Neuro Navigators & Specialist Inpatient Neuro Rehab Pathways

Shona Falkner Mesner – Southwark
Ally Malcolm– Lewisham
Gerry Owusu-Gyamfi – Greenwich
Jenny Barrass – Lambeth
Ana Santos – Bromley&Bexley

Contents

- The role of Neuro Navigators (NN)
- South East London Neuro Navigator Service (SELNNS)
- Structure and commissioning of Specialist Neuro Rehabilitation
- NHSE Level 1/2a Service Specification **D02/S/a**
- Badgernet referral system
- Network of Specialist Units in London
- Other options
- Contacts
- Questions

The role of the Neuro Navigator

A collaborative role working with patients, their family/carers, treating teams across health and social care, and external agencies / organisations

- Identify **right place, right service, right time!**
- Facilitate specialist neuro rehab referrals for patients with complex neurological needs
- To identify those patients whose needs can be met via non-specialist provision/alternative care pathways e.g. community provision, specialist nursing home
- Different ‘hats’ – advocate for patient and services
- Monitor patients whose needs may be changing whilst awaiting specialist provision

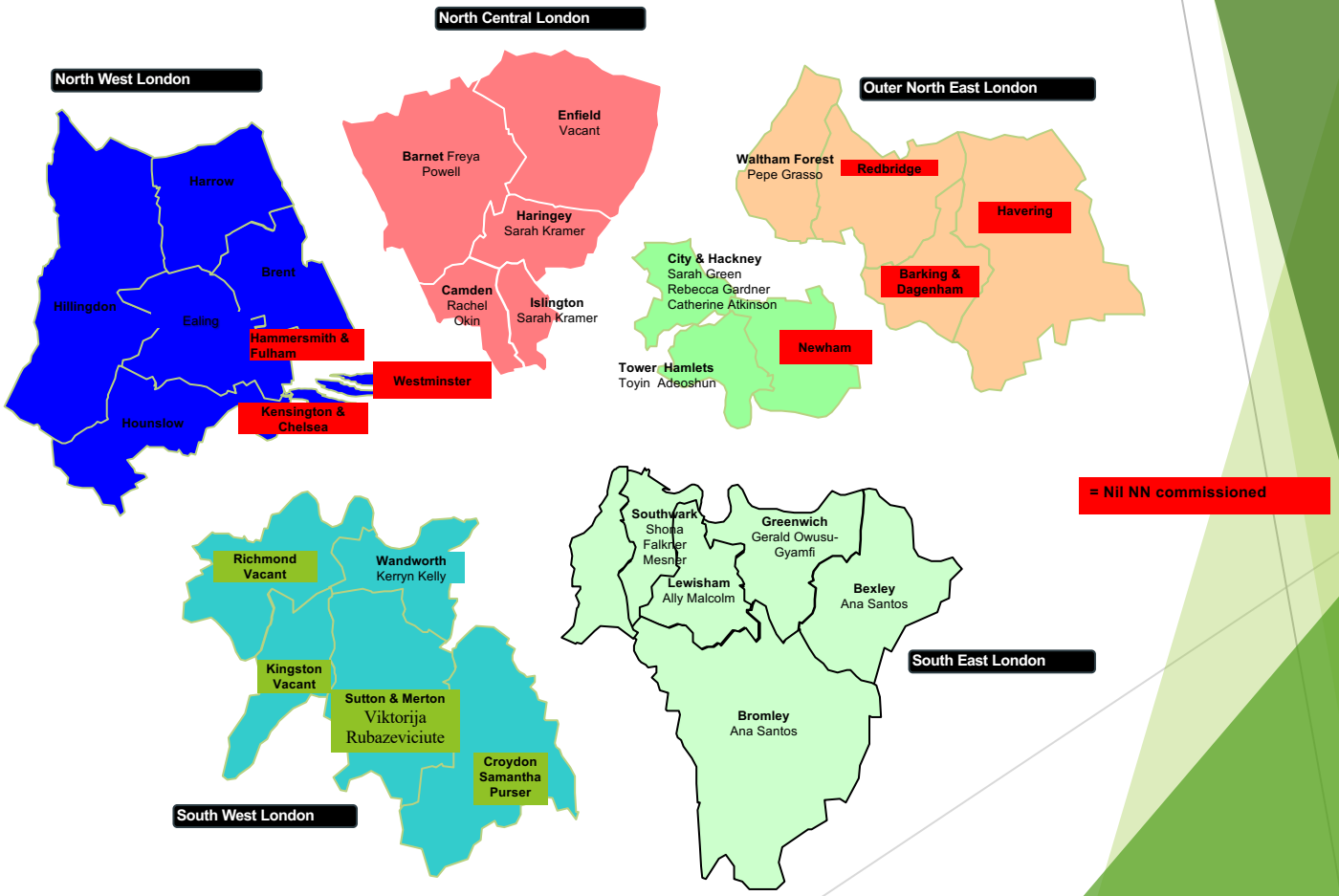
Core Roles of the NN

- **To provide continuity of contact for patients and patients' families through the complex neuro rehabilitation pathway**
- To work with treating teams, patients and families to manage expectations of specialist rehab
- **To work closely with specialist neuro rehab units to facilitate timely discharge, and to coordinate with community services as indicated.**
- To provide expert knowledge on local neurological rehabilitation service provision (demand and gaps in services) to liaise with ICB to contribute to future commissioning decisions
- **The NN also has an educational role within the local health services, to advise clinicians on appropriate neuro rehabilitation pathways.**

Variations in Neuro Navigator roles?

- All London Neuro Navigators have the **same core roles**
- Some Neuro Navigators have **ADDITIONAL** roles
  - Continuing Healthcare Assessments & Specialist Placements
  - Clinical Leads within a therapy team
  - Referral and triage point for community neuro rehab teams
- Neuro Navigator role **shaped by local demands** and challenges in the neuro rehab pathway. Eg.
  - Reduced neuro rehab speciality in local hospitals
  - Gaps in level 2B bed commissioning
  - Gaps in community neuro rehab service commissioning
  - Gaps and barriers to adjunct services eg. vocational rehab/neuro psychology.

Who are the Neuro Navigators?



SE London Neuro Navigator Service (SELNNS)

- Confirmed neurological diagnosis (including FND)
- 16 and over
- Advise on most appropriate rehab pathway/location
- Complex needs where the rehab pathway is not clearly defined
- Residential address or GP within boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham or Southwark

- 1 Clinical Manager and 5 Neuro Navigators (currently OT and PTs)

SE London Neuro Navigators (SELNNS)

Referrals from any source: specialist units, acute hospitals, community teams, SS, ICB, GPs and self-referral

Via phone, email, or face to face when in-reaching:

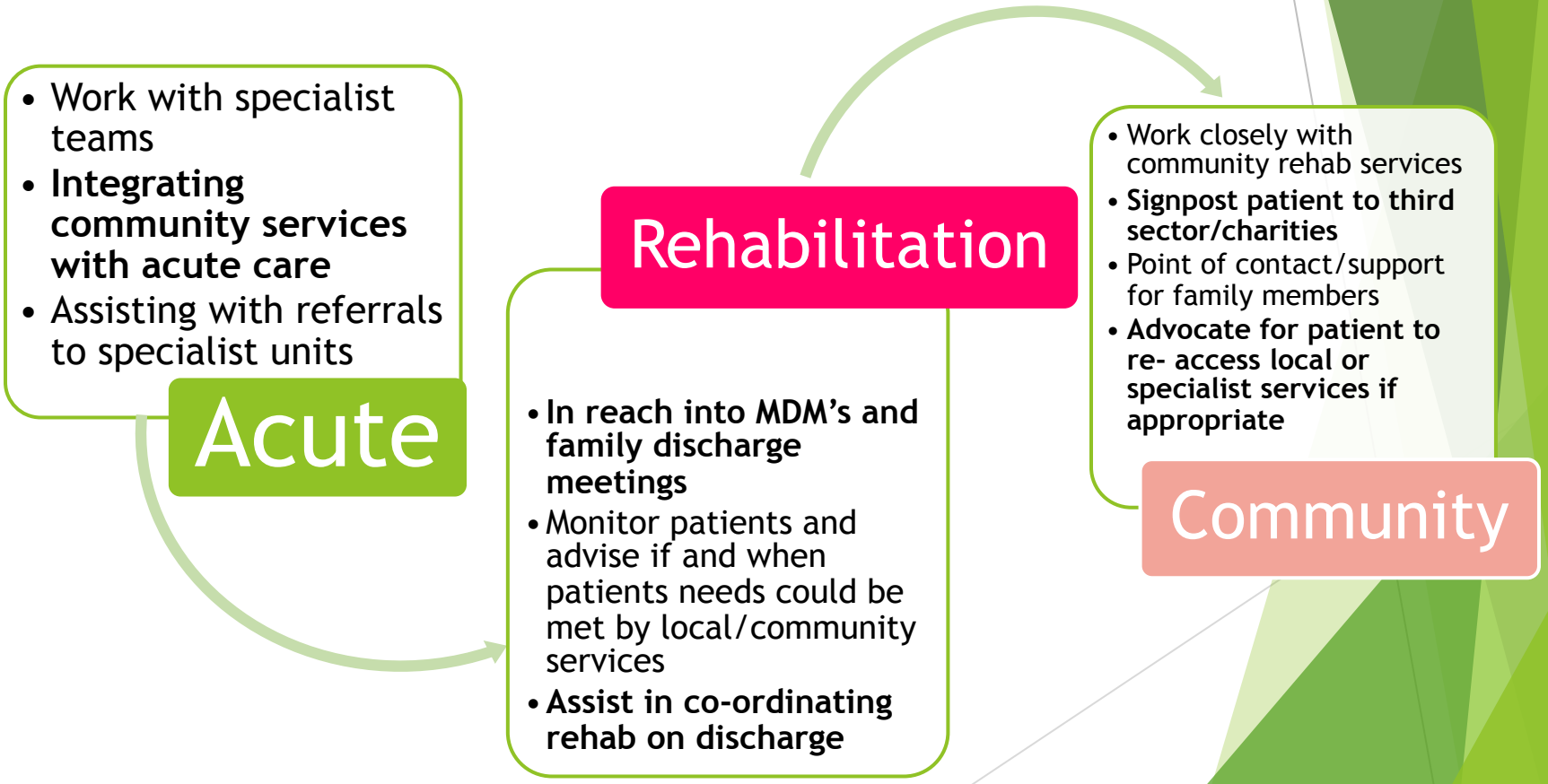
Weekly attendance at:

- MDMs/hospital rounds at: QEH, KCH, UHL, STH, PRUH, DVH

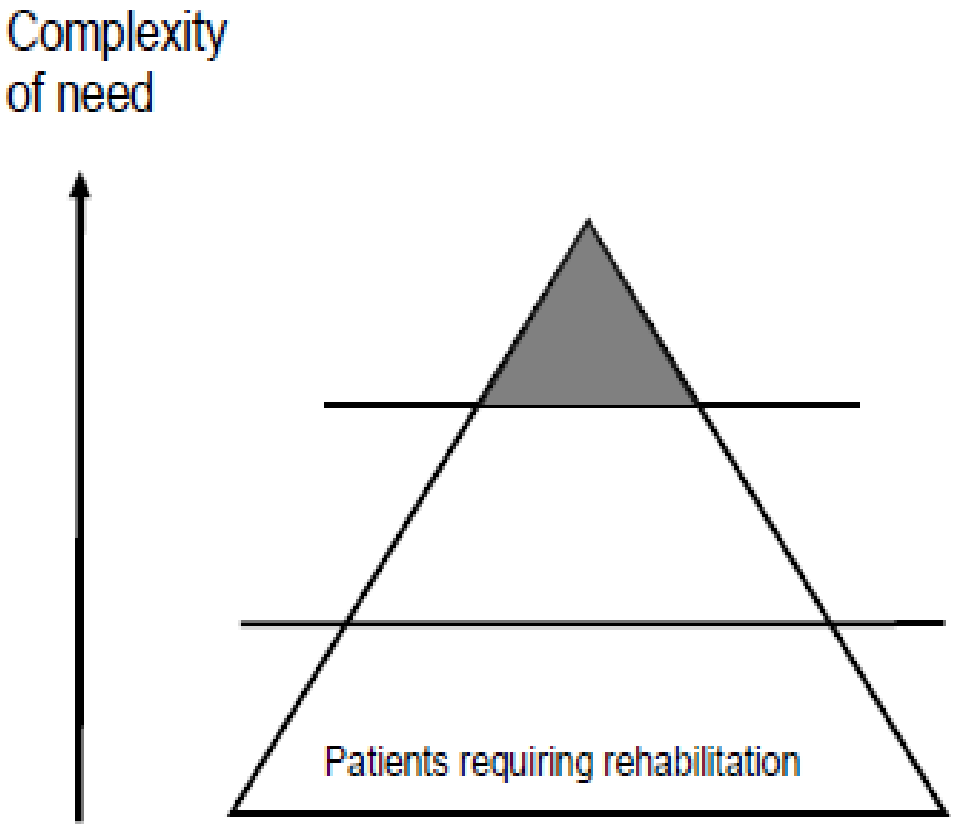
- Frank Cooksey/SEL 2B beds, Blackheath Brain Injury Unit assessment meetings, Wolfson assessment/discharge meeting, St George's RAAR beds meeting.

