AIMS Rehab
QUALITY NETWORK FOR MENTAL HEALTH REHABILITATION SERVICES

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AIMS Rehab: a Quality Network for Mental Health Rehabilitation Services

Annual Report 2017

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Contents

Front cover artwork: 'Local Landmarks' Hopewood Park Hospital, Northumberland, Tyne and Wear NHS Foundation Trust

Foreword

It is with great delight that I introduce the Second Annual Report of AIMS Rehab: a Quality Network for Mental Health Rehabilitation Services.

Launched last year, the Quality Network has grown significantly over this period and now has over seventy members. The network highlights the aspiration and commitment of rehab to deliver outstanding mental health services. Despite many services facing challenges, such as reconfiguration and closure, it is heartening to see the enthusiasm of our members towards high quality care and innovation. This commitment was clearly evident at the Second AIMS Rehab Annual Forum with many passionate services showcasing their creative approaches to service provision, generating much lively discussions and the ideal opportunity to learn from each other.

The Quality Network is not just for those performing well. It is to help and support all rehab services to engage in quality improvement, including those who are perhaps not yet in a position to apply for accreditation. To this purpose, this year, the Rehab Quality Network has expanded to include developmental (peer-review) and associate membership options. We invite all rehab services, both within the NHS and the independent sector, to reach out and join us in making a difference for our service users. There are multiple benefits to membership including training opportunities and networking; becoming a peer-reviewer is a fantastic opportunity for shared learning and I would urge you to embrace this opportunity.

Although there has been significant progress, there is still more work to be done. The network is considering expanding to cover different types of rehab services, not just inpatient wards. In addition, there are exciting educational events being arranged, including the first Nurse's Training Day later this year, with plans to offer similar events for the wider MDT group working within rehab.

The achievements over the last year within the Rehab Quality Network would not have been possible without the tireless work of the CCQI (College Centre for Quality Improvement), the AIMS Rehab Advisory Group and Accreditation Committee. I would like to pay tribute to their efforts and diligence. In particular, I would like to thank our service users and carers, whose voice is essential to accomplish our aims. Co-production is incredibly powerful and we would warmly welcome any individuals who wish to work with us in this respect.

We hope you will join us in supporting our members to develop high quality rehab services. Together we can make a difference.

Dr Sabina Burza

Deputising as Chair, Rehab Advisory Group

Introduction

AIMS Rehab: a Quality Network for Mental Health Rehabilitation Services, is a quality improvement initiative managed by the Royal College of Psychiatrist's Centre for Quality Improvement (CCQI). The network was developed in 2009 to improve standards of care in inpatient mental health rehabilitation services. The backbone of the network is quality improvement through peer-review and accreditation but member services are also able to benefit from specialist events, publications, and the knowledge and experience of peers.

The network continues to be supported by its Advisory Group and Accreditation Committee who play crucial roles in advising the project team on the development of the network and assessing services' performance against the standards.

2016-17 has been a year of continued development for the network. Originally known as Accreditation for Inpatient Mental Health Services - Rehab (AIMS-Rehab). Our 2016 Annual Forum saw the launch of a re-branded Quality Network, allowing us to champion rehabilitation services under a specific identity. The focusing on providing a network for services, professionals and service users has seen us expand our offering to allow all inpatient rehab services to engage in quality improvement, even if they face barriers to accreditation. There are now three levels of membership (associate, developmental and accreditation) to enable services to participate at a level they are comfortable with. More information about these options is explained within the report.

About this Report

This report compiles the findings from 12 services that were visited as part of their accreditation process, between 1st April 2016 and 31st March 2017. The data generated provides an insight into inpatient rehabilitation services in the UK, the challenges they face and recommendations to improve quality of care. Alongside this data we consider how services can engage with and benefit from the network.

Of the 12 services, nine were assessed against the Standards for Inpatient Mental Health Rehabilitation Services: Third Edition which were published in April 2016 (available at www.rcpsych.ac.uk/aims-rehab). The other three services were assessed against the previous second edition standards.

What we said, what we did

The 2016 Annual Report identified several areas that the network wished to focus on and develop over the following 12 months.

Piloting developmental peer-reviews

Developmental membership has now been introduced to help services engage and be supported in continuous quality improvement within the context of the AIMS Rehab standards. The first peer-review visits have been booked in and will take place throughout the second half of 2017.

Introducing Special Interest Days

November 2016 saw the network's first Nursing Special Interest Day, with the aim of providing training specifically for professionals working in rehab services. The day brought together an experienced group of rehab professionals to think about what they would want from such a training. This has helped shape plans for the first rehab nurses training day later in 2017.

Continuing support from the Advisory Group

The Rehab Advisory Group (AG) have supported the project team with the network's business plan, Annual Forum & Special Interest Days. The Advisory Group have also supported the network with the use of Quality Indicator for Rehabilitative Care reports (QuIRC) reports, recruitment of members and training for rehab professionals. Finally, the AG helped judge the inaugural AIMS Rehab art competition with winning entries featured on network publications including the cover of this report.

Rehab specialists on review teams

We said that our review teams would be filled with professionals who currently work at a rehab service. We are pleased to report that of the 35 professionals who attended visits between April 2016 – March 2017, 34 (97%) were professionals at rehab services. The one other reviewer was asked to attend a visit due to their additional experience which was relevant to the service.

