Service Model	Greater Manchester Integrated Community Neurorehabilitation Service Model
Author	Greater Manchester Neurorehabilitation & Integrated Stroke Delivery Network
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1. Context

There are an estimated 14.7 million cases of neurological disorder in the UK, with one in six people living with a neurological condition[1,2] These can have a significant impact on a person's life, and also their family[2]. Each year, the NHS spends £4.4bn on neurological conditions[3].

Patients with neurological conditions should receive co-ordinated multidisciplinary team (MDT) care and timely review in a setting that is suited to the patient. This should be from health care practitioners best suited to the patient's needs, with associated seamless and timely MDT communication and care planning, including provision of information about voluntary organisations that can offer support for the specific neurological condition[4].
Rehabilitation is a process of assessment, treatment, and management by which the individual (and their family/carers) are supported to achieve their maximum potential for physical, cognitive, social and psychological function, participation in society and quality of living. Patient goals for rehabilitation vary according to the trajectory and stage of their condition. Specialist rehabilitation is the total active care of patients with a disabling condition, and their families, by a multi-professional team who have undergone recognised specialist training in rehabilitation[3].

Within Greater Manchester, there are an estimated half a million people with a neurological condition[5], who will require access to specialist neurological rehabilitation. All localities across Greater Manchester have the provision of a Community Neurorehabilitation Team (CNRT), which have undergone significant transformation in recent years.
This model provides clarification of service provision to ensure high quality standards of care, equity for all patients, and support service development.

2. Outcomes

The Greater Manchester Neurorehabilitation & Integrated Stroke Delivery Network[6] (GMNISDN) has collaboratively developed a set of outcome measures for the community neurorehabilitation pathway based relevant standards and guidelines including NICE, alignment with stroke standards, previous Greater Manchester Community Neurorehabilitation Model and Service Specification (version 1.3) and consensus best practice.

Measure description	Threshold	Data collection tool	Data collection timeline
Percentage of patients triaged within 2 working days of referral	90%	GMNISDN	Date referral received to date of triage
Percentage of high risk patients assessed within 2 working days	90%	GMNISDN	Date of triage to date of initial assessment
Percentage of moderate risk patients assessed within 14 days	90%	GMNISDN	Date of triage to date of initial assessment
Percentage of low risk patients assessed within 21 days	90%	GMNISDN	Date of triage to date of initial assessment
Percentage of patients commencing treatment within 7 days of discharge from hospital (acute referrals)	90%	GMNISDN	Date of discharge from hospital to date commencing therapy
Proportion of patients who demonstrated positive EQ5D5L following team intervention	Benchmark locally	GMNISDN	Admission and discharge

3. Service information

3.1. Aims and objectives of the service

- To provide evidence-based rehabilitation care pathways with access for patients with neurological conditions being discharged from hospital or living in the community, using clinical consensus when no evidence exists.
- To offer adults with community neurorehabilitation needs responsive and appropriately intensive rehabilitation to meet their clinical goals and potential.
- To provide equality of patient experience across the conurbation through access to appropriate, timely care including shared decision making with patients and carers.

- To provide a consistent, flexible and needs-led approach with integration between inpatient and community rehabilitation teams, as well as other NHS and social care providers (e.g. primary care).
- To support timely discharge from hospital via in-reach to support people returning home more quickly where appropriate, and prevention of unnecessary readmission to hospital or attendance at GP.
- To promote involvement and integration with other providers such as the voluntary sector to develop a more blended, asset-based approach to rehabilitation care with active signposting and referral to appropriate services for ongoing support to address the wider needs of the patients and carers (e.g. wellbeing services).
- To ensure timely discharge from the service using community assets effectively to continue longer term goals and ensuring there is capacity to provide responsive assessment and treatment times following referral to the service.
- To provide standardised geographical inclusion criteria for all localities in Greater Manchester to promote efficient referrals from acute to community.
- To use the collaboratively developed outcome measures and Key Performance Indicators (KPIs) that are a mixture of process indicators and measures that include patient reported experience and outcomes to demonstrate the quality and experience of the service.
- To ensure that people who require neurological rehabilitation achieve maximum achievable independence.
- To promote self-management where appropriate.
- To ensure longer term support for the patients via self-referral back into the service if needed.

3.2. Population covered

People who have neurorehabilitation needs relating to a primary neurological diagnosis, that are newly diagnosed or have a change in their neurological presentation.

People who are a resident within the previously determined clinical commissioning boundaries or registered with a GP within the commissioning locality boundaries. Cross boundary issues should be resolved locally and be in the best interests of the patient.

