

Acquired Brain Injury London

Wednesday 20th June 2007



London Specialised in-patient Neuro-rehabilitation

Kellie Blane
20th June 2007

Outline


- What is a consortium
- Benefits of a consortium
- Key facts and figures
- Way forward

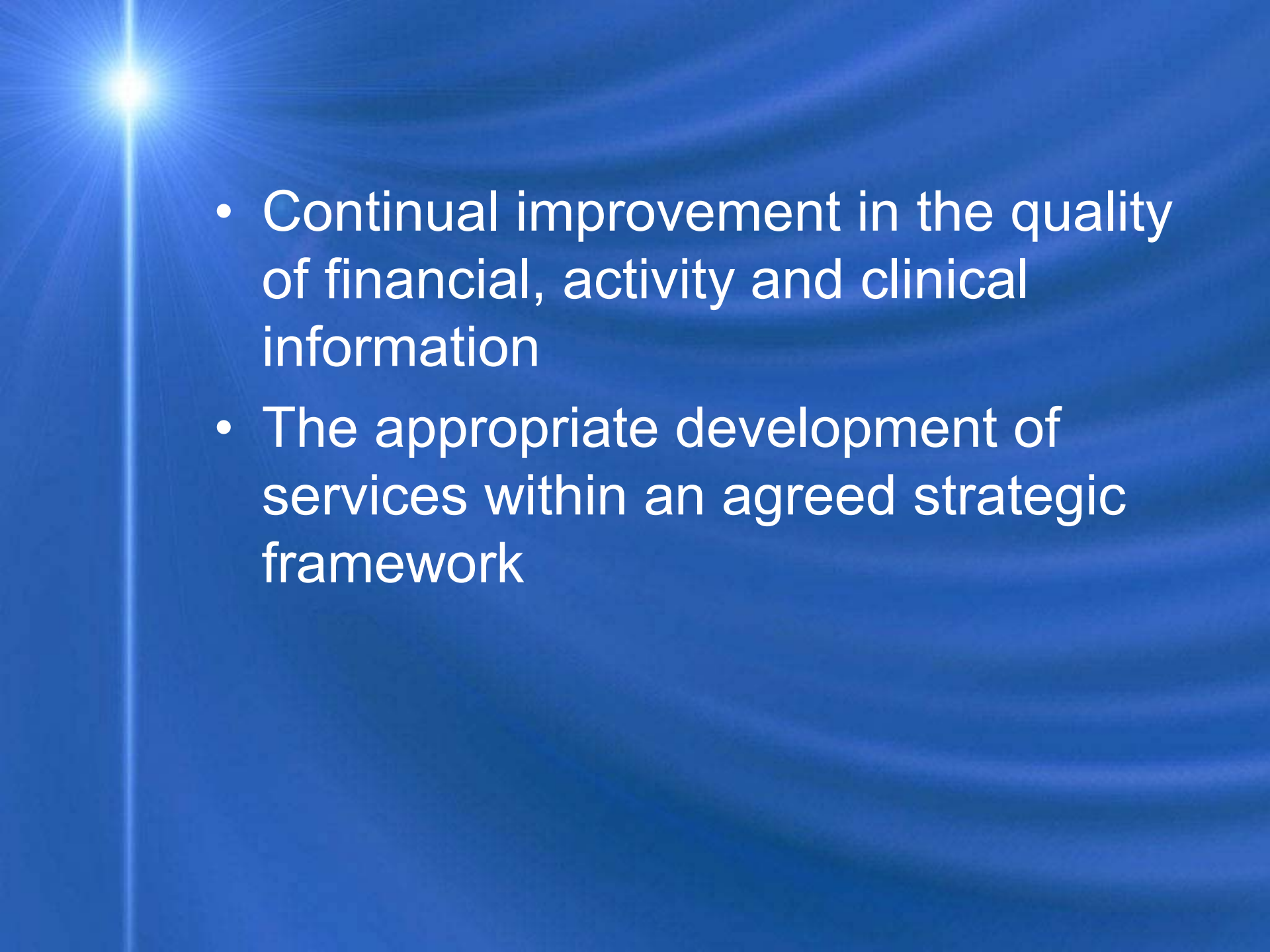
What is a Consortium ?

“A group of PCTs pooling their resources to commission a service on behalf of a larger population base, in order to generate economies of scale and reduce financial risk for the individual organisations”

Main Tasks of a Consortium

- Assessing need for services, and comparing this with current provision
- Developing strategic plans, incorporating agreed service standards
- Achieving equity of access

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- Involving stakeholders, in particular patients groups and service users
 - Developing arrangements to manage financial risk between commissioners, and between commissioners and providers
 - Monitoring and addressing performance to achieve targets and quality standards, including long-term health outcomes

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- Continual improvement in the quality of financial, activity and clinical information
 - The appropriate development of services within an agreed strategic framework