Attendance at case review/family meetings/DPM at rehab units

Neuro Navigation in Practice



Structure of Specialised Rehabilitation 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

Structure of Specialised Rehab services

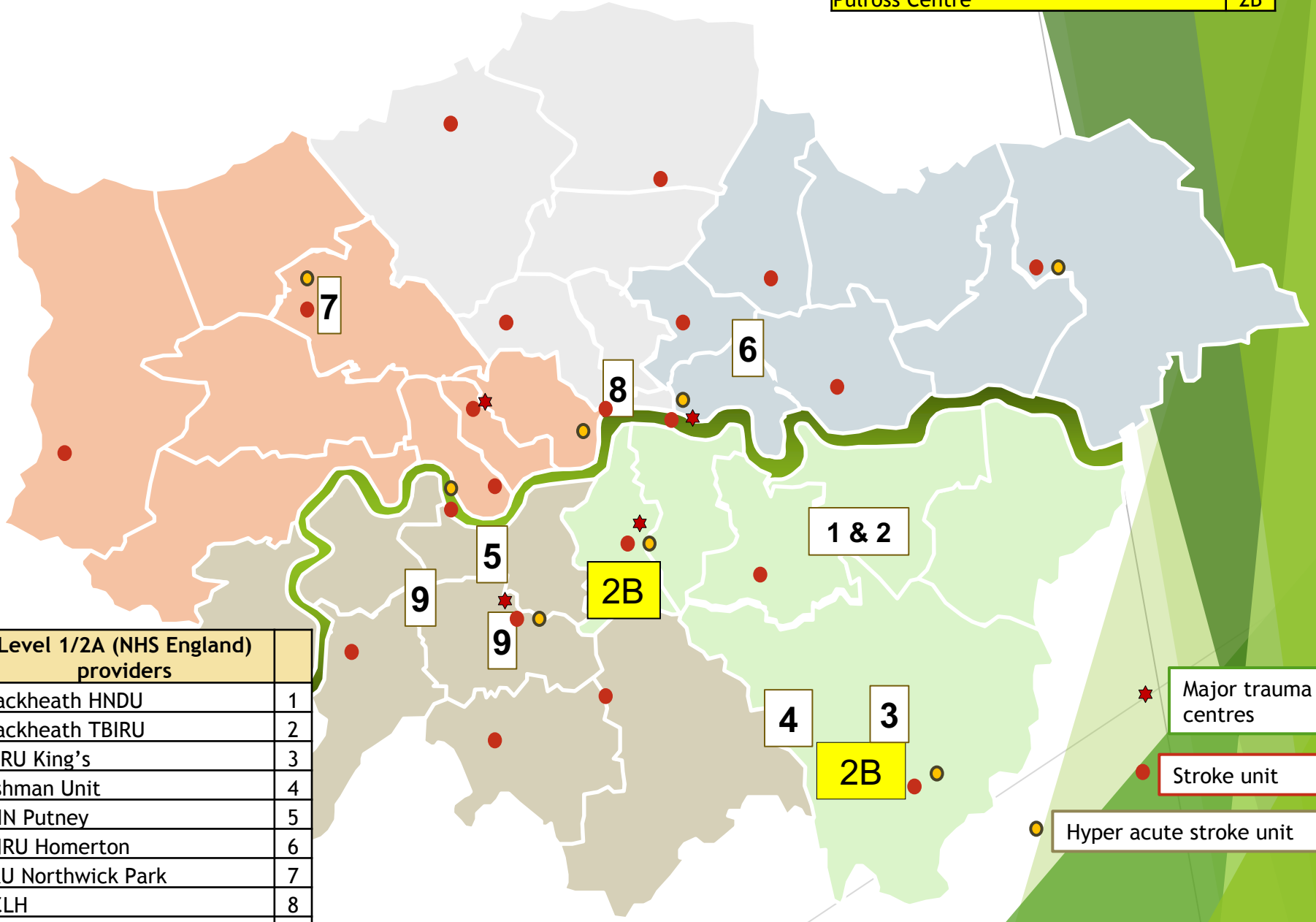
Classified into ‘Levels’ 1, 2 or 3

- Level 1 and 2A ‘Tertiary Specialised’ services are commissioned by NHS England (category A needs)
- Level 2B ‘Local Specialised’ (category B needs) are commissioned by local Clinical Commissioning Groups (CCGS)
- Level 3 ‘Local Non-Specialised’ services (category C & D needs) are commissioned by local CCGS

- Each service has its own criteria
- Patients’ rehabilitation needs are assessed to identify the appropriate service for the patient at that time
- Complexity and Category of needs: PCAT, RCS

London 1/2A & 2b Provision

Level 2b (CCG) providers	
Kings Health Partners - Ontario Unit & Pulross Centre	2B



Level 1/2A (NHS England) providers	
Blackheath HNDU	1
Blackheath TBIRU	2
FCRU King's	3
Lishman Unit	4
RHN Putney	5
RNRU Homerton	6
RRU Northwick Park	7
UCLH	8
Wolfson	9

Level 1/2A Units in London

Hyperacute Rehabilitation (multiple co-morbidities, medical instability etc)	Regional Hyperacute Rehab Unit, Northwick Park hospital	24 beds in total
Assessment for Prolonged Disorders of Consciousness (SMART, WHIM, CRS-R)	Royal Hospital for Neurodisability, Putney	39 beds in total
	Regional Rehab Unit, Northwick Park hospital	As per above
Complex physical, tracheostomies etc	Royal Hospital for Neurodisability, Putney	As per above