Continuation of Annual Forums

We held the second AIMS Rehab Annual Forum on 16 May 2017, bringing together over 140 professionals, service users, carers and CCQI staff. The forum featured a key note speech from representatives of the CQC, a series of member-led workshops on a variety of subjects including increased collaboration in risk assessments and service user led cafes in hospital trusts. The forum received excellent feedback with 90% of attendees rating it 'excellent' or 'good'. Some of the quotes from attendees were:

"Feeling positive about our new membership - took away a lot of ideas for service improvement. Great to see service user involvement today. Looking forward to rolling out the tools."

"It's the first time I've attended the forum, and I'm glad I did. Very interactive and engaging. The workshops were quite comprehensive covering a variety of topics and themes. A good forum to exchange ideas, increase the motivation to go back to your service, implement innovative ideas and promote examples of good practice."

"Looking forward to the peer reviewer training as feel it can only help in ensuring my own hospital can maintain high standards and improve upon areas that may not be at a satisfactory level already."

The Network

Services

There were 66 AIMS Rehab member services between 1st April 2016 - 31st March 2017 and seven services that withdrew. The network has 58 NHS members based in 28 Trusts/Boards and eight services in six independent organisations. The network is constantly growing and expanding with 20 services joining in this period. The majority of services that withdrew cited service reconfiguration as the reason.

There are 13 accredited services, 16 accredited as excellent[1], 35 participating and two deferred. These are shown in the map below.

Fig.1 AIMS Rehab Member and Withdrawn Services (01/04/2016 – 31/03/2017)

[1] The status of accredited as excellent no longer exists; services with this status were awarded it before January 2016.

Types of Membership

There are three types of membership offered by the network; developmental, accreditation and associate. 62 services are participating through accreditation and 4 have joined as developmental members.

Developmental Membership uses peer-reviews to support those new to the network or who aren't able to go through the accreditation process. It enables participants to engage in quality improvement work within the structure of the AIMS Rehab Standards and the opportunity to focus on particular areas of need for their service. There is no expectation that services meet a set number of standards. Services complete a self-review against the standards, which is followed by a peer-review visit from rehab professionals and a service user or carer representative. This process identifies areas of achievement, areas for improvement and potential ideas for implementing the latter. Services can use this process to move towards accreditation but are able to continue as developmental members for as long as they wish.

Accreditation Membership is the aspiration for applicable services who are identified as performing well against the standards. This is a more rigorous process involving the collection of evidence at the self and peer-review stages. Services assessed as meeting the required number of standards can be accredited for up to three years.

Associate Membership was launched to coincide with our 2017 Annual Forum. It allows services to engage in the network, attend events and conduct a self-review against the standards but they do not receive a peer-review visit. The lower cost of this membership enables a wider range of services to participate in the network. Associate membership is limited to two years, at which point services are required to upgrade to developmental membership.

For more information on these membership options please visit our website[2] or contact the team.

[2] www.rcpsych.ac.uk/aims-rehab

Reviewers

Member services are required to have at least two staff trained as peer-reviewers. These staff (one nurse and one medical or MDT professional) would attend, annually, one or two accreditation or peer-reviews at other services in the network. This is a great opportunity for shared learning, which can then be used for further quality improvement within the reviewer's own service. Attending reviews acts as continuous professional development and CPD certificates are available.

In the last year, over 70 professionals were trained at two sessions in Manchester and London. This increased our pool of reviewers to over 100. The network will continue to hold reviewer training sessions, for more information please contact the project team.

Lead Reviewer's Perspective

In preparing for an accreditation visit, I email my fellow reviewers and the host team to introduce myself and plan for the assessment. I also spend time reading their self-review and highlighting any areas I think we need to check on the day or get evidence for.

On the day of the visit I always like to make the host team feel comfortable. Going through the accreditation process numerous times myself I know how nerve-racking it can be. I emphasise the need for good time-keeping, otherwise essential areas of practice can be missed out. I try to encourage as much participation throughout the day with service users, carers and staff to try to get a really good feel for the unit and the care it delivers. I like to make the host team feel they have done a good job at the end of the day. I know how much effort it takes to prepare.

After taking 2 acute and 5 rehab wards through accreditation, I am well aware of how demanding it can be. I know the host teams really want to showcase their good work and be commended for doing a good job and that is so important to staff. Through doing the lead reviewer role I am not there to judge – I want to see the best and maybe even steal some ideas along the way!

Donna Bradford, Service Manager, Discovery House,
Lincolnshire Partnership NHS Foundation Trust

Reigniting my passion

Being part of a review team has been hard work, but it has been worth it. It has given me so much confidence in my abilities, but that didn't stop me from being really nervous on my first peer-review. The peer-review training was a great day and it helped me to get a better understanding of what our peer-review will be like. I still thought that everyone else on the team would see straight through me and think 'who asked that HCA with her pointless questions to join our peer-review team.'

How wrong I was! Everyone was so lovely and made me feel at ease. I was included in every part of the review and supported throughout. At no point did any of the team make me feel like the new kid at school. I didn't even feel like it was my first review and I felt like a valued member of the team.

It has helped me to understand what our own peer-review day will be like. I have reassured everyone that it is a friendly experience and that review teams are there to support and advise, not to be critical and pick fault. We can all support each other and share best practice. Why reinvent the wheel when someone else is doing a fantastic job and is willing to share?

My managers are really supportive and trust me to do what is best for our service users and the unit; they allow me extra time to get my work done.

Being a peer-reviewer really has reignited my passion for what I do, but I keep finding more things to do. I don't just want to achieve the standards; I want to go above and beyond. I hope that the network has reignited the passion in others, because it is a great feeling.

