Isle of Wight Clinical Commissioning Group

IMPROVING ADULT PHYSICAL REHABILITATION SERVICES

HAVE YOUR SAY

Please let us know your views by 29th June 2015.

Email us at: rehabconsult@iow.nhs.uk

Or write to us at:
Rehabilitation Consultation, Isle of Wight Clinical Commissioning Group, Building A, The APEX, St. Cross Business Park Monks Brook, Newport, Isle of Wight, PO30 5XW

What is Rehabilitation?

When people have a minor illness or accident they usually recover fairly quickly, in their own time, sometimes needing treatment from a Nurse or Doctor or Pharmacist.

When more serious illnesses or accidents occur people may need extra support to recover or to become used to living with a disability. Physical Rehabilitation involves helping these people to become as independent as possible – to live their lives in the way that they want to.

After setting goals about what they want to achieve during their rehabilitation, they are helped to relearn skills, recondition their muscles and practice their daily activities working with teams of specially trained health and social care professionals.

Background and present situation

During 2014/15 the Isle of Wight Clinical Commissioning Group (CCG) and the Isle of Wight Council agreed to work together to see if they could integrate the existing rehabilitation and reablement services.

We agreed to have a phased approach and the CCG started by reviewing the rehabilitation services that they commission. We discussed with the people providing them and the people using them, what the services currently offer.

We also looked at the changes that are happening within health and social care on the island (see www.mylifeafulllife.com) and thought about how best rehabilitation services could fit into the proposed new ways of working. For example, closer liaison with GPs in local community teams of health and social care professionals working for our older population (Locality Teams).

At the moment the CCG's rehabilitation services for adults with physical disabilities are managed from a central point at St Mary's Hospital where they liaise with rehabilitation teams working around the island and on the hospital site.

We found that sometimes a few people have to go to the mainland for rehabilitation when they need more specialist help. We realised this may always be the case because we are living on a small island which cannot provide all the services that are available on the mainland.

We also found that, although the people receiving the services were generally happy with them, there were problems for the staff delivering the services and that some people were not receiving enough rehabilitation to achieve their goals.

There were particular problems around the need for speedy discharges for patients from hospital to ensure that there were enough beds available for new, very ill patients. Sometimes people were not as well as they might be in order to start their rehabilitation and this meant that staff had to spend time nursing people rather than helping with their rehabilitation.

We realised that we will have to consider where best to provide rehabilitation beds as, due to a shortage of space for beds for very ill people, often the General Rehabilitation Unit at St Mary's Hospital had to be used to nurse these people which meant that it was not being used exclusively for rehabilitation, as it should have been.

This may be an opportunity to consider providing rehabilitation beds and teams closer to people's homes so that they can be accessed more easily.

We looked at the different needs of the people currently receiving rehabilitation and realised that there are now two different types of service required.

We recognised that the majority of people requiring rehabilitation have the illnesses and injuries that are usually associated with later life. This is in line with the larger elderly population on the island. These people might for example, need help to recover from falls, infections and hip fractures.

However increasing numbers of referrals are coming for a slightly younger group of people who have more complex, and often ongoing, rehabilitation needs. These might have, for example, neurological conditions or brain injury or have had major accidents or need vocational rehabilitation to get back to work. The rehabilitation services for these people are currently available in a limited way or not at all.

It was acknowledged that the rehabilitation needs of patients in the later life group are subtly different to those in the more complex rehabilitation group so we are suggesting that two different rehabilitation streams now need to be provided.

We will be taking your feedback on this paper into account and moving the services forward during 2015/16.

What will change?

Here are two fictitious case studies to illustrate how the services might change:

1. *Mrs Blue is a 90 year old lady who lives on her own in her own home in Ventnor. She usually looks after herself and is fairly fit - she has some osteoarthritis and has slightly swollen lower legs due to heart failure. She has no relatives living nearby but is well known at her local church. One day she falls and breaks her right hip.*

   What happens now?
   - *Emergency admission to St Mary's Hospital orthopaedic ward where her hip is treated*
   - *Central referral point (SPARRCS) is notified of her possible rehabilitation needs and manages her rehabilitation pathway as far as possible. There are some problems because the IT system that could share notes between teams is not fully operational*
   - *Move to General Rehabilitation Unit because she has not had time to recover sufficiently well on the orthopaedic ward and needs the support of the Consultant for Elderly Care for a time*
   - *Move to Community Rehabilitation Bed in a Nursing Home in Bembridge (only available bed) where she receives excellent care and rehabilitation with additional support from a GP*
   - *Friends find it difficult to visit and Mrs Blue becomes quite lonely and fed up*
   - *She goes home and her friends have to rally round to help her as she is nervous about managing on her own.*
   - *Her GP finds out she has gone home about a week afterwards and realises she needs some extra help*
   - *The Council's Reablement Team is called in to help her regain her independence*
   - *6 months after her emergency admission Mrs Blue feels she is back to "normal"*

What could happen in the future when the Later Life Rehabilitation Service is involved?