	Regional Rehab Unit, Northwick Park hospital	As per above
Primarily cognitive/communication and challenging behaviour	Thames brain Injury Unit, Blackheath	16 beds total
	Lishman Brain injury unit, Bethlem hospital	7 beds total
	Wolfson Neuro-Rehab Centre St Georges/Queen Marys Hospitals	32 beds total
Mixed complex specialised rehabilitation	Heathside Neurodisability Unit, Blackheath	17 beds in total
	Frank Cooksey Rehab Unit, Orpington Hospital	15 beds in total
	Neuro-Rehab Unit, National Hospital for Neurology & Neurosurgery/Queens Square	18 beds in total
	Regional Neurological Rehab Unit, Homerton Hospital	24 beds in total
	Wolfson Neuro-Rehab Centre, St George's & Queen Mary Hospitals	As per above

Considerations for Specialist Inpatient Neuro Rehabilitation

- What are the patient's primary neuro rehab needs at present? E.g. Cognitive Communication, Behavioural, Functional Neurological Disorder, Spinal, Physical etc.
- What are the patient's goals and what gains have they made?
- What is the patient's rehab tolerance? eg Number and duration of rehab sessions per day?
- Is the patient engaging in rehab?
- Is the patient consenting to rehab referral? (considerations for Capacity/DoLs/Best interest decisions)
- How long is the patient likely to need inpatient rehab?
- Will inpatient rehab change the patient's functional level / care needs?
- Does the patient and family have realistic expectations of rehab?
- ***Have the patient's needs changed since referral made to inpatient neuro rehab?***
- ***What is their rehab potential?***

How do we know if a patient needs Level 1/2a or Level 2b?

