NHS
Bath and
North East Somerset

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Clinical Commissioning Group

Re-Provision of Outpatient Neuro-Rehabilitation Services

1 Purpose

This paper provides an overview of the current outpatient neuro-rehabilitation service at the RNHRD and the proposals to re-provide the non-specialised service including arrangements for communicating these changes to patients. The non-specialised elements of the outpatient service includes service arrangements for patients who are stepping down from more intensive follow-up arrangements at between 6-12 months after an inpatient stay and for patients who may have been referred for outpatient neuro-rehabilitation support from primary care. This could be by their GP or from another health care professional such as a district nurse.

(This paper should be read in conjunction with the South of England Specialised Commissioning Group's Briefing on the re-provision of the specialist Inpatient and Outpatient Neuro-rehabilitation service).

2 Description of service

There are several strands to the outpatient service for Neuro rehabilitation at the RNHRD. These include:

- General medical clinic
- Spasticity clinic (Consultant led)
- Physiotherapy (including Functional Electrical Stimulation)
- Psychology
- Counselling
- Splinting / orthotics

A description of each of these service components in set out in Annex 1.

3 Current Patient Activity

The current patient activity by geographical area that has been overseen by the Consultant led service is set out below in Table 1:

Table 1:

Primary Care Trust/ CCG Area	Total
B&NES	49
Wiltshire	54
Somerset	14
S. Gloucestershire	3
Bristol	4
Other	10
Total	134

This shows that the largest group of patients are from B&NES (37%) and Wiltshire (40%) and with 23% of patients coming from other geographical areas.

In addition there is a group of patients who are provided with outpatient therapy for physiotherapy and Functional Electrical Stimulation, Psychology, Counselling, Splinting and orthotics provision.

4 What is Important to Patients in Re-providing this Service?

The outputs from the patient engagement events that were held on Friday 1st March and Friday 8th March 2013 are set out in detail in attached accompanying papers. These events were very useful in identifying what is important to patients in re-provision arrangements. These include services that are:

- Patient centred and provide holistic care
- Are able to ensure there is excellent communication between service professionals within the team and with external professionals e.g. the patient's GP
- Focused on the needs of families as well as patients
- Have highly trained and experienced staff who understand patients conditions and can offer support and advice
- Staff have access to training to ensure they are providing the best possible care
- Links with voluntary sector organisations such as Headway are important

5 Re-provision Arrangements for Patients

This section of the paper describes an overview of re-provision arrangements for patients for all geographical areas but with more detailed information on future service arrangements for B&NES patients.

5.1 Future service arrangements for B&NES patients

From the 1st April 2013 an out-patient neuro-rehabilitation service will be provided by Sirona Care and Health. This is the current provider of community health and social care services for B&NES.

They currently provide a Community Neurological Rehabilitation & Stroke Service which supports patients who have had a stroke and for patients with other long term neurological conditions such as Multiple Sclerosis and Motor Neurone Disease.

Proposed Service model:

Due to the diagnoses of the patients requiring this service it is considered that day-time weekday clinics would be the most suitable for this client group. Based on patient activity reported by the RNHRD it is proposed that the following will be required;

- 1 x Clinical Specialist Physiotherapist (Band 7) OP session per week
- 1 x Orthotics / Clinical Specialist Occupational Therapist (Band 7) per month
- 1 x Consultant led OP clinic per week (2 x follow-up and review and 2 x spasticity management per month)
- 1 x Clinical Specialist Physiotherapist (Band 7) to attend spasticity management clinics (x2 per month)
- 1 x Clinical Specialist (Band 7) session per week to manage and support the assessment, monitoring, review and discharge planning of B&NES patients referred for admission to specialist brain injury units.

The service will be based in the Therapy department at St. Martin's Hospital in Bath. This has purpose built therapy facilities and offers good access to patients in terms of parking facilities. St. Martin's Hospital is approximately 3 miles and a 10 minute drive from the RNHRD and the centre of Bath.

At the request of NHS Somerset and Somerset Clinical Commissioning Group this service will also be provided to Somerset patients who have or would previously have been treated by the RNHRD for outpatient neuro-rehabilitation provision. This is for patients who are geographically based in the Mendip locality.

Service arrangements will be formally reviewed with Sirona after 6 months to ensure that the service is able to fully meet patients' requirements or sooner at either the request of B&NES Clinical Commissioning Group or Sirona Care and Health. However, it is the aim of commissioners and Sirona Care and Health to offer an equivalent and high quality service. This will be supported through an on-going engagement process with patients.

