



Capturing the impact of case management within the NHS England complex rehabilitation pathway in the South West

Context

Patients who are admitted to acute hospital following a brain or spinal cord injury require specialist in-patient rehabilitation to treat and manage their complex disabilities.

Within the South West, NHS England funds specialist in-patient rehabilitation services, delivered by a team of doctors, nurses and allied health professionals.

Over the years the demand for these services had continued to grow, resulting in patient flow pressures within the acute hospitals. Although additional beds had been procured the problem continued to grow, with little real understanding in the system of the root cause of the problem and whether the capacity issues were real or apparent.

Key issues included:

- The waiting lists for rehabilitation services were not easy to understand and the referrers struggled to get accurate information on how long patients would wait
- The acute hospitals cited delays for specialist rehabilitation as the main blockage in patient flow
- There was little understanding of which patients were being admitted and which ones never got there
- The pathways into and out of specialist rehabilitation were not clearly defined.
- There was limited understanding of the patients' support and pathway post discharge
- The specialist services were not always clear on who they needed to speak to within the CCGs

- There was limited understanding of how community rehabilitation services were set up and how they supported the patient flow out from the specialist rehabilitation services.
- Communication between organisations across the South West was mixed
- There was little assurance that patients were receiving the 'right care in the right place at the right time'.

On a daily basis there were:

- Bottle necks
- Delayed Transfer of Care (DTOC) from acute hospitals
- Specialist units stating they had long waiting lists and needed more beds
- Lack of clarity on what was creating the problems
- Lack of intelligence related to whether the capacity issues were real or apparent
- Lack of awareness of key clinical issues and specific complexities.

Response to the problem

A proposal was put to the Quality, Innovation, Productivity and Prevention (QIPP) board, whose remit is all about ensuring that each pound spent is used to bring maximum benefit and quality of care to patients.

The NHS England South West Hub Service Specialists recommended the appointment of two Complex Rehabilitation Case Managers for a fixed period of time to unpick the issues and sort out the waiting times and patient flow.



In September 2016 and January 2017 (fixed term until December 2017), two case managers were appointed to address these issues and to provide clinical support and guidance, supporting the South West NHS England commissioners to provide robust clinical intelligence to their contracting process. The two case managers worked across the NHS England South West hub with all stakeholders and service providers; including the three NHS England Supplier Managers, two major trauma centres (MTCs), ten acute hospital trusts, four specialist rehabilitation providers and 11 CCGs. They drilled down into the problems and developed an action plan to improve the patient flow.

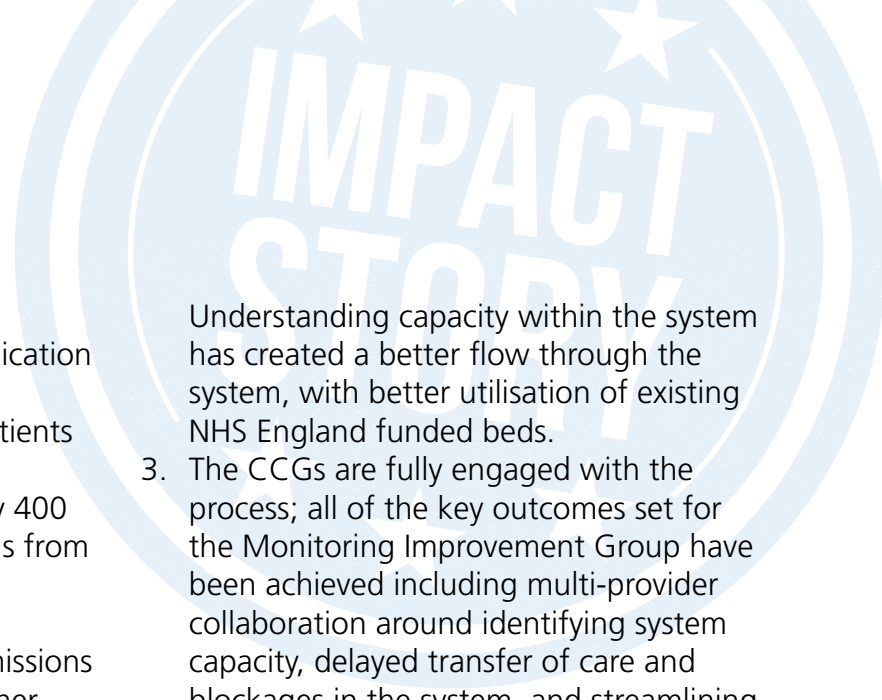
Actions undertaken quickly included:

- Developed a Directory of Services for better regional networking and communication between key stakeholders, to ensure provider services knew who to contact with the CCGs and NHS England.
- The Service Specialist convened a Monitoring Improvement Group, with a specific focus around North Bristol Trust (NBT) and Bristol, North Somerset and South Gloucester (BNSSG) CCGs.
- Carried out an initial audit of four specialised services which admitted patients with Category A (complex, intensive rehab need) with report back to the commissioners and Senior Management Team in October 2016. Helped the specialist neurorehabilitation units to understand the patient cohorts, with recommendations and report back to the commissioners on how to improve the pathways.
- Reviewed the acute to rehabilitation pathway with engagement from key stakeholders from NBT, specialist rehabilitation providers, CCGs and NHS England commissioners.

Working with the NHS England Sustainable Improvement team, the case managers were able to demonstrate the impact they had over an initial 12 months period by using the Logic Model and Impact Framework. This was submitted to the Senior Management Team in September 2017 and resulted in the posts being extended by a further 12 months (until December 2018).

Additional activities/impacts over the past 12 months include:

1. Engaging with all 11 CCGs within the South West and working with the leads for complex rehabilitation and CHC to ensure they understood the NHS England complex rehabilitation pathway, including their roles and responsibilities.
2. Engaging and working with 12 acute hospitals and four additional neurorehabilitation providers in the South West area, to ensure they understood the NHS England complex rehabilitation pathway and the interface with their services.
3. Challenging pre-conceived perceptions of what the problems were within the system, and determining responsibilities within the patient's pathways.
4. Establishing regular day-to-day communication, including weekly Delayed Transfer of Care meeting with NBT and BNSSG.
5. Establishing weekly telecom meetings with the level 1 rehabilitation service, to discuss all referrals, admissions and discharges, to trouble shoot potential issues which could impact on patient flow.
6. Establishing regular day-to-day contact and weekly telecom meeting with the Spinal Cord Injury Centre (SCIC) to discuss all referrals, admission and discharges, to trouble shoot issues with patient flow.



7. Establishing links with the two Major Trauma Centres and regular communication with the Trauma Coordinators.
8. Developing a database to track all patients through the system and to monitor Capacity and Demand (approximately 400 patients referred, with 312 admissions from January - June 2017).
9. Developing an acute provider to rehabilitation provider referral to admissions process flowchart, with roll-out to other district general hospitals.
10. Developing the specialist rehabilitation unit's admissions to discharge process flowchart, with roll-out to other specialist rehabilitation services.
11. Sign-posting patients to clinically appropriate alternative pathways within the community.
12. Ensuring the NHS England commissioned beds are utilised effectively and providing assurance that patients received the 'right rehab, right place, right time'.
13. Supporting the level 1 rehabilitation service provider who has seen a change in the referrals they receive from a broad mix of patients, with variable levels of need, to a much more complex cohort of patients with neurorehabilitation / cognitive rehabilitation need.
14. Using clinical intelligence used to scope services throughout NHS England South and inform the trauma programme across the South, whilst assisting South East commissioners with specific clinical issues.

Key outcomes achieved

1. Patient flow through the system is actively managed, with patients being navigated from acute trusts to appropriate pathways, including NHS England funded complex rehabilitation beds and alternative CCG funded rehabilitation pathways.
2. There is oversight of all waiting lists, with an understanding of the difference between waiting lists and referrals lists.