Tracey Stroud, Healthcare Assistant, Meadowbank Rehabilitation Unit
Northamptonshire Healthcare NHS Foundation Trust

Membership

This section contains a summary of the performance of 12 services who received an accreditation visit between 1st April 2016 and 31st March 2017. There are five Community, four Complex Care and three High Dependency Units (HDUs) ranging from nine to 32 beds. The following data provides an insight into contemporary rehab provision and an opportunity to learn from similar services.

Within the network we have started to use the classification of services contained within the Joint Commissioning Panel Guidance for Rehabilitation Services[3].

Contextual Data

Average length of stay (months)

Figure 2 plots the average length of stay, in months, of the 12 services who had accreditation visits over the time-period. The average (mean) length of stay was 18 months. Both minimum and maximum lengths of stay, 6 and 45 months, were within Community rehab units with the other three having average lengths of stay of less than 12 months. The four Complex Care services had the most consistent lengths of stay which ranged between 16 and 21 months. The lengths of stay in HDUs ranged from seven to 34 months. A more detailed analysis of the services and their client population would be needed to understand the reasons for this variation.

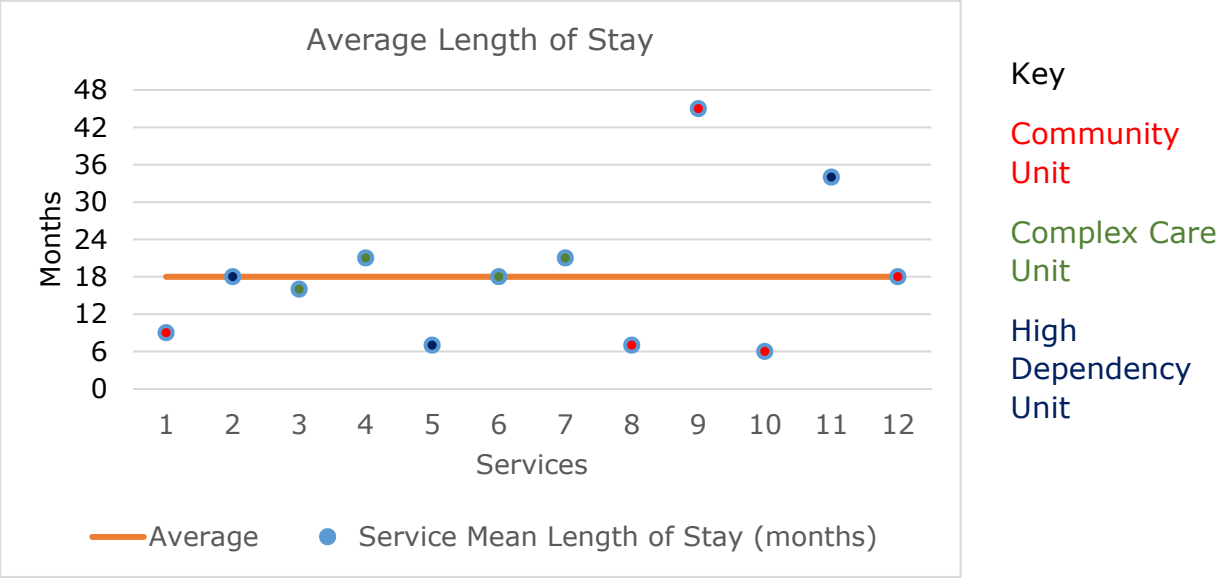

Fig.2. AIMS Rehab Member Services Average Length of Stay in Months (01/04/2016 – 31/03/2017)

[3] For more information on these classifications please refer to http://www.jcpmh.info/resource/guidance-for-commissioners-of-rehabilitation-services-for-people-with-complex-mental-health-needs/.

Whole Time Equivalent Staffing

This whole time equivalent (WTE) staffing data is an average of staffing provision from a range of service types and bed numbers. Services are asked to provide data on the number of substantive staff during their self-review.

Table 1 AIMS Rehab Member Services Staffing Contingents (01/04/2016 - 31/03/2017)

Staff Role	Average WTE	Minimum WTE	Maximum WTE
Healthcare Assistant	12.2	6	25
Registered Nurse	9.2	3	13
Consultant Psychiatrist	0.9	0.4	1
Psychologist	0.6	0.2	1
Occupational Therapist	1.2	0.5	2.4
Administrator	0.8	0.2	2

The largest staffing discipline is healthcare assistants (HCAs) followed by registered nurses (including charge and staff nurses). Consultant psychiatrists were resident at a service for over four days a week, with seven of the 12 services reporting a full-time psychiatrist. There was wide variety of psychological provision with five services reporting a full-time psychologist but three stating they had input for just one day a week. There was also a mix of input from occupational therapists (OTs) of between 0.5 and 2.4 WTE. These differences may be explained by the provision of other members of staff, for example increased junior doctor input with lower consultant input or an activity co-ordinator role with lower OT input.

The data does not include figures for other MDT staff such as occupational and psychology assistants, non-consultant medical input, activity co-ordinators etc. as this was only collected during the current standards edition. Going forward, the network will be able to present and analyse the data for all clinical and therapeutic staff working in services to give a wider understanding of service provision.