People living in the community setting either in their own home, residential or nursing home which can be a temporary placement.

3.3. Acceptance and exclusion criteria and thresholds

Referrals will be accepted if the person:

- Is over 18 years old, however, exceptions where the patient is 16 years or older and whose needs have been identified as being best met with the skills of the community neurological rehabilitation team.
- Has a diagnosed neurological condition, and requires neurological rehabilitation within the community.
- Can participate in rehabilitation and has identifiable goals that are best met by the community neurorehabilitation team.
- Is medically stable with appropriate medical investigations completed.
- Consents to intervention by the team.

Patients may have uni-disciplinary and multi-disciplinary neurorehabilitation needs.
Management of patients with Functional Neurological Disorder who require community rehabilitation should be discussed with the community neurorehabilitation team or generic rehabilitation services as to who is most appropriate to meet the patient's needs.

Patients who have a clear neurological presentation, and neurorehabilitation needs who are awaiting a neurological diagnosis may be eligible for specialist neurological rehabilitation following a clinical review and discussion with other local community services to establish the most appropriate rehabilitation pathway to meet the patient needs.
Individuals with cognitive or psychological difficulties (e.g. those with dementia or intellectual disabilities) are eligible if they have needs arising from concurrent neurological disabilities and are able to participate in rehabilitation.
For patients discharged alone to a private address they must be able to maintain their own safety independently, or with an appropriate support package.

Patients cannot be discharged to the community neurorehabilitation team until necessary care, equipment (e.g. wheelchair) and transportation are in place which should be organised by the inpatient team.

There must be an appropriate space in the person's home (or in a clinic) so that the rehabilitation can be delivered safely.

If the patient with a neurological condition is at a palliative stage of life or on an end of life pathway, then palliative goals are to be discussed and managed with the palliative care services to ensure appropriate input is provided by the most appropriate team.

Re-referrals of people with a neurological condition are accepted if there are specific rehabilitation goals. The team may advise on 'maintenance' interventions that have a preventive rationale and may assess care needs and provide advice and information in response to changing needs, but does not itself provide ongoing 'care'.

Exclusion criteria

All referrals will be screened /triaged; however, assessment or treatment may not be provided for the following reasons:

- If the overriding requirement is for management of symptoms rather than disabilities (e.g. pain, headache, or seizures) without additional rehabilitation needs being identified or where symptoms mean rehabilitation is not possible.
- If the dominant impairment is reduced cognition or mood or behavioural disorder without other neurological impairments being present (e.g. primary dementia or intellectual disability).
- Patients or their families cannot identify rehabilitation goals.
- The patient cannot or does not wish to participate in rehabilitation.
- There has been no significant change since last discharged from the service.

If any patients are deemed not appropriate for intervention by the community neurorehabilitation team, the team will provide advice and support to sign-post to the most appropriate service.

3.4. Team composition

The community neurorehabilitation team is multidisciplinary and works in partnership with local authorities and other service providers including the voluntary sector.

3.5. Specialist service

The key component of a specialised rehabilitation service is the formal commissioning of a multidisciplinary team of relevant professionals of Occupational Therapy, Physiotherapy, Speech and Language Therapy, Psychology, Psychology Assistant, Nurse, Social Worker, Dietician and Rehabilitation Support Worker and Rehabilitation Medicine who have specific knowledge and experience in managing complex disabilities, and who work closely together with service users in an interdisciplinary manner to achieve patient directed outcomes/goals[3].
Specialist community rehabilitation services should be:

- Patient-centred and accessible to all who need them.
- Designed to meet clusters of patient presentations and needs rather than diagnosis.
- Delivered by specialised Multidisciplinary professional teams with relevant knowledge, training and expertise who meet regularly to ensure shared discussion and coordinated patient care.
- Embedded in rehabilitation networks.
- Easy to access with a clear referral process and single point of access when possible.
- Offering an Initial assessment that includes advice from relevant senior clinicians.
- Delivering evidence based holistic, goal focussed rehabilitation in a timely manner.
- Seeing patients intensively when appropriate and offering long term support or review as needed.
- Well led by senior rehabilitation professionals.
- Using rehabilitation prescriptions or other patient and service shared documentation.
- Collecting and reporting patient and service level data on needs and outcomes.
- Using complex case reviews including all relevant services when needed[3].

