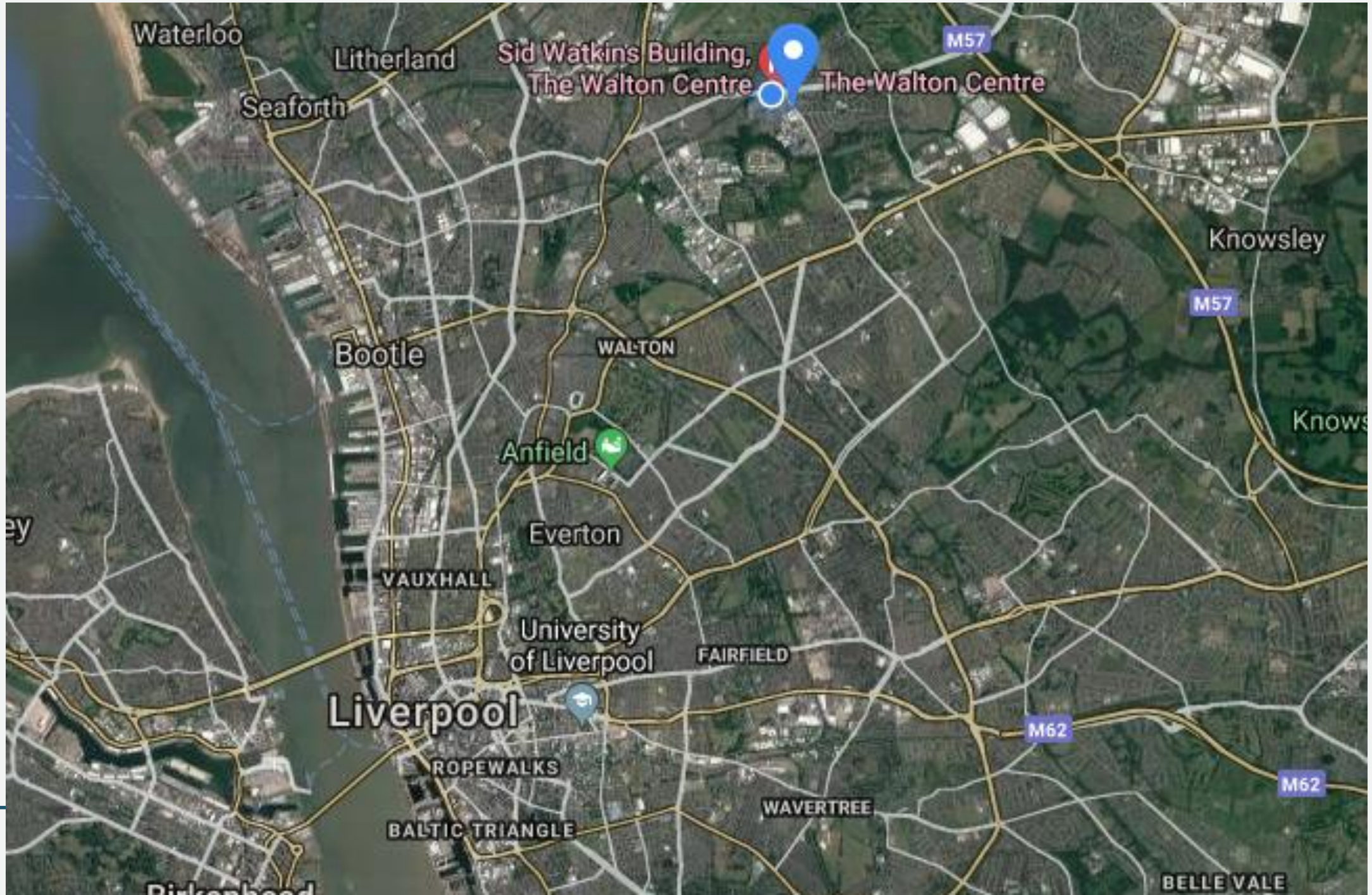
# MY UK EXPERIENCE

*THAPANEE SITHAWATDECHA*
*Third year PM&R resident, Siriraj Hospital*


Liverpool
Bangkok
14 h 40 min
Norway
Denmark
Ireland
Belarus
Poland
Germany
Ukraine
Austria
France
Romania
Italy
Spain
Portugal
Greece
Kazakhstan
Mongolia
Uzbekistan
Kyrgyzstan
Turkmenistan
China
Syria
Iraq
Iran
Afghanistan
Pakistan
Nepal
India
Myanmar (Burma)
Thailand
Tunisia
Morocco
Algeria
Libya
Egypt
Western Sahara
Saudi Arabia
Oman
Mauritania
Mali
Niger
Chad
Sudan
Yemen
Burkina Faso
Guinea
Nigeria
Ghana
South Sudan
Ethiopia
Somalia
Kenya
Gabon
Gulf of Aden
Arabian Sea
Bay of Bengal
Gulf of Thailand
Laccadive Sea
Gulf of Guinea
Malaysia
Indonesia


