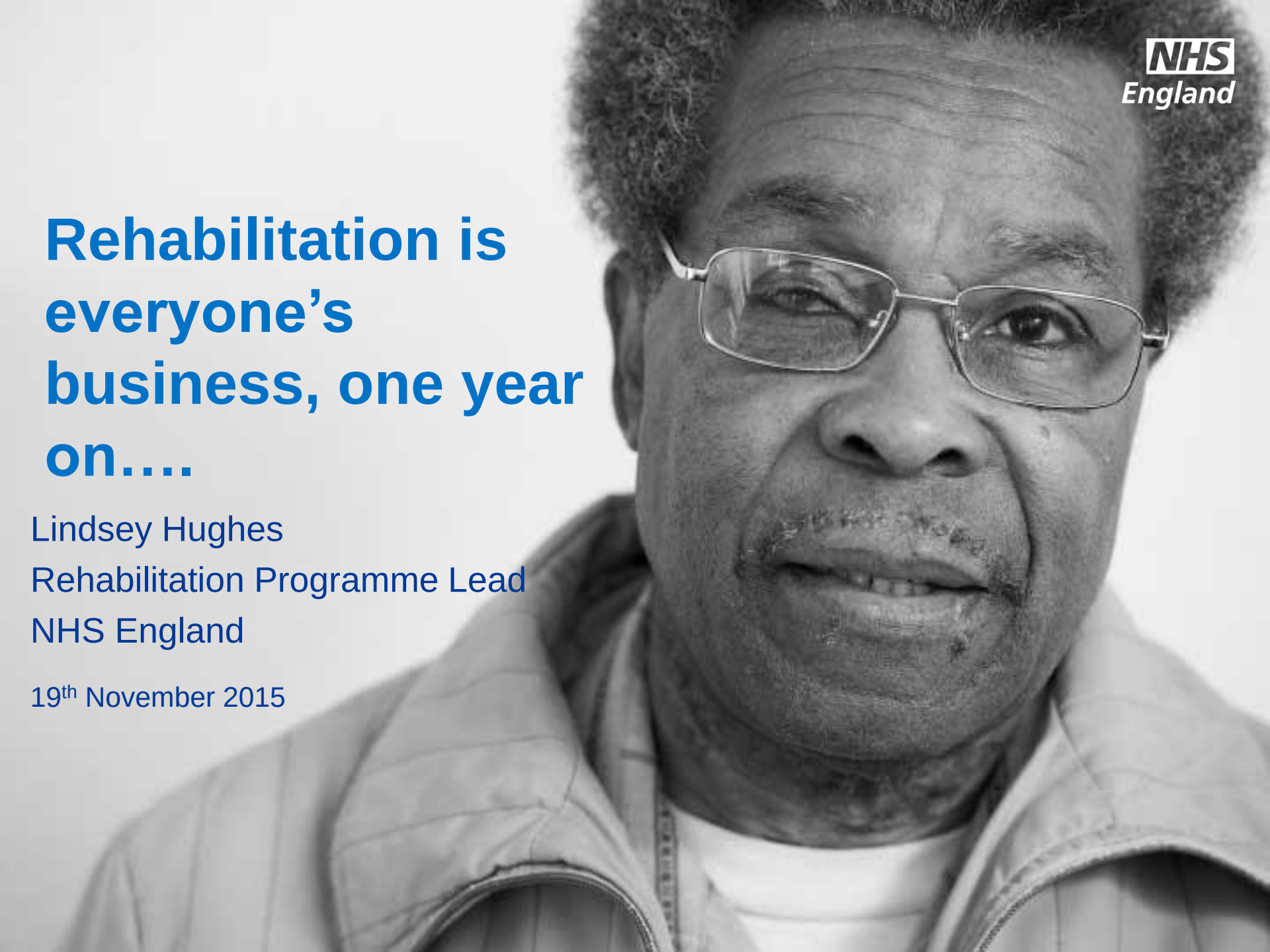
Rehabilitation - Can it be Achieved in the Community?

Thursday 19 November 2015

#rehabachieves15



Rehabilitation is everyone's business, one year on….

Lindsey Hughes
Rehabilitation Programme Lead
NHS England

19th November 2015

Future for the NHS

Health and Wellbeing gap
Radical upgrade in prevention

Care and Quality gap
New models of care

Funding gap
Efficiency and investment

Challenges:

- Ageing population – ageing well and preventing frailty
- Long Term Conditions
  - Costs NHS £7 in every £10
  - 50% of all GP appointments
  - 59% in work vs 72% of general population
- People's expectations are changing
- Need to break down traditional boundaries
- Delivering patient centred care

Solutions?.....

"Rehabilitation is a good investment because it builds human capacity

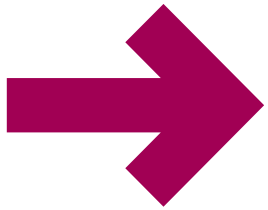
WHO, World Bank and WCPT

The Vision

Rehabilitation will be key to every episode of care.

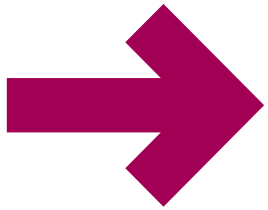
It will maximise mental and physical health, independence and occupation.

Rehabilitation is everyone's business



Opportunities

- New Care Models ~ Vanguard sites
  - Multispecialty community providers (14)
  - Integrated primary & acute care systems (9)
  - Enhanced health in care homes (6)
  - Urgent & Emergency Care (8)
  - Acute Care Collaborations (13)
- New models of funding
  - Devolution
  - Personal Health Budgets
  - Integrated Personal commissioning
- Patient Choice
- Innovation / technology

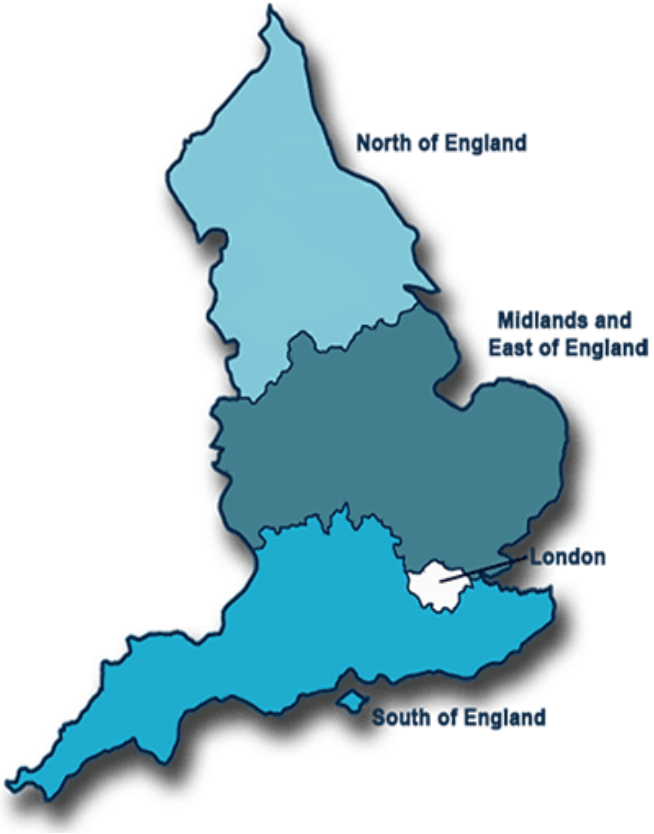


To optimise the rehabilitation solution we need to…

- Know what the challenges are
- Define what good looks like
- Have the tools to measure it
- Demonstrate effectiveness and efficiency
- Use this to continually drive rehabilitation across all pathways to maximise mental and physical health, independence and occupation.

Work in the regions – key themes

- Raising awareness
- Leadership
- Workforce planning
- Demonstrating effectiveness
- Commissioning
- Networks



Children and young people's rehabilitation scoping project

Key Themes:

- Commissioning for need not diagnosis
- Workforce
- Economic data generation
- Enabling and empowering services
- Sharing information

Raising Awareness

There is poor awareness of the scope of rehabilitation and the fact that rehabilitation happens along and across every pathway of care, from birth to end of life.

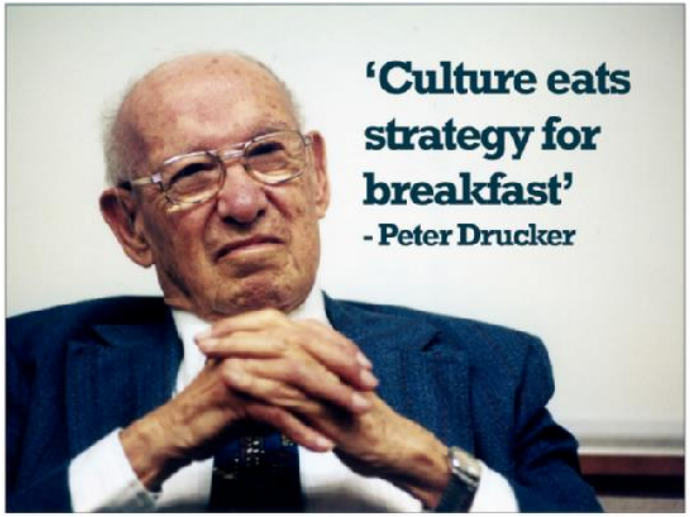
What we need:

- Rehabilitation as a philosophy of care across all pathways and health conditions which is essential to achieve the vision in the Five Year Forward View.
- Requires a shift away from focusing on the medical model to a biopsychosocial model
- Rehabilitation is the guiding philosophy.

Workforce Development & Planning

Transformational change and better integration of services will largely depend,

"..not on new structures but on the people who work in health and social care, who will need to adapt to new roles and services and learn new skills" (Council of Deans for Health, March 2015).



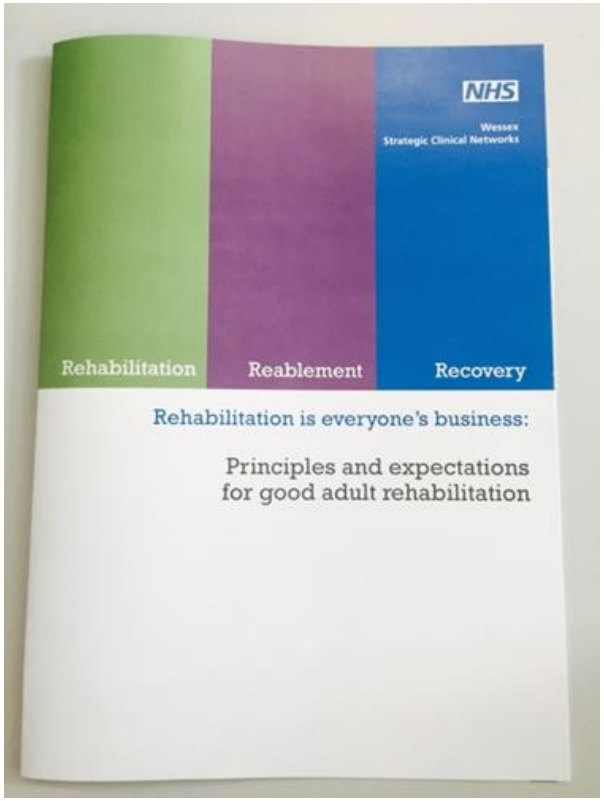
Working in a different way

- Radical upgrade needed in prevention and public health: citizens learning good habits for life
  - *Physical activity*
  - *Dietary habits*

- Patients gaining greater control of their care, supporting self-management and self-care
  - *New skillsets e.g. motivational interviewing*
  - *A shift in philosophy from 'caring to 'enabling'*

What does good look like?

- ✓ Focus on outcomes
- ✓ Centred on people's need
- ✓ Aims high – gives hope
- ✓ Active and enabling process
- ✓ Integration core and specialist
- ✓ Responding to change in need



http://www.wessexscn.nhs.uk/index.php?cID=306

NHS England

Five Year Forward View		Principles of good rehabilitation practice.
Sustained action required to address demand.	Radical upgrade needed in prevention and public health.	Make use of a wide variety of new and established interventions to improve outcomes e.g. exercise, technology, Cognitive Behavioural Therapy.
	Support people to get and stay in employment	Instil hope, support ambition and balance risk to maximise outcome and independence. Use an individualised, goal-based approach, informed by evidence and best practice which focuses on people's role in society.
	Patients gaining greater control of their care supporting self-management and self-care.	Support self-management through education and information to maintain health and wellbeing to achieve maximum potential.
Sustained action required to address efficiency.	Breaking down traditional barriers - GPs/hospitals, physical/mental health, Health/social care	Optimise physical, mental and social wellbeing and have a close working partnership with people to support their needs.
	Integrated out of hospital care: single point of contact, case management, risk stratification etc.	Recognise people and those who are important to them, including carers, as a critical part of the interdisciplinary team. Deliver efficient and effective rehabilitation using integrated multi-agency pathways including, where appropriate, seven days a week. Require early and ongoing assessment and identification of rehabilitation needs to support timely planning and interventions to improve outcomes and ensure seamless transition.

What Commissioners say…

"No real strategic vision for the future or rehabilitation or reablement locally, even though they are recognised as key enablers.."

This work is massively important…. it is currently hit and miss and there is so much misunderstanding about rehabilitation…"

"Relationships are hugely important and commissioners and providers need to be working collaboratively

It would be great to be allowed the time to commission rehabilitation correctly ……a Commissioning Framework is important to give support and confidence to commissioners"

We need to let local areas decide what success looks like, but guidance is needed on what outcomes should be looked at; patient and financial".