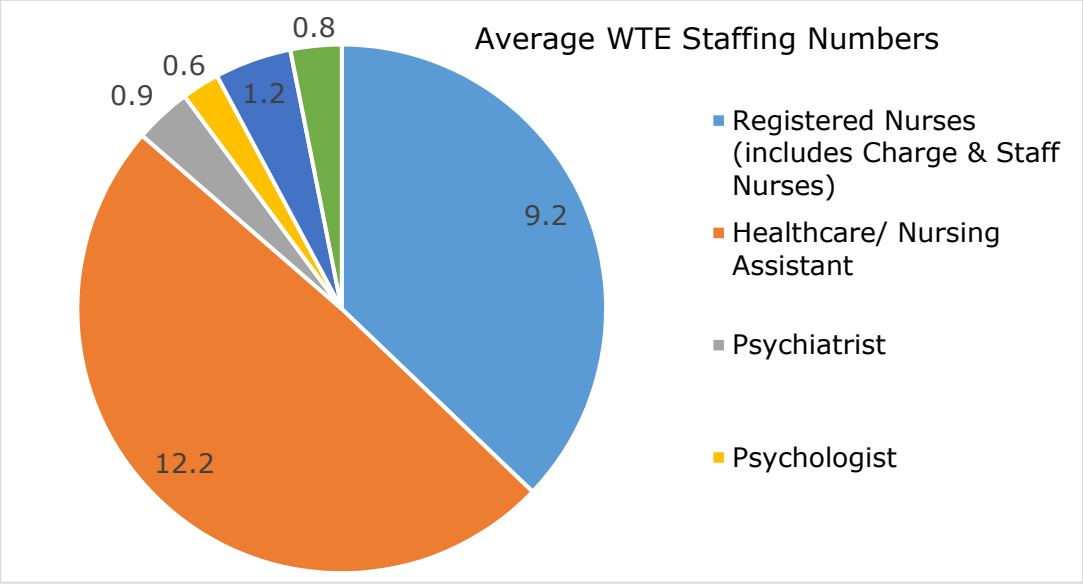

Fig.3. AIMS Rehab Member Services Average Staffing Numbers (01/04/2016 – 31/03/2017)

Occupancy levels

Average occupancy was 87% with the lowest at 65%. Five of the 12 services reported operating at an average of 100% occupancy. The 5 Community units all operated at above 90% occupancy. Complex Care services operated between 65-97% (average 85%) occupancy with all HDUs operating above 96% occupancy. None of the services reported an average occupancy of over 100%. This is not surprising due to the planned nature of admissions within rehab services, but is worth noting as other types of mental health wards often exceed bed occupancy.

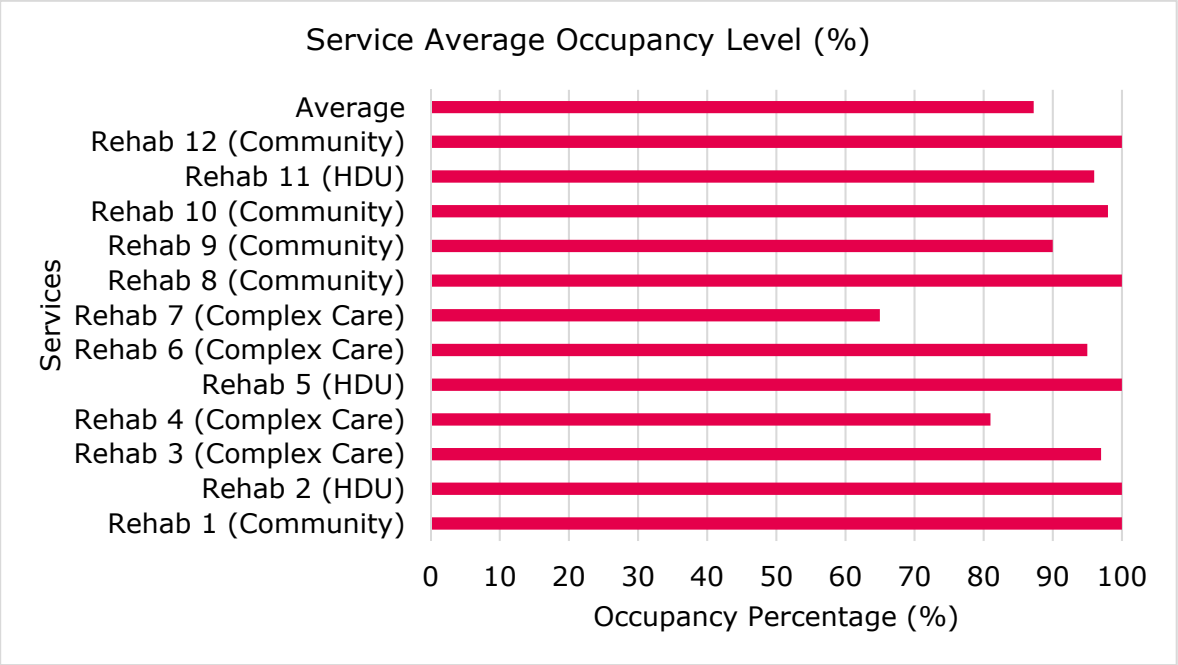

Fig.4. AIMS Rehab Member Services Average Occupancy Levels (01/04/2016 – 31/03/2017)

Service Performance Against Standards

Standards Compliance

Compliance against Type 1, 2 and 3 standards has remained extremely consistent between 2015 and 2017. Figure 5 compares data from both sets of standards within this report to the 2016 Annual Report. This data supports the notion that services who choose to participate in the accreditation process are already performing well against the standards. The introduction of developmental and associate memberships allows a wider range of services and those not performing as well the opportunity to engage in quality improvement. Next year's annual report will be able to examine how these services are performing. Over the next few years, the network will be developing more aspirational Type 3 standards so that services are constantly driving towards quality improvement.