Waterloo
Litherland
Seaforth
Sid Watkins Building, The Walton Centre
The Walton Centre
M57
Knowsley
M57
Bootle
WALTON
Anfield
Everton
VAUXHALL
University of Liverpool
FAIRFIELD
Liverpool
M62
ROPEWALKS
WAVERTREE
M62
BALTIC TRIANGLE
BELLE VALE


The Walton Centre

NHS Foundation Trust

*Excellence in Neuroscience*

- The only specialist hospital trust in the UK dedicated to providing comprehensive neurology, neurosurgery, spinal and pain management services

The Walton Centre NHS
NHS Foundation Trust

## Medical service

- Neurology
- Neurosurgery
- Pain Medicine

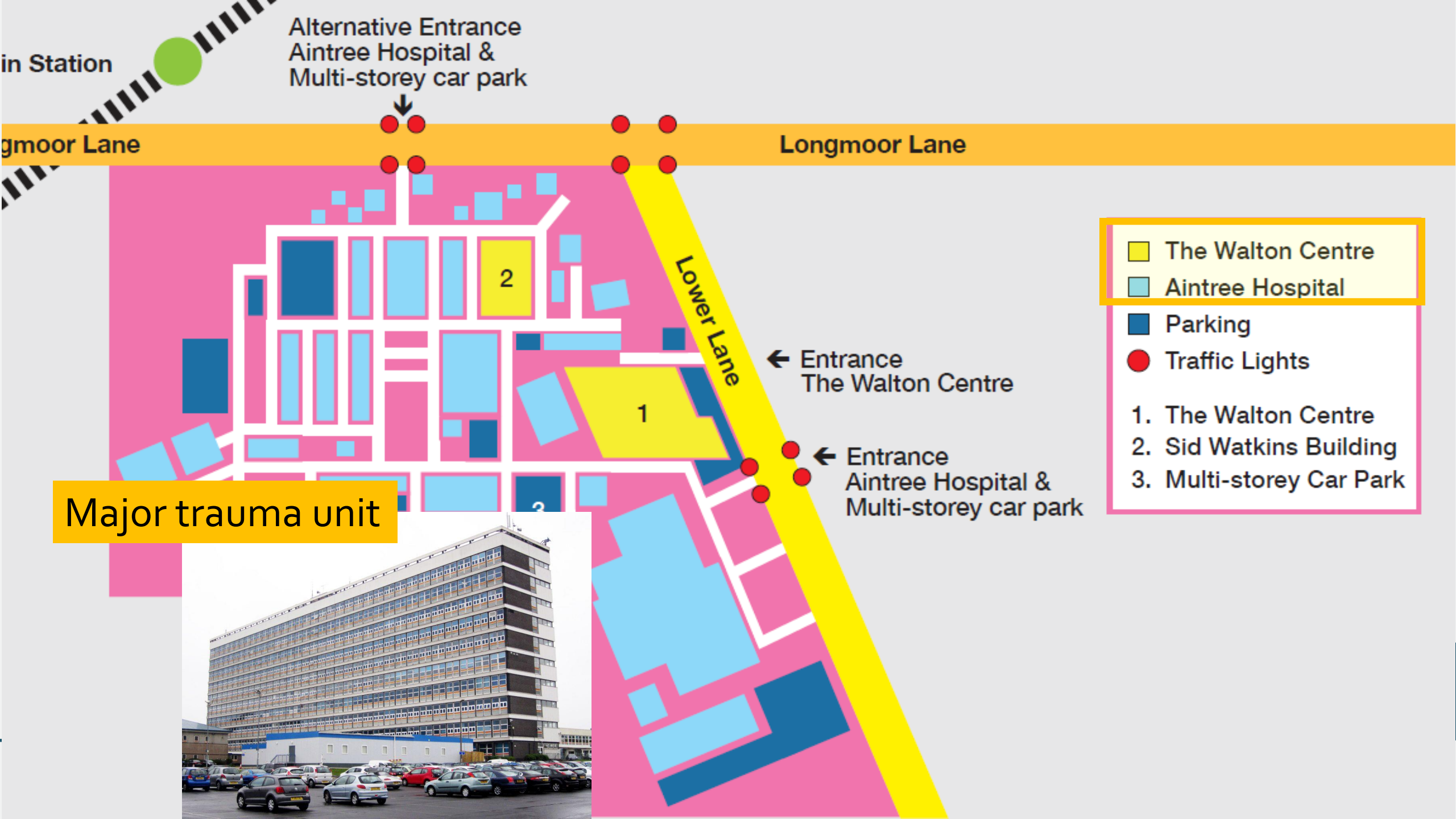
## Medical education

Undergraduate

- University of Liverpool

Postgraduate

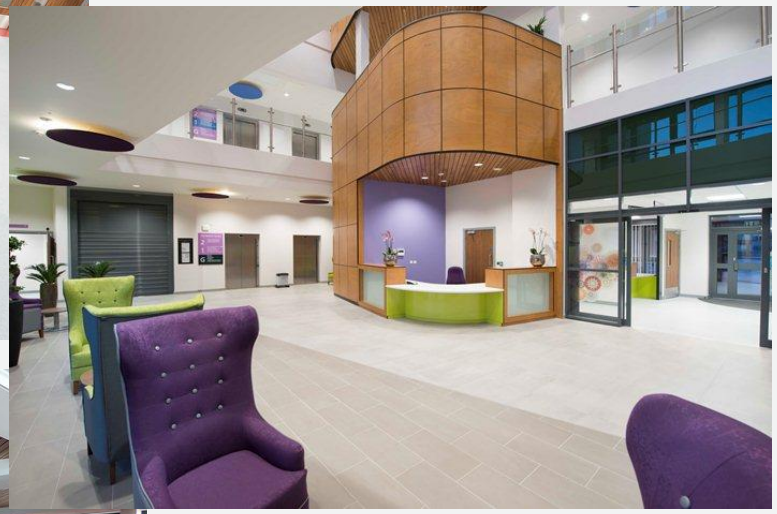
- Neurology
- Neurosurgery
- Neuroanaesthesia