Commissioning Framework

- Strategic framework
  - consistency to reduce variation and facilitating flexibility in implementation for local populations
- To include:
  - Strong national narrative
    - scope and purpose and how rehabilitation can deliver better outcomes for citizens
  - Benchmarking tools – Principles and Expectations
  - Embed the vision – early rehabilitation planning
  - Transition across patient pathways
  - Effective use of both core and specialist rehabilitation services,
  - Data collection - patient experience and economic benefit

Economic argument in health

- **Rehabilitation reduces length of stay**: physiotherapy services have been key in reducing length of stay for patients with dementia and contributing to a £6million/year cost saving (RCP, 2010)

- **Rehabilitation prevents unnecessary hospital admissions:** a 7 day integrated community service resulted in a 93% admissions avoidance in patients who would otherwise have been taken to hospital; the service receives 10,000 referrals/year (NHS IQ, 2014)

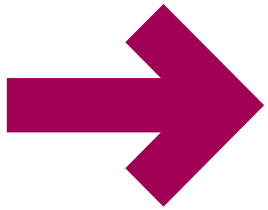
- **Rehabilitation improves outcomes from surgery:** pre-operative pulmonary rehabilitation for lung cancer patients has been shown to reduce complications and re-admissions and reduce costs (Bradley et al. 2013).

Rehabilitation for Wider Economic Growth:

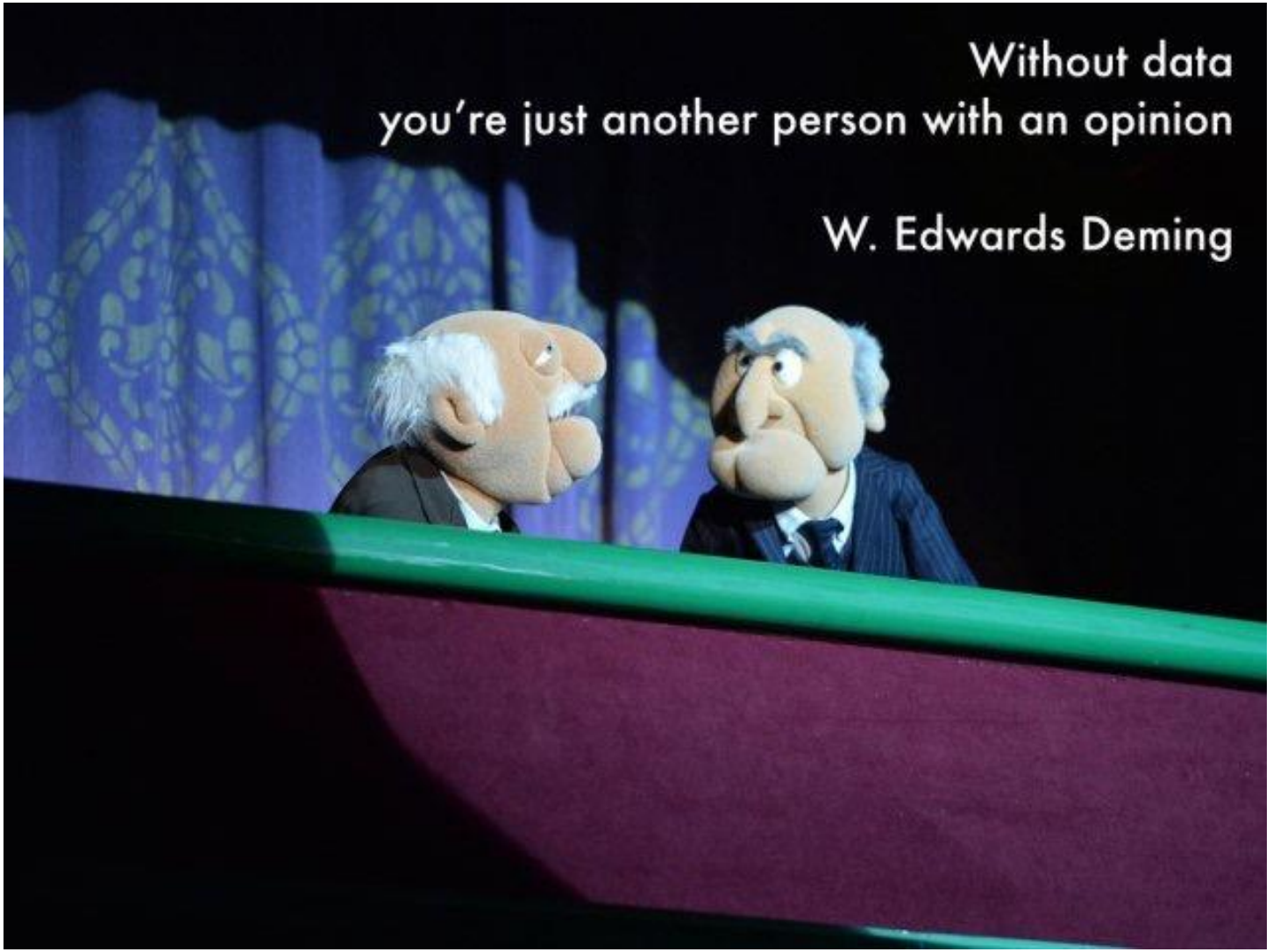
Issue	Stakeholders
Return to work reduced reliance on state benefits	DWP
Enable people to remain in work	DWP, employers
CYP – maximise educational opportunities and decrease cost to social care	Department for Education Social care DWP
Supporting people to maintain independence	Social care/local government
Increase participation in society/reduced behavioural issues	Ministry of Justice
Injury Cost Recovery	Insurers / NHS Trusts

Return to work – the evidence

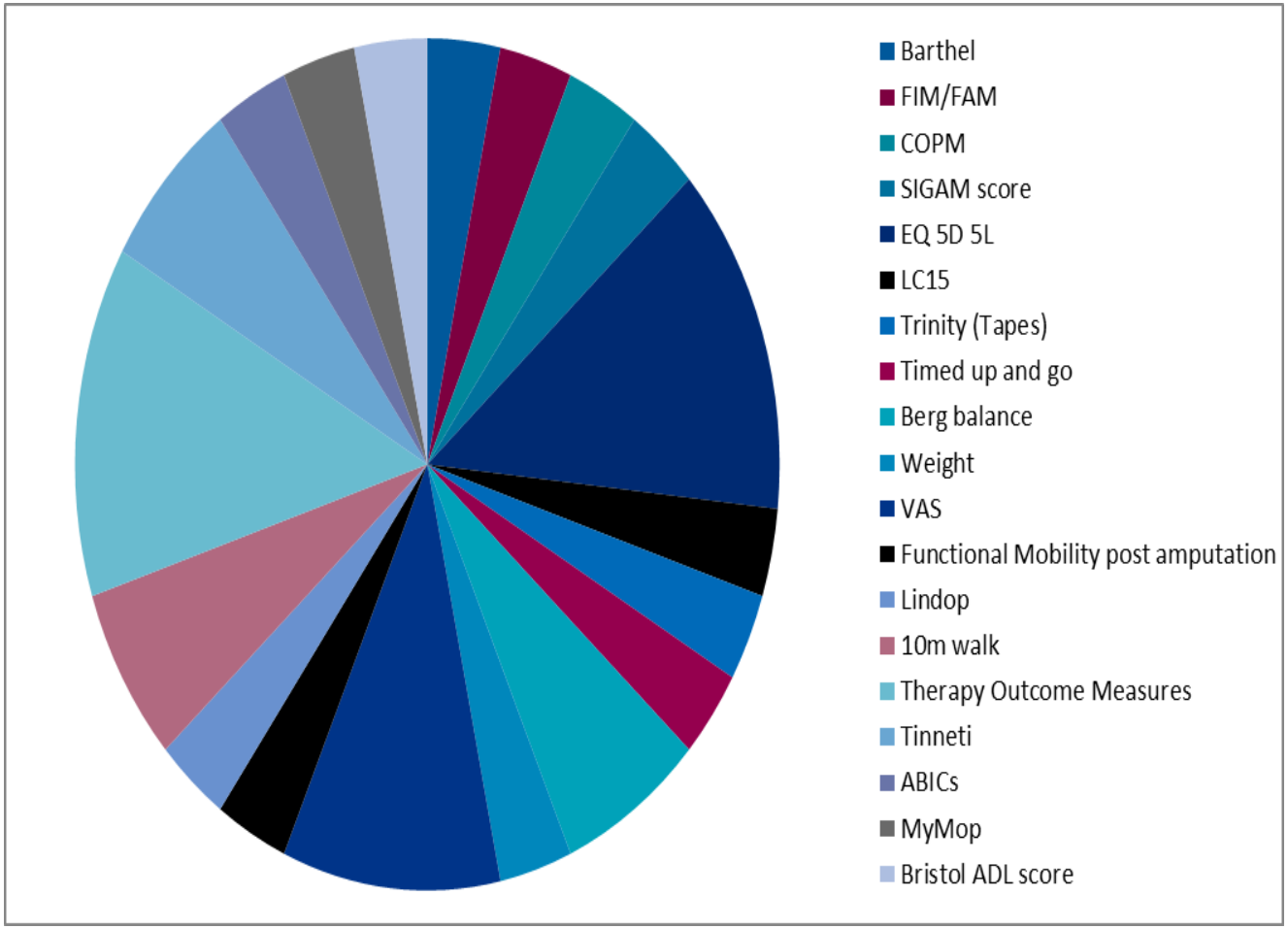
- NHS Staff
  - York - Early intervention = 40% reduction in long term sickness (Black & Frost 2011)
  - Derbyshire - £48K investment = 250K savings (NHS England 2015)
- Defence rehabilitation
  - 92% of those with traumatic brain injury in community employment at 4 months (in press)
- Vocational Rehabilitation
  - Macmillan(2015) pilots 38% from not working to working
  - Average cost per patient estimated to be recouped in tax in 3 months



Demonstrating effectiveness



Demonstrating Effectiveness



- There is an urgent need for consistent data sets to define citizen need and measure citizen outcomes.

Demonstrating effectiveness

- AHP data improvement project
  - AHP national data set
  - Rehabilitation data set
- Commissioning for Outcomes
  - Commissioning guidance narrative
- Community data set
- NHS benchmarking

Innovation, evidence and best practice

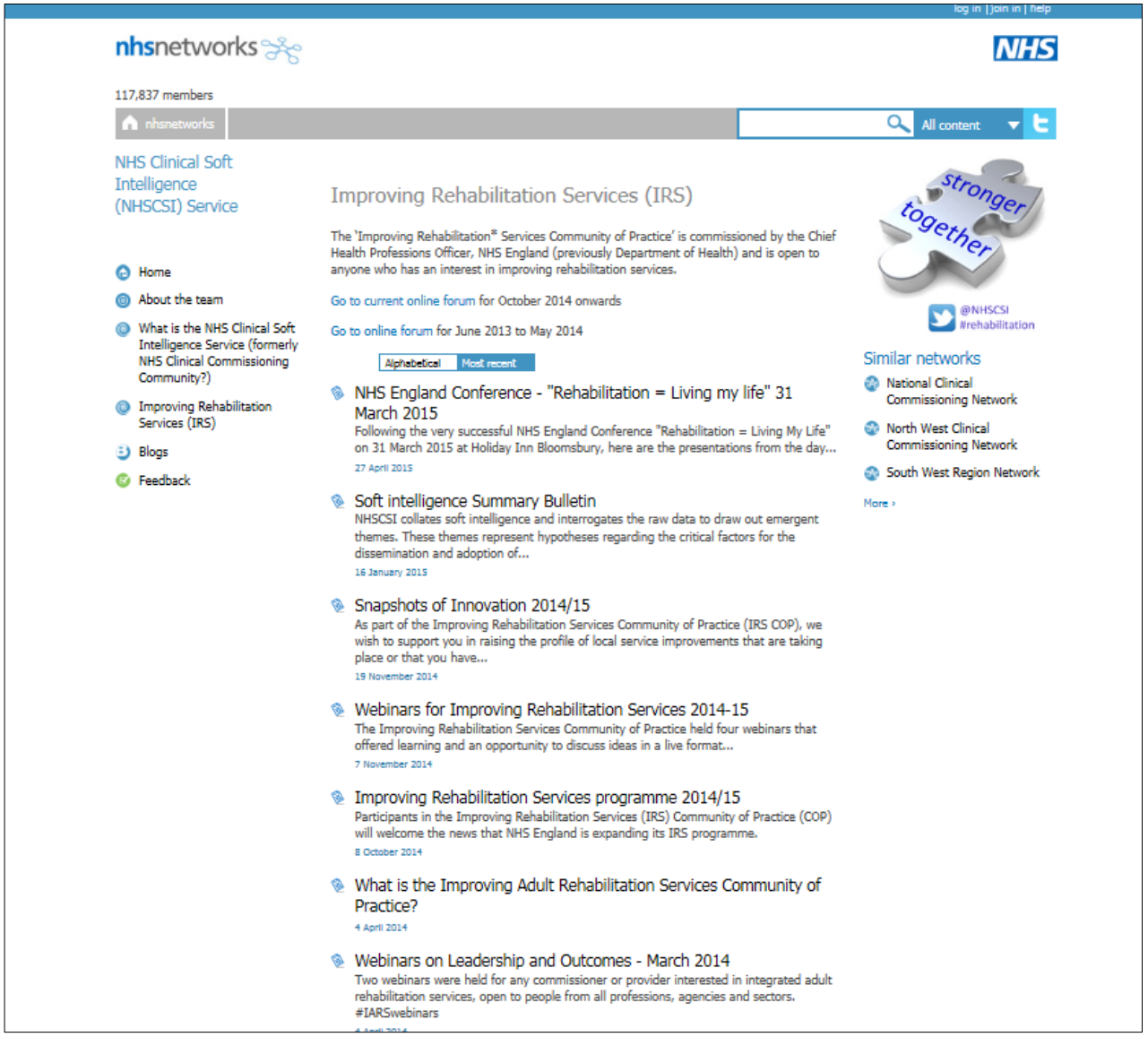
Rehabilitation Innovation Challenge Prizes

1. Rehabilitation Challenge Prize to recognise and award initiatives that exemplify a modern patient pathway in rehabilitation
2. Rehabilitation Acorn prizes – small ideas with big impact

- Total Prize fund = £90K
- Mentoring from AHPF
- http://www.england.nhs.uk/challengeprizes/
- @challengeprizes

NHS INNOVATION CHALLENGE PRIZES
ENCOURAGE, RECOGNISE AND REWARD...

