Bath and North East Somerset (B&NES) Health and Social Services Overview & Scrutiny Panel
Briefing FOR INFORMATION
Potential Re-provision of RNHRD Neuro-Rehabilitation Service

NHS
South of England
Specialised Commissioning Group

NHS
Bath and
North East Somerset

PART 1

Re: Provision of Neuro-Rehabilitation at the Royal National Hospital for Rheumatic Diseases OSC Briefing: For Information & Comment

PCT Sponsoring Director/s:	Jennifer Howell, Interim CEO, NHS Bath and North East Somerset (B&NES) Dominic Tkaczyk, Interim Director of Finance, NHS B&NES Tracey Cox, Associate Director of Commissioning NHS B&NES & Chief Operating Officer (designate), B&NES C.C.G. Craig MacFarlane, Communications & Engagement Lead, NHS B&NES Corinne Edwards, Associated Director for Unplanned Care & Long Term Conditions, NHS B&NES
Specialised Commissioning Team:	Sue Davies, Acting Director of Commissioning, South of England Specialised Commissioning Group, South West Team Esther Giles, Acting Director of Finance, South of England Specialised Commissioning Group, South West Team Arthur Ling, Lead Commissioner for Specialised Neuro-Rehabilitation Services, South of England Specialised Commissioning Group, South West Team Lou Farbus, Head of Public & Patient Engagement, South of England Specialised Commissioning Group, South West Team

1 Purpose of the Report

1.1 To report to the Bath and North East Somerset (B&NES) Health and Social Services Overview & Scrutiny Panel:

- the proposed re-provision of **specialised** neuro-rehabilitation services (inpatient and outpatient) provided at the Royal National Hospital for Rheumatic Diseases (RNHRD's) from April 1st 2013;
- that additional capacity for the provision of level 1/2A neuro-rehabilitation has been identified and agreed in principle with two alternative providers at Level 1 and a wider range of providers at Level 2A to ensure continuous provision from 1st April should scrutiny vote to support this interim re-provision proposal;
- that a programme of stakeholder (patients, carers, public, RNHRD staff and providers) engagement on the short- and long-term provision of neuro-rehabilitation in the South West has been carried out, with due regard given to two extensive reviews of local services recently carried out by Somerset and Devon Local Involvement Networks.

(This paper should be read in conjunction with the Bath & North East Somerset Primary Care Trust's briefing on the re-provision of the non-specialised Outpatient Neuro-rehabilitation service).

2 Decisions / Actions Requested

2.1 The B&NES Health and Social Services Overview & Scrutiny Panel is asked to :

- note that patients from the South West have and will continue to receive the best quality neuro-rehabilitation services that the NHS is able to provide;
- note there have been no issues regarding quality or safety in the RNHRD's decision to cease providing neuro-rehabilitation after the 31st March 2013;
- note the continued high level of quality care and family experience that the recommendations are able to support;
- note commissioners' collaboration with key stakeholders, including patients and the public as well as potential providers, in developing the recommended re-provision option;
- note that proposals should maintain the existing high quality of care without any adverse effect on current in-patients or future access to the service;
- support the proposal for service re-provision in the proposed centres.

3 Background to Neuro-rehabilitation Services

3.1 The Royal National Hospital for Rheumatic Diseases (RNHRD) in Bath specialises in Rheumatology, Neurological Rehabilitation, Fatigue Management and Chronic Pain. As the smallest Foundation Trust in the country it is currently addressing significant financial challenges. It therefore needs to consider carefully the future of any service where patient referrals are reducing.

3.2 The neuro-rehabilitation service provides care for patients requiring either specialised or non–specialised (less complex) care. Specialised rehabilitation is the total active care of patients with a disabling neurological condition, and their families, by a multi-professional team who have undergone recognised specialist training in rehabilitation, led/supported by a consultant trained and accredited in rehabilitation medicine (RM) or neuropsychiatry in the case of cognitive / behavioural rehabilitation.

3.3 Services are identified on the basis of complexity of their caseload.

3.4 Generally, the severity of the condition is broken down into different categories as follows:

- Four categories of rehabilitation need (categories A to D)
- Three different levels of service provision

3.5 Following brain injury or other disabling conditions:

- The majority of patients have category C or D needs and will progress satisfactorily down the care pathway with the help of their local non-specialist rehabilitation services (Level 3).

- Some patients with more complex needs (category B) may require referral to local specialist rehabilitation services (Level 2b).
- A small number of patients with highly complex needs (category A) will require the support of tertiary 'specialised' services (Level 1/2A).

3.6 'Tertiary specialist' rehabilitation services (Level 1/2A) are high cost/low volume services which provide for patients with highly complex rehabilitation needs following illness or injury, that are beyond the scope of their local general and specialist services. These are normally provided in co-ordinated service networks planned over a regional population of 1 to 3 million through collaborative (specialised) commissioning arrangements.

3.7 Levels 2b-d are not specialised services and are therefore currently commissioned by Primary Care Trusts. Level 1 and 2A services are specialised and are the only levels of care that are currently commissioned by specialised commissioning groups. From 1 April 2013 Level 1 and 2A services will be commissioned by the NHS Commissioning Board and non-specialised aspects of the service will be commissioned by Clinical Commissioning Groups (CCGs).