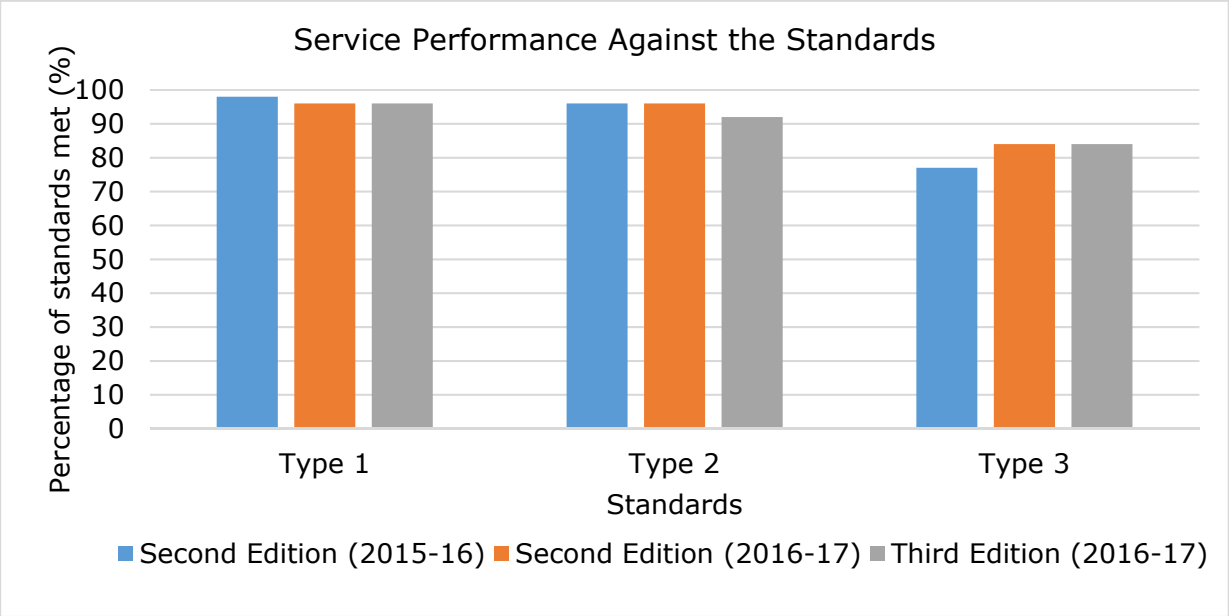

Fig.5. Average Compliance against Second & Third Standards Editions

Recommendations for Services

Recommendation 1: The Welcome Pack

Second Edition

U18.5(1) On the day of their admission or as soon as they are well enough, the patient is given a 'welcome pack' that contains the following:

- *a clear description of the aims of the ward/unit;*
- *the programme and modes of treatment;*
- *a clear description of what is expected and rights and responsibilities;*
- *a simple description of the ward/unit's philosophy, principles and their rationale;*
- *the ward/unit team membership, including the name of the patient's Consultant Psychiatrist and Key Worker/Primary Nurse;*
- *visiting arrangements;*
- *personal safety on the ward/unit;*
- *facilities and the layout of the ward/unit;*
- *programme of activities;*
- *what practical items patients need in hospital and what should be brought in;*
- *resources to meet ethnicity and gender needs.*

Third Edition

4.1(2) The patient is given an age appropriate 'welcome pack' or introductory information that contains the following:

- *a clear description of the aims of the ward/unit;*
- *the current programme and modes of treatment;*
- *the ward/unit team membership;*
- *personal safety on the ward/unit;*
- *the code of conduct on the ward/unit;*
- *ward/unit facilities and the layout of the ward/unit;*
- *what practical items can and cannot be brought in;*
- *clear guidance on the smoking policy in smoke-free hospitals and how to access smoking breaks off the hospital grounds;*
- *resources to meet spiritual, cultural and gender needs.*

Between the second and third editions, this standard has changed from being a Type 1 to Type 2 combined with a simplification of the language and an inclusion of specific information about the service's smoking policy. These changes were made as part of the introduction of CCQI core standards, which are applicable across all inpatient quality networks. On the review day, services are asked to provide a copy of the welcome pack so that the review team can assess whether it includes key information. Service users are also asked in their meeting whether they received a pack and whether its contents were explained to them. The review team may also assess health records to see if there are documented discussions or checklists about service users receiving a copy of the welcome pack. Seven of the 12 services (58.3%) assessed over the last year met the standard.

Challenges

The data from services, both quantitative and qualitative raises several issues around welcome packs. Many service users, both at self-review (38% of respondents) and on the review day, stated that they had not received a copy. Review teams raised issues such as a lack of clear information about the provider's smoking policy and information about what items can and should be brought onto the unit. Review teams and service users at some services commented that welcome packs were too long, difficult to navigate or text heavy.