- Neuroradiology
- Neuropsychology
- Neurorehabilitation
- Neurophysiology
- Neuropathology
- NeuroTrauma


in Station
Alternative Entrance
Aintree Hospital &
Multi-storey car park
gmoor Lane
Longmoor Lane
Lower Lane
2
1
3
Entrance
The Walton Centre
Entrance
Aintree Hospital &
Multi-storey car park
The Walton Centre
Aintree Hospital
Parking
Traffic Lights
1. The Walton Centre
2. Sid Watkins Building
3. Multi-storey Car Park
Major trauma unit

# The Walton Centre NHS Foundation Trust


# *Sid Watkins Building*

The Walton Centre NHS
NHS Foundation Trust



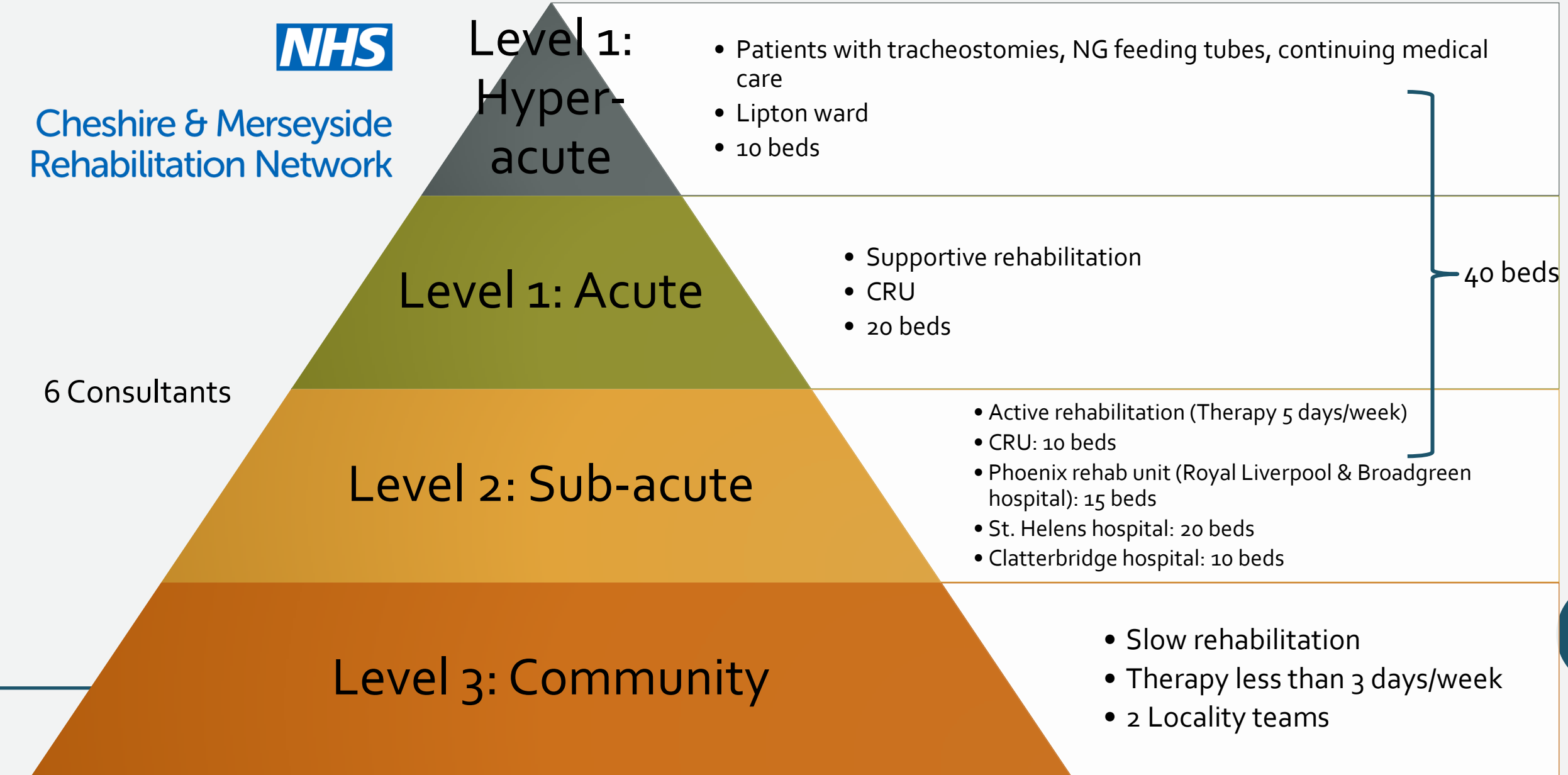
- Complex rehabilitation unit (CRU)
- Pain Management Programme (PMP) department
- Brain Injuries Unit
- Relatives' accommodation
- Medical education centre
- OPD

