shift from analogue to digital for NHSE.

2.1.2. Provide easy to use competency assessments and map training opportunities to these. Alongside these, NHSE should create digital skills passport and / or relevant competency frameworks.

2.1.3. Integrate foundation data and digital skills into undergraduate training, organisational mandatory training and professional CPD training standards for healthcare professionals.

2.2. Create a network of digital champions across the rehab workforce

2.2.1. Create the roles and networks to support clinical and non-clinical digital champions. These should be across teams, organisations, systems, and professions.

2.2.2. Develop the role and structures for supporting service user digital champions in NHSE digital networks.

2.2.3. Empower digital champions to drive change /transformation across local and health and care services by influencing appropriate stakeholders.

2.2.4. Digital champions educate and support staff within their networks to develop digital competence and confidence

3.Challenge Three is to provide the systems and infrastructure that allow the rehabilitation workforce and the people they support to flourish.

Enablers

3.1. Optimise the electronic health record (EHR) so that all users can access the information they need, at all times

3.1.1. Consult rehabilitation teams in the procurement, design and deployment of EHR to ensure it's fit-for-purpose in terms of rehabilitation activities.

3.1.2. Clear pathways for rehab teams to contribute to the improvement of existing EHR software. This will include functional and non-functional requirements.

3.1.3. Identify and engage with EHR super users from the rehabilitation workforce to support the ongoing development of EHR.

3.1.4. Easy public access and navigation of EHRs, which will provide opportunities for service users to update and add to their record. To increase agency, they should have the ability to add or amend transactional data, PROMS, PREMS, About me and similar.

3.1.5. Remote access to EHR and any other necessary system (see 3.5.1) should be available from any work location (community, rural etc). Remote / mobile interface should provide similar functionality to the desktop app.

3.1.6. Open API for interoperability should be introduced across different systems and technologies to integrate wearable technologies and similar into the EHR.

3.2. Co-design and co-production with all stakeholders (including service users) is embedded in all digital and data work from the outset and is continuous through the digital product life cycle.

3.3. Ensure that all systems being used across the rehabilitation pathway are interoperable so that service user data is easily accessible to all users at the time it is needed

3.3.1. Interoperable systems will provide equitable and easy access to all users at need. This will limit the duplication of effort for staff and public using systems eg single sign-on to reduce the number of passwords each individual user needs to maintain.

3.3.2. Information standards will support the seamless flow of appropriate data across the health and social care system. This will reduce duplication of effort by those entering data, and reduce the likelihood that service users will need to repeat the same conversation with

different stakeholders such as that contained in their About Me information. The service user will feel listened to and valued by having to enter their information once only, and having this accessible to all health and social care services they interact with.

3.3.3. Open API should be implemented to foster safe and effective data sharing between integrated health and social care systems, and appropriate external devices and platforms.

3.4. Provide long-term capital funding to support the transition of rehabilitation to become tech enabled

3.4.1. Significant infrastructure funding must be made available for the upgrade of outmoded / outdated tech such as legacy hardware and software, which is building inefficiencies into the whole NHS system. This should not be drawn from existing service operational budgets.

3.4.2. Funds for new hospital builds must budget for sufficient technology and infrastructure to support service users across all linked rehabilitation pathways. This should cover the entire episode of care from admission and discharge through rehabilitation to ongoing self-management, with a focus on rehabilitation services provided in the community where digital and health inequalities are currently the widest.

3.5. Ensure access to devices and software is provided across the rehabilitation pathway

3.5.1. Software and hardware must support the rehab workforce to work efficiently irrespective of their location.

3.5.2. Funding for ongoing maintenance of new hardware and software must also be provided, or a vicious cycle of legacy issues will begin again.

3.5.3. Rehabilitation services and service users must be supported by infrastructure and hardware that will ensure connectivity and access at all times.

3.5.4. The rehabilitation workforce must be empowered, and given training and time, to engage with and pilot innovative technology to improve service user experience and/or outcome. Opportunities for funding to support implementation must be made available to the rehabilitation workforce.

3.6. Ensure that the NHS and that rehabilitation workforce and the services they work in are open for innovation.

3.6.1. Create frameworks and pipelines for the rehabilitation workforce and service users to engage with industry to help shape the products of the future.

3.6.2. Understand the potential versus the reality of AI and use that intelligence to drive the safe and effective development and deployment of AI in rehabilitation services.

3.6.3. Explore and routinely pilot novel technologies in practice, understanding how they can be integrated into routine rehab service pathways.

3.6.4. Provide funding for other technologies such as virtual reality, augmented reality, wearables and robotics as part of rehabilitation pathways. Together with awareness-raising of their benefits to healthcare, this will help scale-up the delivery of rehabilitation, maximise user engagement, and reduce barriers to accessing rehabilitation.

3.6.5. Mechanisms to support appropriate integration of technology into rehabilitation pathways must be developed alongside training to support the competency of the rehabilitation workforce, and expand their skills in business case development.

3.7. Improve the functionality of the NHS App as a gateway to the EHR and for the public to interact with rehabilitation services

3.7.1. Benchmark the best aspects of NHS app equivalents delivered in other nations, regions or ICBs and redesign the NHS app into a better gateway for service users to interact with rehabilitation services and their EHR.

3.7.2. Improve the functionality and inclusivity of the NHS app to integrate supported self-management for people with long-term conditions. This should include evidence based and appropriate two-way communication between services and service users.

4.Challenge Four is to create digital leaders across all levels and sectors of the rehabilitation workforce

Enablers

4.1. Create digital leaders across all levels and sectors of the rehabilitation workforce

4.1.1. Digital must be prioritised within national rehabilitation strategy and policy as well as at trust, board and ICS level. These digital leaders should be tasked with embedding a culture of digital integration and innovation and sustaining the momentum of the digital transformation journey.

