REHABILITATION AFTER MAJOR TRAUMA

Douglas Gentleman

NEURO-TRAUMA

- Severe brain injury
  - A significant part of the workload of inpatient and community-based rehabilitation services
- Mild/moderate brain injury
  - Issues with case identification, access to services, and capacity of services
- Spinal cord injury
  - A well-established national service

MSK TRAUMA

- Historically there has been little input from rehabilitation physicians, except for amputees
- No current Scottish RM physician has a special interest in MSK trauma
- Issues of where MSK rehabilitation happens – orthopaedic wards, community teams – and the pathway of care

CLINICAL EFFECTIVENESS

- Multiple studies have shown that patients who access appropriate rehabilitation programmes do better clinically, socially, and vocationally
- The exact style of rehabilitation matters less than being able to access people who understand the condition and are interested in it

COST EFFECTIVENESS

- UK-Rehabilitation Outcomes Collaborative

- UK-ROC data show that up-front costs of specialist rehabilitation are recouped within a mean of 16 months, with a lifetime saving of £1.5m to the public purse.

FUNDING AND RESOURCES

Much of the initial £30m investment in the English major trauma initiative went into building rehabilitation capacity, to keep the pathway moving.

Will Scotland do the same?

MTOG REHAB SUBGROUP

- A virtual group – mainly rehabilitation consultants, elderly care physicians, and senior AHP managers

- It works by email on issues of trauma rehabilitation that should be sorted out at a Scotland level

MINIMUM DATASETS

- An activity dataset will be collected by STAG as part of its core dataset
- This will include the rehabilitation plan (RP) = rehabilitation prescription in England
- Should it also include other measures?

REHABILITATION PLANS (RP)

- = Rehabilitation prescriptions in England
- A single RP for use throughout Scotland at the points of transfer of care
- Beyond that each rehabilitation service should retain ownership of its own clinical documentation

TRAUMA REHABILITATION LEADS

- Open process of advert and interview
- Agreed list of competencies
- Core role:
  - Clinical leadership in rehabilitation of major trauma patients
  - Ensuring appropriate triage and transfer
  - Audit and training

TRAUMA REHABILITATION COORDINATORS

- Competency profile
- Triage, liaison, transfer
- Ensuring RP is completed in a timely way
- Managed by Trauma Rehabilitation Lead
- Could be combined with other roles

TRAUMA REHABILITATION OUTCOMES

A workshop next month will produce a menu of measurable quality outcomes for trauma rehabilitation in Scotland

EXPERIENCE FROM ENGLAND

- Network rehabilitation director 56%
- Clinical lead for acute rehabilitation 88%
- Rehabilitation coordinator post 72%
- Rehabilitation prescriptions used 88%
- Patient information available 79%
- Directory of rehabilitation services 56%
- Clinical psychology dedicated time 80%

THE POSITION IN SCOTLAND

- Scotland has 20 rehabilitation physicians, but 15% of the posts are vacant

- The creative solution will be to make better use of the expertise of senior AHPs, especially in MSK trauma and in community-based rehabilitation

SUMMARY

- Rehabilitation is recognised to be a key element of the trauma pathway of care, but is under-funded and often disorganised
- Adapting the English experience to Scottish circumstances may allow us to get a decent ‘bang for our buck’ from the start
- There is a need for capacity-building and creative approaches to clinical leadership