Understanding capacity within the system has created a better flow through the system, with better utilisation of existing NHS England funded beds.

3. The CCGs are fully engaged with the process; all of the key outcomes set for the Monitoring Improvement Group have been achieved including multi-provider collaboration around identifying system capacity, delayed transfer of care and blockages in the system, and streamlining referral processes.
4. Tracking of patients and liaison with referrers have identified other emergent issues in relation to specific groups of vulnerable patients, who have previously fallen through service gaps or become 'stuck' within the system. These patients were usually associated with causing delayed discharges with added knock-on costs to CCGs and upward pressure on the whole system.
5. These patients are now actively managed, with early identification and collaborative working with CCGs, adult social care and mental health services.
6. Case managers have been involved in around 30 very complex discharges providing co-ordination, challenge and clarity on services' responsibilities.
7. Specific groups identified included those waiting for timely access and support from adult social care, including packages of care; pre-morbid history of drug and alcohol; pre-morbid mental health conditions but now deemed to have a brain injury; housing and homelessness; cross-CCG boundary issues which need resolution; CHC funding delays and appropriate community placement of people in Prolonged Disorders of Consciousness (PDOC), or with complex respiratory management (Tracheostomy/Ventilated care); inadequate pathway for patients with combined spinal cord injury and traumatic brain injury.



Patient Story A: Starting point for case management

John (not his real name) was in a minimally conscious state in an acute hospital bed outside of the South West Hub.

In June 2016, John had been transferred from an intensive care unit to a respiratory high dependency unit, with delayed discharge at that unit of 180 days, causing significant distress to John's family and substantial health care costs. The medical team caring for him spent a significant period of time trying to establish onward care for him, which distracted them from their clinical commitments. Unsure who was best placed to assist, the clinical team finally contacted NHS England commissioners in February 2017. Although out of area, the case manager was able to identify a good quality placement offering a SMART assessment (which determines awareness level and rehabilitation potential), secure an assessment and funding. After consultation with his family, John was transferred within 21 days to this specialist provider. CCG involvement was secured from the outset, to allow time for a suitable, specialist nursing home placement to be found and secured.

John remained in the NHS England funded placement for 100 days, where he received specialist postural support management, tracheostomy care, a SMART assessment, and communication and swallowing assessments before transferring to a specialist nursing home funded by his CCG. Should he show future signs of improvement, the case manager could facilitate a transfer back to the NHS England funded specialist placement for rehabilitation.

Where we are now

- Pathway productivity has been improved without additional bed capacity being introduced, with the two case managers providing oversight of waiting lists, and navigation to alternative, more appropriate clinical care.
- Acute hospitals state they have benefitted greatly from working with the case managers, to identify patients within the hospital, sign-posting onwards transfer and decreasing the number of DTOCs into NHS England funded rehabilitation beds.
- The NHS England commissioners have pro-active clinical monitoring and assurance regarding the specialist rehabilitation contracts. Regular reporting gives a regional round up of demand within the system; whilst involvement in quality assurance site visits and emergent business plans for rehabilitation provision ensures robust clinical oversight.



Patient Story B: June 2017

Alice (not her real name) was referred by an acute hospital to specialist rehabilitation on 5 June 2017 and assessed on 20 June 2017. Alice's care was discussed with the case manager on 3 July, during the weekly referrals telephone meeting. The rehabilitation consultant's opinion was that Alice wasn't suitable for admission and would struggle to engage with rehab. The consultant agreed to keep a watching brief on her, but had not advised the hospital whether or not she would eventually be suitable for their service.

The case manager liaised with the hospital on 5 July to discuss alternative options and onward journey decisions were made, especially as it appeared likely that Alice would not benefit from inpatient rehabilitation and to ensure she did not remain stuck in an acute hospital bed.

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