3.6. Service delivery

The service shall operate for 8 hours between the hours of 8am – 6pm, 5 days a week Monday to Friday, extended to the evenings (ad hoc) to meet patient need and weekend (6 days) dependent on patient need.
The service shall operate a reduced service on Saturdays to support timely discharge from hospital, and continuation of high priority rehabilitation visits of patients already on the caseload or newly discharged on a Thursday or Friday for continuity of treatment.
Recommended minimal levels of staffing at the weekend are one qualified and one unqualified member of staff. This is to ensure the team can carry out new assessments and high priority rehabilitation (based on consultation across Greater Manchester, Lancashire, and South Cumbria) which is additional to the staffing levels below.

The community neurorehabilitation team should be sufficiently staffed to be able to start assessment and treatment as described in the pathways.

The minimum core team as recommended by evidence extrapolated from the NHS England Integrated Community Stroke Service Model[7], Royal College of Physicians and British Society of Rehabilitation Medicine guidelines[3] in collaboration with local clinical consensus in Greater Manchester[6] is for a 5 day/ week service:

- Team Leader (0.134 WTE per 100 referrals/year)

- Occupational Therapy (1 WTE per 100 referrals/year)
- Physiotherapy (1 WTE per 100 referrals/year)
- Speech and Language Therapy (0.4 WTE per 100 referrals/year)
- Nurse (0.4 WTE per 100 referrals/year)
- Social Worker (0.134 WTE per 100 referrals/year)
- Rehabilitation Assistants/Assistant Practitioner (1.34 WTE per 100 referrals/year)
- Physician (0.1 WTE per 100 referrals/year)
- Clinical Psychologist (0.2 WTE per 100 referrals/year)
- Neuropsychology assistant (0.134 WTE per 100 referrals/year)
- Dietitian (0.067 WTE per 100 referrals/year)
- Administrator (0.4 WTE per 100 referrals/year)

Local consensus also agreed that appropriate administration and management support (including data management) were essential in ensuring the community neurorehabilitation service core team was effective, and these should be commissioned as part of the service.

These staffing levels serve as guidance and actual staffing required will also depend on local context, demand and variation, and resources already in place.

Staffing for a 6 or 7 day service will require extra funding depending on the model chosen.

The community neurorehabilitation team should have timely access to appropriate extra support from the following specific disciplines and/or services depending on individual patient need:

- Reablement service or equivalent
- Social care
- Orthotics
- Orthoptics
- Podiatry
- Spasticity clinic/consultant review for botulinum toxin, splinting for management of spasticity
- Specialist seating/wheelchair support
- Generic psychological and neuropsychological services (e.g. IAPT, community mental health services)
- FES foot drop service
- Consultant review
- Specialist inpatient neuro rehabilitation centres
- Driving Assessment Centres
- Department of Work and Pensions
- Drug and Alcohol teams
- Specialist Palliative Care Teams
- Homeless Teams
- Long term conditions services with self-management/expert programme
- Return to work services and vocational rehabilitation
- Voluntary services/carer support

The community neurorehabilitation team shall provide early effective community rehabilitation to all neurological patients leaving hospital requiring ongoing neurological rehabilitation. The team works with the inpatient teams, the patient and their family, and other support services including the voluntary sector to ensure the earliest possible discharge of the patient.

The community neurorehabilitation team shall provide in-reach, including attendance at meetings, joint therapy sessions and attend home visits as needed to support coordination of pathways and discharge planning.

All patients should be effectively discharged into the community at the earliest opportunity once the inpatient team are satisfied that the patient is medically stable and does not require inpatient care. The appropriate pathway within the model of rehabilitation will be identified by the community neurorehabilitation team and provided without delay, considering the patients need.

The community neurorehabilitation team will follow all applicable guidelines and standards of care but will be empowered to use their clinical reasoning to deliver the most appropriate care for patients, and in accordance with their needs and wishes.

The decision to refer on to other generic community rehabilitation teams should only be made by the community neurorehabilitation team when it is deemed specialist neurological rehabilitation management and treatment is no longer needed and patient needs can be met by a generic rehabilitation service.

3.7. Education and training

Specific regular education and training shall be developed and provided within teams. This training should include condition specific, clinical presentation, and treatment focussed education, and staff should be supported in accessing Greater Manchester Neurorehabilitation & Integrated Stroke Delivery Network training and other relevant opportunities.

Staff shall be aware of and understand the implications for patients of relevant legislation including the Mental Capacity Act (2005)[8] and the Care Act (2014)[9].

The patient, their families and carers should be given information about their condition, care and management plan including points of contact for further information if needed. If the patient's family is providing a caring role then their needs should be assessed and appropriate training provided.

