# Merton Council

# Healthier Communities and Older People Overview and Scrutiny Panel

## 13 February 2018

## Supplementary agenda

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**Neurology and Neurorehabilitation Update**

**Merton Adult Care and Health Overview and Scrutiny Committee**

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1. Background

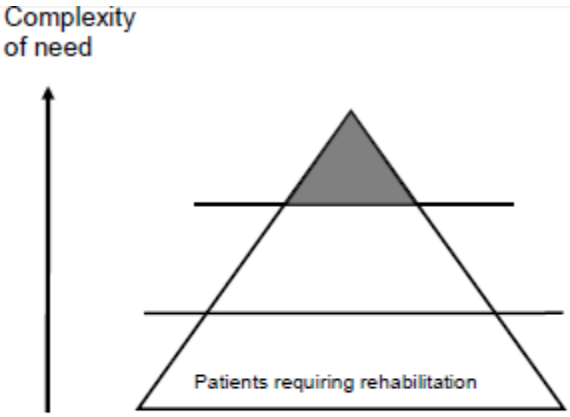
   This briefing follows a discussion at the Adult Care and Health Overview and Scrutiny Committee on 7th November 2017 focusing on Traumatic Brain Injury. As part of the discussion, concerns we raised around issues with the neurorehabilitation pathways in Merton from the perspective of NHS England's Specialised Commissioning team. Accordingly, Merton CCG was asked to produce a briefing on current work in this area and how it is addressing the issues identified to date.

2. Context

   Merton and Wandsworth CCGs (now working more closely under the umbrella of a Local Delivery Unit "LDU") have agreed with St. George's NHS Trust to redesign and transform the way that care is delivered locally. A partnership Board has been operating since January 2017 where all three organisations have initially prioritised ten specialities. Broadly speaking; the proposals are aligned with the ambitions of the Sustainability and Transformation Partnership (STP); to ensure that patients are seen in the right setting, with the right information, by the right clinician and at the right time. Neurology is one of the specialities prioritised due to the fact that services are fragmented and the quality of patient care could be dramatically improved through more co-ordinated care. Work in this area is recent and ongoing, and as such this paper provides a snapshot in time of what is a rapidly moving programme of work.

   The level of complexity involved in the patient's rehabilitation will determine if the responsible commissioner is NHS England **(Level 1& 2a)** or a CCG **(Level 2b and 3)** as illustrated in Figure 1.

**Figure 1: Levels of Neurorehabilitation Services**




**Level 1: Complex specialised rehabilitation services (CSRS)**
Catchment population >1 million
1a – High Physical Dependency
1b - Mixed disability
1c – Cognitive behavioural

**Level 2: Specialist rehabilitation services (SRS)**
2a – Supra-district services
2b - Local district services

**Level 3: Non-specialist rehabilitation services (NSRS)**
3a – Other specialist services
3b - Generic rehab services

| | | |
|---|---|---|
| **TERTIARY SPECIALISED REHABILITATION SERVICES- provided at regional / national level** | | |
| **Level 1:** | **Specialised rehabilitation services**<br>Provided by specialised rehab teams led by consultants trained and accredited in the specialty of rehabilitation medicine (RM) (and/or neuropsychiatry): | |
| | Serving a regional or supra-regional population and taking patients with Category A needs – ie severe physical, cognitive communicative disabilities or challenging behaviours, with highly complex rehabilitation needs* that are beyond the scope of their local specialist rehabilitation services, and have higher level facilities and skilled staff to support these.<br>Collect and report full National Specialist Rehabilitation Dataset | Catchment: 1-3 million<br>Predominantly highly complex caseload:<br>At least 85% pts have Category A needs on admission<br>At least 70% pts with RCS-E score ≥11 cross-sectionally |
| **LOCAL REHABILITATION SERVICES - provided at district level** | | |
| **Level 2:** | **Local (district) specialist rehabilitation services**<br>Provided by inter-disciplinary teams led/supported by a consultant in RM, and meeting the BSRM standards for specialist rehabilitation services | |
| **Level 2a** | Led by consultant in RM. Serving an extended local population in areas which have poor access to level 1 services.<br>Take patients with a range of complexity, including Category B and some Category A with highly complex rehabilitation needs*<br>Collect and report full National Specialist Rehabilitation Dataset | Catchment: 600K-1 million<br>Mixed caseload<br>50-80% Category A needs on admission<br>50-70% RCS-E score ≥11 cross-sectionally |
| **Level 2b** | Led/supported by a consultant in RM. Serving a local population, predominantly patients with Category B needs.<br>Collect and report at least the minimum national dataset | Catchment: 250-500K<br>Less complex caseload eg<br>30-50 % Category A needs on admission<br>30-50% RCS-E score ≥11 cross-sectionally |
| **Level 3:** | **Local non-specialist services.**<br>Includes generic rehabilitation for a wide range of conditions, provided in the context acute, intermediate care and community facilities, or other specialist services (eg stroke units) | |
| **Level 3a** | Other specialist services led or supported by consultants in specialties other than RM - eg services catering for patient in specific diagnostic groups (eg stroke) with Category C needs.<br>Therapy / nursing teams have specialist expertise in the target condition | |
| **Level 3b** | Generic rehabilitation for a wide range of conditions, often led by non-medical staff, provided in the context acute, intermediate care and community facilities, for patients with Category D needs | |

