NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

NICE guidelines

Equality impact assessment

Rehabilitation after Traumatic Injury

The impact on equality has been assessed during guidance development according to the principles of the NICE equality policy.

3.0 Guideline development: before consultation (to be completed by the Developer before consultation on the draft guideline)

3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?
1. Consider how to reflect different commissioning models in the recommendations (for example, in rural and urban environments). Rehabilitation services are organised differently in different parts of the country in addition to the major trauma network and specialised services for major trauma. For rehabilitation that does not fall within major trauma there are broad disparities in service provision in different parts of the country and in rural and urban areas. The committee wanted commissioners to consider the needs of all people with complex rehabilitation needs (as defined in this guideline) to meet local and region needs of those populations and environments and made the following recommendations: 1.10.1 When planning, commissioning and coordinating the delivery of rehabilitation and related services (for example, social care and the voluntary sector), commissioners and providers should design services with whole care pathways in mind, from acute treatment and inpatient rehabilitation through to community provision, including specialised and non-specialised elements. 1.10.4 Commissioners and providers should ensure that rehabilitation services for people after a traumatic injury: • meet the needs of people of all ages and at all stages of rehabilitation • are developed in collaboration with the people who use rehabilitation services and the healthcare professionals who work within them • are outcome-focused and relevant for the people who use them. 2. Preferences for rehabilitation service provision across different socio-economic groups and inequalities in access to inpatient, outpatient and community rehabilitation and lower socioeconomic groups can be disproportionately affected because of impact on family life and income.

3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?

The committee identified how people and families from lower socioeconomic groups could be particularly affected by the lack of effective and joined up rehabilitation in the community and would not have access to privately funded care or may not have access to legal advice or insurance claims due to injuries that would provide a higher level of rehabilitation care. The groups would particularly benefit from discharge planning that involved community practitioners as well as advice about access to services, benefits and other forms of support, information and education about rehabilitation and related support needs, and the committee made detailed recommendations in these areas:

1.8.14 For people who will have significant ongoing needs after discharge:

- arrange a pre-discharge planning meeting with community practitioners who will be involved in the person's rehabilitation, care and support (for example, therapists, social workers and care coordinators)
- encourage pre-discharge visits by community practitioners to meet the person, and their family or carer (as appropriate)
- consider organising a joint 'handover' appointment between the inpatient multidisciplinary team and community practitioners at the point of discharge.

1.6.7 Advise carers about their right to a carer's assessment, an assessment for respite care, and other support (see the NICE guideline on supporting adult carers for recommendations on identifying, assessing and meeting the caring, physical and mental health needs of families and carers).

1.8.5 Advise people that further help with funding for equipment, assistive technology, environmental adaptations and other forms of support with rehabilitation might be available for their home, education and workplace settings (for example, through local authorities, the Education, Health and Care Plan, Access to Work Grants, and the Department for Work and Pensions).

1.8.6 Give people, and their family members or carers (as appropriate), information about services that provide independent legal, financial, employment and welfare advice (for example the Citizens Advice Bureau).

1.8.11 If a person is likely to have continuing health and social care needs after discharge to home:

- inform relevant healthcare professionals, social care practitioners and education practitioners (as appropriate)
- establish the person's eligibility for funded social care support, including for families and carers
- use the NHS continuing healthcare checklist, to establish the person's eligibility for a full continuing healthcare assessment before discharge
- for children and young people, establish their eligibility for funded support through an education, health and social care plan.

Also see the NICE guideline on transition between inpatient hospital settings and community or care home settings for adults with social care needs.

1.8.15 Liaise with community teams (such as community and voluntary sector providers,

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physiotherapists and occupational therapists, education support, and special educational needs coordinators in schools and nurseries for children and young people) to agree a staged return to the workplace or education. (See also the NICE guideline on transition between inpatient hospital settings and community or care home settings for adults with social care needs).

1.8.16 When planning discharge, address potential barriers that may prevent the person accessing rehabilitation in the community. For example, ensure that they can travel to and access the location of treatments, and ensure that the timing and length of appointments will be manageable for them.

1.8.21 If people have complex or long-term conditions or social care needs, consider appointing a key worker as a direct source of advice, support and signposting. This should be a healthcare or social care professional with knowledge and expertise about inpatient or community-based rehabilitation and support, including education or training support for children and young people.