Consortium Structure





Risk Share Examples

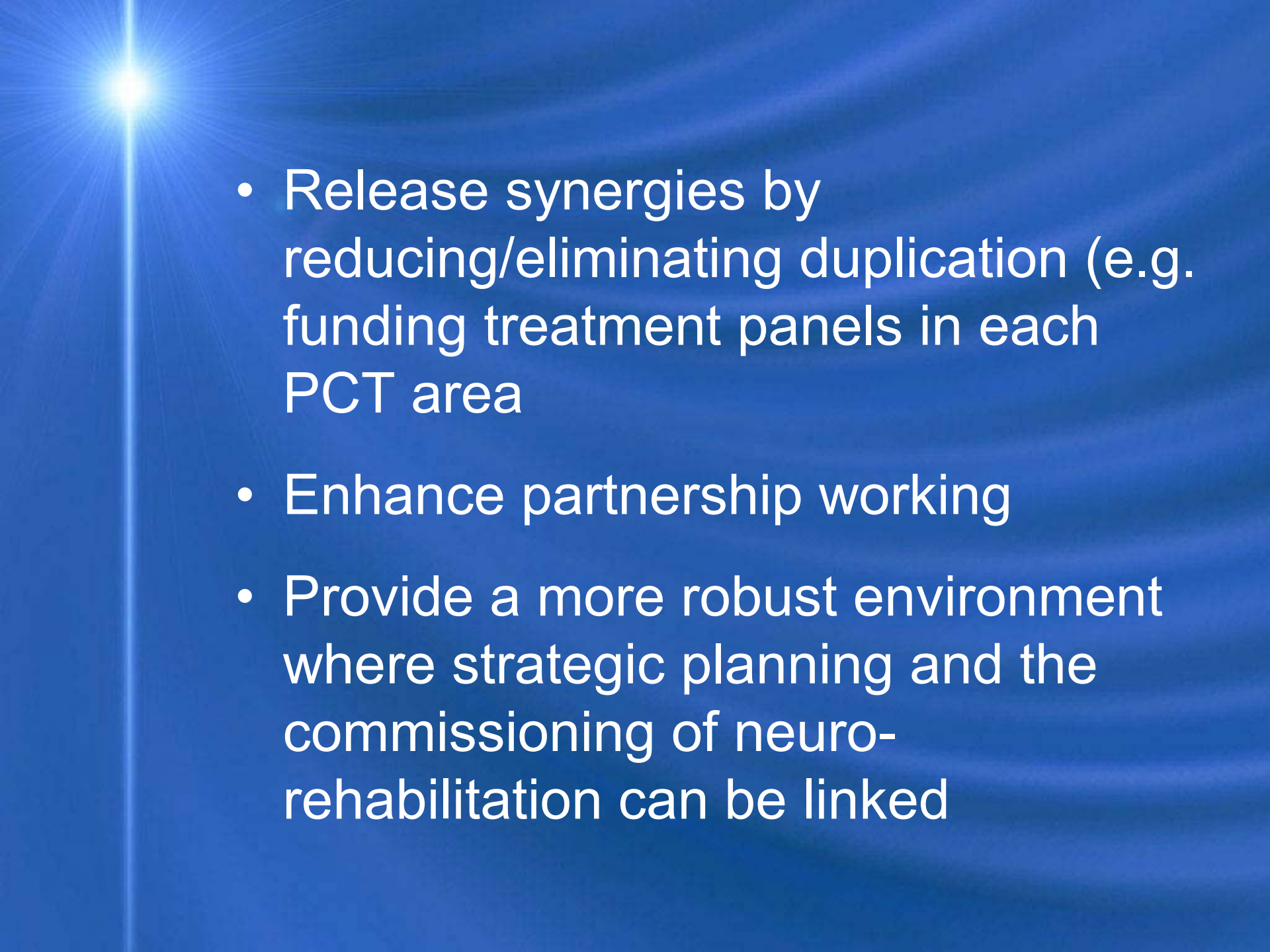
- PCTs risk share based on their % contribution
- Over-performing PCTs share the over-performance
- Under-performing PCTs off-set over-performing PCTs then remaining PCTs pick up the balance
- Thresholds whereby an individual PCT picks up financial responsibility after the agreed trim point is reached

Benefits of a Consortium

- Stabilise the overall effect of potentially volatile activity fluctuations on PCTs and Providers
- Ensure equitable access for all Neuro rehabilitation patients
- Provide a stable commissioning environment within which regional decisions can be made and robustly managed

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- Contribute to the development of robust and improved discharge arrangements supported by a central point of coordination
 - Provide a single point of contact for providers to agree placements in line with the service specification
 - Provide commissioners with timely, accurate and standardised activity monitoring information

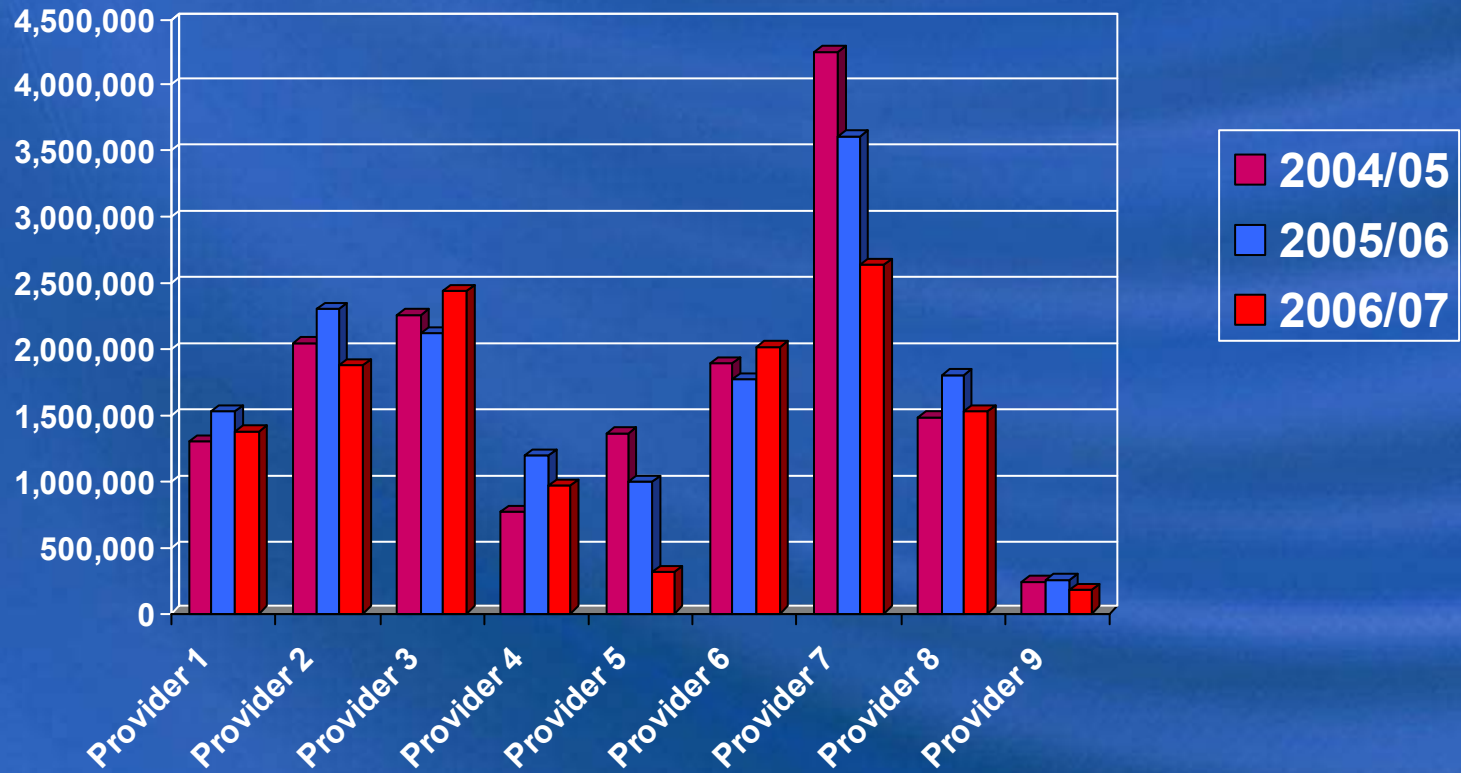
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- Provide a platform to enable more robust clinical reviews feeding into the commissioning of neuro-rehabilitation services
 - Facilitate the sharing of good practice across Providers
 - Facilitate workforce planning across London

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- Release synergies by reducing/eliminating duplication (e.g. funding treatment panels in each PCT area)
 - Enhance partnership working
 - Provide a more robust environment where strategic planning and the commissioning of neuro-rehabilitation can be linked