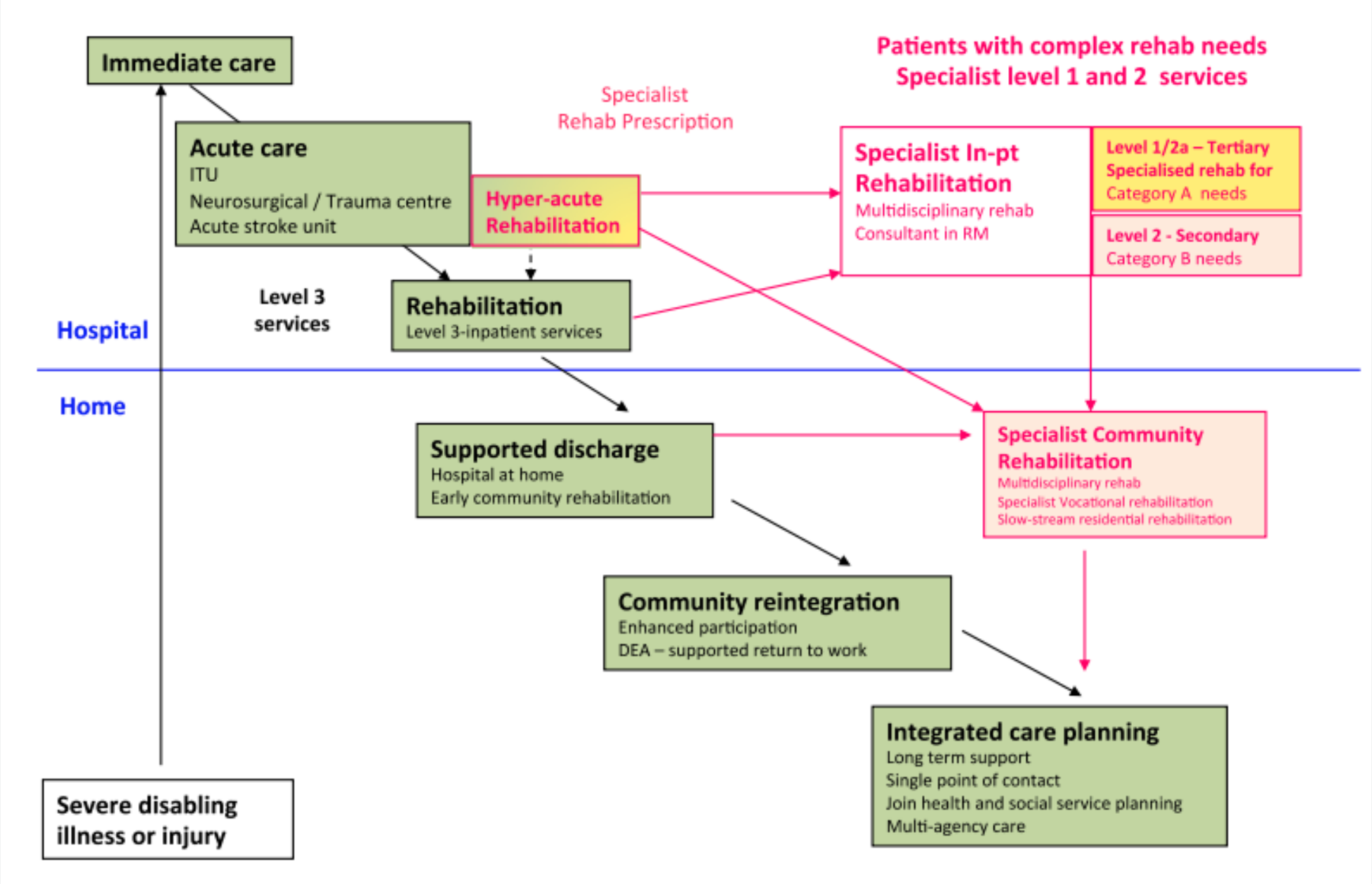
# *Rehabilitation system in the UK*

- Neurorehabilitation
- Spinal cord injury rehabilitation
- Musculoskeletal rehabilitation
- Amputee rehabilitation, orthotics and prosthetics