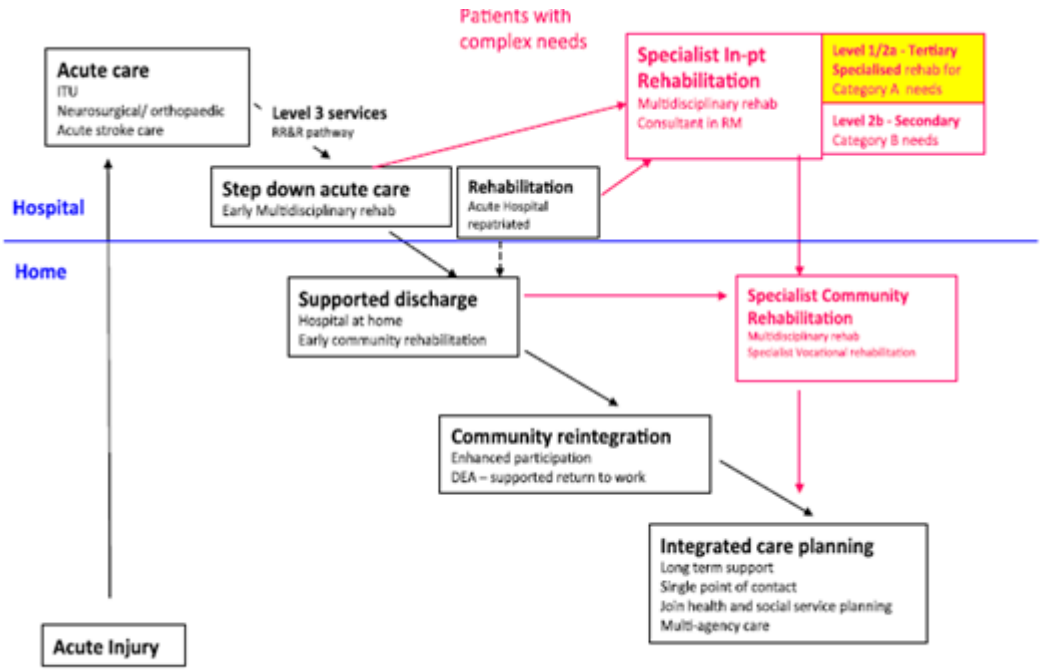
## 2.1 Patient Pathway

Patients' rehabilitation needs are assessed to identify the appropriate service for the patient at that time depending on the level of need that is identified via a clinical assessment. The level of need is defined using the Department of Health Specialist Services National Definition Set (SSNDS), that defines four categories of patient need (A,B,C,D)

After severe disabling illness or injury many patients have category C or D rehabilitation needs and will progress satisfactorily down the pathway to recovery with the support of the local recovery, rehabilitation and re-enablement (R R &R) Level 3 services (commissioned by CCGs and local authorities).

A significant number of patients will have more complex (Category B) needs requiring more prolonged treatment in a specialist (Level 2) rehabilitation service (commissioned by NHSE if 2a and CCG if 2b). (Please see Appendix 2 for map of Level 1 and 2b provision in London)

**Figure 2: Pathways for rehabilitation following illness or injury**




**Red part of the pathway**: CCG commissioned rehabilitation
**Yellow cell:** Tertiary specialised services- NHS England commissioned
**Black part of the pathway:** Usually provided by non-specialist (Level 3) rehabilitation services

2.2 Service provision in Merton

Table 2 below shows the individual referral rate per 100K population for the South West London (SWL) sector. The borough of Merton (highlighted in grey) is on the mid-range scale, with 29 annual referrals per year, of which 14 resulted in admissions. It should be noted that not all referrals result in admission either because (a) they are duplicate referrals (b) they are not appropriate for 1 and 2a services. The introduction of Neuro-navigators should see a drop in this type of referral as they support referring hospitals to get the referral right first time

