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# Rehabilitation Medicine

## The National Position in 2007

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## Summary

1. This paper describes the medical specialty of Rehabilitation Medicine (RM) at both clinical and policy levels.

2. Rehabilitation Medicine provides services for people with highly complex disabilities.

3. Rehabilitation Medicine consultants work in multidisciplinary teams both in acute settings and in the community. Their specialist medical skills are required in the assessment of complex needs and in the provision of a range of specific interventions.

4. In implementing the National Service Framework for Long-term Conditions, RM is the lead NHS resource for most Quality Requirements.

5. Rehabilitation Medicine makes crucial contributions to the implementation of other NHS policies, including the development of primary care-led services.

6. Evidence of cost-effectiveness is accumulating. Three principal economic contributions of RM are:
   **6.1** the prevention of costly complications and avoidable hospital admissions
   **6.2** reduction in the duration of admissions through co-ordination of complex discharges, and
   **6.3** facilitation of employment for disabled people.

7. The UK lags behind all other comparable countries in the provision of Rehabilitation Medicine.

# 1. What is Rehabilitation Medicine?

Rehabilitation Medicine (RM) consultants provide medical advice for adults with complex disabilities resulting from conditions such as spinal and head injuries, stroke, multiple sclerosis, musculoskeletal disorders and amputation. In these patients, psychological and social factors are often intertwined with physical problems. The specialist scope of RM includes medical interventions for spasticity, incontinence and other disabling symptoms, and also complex assistive technologies such as electronic environmental controls and specialist wheelchair seating. A typical RM consultant supervises inpatients in a neurological rehabilitation unit as well as providing clinics. Additional activities include team meetings, family conferences, home visits and community liaison.

Clinical assessment in RM requires high-level analytical skills, drawing on data from a wide range of sources. Rehabilitation programmes are carried out in collaboration with the patient, the family and specialist multidisciplinary teams. The principles of the International Classification of Functioning, Disability and Health[1] are fundamental to RM, which aims to facilitate activities and social participation. The individual's physical and social environments are crucial in both assessments and interventions: for example, someone complaining of spinal pain is as likely to benefit from different sitting arrangements as to require drugs or other strictly medical treatments.

Karl H (24) had severe brain damage as a result of a car accident. During his stay on the regional neurosurgical unit a Rehabilitation Medicine consultant assessed him and then transferred him to the DGH-based specialist neurological rehabilitation unit. Karl had severe physical disabilities and was aggressive, with a short attention span. The RM consultant's expertise was important in the management of disruptive behaviour, epilepsy, malnutrition and other complications, including hydrocephalus which required further neurosurgical input. The RM consultant continued to co-ordinate the complex therapeutic and social processes leading to Karl's discharge to a community hostel. In the following months, the RM consultant co-ordinated a programme of vocational rehabilitation, and Karl eventually obtained part-time employment combined with placement in a training programme.

Lisa P was born without tibiae (shin bones). Orthopaedic specialists planned bilateral through-knee amputations. This decision was modified following the advice of the RM Consultant, who recommended a less radical procedure on one side. As a result, Lisa is now up and about on two prostheses. Gait is less ungainly and much less fatiguing than would have been possible with the original plan. The RM Consultant's expertise has continued to help Lisa to maintain optimal function as her needs change.

## 2. Working with other professionals and agencies in hospital and community

Multidisciplinary working is integral to RM both in specialist inpatient rehabilitation units and in the community. Rehabilitation Medicine consultants constantly interact with professionals in primary healthcare teams, social services and other agencies. Home-based assessments are often required and in some centres consultants are members of community teams.

Helen B, diagnosed with multiple sclerosis six years previously, presented to her GP with complex problems including spasticity, urge incontinence and depression. The RM consultant provided an integrated assessment, advised the GP on management of impairments and disabilities, and organised assessments by both social services and neurological physiotherapy. Over the following years the RM consultant shared Helen B's follow-up with a specialist rehabilitation nurse. At intervals, the RM consultant assessed her in the clinic and at home, advising on symptom control, environmental controls and specialist seating. She was eventually admitted to a nursing-home where the RM consultant continued to support her care, for example with botulinum toxin injections to control salivation, and seating reviews.

## 3. Implementing the National Service Framework for Long-term Conditions

The Co-Chair of the NSF for Long-Term Conditions[2] was an RM Consultant, and RM has key roles in the delivery of all the NSF's quality requirements (QRs). The whole ethos of RM is person-centred (QR 1). Neurology leads the diagnostic process (QR 2) and acute care (QR 3) for many conditions. However, RM and Trauma consultants collaborate in the early assessment of head injuries, and in some centres RM consultants lead the entire service for progressive conditions such as Huntington's disease (eg in Derby) and motor neurone disease (eg in Kent). Rehabilitation Medicine provides multidisciplinary working models for the support of people with long-term conditions[3], and RM is the lead NHS agency for:

- early and specialist rehabilitation (QR 4)
- community rehabilitation and support (QR 5)
- vocational rehabilitation (QR 6)
- specialist equipment and accommodation (QR 7).
- provision of personal care and support (QR 8), through advice to social services on the design of care packages
- optimal symptom control and function in the later stages of long-term conditions (QR 9) – in collaboration with palliative medicine teams
- supporting family and carers (QR 10)
- co-ordination of care for people with neurological conditions during hospital admissions (QR 11).

## 4. Implementing national policy

Rehabilitation Medicine enables people with long-term conditions to lead healthier lives, a key objective of the NHS Improvement Plan (2004) and of the Health and Social Care White Paper, *Our Health, Our Care, Our Say* [4] . Using a community-orientated service model, RM contributes to this agenda for people with some of the most complex conditions. As highlighted in a recent BSRM report[5], one of the core activities for RM consultants is helping people with complex disabilities retain or regain employment, and they are well positioned to make a major contribution to the new policies for employment as described in *A New Deal for Welfare: Empowering People to Work* [6] and the inter-departmental strategy *Health, Work and Well-being* [7].