3. Rehabilitation service provision related to all ages, avoiding age related generalisations whilst still making age specific recommendations where necessary and appropriate.

The committee was particularly mindful of the large numbers of older people admitted to hospitals with injuries that result in very complex rehabilitation needs and this may be due to fragility, disability and pre-existing conditions that need careful consideration alongside rehabilitation interventions. Similarly the committee wanted to emphasise the importance of identifying these needs, risks and referring accordingly to specialists and for specialist assessments

1.4.5 Manage the care of adults with fragility fractures of the femur within a specialist pathway involving orthogeriatricians. Also see the NICE guideline on hip fracture.

1.4.6 If an older person with a traumatic injury is on a care pathway that does not routinely involve geriatrician support, consider referral to an orthogeriatrician, a surgical liaison or a perioperative physician (as appropriate).

1.4.7 For adults with a fragility fracture, assess bone health and refer as necessary, for example, to a specialist bone health clinic or outpatient service. Also see the NICE guideline on osteoporosis.

1.4.8 If a traumatic injury has been caused by a fall, ask the person about previous falls, and consider a falls risk assessment and a referral to a community falls service (as appropriate). Also see the section on multifactorial risk assessment in the NICE guideline on falls.

1.4.9 Assess all adults over 65 who have a traumatic injury for their risk of falls in line with the recommendations on multifactorial risk assessment in the NICE guideline on falls.

1.17.10 Assess adults presenting with rib fractures for their risk of fragility fracture in line with

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NICE guideline on osteoporosis. 1.15.18 For people with a spinal cord injury who are using a spinal orthosis (for example, cervical collar or thoraco-lumbar spinal orthosis), regularly assess them for complications such as pain, pressure sores, swallowing or breathing difficulties (particularly in older people or those with dementia or delirium). The committee also identified that practitioners sometimes make assumptions about the needs and capabilities of older people that are not based on actual assessment and made the following recommendation: 1.11.13 Do not withhold aerobic exercise programmes from older people after a traumatic injury. The committee also reviewed evidence about rehabilitation for children and young people and although it was agreed the majority of the recommendations would apply to adults and children and young people the committee were particularly keen to identify issues relating to children and young people that needed to be highlighted in the guideline for practitioners. These key issues and their recommendations are: *The voice of the child* 1.5.9 For children, young people and vulnerable adults, offer additional support to develop and deliver a self-management programme that takes into account their own views and priorities. 1.6.2 Encourage and support children and young people to be actively involved in decision making about their rehabilitation to the best of their ability. 1.15.6 When discharge planning for children and young people after a spinal cord injury, ensure that meetings take place early and involve the child or young person and their parents and carers (as appropriate), together with the local education authority, specialist play services and multidisciplinary team. *Safeguarding* 1.1.12 Complete a safeguarding assessment for children, young people and vulnerable adults after a traumatic injury, taking into account any known or suspected non-accidental injury. (Also see the NICE guidelines on child abuse and neglect and child maltreatment.) 1.17.12 Consider assessing children and young people with rib fractures for bone density disorder and for the possibility of non-accidental injury (see recommendation 1.1.8 on safeguarding). *Hospital stays* 1.11.33 For children and young people, keep their hospital bed as a ‘safe’ space, and carry out potentially painful scar management techniques such as massage, or other painful treatments, away from their bed if possible.

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Emotional needs, puberty and change

1.15.32 Take into account the long-term psychological impact of change in body image as a result of injury for all people and for children and young people as they grow.

1.9.12 The team around the child should offer emotional and psychological support to children, young people and their families and carers to help with lifestyle adjustments and the effects of the traumatic injury (for example, prolonged hospitalisations), and support their gradual return to education, play, social and leisure activities.

1.15.31 For children and young people, the team around the child should actively monitor for any emerging emotional difficulties as the child or young person grows and develops (for example, moving schools, puberty and emotional relationships).

1.14.20 For children, consider play or play therapy when offering psychological and emotional support.

Taking account of pre-existing conditions and needs

1.12.6 For children and young people:

- ask parents and carers if there are any pre-injury cognitive issues, for example, any known special educational needs
- liaise with their education provider if information about their pre-injury cognitive performance is needed
- inform education providers and teachers, including those in the hospital setting, about the child or young person's needs and any problems with cognitive functioning.