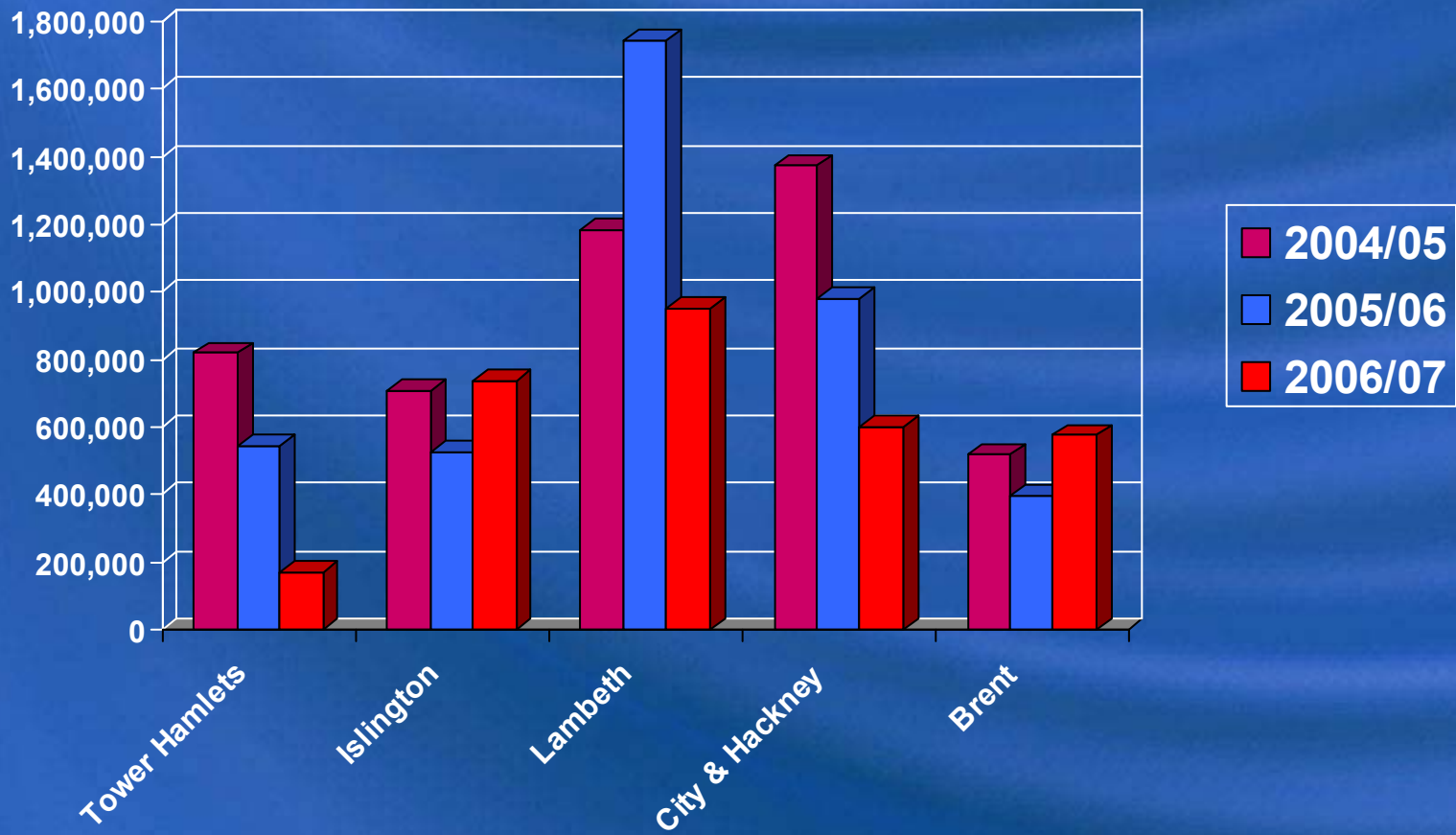
Providers of the Consortium

- **Brain Injury Rehabilitation Unit, Edgware**
- **Frank Cooksey Rehabilitation Unit**
- **Regional Neurological Rehabilitation Unit, Homerton**
- **Lishman Brain Injury Unit**
- **Neurological Rehabilitation Unit, UCLH**
- **Regional Rehabilitation Unit, Northwick Park**
- **Royal Hospital for Neuro-disability, Putney**
- **Wolfson Neuro Rehabilitation Centre**
- **Blackheath Brain Injury Rehabilitation Centre**

Provider Expenditure Over 3 Years



PCT Expenditure Over 3 Years



Way Forward

- Ensure the Services are fit for purpose
- Patient involvement
- Review access to service
- Identifying the future challenges
- Value for money and cost efficiency

2007/08 Work Programme

- Lead on the Health Delivery process for the 26 London PCTs
- Provide reliable monitoring information for the members of the Consortium
- National benchmarking exercise reviewing current referral costs

- Participate in the DoH expert Working Group to determine the v4 HRG tariff for Rehabilitation services in 2008/09
- Uses of rehabilitation complexity score to review the financial implications of moving to PbR
- Develop quality measures from the NSF
- Identify clinical outcome measures currently used in each Trust
- Develop London wide assessment process

Contact Details

Kellie Blane

Associate Director of Specialised
Commissioning – North East Sector

0207 456 6781

Kellie.blane@thpct.nhs.uk

Kellie Blane, Acquired Brain Injury Forum
20th June 2007



London Specialised Neuro- Rehabilitation Consortium

Kalex Kalialia
20th June 2007

Background

Work of London Neuro-rehab Working Group as predecessor to Consortium:


- Mapping exercise looked at current provision
- Development of the pan-London service specification
- Survey of Reasons for delayed discharges
- Input in the development of HRGs & tariff for PbR (via Prof Lynne Turner-Stoke)

Challenges

- Complex clinical pathways
- Partnerships / integration between organisation
- Patients journey through the pathway
- Harmonised referral systems
- Common assessment process
- Outcome measurement tools

Brain Injury Pathway

- Close capacity deficiencies and provision gaps where they exist
- Address delayed transfers of care – to safeguard rehab gains
- Tackle delayed discharges, bed blocking, lost bed days

