
NHS England

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# Rehabilitation for Economic Growth

## National Clinical Director for Rehabilitation and Recovering in the Community

5 November 2014

# Vision:

Rehabilitation will be key to every episode of care.

It will maximise mental and physical health, independence and occupation.

Rehabilitation is everyone's business

# Rehabilitation Plans For:

- Diabetes
- Cardiopulmonary Disease
- Mental Illness
- Cancer
- MSK
- Frail and Elderly
- Trauma

CYP
Working age population
Elderly

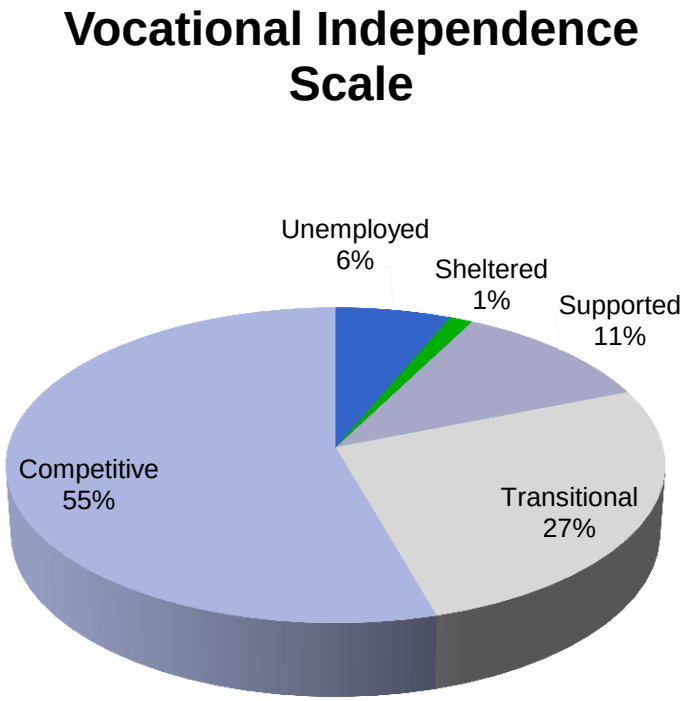
# Good Clinical Outcomes

- Capability
  - Skilled, Knowledgeable Workforce
  - Equipment
  - Infrastructure
- Capacity
  - Workforce
  - Time

**MONEY**

# 3 year study on TBI inpatients

## n = 91 Follow up data on 79 patients at 4 months




- Community Employment: 92%
  - Supported
  +
  - Transitional
  +
  - Competitive

**Dharm-Datta S, Gough M, McGilloway E, 2014**

# History

- Piercy Committee in 1956
  - There should be no clear-cut demarcation between medical, social and employment rehabilitation.
- The Tunbridge Report 1972
  - ‘the division of responsibility for rehabilitation between several government departments had a deleterious effect on services as a whole’