**Table 2: Individual referral rate per 100K population in SWL**

| | Croydon | Wandsworth | Merton | Richmond | Sutton | Kingston |
|---|---|---|---|---|---|---|
| Referrals per annum | 93 | 37 | 29 | 30 | 23 | 11 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Population | 400,679 | 384,971 | 221,096 | 210,369 | 190,700 | 202,786 |
| Rate per 100,000 | 23 | 10 | 13 | 14 | 12 | 5 |

3. Issues Identified

A series of workshops have taken place throughout 2017/18 with St George's Hospital's acute and community neurology teams (already comprising of a wide skill-mix, including; specialist nurses, occupational therapists, physiotherapists, speech and language therapists and rehabilitation assistants), acute geriatric services, community geriatric services, GP Federations, and Commissioner Clinical Leads (for Planned and Unplanned Care).

Partners agreed the following areas as in need of change:

- There are large numbers of neurological conditions unnecessarily seen in acute and outpatient departments, which could be managed better in an integrated community care model.
- Traditional models of care with referrals of patients through routine outpatient pathways means response is slow, and significant numbers go to Accident & Emergency (A&E), leading to admission by non-neurologically trained personnel.
- Patients with acute neurological conditions cannot be managed efficiently due to the pressures on the outpatients department; this has an impact on patient admissions, length of stay and risk of institutionalisation.
- GP, A&E and outpatients focus on diagnosis and immediate relief of symptoms. Personal care plans are provided, but there is local variation. More could be done to provide effective self-management, understanding the condition and the consequences of personal lifestyle and the provision of more holistic care.
- There is a significant rate of returners to A&E and medication over use. In 2015/16 there were 8,692 common condition readmissions, of those, 11% were the third readmission or more.

In addition a workshop focusing on the patient voice and the 2015 Public Health Needs Assessment identified the following key issues:

- Improved access to highly-valued and specialist Parkinson's, MS, Epilepsy and NMD nursing input. This included a number of gaps in provision of specialist nursing, in particular Parkinson's and epilepsy nursing.
- Variation in access to the range of services required by people with long term neurological conditions, including therapies, equipment, social services and primary care.
- Access to more rehabilitation places.

- Improved co-ordination and communication between all professionals involved with patient care; rather than leaving it for the carer/spouse to coordinate. This includes the potential for more systematic and proactive coordination of care across agencies; which could be aligned with existing multi-disciplinary services (e.g. HARI at the Nelson Health Centre).
- A need for greater mental health support for people who are diagnosed with LTNCs to assist with the difficulties in coming to terms with limitations in ability and functioning. This would include access to emotional well-being support; and would also need to recognise the needs of the "whole person" and not just the disease.

Specifically in terms of neuro-psychiatric care, while services are available, they neither have adequate capacity nor are targeted to all the appropriate patient cohorts. This challenge is reflected in NHS England's critique of local services which could be leading to a disproportionate use of the Wolfson Unit in Merton.

4. <u>Commissioning plans/developments</u>

A Neurology Workshop was held again in December 2017 which agreed to pilot new ways of working to help relieve pressure on acute services and improve the quality of care delivered. The following areas are prioritised:

- Risk stratification (the process of identifying those most at risk of admission) and multi-disciplinary teams for more co-ordinated care of higher risk patients between the all main neurology services. This to be aligned in Merton to the existing Holistic and Rapid Investigation (HARI) service.
- Additional capacity for specialist physiotherapy.
- Additional capacity for Parkinson's Disease specialist nursing.
- Review and trial additional roles and responsibilities for the existing community neurology service; so they have an enhanced function.
- Additional capacity for counselling and neuro-psychiatric care.

The five areas outlined above will be subject to a CCG business case to be developed in quarter one of 2018/19 financial year, with service developments to begin in quarter three. In addition, building pathways and additional capacity in neuro-psychiatric care is within the Central London Community Healthcare contract as part of the Service Development and Improvement Programme.

To more clearly understand the impact of the gap in counselling and neuro-psychiatric services as well as how these services could best be trialled to meet the needs of patients; the LDU has been seeking to meet with the following local voluntary sector and community groups.

- Muscular Dystrophy UK.
- Motor Neurone Disease Association.
- Parkinson's Disease Society.
- MS Society.
- Epilepsy Action & Epilepsy Society.

We intend to provide regular update reports to HOSC on how these developments progress.

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