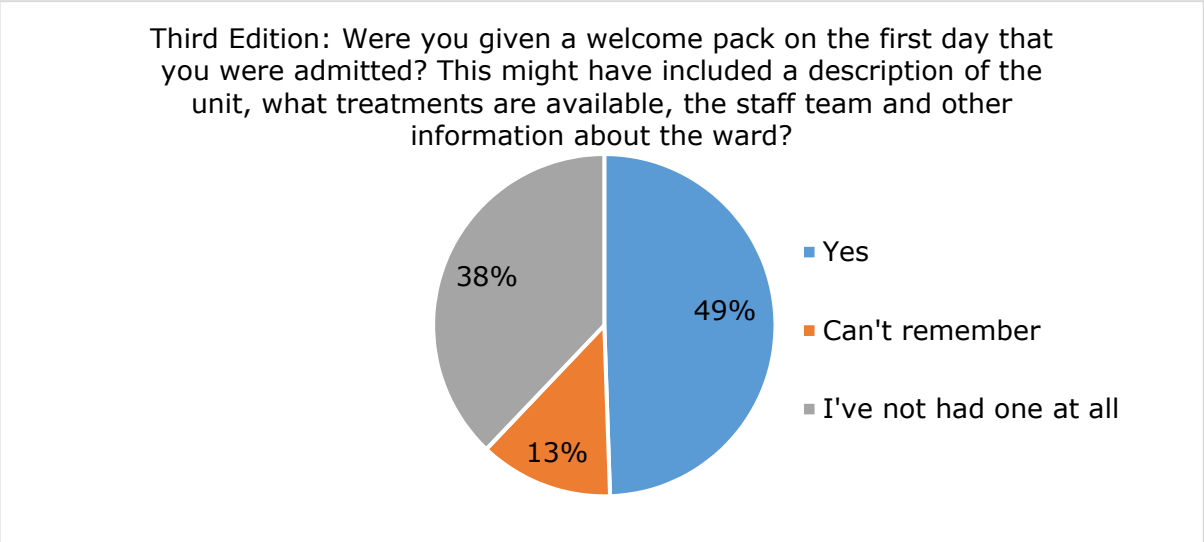

Fig.6. Percentage of service users that self-reported to have received a welcome pack (01/04/2016 - 31/03/2017)

Recommendations

It is important that welcome packs (and revisions) are co-produced, regularly reviewed and made easy to understand. Co-production between services and service users will help ensure that relevant information is included in an accessible format. It is worth regularly reviewing the welcome pack with service users, especially at times of service reconfiguration, to ensure that any changes are included. Revised packs should include dates of publication, set dates and who is responsible for their next review. Packs should reference the trust's smoking policy and the location of any smoking areas.

Pictures should be used where possible, to make the pack more visually appealing and less text heavy. Images could include pictures of the ward and examples of items that can be brought onto the unit. Services could also consider making the format of the pack more user friendly. Having a folder containing different leaflets or a larger welcome pack alongside a smaller, simplified 'pocket pack', can make information easier to find and less overwhelming. Including the welcome pack within the service's admission checklist could help ensure that service users receive a copy and would also act as readily available evidence for the review process. When changes are made to the information, service users should be informed, this could be done within a community meeting or service users' one-to-ones. In order to provide evidence for accreditation, services should keep a record of whether service users have been given the updated information. The project team will support teams in this area by requesting examples of best practice in the development of welcome packs and distribute them throughout the network.

Recommendation 2: Carer's Assessments

Second Edition
22.5(3) The principal carer is advised how to obtain an assessment of their own needs.

Third Edition
15.2(1) Carers are advised on how to access a statutory carers' assessment, provided by an appropriate agency.

This standard has changed from Type 3 to Type 1 to reflect the statutory nature of the carer's assessment and service's role in supporting carers. The wording of the standard has changed slightly between the editions, including the clarification that it is not the responsibility of the ward itself to provide the assessment.

Carers were surveyed at self-review and interviewed on the review day about whether they were made aware of how to access an assessment.

Challenges

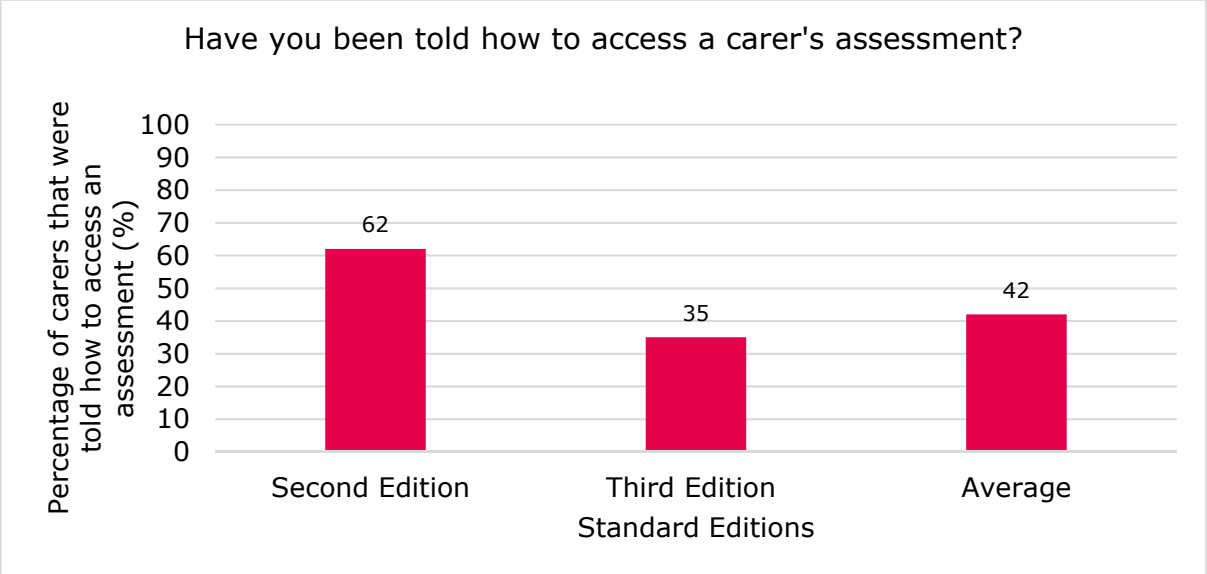

Fig.7. Responses from carer's surveyed at self-review about whether they have received a carer's assessment (01/04/2016 - 31/03/2017)

Overall, 50% of the 12 services did not meet this standard. For services assessed using third edition standards, nearly two-thirds of carers stated at self-review that they had not been told how to access an assessment. Between the standards editions, there is a marked decrease in the number of carers self-reporting that they had been informed about how to access an assessment. However, with only 12 services being assessed in total, it is difficult to draw any definitive conclusions from this.