- *Emergency admission to St Mary's Hospital orthopaedic ward where her hip is treated*
- *Central referral point is notified of her possible rehabilitation needs and refers her case to the Later Life Rehabilitation (Blue)Team which is part of the Locality Team for Mrs Blue's home area*
- *The Team manages her rehabilitation pathway using a shared IT system*

- *Move to a Community Rehabilitation Bed in a more local Nursing Home where she receives excellent care and rehabilitation supported by her own GP and the Consultant for Elderly Care, who visits the Home regularly*
- *Mrs Blue's Locality Management Team is aware of the input and monitors her recovery, ensuring that her GP is kept informed*
- *Friends visit often so Mrs Blue is kept up to date with local news*
- *She goes home and the Later Life Rehabilitation Team negotiates with the Council's Reablement Team to provide a further period of support, only if she hasn't achieved her rehabilitation goals*
- *Mrs Blue is made aware of all the other services that can support her in the her local community*
- *4 months after her emergency admission Mrs Blue feels she is back to "normal"*

2. *Mr Green is a 60 year old man who lives with his wife in Ryde. His ability to manage essential activities of daily living is beginning to deteriorate as he has Parkinson's disease. His wife is finding it increasingly difficult to support him and they are not going out and about as much as they have in the past.*

   What happens now?
   - *Mr and Mrs Green visit his GP and explain how difficult life is becoming*
   - *GP refers Mr Green to central referral point (SPARRCS) who manages his rehabilitation pathway as far as possible. There are some problems because the IT system that could share notes between teams is not fully operational*
   - *There is a 5 week wait for rehabilitation because his needs are not urgent*
   - *The Parkinson's disease nurse is not part of the rehabilitation team and so is not fully involved with his rehabilitation*
   - *Mr Green is asked to attend an out-patient clinic weekly for assessment and rehabilitation. He finds the journey tiring and Mrs Green struggles to get him into and out of the car. Sometimes he does not feel like attending and often the benefits of the rehabilitation wear off quickly*
   - *The Rehabilitation Team agrees to visit Mr Green at home but can only do so once a month as they are short of staff*
   - *Mr Green becomes quite fed up and less able to manage*
   - *The Rehabilitation Team discharges Mr Green as he is not making much progress with his rehabilitation goals*
   - *The GP has additional calls for help from Mr & Mrs Green*

- *The GP re-refers Mr Green to rehabilitation and the pathway starts again*

What could happen in the future when the Complex Rehabilitation Service is involved?

- *Mr and Mrs Green visit his GP and explain how difficult life is becoming*
- *GP refers Mr Green to the central referral point which alerts the Complex (Green) Rehabilitation Team*
- *The Team manages his rehabilitation pathway using a shared IT system and ensures the GP is kept informed of progress*
- *The Parkinson's disease nurse is part of the rehabilitation team and so is fully involved with his rehabilitation*
- *Mr Green is asked to attend his nearest out-patient clinic for assessment and rehabilitation.*
- *When he explains that he cannot manage the journey the Rehabilitation Team agrees to visit Mr Green at home regularly for a period of time until he can cope with the journey*
- *Mr & Mrs Green are supported by the Team's Clinical Health Psychologist*
- *Mr Green is discharged when he has achieved his goals*
- *Mr and Mrs Green are made aware of all the other services that can support them in the local community*
- *Mr Green is able to self-refer to the Team if he would benefit from their support again.*

What staff will be in each Team?

The two different groups of patients have different needs and therefore will need different levels of support during their rehabilitation. Below are the likely staff members to be recruited into each team:

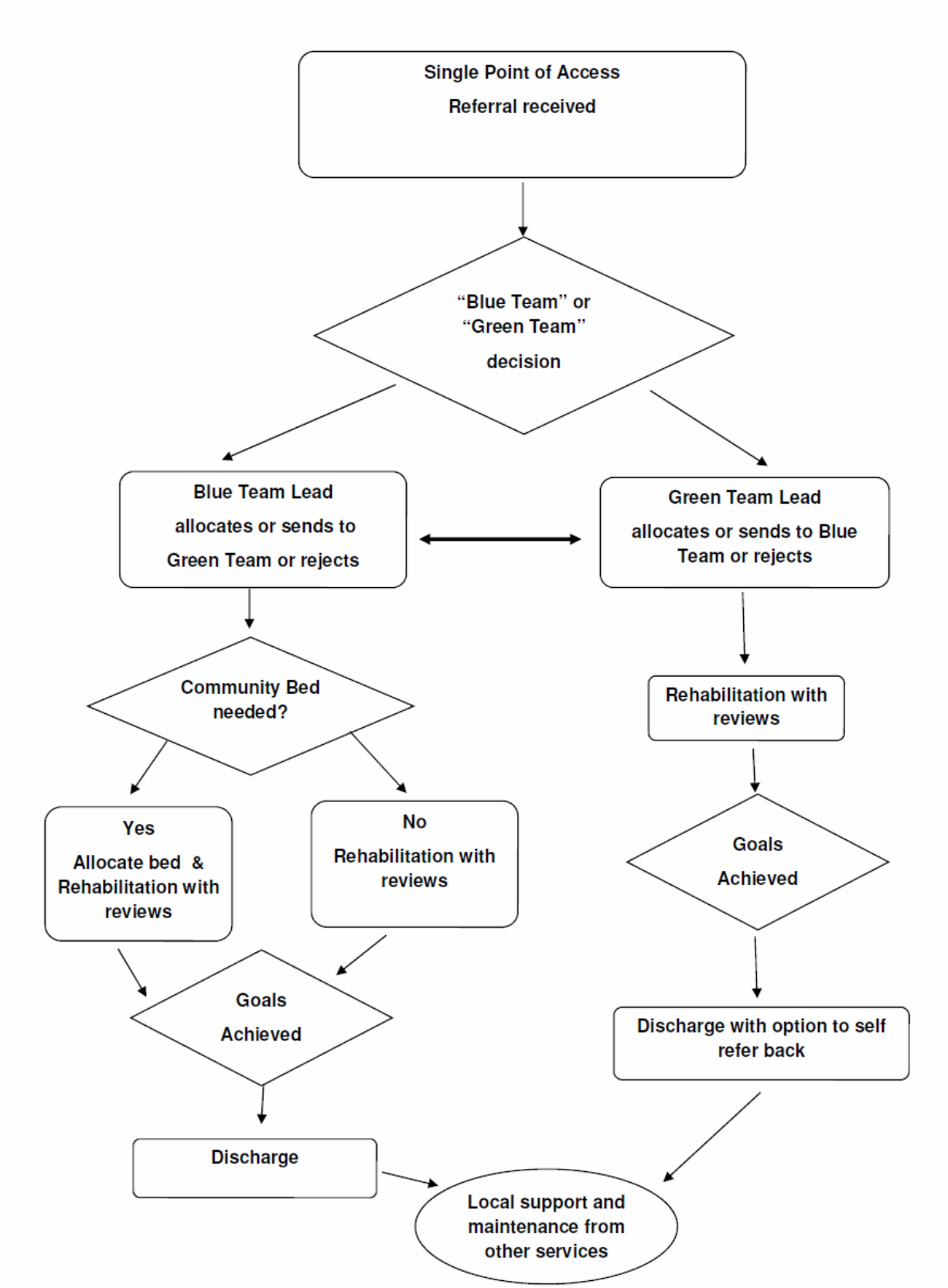
Later Life Rehabilitation (Three Blue Teams, one attached to each Locality Team)	**Complex Rehabilitation (One Green Team covering the island)**
Consultant for Elderly Care Nurses Physiotherapists Occupational Therapists Speech & Language Therapists Generic assistants	Rehabilitation Consultant Physiotherapists Occupational Therapists Psychologists Clinical Nurse Specialists in Multiple Sclerosis and Parkinson's Disease Speech & Language Therapists Generic assistants

Working closely with other services, for example: ○ Locality Management Teams ○ GPs ○ Community Nurses ○ Falls Coordinator ○ Falls Prevention team ○ Tissue Viability Nurse ○ Continence Advisors ○ Reablement Team ○ Community Rehabilitation Bed Providers ○ GPs working with Community Rehabilitation beds ○ Independent Living Centre ○ Voluntary Sector e.g. British Red Cross/Age UK/Action on Hearing Loss ○ Independent sector ○ Wheelchair Service ○ Integrated Community Equipment Service (ICES) ○ Social Care providers ○ Housing ○ Third sector ○ Support Groups ○ Adult education ○ Leisure services	Working closely with other services, for example: ○ GPs ○ Falls Coordinator ○ Falls Prevention team ○ Reablement Team ○ Tissue Viability Nurse ○ Continence Advisors ○ IOW Council Home Adaptation Team ○ Independent Living Centre ○ Job Centre ○ Voluntary sector e.g. Headway, other support groups ○ Community Musculoskeletal Physiotherapy Services ○ Independent sector ○ Consultants in Neurology and Rheumatology ○ Wheelchair Service ○ Integrated Community Equipment Service (ICES) ○ Social Care providers ○ Housing ○ Adult education ○ Leisure services

Glossary

- Continence Advisors – undertake assessment for, and provision of, continence aids
- Independent Living Centre – offers free impartial advice to elderly and disabled people, offering practical solutions to difficulties in daily living to people
- Tissue Viability Nurse – provides specialist clinical advice and support in skin health and complex wound management

Here is the proposed rehabilitation pathway



Please tell us…

We would like your thoughts about what we are proposing.

1. Have we forgotten anything?
2. Could we do things in a better way than we are suggesting?
3. Do you have any other issues that are important to you about rehabilitation on the island?

Thank you

Please let us know your views by 29th June 2015.

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