IRS Community of Practice



IRS community of practice

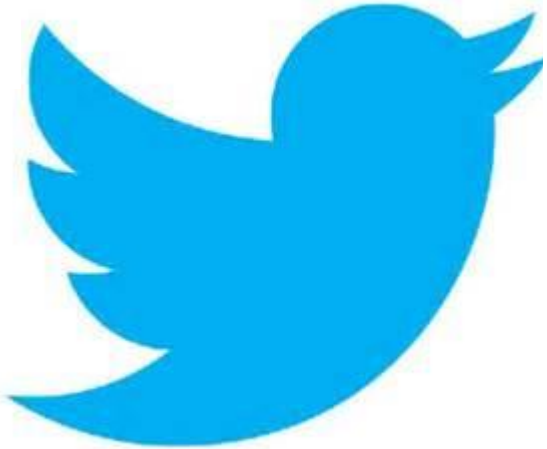
- Online discussion forum
- Programme resources
- Soft intelligence gathering
- Webinars
  - Managing Relationships for Transition
  - Integration in Action
  - Unlocking the Evidence
- Vodcasts
- Social media

Finding and sharing good practice

NHS England


#weAHPs

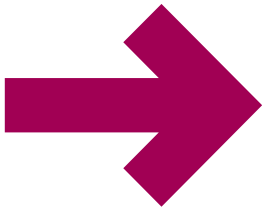

#weNurses




#WeComsers
weCommissioners


#weDocs


wePharmacists



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#rehabimprovers

Follow the team:
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Thank you

Questions?

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Disability at Work: Assessing Routes towards Fair and Sustainable Employment

Victoria Wass, Melanie Jones, Kim Hoque and Nick Bacon

Rehabilitation: Can it be Achieved in the Community?
19th November 2015

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Disability disadvantage at work

1. Employment gaps
2. Wellbeing gaps

Workplace Employment Relations Study (WERS) 2011

- % disabled employees in the workplace
- disabled employees perceptions of wellbeing, fairness and job quality/satisfaction

Workplace characteristics that shape the experience of disabled employees

- Equal opportunities polices and practices

  Hoque, K. and Noon, M. (2004) Equal Opportunities Policy and Practice in Britain: Evaluating the 'Empty Shell' Hypothesis, *Work, Employment and Society* 18(3): 481–506

- Trade union representation

  Bacon N and K Hoque (2015) The influence of trade union Disability Champions on employer disability policy and practice, *Human Resource Management Journal*, forthcoming

  Hoque K and N Bacon (2014) Unions, joint regulation and workplace equality policy and practice in Britain: evidence from the 2004 Workplace Employment Relations Survey, *Work, Employment and Society,* 28(2): 265-284

- Organisation and management of work

  Foster D and V Wass (2013) Disability in the labour market: An exploration of concepts of the 'ideal worker' and organisational 'fit' that disadvantage employees with impairments, *Sociology*, 47(4): 705-721

  Bacon, N, Hoque K, Jones M and V Wass (2015) Are High Performance Work Systems Disabling? Evidence from WERS 2011, Equal is not enough conference, Antwerp University 5th-6th February 2015

The Experience of Disabled Employees during the Great Recession

Melanie Jones, Kim Hoque, Victoria Wass and Nick Bacon

Background

Disadvantage in employment (Jones, 2006; Bell & Heitmueller, 2009; Baumberg *et al*., 2015)

Disadvantage once in work (Schur *et al*., 2009; Fevre *et al*., 2008, 2009; Longhi *et al*., 2012; Jones, 2015)

External environment

- How does this change in response to changes in legislation?
- To what extent does it change over the economic cycle?

Disability and the Economic Cycle: Theory

Theory would suggest labour market inequality is exacerbated during an downturn

- Focus on performance (Rubery & Rafferty, 2013)
- Opportunity to discriminate (Becker, 1957; Biddle & Hammermesh, 2013)
- Concentration in ‘sensitive’ employment (Rubery & Rafferty, 2013

Disability and the Economic Cycle: Evidence

Evidence in relation to disability is limited, focuses on employment and provides mixed conclusions.

US

- ‘Last hired, first fired’ (Kruse & Schur, 2003: 31)
- Enhanced sensitivity to the recent recession (Kaye, 2010)

UK

- Relative cyclical employment insensitivity (Berthoud, 2009 and 2011)

Our Contribution

New evidence Britain recent ‘Great’ Recession

Secondary data Workplace Employment Relations Survey 2011

- 21,981 employees
- 1,923 workplaces

Relative ‘in-work’ experience of disabled employees

- Personal characteristics
- Job characteristics
- Workplace characteristics

Interaction between the internal environment and experience (Stone & Colella, 1996)

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Impact of the Recession

Did any of the following happen to you as a result of the most recent recession, whilst working at this workplace?

1. I was not working at this workplace during the recession
2. My workload increased
3. My work was reorganised
4. I was moved to another job
5. My wages were frozen or cut
6. My non-wage benefits (e.g. vehicles or meals) were reduced
7. My contracted working hours were reduced
8. Access to paid overtime was restricted
9. I was required to take unpaid leave
10. Access to training was restricted
11. None of the above.

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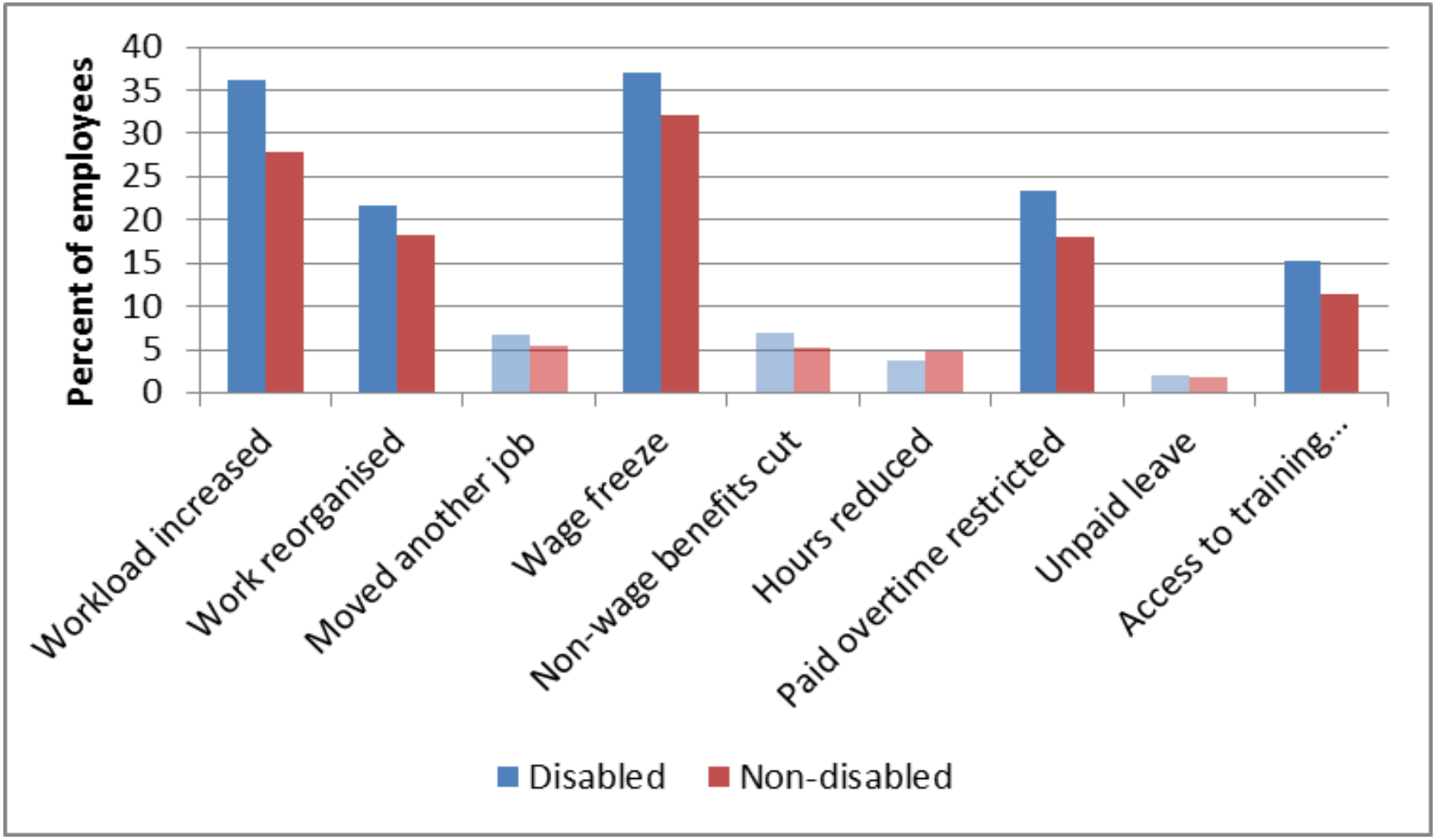
Disability

Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?

1. No
2. Yes, limited a little
3. Yes, limited a lot.

Disabled employees (9.7%) are either limited a little or a lot.

Experience of the Recession by Disability



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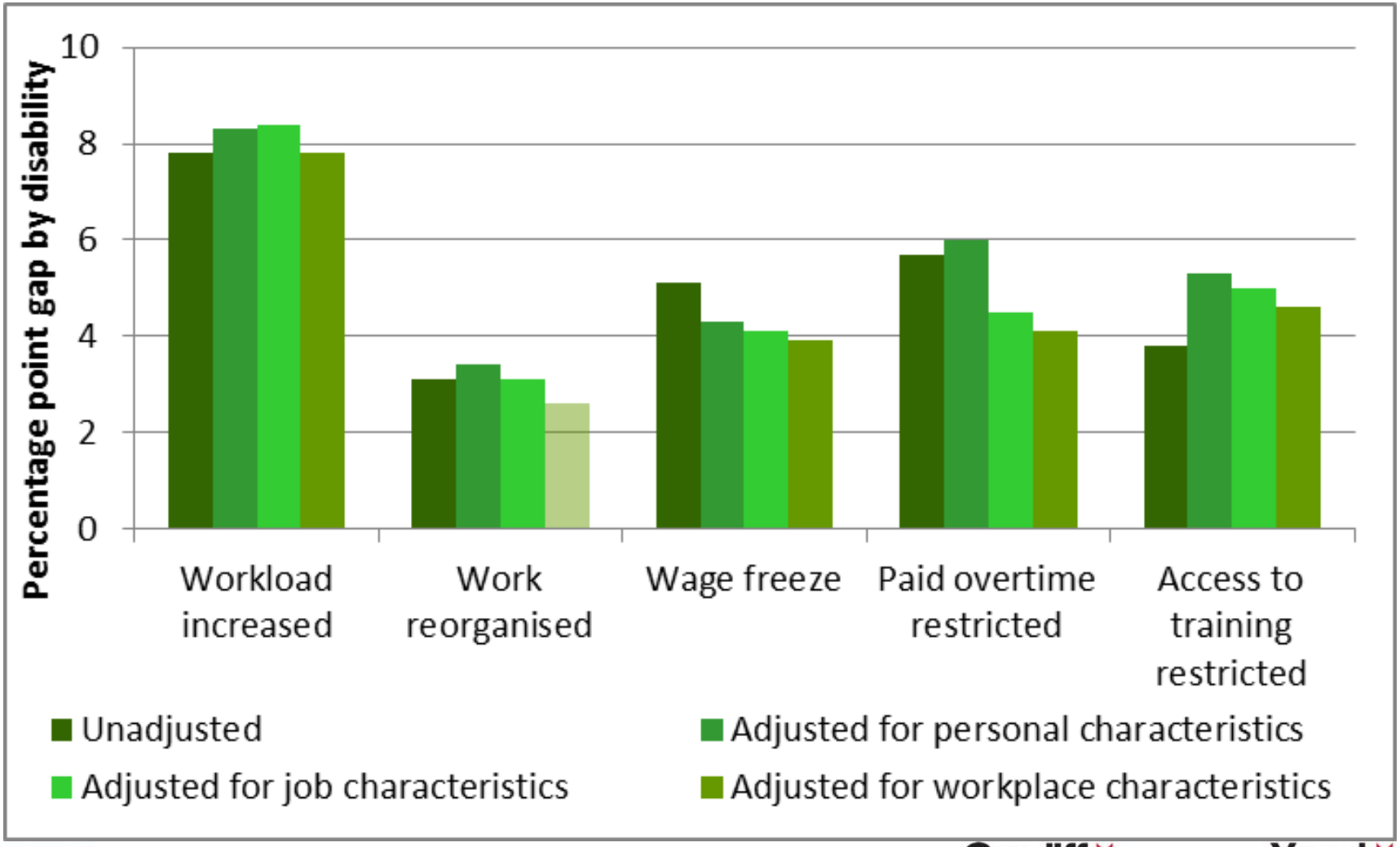
Relative Experience of the Recession by Disability



Relative Experience of the Recession by Disability

Disabled employees report a more averse relative experience

- Workload increased
- Work reorganised
- Wage freeze
- Paid overtime restricted
- Access to training restricted

This is not explained by personal, job or workplace characteristics and suggests it is related to disability *per se*.

Relative Experience of the Recession by Workplace Characteristics

The relative experience does not vary by workplace characteristics designed to proxy the equality environment.

- Equal opportunities policy and practice
- Sector
- Trade union recognition

Suggests not driven by inequality in policy implementation

Differential *experience* of the same policy? Roulstone and Williams (2013) ‘glass partitions’.

Conclusion

Differences in the reported experience of the recession between disabled and non-disabled employees in Britain in 2011

- Disabled employees report a more negative experience
- This is not simply a reflection of pre-existing disadvantage
- Reported experience does not vary significantly *between* workplaces
- Suggests an influence of disability across workplaces

The Experience of Disabled Employees during the Great Recession

Melanie Jones, Kim Hoque, Victoria Wass and Nick Bacon

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Rehabilitation

Can it be achieved in the community?