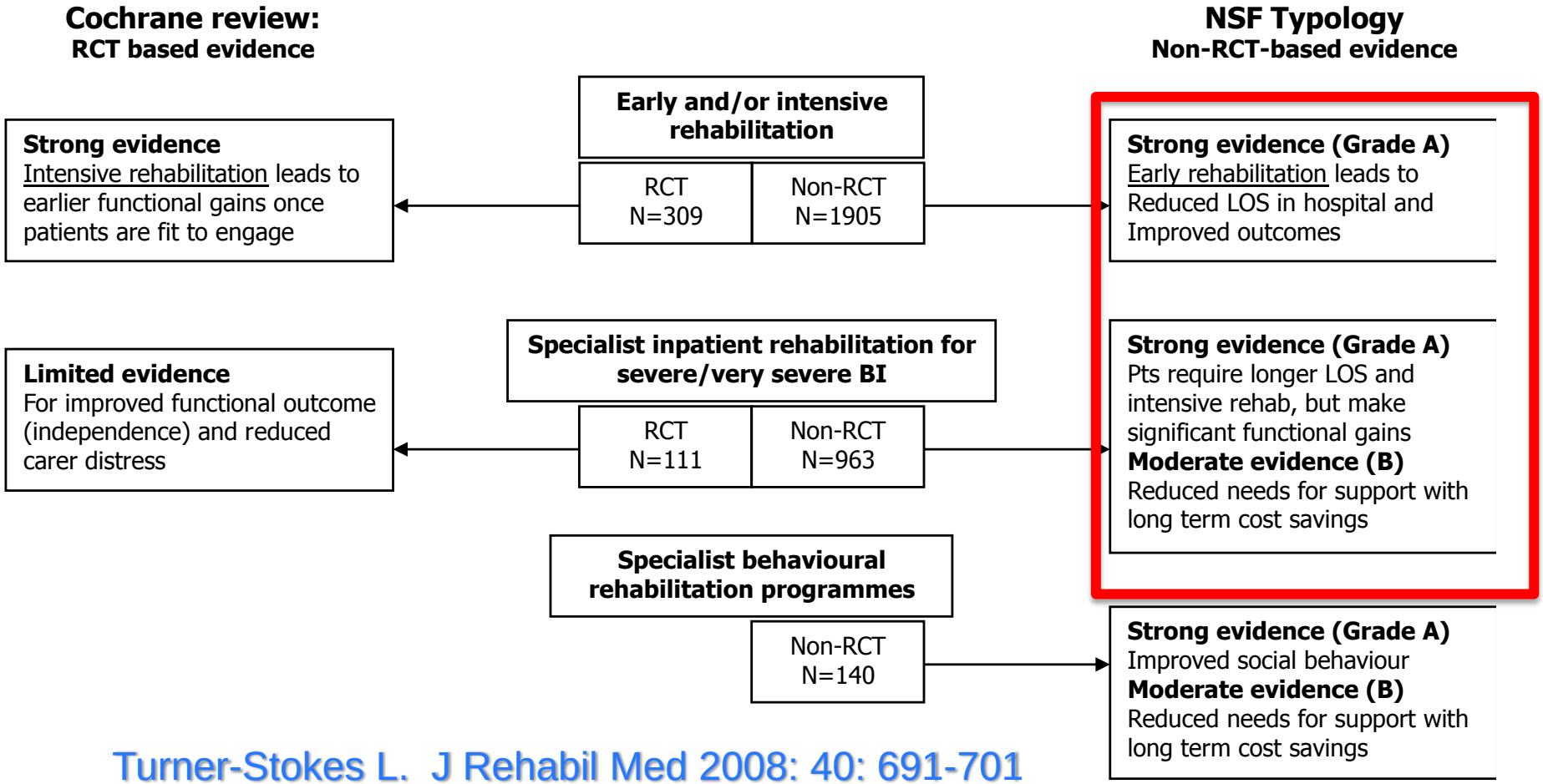
# Winning Argument?