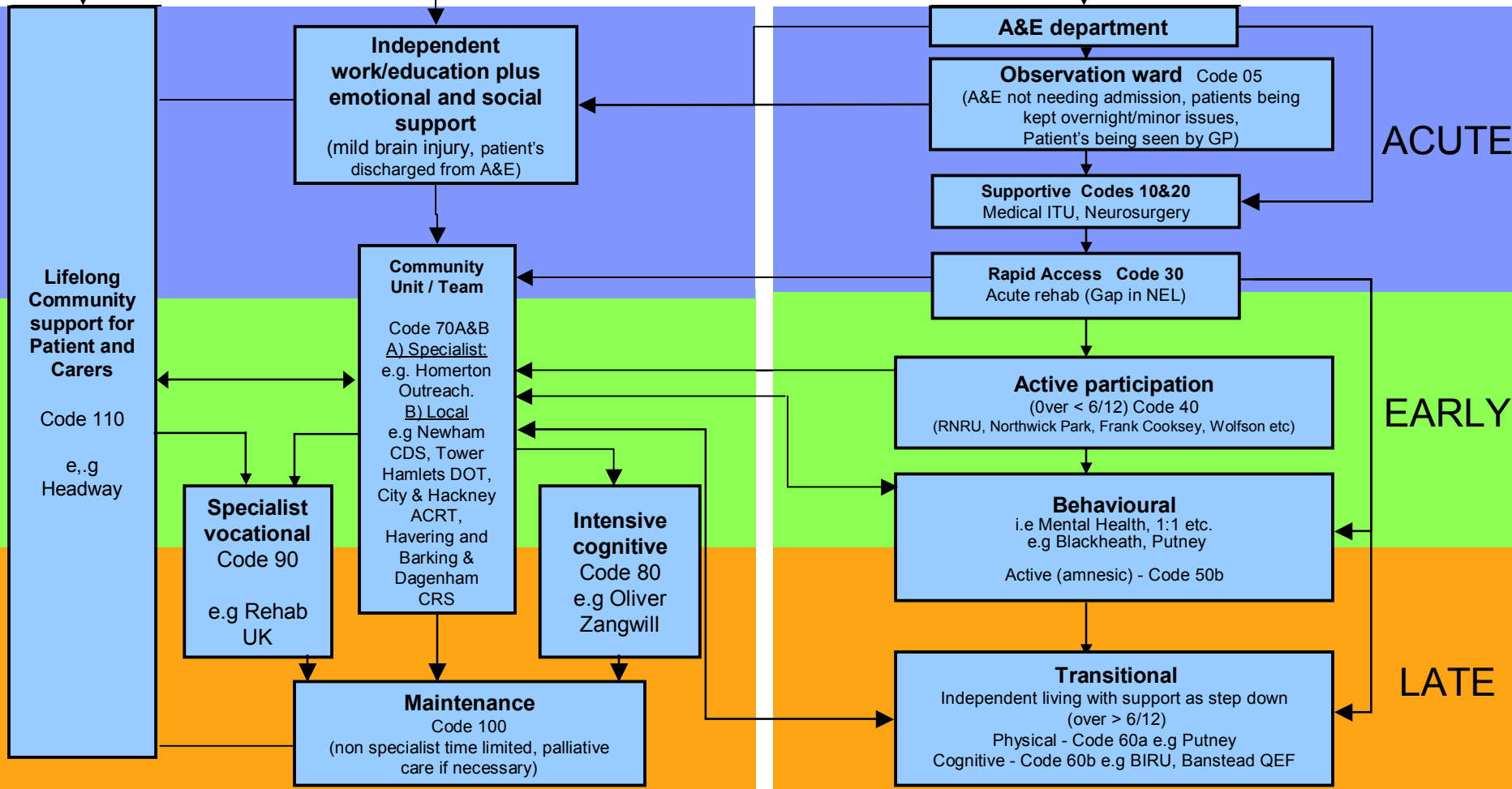
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- Maintain good accessibility – equity and waiting times
 - Develop innovative models: e.g. outreach rehab

NEURO-REHABILITATION CARE PATHWAYS FOR BRAIN INJURY PATIENTS FROM NORTH EAST LONDON

Community and Outpatient Services

Hospital and Inpatient services

Acquired Brain Injury



GPs and social services will be involved in all stages of care in the pathway, which will be underpinned by the social model of care.

Contact Details

Kalex Kaliaia

Specialised Commissioning
Manager– North East Sector

0207 456 6771

kalex.kaliaia@thpct.nhs.uk

Kalex Kaliaia, ABIL, Acquired Brain Injury
Forum for London 20/06/07



London Specialist Neurorehabilitation Consortium

South East London

2007-2008

What is in the Southeast?

- 6 Primary Care Trusts
- 6 Acute Hospitals
- 3 Neurorehabilitation units (within the consortium)

What process in place?

- Different processes and pathways in different PCT's
- Processes depends on services available in the community
- These processes are robust and suitable for these PCT's

Meanwhile....

- Every PCT using their own pathway
- We, southeast sector, trying to work together
- We have met once and trying to set up further meetings soon
- We are aiming to have a common operational guideline
- The following are some examples of the current processes

Bromley PCT

- Referrals

- PCT must be informed
- PCT must check G.P registration
- Patient must be seen by neurologist
- All necessary referral documentation to be sent directly to the proposed receiving neuro-rehabilitation centre. Copies must be sent to the PCT's commissioner. This enables the commissioner to be aware of progress and to raise any concerns or issues.

- Admission

- The initial admission period is in twelve weeks with clear evidence of progress and potential at the first review.
- PCT must inform G.P
- PCT must inform Social Services ABI/TBI lead.
- PCT must inform PCT Wheelchair Service

Lambeth, Southwark and Lewisham PCT's

- Younger Persons' Disability (YPD) Service takes the lead for neurorehabilitation pathway
- The service provide a Case Management and funding for clients requiring specialised rehab
- A full MDT report send with a referral to the team
- All new referrals get discussed on Monday
- If accepted, a Case Manager (CM) is allocated
- CM will discuss with referring team and recommend action
- The team will confirm the placement directly with the unit
- Clients (in independent sector) will be reviewed every 12 weeks to determine progress and further goals
- The team will ensure Social Services involved as soon as required