4.1.2. Develop roadmaps for digital leadership skills for the rehabilitation workforce (across all levels), and support transitions from novice to beginner, from beginner to intermediate, and from that to a leadership level.

4.1.3. Ensure digital leadership at service and system level is diverse and is drawn from a range of clinical backgrounds, including the rehabilitation workforce. This will support better development and delivery of digital across the workforce and national and local pathways.

4.1.4. Embedding a digital mindset in all senior leaders will help support the shift to a digital culture for all teams.

4.1.5. Make it mandatory to appoint a digital leader (such as a chief information officer or chief digital information officer) on the board or executive group in every trust or board in England who is tasked with overseeing the shift from analogue to digital at a place-based level.

4.1.6. In addition to ensuring there is an AHP leader in every trust or board in England, there should also be a digital AHP leader (chief allied health professions information officer).

4.2. Develop clinical safety roles within rehabilitation to ensure technology products deployed in rehabilitation are fit for purpose and suitably monitored

4.2.1. Build links between the rehabilitation workforce and clinical safety roles to ensure technology products deployed in rehabilitation are fit for purpose and suitably monitored.

4.2.2. Organisational support for clinical safety officer training to be made available to those in the rehabilitation workforce. Where appropriate, include in job descriptions and job plans.

4.2.3. Strengthen links between rehabilitation workforce and industry, fostering a culture of innovation meaning that innovative technology can be trialled, tested, and then deployed at scale quickly, efficiently and safely.

4.2.4. Innovation is led by the problems and challenges identified by the rehabilitation workforce and the public they serve rather than being solution focused and led by industry.

4.3. Facilitate links between rehabilitation workforce and clinical academics to help develop the evidence base and drive digital innovation across rehabilitation

4.3.1. Grow a robust evidence base and drive innovation across rehabilitation by strengthening links between the rehabilitation workforce and clinical academics.

4.3.2. Foster collaboration between the rehabilitation workforce, academic and tech researchers in innovation hubs that attract funding for rehabilitation innovation.

4.3.3. Robust evaluation and evidence of impact must be included in business cases allowing innovative technology to empower rehabilitation services and the public they serve.

Ideas For Change

To build out the changes needed for the three shifts, we need the strong foundations of essential infrastructure, a leadership that drives forward transformation and an engaged workforce with the right skills and tools.

Quick wins to deliver by summer 2025

- Commit to developing an action plan with targets on reducing the healthy life expectancy gap which should include a focus on rehabilitation services.
- All ICBs appoint a strategic lead responsible for rehabilitation and reducing the gap in healthy life expectancy.
- Ensure surgical hubs include rehabilitation workforce planning.
- Ensure current commitments to improve access to rehabilitation are

reflected in annual NHS planning guidance with ringfenced funding.

- Ensure the 2025 revision of the NHS Long Term Workforce Plan goes further in expanding the rehabilitation workforce, fully utilising existing supply to meet need.
- Bring forward a Long Term Social Care Workforce Plan which includes specialist rehabilitation staff, as well as upskilling the whole workforce, paid and unpaid carers and volunteers to support an individual's rehabilitation and self-management of long-term health conditions.
- Replace legacy hardware and software with fit-for-purpose upgrades.
- Map and understand the current rehabilitation data, identifying gaps in provision and EHR items, and develop benchmarking tools.
- Run a digital culture change campaign across NHSE promoting good data behaviours and the role that digital and data has in improving rehabilitation services.
- Roll out education and training in digital and data skills, backed by supportive networks.
- Involve the rehabilitation workforce in the early roll out of new tech for their areas, from procurement through to implementation.
- Explore how to introduce bespoke, interoperable systems and software for rehabilitation services.
- Provide strategic and organisational direction for digital transformation, appointing digital leaders at local, regional, and national level.

Ambitions for the next five years

- Introduce new performance measures linked to funding that would drive funding to community-based rehabilitation and ensure ROI created by community-based rehabilitation and intermediate care is reinvested into those services.
- Carry out a review of existing programmes to improve access to rehabilitation, to make recommendations on applying lessons to rehabilitation for other service user groups, including cancer rehab/ prehabilitation, rehabilitation post-ITU, rehabilitation for other neurological conditions, limb loss.
- Work with NICE to ensure the latest research on innovative rehabilitation service design can be quickly put into guidance.
- Deliver an integrated, standardised dataset with good coverage of rehabilitation workforce, settings, service user outcome and experience.
- Develop and deliver onward data usage.
- Digital leaders drive forward the integration of data and digital technologies into rehabilitation settings to speed up service improvement and planning.
- Integrate informatics education across the undergraduate, preceptee and existing workforce, supported by digital leaders and champions.
- Optimise the new digital infrastructure (hardware and software) for all users. This will allow service users, and the rehabilitation workforce to access, use and share key information at any time, irrespective of where they are, and will reduce duplication of effort and/ or content.
- Identify innovative technologies that add value to services and service users, such as by increasing productivity or improving outcomes, and scale up implementation.
- Create new digital leadership roles.
- Foster partnerships between rehabilitation services and industry.
- Strengthen existing links between clinical practice and academia.

Long term change for the next parliament

- An increased proportion of NHS funding is spent in community and primary care services.
- Building on earlier investment in improving data flow, architecture and in rehabilitation data being part of the federated data platform, sustained digital funding enables supporting services and systems to develop robust population health monitoring, predictive analytics, and a move to preventative health and real time monitoring of improvement projects.
- Wearable technologies, open API and other tech innovations are integrated into the EHR, growing the available data for predictive analytics.
- To support safe and effective data sharing between systems, platforms and technologies, open API should be implemented as a standard across health and social care.

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