- Clinical Benefits
- Quality of Life
- Humanity

# Rehabilitation for Economic Growth

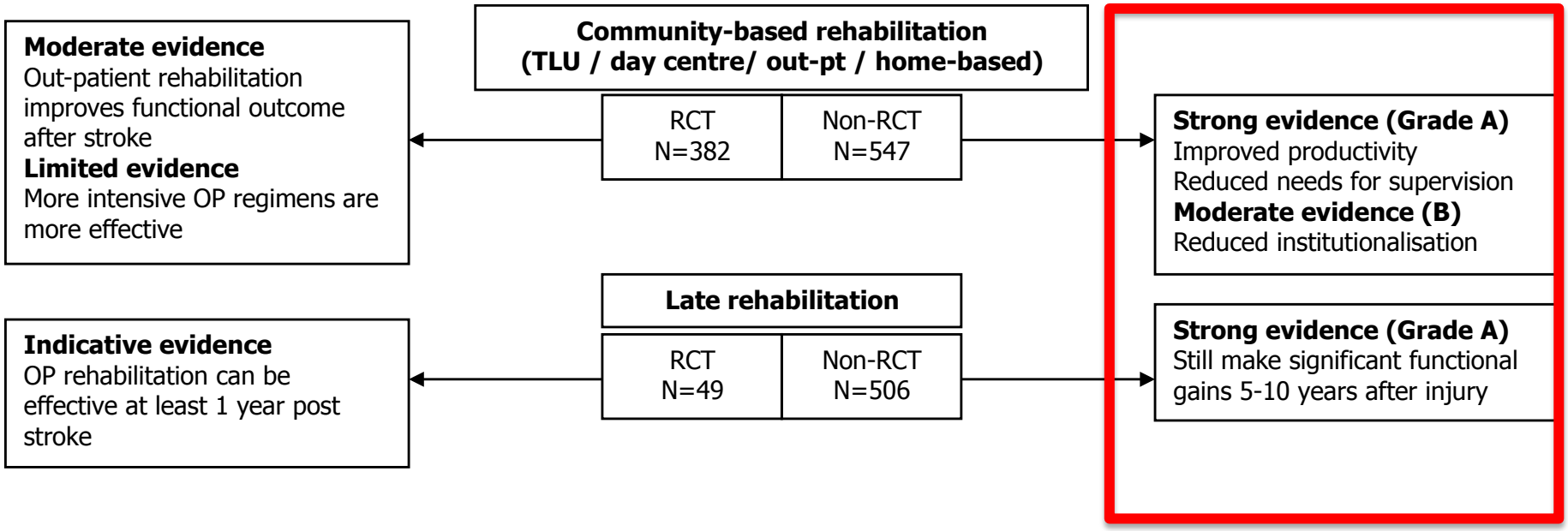
Rehabilitation can be a net contributor to NHS and Society

# Early and specialist rehabilitation




Turner-Stokes L. J Rehabil Med 2008: 40: 691-701

# Community based rehabilitation

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# Cost-efficiency

| Dependency on admission | High<br>NPDS > 25<br>N=2035 | Medium<br>NPDS >10-24<br>N=1203 | Low<br>NPDS <10<br>N=684 |
|---|---|---|---|
| Mean reduction in care costs /wk | £663 (±900) | £361 (±590) | £115 (±400) |
| Length of stay | 93 (±74) | 59 (±112) | 45 (±48) |
| Cost of rehab | £39,652 | £25,011 | £19,057 |
| Time offset cost | 15 months | 17 months | 41 months |
| Cost efficiency index | 7.1 | 6.1 | 2.5 |

# Evidence

- The Australian vocational rehabilitation [1]
  - benefit to cost ratio of more than 30
  - a total economic benefit of more than $125,000 / patient and a greater than 50% reduction in health service use .

- The Canada Pension Plan Disability Vocational Rehabilitation Program [2]
  - benefit/cost ratio of 4.5 and $16,000 saved per patient over 4 years.

- York Teaching Hospital Foundation Trust [3] investment of £160,000 in an MDT working with hospital managers and trade unions to help employees return to work.
  - 54 more FTE staff available for work with
  - direct cost savings in pay of £1.2 million pa from a reduced need for agency staff .

1 Kenyon P, Koshy,P, Wills-Johnson N A cost benefit analysis of vocational rehabilitation services provided by CRS Australia
2. The Canada Pension Plan Disability Vocational Rehabilitation Program Sept 2004 ISBN 0-662-38731-7
3. Black C, Frost D. Health at work an independent review of sickness absence. . London: Department of Work and Pensions; 2011.