3.8 RNHRD has experienced a steady decline in patient numbers over the last few years, with patients from outside the area particularly, being treated closer to where they live. There have also been new pathways for some of the non–specialised patients. These are appropriate and reflect ongoing changes in the way care is delivered.

3.9 Recognising that specialised services can be subject to fluctuating levels of demand the South West Specialised Commissioning Team's (SWSCT) contract for 2012-3 for inpatient neuro-rehabilitation activity at the RNHRD has been agreed as a 'block with a collar and cap arrangement'. This simply means that commissioners have tried to ensure a reasonably consistent level of income for the provider such that, it receives additional income if over 11 beds are used, but does not have to refund income if only 9 beds are used. However if less than 9 beds are used, the Trust would not receive the full level of income.

3.10 The table below shows that whilst the trend of reducing patient numbers is not the case for specialised patients, the numbers of these patients in any year across the South West and for individual PCTs is low. The overall change in demand when non-specialised referrals are taken into consideration however has meant that the income for the service has reduced by almost 50% over this period. The service went from a peak in August 2010 when the unit provided 578 occupied bed days to August 2012 when activity had reduced to 192 occupied bed days. This has led to the service becoming financially unsustainable and the Trust's decision at the end of December 2012 to cease providing the service after March 2013.

PCT Population	2009-10	2010-11	2011-12	2012-13
Bath & North East Somerset	13	20	20	12
Bournemouth & Poole	0	1	0	0
North Somerset	2	0	1	0
South Gloucestershire	3	1	2	2
Swindon	3	0	0	0
Bristol	2	1	1	1
Cornwall & Isles of Scilly	0	0	1	0
Devon	1	0	0	3
Dorset	0	1	0	0
Gloucestershire	0	0	3	1
Somerset	1	2	4	3
Wiltshire	6	4	2	7
Hampshire	16	13	9	1
All other PCTs	8	5	6	0
Grand total	55	48	49	30

N.B. The table shows the number of patients requiring specialised care over the last 3.5 years because the figures for 2012/13 are for 6 months only.

4 Re-provision

4.1 Since the RNHRD announced its final decision at the end of December the SWSCT have met with the neuro-rehab team at the RNHRD to discuss:

- In the short term, what aspects would be needed in service re-provision. This focused on Levels 1 and 2A (specialised) care only.
- What aspects of the current service staff feel add value.
- In the medium and long term, what aspects of the service would current staff like to see incorporated in a future commissioning plan.

4.2 Looking at annual usage and lengths of stay, the SWSCT identified that it would require 8-9 beds per annum with a split as follows:

- 6-7 Level 1
- 1-2 Level 2

In addition approximately 30-40 patients per annum will need outpatient follow up care following their inpatient admission.

4.3 There are only a few providers in the region able to provide Level 1and 2A care either owing to the complexity of care required and an inability to provide the standards

required for 1and 2A care or lack of capacity to be able to receive additional patients. However, after a series of discussions with various providers of specialised neuro-rehabilitation the following arrangements have now been agreed in principle

4.4 There is provisional agreement from April for the following Level 1 care:

- an additional 2 beds to be provided at Frenchay's Brain Injury Rehabilitation Centre (BIRC) with an additional 3 beds coming available following some building alterations by the end of June 2013. (The BIRC is currently a 24 bedded unit.)
- 2 additional beds at Oxford Centre for Enablement (OCE), from April with the potential to increase to 3 if required. The OCE is a 26 bedded unit currently.

Both of these services will provide follow up outpatient care to any patients admitted.

4.5 There has also been a review of providers which provide level 2A care. There is a wider number of providers which provide this level of care and it has been identified that several of these have capacity .Where appropriate, patients requiring this level of complexity would thus be referred to the most local geographic service. These services are:

- The Plym Rehabilitation Centre, Plymouth
- Rehabilitation unit at Taunton and Somerset NHS Trust
- Glenside
- The Dean Neurological Centre, Gloucestershire
- Swindon BIRT (opening May 2013)
- Rehabilitation unit, Poole General Hospital

4.6 Admissions to the RNHRD have been reviewed over the last two months to ensure that any patients admitted were likely to be discharged by the end of March 2013, to avoid disruption to their inpatient care. This is being closely monitored and it is anticipated that all current inpatients will be discharged by the end of March. Were there to be any change in their condition arrangements will be made to transfer them to BIRC or OCE as appropriate.

A review of all outpatients has also been carried out by the RNHRD clinical team and those requiring further specialised outpatient treatment following a recent inpatient admission will be referred on to BIRC or OCE (or a more local neuro-rehabilitation service if recommended).

5 Local Impact Assessment

5.1 The potential impact of the service change was also considered. For example, the average times/distances (see table below) was calculated by looking at the post code of residence for all inpatients admitted to the RNHRD during the calendar year 2012 and then averaging the journey time to each of the providers by public transport and car.