Defining Complexity in Rehabilitation -

- In rehabilitation, diagnosis is a poor indicator of need for rehabilitation or the costs of providing it.
- The key factors that determine complexity of **rehabilitation needs** are:
  - Needs for basic care and safety
  - Needs for skilled nursing care
  - Needs for therapy input – no of disciplines involved and intensity of treatment
  - Needs for medical care and intervention
  - Needs for specialist equipment / facilities.
- The assessment tools used for Level 1& 2 rehab include:
  - Rehab Complexity Scale (**RCS-Extended**)
  - Patient Categorisation Tool (**PCAT**)

Level 2b Beds – SE London

- **Locations**
  - Pulross (Brixton, GSTT) – 6 beds
  - Ontario (Orpington Hospital, King's) – 14 beds
- **Central referral via Badgernet**
- **All referrals discussed in weekly referral meeting**
  - Opportunity for NNs to raise any questions / additional info / advocate for patients with borderline needs
- **Patients can be listed for either unit, but tend to go to the closer one**
  - Ie. Pulross – Lambeth & Southwark
  - Ontario – Lewisham, Bexley, Greenwich, Bromley

Other Inpatient Rehab Options

- **Common reasons why patients declined by Level 1 / 2 Units**
  - Patient can't tolerate intensity of rehab
  - Needs higher than can manage – such as needing 2:1 supervision
  - Co-morbidities that could impact on rehab – such as alcohol or drug dependency, active mental health conditions, dementia
  - Pre-morbid function – patient unlikely to make significant gains / needs close to how they were before admission
  - Cognitive & behavioural & physical needs
  - Medical reasons – needing IVs, NG tubes, renal dialysis, infectious status,
  - Excluded by diagnosis – eg. Functional Neurological Disorder (FND)
  - Need longer than 6 months in level 1/2a
  - Needs can be met in community (regardless of whether this is provided within their borough)

Other Inpatient Rehab Options

- Usually patients referred and declined by Level 1 & 2 services before looking at alternative 'Spot purchased' rehab
- Examples of Spot Purchased Rehab i.e. paid for directly by the ICB
  - 'Slow stream rehab'
    - The patient is making slow and steady gains but can't manage the intensity of Level 1/2.
    - Would need to be very clear reasons of what the goals and expected functional &/or quality of life changes would be made to justify it
  - More specialist Neuro behavioural unit
    - Significant challenging behaviour
    - Dual diagnosis – active mental health needs
    - Physical needs that can't be met at other units

NHSE Level 1/2a Service Specification D02/S/a

- NHS STANDARD CONTRACT FOR SPECIALISED REHABILITATION FOR PATIENTS WITH HIGHLY COMPLEX NEEDS (ALL AGES)
  - SCHEDULE 2 – THE SERVICES A. SERVICE SPECIFICATIONS

Tertiary Inpatient Rehabilitation Programmes

- Specialist rehabilitation services provided along three main pathways:
  - **Restoration of function** (e.g. for those recovering from a 'sudden onset' or 'intermittent' condition) where the patient goals are focussed not only on improving independence in daily living activities, but also on participatory roles such as work, parenting, etc.
  - **Disability management** (e.g. for those with stable or progressive conditions) where the patient / family goals are focussed on maintaining existing levels of functioning and participation; compensating for lost function (e.g. through provision of equipment / adaptations); or supporting adjustment to change in the context of deteriorating physical, cognitive, and psychosocial function
  - **Neuro-palliative rehabilitation** where the goals are focussed on symptom management and interventions to improve quality of life during the later stages of a progressive condition or very severe disability, at the interface between rehabilitation and palliative care.

Tertiary Inpatient Rehabilitation Programmes

- **Time-limited (normally limited to a maximum of 6 months)**
  - Many people with complex needs require programmes that last 3-6 months.
  - Longer-term intervention is occasionally required, e.g. for severe neurological injury, and is shown to be highly cost-effective for some patients, particularly for young patients with catastrophic brain injuries
  - Some patients will require repeated episodes of rehabilitation planned over a period of time, with intermittent periods of consolidation.
  - The process for requesting time extension of a rehabilitation programme is described in 3.3.
- **Fall broadly into four categories:**
  - Programmes for people with profound and complex physical disability
  - Cognitive/behavioural rehabilitation programmes for people who are independently mobile but have severe cognitive / behavioural / neuropsychiatric needs
  - Specialist community integration / vocational rehabilitation programmes
  - Programmes for children, adolescents (including 16-18 year olds) or young adults who require tertiary specialised rehabilitation in the context of schooling or on-going education