NORTH EAST LONDON NEUROLOGICAL CONDITIONS NETWORK

NEURO REHABILITATION SERVICE PROVISION MAPPING

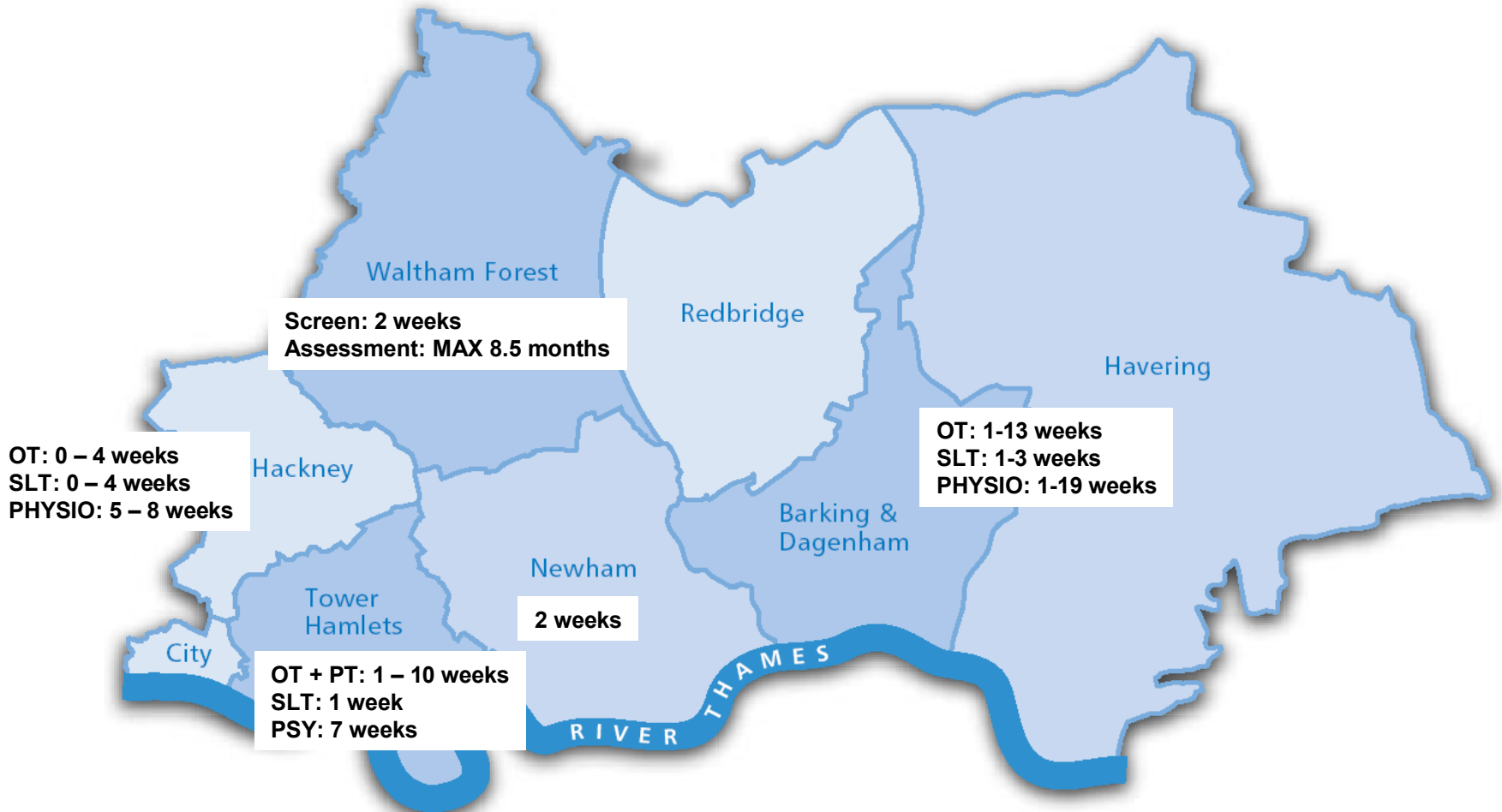
Acute, Community and Outreach Rehabilitation



- ▲ Acute
- ★ Community
- Outreach Rehab

Waiting Times

Referral to Assessment



Waiting Times

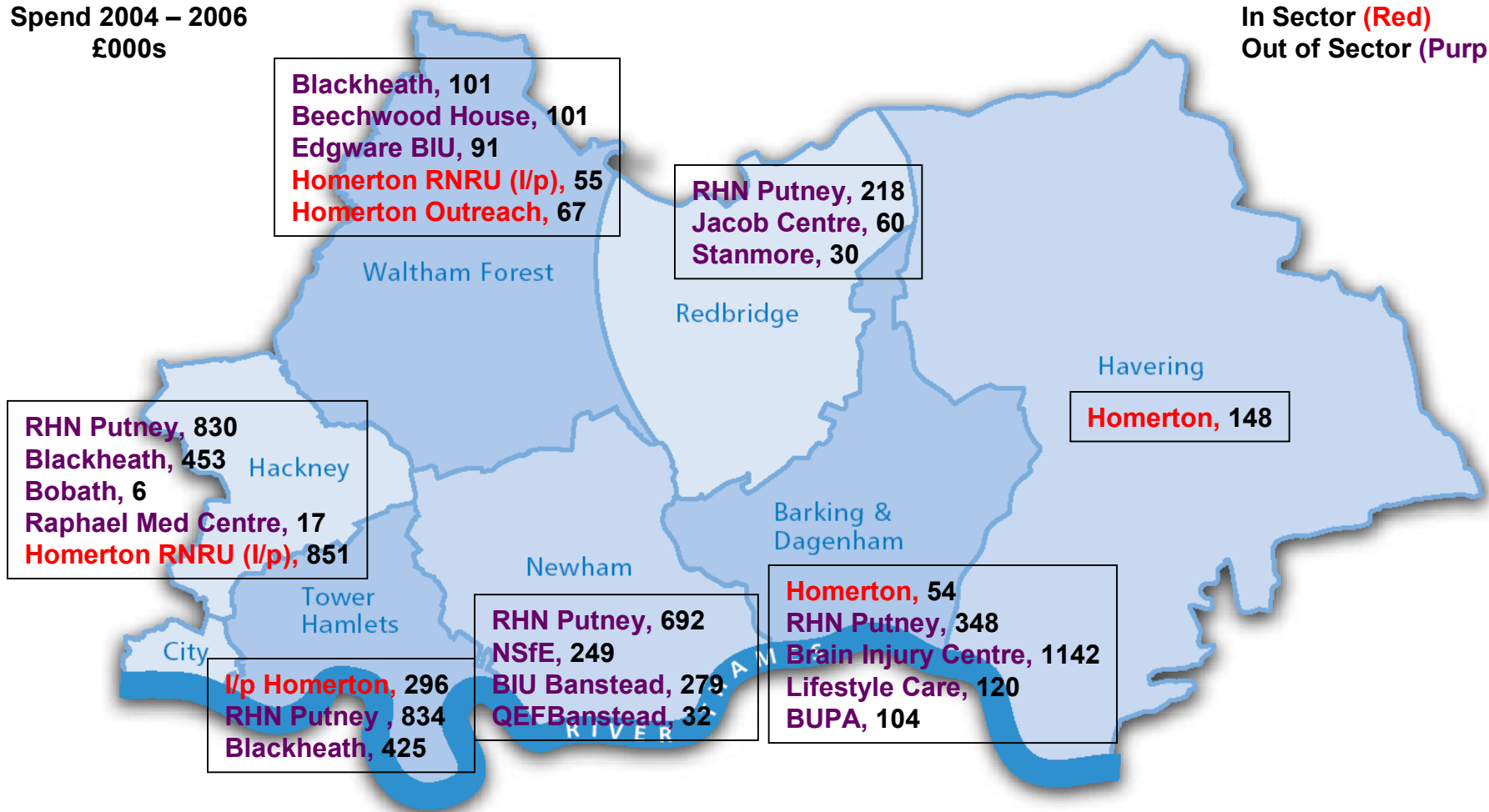
Assessment to Rehab



Commissioning In-Patient Specialised Neuro Rehab

Spend 2004 – 2006
£000s

In Sector (Red)
Out of Sector (Purple)