## 5. Developing primary care-led services

The workload of RM consultants includes a higher proportion of service development work than most other specialties, because of an acknowledged responsibility to provide equitable services for populations of disabled people. For example, RM has contributed to the development of care pathways stimulated by the *Action on Neurology* initiative.

RM consultants have played leading roles in the Trent Neurosciences Network http://www.tin.nhs.uk/local-networks/neurosciences with the goal of re-engineering neurological and neurosurgical services to create more accessible and patient-centred pathways. Based on the principles of the NSF for Long-term Conditions, all aspects of the pathways are underpinned by rehabilitation processes and informed by Quality Outcome Frameworks.

As a young and constantly evolving specialty, RM continues to develop innovative approaches to the deployment of rehabilitation expertise within health communities. One response has been the development of effective models for joint working between medical specialists and medical generalists (GPs), as recommended in a recent Joint Statement from the Royal Colleges of Physicians and General Practitioners[8]. Similarly, RM consultants provide an ideal interface for the developing roles of Community Matrons, in line with the agenda defined by *Supporting People with Long Term Conditions* [9].

## 6. Optimising use of specialist medical skills

Being spread so thinly, and being committed to interdisciplinary working, RM consultants constantly aim to hone down their specialist medical input to the minimum effective level, transferring roles to a range of extended role practitioners. For example, specialist nurses can have pivotal roles within community services[3]. By

working closely with a specialist occupational therapist, the RM consultant can be relieved of some aspects of environmental controls assessments. Similarly, a physiotherapist or nurse can make a major contribution to a spasticity service, including taking on the extended role of botulinum toxin injections in some cases.

*Making the Best Use of Doctors' Skills*[8] raises the question: How can care be organised so that patients see the right doctor at the right time and in the right setting? In order to provide the best outcomes for people with complex and progressive disabilities, a GP needs access to a Rehabilitation Medicine team in which medical expertise is represented. Within the team individual RM consultants contribute a range of specific specialisms in neurological rehabilitation and musculoskeletal rehabilitation. Non-medical team members, with specialist extended roles, provide a range of services. Input from RM consultants, as members of the team, is required where medical and technical problems are especially complex or unstable.

## 7. Education

Disability and rehabilitation are now mandatory elements in both undergraduate and postgraduate medical training[10]. NHS and academic consultants lead the delivery of these elements of the undergraduate and postgraduate curricula. Rehabilitation Medicine also has educational affects through the demonstration of best practice for other medical specialties.

## 8. Cost-effectiveness

Evidence on the cost-effectiveness of specialist rehabilitation is accumulating[11, 12]. Rehabilitation Medicine helps to contain the costs of disablement for health and social services, for employers and also for disabled individuals and their families. The economic benefits of RM can be summarised under three main headings:

### 8.1 Preventing costly complications and avoidable hospital admissions

Rehabilitation Medicine consultants support their primary care colleagues in creating strategies to prevent disastrous complications such as skin sores, joint contractures and fractures which add to the burden of long-term conditions. The medical skill of predicting natural history and preventing complications can make a vital contribution to the work of Community Matrons and others involved in the new approaches to managing long-term conditions[9]. Rehabilitation Medicine also supplies preventive objectives for social care processes, eg when an opportunity for facilitating a self-care task discourages increased dependency. These strategies relieve pressures on acute services, thus helping to break the 'vicious circle' highlighted in the Audit Commission's report, *The Way to Go Home* [13].

### 8.2 Reducing the duration of hospital admissions

As the NSF has recognised[2], long-term conditions have a highly disproportionate effect on hospital bed occupancy, because of delays in discharge. Such delays are reduced where RM expertise is available to co-ordinate complex discharges. Recent suggestions for restructuring post-acute rehabilitation[14] would fit well with the proven ability of RM specialists to work across disciplines and between agencies. Extending these roles would realise significant savings for acute Trusts within the broad framework of post-acute rehabilitation.

### 8.3 Helping disabled people return to the workforce.

Many people with complex disabilities are frustrated by the barriers they face in retaining or regaining employment[5]. The specialist expertise of RM consultants helps such individuals to achieve their potential for economic participation[6].

## 9. International comparisons

The UK specialty of RM broadly corresponds to that of Physical Medicine and Rehabilitation, which is a standard element in modern specialist services throughout the world. In comparison with the largest EU economies, for example, the UK has by far the lowest number of RM specialists per capita and also the lowest number as a proportion of all medical specialists.

| | France | Germany | Sweden | Italy | UK |
|---|---|---|---|---|---|
| **Number of RM specialists** | 1760.0 | 1571.0 | 160.0 | 2200.0 | 152.0 |
| **Number of RM trainees** | 125.0 | 65.0 | 20.0 | 350.0 | 57.0 |
| **Specialists (all types) per 100k population** | 155.0 | 326.8 | 207.1 | 271.2 | 36.2 |
| **Specialists (RM) per 100k population** | **2.9** | **2.0** | **1.9** | **3.7** | **0.2** |
| **RM as proportion of all specialists (%)** | 1.87 | 0.61 | 0.92 | 1.36 | 0.55 |

Source: UEMS Section of PRM Data, The White Book of Physical & Rehabilitation Medicine in Europe. Eds. Gutenbrunner C, Ward AB, Chamberlain M.A. Journal of Rehabilitation Medicine 2007; 41 (Suppl. 1)

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