©Karen Beaulieu
MSc Advanced Professional Practice
Occupational Therapy Pathway Leader
19 November 2015

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Plan

- PhD aim & objectives
- Why is return to work important?
- Brain injury (BI) & return to work
- Methodology
- Phase one & two findings
- Developing a new conceptual framework to facilitate return to paid work rehabilitation following an acquired or traumatic brain injury (ABI or TBI)

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PhD aim

To explore & understand the factors which impact on the return to paid work of individuals following a brain injury & to subsequently develop a conceptual framework for return to paid work rehabilitation.

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Objectives

To;

- Critically appraise evidence based literature related to brain injury & return to paid work.
- *Collect & analyse data of the return to paid work experiences of brain-injured individuals to establish potential barriers & success factors (phase one).*
- *Collect & analyse data from employers who have experienced brain injured individuals return to paid work to establish potential barriers & success factors (phase two).*
- *Evaluate findings to inform practice & to develop a return to paid work conceptual framework.*

Why is work important?

- Employment is valued in industrialised societies & cultures, & impacts on individual identity & status (Yerxa, 1998; Winefield *et al.*, 2002; Nightingale *et al.*, 2007).
- Paid work can be good for physical & mental health & well-being, provides an independent financial income, structures the day, & provides social contact & a sense of purposefulness (Waddell and Burton, 2006; Barnes and Holmes, 2007).

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Brain injury and return to work

- In the UK following moderate-severe TBI 40% of individuals return to work one year post injury (Friedland and Potts, 2014).
- Few BI return at the same level, for the same pay or for the same hours (Gamble and Moore, 2003; Winkler *et al*., 2005).
- Unemployment rates for persons following a TBI are considerably higher than the general population (Sabello, 2014).
- For most, returning to paid work following a BI can be impossible.

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Methodology

- A qualitative, descriptive phenomenological approach recruited 16 BI individuals to phase one & 11 employers of BI individuals to phase two.
- Included TBI or ABI of moderate to severe severity (Glasgow coma scale score 12 or below).
- Following University & UK NHS National Research Ethical approval data was collected from unstructured interviews with men & women & explored their return to paid work lived experiences.

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Method

- Data was analysed using Giorgi's descriptive phenomenological approach & significant statements extracted from transcripts.
- 61 meaning units were aggregated into clusters of themes to create description for phase one & 50 meaning units for phase two (Giorgi,2000a).
- Meaning units for both phases were collapsed into six themes which describe each participant groups lived experiences.

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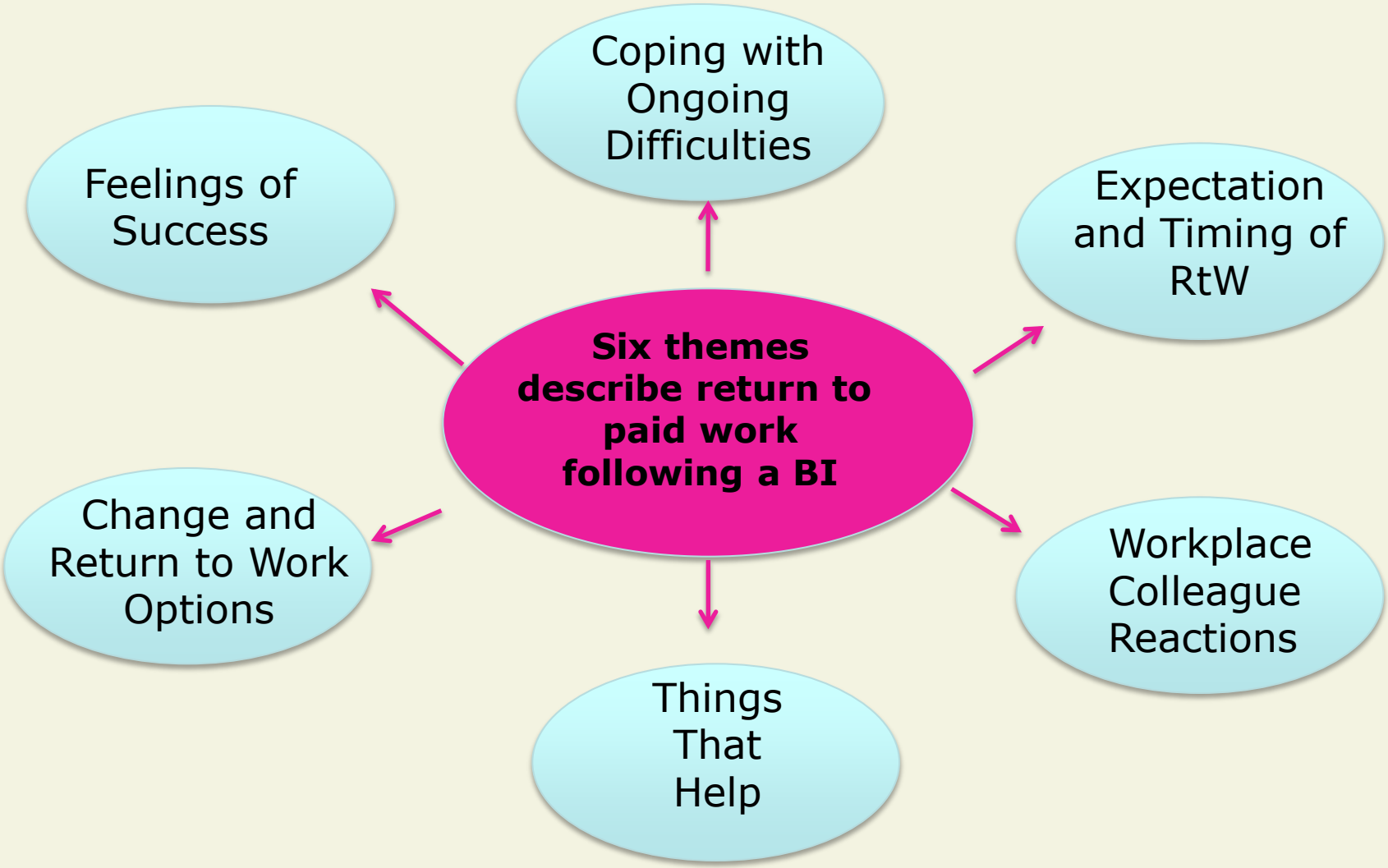
Phase One Participants

- Male: female-10:6
- ABI:TBI-11:5
- Aged 17-54 at time of injury
- Aged 31-63 at time of interview
- Represented a wide range of paid jobs; global banker, weed sprayer, apprentice engineer, railway clerk, travel agent, train driver, classroom assistant……

Phase One Findings



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Feelings of Success

- Participants described feeling good by earning their own way, valued, being made whole again, having increased self-esteem & that their perception of their job was very much part of who they are.

…felt like I was almost made whole again. The relief was great. (P1)

Coping with Ongoing Difficulties

- Poor memory & slow information processing, fatigue, benefit issues & mental health difficulties impacted progress.

…I was on my feet all day and I was really tired and had no stamina, I found it really draining so I didn't really last…(P9)

Expectation & Timing of Return to Work

- A determination to return to work linked to occupational identity. Slow phased return was more successful & satisfying. Fast return resulted in failure.

…in the early days after my accident something was driving me, I wanted to be how I was and was trying to get back…. (P2)

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Workplace Colleague Reactions

- Colleague reactions were hurtful & they had little tolerance. Participants were alone a lot, treated like children & socially excluded.

…some people actually walked away when they saw me coming and that felt incredibly hurtful…(P1)

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Things That Help

- Professional help included Social Work, Council Support Services, BI Team Rehabilitation, Occupational Therapy, Headway & Disability Employment Advisors. Ranging from CV preparation, advice & support once employed.

…my OT at Headway has gone mad with me about the hours I was working… (P10)

Change & Return to Work Options

- Most participants faced difficulty as the workplace & colleagues had moved on. No established return to work route exists & participants experienced different return paths.

…I was officially told that my job was at risk… I knew I would go and not the others. It was like working in a state of permanent anxiety… (P8)

Phase Two Participants

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- Employers interviewed were 4 male & 7 female.
- Employers organisiations were from a wide range; Public sector, International Banks, Schools, Global IT, Small Business, Charities, Self Employed.
- Employees were 10 male & 1 female.
- 5 employees had ABI, 6 had TBI.
- Employees were aged 33 to 60 at time of interview.
- Employees were aged 20 to 60 at time of injury.
- Time away from work ranged from 3 months to 10 years.
- 2 employees had vocational rehabilitation, 9 had none.
- Employees were from a wide range of paid jobs; Admin assistant, Postman, Financial manager, Learning assistant, Factory worker, Teacher, IT consultant, IT analyst, Bus driver, F1 trainer.

Phase Two Employer Findings

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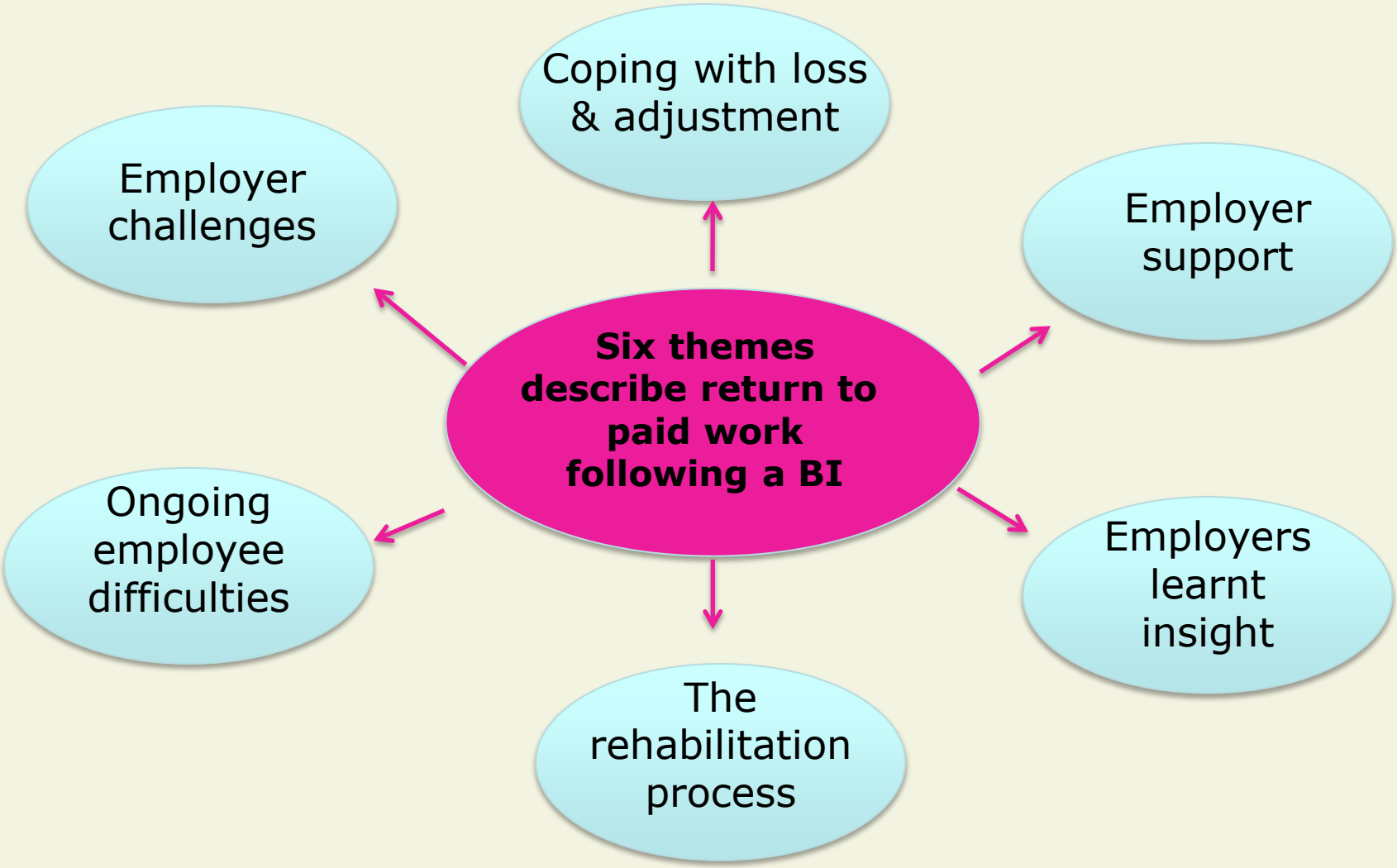

Coping with loss & adjustment

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Employers described that;

- Employees had financial worries due to extended sick leave & family commitments.
- Employees went back to work too early due to these fears & because of lost confidence and ability to make decisions.

He was off sick for a year and was concerned he had a mortgage and three young children (E4)

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Employer support

- Employers provided remote support before planning & 6-8 week progress reviews either in the workplace or home.
- Early employer support ensured phased planning took place at each review meeting.

The supportive environment really encouraged him to say, I can do this, I can move but I know I've got space and time (E7)

Employers learnt insight

- Employers respected employees as they had observed how hard they had worked & adapted to work again despite not being appreciated by wider colleagues.
- Some employers observed that colleagues behaved more positively when appraised of what was happening.

His colleagues were appraised of what was happening and progress he was making. I think when he started back there was admiration for his grit and determination (E4)

The rehabilitation process

- Rehabilitation started with early employer contact for some by text, others by monthly meetings whilst on sick leave & goals were agreed mutually.
- Phased increase in hours was described as the most common with some who returned too quickly experiencing failure.

I suggested he could come into the office even though he was off sick and practice to see how he coped with phones going and people talking around him…(E8)

Ongoing employee difficulties

- Fatigue was the most described difficulty & varied from day to day. Most employees were unable to drive post injury due to post injury epilepsy or surgery.
- Ongoing difficulties described were reduced; memory, vision & tolerance, poor attention, inflexibility, slow mental processing & limited insight. All were made worse where colleagues did not understand their association with BI.