Averages	Leaving 0900 11/12/2013	Public Transport (minutes)	Car (minutes)	Distance (miles)
RNHRD	BA11RL	64.00	33.67	19.28
BIRC	BS161UU	106.98	41.49	26.27
OCE	OX37HE	174.16	108.84	89.12

- One patient would have had a shorter journey if travelling to the OCE rather than the RNHRD.
- One patient would have less miles to travel if they were to travel to the OCE rather than the RNHRD.
- 12 patients would have less miles to travel if they were to travel to BIRC rather than the RNHRD.
- 14 patients would have had a shorter journey if travelling to the BIRC rather than the RNHRD.
- 31 patients would have had more miles to travel if they were to travel to BIRC rather than the RNHRD.
- 29 patients would have had a longer journey if travelling to the BIRC rather than the RNHRD.

5.2 This shows that the greatest impact in terms of travel is likely to be on families who do not receive a means tested benefit who are visiting people receiving inpatient care and patients receiving outpatient care at OCE. However, only a small proportion of the people from BaNES that may access this service each year are likely to be referred to OCE. In addition, a significant proportion of patients will have less far to travel to BIRC. Moreover, many of those travelling to attend out-patient appointments would also be eligible for support with transport costs either through hospital transport services (such as hospital car or ambulance) or the financial support set out in the Department of Health guidance 'HC11 – Help with NHS Costs'.

5.3 In terms of the potential impact on 'protected' groups, we found no difference in the ability of the current and proposed providers to meet the needs of different patient groups as each patient receiving neuro-rehabilitation is an individual, with very specific needs that require a service that is sufficiently flexible to be able to meet those needs. Consequently, those who deliver neuro-rehabilitation are particularly experienced and skilled in adapting to accommodate the challenges in verbal and written speech and language, mobility, cognition, culture, mood and behaviour that their patients experience. Similarly, every NHS contract (Section B. 14.2.3.) requires all NHS services to provide assurance of how it will meet its equality duties. This supports services to be commissioned, provided and contractually monitored so that they meet the needs of all patients and local communities.

6 Stakeholder Engagement

6.1 As previously stated, the SWSCT met current staff at RNHRD to take their views on the features which were most important for securing service excellence. Here, staff stressed the importance of providing care that was based on best, evidence-based practice, highlighting the importance of staff training and development. Equally, the best neuro-rehabilitation services have multi-disciplinary (having the right range of experts) and inter-disciplinary (mutual respect and understanding of each discipline's expertise) teams that are highly experienced. These teams take a holistic approach by providing facilities for families such as counselling, accommodation for loved ones to stay whilst visiting inpatients and support to prepare families for patients returning home. Facilitating good working relationships with community-based services was also said to important to ensure patients had the greatest chance of a successful discharge.

6.2 This information was used to identify available specialised level 1/2A care that most closely matched the excellent service provided at RNHRD in an attempt to ensure continuity in patient care and family support.

6.3 Specialised and PCT commissioners then worked with an expert patient to jointly develop a programme of public and patient engagement designed around the options for re-provision and targeted at the populations most affected by any potential change in the location of the service. Hence, two public and patient engagement events were held. One at the RNHRD in Bath to make it easier for affected patients and families to attend and one in Taunton, the geographical centre of the South West, for people who lived further afield.

6.4 All information and materials used in relation to the neuro-rehabilitation engagement programme can be viewed at http://www.swscg.org.uk/consultation/ New information will be posted here as it becomes available. For example, stenographers were present at each of the events so that verbatim transcripts of what was said could be made available for people who were unable to attend and people with speech difficulties. The transcripts will be posted on the website soon as the SWSCT receive them.

6.5 At each event commissioners outlined the work carried out and the proposed re-provision options. Lead consultants from BIRC and OCE attended one event each to answer people's questions about the services they deliver and to hear first hand what people said was important to them. The questions that commissioners asked delegates included questions submitted by overview and scrutiny and local involvement network members.

6.6 In total 51 different people attended at least one of the events. Approximately half of these had received neuro-rehabilitation either as a patient or as the loved one of a patient; the rest were professionals who work in neuro-rehabilitation in some way, scrutiny councillors, local involvement network colleagues, or PCT commissioners from across the region. The information they provided was added to information from completed questionnaires. The questionnaire was, and still is, available on the internet (http://www.swscg.org.uk/consultation/). This will remain there until the end of March and any new data added to the final Engagement Report that will be submitted to the National Health Service Commissioning Board (NHS CB) and Clinical Commissioning

Groups (CCGs) that (respectively) take over commissioning the specialised and non-specialised aspects of the service from 1st April 2013.

6.7 In addition to telling commissioners what aspects of the service they regarded as most important, people were encouraged to question the panel. A summary of the questions people asked and the answers that were given is available in Appendix B.

6.8 It would be wrong to provide a summary of the things people said they would want from a new service without acknowledging that the RNHRD's neuro-rehabilitation service and its staff were universally praised and people would prefer for it to continue. Nevertheless it was acknowledged that the repatriation of out of region patients had reduced activity at the service to such an extent that it was no longer sustainable.

6.9 In telling commissioners what the most important aspects of a quality neuro-rehabilitation service were, the following themes were identified.