# The Walton Centre Rehabilitation Network

NHS
Cheshire & Merseyside Rehabilitation Network





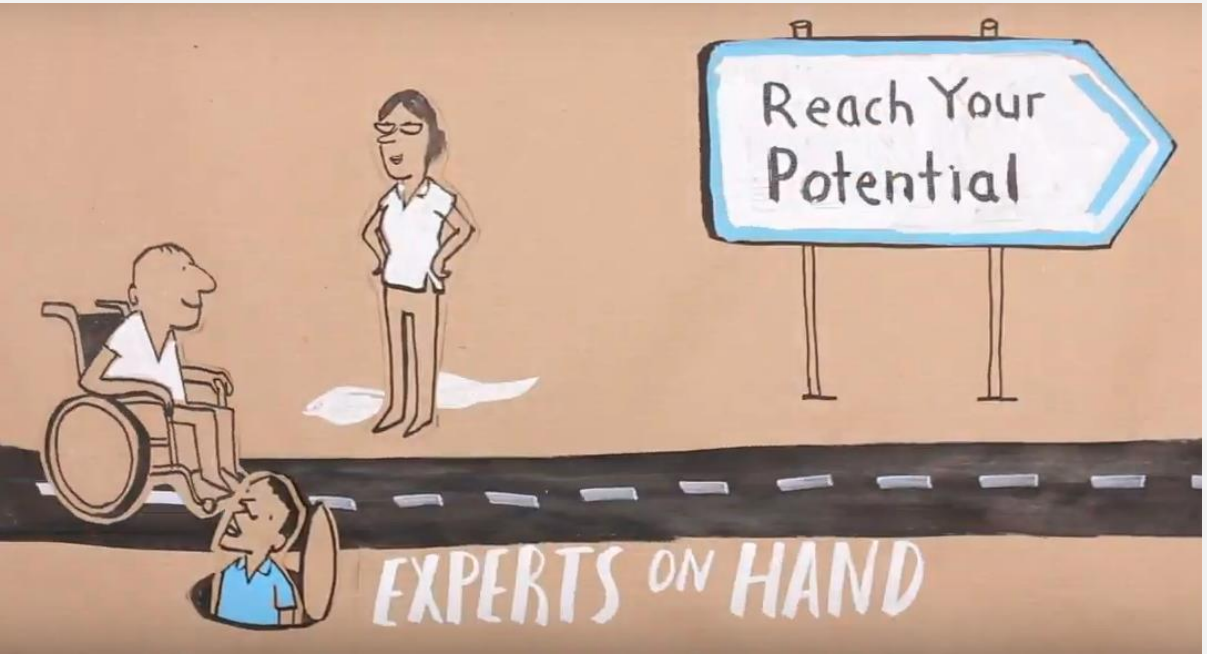

Specialist neuro-rehabilitation services: providing for patients with complex rehabilitation needs

# *Patients*

- Traumatic brain injury
- Brain tumor
- Other neurological diseases e.g. MS

- Spinal cord injury → SCI center
- Stroke → stroke unit

  (different network)