She felt absolutely exhausted even just doing smallest things and it would vary from day to day (E1)

Employer challenges

- Employers had no knowledge of BI & due to patient confidentiality were unaware of serious issues such as epilepsy.
- They felt unsupported as there was a lack of medical support & the only information was from a GP or employee stating they were fit to work.

I had no idea that it affected his decision making capability, I've never had any involvement with brain injuries or mental health (E7)

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Method (cont.)

- General situated structures & descriptive summaries of return to paid work following a BI were established for both phases & reflected all of the participants lived experiences (Giorgi,2000b).
- Following phenomenological analysis of the overall/combined general situated structure, the deeper meaning of the phenomenon was explored using free imaginative variation, responsive reflective writing & categorial intuition (Van Manen, 1990; Husserl, 2001; Giorgi, 2006).
- Four themes emerged from the overall structure; **occupational needs, experiencing loss, grief and adjustment, self-identity & social inclusion and return to the workplace**.
- A return to paid work conceptual framework was developed & emerged from evaluation of the research findings.

A conceptual framework to facilitate return to paid work rehabilitation following an acquired or traumatic brain injury

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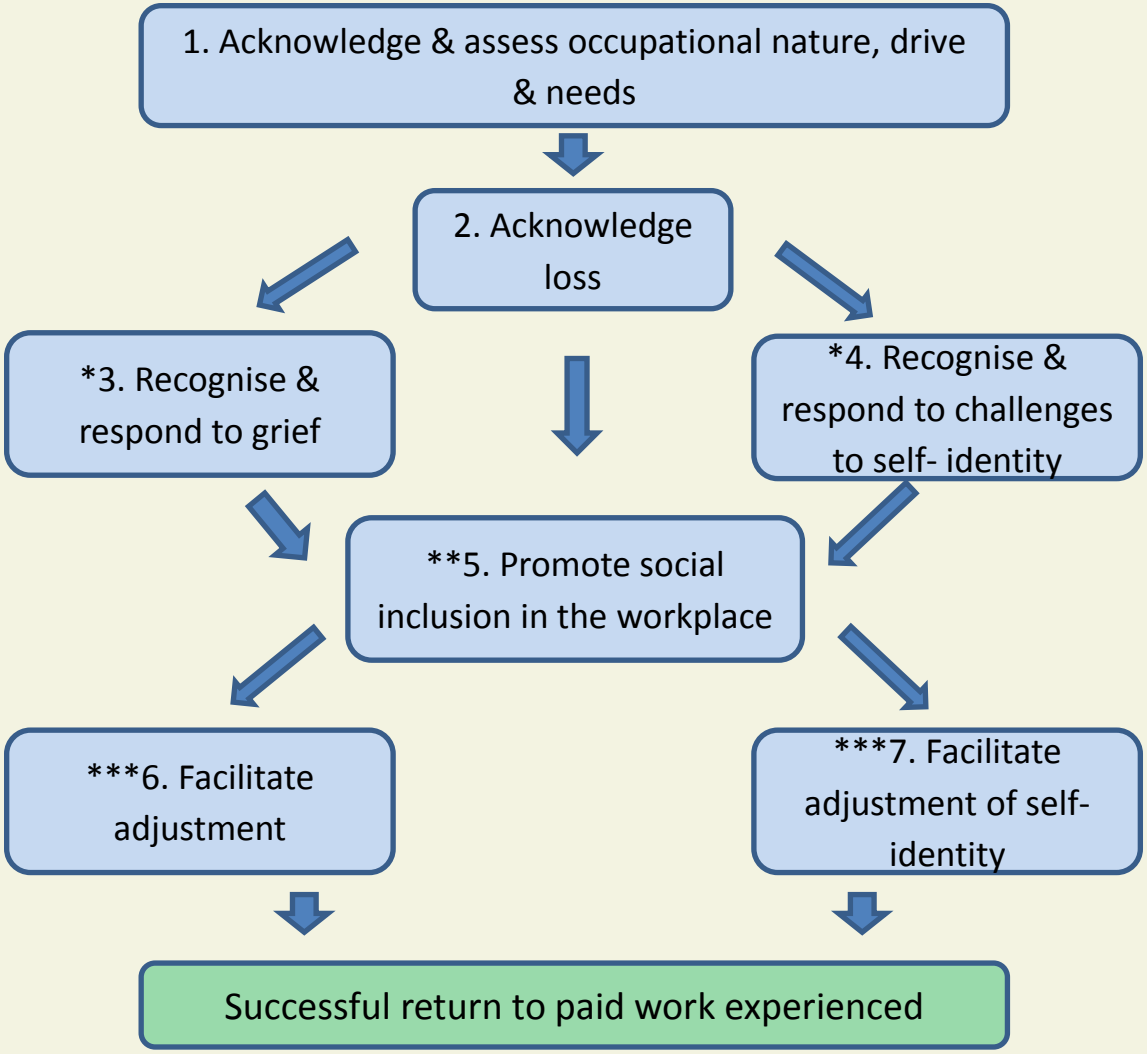

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Acknowledgements

The 16 participants in phase one & the 11 employers in phase two

irwinmitchell IM solicitors

UK Occupational Therapy Research Foundation
Building the evidence – creating the future

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RADIO NORTHAMPTON
104.2FM | 103.6FM
Be part of it.

Headway
the brain injury association

Please contact me if you are interested in the Post Doctoral application of my conceptual framework or resulting PhD publications…….

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Questions and Answers

Written and presented by
karen.beaulieu@northampton.ac.uk

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Rehabilitation - Can it be Achieved in the Community?

Thursday 19 November 2015

#rehabachieves15

NHS
Cheshire and Merseyside
Rehabilitation Network

Developing an innovative Rehabilitation Network

Dr Helen Banks, Consultant In Rehabilitation Medicine, The Walton Centre
Julie Gibbons, Rehabilitation Coordination Team Leader, The Walton Centre

Acknowledgements

- Strong partnership working between clinicians, managers and commissioners
- Thank You to patients and their families and staff who shared their experience with us – some of which are shown in this presentation

CMRN Animation

The development of the Network;
National and Regional Drivers

- **National:**
  - BSRM, UKROC, Specialist rehabilitation service specification standards with an increasing focus on provision, access and quality of services.

- **Regional:**
  - implementation of the Cheshire and Merseyside Major Trauma Collaborative

The development of the Network

Local Drivers - Our Vision and USPs

- ✓ Address **unmet demand** and **inequitable** provision for patients with complex traumatic injury or illness
- ✓ Establish a **co-ordinated** pathway, across **hospital and community services,** based on **need** and **not diagnosis**
- ✓ Deliver **holistic** specialist rehabilitation- **multi-disciplinary team** approach
- ✓ Promote an innovative network to optimise patients' **clinical outcomes, improve experience and maximise independence**
- ✓ Driving **Vocational Rehabilitation**
- ✓ Partnership working between **health and social care**

The Cheshire and Merseyside Rehabilitation Network (CMRN)

- 8 partner organisations across Cheshire and Merseyside and collaborative working region-wide for a wider scope of action than previously possible
- Funded by NHS England and Clinical Commissioning Groups
- Our region developing as the ‘go-to’ network for specialist rehabilitation
- Regional approach to improving health and delivering evidence-based specialist rehabilitation across inpatient and outpatient services
- Single structure to share and disseminate good practice and learning

Our Partner Organisations

The Walton Centre NHS
NHS Foundation Trust

The Royal Liverpool and Broadgreen University Hospitals NHS
NHS Trust

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

Bridgewater Community Healthcare NHS
NHS Trust

Mersey Care NHS
NHS Trust

H&SCP
health & social care partnerships

Liverpool Neuro Physio

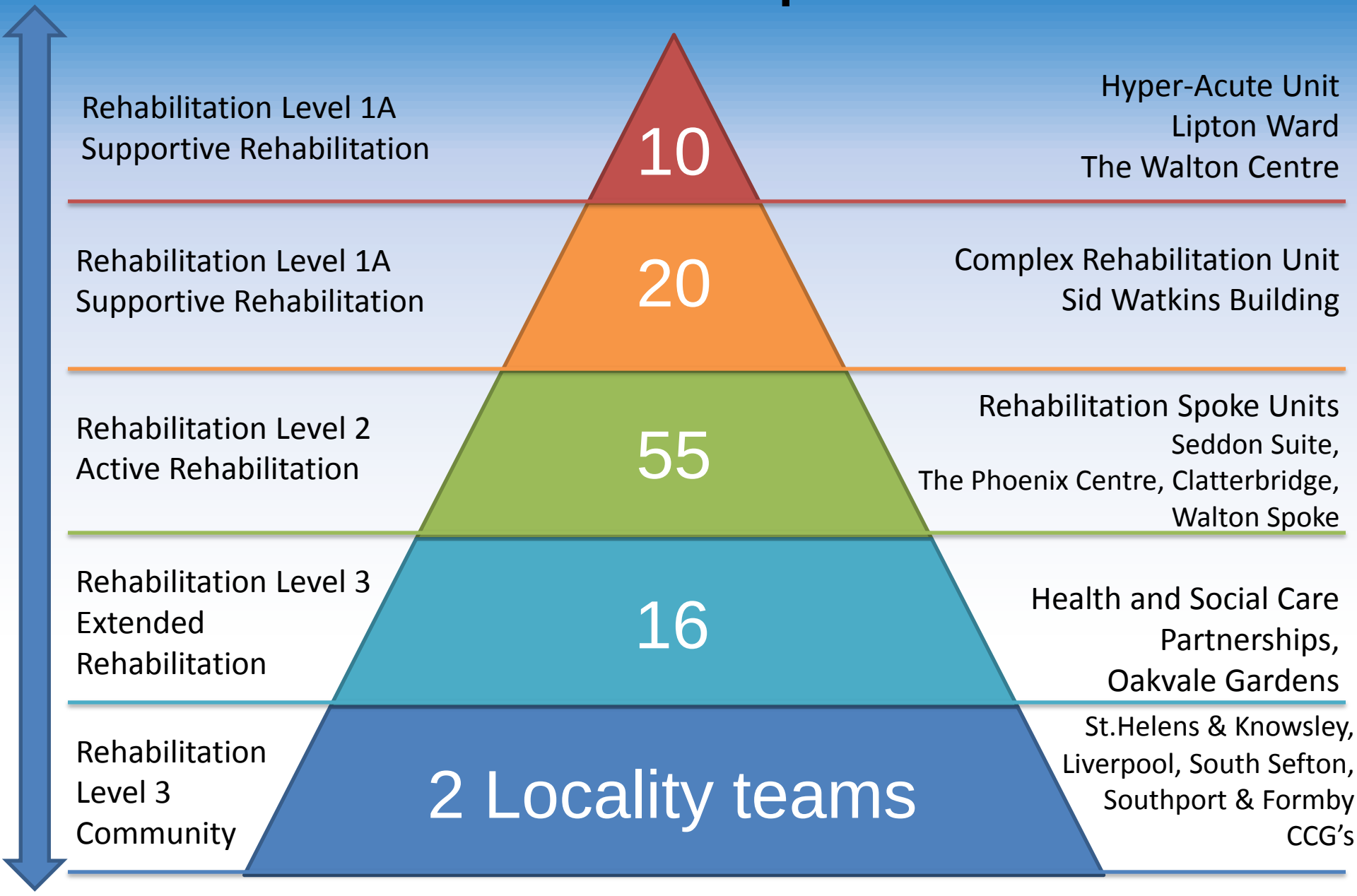
Collaborative working region-wide

- Brain Injury Rehabilitation Centre
- Southport Spinal Injury Unit
- Cheshire and Mersey Major Trauma Collaborative
- Cheshire and Mersey Critical Care Network
- Aintree amputee and prosthetic services
- North West Assisstive Technology
- BIRT
- Headway, Neurosupport, SIA and other charitable organisations
- Isle of Man and North Wales specialist rehabilitation services

CMRN Objectives

1. Establish **A SERVICE PATHWAY**
2. Deliver **PATIENT FOCUSED** services
3. Deliver **COST EFFICIENT** services
4. Attract and retain **A HIGH CALIBRE WORKFORCE**
5. Work in **PARTNERSHIP** to deliver High Quality Clinical Audit, Research and Innovation and to drive **EXCELLENT PATIENT CARE**

A Framework for Partnership and Collaboration



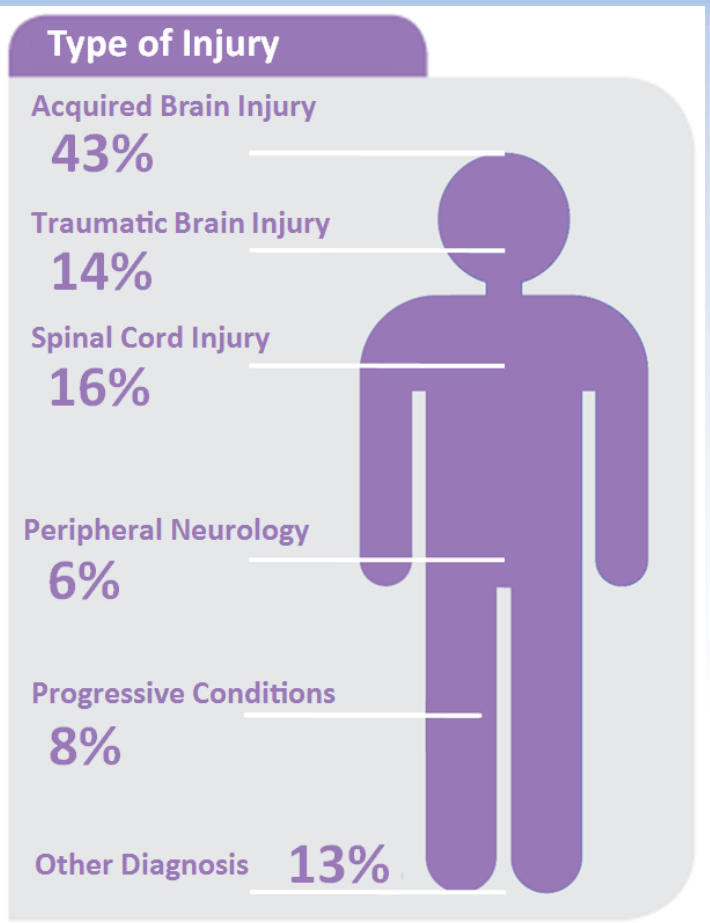
CMRN Services offered

- Comprehensive therapy team
  - Physiotherapy
  - Occupational therapy
  - Speech and Language therapy
  - Clinical and Neuro Psychology
  - Dietetics
- Rehabilitation consultants
- Rehabilitation coordination team
- Rehabilitation nurses
- Vocational rehabilitation specialist
- Mental health team
  - Consultant Neuropsychiatrist
  - Mental health nurse
  - Liaison Psychiatry
- Links with orthotics, orthoptics, medical and surgical specialties