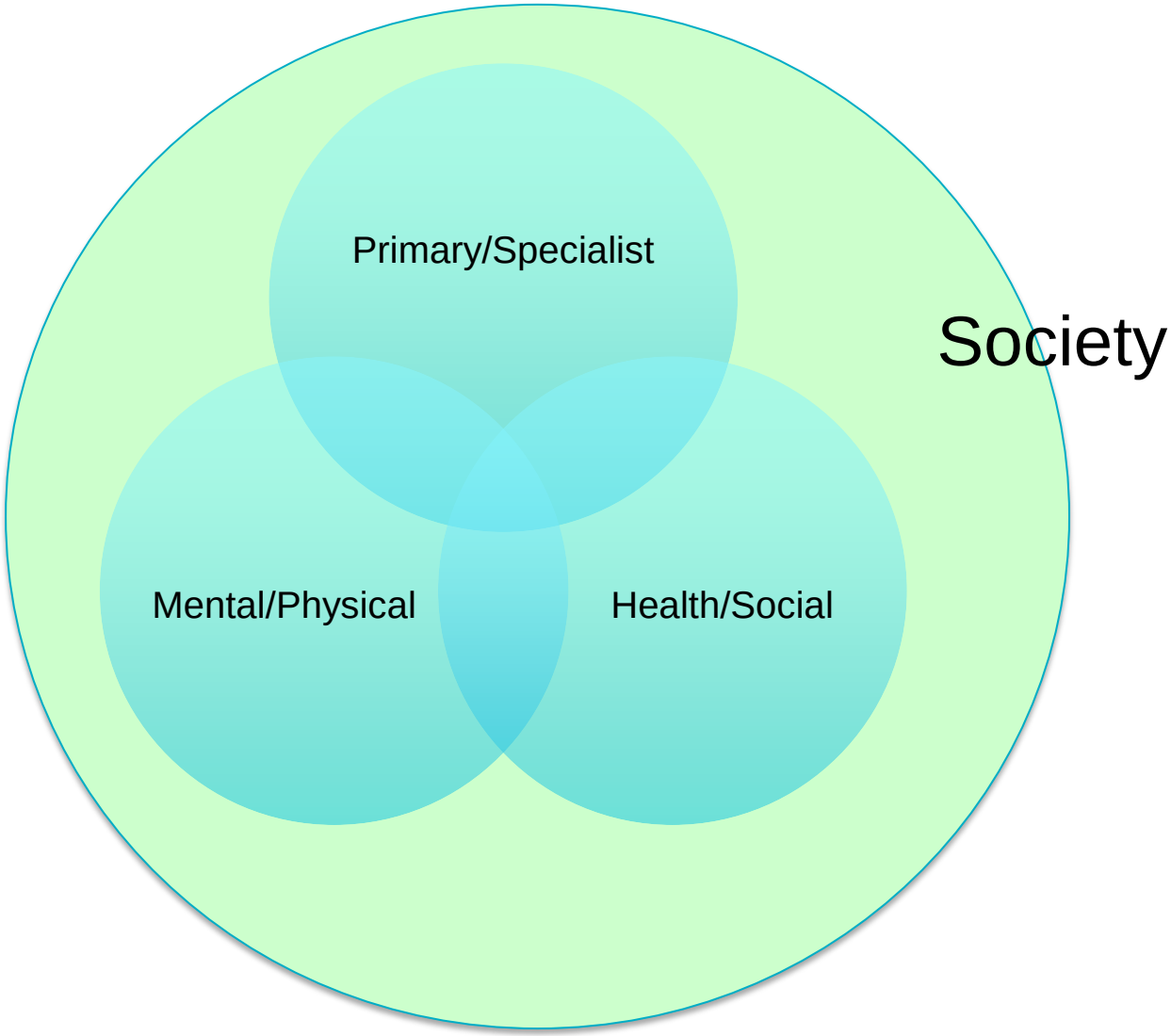
# Costs and Benefits

- Health Costs
- Societal Benefits

# National Economic Benefits of Rehabilitation
# Fall to other agencies

| Issue | Stakeholders |
|---|---|
| Return to work reduced reliance on state benefits | DWP |
| Enable people to remain in work | DWP |
| CYP – maximise educational opportunities and decrease cost to social care | DfE<br>Social care<br>DWP |
| Supporting elderly to maintain independence | Social Care |
| Increase participation in society/reduced behavioural issues | MOJ |
| Injury Cost Recovery | Insurers / NHS Trusts |

# Triple Integration



# BEYOND TRIPLE INTEGRATION

- The NHS needs to embrace broader societal outcomes
  - work, wellness, injury and illness prevention.

- Improving mental and physical health rehabilitation outcomes will generate national financial savings by the reduction:

  - Welfare costs
  - Impact on the justice and education system
  - Life expectancy, work and recovery.
  - Children and young people – patient/parents and carers returning to work.