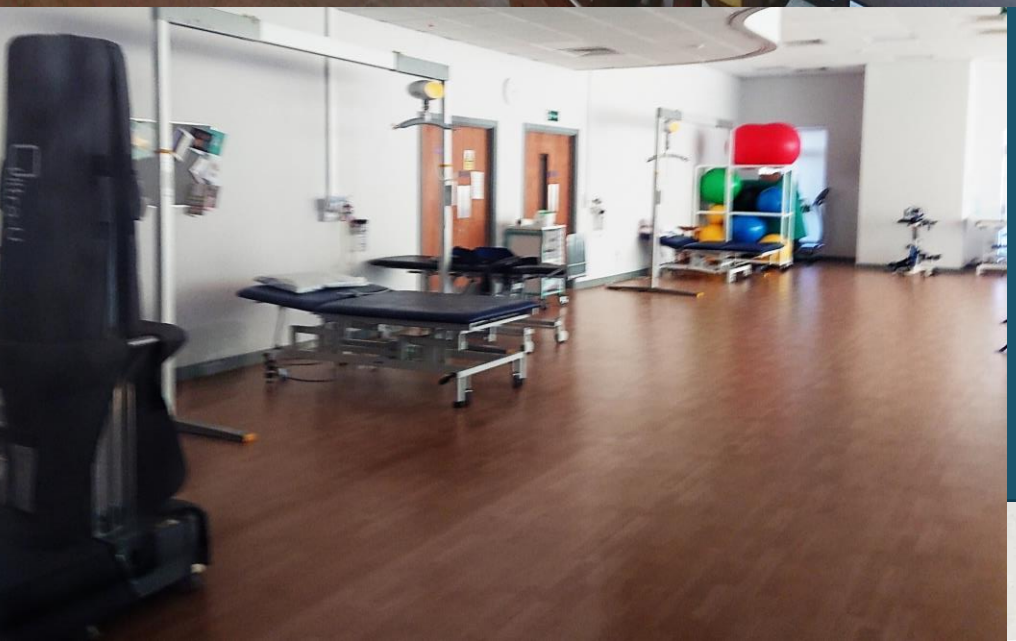


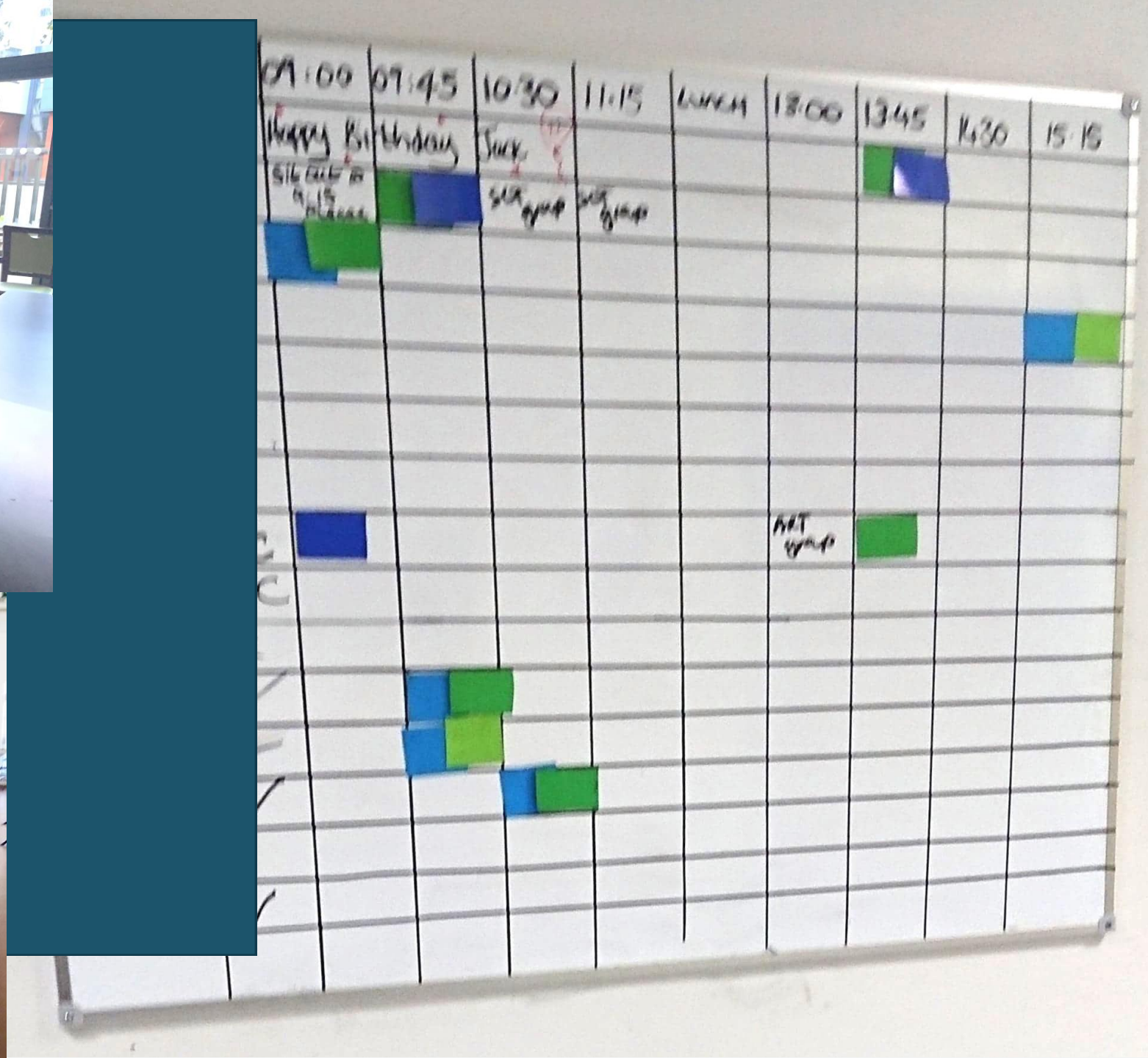

Note: community team- takes care of wider range of illnesses

The Walton Centre NHS
NHS Foundation Trust

| | | | |
|---|---|---|---|
| Rehabilitation coordinator | Rehabilitation Consultant and ward Doctors | Nurses and Health Care Assistants | Occupational Therapist |
| Physiotherapist | Speech and Language Therapist (SALT) | Dietitian | Therapy assistants |
| Psychologist | Consultant Neuropsychiatrist | Mental Health Liaison Nurse | Social Worker |


Fire exit
Complex Rehab Unit
Uned Adsefydlu Cymhleth
INFECTION PREVENTION & CONTROL




09:00
09:45
10:30
11:15
LUNCH
13:00
13:45
14:30
15:15

# *Activities*


- Ward round: 1 time/week
- Multidisciplinary team (MDT) meeting
  - Every week for CRU
  - Every 2 weeks for Lipton ward
- Major trauma discussion: every week
- Rehab admission discussion: every week
- Allocation meeting
- Goal setting meeting
- Grand round teaching
- Outpatient clinic & spasticity clinic

Consultant | GP | PT | OT | SALT | Psychologist


Single Point of Contact (SPOC)

