Healthcare for London

NHS

The shape of things to come

Whole pathway assurance – rehabilitation
Major trauma

Appendix 6f

Contents

1 Introduction

The aim of this paper is to provide the JCPCT with assurance that issues associated with rehabilitation are unlikely to cause any derailment to the plan to introduce a London trauma system; nor will the establishment of the system have a detrimental effect on current rehabilitation provision. It will also provide detail of other factors which should be considered in the decision making process and provide an overview of the current Healthcare for London rehabilitation workstream.

This will be presented in two parts:

- Part A provides assurance that there is nothing to indicate that the implementation of the major trauma system or any of the options set out in the consultation document would have a detrimental effect on rehabilitation.
- Part B provides an overview of the current work taking place in preparation for the establishment of the system with regard to the development of services associated with rehabilitation.

2 Executive summary

Part A – Assurance
Factors that determine whether a particular decision or option should be discounted

There is no indication that delivery of rehabilitation will be detrimentally affected by the establishment of a major trauma system for London, nor by the number of networks developed.

Other factors which may influence a decision

There will be potentially beneficial opportunities arising from systemisation and network development. The analysis of the consultation highlights the importance of addressing the rehabilitation issues associated with major trauma *(see Part B below).*

Part B – Supplementary information
This workstream will undertake 10 key pieces of work to underpin the development and improvement of rehabilitative aspects of the system. These have evolved from the work undertaken last year to identify the problems currently experienced with delivery of rehabilitation.

3 Scope and context

At the outset, the Healthcare for London major trauma project recognised that the organisation and delivery of rehabilitation for this patient group is complex. This is not least because, until recently, major trauma was not a formally recognised care pathway. In addition, although multiple problems require the involvement of multiple professions and organisations, there was little consistency of provision across the health economy. The first phase of this work was a review of the rehabilitation services for this patient group in the capital, commissioned in 2008.

In May 2009 a formal workstream for trauma rehabilitation was set up within the Healthcare for London project, tasked with taking the work forward to the next stage (including producing a set of recommendations). This paper provides information on the current understanding of the potential impact of establishing a major trauma system on the delivery of rehabilitation to this patient population. In addition, a summary of the previous work and overview of current deliverables of the Healthcare for London rehabilitation workstream are provided.

4 Part A – Assurance

Factors that determine whether a particular decision or option should be discounted

Rehabilitation is unlikely to be any worse as a result of implementing the London trauma system. The number of trauma networks (i.e. three or four) does not appear to have an impact on the proposals for rehabilitation.

Other factors which may influence a decision

No other factors associated with rehabilitation have been identified which may influence the configuration decision. However, the broader issues regarding rehabilitation which require attention are set out in the section below.

5 Part B – Supplementary information relating to implementation and workstream deliverables

5.1 Introduction to Part B

There are early indications that rehabilitation could be improved as a direct result of a London trauma system which concentrates resources in a defined number of networks, supported by some early 'quick win' recommendations from this workstream. These focus on the co-ordination of existing rehabilitation provision and communication between organisations and professionals. The network model is seen as an important vehicle for supporting this approach.

The London trauma system concentrates resources for major trauma in fewer centres which will require flow to be maintained in order to be successful. Rehabilitation and repatriation play a critical role in this, and therefore major trauma centres will be expected to demonstrate their ability to manage the early phase of rehabilitation and demonstrate a joined-up approach with the other providers in their networks.

The analysis of the public consultation on major trauma by Ipsos MORI highlights the importance to respondents of addressing rehabilitation aspects of the system. This is echoed by the recommendations put forward by the Joint Health Overview and Scrutiny Committee (JHOSC) and the findings of the Integrated Impact Assessment (IIA) which has been commissioned by Healthcare for London. These views can be summarised as follows:

- rehabilitation is crucial to the success of the system. In future phases of work it should be given the same priority as the early part of the pathway;

- future consultations by the JCPCT should address the whole care pathway, rather than concentrating predominantly on a particular element, such as acute care;

- the Association of Directors of Adult Social Services (ADASS) and London Councils (as well as London local authorities and social services authorities bordering London) need to be engaged more fully in developing plans for a seamless care pathway;

- the JCPCT should undertake an audit of rehabilitative trauma services across London, with a view to determining:
  - which PCTs need to invest more in rehabilitation; and their capacity to fund this further investment;
  - the capacity of PCTs to put in place follow-up teams at trauma centres to take responsibility for ensuring that once a patient is discharged, they do not 'fall through the care net';
  - a mechanism for JCPCT assurance that all PCTs are in a position to ensure consistency of access to rehabilitative care across London.