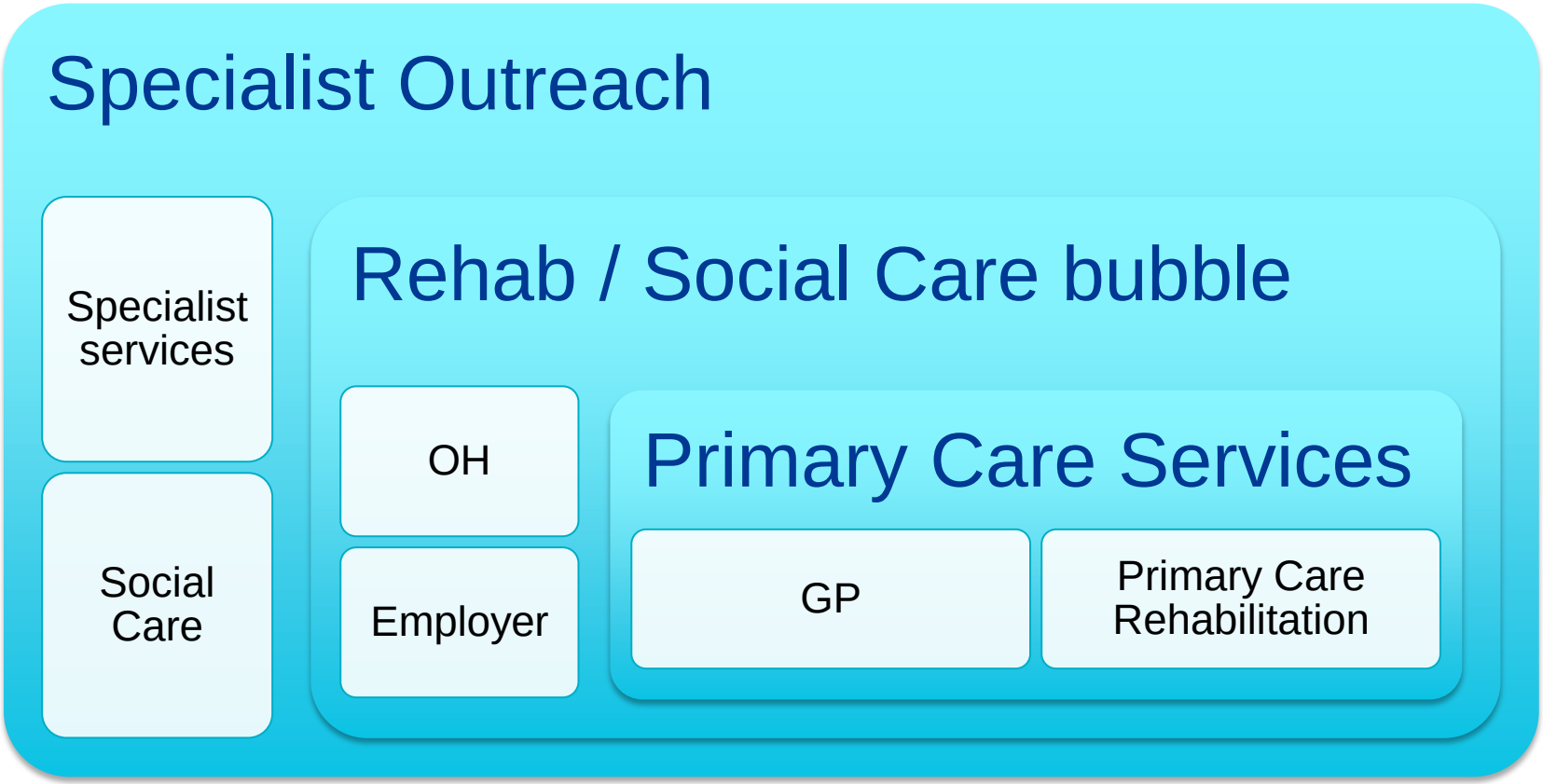
# Five Years Forward View

- Develop and support new workplace incentives to promote employee health and cut sickness-related unemployment
- Manage systems – networks of care – not just organisations.
- Out-of-hospital care needs to become a much larger part of what the NHS does.
- Need to evaluate new care models to establish which produce the best experience for patients and the best value for money.
- Primary and Acute Care Systems
- Multispecialty Community Provider.