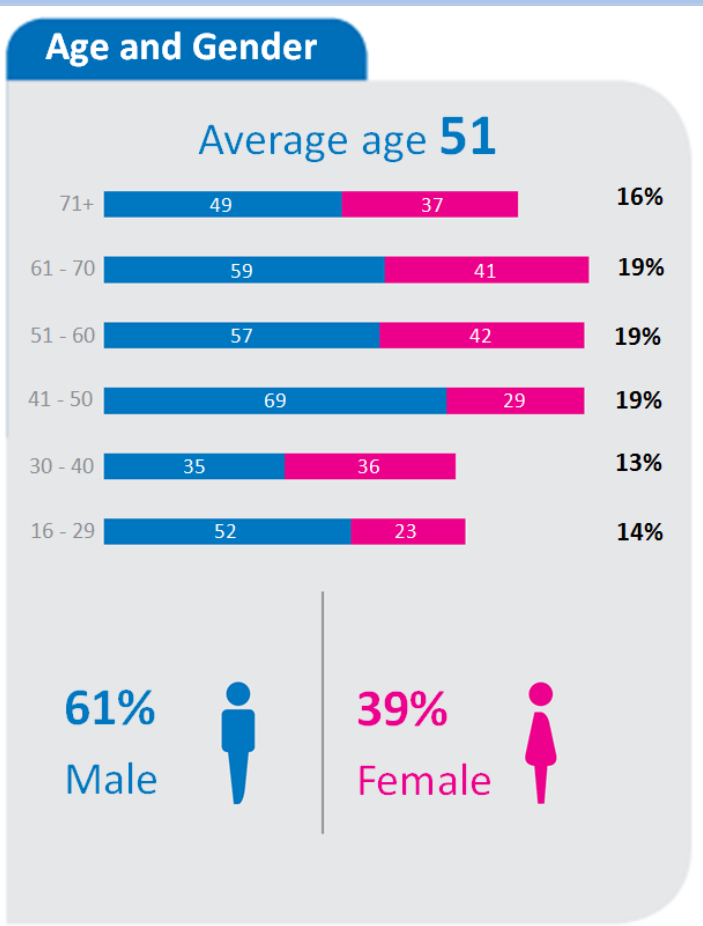
CMRN Performance
over the first 18 months

Who uses our services

Type of Injury



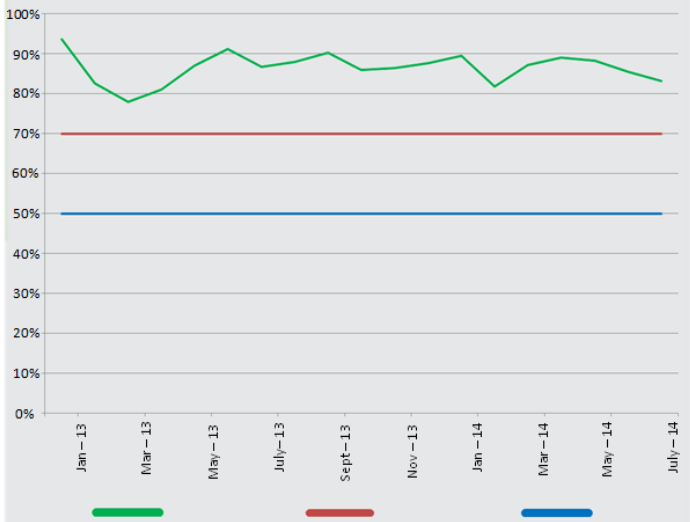
Age and Gender



Co-ordinated Rehabilitation Pathway

Rehabilitation Complexity

Rehabilitation Complexity Score



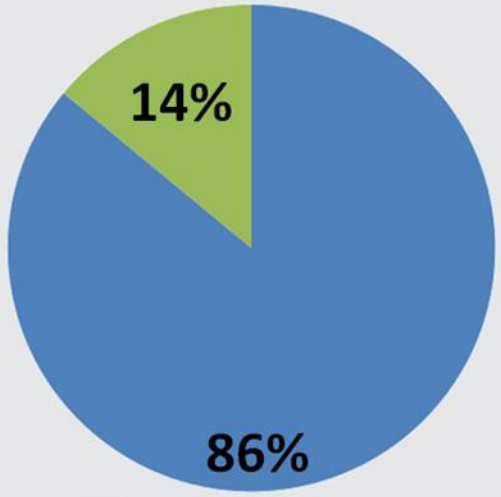
Average Rehabilitation Complexity Score ≥ 10

70% Hub Target Rehabilitation Complexity Score ≥ 10

50% Spoke Target Rehabilitation Complexity Score ≥ 10

Rehabilitation Complexity

Categorisation of Rehabilitation Need



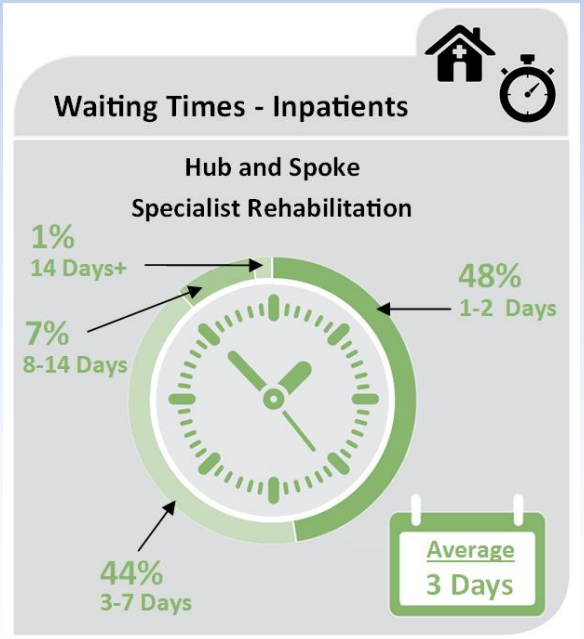
Percentage of Category **A** Patients

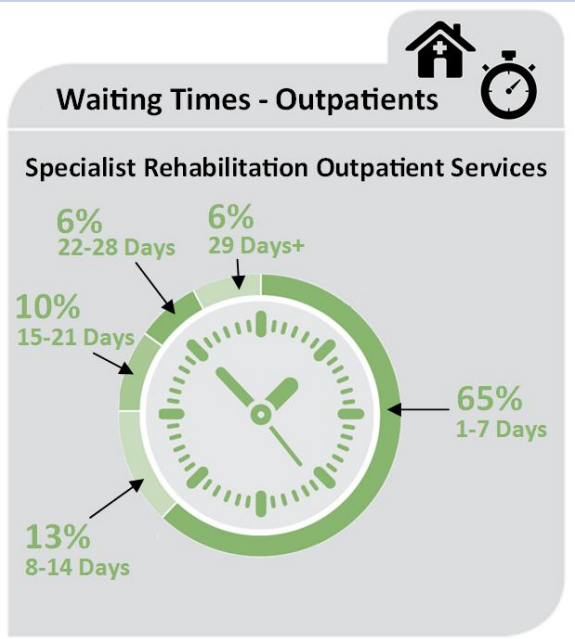
Percentage of Category **B** Patients

Hub target percentage for category A patients = 85%

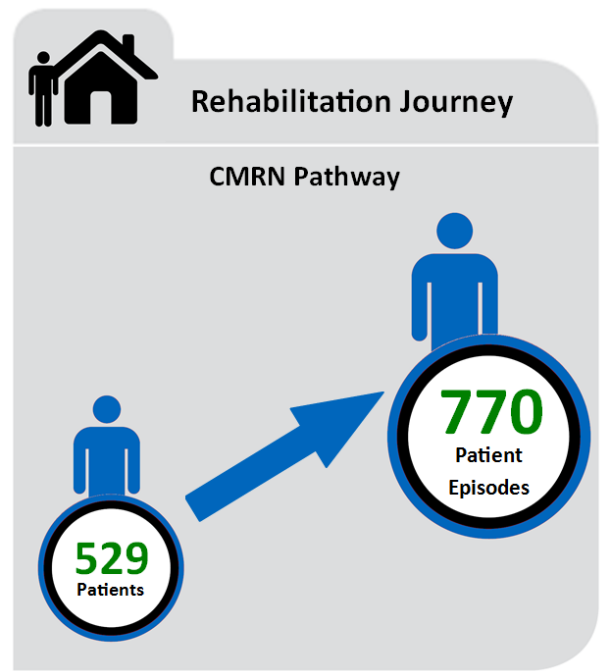
Spoke target percentage for category A patients = 50%

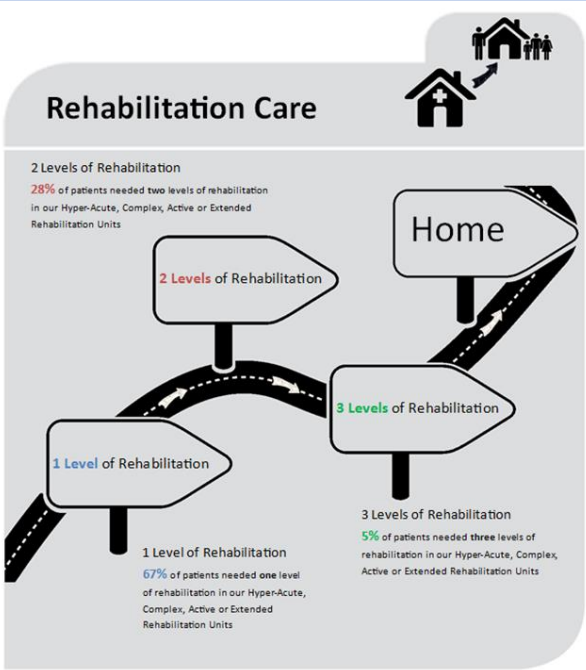
Waiting Times

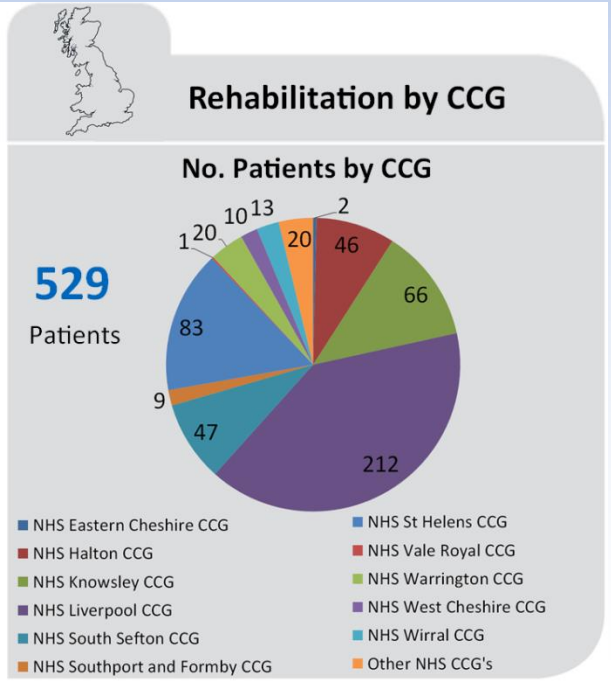




Access to Specialist Rehabilitation







Co-ordinated Rehabilitation Pathway

Inpatient Rehabilitation

Hub, Spoke and Extended

90 patients needed supportive rehabilitation in our **Hub HARU**

158 patients needed supportive rehabilitation in our **Hub CRU**

238 patients needed active rehabilitation in our **Spoke Units**

40 patients needed a further period of rehabilitation in our **Extended Unit**

Outpatient Rehabilitation

Outpatient Services

30 patients received outpatient specialist rehabilitation

5 treatment sessions were provided at **The Royal Liverpool and Broadgreen Hospital**

173 treatments sessions were provided at **The Seddon Suite**

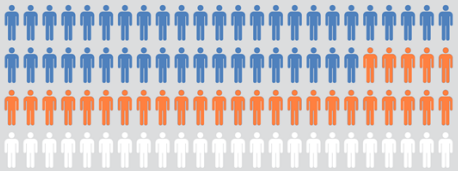
Community Rehabilitation

Community

of referrals met criteria for on-going specialist rehabilitation at home

116 patients registered with a **Liverpool, South Sefton or Southport and Formby CCG**

77 patients registered with a **St Helens or Knowsley CCG**



road to recovery....