3.8. Rehabilitation pathways

3.8.1. Acute referrals (hospital discharge)

Home with Community Neurorehabilitation Team input (including residential and nursing home)

Supporting people home as early as possible is a key principle of the model and community neurorehabilitation teams will in-reach, as described above into inpatient neurorehabilitation services where practical and appropriate to draw people out of hospital to support a seamless transition from inpatient to community services.

Specialist community rehabilitation can, when available, reduce the length of stay in acute settings and facilitate patients' return to work or other chosen activity, as well as preventing development of long term complications or readmission to hospital[3].
A member of the community neurorehabilitation team shall telephone the patient within 2 working days of discharge and assess clinical needs. Treatment intervention will commence within 7 days of discharge from inpatient services, as appropriate.

Level of intervention should be based on clinical need tailored to goals and outcomes.

If a patient is discharged home with reablement, liaison and a joint management plan should be put in place as appropriate.

3.8.2. Community referrals

Referrals will be triaged via telephone or face-to-face (as appropriate) within 2 working days of receipt. The triage is to identify the overall impact of the problem on the patient's life and assess for clinical need and assessment priority.

Patients will have an assessment within 21 days of the triage; the timescales will be based on the person's needs as identified during the triage.

Patients' assessments will be prioritised accordingly:

- Patients deemed to be at high risk will be assessed within 2 working days of the triage (Priority 1)
- Patients at moderate risk will be assessed within 14 days of the triage (Priority 2)
- Patients at low risk will be assessed within 21 days of the triage. (Priority 3)

Treatment intervention will commence within 7 days of assessment, as appropriate.

3.9. Medical support

The community neurorehabilitation team shall have pathways in place to access consultant support if needed during the rehabilitation process in the community. The community neurorehabilitation team shall seek clinical support from specialist nurses and care teams, GPs and appropriate consultants as necessary to ensure medical issues are reviewed and managed appropriately.

3.10. Intensity of treatment

Patients will receive therapy at the intensity appropriate to their need. Professionals within CNRT should be empowered to exercise their clinical judgement and provide therapy as per clinical need and in accordance with patient choice, whilst taking the relevant guidelines into account.

The majority of patients will complete their rehabilitation within 3-6 months of being admitted into the CNRT. For the small number of individuals who require rehabilitation beyond 6 months, a review will take place prior to 6 months to ensure that remaining in the service beyond 6 months is the most appropriate treatment option for the patient.

Following discharge from the service, patients can self-refer back into the service as further neurorehabilitation need arises.

3.11. Neurological rehabilitation management

Specialist neurological rehabilitation, support and any appropriate management plans shall address the following issues below either directly or by seamless onward referral where required. These issues include:

- Mobility and movement (including exercise programmes, gait retraining, mobility aids and orthotics)
- Upper limb rehabilitation
- Management of spasticity and tone
- Sensory impairment screening and sensory discrimination training
- Falls prevention (including assessment of bone health, progressive balance training and aids)
- Cognitive rehabilitation (including addressing impairment in attention, memory, spatial awareness, perception, praxis, and executive function)
- Communication rehabilitation (including aphasia support, techniques or aids for dysarthria and apraxia, information about local groups)
- Everyday activities including provision of daily living aids and equipment (e.g., dressing, washing, meal preparation)
- Emotional and psychosocial issues (e.g., depression, adjustment difficulties, changes in self-esteem or efficacy, emotionalism)
- Swallowing (including swallowing rehab, maintenance of oral and dental hygiene, nasogastric tube feeding, gastrostomy)
- Skin integrity (i.e., pressure care and positioning)
- Nutrition (including specialist nutritional assessment, nutritional support)
- Visual disturbance
- Continence (bladder and bowel)
- Social interaction, relationships, and sexual functioning (including psychosocial management or medications)
- Pain (assessed regularly using validated score, referred to specialist where indicated)
- Home assessment (including need for larger scale equipment or adaptation)
- Carer support and training
- Driving
- Financial management and accessing benefits
- Return to work including referral to specialist in employment or vocational rehabilitation (see below)
- Review of rehabilitation goals (see below)
- Community integration and participation (see below)

Services and support may be delivered by the NHS or by providers such as the voluntary sector and members of the community neurorehabilitation team should have sufficient knowledge to ensure appropriate access to services.

The community neurorehabilitation team should work in partnership with hospital teams, GPs, local integrated services, and other primary and secondary care services to provide a holistic approach to patient care.