- there should be early involvement of hospital social work teams in planning longer-term care pathways following initial clinical treatment;

- assessment of joint financial incentives needs to be undertaken, in order to allow more co-ordinated investment in enhanced community-based resources to be achieved;

- staff on wards should possess relevant neuro-training as part of achieving high-quality rehabilitation;

- specialised neuro-rehabilitation services should be linked into the work of the trauma networks and that all PCTs provide multi-specialist rehabilitation.

5.1.1 Rehabilitation workstream report, September 2008[1]

This work focused on adults who have sustained major traumatic injuries, and aimed to cover the rehabilitation pathway in its entirety - from critical care through to the achievement of maximum functional potential and discharge from services; definitive care package; and/or ongoing case-management. The intention at this stage was not to be specific or prescriptive in how rehabilitation should be provided following major trauma, but rather to establish what the overarching problems are and how these impact upon rehabilitation provision. Information was gathered through focus groups and general discussion with clinicians involved in the delivery of rehabilitation and associated services, and from service users on the major trauma project's patient panel. Comment and general agreement was sought from these groups on the conclusions drawn and suggestions made within the report. In addition, providers of specialised regional services were consulted as part of the process, including the military rehabilitation facility at Headley Court. The key findings of the report are outlined below:

- the spectrum of rehabilitation needs within the major trauma population is broad. By addressing the problems with provision of rehabilitation for this group, the needs of other less-severely injured patients are also likely to be better met;

[1] Worrall B (2008), Rehabilitation Workstream Report, Healthcare for London

- the range of rehabilitation pathways followed by major trauma patients is necessarily diverse. It is important to have the range and flexibility of services in order to meet needs in a patient-centred way;

- in order to ensure that patients achieve their maximum functional potential, including return to paid employment wherever possible, services need to be developed which are comprehensive, consistent and collaborative in their approaches to rehabilitation and social care delivery;

- clear, consistent standards, governance structures and data management are needed to underpin effective and efficient functioning of the rehabilitation aspects of the system. This will enable the system to be able to accurately evaluate provision and develop services to improve outcomes.

The report identified problems with the existing system in the following areas:

- co-ordination of health and social care and navigation through the system;
- cross-boundary working, including policies, knowledge and access to equipment and adaptations;
- repatriation;
- access to rehabilitation services;
- service delivery and access;
- data management;
- housing and immigration issues.

Table 1 outlines the strategies to address the inequalities and inefficiencies in the current system. These are being addressed through the rehabilitation workstream deliverables set out in Table 2 on the following page.

Table 1: Developing a strategy for trauma rehabilitation

1. Service delivery models and structure	**2. Workforce**
• Development of acute rehabilitation facilities • Common standards and policies • Governance opportunities • Shared care models	• Development of a workforce model • Workforce development plan • Case management/co-ordination
3. Information	**4. Capacity**
• Development of common data standards across the system • Directory of services	• Detailed capacity analysis of services contributing to major trauma rehabilitation

5.2 Rehabilitation workstream – project plan

5.2.1 Preliminary work – rehabilitation service specification

The original designation criteria references rehabilitation. However at the time of the bidding process it was recognised that the focus needed to be on pre-hospital care and early management of patients since this follows the natural sequence of the pathways along which patients travel. It was always intended that further work would

be undertaken to enhance the rehabilitation aspects of the service specifications. The report produced in 2008 initiated the work now being progressed by this workstream[1]. It also takes into account the recommendations from the JHOSC.

The service specifications used for the designation of major trauma networks has been reviewed and updated to indicate requirements for rehabilitation. This updated version will be reviewed and agreed by an expert panel to be set up with the support of the London trauma director. A phased approach may be necessary to achieve the specifications.

At this stage, the service specifications for rehabilitation focus on the acute phase of care which takes place within the major trauma and trauma centres (in line with the original framework). However, it is recognised that rehabilitation stretches far beyond the acute phase and therefore further additions to reflect the requirements of the longer term community-based rehabilitation phase will need to be developed once the system is established (see JHOSC recommendations above).

5.2.2 High-level overview of the project deliverables

Table 2 outlines the intended deliverables of this workstream. These represent the practical ways in which the strategies outlined above in Table 1, and key recommendations from the JHOSC, can be implemented. The direct links between the strategy (Table 1) and the deliverables of the workstream are referenced in column three in the table below. For example, development of the navigation model (deliverable 5), which includes a defined role in co-ordinating the rehabilitation pathway, addresses elements of sections one, two and three of the strategy.

