Midlands Critical Care & Trauma Networks NHS

Rehabilitation Coordinator Workshop

24th June 2015

Midlands Trauma Network Offices, Birmingham

Background & Reason for the workshop

The Midlands Trauma Networks are a collective group of networks that include the:

- Birmingham, Black Country, Hereford and Worcester Trauma Network
- Central England Trauma Network
- North West Midlands and North Wales Trauma Network

Since Go-Live on 26th March 2012, we have endeavoured to bring together the wide group of professionals involved in the coordination of rehabilitation for our population of trauma patients.

Early on, we ran Rehabilitation Network meetings and workshops, that helped steer the work plans but we have never felt we have a full and clear picture of staff numbers, contacts, roles and responsibilities. Early in 2015, we took part in the National Peer Review visits to trauma units, major trauma centres and networks. This showed there were far more staff performing rehabilitation coordination than we realised and that problems with repatriation and rehabilitation prescriptions were significant. To explore this further, we organised the Rehabiliation Coordinator Workshop.

Delegate Breakdown

- The workshop was attended by 38 people, with representation from:
- MTCs: 4/4 by 14 staff
- TUs: 10/13 by 20 staff (excludes North Wales)
- LEHs 1/7 by 1 staff member
- Specialised Rehab Centres 2/3
- Network Staff 2

MTC, TU & LEH STAFF ONLY BREAKDOWN

	OT	Rehab Cons	Therapy Team Leader/ Manager	Sister/ Nurse	Rehab Keyworker	Physio/ Lead/ Specialist	Rehab Coord	T/O Coord	Total
TU	1	0	3	5	0	10	1	1	**21**
MTC	1	1	1	0	1	6	4	0	**14**
	2	1	4	5	1	16	5	1	**35**

Presentations

There were presentations from Dr Alex Ball (Network Rehabilitation Lead and Consultant in Rehabilitation Medicine, Stoke-on-Trent), Louise Brookes (Therapy Team Leader, Russell's Hall Hospital, Dudley), Steve Littleson (Data Analyst for the Trauma Networks) and Trudi Massey (Rehabilitation Coordinator, Royal Stoke University and Haywood Hospitals, Stoke-on-Trent).

Facilitated Groups

There were two facilitated group sessions during the day. The first of these sessions discussed:

Rehabilitation Prescriptions outside the MTC.

Questions posed:

a) How should all eligible patients for rehab prescriptions be captured in the TU?
   Challenge of identifying ISS>8 patients on admission
   How can this work over 7 days?
   Share any best practice about how TUs do this
b) Who is completing the RPs? Who should?
c) Who gets a copy of the RP? Who should?
d) What are the main barriers to delivery of RPs in the TU?
e) What are the suggested solutions to implement delivery of RPs to all eligible patients?

Feedback: Main issues identified:

i. Identification of patients

- No-one able to score the patient initially as don't know the ISS score on admission
- Need to work closer with TARN coordinators to identify the patients

ii. Production and provision

- Who should start the RP? As there is a lack of awareness about it, lack of interest by consultants and a general lack of staffing to start the paperwork
- Too much paperwork and not useful for TUs to produce as it is only duplicating information already available, no value
- Need a simple RP template, integrated between units/wards etc
- Needs to be single electronic document for use by all therapies
- Need centralised web system/database as no central point to keep information
- Learn from existing pathways e.g. #NoF (fractured neck of femur), avoid duplication
- Community teams find prescriptions useful if received before discharge

iii. Limitations

- Nurses have no input
- The RP doesn't identify the service gaps e.g. neuro psychology, psychiatry and thus doesn't change anything
- IT systems don't allow for continous update of RPs received from MTCs

iv. Suggested ways forward

- Improve education and access to information e.g. NHS.net accounts for transfer of RPs
- Find out where it is working well and share good practice
- Analyse numbers of patients discharged and how many could have benefited from a prescription
- Raise issues at national level, to inform the way forward for RP provision beyond the MTC

The second facilitated group session focussed on:

Repatriation/care closer to home pathways

Questions posed:
What are the (perceived) barriers to accepting patients back from MTCs?
a) Can a 'single point of contact' system be implemented?
If so, who could this be?
Can this work over 7 days / out of hours?

Feedback: Main issues identified

i. Communication

- Getting referrals done in the first place, as often poorly hand-written and left to juniors who are inexperienced
- Consultant to Consultant referrals needed and must be quicker and clearer
- Inappropriate or lack of information provided in referrals
- Problems where more than one team involved in the patient's care in MTC

ii. Coordination

- MTC agreeing point of handover
- Need a robust method of RPs being received from the MTC to ensure effective carry-over of rehab input
- Lack of pathway/process knowledge within teams
- Clearer LEH and out-of-region repatriation process
- Lack of CCG prioritisation

iii. Capacity /staffing

- More capacity – specifically specialised rehab beds (as TUs taking patients whilst they wait for admission to units with lengthy waiting lists)
- Need MDT meetings daily
- No money for development in contrast to funding for MTC services

iv. Complex situations

- Complex cases e.g. tracheostomies, mental health problems, when TU's who don't have the skills and equipment required to provide appropriate care (probably significant numbers of these patients actually warrant specialised rehab rather than care closer to home in TU)

- Families not wanting relative moved to TU
- Patient with no fixed abode / GP

Other items that were highlighted as aspirational or needing further improvement included the following:

- Need to collect better evidence/data
- Need CCG engagement
- Peer Pressure to improve national drivers
- Improve patient expectations, RP becomes patient-held document
- Enhance communication and support from MTCs
- Rehab coordinators in every TU with clear roles and responsibilities
- 7 day cover for all coordinators in TU's
- Improve knowledge of other facilities in the region

Potential Workstreams

1. Identify the cohort of patients with complex rehab requirements who go to TUs because they cannot access beds in the right specialist facilities. 'Measure the gap' between those who need admission to specialised rehabilitation and those who get it (currently approx. 5% of all major trauma cases), including how long they stay in the TU.

2. Find out what rehabilitation services the TUs are able and unable to offer and what could be supported via Rehabilitation Medicine outreach models.

3. Upskilling, training the Staff in the TUs to deal with complex patients, including outreach services from specialised rehabilitation units.

4. Develop network meetings of this group of staff to improve knowledge and communication.

5. Develop regional contacts and demographics information.

6. Present findings at National Trauma Conference in September 2015- platform presentation and breakout sessions now dedicated on the programme for this.