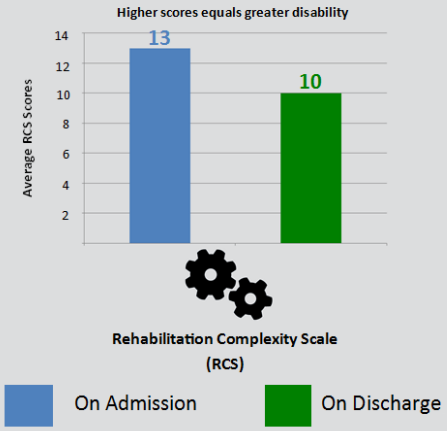
Rehabilitation and Outcomes

Rehabilitation Support

- **100%** of patients received Specialist Rehabilitation from the **Multi-disciplinary Team** as required
- **95%** of patients required **Speech and Language Therapy**
- **81%** of patients required **Psychology**
- **100%** of patients required **Neuro-psychiatry**
- **100%** of patients had a dedicated **Rehabilitation Case Manager/Coordinator**

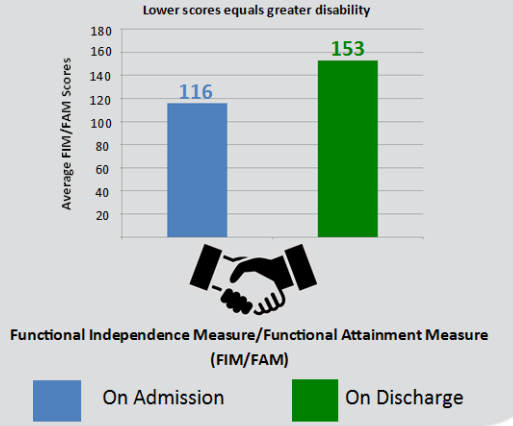
Rehabilitation Complexity

RCS measures of rehabilitation complexity



Rehabilitation Complexity

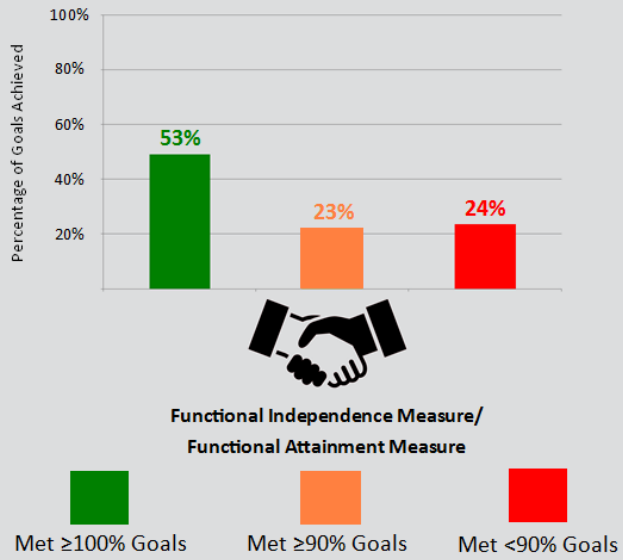
FIM/FAM measures of rehabilitation complexity



Rehabilitation Adjustment and Abilities

Adjustment and Abilities

Achievement of Inpatient Goals



Adjustment and Abilities

Achievement of Community Goals

of patients **fully achieved** their individual goals (E.g. Activities of Daily Living, Recreational Activities and Mobility)

of patients **partially achieved** their individual goals

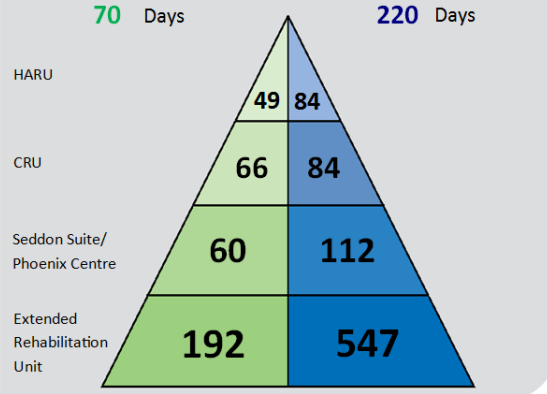
of patients **did not achieve** any of their individual goals

Length of Stay and Discharges

Length of Stay

Actual *versus* Forecast Days

Actual Patient LOS (Average)	Forecast Patient LOS
70 Days	220 Days



Discharges

From CMRN Pathway
(Total 372 patients)

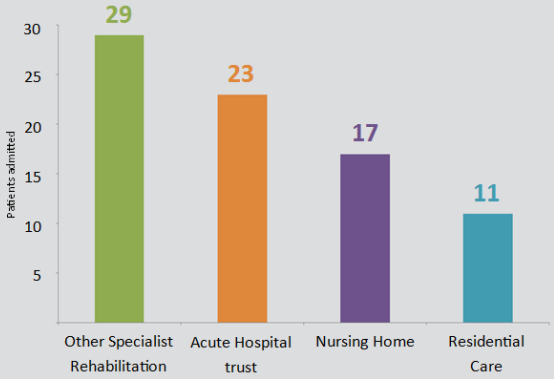
On discharge

81% of patients were discharged home

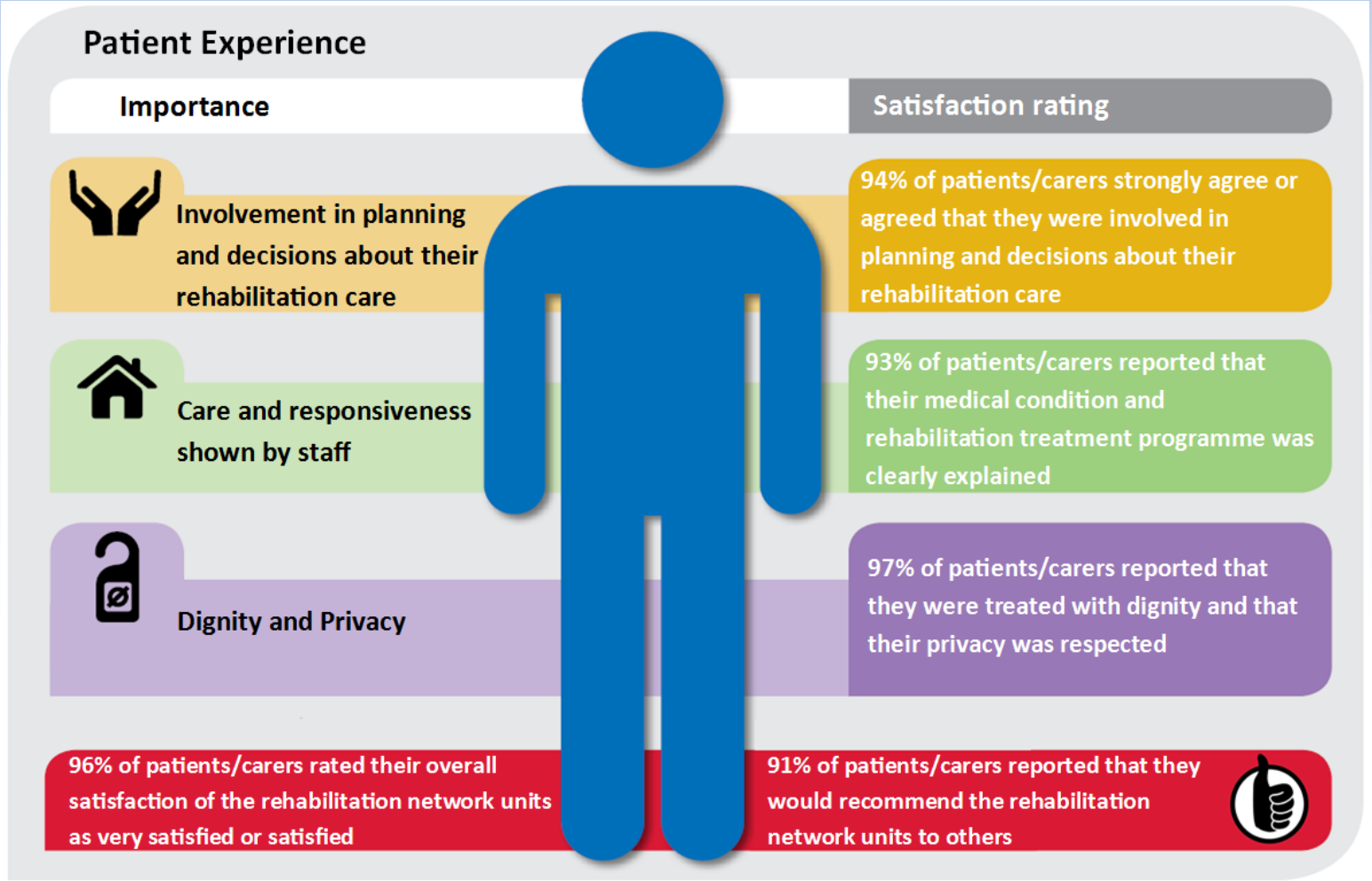
19% of patients were admitted to alternative destinations

Discharges

Breakdown of alternative destinations
(Total 80 patients)



Patient and Family Experience

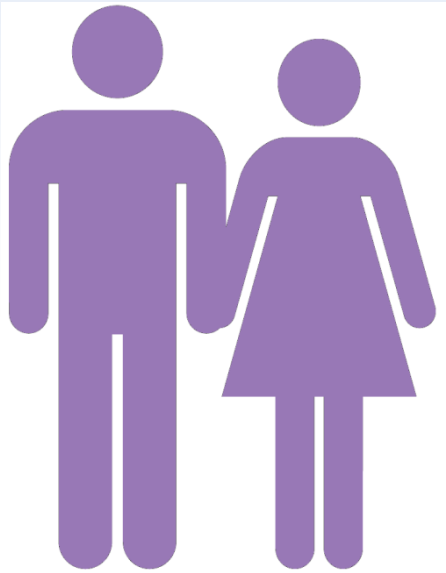


A snapshot of comments from our patients

'Fantastic care with a real emphasis on dignity'
(Hub Hyper Acute Rehabilitation Unit)

'The staff have been kind and helpful and have been very impressed with the level of care and rehabilitation. I was treated with respect'
(Broadgreen Spoke Specialist Rehabilitation Unit)

'This is the type of service that all individuals with complex needs can benefit from. This service is the most person centred I have ever observed. Very pleased with all treatment and conditions – thank you for giving me back my life'
(St Helens Spoke Specialist Rehabilitation Unit)



'The care, support and treatment he received was outstanding. His treatment was always explained to us and staff would answer any questions or concerns and were always there to help. I most definitely trusted and had 100% confidence on all the care professionals'
(Hub Complex Rehabilitation Unit)

Recognising and overcoming the challenges…

- Working as a large team and across multiple organisations
  - infrastructure to work with all partners, governance structure, processes, communication, linking research and innovation with clinical themes
- Increasing demand and impact on waiting times
  - proactive systems, early discharge planning, social workers as part of the team
- Maintaining the same rehabilitation ethos across all service levels
  - Network themes and branding, network wide educational events, speciality forums
- Inequitable provision of level 2 rehabilitation for Cheshire patients
  - Met in part by 10 additional level 2 beds now opened at Walton Centre, available for spot purchase by any CCG
  - Parts of Cheshire do not have community services commissioned through the Network

Looking Forward

- Continuing to address these challenges
- Education and Teaching
- Local NHS and University partnerships - driving collaborative research and innovation

A patient experience film

Patient film

A staff experience film

- *Beverley Webster, A Physiotherapist working at St Helens Spoke Rehabilitation Unit*

Summary

R - Regional co-ordinated pathway across a whole systems model of care

E - Clinically effective and cost efficient

H - Holistic, person-centred approach

A - Achievement of regional and national specialist rehabilitation standards

B - Based on rehabilitation needs, not diagnosis

Thank you

Any Questions?

Latest Developments in Assistive Technology

Birmingham – Thursday, 19 November 2015

History

- C3 Quadriplegic on full-time ventilation
- Motorcycle accident 27th May 1995, same day as Christopher Reeve, similar injuries
- Paralysed from the shoulders down
- 11 years experience in computing hardware and system software at time of accident in 1995 in the role of International Support Consultant
- Started using/supporting speech recognition software Dragon Dictate in 1996
- Involved in Dragon NaturallySpeaking software development programs since 1999
- Involved in various assistive technology trials and assessments
- 2001 onwards provide Assistive Technology Consultancy and Expert Witnessing services for the legal profession mainly for spinal injuries
- Married with 2 children born 2001 and 2004
- BSc (1st Class Hons) Computing and Software Development 2007, Dip Comp. 2003
- Distinction dissertation in speech recognition software development and other software development with regard to disabled needs
- Speech application commercial development, setting up pcbyvoice in 2011
- Environmental Control development since 2011/2012
- Project Management of complex Assistive Technology disabled home installations