Staff

- A highly trained and experienced multi-disciplinary team
- Continuity of care from the same multi-disciplinary team throughout the pathway
- Active in research and development
- Good communication between all members of the care team, community based colleagues, patients and families

Holistic Care

- A wide range of therapies available
- Support and facilities for carers
- Access to latest treatments and research studies
- Bespoke care that is needs led
- Regular follow-ups
- Self-referral back into the service after discharge
- Access to community-based interventions/3rd sector support
- Clear referral pathways communicated to all stakeholders
- Emotional and practical support for carers

Travel

- Outpatient care closer to home, with one person suggesting 80 miles would be the furthest they would travel to receive the best outpatient care
- People would travel any distance to access the best in-patient care
- Accommodation for families
- Financial support for those on a low income (travel, parking, radio and TV charges)

Communication

- Access to information that is easy to understand

- Good communication between all those involved in providing support
- The impact of terminology and language (e.g. people who access neuro-rehabilitation services do not like being referred to as a cohort and the term 'spasticity' clinics)

7 Outcome

7.1 The SWSCT has provisionally secured additional beds at both Frenchay BIRC and Oxford OCE. The RNHRD has stopped accepting new referrals and it is anticipated that all current inpatients will have been discharged by the end of March when the service will cease. In the event of a change in a patient's condition arrangements will be put in place to transfer them to BIRC or OCE.

7.2 There is ongoing work to ensure that any current outpatients are referred on to the service of their preference in a timely and uninterrupted manner. However, some outpatient services, such as hydrotherapy, will remain at RNHRD.

8 Expected Benefits

8.1 The additional capacity will be at centres that adhere to the nationally mandated specialised service specification, which outlines the quality standards to be achieved. This is the same specification to which the RNHRD would have worked.

8.2 There will not be a reduced level of capacity in the South West, which means that patients and their families will continue to have the same access to care.

9 Timescales and Next Steps

9.1 The additional capacity has been provisionally agreed to ensure continuity of service delivery.

9.2 The SWSCT is currently preparing 2013/14 contracts.

10 Summary

10.1 The RNHRD has given notice to commissioners that it will cease providing its neuro-rehabilitation service from the end of March 2013.

10.2 The South West Team of the South of England Specialised Commissioning Group has identified alternative providers able to provide a similar complex level of care and has engaged with patients and the public about the proposals.

10.3 It will be possible to re-provide the same level of neuro-rehabilitation capacity at the appropriate levels of complexity currently provided at the RNHRD at the alternative providers (BIRC and OCE for Level 1 care and a slightly wider range of providers for Level 2A care)

11 Recommendations

11.1 The B&NES Health and Social Services Overview & Scrutiny Committee is asked to:

- note that patients from the South West have and will continue to receive the best quality neuro-rehabilitation services that the NHS is able to provide;

- note there have been no issues regarding quality or safety in the RNHRD's decision to cease providing neuro-rehabilitation after the 31st March 2013;
- note the continued high level of quality care and family experience that the recommendations are able to support;
- note commissioners' collaboration with key stakeholders, including patients and the public as well as potential providers, in developing the recommended re-provision option;
- note that proposals should maintain the existing high quality of care without any adverse effect on current in-patients or future access to the service;
- support the proposal for service re-provision in the proposed centres.

Appendix A - Glossary

BIRC	The Brain Injury Rehabilitation Centre in Bristol provides comprehensive assessment, rehabilitation, therapy and community integration programme for people with physical and cognitive impairment and people with challenging behaviour following brain injury. We also provide SMART (Sensory Modality Assessment and Rehabilitation Technique) assessment for people who are in a minimally conscious state. More information about them can be found at: http://huntercombe.com/centre/frenchay-brain-injury-rehabilitation-centre/
BIRT	The Brain Injury Rehabilitation Trust in Swindon is a continuing rehabilitation centre that provides residential rehabilitation for adults with an acquired brain injury showing behavioural and/or cognitive deficits which in turn means lead to complex care needs. Service users may also have pre-existing or concurrent mental health problems in addition to their brain injury and may also be subject to detention under the Mental Health Act. More information about them can be found at: http://www.thedtgroup.org/brain-injury/news/new-service-in-swindon.aspx
CCG	Clinical commissioning groups are groups of GPs that will, from April 2013, be responsible for designing and commissioning local NON-SPECIALISED health services in England. They will do this by commissioning or buying health and care services including: • Elective hospital care • Rehabilitation care • Urgent and emergency care • Most community health services • Mental health and learning disability services
Commissioning	Term used to describe the overall process of planning, funding, procuring (purchasing), and monitoring of healthcare services.
Constraint-induced movement therapy	Constraint-induced movement therapy (CI or CIMT) is a form of rehabilitation therapy that improves upper extremity function in stroke and other central nervous system damage victims by increasing the use of their affected upper limb Types of restraints include a sling or triangular bandage, a splint, a sling. combined with a resting hand splint, a half glove, and a mitt. Determination of the type of restraint used for therapy depends on the required level of safety vs. intensity of therapy.
FES	Functional Electrical Stimulation is a method of using electrical