Table 2: Workstream deliverables

Deliverable	Description	Strategy link	Phase one	Phase two	Phase three
1	Service specification	1, 2, 3, 4	✓		✓
2	Acute rehabilitation service	1, 2, 4	✓	✓	✓
3	Trauma rehabilitation pathway	1, 2, 3	✓	✓	✓
4	Core rehabilitation data-set	3, 4	✓	✓	✓
5	Navigation model	1, 2, 3	✓	✓	
6	Directory of services	3		✓	✓
7	Documentation	1, 3	✓	✓	✓
8	Clinical governance	1, 2, 3, 4		✓	✓
9	Evaluation			✓	
10	Outline of future work			✓	

This project plan will be delivered in a series of phases:

- Phase 1 – May to June 2009
- Phase 2 – July to mid-August 2009
- Phase 3 – continues and extends the work of Phase 2 and also focuses on embedding outputs from Phases 1 and 2, which are deemed viable. The latter will be determined by commissioners of the networks and the London trauma office. Resourcing of Phase 3 is yet to be confirmed.

5.2.3 Description of deliverables

Deliverable 1 – Development and agreement of major trauma centre and trauma centre rehabilitation service specifications

The original designation criteria contained 'greyed out' areas in the rehabilitation section, indicating that further service specifications were to be developed. These had been drafted as part of the preliminary work of the rehabilitation workstream and now need to be scrutinised and reviewed by a panel of rehabilitation experts. This will ensure they reasonably reflect the minimum requirements to deliver rehabilitation services in both major trauma centres and trauma centres, whilst acknowledging the need for further enhancements of these specifications in the future. Once agreed by the panel, Healthcare for London and/or the London trauma office, these specifications will be rolled out to the networks to guide service delivery.

Proposed timescale: agreement by mid August 2009.

Deliverable 2 – Service model for an acute rehabilitation service for major trauma patients

A paper will be provided detailing the rationale, estimated volume requirements and potential delivery models for acute rehabilitation for complex and polytrauma. This is based on a service model developed for neuro-rehabilitation designed to improve patient outcomes and efficiency. This is a service which is more intensive and therefore distinct from, and in addition to, the rehabilitation delivered during the acute phase of recovery. This phase will largely take place in the major trauma centres and trauma centres. At present no such service exists for polytrauma within the UK as far as can be determined (other than Headley Court) and the absence of this was highlighted by the 2008 report. The model will be tailored to the major trauma population and emergent system for London.

Proposed timescale: mid July 2009.

Deliverable 3 – Pathway for major trauma rehabilitation

An overview pathway will be produced outlining key milestones, critical decision points, interventions, competencies, resources and facilities required to deliver effective and efficient rehabilitation to major trauma patients. This will encompass existing guidance; for example the NICE critical illness rehabilitation guidelines[2], and will provide a framework for assimilation of relevant information, such as guidelines, policies and protocols, developed through the London trauma office and the networks. The intention is to develop this in conjunction with experts from the field of rehabilitation. A forum for engagement of appropriate experienced healthcare professionals will be developed once the London trauma director is in post.

Proposed timescale: overview of entire pathway by mid August 2009; further development of detailed proposals will be ongoing.

Deliverable 4 – Core rehabilitation dataset

Performance metrics for rehabilitation aspects of the major trauma system will be identified and contributions will be made to the development of a performance management framework in partnership with the Trauma Audit & Research Network (TARN). This dataset intends to enable accurate and effective review and evaluation

[2] NICE (2009), Critical Illness Rehabilitation Guidance, http://guidance.nice.org.uk/CG83 (accessed 12.06.09)

of rehabilitation aspects of the trauma system. This work will include consideration of the practicalities of collection within, and across, different organisations.

Proposed timescale: mid August 2009.

Deliverable 5 – Rehabilitation navigation

An understanding of the skills required to facilitate the patient pathway through the process of rehabilitation will be developed using models from other countries and other care pathways where these roles have already proved successful. An example job description for a complex-case manager, or navigator, for the major trauma centres will be developed and banded. In addition, suggestions will be made for the establishment of key workers in community settings. This will facilitate the transition of patients between organisations and provide ongoing support after discharge from inpatient settings. This work can be distributed to networks to give an overview of potential benefits and associated finances. This paper will also include references to other elements of the workstream that are designed to facilitate patients' progression along their rehabilitation pathway, such as the prescription for rehabilitation, shared documentation and governance arrangements.

Proposed timescales: for distribution to networks end July 2009.

Deliverable 6 – Directory of services

A scoping document will inform the development of a directory of health and social care services that relate to the rehabilitation pathways for the London trauma networks.

This resource is essential to improve the efficiency of planning and executing patient transitions between organisations. This resource will allow clinicians to have easy access to up-to-date and local information about services that their patients may require, thus enabling timely and appropriate referrals. It is proposed that a resource specification will also be developed as part of this phase, with the development of the directory outsourced to a specialist provider.

Proposed timescale: resource specification mid August 2009 for tendering. Resource goes live April 2010.