Key Staffing

Acute Based Rehabilitation

	Medical Staff	Nursing	Physio	Occupational Therapy	Speech & Language Therapy	Specialist Nurse	Psycho	Social Worker	Total
Homerton	4	23.5	6	7	4	0	3	2	49.5
BHR	2	1	3	1.5	1	1	2	0	11.5
BLT	1	1	1	1	1	0	0	0	5
Multi-disciplinary support from neurological and neurosurgery medical MDTs + THPCT's DOT									

Key Staffing

Community Rehabilitation

	Medical Staff	Nursing	Physio	Occupational Therapy	Speech & Language Therapy	Specialist Nurse	Psycho	Social Worker	Total
Tower Hamlets DOT	0	0	2	4	1	0	2	2	11
Newham Community Disability Service	0	0	2	2	1	1	1	1	8
Havering Community	0	0	3	3	1.7	0	0	0	7.7
City & Hackney Community	0	0	4	3	2	0	0	0	9

Key Staffing

Outreach Rehabilitation

	Medical Staff	Nursing	Physio	Occupational Therapy	Speech & Language Therapy	Specialist Nurse	Psycho	Social Worker	Total
Homerton RNRU	0	0	1	2	0.5	0	1	0	4.5

Key Staffing

Social Rehabilitation

	Medical Staff	Nursing	Physio	Occupational Therapy	Speech & Language Therapy	Specialist Nurse	Psycho	Social Worker	Total
Headway House East London	0	0	0	0	0	0	1	0	1

Key Staffing

Vocational Rehabilitation

	Medical Staff	Nursing	Physio	Occupational Therapy	Speech & Language Therapy	Specialist Nurse	Psycho	Social Worker	Total
London Brain Injury Centre, (formerly Rehab UK)	0	0	0	2	0	0	3	0	5

CARE PATHWAYS

ISSUES

Brain Injury

- Rapid Access (Acute) Rehab gap
- Behavioural/Cognitive
 - Currently spot purchased
 - Local proposal in pipeline
 - To be addressed in pan-London context

Spinal Injury

- Emphasis on developing long term follow up (outpatients)

Multiple Sclerosis

- MS Nurse – roll out in locality where there are gaps

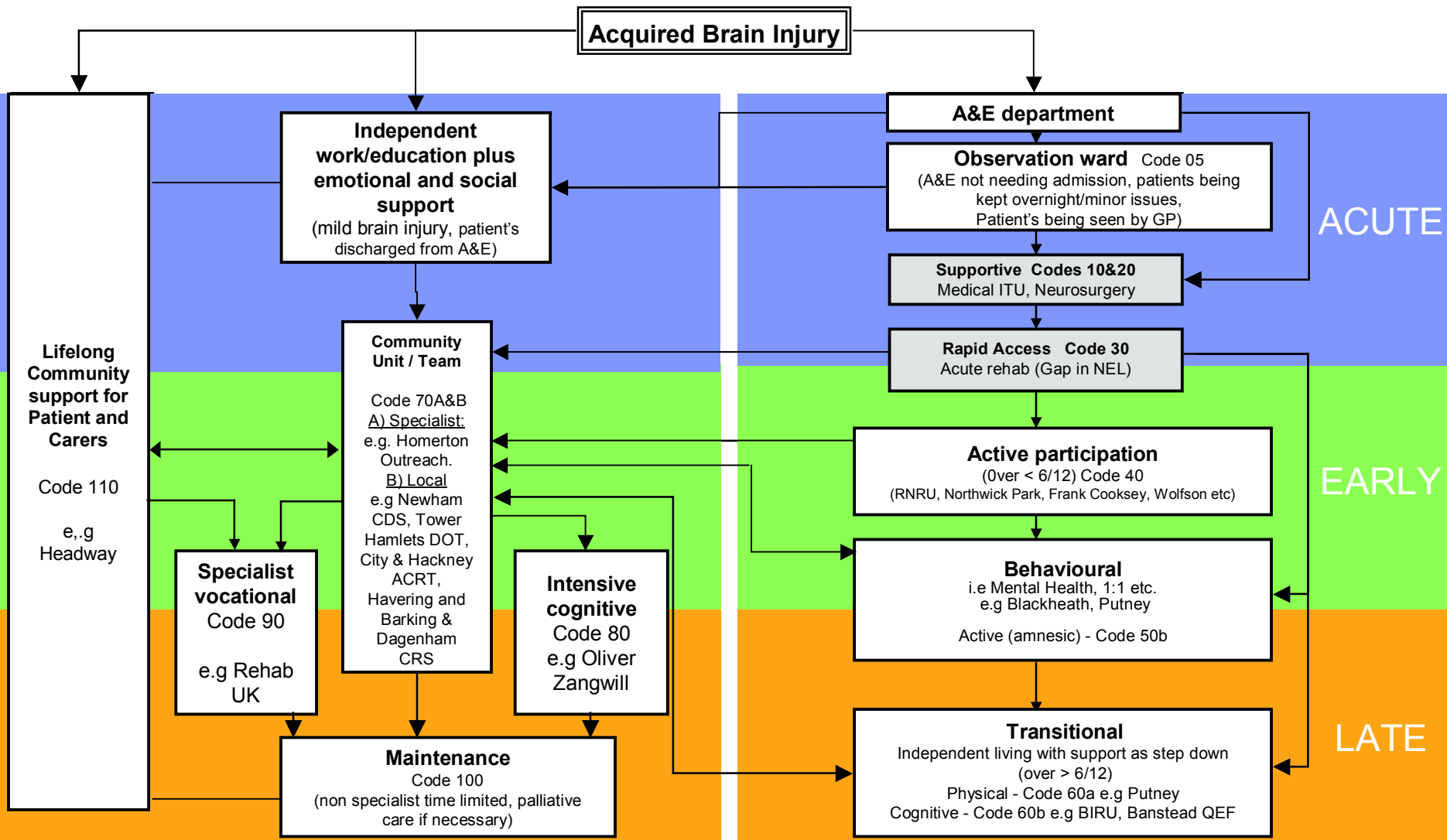
MND

- Support the Association's care centre programme roll out

NEURO-REHABILITATION CARE PATHWAYS FOR BRAIN INJURY PATIENTS FROM NORTH EAST LONDON

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Hospital and Inpatient services