	stimulation to activate muscles that are weakened or paralysed as a result of neurological disease or injury, e.g. stroke, multiple sclerosis, traumatic brain injury. FES is most often used for the correction of drop foot.
General Medical Clinic	General clinic: all (except those a long distance away) patients ideally 6-8 weeks post discharge in the general clinic, also patients with behaviour, or cognitive or issues such as pain in the general clinic. Patients are referred from the community and from the current in-patient service.
Glenside	Glenside Neuro-rehabilitation Hospital provides a complete range of inpatient medical care and rehabilitation services to adults who are living with severe physical, cognitive or behavioural impairments, resulting from long-term neurological conditions including acquired or traumatic brain injury. More information about them can be found at: http://www.glensidecare.com/
Hydrotherapy	Hydrotherapy involves the use of water for pain relief and treatment. The term encompasses a broad range of approaches and therapeutic methods that take advantage of the physical properties of water, such as temperature and pressure, for therapeutic purposes, to stimulate blood circulation and treat the symptoms of certain conditions.
Inpatient	Inpatient care is the care of patients whose condition requires admission to a hospital.
Local Area Team	Ten of the NHS commissioning board's 27 local area teams will commission specialised services for their whole region.
Neuropsychology	Neuropsychology is the application of neuropsychological knowledge to the assessment, management, and rehabilitation of people who have suffered illness or injury (particularly to the brain). • A Consultant Clinical Psychologist provides an outpatient service one day per week to cover child, adolescent and adult outpatients. • Referrals are from the Consultant in Rehabilitation Medicine, GPs and Solicitors. Typical referral requests relate to assessment and intervention for level of cognitive, emotional or behavioural disorders with people with neurological conditions.
NHS Commissioning Board (NHS CB)	The NHS CB will, from April 2013, be responsible for designing and commissioning SPECIALISED health services in England through local area teams. Specialised services involve complex treatments or packages of care, often for relatively rare conditions. The services may involve the use of very specialised technology and equipment or drugs delivered by a specialist expert workforce. Some, but not all, specialised services are high cost. To be most safe and cost effective specialised services need to be planned and

	commissioned using populations of at least 1 million, which is larger than most Primary Care Trusts/CCGs, with many of the rarer conditions needing much larger planning populations than this. Consequently, specialised services are not provided in every hospital and tend to be found only in larger ones, which perhaps provide a range of specialised services.
OCE	The Oxford Centre for Enablement (OCE) provides specialist neurological rehabilitation services for patients with long-term conditions. More information about them can be found at: http://www.noc.nhs.uk/oce/
OSC	Overview and Scrutiny Committees – Committees established by Local Authorities with social services responsibilities to undertake their powers outlined in the Local Authority (Overview and Scrutiny Health Scrutiny Functions) Regulations 2002. Local Authority Overview and Scrutiny Committees are responsible for monitoring and regulating key service integration. NHS Trusts are required to consult with the Committee with respect to any proposed and significant changes to the pattern or location of local services. In summary, Overview and Scrutiny Committees can: • Review and scrutinise all matters relating to the planning, provision and operation of health services in the area of the local authority. • Make reports and recommendations to local NHS bodies and their local authority on any matter reviewed or scrutinised, and must be consulted by NHS bodies on any proposal for a substantial development or variation in health services. • Have matters referred to them by PPI Forums • Require the attendance of a local NHS body to provide information to them.
Out of Area	Outside of the South West of England
Outpatient	***Outpatient care*** describes medical care or treatment that does not require an overnight stay in a hospital or medical facility. There are several strands to the outpatient service for Neuro-rehabilitation: • General medical clinic • Spasticity clinic (Consultant led) • Physiotherapy (including FES) • Neuropsychology • Counselling • Splinting • Hydrotherapy
Plym(outh) Neuro	The Plym Neuro Rehab Unit is a 15 bedded inpatient neurological

Rehab Unit	rehabilitation unit for adults aged 16 years and over who have suffered an acquired brain injury, spinal cord injury and other neurological conditions. More information about them can be found at: http://www.plymouthcommunityhealthcare.co.uk/services/plym-neurological-rehab-unit
Poole Hospital NHS Foundation Trust	Neurological rehabilitation provides a service for both in-patients and out-patients. 1. For inpatients, an assessment and rehabilitation service is based on the acute medical wards including the acute stroke unit; 2. For outpatients, an ongoing rehabilitation service it offered to patients within the Poole area who have physiotherapy needs. More information about them can be found at: http://www.poole.nhs.uk/our_services/therapy_services.asp
PPE	Public and Patient Engagement refers to a variety of techniques used to ensure members of a community are given meaningful opportunities to influence the public services they receive.
Rehabilitation	Rehabilitation is the 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 psychosocial function, participation in society and quality of living. Patient goals for rehabilitation vary according to the recovery 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, led/supported by a consultant trained and accredited in rehabilitation medicine (RM) or neuropsychiatry in the case of cognitive / behavioural rehabilitation. Services are identified on the basis of complexity of their caseload. Generally, the severity of the condition is broken down into different categories as follows: • Four categories of rehabilitation need (categories A to D) • Three different levels of service provision Following brain injury or other disabling conditions: • The majority of patients have category C or D needs and will progress satisfactorily down the care pathway with the help of their local non-specialist rehabilitation services (Level 3). • Some patients with more complex needs (category B) may require referral to local specialist rehabilitation services (Level