While there were some cases of carers believing, or being told an assessment was not relevant to them, it is likely due to the wider challenges faced by rehab services in carer involvement. Anecdotally, it appears that a lower percentage of service users in rehab services have someone who would be regarded as a carer

or someone who is involved in their care. However, it is still important that services have clear processes in place to identify and support carers. Some patients will refuse consent for a carer to be involved in their care, but these individuals should still be informed about carer's assessments. Where services admit service users from out of area, carers should be supported to access one from the relevant local authority.

Recommendations

The network recommends increasing the provision of information and appointing a carer's lead. While the challenges highlighted can impact on carer's involvement, there are some fundamentals that should still apply. Carers should be offered a carer's assessment even if they are not involved in care planning etc. It is recommended that services appoint a carer's lead or champion (third edition standard 15.7) to oversee processes relating to carers and to promote contact between staff and carers. Having a dedicated staff member alongside a named nurse will help support families with any issues they may have. A carer's checklist with actions relating to providing support and information can be used. If they don't already have one, services should consider introducing a carer's pack (third edition standard 15.4) where information about carer's assessments can be included alongside other relevant information.

Challenges in engaging carers is a common issue for rehab services. Therefore, the network will be exploring ways to further support services with addressing this issue through guidance and events.

Recommendation 3: Managerial Supervision

Second Edition
U6.7(1) Staff who receive regular management supervision do so from a person with appropriate experience and qualifications

Third Edition
24.6(2) All staff members receive monthly line management supervision

These two standards from different editions ask similar questions about whether staff are offered managerial supervision. The standard in the second edition is a Type 1 including a requirement about the experience and qualification of the supervisor. The third edition standard is a Type 2, which is accompanied by a Type 1 on clinical supervision (see full standards for more information). These standards were met by two-thirds (66.67%) of the 12 services. The three second edition services all met the standard with four of the nine third edition services (44%) not evidencing monthly managerial supervision.

Challenges

Figures 8 and 9 present responses from staff surveyed at self-review. Figure 8 demonstrates the percentage of respondents (92%) across the three second edition services that stated they received regular managerial supervision from an appropriately experienced and qualified person. Figure 9 aggregates responses of staff surveyed from the nine third edition services about the frequency of their managerial supervision with 57% reporting they have it every month.

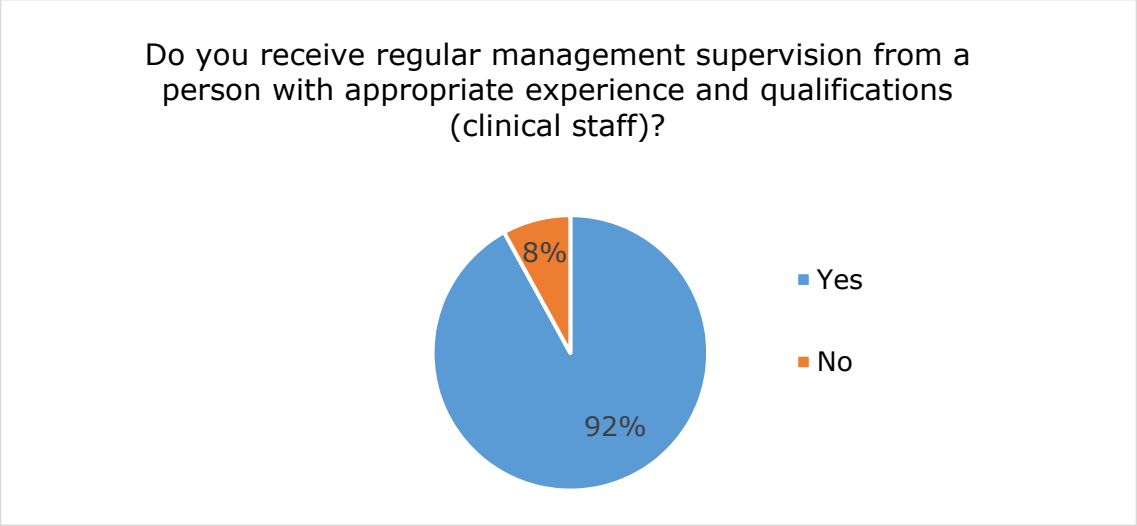

Fig.8. Responses from staff surveyed at self-review about whether they receive regular management supervision (second edition services)