5.2 Future service arrangements for Wiltshire and patients from other geographical areas

From the 1st April 2013 an out-patient neuro-rehabilitation service for patients registered with a Wiltshire GP will be provided by Great Western Community Services, the current provider of community health care services in Wiltshire.

Patients from other geographical areas will be re-patriated back to local services. Commissioners from these areas have been provided with patient level lists of their patients including details of their care needs so that appropriate alternative arrangements can be made.

5.3 Other related and linked services at the RNHRD

The public engagement events highlighted that many patients were concerned about on-going arrangements for other services that are provided by the RNHRD but that form part of their overall care package. This included on-going arrangements for patients who have support from the Orthotic service provided by Mr Elmer and the hydrotherapy service.

These services will remain in place at the RNHRD and patients will be able to access these services in the usual way.

6 Communication with Patients about Future Service Arrangements

All affected patients have been contacted by the RNHRD to explain to them that the Neurological Rehabilitation service is closing after Thursday 28th March 2013 and that alternative arrangements are being put in place. Each patient will receive a further letter to advise them of the name and contact details of the new service provider. Patients will be advised that their clinical case records will be transferred to the new provider and that if they are not happy for their clinical details to be shared that they contact the RNHRD.

7 Equalities Impact

An equalities impact assessment on the re-provision of the non-specialised elements of the outpatients is being completed and the findings of which will be made available to the Well-being Policy Development & Scrutiny Panel on 22nd March 2013. (Unfortunately due to the timing and deadline of papers required for the meeting it was not possible to complete this analysis at the time of writing). The impact assessment will look at all protected characteristics.

8 Recommendations and Next Steps

The Well-being Policy Development & Scrutiny Panel is asked to note and comment on the re-provision arrangements for non-specialised outpatient neuro-rehabilitation services.

NHS B&NES PCT and Bath & North East Somerset Clinical Commissioning Group will continue to progress transfer arrangements for B&NES and Somerset patients to Sirona Care and Health and to continue to liaise with other commissioners to ensure that all patients have on-going arrangements in place.

Contact person	Tracey Cox, Chief Operating Officer, B&NES CCG. Tel 01225 831736, or Corinne Edwards, Senior Commissioning Manager for Unplanned Care & Long Term Conditions, B&NES CCG Tel: 01225 831868
Background papers	December 2012 Briefing to the Health and Well-being Panel on Neuro-rehabilitation services at the RNHRD
Please contact the report author if you need to access this report in an alternative format	

Annex 1 - Description of Outpatient Neuro-rehabilitation Services

Consultant Led Outpatients

- General clinic: all 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. (Specialised services until 6-12 months post discharge).Patients are referred from the community (can be GP or AHP/community nursing) and from the current in-patient service.
- The spasticity clinic is led by a consultant supported by a physiotherapist. Some of these patients can be very complex and require an hour's appointment as they may need to be hoisted or have complex communication need e.g. touch sign language

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.
- Treatment packages are modular and consist of 4 to12 hour-long sessions depending on the requirements.
- Treatment delivery will be individually tailored and involve the patient with the carer/family if a behavioural component is required.
- Referrals are currently received at the rate of 2 per month.

Neurological Physiotherapy in the Spasticity Management Service

Experienced (band 7) physiotherapist's work alongside the medical team in the spasticity clinic as recommended in National Guidelines[1]. The 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.

Functional Electrical Stimulation (FES) Service

FES 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.

Experienced (Band 7) physiotherapists at the RNHRD are able to provide an FES service to patients who have funding approval from their local commissioning team. Provision is based on NICE and Royal College of Physicians guidelines[2,3].

An initial assessment is performed to establish if FES will be helpful in reducing the risk of trips/falls and in reducing the effort of walking. It may also be used as part of spasticity management, as an adjunct to botulinum toxin injections and in upper limb rehabilitation.

Outcome measures including walking velocity, falls efficacy scale and effort of walking are used to evaluate the effectiveness of the intervention.

If suitable, patients and/or their carer's are educated in the use of the device and issued with equipment to take home to assist their walking. Follow-up appointments are usually given at around 2 weeks, 6 weeks and 3 months for initial support in using the device. This is reduced to 6 monthly reviews to ensure appropriate and effective use of the FES device in the long term.

Specialised Brain Injury Counselling

The referrals are usually for 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 is provided 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

Specialist splinting is performed by the neuro OTs 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