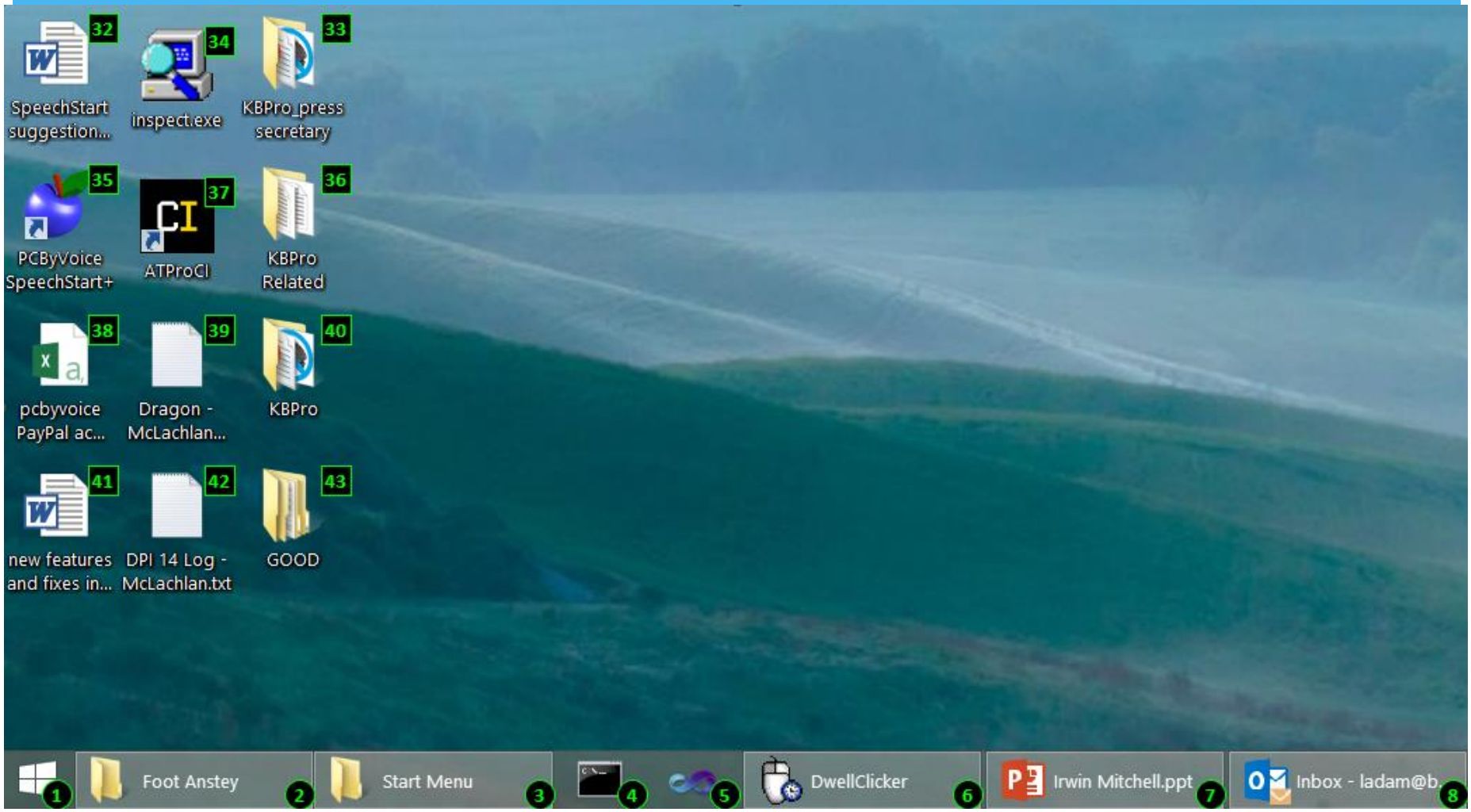
pcbyvoice Ltd – What we do

- Disabled Home Assistive Technology Project Management
- Disabled Home Assistive Technology Implementation and Installation including Environmental Control customised solutions
- IT Automation Services
- Assistive Technology Consultants
- Expert Witness Services
- Hands Free and impaired mobility Environmental Control Solutions
- Speech-based software development for the disabled
- Speech development programs with Nuance, Sonos
- Software Development Services to speech enable your application
- Speech Recognition Software Consultancy and training

Areas of Assistive Technology

- Hands-free Computer Control
- Hands-free Tablet/Smartphone control
- Hands-free Environmental Control
- The latest in the world of Speech Recognition
- Thought Control
- Robotics
- Exoskeletal and Environmental Control

Speech Application Development



The World of Smartphones and Assistive Technology
Housemate Pro / ClickToPhone

100% Hands-Free Access to Android
Make and receive calls, texts
100% access to any app
Complete Environmental Control

pcbyvoice.com

Why choose ClickToPhone / Housemate Pro?

- We work on any android device 100% hands-free:
- the latest Galaxy S6 Edge+, the new Galaxy Tab S2 tablets, budget android devices. HTC, Sony, LG. Anything Android.
- Everything hands-free. Built-in text-to-speech app, make and receive phone calls, send and receive texts (integrated speech recognition), Internet access, email, alarms, environmental control, music, diary/reminders, text alerts.
- We provide 100% hands-free access to any app.
- Use any assistive technology switch, buddy button, suck and blow, tongue switch, muscle twitch…
- Integrate with any joystick or wheelchair joystick control system. Dynamic Controls or Penny and Giles.
- Simple to complex user levels and protection. Hands-free mouse systems.
- Who uses ClickToPhone / Housemate Pro?
- Flexibility in every department from ECU grids, icons, app access…
- Weekly and monthly enhancements and function requests. Software version 129. Dedicated development.
- True environmental control providing access to all the latest apps from complete central heating control, fire alarms and security, air conditioning, wireless music, lighting control.

European Conformity (CE Marking)

HouseMate is marketed as a technical aid for people with disabilities and satisfies the requirements of the Medical Device Directive 2007/47/EC.

This includes conformity with essential requirements of Council Directive 2004/108/EC of 15th December 2004 concerning electromagnetic compatibility.

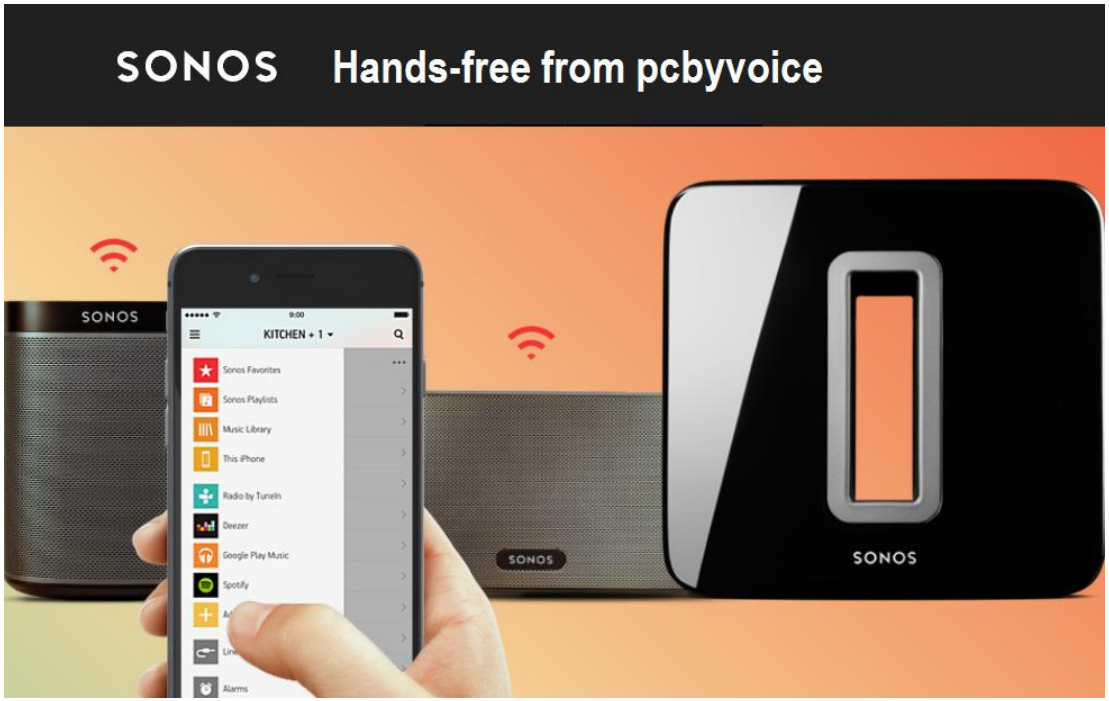
The following international standards have been applied:
I.S. EN ISO 16201:2006 – Technical aids for disabled persons
- Environmental Control Systems for Daily living.
I.S. EN ISO 14971L2012 – Medical devices
– Application of risk management to medical devices.
EN60601-1-2: 2011
EN 55016-2-3 (2010) & A1 (2010) - Emissions
EN61000-4-2 (2009) – Electrostatic discharge
EN61000-4-3 (2006) – Immunity
R&TTE Directive 1999/5/EC

Housemate Pro / RAKO Hands Free lighting

Hands-free Smart Lighting

Housemate Hands-free music

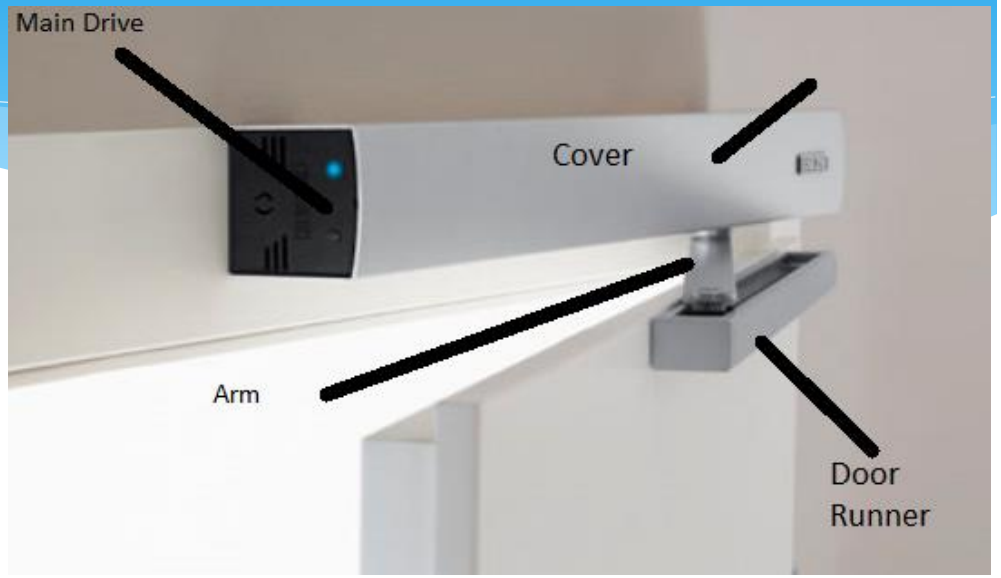
Take advantage of hands-free music in any part of your house using Housemate and, for example, Sonos the ever popular Wireless music system



Housemate Pro ECU / Various automation equipment videos.

- Automatic Door with Video Entry
- Patio door and curtains
- Patio Doors from the outside
- Automatic Blinds

Retrofitted Window Opener and Internal Door Opener



- Retrofitted window opener
- Close-up of internal opener
- Discrete installation

Housemate Pro and Apple?

Housemate Pro available with iOS from January 2016.

Use it with:

Your iPad
Your Mini iPad
Your iPhone 6
Your iPod
Any other iPhone
(iOS 7 and above)

Available for Windows from Spring 2016

- Use Housemate Pro with your Surface Pro 2, 3 or 4 or any other Intel Windows tablet.
- Fully voice integrated using Nuance software development kits. pcbyvoice are a Nuance advantage partner and software developer.
- Integration with any HeadMouse technology including SmartNav, Quha, Tracker Pro…
- Integration with the latest eyegaze-technology, the new Tobii IS4 eye tracking platform, Tobii EyeChip™

Panel session - Q&A

Thursday 19 November 2015

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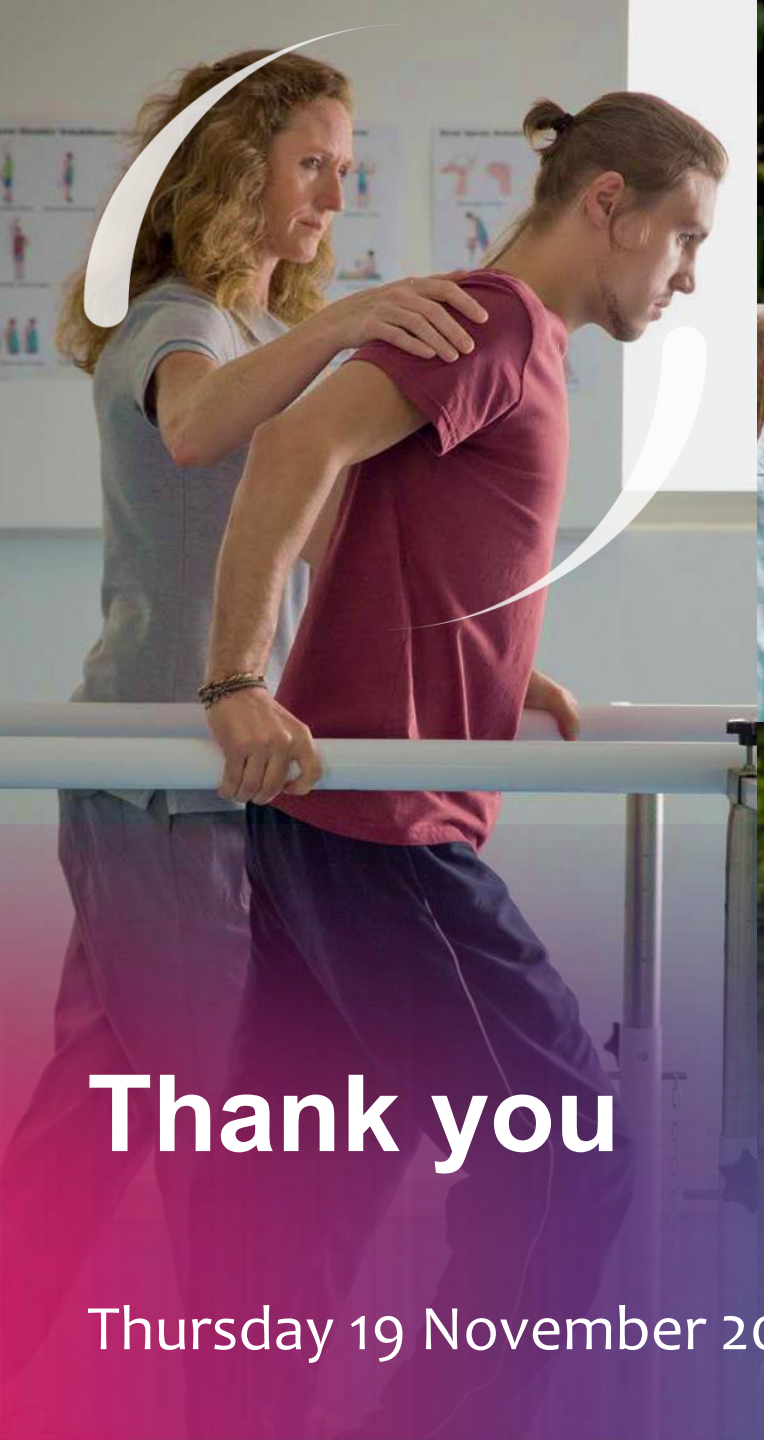

Thank you

Thursday 19 November 2015

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