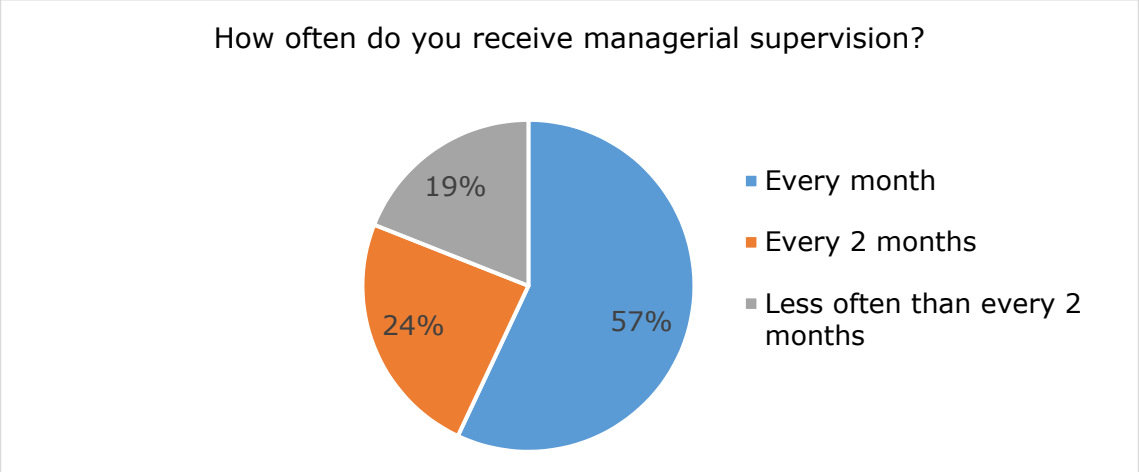

Fig.9. Responses from staff surveyed at self-review about how often they receive managerial supervision (third edition Services)

The reasons for services not providing monthly managerial supervision varies widely between wards. Staff shortages or changes in management can disrupt the routine of supervision and often busy wards or high acuity levels lead to supervision being neglected. Some services completed supervision every two months, which is in line with their own trust/organisational policies. There was often uncertainty from staff about the frequency of supervision. Different members of the MDT had separate supervision arrangements and sometimes clinical and managerial supervision was delivered in a combined session. Services also reported that supervision, both clinical and managerial, was performed on an ad-hoc basis and not necessarily documented.

Recommendation

In order to meet network standards, services may find that they need to apply processes that are in excess of trust/organisational policy; supervision is an example of this. Whilst trust policy may state that supervision can be held bi-monthly, to meet this standard services need to facilitate individual monthly managerial supervision. AIMS Rehab standards reflect best practice not minimum standards.

Some organisational policies may also allow for the combination of managerial and clinical supervision; however best practice is that these are held separately. Professional guidelines for individual professions may vary but CQC guidelines state "generally clinical supervision is seen as complementary to, but separate from, managerial supervision, which is about monitoring and appraising the performance of staff" (Supporting effective clinical supervision, 2013)[4].

Services should ensure that they have processes for monthly managerial supervision, which ensure that appropriate time is allocated within the schedules of both supervisors and supervisees. In order to provide evidence within the accreditation process, services will need to keep records showing when these sessions occur. To support services with this, the network will develop a staff supervision tracker that services can use to monitor supervision on an ongoing basis and as part of their accreditation.

[4] https://cqc.org.uk/sites/default/files/documents/20130625_800734_v1_00_supporting_information-effective_clinical_supervision_for_publication.pdf).

Looking Ahead

Expanding the Network

We are looking forward to working with our new developmental, associate and accreditation members. Having worked with services who have been through reconfigurations we are aware that there are a growing number of specialist rehabilitation services that are currently unable to participate in the network as we only have standards for inpatient wards. We are in the early stages of thinking about how we can work with other services and are hoping to be able to give more information about this in 2018.

Nurses Training Day

Following the success of the Special Interest Day on this topic in 2016 the network will be holding the first Nurses Training Day in November 2017. The content of the day will be decided by our steering group made up of rehab professionals, particularly nurses. We hope that this will be an annual event responding to the lack of specialist training for rehab nurses.

More Special Interest Days

The network will be providing more special interest days in addition to the Nurses Training Day. The content of these is yet to be decided by our members but could either focus on a different profession or a theme that would be relevant to all. We will be moving forward with an idea raised at the annual forum or within the advisory group.

Feedback from Members

Since moving to our new set of standards we've been focusing on smoothing out our systems and processes but next we need to make sure we know what our members think of them. We will be introducing feedback mechanisms covering all aspects of membership so that we can identify what they like and what could be changed.

Over the coming year we will continue to work with our members, advisory group and accreditation committee to run the quality network for mental health rehabilitation services, helping services to improve and monitor the quality of the services that they provide. If you have any comments, suggestions or questions please contact the team.

Conclusion

AIMS Rehab: a Quality Network for Mental Health Rehabilitation Services is stronger than ever. The healthy membership base is continually expanding and participation in events and reviews is increasing. New membership types are allowing more services to participate and a new set of standards is enabling the network to measure quality improvements over time. However, there is still more work to be done. We have seen a number of services withdraw due to service reconfiguration and there is anecdotal evidence of a trend throughout England, at least, for trusts and commissioners to re-evaluate the way that rehab services are being commissioned and delivered. This will not be a surprise to many working within the field and makes it even more important that there are strong messages about the value of providing good quality, effective rehab services. The network will continue to expand its profile and support services in this endeavour.

Recommendations for services

- Ensure welcome packs (and revisions) are co-produced, regularly reviewed and are easy to understand.
- Review the provision of information to carers, including on carer's assessments, and appointing a carer's lead to oversee support for carers.
- Ensure that supervision practices are in line with the network's best practice standards, which may be in excess of organisational policies.

Actions for Project Team

- Present baseline data for developmental peer reviews in next year's annual report. This will enable the network and members to establish improvements in these services over time.
- Share best practice examples of the revision and co-production of welcome packs.
- Support the development of information to carers, providing guidance through documentation or events.
- Develop a supervision tracker for services to use on an ongoing basis and within network processes. Work with services to identify barriers to supervision.
- Introduce feedback mechanisms covering all aspects of membership to shape innovation to members' needs.

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