	2b). • A small number of patients with highly complex needs (category A) will require the support of tertiary 'specialised' services (Level 1/2a). 'Tertiary specialist' rehabilitation services (Level 1) are high cost/low volume services which provide for patients with highly complex rehabilitation needs following illness or injury, that are beyond the scope of their local general and specialist services. These are normally provided in co-ordinated service networks planned over a regional population of 1 to 3 million through collaborative (specialised) commissioning arrangements. Level 2b-d are not specialised services and are therefore currently commissioned by Primary Care Trusts. Level 1 and 2a services are specialised and are commissioned by specialised commissioning groups.
Service Specification	Service specifications are drawn up by a commissioner before organisations are invited to put in applications to provide the service. Service specifications describe the service that the commissioner wants provided. They often set the standards required and may include things like staffing arrangements, skills, levels of activity, referral criteria, inpatient care and follow-up.
Sirona Care & Health Community Neuro & Stroke Service (Bath)	The neuro & stroke service can support you if you have had a stroke or have a long term neurological condition such as multiple sclerosis (MS), parkinson's disease (PD) or motor neurone disease (MND). The team has very experienced and skilled therapists, nurses and rehabilitation assistants who can provide advice, support and rehabilitation if you require this.
Social care	The range of services that support the most vulnerable people in society to carry on in their daily lives.
Spasticity Management Service	Physiotherapists have a specific role in the clinic that includes: • Helping to identify the potential for functional improvement through improved spasticity management • Liaising with community therapists regarding functional difficulties associated with spasticity and the benefit of intervention(s) implemented in the clinic • Recording appropriate outcome measures to evaluate the effectiveness of the clinical service and help guide future management • Providing follow up therapy as required; these are usually interventions not available to the patient locally and include Functional Electrical Stimulation, custom made splinting, Constraint Induced Movement Therapy and hydrotherapy.

Specialised Brain Injury Counselling	Specialised Brain Injury Counselling is psychological adjustment work for people who have had a brain injury and also for couples where one partner has a brain injury. It is very specialist and will only be funded where the work is over and beyond that which could be provided by a GP counsellor, or locally by the psychologist in the community team.
Splinting	People with acquired brain injury often experience decreased function in their upper limbs. Splinting is one of the intervention methods widely used to address these issues. Specialist splinting is performed by Neuro Occupational Therapists for patients following a brain injury who have require management of increased or decreased muscle tone. It is often in conjunction with the spasticity clinic to help increase or maintain range of movement. Patients require assessment and then a minimum of one follow up.
The Dean Neurological Centre, Gloucestershire	The Dean delivers specialist 24 hour nursing and therapy services for people with: • Complex long term neurological conditions • Brain or spinal injuries who require ongoing support and assistance to maximise functional ability More information about them can be found at: http://www.ramsayhealth.co.uk/pdf/The_Dean_Booklet_Web_Version.pdf

Appendix B - Neuro-rehab PPE Event Q&A Sessions

The closing of the unit:

What is happening to the staff that work at the unit and their expertise?
Kirstie Matthews, CEO at the RNHRD:

- Very conscious of the challenge the staff now face and acknowledge it is a very difficult and sad situation for all involved
- The Trust is working with all staff to redeploy and seek alternative employment

Has the medical profession been involved in the decision to shut the unit?
CEO at the RNHRD:

- *The decision was taken by the Board which includes our Medical and Nursing Directors*
- The number of patients admitted to the RNHRD and using the outpatient service has and continues to radically decline – 50% in recent years, and the lowest number of patients has been experienced in the last 2-3years
- A certain number of patients is required to support the running of a neuro-rehab unit which the Trust no longer experiences

Where are the patients from Hampshire that used to use the service going?
CEO at the RNHRD:

- Unfortunately I don't have that information to provide.

FES has been an important development for the Trust, what will happen to this facility? I received FES in the past and had an adverse reaction to it, what is in place to prevent this happening to other patients?
Corinne Edwards, Senior Commissioning Manager from B&NES PCT/CCG:

- Q1 – we (B&NES) are in discussion with Sirona to continue this service from 1st April.
- Q2 – There are clear clinical guidelines in place for the use of FES to ensure appropriate use.

What will happen to the training provided by the RNHRD for healthcare professionals in this field with regard the Wiltshire area?
Maddy Ferrari, Commissioner from Wiltshire PCT/CCG:

- Wiltshire CCG will be investing in GWH to provide training going forward but the finer details have not yet been established.

Has it just been good fortune that no new patients have been admitted to the RNHRD in the last two months or have you had to deny access to new patients?
Sue Davies, Acting Director of Specialised Commissioning:

- If the Trust identified that a patient would require treatment beyond the end of March these patients have been admitted to other centres. No waiting lists have been building up during this period.