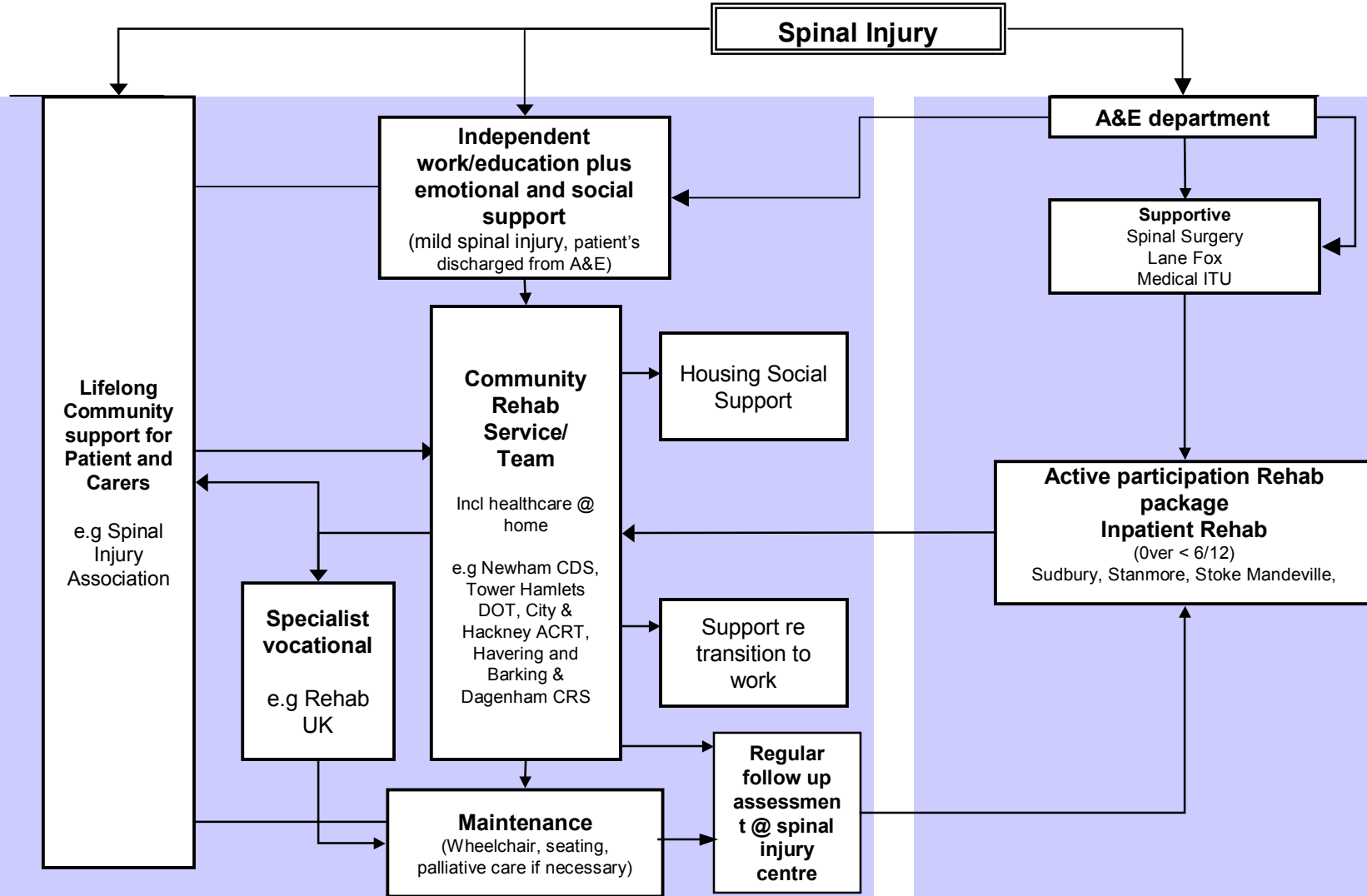


GPs and social services will be involved in all stages of care in the pathway, which will be underpinned by the social model of care.