Level 1/2a Service Specification

Referral and assessment

- Assessment should be completed within **10 working days** of the initial referral.
- The outcome of assessment should be reported back to the referrer **within 2 working days** of the assessment. Assessment reports should include:
  - An evaluation of clinical need, including assessment using the patient categorisation tool
  - A recommendation of service(s) most likely to meet the assessed need
  - An indication of the ability to benefit from rehabilitation and possible outcomes
  - Aims of admission
  - An indication of the likely duration of specialist rehabilitation
  - The likely discharge destination and care and support needs on discharge.
- Patients should be admitted to the facility assessed as best to meet their needs **within 6 weeks** of being fit for transfer to rehabilitation.
- Local Clinical Commissioning Groups (CCGs) retain overall responsibility for patients admitted to the service **in collaboration with** the Local Area Team commissioners for tertiary neuro-rehabilitation.
- Level 1/2a service providers **should keep CCGs advised** with respect to all assessments, admissions and discharges.

Level 1/2a Service Specification

Referral and assessment

- All referrals via electronic referral system ‘Badgernet’
- Can refer to up to 3 units via Badgernet
  - If a referral is declined, can then refer to another unit, but only 3 active referrals allowed at any one time
- Referral outcomes and notes should be recorded on Badgernet – but often limited information so may need to contact unit for further info on referral outcome and recommendations
- Badgernet also used for referrals to SEL 2B beds

Discharge Planning

- Discharge planning should start **immediately** following multidisciplinary assessment within the unit. If the individual is to be discharged to their home, a home visit should be conducted as appropriate to establish access and equipment needs.
- Providers and commissioners will work closely together to ensure that:
  - The individual's needs for equipment and seating are drawn up as soon as needs are established and ordered as soon as provision and funding has been agreed.
  - If required a care manager is identified within the individual's local health or social care agencies to coordinate their care following discharge.
  - A care plan is produced.

Discharge Planning

- Before discharge [agreed number of weeks] a discharge planning meeting should be organised involving the:
- The family and other carers should be involved in discharge planning throughout.
- Family/ carers should receive advice and/or training with respect to managing on-going needs as appropriate including:
  - Physical management - positioning, transfer methods, nutrition, continence management communication methods etc.
  - Dealing with cognitive and behavioural problems.
  - Communications needs

Potential barriers & the NN Role

Accommodation / environment	Access visit. Home visit near d/c once functional level established. Decluttering/Deep clean – early ref to SS Managing patient and/or NOK expectations of rehousing – LENGTHY!!! Equipment – who is responsible, essential for d/c versus major adaptations Day leave/weekend leave Micro environment/community access
Care package/24hr care needs	Not 24hr, not overnight, not 1:1 through SS!!! Consider CHC or LA Safety between care calls/call for help Risk Ax Simulate care calls on ward Night time needs Continence Behavioural needs – Evidence/charts/waterlow

Homelessness	Confirm homelessness status – section 21 served eg status of eviction notice Cohabitation/legal rights Duty to refer – start early – pre admission Interim placement expectations Repatriation Housing officer allocation Check with acute
NRPF/NHS charges	Confirm with oversea's team, patient and NOK Refer to borough NRPF as early as possible if already not known
Local authority or CHC	Checklist/DST - timings CHC/FNC/LA
Capacity	IMCA DOL's
Community therapy access	Self management/support by NOK Exercise on prescription Community classes Day centre/headway Patient/family expectations Slow stream rehab
Needs can't be met at home	Trial at home? Home first Placement Slow stream rehab

Transition into the community

- Improved functional independence,
- cost-efficiency, enhanced social integration,
- increased engagement with family/carers
- How do we managing expectations?
  - Start the conversation early
  - Joint home assessment can be helpful
  - Liaise with community team
  - Set realistic functional goals
  - Clear communication: patient will not be discharged from rehab at baseline

SELNNS Contact list

Shona Falkner Mesner – Southwark. Shona.falknermesner@nhs.net

07585 960050

Ally Malcolm – Lewisham. Alexandria.malcolm2@nhs.net

07464 980606

Gerry Owusu-Gyamfi – Greenwich. G.owusu-gyamfi@nhs.net

07918 338782

Jenny Barrass – Lambeth. Jennifer.Barrass@nhs.net

07585 987351

Ana Santos – Bromley&Bexley. Ana.santos1@nhs.net

07879 801175

Thank you…

…Any Questions?