Delegate comment to commissioners; an article was published in The Telegraph recently reporting that care of patients requiring neuro-rehabilitation was a postcode lottery, particularly in the South West where there is an under-provision of care. If neuro-rehabilitation is under provided in the South

West, why is the unit at the RNHRD being closed when there is clearly a demand; particularly as carer costs etc are far in excess of hospital provision of these services? The service, quality and approach at the RNHRD has been grossly underestimated and should not be disseminated across the region.

Acting Director of Specialised Commissioning:

- A piece of national work has been undertaken recently creating networks of trauma providers and reviewing how care is provided. For example in the South, trauma patients are taken to designated trauma centres at , Plymouth, Southampton, Oxford or Bristol.
- Part of this work means that trauma centres must now prescribe a patient's rehabilitation needs to establish for commissioners what needs to be provided for the patients' ongoing care.
- This encourages a much more joined up approach to working, which will be further enforced in April via the NHSCB. From April, under the NHSCB, there will be greater opportunities to improve services for neuro-rehab patients by working to nationally consistent standards.
- I have not seen the article and am not aware of a view that the South west is under-provided at this complex end of the care pathway. I accept that good rehabilitation can save costs for services and patients in the longer term.
- With regard maintaining the service at the RNHRD, the service has been affected by dropping patient numbers and patients moving away from the Trust. The Trust is a very small and it's financial cost base therefore much smaller than other Trusts. Extra money into the service would not solve the problem.

Dr Henderson-Slater, Clinical Director of OCE and consultant in neuro-rehab:

- The position of the RNHRD is not unique, neuro-rehabilitation centres must have a certain number of patients to remain a safe and effective unit because of the complexities of the service. Units cannot function as small units.

Delegate comment regarding the commissioning process: the commissioning of the service is being undertaken at the wrong level, i.e. Hampshire's decision to move provision to Glenside. The patient demand is still there but the pathway moved elsewhere.

Patients' needs:

Where will we have to go for new equipment or physio when it's not easy for us to travel?
Senior Commissioning Manager from B&NES PCT/CCG:

- Sirona will provide the outpatient service for B&NES patients inc splinting
- Sirona service will be equivalent to the service patients received at The Min

Will we continue to see our current Consultant(s)?

- Each patient will be reviewed on an individual basis and their health needs reviewed
- Will endeavour to ensure continuity and we are working closely with Sirona

Where will other neuro-rehab related services i.e. hydro, orthotics and bone density be provided from?
Chief Operating Officer from &aNES CCG:

- These will continue to be provided at the RNHRD

Comment from a delegate the meeting was not well advertised.
Acting Director of Specialised Commissioning:

- Explained the process of consultation requires a service model(s) to consult on hence why the meetings were called at this stage in the process.

Delegate comment regarding patient funding for travel; patients on low income have to make the journey for treatment before they are assisted with finance.
Acting Director of Specialised Commissioning:

- Agreed that this was an issue. Aware of some charities which might be able to assist with upfront costs.

Head of Public & patient Engagement for Specialised Commissioning:

- Some hospitals or local authorities provide hospital cars or transport free of charge. Funded by charitable means.
- Recognise that this information is often not provided immediately and that patients families often find out from other patients – means of communication need to be improved.

Delegate comment regarding patient funding for travel; travel is particularly difficult in rural areas where funding has been cut over the last few years.

The new service:

Delegate comment: planning a new service should be included in the planning of the closure of an existing service, not as an after thought. It is important to consider that neuro-rehab service cannot be included in a budget, they are expensive and you cannot put a price on the spend or cap it to meet budget restriction.

Comment from a delegate regarding replacing the service at the RNHRD with an equivalent service:
The team at the RNHRD are irreplaceable. If you really wanted to provide an equivalent service, this service should be running now in parallel to the current service to ensure the service is equivalent and to provide a baseline to evaluate the new service against.

What will happen to our medical notes?
Senior Commissioning Manager from B&NES PCT/CCG:

- These will transfer to your new outpatient service.

Are you working with 3rd sector organisations in planning our new service?
Head of Public & Patient Engagement for Specialised Commissioning:

- Some organisations that you will find in the glossary are 3rd sector
- We are working with a variety or organisations
- It is important to remember that once the NHS contracts an organisation to provide a service a standard of care is required regardless of who provides that service.

Are Sirona employing any of the RNHRD staff? It is really important to have continuity of Consultant because they know your details and history.
Senior Commissioning Manager from B&NES PCT/CCG:

- Aware that conversations have taken place with some staff members of the RNHRD and Sirona, but it is a matter for Sirona to pursue

Chief Operating Officer from B&NES CCG:

- Once the new service is confirmed an event will be held as an opportunity for patients to meet the new service staff

What will happen to the capacity at the hospitals that will take new neuro-rehab patients that would have been treated at the RNHRD, how will they cope with the extra patients?
Acting Director of Specialised Commissioning:

- The new centres are in the process of putting in additional beds.
- Transferring patients who would have been treated at the RNHRD to another service will not prevent other patients being treated because extra,beds are being created, rather than expecting existing capacity to cope.

How do we have confidence in the commissioning process for our service if Hampshire has not and does not send patients here?