Deliverable 7 – Documentation for rehabilitation

It has been recognised that a common approach to trauma documentation supported through the London trauma office would be beneficial in facilitating pathways and data collection in a more consistent manner. A draft framework for documentation of the rehabilitation aspects will be developed. This will provide a centralised record of rehabilitation assessments, goals and interventions during the patient's acute phase of care. In addition, the scope and purpose of a prescription for rehabilitation will be considered. The documentation structures outlined will facilitate the achievement and monitoring of performance measures and indicators which links to deliverable four.

Proposed timescale: draft documentation and briefing paper by mid August 2009.

Deliverable 8 – Outline potential clinical governance structures for major trauma rehabilitation

This will support the ongoing delivery and development of the rehabilitation aspects of the major trauma system. An overarching governance framework will be developed that will reflect and complement the governance structures used by other

parts of the system in particular those used by the medical profession such as case reviews. This framework will have key links to other elements of the workstream such as the development of the pathway, documentation and data management. It is proposed that this work will also outline other initiatives such as multi-professional, cross-network case reviews and suggestions for future developments.

Proposed timescale: paper outlining clinical governance framework and structures mid August 2009.

Deliverable 9 – Evaluation

A summary paper will indicate how the deliverables of this workstream will address the identified problems in the current system evaluating their potential impact, to enable the London trauma office and commissioners to prioritise and implement the products of this workstream.

Proposed timescale: evaluation paper completed mid August 2009.

Deliverable 10 – Development of future work plan

This rehabilitation workstream will culminate in the development of a paper outlining suggestions for the future development of trauma rehabilitation. This plan is likely to include the following:

- audit, evaluation and analysis of rehabilitation services to establish an accurate demand:capacity ratio – as recommended by the JHOSC and the IIA;
- establishment of initiatives to support the ongoing development of the pathway, and associated system and workforce requirements;
- exploring the use of patient goal setting as an outcome measure;
- development of the potential commissioning model based on outcomes – linked to opportunities arising from Commissioning for Quality and Innovation (CQUIN);
- an intensive rehabilitation model for polytrauma potentially developed in partnership with the existing specialised neuro-rehabilitation and spinal services and with the military (i.e. Headley Court);
- consideration of the role of shared care models within networks to better enable delivery of care in local services, facilitate patients' progression along the rehabilitation pathway and develop skills across the workforce.

The future work plan will include any other opportunities or initiatives identified through the current phase of the workstream.

Proposed timescale: mid August 2009.

Whilst it is proposed that a full cost-benefit evaluation of the above solutions is undertaken, it is also acknowledged that in the current economic climate solutions which aim to make the most efficient use of existing resources should be prioritised (for example, the navigator roles, prescription for rehabilitation, data collection, documentation and network governance). This aligns with the discussions held with Keith Willett, National Clinical Director for Trauma Care, and gives consideration to the importance of maximising efficiency of existing provision in the first instance.

5.3 Links to other work

A number of the strategies (Table 1) and the workstream deliverables outlined above cross-reference to other Commissioning Support for London (CSL) and NHS London initiatives:

5.3.1 Links to continuing professional development (CPD) framework for major trauma

The continuing professional development (CPD) Project is being set up to establish a framework for professional development of allied health professionals working with major trauma patients throughout recovery and rehabilitation. The intention is to identify the skills required and map these to *Skills for Health* and the *Knowledge and Skills Framework*, and design a specification for an associated education programme and network supervision function. This addresses key aspects of section two of the strategy (Table 1). There are important links between this CPD project, the rehabilitation workstream and the NHS London workforce initiative (see below). These links will be established and maintained through regular contact across all project teams.

5.3.2 Development of expert panel for rehabilitation

It may be appropriate to create an expert panel (similar to that established for the designation phase of the trauma project) to scrutinise and inform suggestions made by the products of this workstream.

5.3.3 NHS London workforce initiative

The People and Organisational Development Directorate (POD) within NHS London is responsible for considering London's future healthcare workforce needs. Close links will be developed to ensure that the workforce implications associated with the recommendations and suggestions made as part of the rehabilitation workstream are incorporated into the work being undertaken by POD.

5.3.4 Stroke project

There is some congruence between the rehabilitation services required for stroke patients and those who have sustained traumatic injuries. The synergies will be explored and links will be forged as appropriate. The CPD framework development is being run as a project in conjunction with the stroke project which will therefore facilitate this process.

6 Conclusion

This paper provides assurance to the JCPCT that whilst rehabilitation for major trauma is a deeply complex area with recognised gaps in service provision and co-ordination, it is unlikely that these will decline further as a result of implementing the London trauma system. On the contrary, early indications contribute to the view that the London model, which concentrates co-ordination of clinical expertise into defined number of networks, will create a helpful framework for the ongoing development of rehabilitation systems.