Initial evaluation

MDT meeting

# Referral process

## *Patient from community*

Cheshire & Merseyside Rehabilitation Network

Rehabilitation coordinator

# *Referral process*

## *Patient from Aintree, Walton Centre*

# *After admission*

Assessment by multidisciplinary team

Inpatient Rehabilitation coordinator

MDT meeting

- every week

Discharge Planning

Goal setting meeting

(team + patient + family)

Rehabilitation programmes

- 5 days/ week

# *After discharge*


- Home
- Referral to other hospital

  (e.g. level 1 treatment in Walton Centre → level 2 in Broadgreen Hospital)
- Referral to community team

# *Royal Liverpool and Broadgreen Hospitals*


- Phoenix rehabilitation unit
- Level 2
- 15 beds
- 1 rehabilitation consultant
- Patients from
  - Other Hospital
  - Network MDT meeting
  - Outpatient

# *COMMUNITY TEAM*

- *works with adults who need specialist rehabilitation in the community as a result of injury or illness*
- *accepts individuals into the service who have identified complex rehabilitation needs and require an MDT approach*

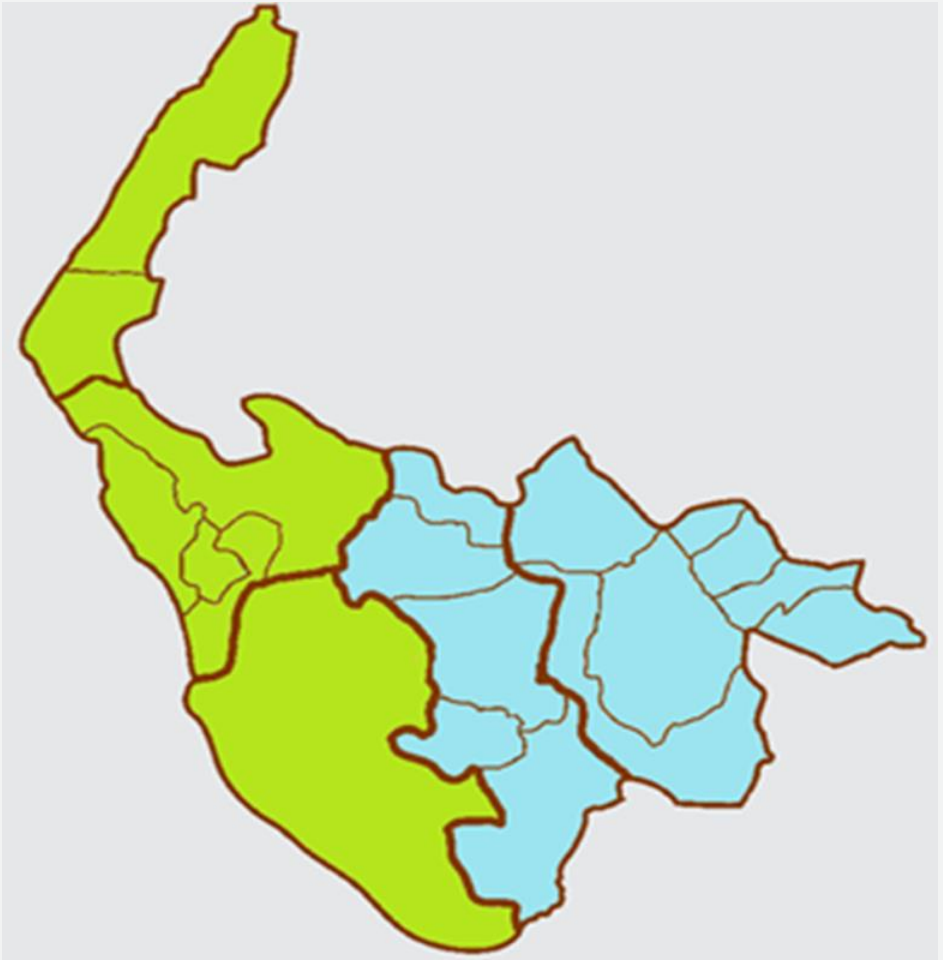
# *Community team*
## *Demographic*

**Locality 2** - Liverpool, South Sefton, Southport and Formby

- Serve a population of approximately 700,000 adults

**Locality 1** – St Helens and Knowsley Borough

- Serve a population of approximately 300,000



# *Community team* Referral Criteria

## GP

- Must be within Liverpool, South Sefton or Southport & Formby CCGs.

## Age

- The patient must be 18 years and over (16 and 17 year olds will be considered on an individual basis).

## Diagnosis

- The service is based on rehabilitation need rather than diagnosis, so patients must have achievable rehabilitation goals and demonstrate a commitment to engage in a rehab programme. The patient needs to be aware of their diagnosis.

## Consent

- The patient must be made aware of the referral to the service. Consent will also be gained at the initial assessment.

## Disciplines

- The patient must have identified rehabilitation goals from two or more disciplines to inform a multi-disciplinary approach to rehabilitation.

## Other

- Where there are other pre-existing services/pathways available to meet their needs (e.g. Early supported discharge, stroke services, palliative care, community team service, community mental health team) the referrer will be signposted to such services.