The community neurorehabilitation team should work with the voluntary sector to develop appropriate ongoing support services and extending pathways to support the long-term needs of patients and their carers/families. This should ensure provision of effective support and information as part of the rehabilitation process and encourage self-management where appropriate. Patients should be made aware of and offered options to promote their wellbeing, including health education, community leisure activities and exercise classes, peer-led support groups and social prescribing.

3.12. Return to work (vocational rehabilitation)

Support to return to work should be offered by the community neurorehabilitation team[11]. Return to work issues should be identified as soon as possible, reviewed regularly, and managed actively whilst within the service by:

- Identifying the physical, cognitive, communication and psychological demands of the job (for example, multi-tasking by answering emails and telephone calls in a busy office).
- Identifying any impairments on work performance (for example, physical limitations, anxiety, fatigue preventing attendance for a full day at work, cognitive impairments preventing multi-tasking, and communication deficits).

- Tailoring an intervention (e.g. teaching strategies to support multi-tasking or memory difficulties, teaching the use of voice-activated software for people with difficulty typing, and delivery of work simulations).
- Undertaking workplace visits and liaison with employers to establish reasonable accommodations, such as provision of equipment and graded return to work.

3.13. Review of rehabilitation goals

Rehabilitation should be delivered by a co-ordinated, appropriately experienced multi-disciplinary team who meet regularly and frequently in a structured way to ensure shared discussion and decision-making throughout the patient pathway from referral, assessment, rehabilitation interventions, to review, onward referrals and discharge[3]

All patients will have their rehabilitation goals reviewed at regular intervals.

Goals will be specific, measurable, realistic, achievable and timely and set in collaboration with the individual and/or their carers. They will be reviewed in an appropriate timescale depending on the needs of the person.

Goals shall be incorporated into a personalised plan that allows the patient to take ownership of their rehabilitation and shall be reviewed regularly (every 4-6 weeks) with the patient throughout the treatment period which will promote and support the wellbeing principle. The team should use a 'stepped care' approach to delivering psychological care.

Individuals should be encouraged and supported to self-manage through practice between rehabilitation sessions.

3.14. Community integration and participation

There should be joint working with stakeholders to develop pathways from the community neurorehabilitation team into community leisure and exercise classes for patients, who are then supported to attend by the community neurorehabilitation team as part of the rehabilitation process, where appropriate.

There should be joint working with voluntary sector providers to develop links to ensure effective provision of support and information as part of the rehabilitation process.

Patients should be made aware of and offered options to promote their wellbeing, including peer-led support groups, engagement in community activities and professional psychological therapies including IAPT and community mental health services.

The community neurorehabilitation team will:

- Work with the patient and their family or carer, identify their information needs and how to deliver them, taking into account condition specific information and specific impairments such as aphasia and cognitive impairments and pacing the information to the person's emotional adjustment.
- Provide information about local resources (e.g., leisure, housing, social services, and the voluntary sector) that can help to support the needs and priorities of the person and their family or carer.
- Support and educate people with neurological conditions and their families and carers, in relation to emotional adjustment, recognising that psychological needs may change over time and in different settings.
- Ensure carers needs are considered as part of the rehabilitation process.
- Appropriately educate and train carers to recognise and report causes of illness that could result in avoidable admission e.g., constipation, urinary tract infection, swallowing problems.
- Promote the practice of skills gained in therapy in the patient's daily routine in a consistent manner and patients shall be enabled and encouraged to practice that activity as much as possible.
- Refer to IAPT services if required with advice and input from the community neurorehabilitation service psychologist.
- Refer to Functional Electrical Stimulation for foot drop services where appropriate.
- Refer to ACE for communication support.
- Refer to North West Ventilation Service for support.
- Refer to specialist condition specific clinics for review, support and guidance.

3.15. Remote working and telerehabilitation

The pandemic has demonstrated NHS services' ability to adapt to using digital solutions and to explore the use of telerehabilitation[12]. Use of virtual multidisciplinary meetings and frequent virtual communication with other services has facilitated decision-making processes for delivery of rehabilitation and seamless transfer of care. Other changes in community neurorehabilitation services include blended models of remotely delivered rehabilitation or telerehabilitation and face-to-face rehabilitation, for individuals and groups of patients.

3.16. Discharge from the Community Neurorehabilitation Team

Discharge will be by the team based on agreed local protocol. As the service is goal led, people may be discharged from the service for one of the following reasons:

- Achievement of agreed goals, no new goals.
- When an individual declines further input.
- Rehabilitation no longer demonstrates any impact if goals are not achieved.
- Where no feasible rehabilitation goals can be agreed.
- Referred on to more appropriate services.
- Joint working with the end of life care pathway where appropriate.