NEURO-REHABILITATION CARE PATHWAYS FOR SPINAL INJURY PATIENTS FROM NORTH EAST LONDON

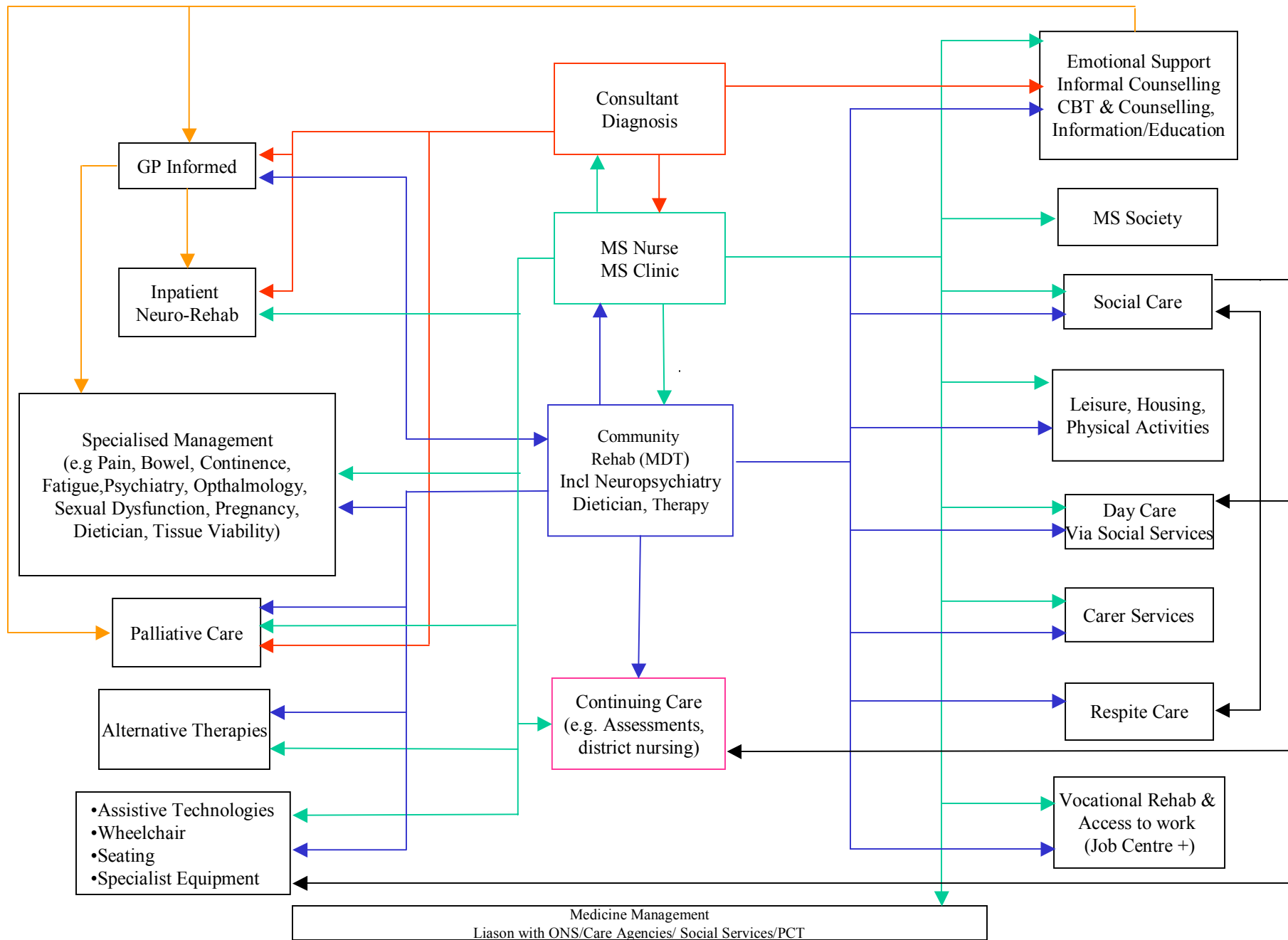
Community and Outpatient Services

Hospital and Inpatient services

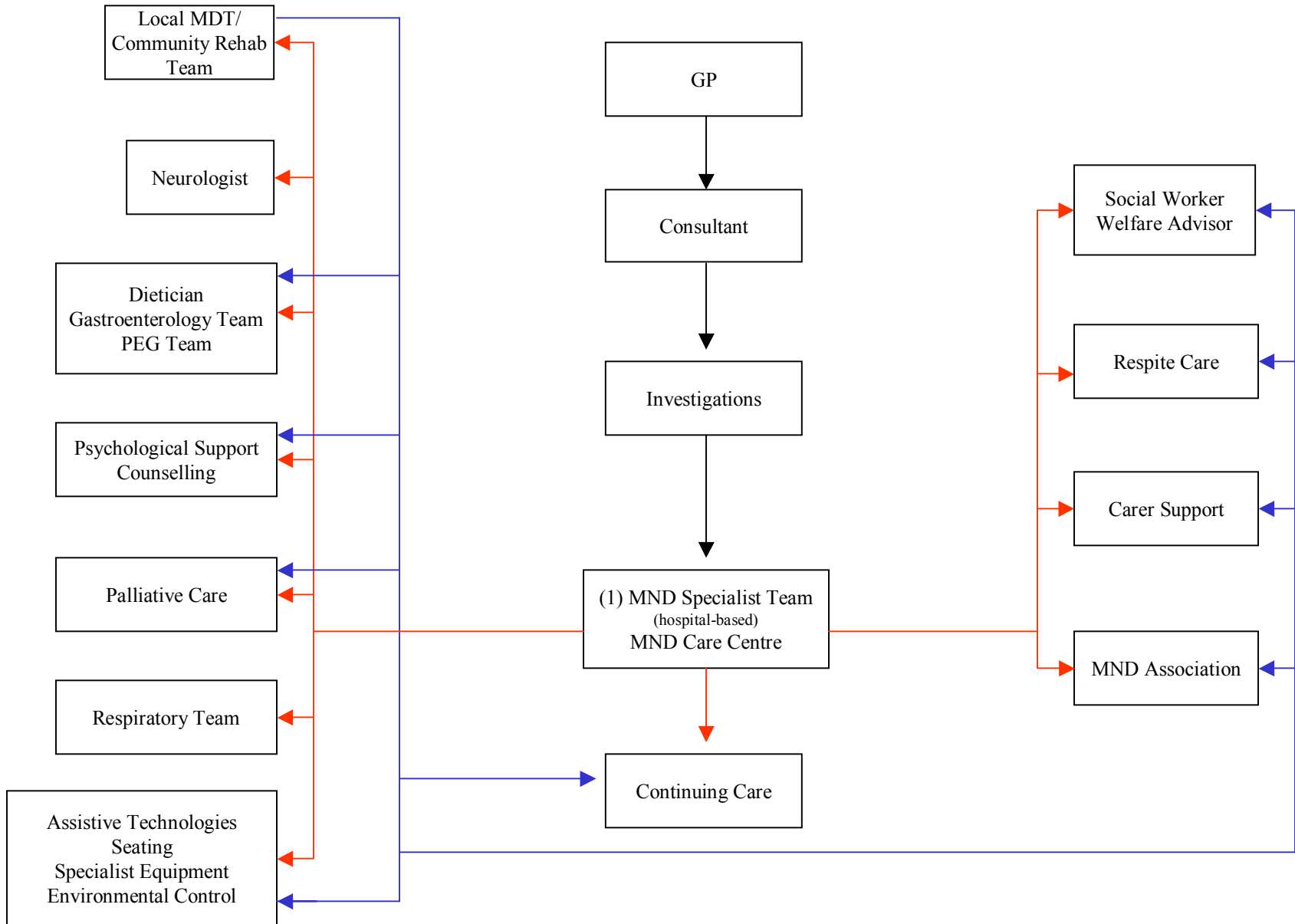


GP's and social services will be involved in all stages of care in the pathway, which will be underpinned by the social model of care.

Neuro-rehabilitation Care Pathways for MS Patients from North-East London



Neuro-rehabilitation Care Pathways for MND Patients from North-East London



(1) SLT, Neurologist, Specialist Nurse/Co-ordinator, OT, Dietician, direct access to respiratory and palliative care expertise



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ISLINGTON

Islington **NHS**
Primary Care Trust

Neuro-Rehab Referral Pathways (North Central Sector)

Laura Gordon

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North Central Sector

- Islington (Laura Gordon)
- Camden (Ray Keane)
- Barnet (Dominic Wright)
- Enfield (Gill Webster)
- Haringey (Gill Webster)

Islington PCT/LBI (Laura Gordon)

- Prior to April 1st IPCT operated two access routes into specialist rehabilitation:
 - Referrals to UCLH and RNRU were managed consultant to consultant
 - All other referrals routed via Islington Community Rehab Team (CRT)
- Post April 1st all referrals routed through CRT
 - Referral by consultant to provider of choice>provider passes referral to CRT
- CRT received investment to accommodate expanded role:
 - 0.2 Medical Consultant
 - 1.0 Psychologist
 - 1.0 Speech and Language Therapist
 - 2.0 OTs
 - 2.6 Physiotherapists
 - 1.0 MS Specialist Nurse (funded MS Society)
 - 4.0 Rehab assistants
 - Partner arrangements with Specialist PD Social Workers

Benefits

- Single Point of Access (supports monitoring, tracking of patients)
- Each patient is allocated a CRT therapist (determined by the primary needs of the patient)
- CRT considers if rehabilitation needs can be met in the community – if not, CRT routinely agrees placement can proceed within 48hrs of receiving referral
- CRT supported by Complex Needs Panel
 - Comprises of senior medical, nursing, therapy clinicians and commissioner
- Key working therapist oversees placement and supports seamless discharge arrangements

Camden PCT (Ray Keane)

- Camden Community Rehabilitation Team (CCRT)
Assess new referrals
- CCRT is a joint health and social services team:
 - Physio, OTS, Psychologist, SLT, SWs, Community Matron
- Community Rehabilitation considered as the preferred option
- Referred to Commissioner (budget holder) for final agreement

Barnet PCT

- Local SLA with Marie Foster Centre (MS Service)
- Commissioning intention is for the Royal Free to manage access to the Marie Foster which will have a broader neuro rehab remit

Enfield/Haringey PCTs (Gill Webster)

Enfield: access to neuro rehabilitation is recommended by insitu multi-disciplinary teams

Haringey: a continuing care 'Higher needs' application is required to access specialist neuro rehab

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