



# British Society of Rehabilitation Medicine

Promoting quality through  
education and standards

**This document has been prepared by the British Society of Rehabilitation Medicine.**

**Rehabilitation Medicine is the specialty that encompasses the diagnosis, assessment, acute and long-term management of people with complex disabilities. Specialists in Rehabilitation Medicine practice across the disease trajectory in a range of settings from acute to the community.**

**This document was prepared in response to the report produced by the Royal College of Physicians' Future Hospital Commission of September 2013 'Future hospital: caring for medical patients'. Initial discussions were held by a working party (see below for membership), followed by consultation with the BSRM membership as a whole via Survey Monkey™.**

**BSRM Future Hospital Commission Working Party Membership:**

***Dr John McCann, Consultant in Rehabilitation Medicine, Belfast***

***Dr Margaret Phillips, Associate Professor in Rehabilitation Medicine, Derby***

***Dr Diane Playford, Reader in Neurological Rehabilitation, London***

***Dr Krystyna Walton, Consultant in Rehabilitation Medicine, Salford***

**The document describes how the role of Rehabilitation Medicine in the management of people with disabilities, can be used most effectively in the future hospital.**

**July 2014**



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# BSRM response to the Future Hospitals Commission

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## BSRM response to the Future Hospitals Commission

The BSRM welcomes the report on the future hospitals commission which it believes will lead to improvements in care, ensuring real change in the way services are delivered to better meet the needs of patients.

This response, which focuses on the needs of people with disabilities, was developed by a working party consisting of Dr John McCann, President BSRM, Dr Diane Playford, Chair JSC, Dr Margaret Phillips and Dr Krystyna Walton. The members of the BSRM who are working in England were then consulted using survey monkey. 285 invitations to respond to the survey were sent out, of whom 182 were working at consultant level. Respondents were asked whether they 'strongly agreed', 'agreed', 'disagreed' or 'strongly disagreed' with the statements. 99 responses were obtained, 64 from consultants. Levels of support for the principles listed below were very high, with the majority of statements being endorsed by over 90% of respondents. Where the proportion was less than 90% the percentage of respondents either strongly agreeing or agreeing is in brackets after the statement.

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### 1. General principles

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1.1 The BSRM believes patients should have care delivered as close to their own homes as possible while delivering the level of expertise required for the patients need.

1.2 We also believe a rehabilitation approach should be embedded across the patient pathway as this will minimise admissions to hospital.

1.3 The World Health Organisation international classification of function should be considered as a model of health and disability that incorporates a biopsychosocial approach for all patients.

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### 2. Creating a culture of active disability management

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2.1 Nursing acuity scores should reflect the needs for nurses to facilitate independence.

2.2 Appointing a lead therapist for each ward to work with the ward manager would ensure patients independence was placed centrally in decision making. Such therapists would ensure that patients were directed to the appropriate rehabilitation service through the use of a rehabilitation prescription (78%).

2.3 The importance of clinical psychology services in working with patients with physical and cognitive disability recognised and their role promoted.

2.4 All clinical staff should promote basic methods to regain independence and enhance recovery, such as sitting out of bed, optimising diet, and early mobilisation. They should actively work with and acknowledge each patient's expertise in managing their disability.

2.5 Hospitals should have access to appropriate equipment and training for patients to be hoisted for investigations without incurring delay greater than that for any other patient.

2.6 Hospitals should have access to appropriate rehabilitation tools, including an assessment kitchen, shower chairs, and specialist seating.

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### 3. Acute management

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3.1 Rapid and open access through multiple referral pathways (e.g. therapist led or patient initiated) should exist to rehabilitation medicine and multidisciplinary to manage both predicted and unpredictable events thus preventing hospital admission.

3.2 Rehabilitation medicine physicians should not be involved in the acute medical take but should review all patients who have been in hospital for 72 hours or longer with a disabling musculoskeletal diagnosis (80%).

3.3 All trauma, stroke, neuroscience, and critical care units should have access to RM services who should assess and triage patients, directing patients to appropriate services, (therapists, community rehabilitation teams, level 1, 2 or 3 rehabilitation services).

3.4 Specialist services, such as those developed for stroke, which have had a significant impact on mortality and morbidity, should be protected and developed further.

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### 4. Subacute and chronic management

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4.1 Rehabilitation physicians should work with community rehabilitation teams to prevent unnecessary hospital admission.

4.2 Community based services should not be confined to a single diagnosis or impairment specific but tailored to disability and disease trajectory.

4.3 Services should have the capacity manage both complexity and intensity in the community, for example, through access to rehabilitation medicine physicians, use of day beds and early supported discharge teams for all patients who need them.

4.4 Models of care should exist for patient with long term neurological and long term musculoskeletal conditions which co-ordinate active management within the community, minimising the need for hospital admission. These models of care should

- include access to rehabilitation medicine physician.
- be able to manage rehabilitation complexity (89%).
- be able to deliver appropriate levels of intensity.
- be able to deliver within an appropriate time frame.

4.5 Such models for care should work with community rehabilitation teams and identify clear care pathways. These pathways should be able to manage

- Resettlement into home after a single incident disabling disorder such as stroke, or brain injury.
- Deliver ongoing condition management and regular review for people with long term neurological and musculoskeletal conditions.
- Provide crisis management to prevent transfer of care to another setting such as hospital or nursing home (85%).
- Support palliative and end of life care (75%).
- Provide vocational rehabilitations services for people whose health condition impacts on their ability to work.

4.6 Patients with complex conditions should be able to access specialist AHPs and extended scope practitioners whether they are treated in primary or secondary care (87%).

4.7 All CCGs should have a long term conditions register as recommended in the NSF for LTNC which enables annual review of patients with disabling conditions.

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## 5. Integration of services

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5.1 Integration of rehabilitation services needs to occur between community and secondary, for example through joint appointments of RM physician and therapists.

5.2 Integration of community rehabilitation services with social services needs to occur, so that budget lines do not inhibit the delivery of excellent care.

5.3 The continuing health care process should be reviewed with the aim of ensuring the treatment and appropriate placement are not delayed by the process, and knowledge and skills of rehabilitation staff working with patients are acknowledged and utilised. Integration of this process with combined health and social care should be considered.

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## 6. Medical training

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6.1 The case conference assessment tool which has been developed as a psychometrically robust measure of competence in running family meetings for RM trainees should be embedded in training for all physicians.

6.2 The World Health Organisation international classification of function should be taught at Foundation level as model of health and disability that incorporates a biopsychosocial approach.