Service provision will be for up to 6 months, with extensions for patients who require further rehabilitation, and are still achieving goals, based on clinical reasoning.

Self-management and access to relevant community assets to support the patients on discharge from the service should be coordinated by the community neurorehabilitation team including support from voluntary services, social prescribers, and exercise pathways to ensure longer term support and re integration is successful and needs led.

A support plan which includes who to contact and what to do if there is a deterioration, or information needed should be in place prior to discharge.

A discharge summary should be sent to the GP within a week of discharge from the community neurorehabilitation team.

Patients can re-refer themselves back to the community neurorehabilitation team at any point post-discharge for assessment of need. The community neurorehabilitation team will help determine the most appropriate pathway or referral to other services.

3.17. End of life care

If a patient is identified as being at the end of their life at any stage of the pathway, advance care planning should be initiated and/or reviewed and a gold standard framework for an end-of-life care model adopted. Seamless transfer of care to palliative care services may be appropriate[10].

3.18. Hours of service

The service shall operate for 8 hours between the hours of 8am – 6pm, during locally agreed hours (normally office hours such as 8.30am-4.30pm) 5 days a week Monday to Friday, extended to the evenings (ad hoc) to meet patient need and weekend (6 days) dependent on patient need.

3.19. Audit and service development

Standard sets of data should be determined and collected/recorded routinely with the creation of a neurology dashboard, building on routinely collected data, to enable monitoring of key metrics to support continual quality improvement[2].

The service should actively engage with and contribute to the work of the GMNISDN[6]

Data will be collected by the GMNISDN at 6 monthly intervals (April-September and October to March) with a snapshot audit halfway through each collecting period for process related indicators (July and January). The clinical data will be collected 2 months after the data collection period ends (November and May).

An annual report should be collated that presents the outcomes of the service in terms of service delivery, patient's outcomes, and satisfaction with action plans for service improvement.

The GMNISDN are a key resource to support service developments and the planning process for any service development should include active involvement of neurological patients and carers.

4. References

1. The Neurological Alliance. Neuro Numbers 2019. www.neural.org.uk/assets/pdfs/neuro-numbers-2019
2. Neurology GIRFT Programme National Specialty Report 2021
3. 2021 BSRM Standards for specialist rehabilitation for community dwelling adults update of 2002 standards
4. NHSE RightCare Progressive Neurological Conditions Toolkit 2019
5. Manchester Centre for Clinical Neurosciences: NorthCare Charity - https://www.northcarecharity.org/about-us/manchester-centre-clinical-neurosciences
6. Greater Manchester Neurorehabilitation & Integrated Stroke Delivery Network - www.gmnisdn.org.uk
7. NHS England National Integrated Community Stroke Service Model (2022) - https://www.england.nhs.uk/publication/national-service-model-for-an-integrated-community-stroke-service/
8. Government (2005). Mental Capacity Act - www.legislation.gov.uk/ukpga/2005/9/contents
9. Government (2014) Care Act - www.legislation.gov.uk/ukpga/2014/23/contents/enacted/data.htm

10. North West Coast Strategic Clinical Network (2014) *End of Life Care Model* (online). Available at: http://www.nwcscnsenate.nhs.uk/strategic-clinical-network/our-networks/palliative-and-end-life-care/north-west-end-life-care-model/
11. Vocational Rehabilitation: BSRM brief guidance 2021
12. Rehabilitation in the wake of Covid-19 -A phoenix from the ashes (2020) British Society of Rehabilitation Medicine (BSRM)

Documents that help inform the model

1. Specialised Neurorehabilitation Service Standards 7 30 4 2015-PCATV2-forweb-11-5-16-Annexe2_Updated_May2019.doc Last Updated 22-5-19_Annexe2
2. NHS England (2016) Commissioning Guidance for Rehabilitation. Department of health. London.
3. NHSE RightCare: Community Rehabilitation Toolkit 2020
4. Rehabilitation is Everyone's Business: Principles and Expectations for Good Adult Rehabilitation (2015) Wessex Strategic Clinical Network
5. Government (2020) Hospital discharge service: policy and operating model Available at: https://www.gov.uk/government/publications/hospital-discharge-service-policy-and-operating-model
6. National Clinical Guideline for Stroke (2023) www.strokeguideline.org/

Appendix 1: Community Neurorehabilitation Service Model