Physical growth

1.15.5 For children and young people, monitor growth and nutrition throughout the rehabilitation process.

Education and school

1.9.9 Give children and young people, and their families and carers (as appropriate), information about educational support and return to school.

1.9.8 Provide information for early years settings or schools about the child or young person's rehabilitation needs, and the adjustments needed to enable their return to education, for example, a staged return.

Transition to adult services

1.9.10 For young people who are starting to access support from adult rehabilitation services, see the NICE guideline on transition from children's to adults' services for young people using health or social care services.

4. Hospital discharge and other issues for people who are homeless.

Although the committee did not address homelessness directly in the recommendations, a number of recommendations support the importance of

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discharge planning in the hospital and involving community practitioners in planning for post discharge therapies and treatments. These recommendations will benefit people who are homeless so that rehabilitation needs are considered pre-discharge.

1.2.4 The multidisciplinary team involved in assessing people's rehabilitation needs in hospital should consist of healthcare professionals and practitioners with expertise in rehabilitation after traumatic injury. Depending on the nature of the injury, the setting for assessment and treatment, the age of the person and other pre-existing health or care issues, the multidisciplinary team could involve:

- surgeons, rehabilitation medicine specialists, intensive care specialists, elderly care specialists and/or paediatricians (as appropriate)
- allied health professionals such as occupational therapists, physiotherapists, dietitians and speech and language therapists
- practitioner psychologists
- specialist nurses
- a trauma coordinator and/or rehabilitation coordinator
- when planning discharge:
  - a social worker
  - a discharge coordinator.

1.4.2 The rehabilitation plan should be:

- a tailored and individualised journey towards the person's agreed goals, focusing on what is important to them
- developed with the person, and their family members or carers (as appropriate)
- based on advice and input from all members of the multidisciplinary team
- written in clear English
- a single document or file
- shared with the person, their families and carers (as appropriate), the person's GP, and healthcare professionals involved in their ongoing care
- regularly updated in partnership with the person to reflect their progress, goals, ongoing needs and key contact information, particularly at key points of transition in care.

5. People whose first language isn't English where this isn't already covered in existing NICE guidelines.

The committee mainly referred to existing NICE guidelines on this issue but did make one specific recommendation:

1.6.4 In discussions and when giving information to people, and their family members or carers (as appropriate), use clear language, and tailor the timing, content and delivery of information to the needs and preferences of the person. Information should be:

- specific to the person's injuries
- offered in face-to-face (in person or remotely by video link) discussions, and in a suitable format, for example, digital, printed, braille or Easy Read
- offered throughout the person's care
- individualised and sensitive
- supportive and respectful

3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?

- evidence-based and consistent between healthcare professionals.

For more guidance on communication, providing information (including different formats and languages) and shared decision making, see the NICE guideline on patient experience in adult NHS services.

6. People with mental health conditions, including pre-existing mental health conditions and those related to the traumatic injury and
7. People with pre-existing conditions, physical and learning disability and for frail elderly people.

The entire scope of the guideline and the definition of complex rehabilitation needs was based on the principle that successful rehabilitation considers the whole person who has been injured and not just the injury itself. This means that consideration of pre-existing conditions and disability play an important part in rehabilitation needs assessment.

The committee made a number of recommendations in relation to the issue of identifying and supporting people with mental health conditions particularly. For example:

1.2.20 As part of the rehabilitation needs assessment after a traumatic injury, the multidisciplinary team should ask about psychological and psychosocial risk factors, for example:

- past or present mental health problems, such as anxiety or depression
- past or present mental illness or psychiatric treatment
- history of traumatic brain injury
- history of self-harm or suicide attempts
- history of domestic violence or abuse
- history of child protection issues or safeguarding concerns
- excessive alcohol consumption or recreational drug use
- the circumstances of the injury, for example, self-harm or a violent crime
- social factors that mean the person may need additional support, for example, if the person is homeless, a refugee or recent migrant, if they have difficulty reading or speaking English, or if they have learning disabilities or other needs.