# Community team
## *Referral process*

Cheshire & Merseyside Rehabilitation Network

Community rehabilitation coordinator

**Referral Form completed by referrer**

GP/consultant /PT/OT/SALT

- All sections must be completed, with clearly identified rehabilitation goals

**Referral form faxed and triaged**

- Demographic details are checked to ensure patient is within our criteria

**Referral form discussed in weekly MDT meeting**

- All decisions are made by the MDT as a whole

**Allocation meeting**

**Outcome reported to patient, referrer, GP and medical consultant (as appropriate)**

- Discipline specific information sought
- Letters posted
- Initial Assessment appointment arranged (if accepted) within 2 weeks

Patient Name: DOB:

NHS Cheshire and Merseyside Rehabilitation Network

**Community Specialist Rehabilitation Service, Locality 2 Referral Form.**

***CONFIDENTIAL*** **Please ensure *all* sections are completed— uncompleted forms will be returned to the referrer and not processed**

**Patient Details:** Title: ..... Sex: M/F Date of Birth ..... Age: .....

Surname: .....

First Name: ..... NHS Number: .....

Address: ..... Telephone Number: .....

..... Mobile Number: .....

..... Post Code: ..... Email: .....

Languages spoken (list first as main language): .....Translator needed? Yes □ No □

**Next of Kin:** .....

Relationship: .....

Address: .....

.....

.....Post Code .....

Telephone .....

**GP Name:** .....

Practice: .....

Address: .....

.....

.....Post Code .....

Telephone .....

**Past Medical History:**

**Mental Health Background:**

Please attach medication list □ **Known drug allergies:**

**Medical Diagnosis pertaining to this referral:**

**Is the patient aware of diagnosis? Yes □ No* □ If 'no' state reason:**

**History of presenting illness or injury:**

**Relevant medical investigations (please include CT/MRI and relevant X-ray reports)to date:**

**Brief summary of input patient has received to date (please attach discharge report if available)**

**If patient is currently an in-patient, what is the predicted date of discharge? ____/_____/_____**

**Community Specialist Rehabilitation Service Please identify the disciplines required and the identified rehabilitation goals:** (please supply on additional page if required) □

**Physiotherapy**

**1**

**2**

**3**

**□ Occupational Therapy**

**1**

**2**

**3**

**□ Speech and Language Therapy** Current Diet Texture and Fluid Consistency: .....

**1**

**2**

**3**

**□ Psychology**

**1**

**2**

**3**

**□ Vocational Rehabilitation**

**1**

**2**

**3**

Patient's employment status and job prior to illness .....

**Equipment:** Please list all current equipment that patient has (for mobility, ADLs and communication) and those which have been ordered:

**Other disciplines involved:** Social Services □ District Nurse □ Dietitian □ Orthotics Team □ IMCA □

Social Package of care □ (Frequency of visits: .....)

Consultant □ (Name: .....) Other: .....

**Patient's Housing status:**

Bungalow □ House□ Flat□ Care Home □ Sheltered Accommodation □ Hostel □ Homeless□

Specific information about access: (key safe, unable to answer door etc) .....

.....

**Risk for home visit:** Are there any known risks to the patient or family / friends that the team should be aware of prior to visiting? Please detail any **environmental risks** and **risk to self/others** (please include any details regarding possible drug, alcohol and mental health concerns)

**Environmental risk** .....

.....

**Risk to self / others** .....

.....

**Does the patient have caring responsibilities / dependents? Yes □ No □**

If yes, please give details: .....

.....

Has patient consented to this referral and sharing of information contained? Yes □ No □ Best Interests □

**Additional Information: Please attach any further information you feel would support the referral or be beneficial**

---

**Referrer details:**

Name: ..... Profession: .....

Address: ..... Telephone number: .....

..... Email address: .....

.....Post Code: .....

SIGNED: ..... Date: .....

**Send to:** CMRN Specialist Community Rehabilitation Service (Liverpool & Sefton) CRU MDT Office, Sid Watkins Building, Lower Lane, Liverpool, L9 7BB **OR Fax:** 0151 529 4160 **OR** if from a nhs.net email account to **wcf-tr.csrsloc2@nhs.net**

**Please do not email referrals to individual clinicians**

**OFFICE USE:**

**Date received:** **Accept:** **1st Appt:** **Declined:**

# Community team

## Working process

**First visit**

- Usually with the rehabilitation co-ordinator, at home or in outpatient clinic
- Introduction to the team and the service
- To discuss expectations of the service

**Community MDT meeting**

**Assessment**

- Initial assessments completed by individual professions involved
- May take place over a number of sessions
- Contact with other professionals that may be involved

**Rehabilitation programmes**

- Individual rehabilitation programme
- Based on realistic goals, set jointly with the patient and the MDT

**Review care**

- Complete case report → consultant
- Every 8 weeks

**Review goal**

- Complete case report → consultant
- Every 8-12 week

**Discharge**

- Planned discharge, following achievement of goals but can also be due to other circumstances
- Transition to generic community services if appropriate
- Signpost for further support in the future

Average waiting time: 3 months

# *BBC's Hospital Series*