Rehabilitation Research

Roundtable Discussion Summary

In February 2013, Irwin Mitchell launched a national research report: 'Counting the cost of the rehabilitation postcode lottery for road crash victims' which painted a national picture of use and demand for rehabilitation services in England and Wales.

One year on, Irwin Mitchell were keen to see if the same conclusions of the original research were the same with those who are working on the frontline in the NHS, the independent and charity sectors through a series of roundtable discussions. The aim was to discuss access to rehabilitation in their geographical area, how it could be improved and any positive outcomes for the future.

Access to rehabilitation

Delegates spoke passionately on the key challenges in providing rehabilitation services to serious injury patients and without exception, felt that specialist rehabilitation services for patients with acquired brain injury (ABI) were stretched to the furthest limits of capacity. The following main issues emerged from the various discussions that took place:

The lack of an unambiguous national standard requirement for neurological rehabilitation after acquired brain injury meant that commissioners and other statutory bodies are not compelled to meet any goals therefore do not prioritise resource allocation to neuro-rehabilitation for ABI.

Inadequate funding levels with the emphasis for funding at the acute service stage and then the funding falls away, which may in part be influenced by the foregoing comment, places severe constraints on the amount of input that can be provided for each patient and the duration of that input.

A Cinderella service is still indeed in operation within the NHS. There have been vast improvements in certain acute areas but obviously there is still a long way to go especially in terms of the basics which was recently highlighted in the Mid Staffordshire NHS Foundation Trust Public Inquiry.

The bureaucracy of assessing criteria issues when leaving acute services is letting patients down with an unbalanced approach to needs assessments. There was a strong sense that decision makers were approaching assessments with a specific aim of minimizing the resultant resource allocation rather than an open-minded assessment of the patient's true needs.

The impact of good access to rehabilitation

The benefit of rehabilitation in the long term cannot be underestimated. Not only does that benefit offset the initial costs of funding intensive rehabilitation (whereby the individual's cost to the state are reduced because of less demand for long term practical or social support resources), but also the general balance of understanding in the community of the impact of ABI and the vital role rehabilitation plays. The right rehabilitation programme can reduce the various inter disciplinary resources required to manage this cohort of society.

Effective rehabilitation has a health and social benefit, and examples were given of reducing marital breakdown after serious injury, as well as suicide rates. Concerns were expressed that these benefits will be lost with inadequate funding for rehabilitation.

The impact of poor access to rehabilitation

All of the roundtable discussions agreed that there is an increased burden on family carers. Particular concern was expressed for the amount that consequently falls onto the shoulders of family and friends to pick up the pieces if a patient, has not optimised their function and independence through effective rehabilitation.

It was felt that families need to be provided with appropriate strategies to deal with their family member when they return back home and into the community. Often it is the family having to care for the patient where they do not understand the behavioural issues which of course have a massive knock on effect not only for the patient but the family themselves. There is a high rate of mental and physical health issues within the family who are often in a constant state of stress.

A lack of intensive and properly integrated rehabilitation at the start of a patient's programme post-acute service, can compound the existing myriad of problems suffered by those with an ABI and their families which is felt later down the line.

An initial misunderstanding (and sometime inertia) of the long terms effects of a brain injury, not only has a negative effect on the patient but also the family. Individuals with complex needs post an ABI and their families are simply told: *'They have a brain injury, what do you expect?'* In some instances it is the physical element that is managed but not the brain injury itself, and it is implied that the cognitive problems, maladaptive behavior and obtuse approach of those with an ABI is expected and should therefore be accepted.

Recommendations for improving access

A variety of solutions were provided subject to funding not being an insurmountable hurdle including:

- To adopt a national requirement for a minimum standard of multi-disciplinary neurological rehabilitation after an ABI
- Stroke, neurology and ABI should 'reconnect' into one single service and that by separating into three separate strands as they have tended to, despite having rehabilitation as a common goal, they lose economies of scale and "loudness of voice" with decision makers
- A national standardised pathway with standardised assessments focused round the needs of the patient. This would define their immediate needs and their pathway from acute care to specialist units and the community, whether it is by way of education, community services and/or vocational rehabilitation
- Commissioners of services in any one region should include at least one commissioner with a brain injury special interest.
- A brain injury co-ordinator/case manager's role embedded within the NHS that can oversee the care pathway for ABI patients and ensure that their rehabilitation needs are met by liaising with the various agencies
- Continuity of care for each patient, from acute to community care, looking at opportunities to work with the same support team for each patient in the longer term
- Set one gold standard of rehabilitation with one model for the NHS to follow no matter where you live and with access being improved by giving more choice to the patient.

Initiatives in the field of trauma and rehabilitation services

A number of initiatives were proposed reflecting major changes that have occurred elsewhere in the NHS in recent years including:

Appointment of a Brain Injury Rehabilitation Tzar who would duplicate the role of existing national NHS Tzars and would consider resources, even if limited, where they could be best placed, to press for further support and education in the field of brain injury.

Recouping of funds that the NHS receives from motor insurers after road traffic collisions (where a private insurance claim is made) could be directly reinvested into rehabilitation services. Currently there is no visibility in what sums are recovered, and where those sums are then spent by the Trust.

Vocational Rehabilitation - increase the understanding of employers to increase the potential for those with a brain injury returning back to work. There are positive stories of an understanding employer, but this is not the norm, especially if it is a potential new employer/managerial position in place post injury.

Positive outcomes

It is still relatively early days, it was thought, in the development of the new Clinical Commissioning Groups to draw too many conclusions. On a more hopeful note, some of the delegates considered that there was still the opportunity to engage with the new stakeholders, as things settle down and decision making becomes clearer. Delegates saw more of a role for the private sector in that whilst it certainly wasn't universal, many interactions with the private sector had been positive, provided that they were dealing with specialists, e.g. solicitors, independent case managers, therapists and care providers.

There were positive discussions about working alongside the NHS in the community and how individuals do have positive experiences through their rehabilitation pathways albeit often by their own efforts due to their and their families own personal determination. Reiteration was given to the fact that rehabilitation should be a lifelong approach.

It was suggested that a change model should be introduced whereby there is a consensus of vision that is derived from increasing the need for change, collaboration and then sharing a vision to ensure positive rehabilitation structures are in place for the benefit for those with a brain injury.

Further information

This report is a summary of three roundtable discussions that took place in Derby, Manchester and Bristol. If you would like a copy of any of the full regional findings, please email Lynne Carrick-Leary at: **lynne.carrick-leary@irwinmitchell.com**

You can read the Executive Summary of: 'Counting the cost of the rehabilitation postcode lottery for road crash victims' at: **www.irwinmitchell.com/postcodelottery**

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