1.2.21 As part of the rehabilitation needs assessment after a traumatic injury, look for indicators of psychological problems (including lack of engagement with rehabilitation) beyond that of an acute stress response (see recommendation 1.13.1). Take into account any psychological and psychosocial risk factors (see recommendation 1.2.20) and, if needed, refer the person for a psychological assessment with a practitioner psychologist (with relevant expertise in physical trauma and rehabilitation) to inform their rehabilitation plan and goals.

1.13.7 Treat PTSD, anxiety, depression in adults, and depression in children and young people as part of an overall coordinated rehabilitation treatment package, and in line with the NICE guidelines on post-traumatic stress disorder, social anxiety disorder, generalised anxiety disorder and panic disorder in adults, depression in adults, depression in adults with a chronic physical health problem, depression in children and young people, and service user experience in adult mental health.

3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?

The committee were particularly mindful of the importance of supporting people who lacked mental capacity in decision making about rehabilitation and goal setting and engagement in rehabilitation and made a number of recommendation in this area. Lacking mental capacity may be due to pre-existing conditions or it may be an outcome of the traumatic injury and may be temporary. Either way the consideration of how to support people and make best interests decisions in the persons interest was emphasised in the guideline at key points.

1.2.6 If a person lacks mental capacity or has fluctuating mental capacity, a rehabilitation needs assessment should be carried out in the person's best interests. See the NICE guideline on decision making and mental capacity.

1.6.6 Be aware that people who lack mental capacity or who have care and support needs may be legally entitled to professional advocacy under the Mental Capacity Act 2005 and/or the Care Act 2014. Also see the NICE guideline on decision making and mental capacity.

1.12.7 Be aware that after a traumatic injury, people may present with fluctuations in mental capacity, and that this may affect decision making. See the NICE guideline on decision making and mental capacity.

One theme and area of intervention that came up in the evidence was the use of violence prevention programmes as an intervention for rehabilitation. The committee agreed that these programmes had the potential to benefit a number of groups already highlighted in this equality impact assessment who routinely experienced health inequalities and poorer outcomes for rehabilitation. The recommendations made were:

1.4.11 For people admitted to hospital with violent injuries related to suspected criminal activity, consider a violence prevention programme and follow-up as part of their rehabilitation plans. This could include psychological support (for example, counselling), substance abuse rehabilitation, employment or education training, group sessions, family development, social worker involvement, and rehousing, when needed.

1.4.10 Provide information about, or refer people to, services that may help prevent future injury, such as falls prevention, safeguarding services, violence prevention programmes, and condition-specific support organisations.

3.2 Have any **other** potential equality issues (in addition to those identified during the scoping process) been identified, and, if so, how has the Committee addressed them?

It was noted that some people may not have access to the internet from their home or may have difficulty accessing information on the internet due to a learning disability or other access issues and this could be a barrier to receiving and engaging with education materials about their injuries and rehabilitation including self-managed rehabilitation programmes. The committee agreed that practitioners should explore alternative ways of providing such materials if internet access was a problem.

1.5.7 As part of a self-management rehabilitation programme, consider providing a tailored package of online education and learning materials for people after a traumatic injury, which could include information on:

- movement and physical activity
- energy conservation and pacing
- sleep
- activities of daily living
- work, social activities and hobbies
- nutrition and diet
- pain management and medicines
- wound healing
- mental health
- local and national sources of information
- peer support services.

For people who cannot access the internet, explore alternative ways to provide these materials.

3.3 Have the Committee's considerations of equality issues been described in the guideline for consultation, and, if so, where?

The committee's considerations have been included in the recommendations, and the committee discussion sections of the evidence reports as outlined in the sections above.

3.4 Do the preliminary recommendations make it more difficult in practice for a specific group to access services compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group?

No, the recommendations do not make it more difficult for specific groups to access services.

3.5 Is there potential for the preliminary recommendations to have an adverse impact on people with disabilities because of something that is a consequence of the disability?
No, the recommendations do not have the potential to have an adverse impact on people with disabilities

3.6 Are there any recommendations or explanations that the Committee could make to remove or alleviate barriers to, or difficulties with, access to services identified in box 3.4, or otherwise fulfil NICE's obligation to advance equality?
N/A

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