October 2025 – Foundations

Post-Acute Trauma Recovery, Continuity, and Governance Alignment

Post-acute trauma recovery is increasingly recognised as a complex, multi-dimensional process that extends well beyond the point of discharge. While acute and early rehabilitation phases are typically well defined, the period that follows often lacks consistent structure, oversight, and continuity.

This creates a critical gap within trauma pathways — not because care is absent, but because responsibility, coordination, and accountability become diffuse during a phase where recovery has not yet stabilised. The consequences of this gap are often delayed, emerging once patients are no longer visible within formal systems of care.

Alignment With NICE NG211

This work aligns with the direction set out in NICE guideline NG211, which frames rehabilitation after traumatic injury as an ongoing, coordinated process rather than a discrete

episode of care. NG211 emphasises the importance of rehabilitation planning, review, follow-up, and responsiveness to changing need across the recovery trajectory.

At the same time, NG211 implicitly exposes a structural challenge. While expectations for continuity are clear, responsibility for maintaining that continuity is often distributed across multiple services once acute care concludes. As a result, post-acute recovery may remain clinically active while no single mechanism holds oversight of the whole.

The Post-Acute Trauma Continuity Gap

In many trauma pathways, discharge functions as a structural boundary rather than a clinical one. Formal episodes of care end, while physical recovery, pain processing, psychological adjustment, and functional reintegration remain incomplete.

At this point, responsibility for recovery frequently shifts from services to individuals. Monitoring becomes indirect, escalation routes become unclear, and recovery stability is inferred rather than actively evidenced. Patients may no longer meet service thresholds while remaining clinically vulnerable, resulting in a continuity gap where risk accumulates without clear ownership.

This gap does not represent a failure of care, but a failure of continuity.

Why the Gap Exists

The post-acute trauma continuity gap is not the result of poor clinical practice. It is a predictable outcome of how trauma pathways are structured, commissioned, and governed.

Recovery pathways are often organised around service episodes rather than recovery phases, with physical rehabilitation, pain management, and psychological support delivered across separate services, timeframes, and eligibility criteria. Responsibility is managed through referrals and thresholds designed to control demand, rather than mechanisms designed to hold recovery through instability. Once acute oversight ends, coordination relies on assumptions of readiness rather than demonstrable stability.

Although NG211 recognises the importance of coordinated rehabilitation and review, these functions are frequently distributed across services without a single continuity mechanism to hold responsibility beyond discharge.

What Is Now Being Called For

Across trauma, rehabilitation, and long-term condition frameworks, there is growing recognition that recovery does not end at discharge. What is increasingly being called for is not additional treatment, but greater continuity.

This includes recognising post-acute recovery as a clinical phase in its own right, maintaining coordination beyond acute episodes of care, and integrating trauma response, pain, function, and behaviour within recovery planning. It also requires earlier identification of destabilisation, before deterioration escalates into crisis, disengagement, or re-presentation to services.

NG211 supports this direction by emphasising review, responsiveness, and coordination over time. The challenge lies not in defining expectations, but in operationalising continuity once formal care episodes conclude.

Addressing the Gap at Pathway Level

Addressing the post-acute trauma continuity gap does not require replacing existing services. It requires a structural continuity layer that operates across them.

In practice, this involves maintaining oversight during the vulnerable post-acute phase, integrating physical, psychological, and functional recovery processes, and clarifying responsibility for monitoring, escalation, and review. Crucially, continuity mechanisms must remain active until recovery has demonstrably stabilised, rather than ending at the point of discharge.

This is a pathway design issue rather than a treatment issue, and must therefore be addressed at system level.

Governance, Accountability, and Risk

When post-acute recovery sits outside formal oversight, risk becomes difficult to see and harder to govern. Deterioration may present later as readmission, mental health escalation, or long-term functional decline, while disengagement is often misclassified as non-compliance rather than recognised as emerging vulnerability.

From a governance perspective, NG211 reinforces expectations around coordinated rehabilitation and review, raising important questions about how post-discharge outcomes are monitored, where accountability sits once formal care episodes end, and how predictable risks are identified before harm occurs. Without continuity-focused structures, these risks remain diffuse — present within the system, but unmanaged.

Position Within the Clinical Series

October establishes the technical and policy-aligned foundation for this body of work. Subsequent months explore how continuity gaps, integration failures, and governance blind spots manifest in practice, and how they can be addressed without replacing existing clinical services.

TPS is positioned within this post-acute continuity gap, supporting clinicians and services to operationalise the expectations set out in NG211 where traditional pathways reach their limits.