Head of Public & patient Engagement for Specialised Commissioning:
The decision about where a patient receives treatment is not *always* specified and is dependent on patient choice:

- The patient decides what distance they are prepared to travel
- The patient wants the best care possible according to them and their needs
- From 1st April when the NHSCB is in place, commissioning will be more consistent across England which will allow for greater linkage between centres and a common standard of care across centres

Acting Director of Specialised Commissioning:

- OCE and BIRC offer a very good standard of all level services, comparable to the RNHRD

Dr Graham, Lead consultant at BIRC:

- BIRC is very similar to the RNHRD with an interdisciplinary team.
- Each patient is treated as an individual and their family and friends supported

Delegate comment regarding care at Frenchay; I had a terrible experience at Frenchay because I was seen by a consultant who was not involved with my case, the treatment was impersonal and damaging to my health.

Acting Director of Specialised Commissioning:

- Our job as commissioners is to ensure linkage in the care pathway and to try to prevent negative experiences like this occurring.

Health professional (delegate):

- I have worked with many neuro-rehab patients from a commissioning stance and can assure you that *all* patients feel the same passion you do about your unit; there are other excellent providers of this service *in addition to* the RNHRD.

Dr David Henderson-Slater, could you describe the facility at the OCE so we can get a feel for the service?

- Location: close to a ring road and 1.5miles from a train station.
- 26 beds, 16 allocated to the Oxford region, the remaining 10 take patients from out of area i.e. the South West.

- OCE has taken patients or provided some services to patients from out of region for a number of years now but not in the formal contracted environment that will be in place from 1st April 2013.
- OCE also provides prosthetic services for in and out of region patients.
- Has the capacity to provide more beds If required with minimal disruption
- Multi-disciplinary, large team approx 150 or all types of healthcare professional and a team of consultants with different but complimentary speciality interests.
- New building (approx 11 years old), built to high specification, low level of infection rate, excellent quality of care.

Delegate comment regarding repatriation; the repatriation of patients in area is difficult due to local capacity issues.

Acting Director of Specialised Commissioning:

- Work is required in region in April when the new organisations are in place to establish links between the providers/system and local areas.

Your thoughts on what you would like the new service to look like:

Tell us what you think is brilliant about your current service so we can put this in to your new service:

- The staff and the high level of care they give
- Physio's are highly skilled and personal
- Communication – internally and externally, particularly links with the community
- Holistic approach to patients and their involved friends and family

What do you think we can improve upon when designing your new service?

- Greater access to the RNHRD (or new service) once you have left the outpatient register, i.e. to self refer back to the service
- To spread the word about the capabilities and expertise of the staff at the RNHRD
- A joined up pathway/approach with:
    - Neuro-oncology
    - Young people – a specific pathway, accounting for their ability to be able to recover due to their age
    - Non-traumatic spinal injury
    - Mental health and acquired brain injury
    - Spinal cord injury
- Better support of family and friends to be able to support the patient
- With reference the Dorset service, but relating to the South West generally:
    - A specialised brain injury unit
    - A linking specialised acute unit and transition rehab unit
    - To follow a non-medical model – balance of power between clinician and patient led care model
    - Group and individual support sessions – to listened to in an open, encouraging and supporting environment
    - The ability to speak to all level of service user/provider, i.e. not be protected from some environments because it's not felt appropriate
    - Connected network of 'people who know', patients talking to patients, relatives talking to relatives
    - Range of information types that enables decision making

    - Families at the heart of the service
- Charities providing joint services with the NHS as opposed to just private organisations.

What would you like your new service to look like?

- One multidisciplinary centre that can provide all services
- Accommodation for family of patients on site who have to travel long distances
    - Support for relatives to make them feel safe and supported – emotional support, information about the local area
    - Comment from delegate: this support comes from having the *best* team looking after and treating the *individual.*
- Holistic approach
- Care plan post discharge – care seems to become dormant upon discharge from the hospital
  David Henderson-Slater:
    - Could look into the financial and clinical viability of opening a peripheral OCE clinic in the Bath/Bristol area. Sue Davies: we would need to review this idea in more detail to establish the volume of patients to support such a service
      Consultants are not encouraged to make routine follow up appointments with patients but for patients to make appointments as and when problems or issues arise. What do commissioners think of this process? Sue Davies commented that she would be open to reviewing this and had seen it work in high volume services.

Delegate comment regarding linking to local services; reiterated the need for providers linking with local services to ensure continuity of care for patients. Training for local services with the provider would be useful in establishing these links and ensuring continuity.

David Henderson-Slater:

- Brain injury patients often relapse after many years of improved health so it is important to links back into the service once a patient has been discharged.

How will the new service be funded within the new system and ensure that patients are not prevented or delayed treatment due to access criteria or similar?

Acting Director of Specialised Commissioning:

- Currently around the patch some services do require assessment prior to treatment, but it has been variable. We will be looking for a consistent approach. It is not yet clear whether there will be a formal assessment criteria in this area.

Chief Operating Officer from BaNES CCG:

- In B&NES assessment prior to treatment is undertaken but to ensure the patient is assigned to the most appropriate services.

Arthur Ling, commissioner for specialised commissioning:

- The team is working with CCGs to develop a consistent commissioning approach for the region. The NHSCB has developed a number of service specifications which can be used to assist this.