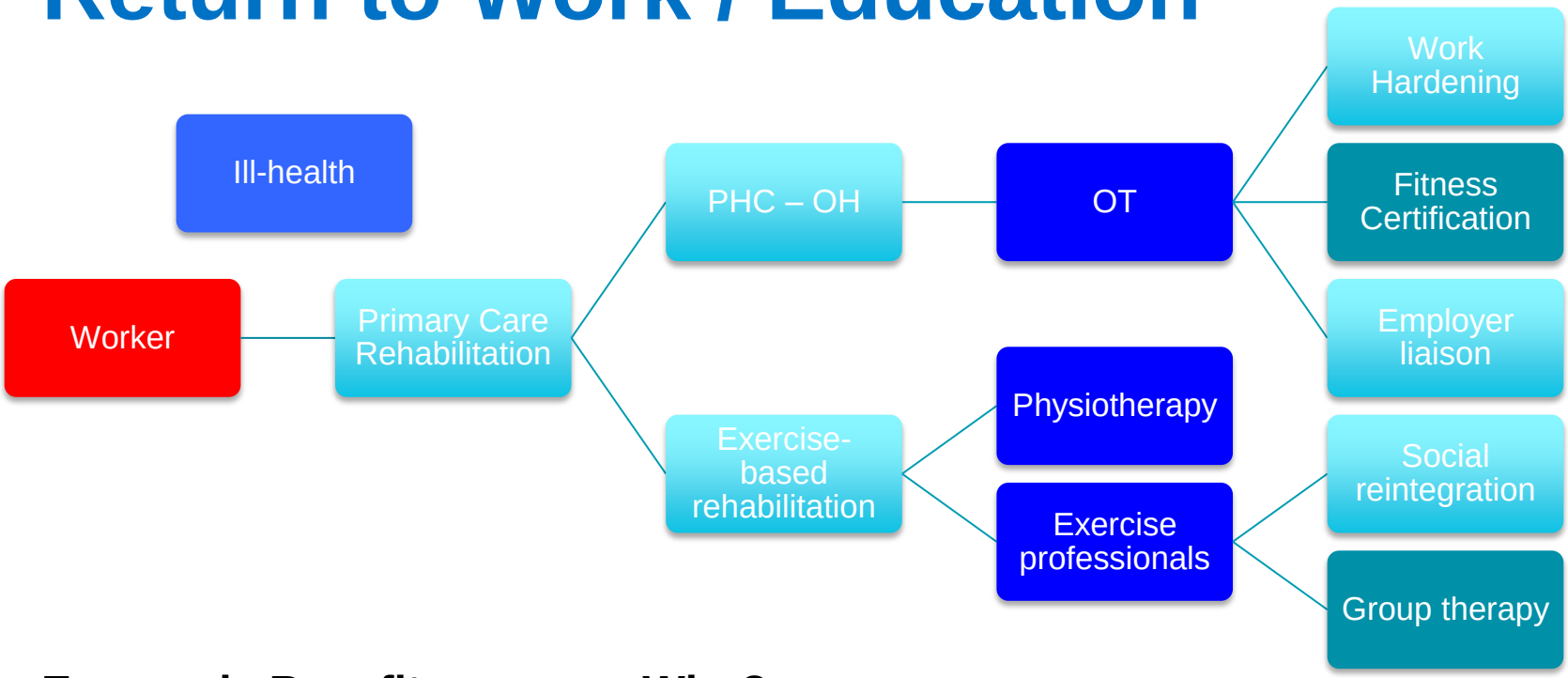
# Multispecialty Community Provider.

- ‘Groups of GPs to combine with nurses, other community health services, hospital specialists and perhaps mental health and social care to create integrated out-of-hospital care’

# MSCP


Specialist Outreach
Specialist services
Social Care
Rehab / Social Care bubble
OH
Employer
Primary Care Services
GP
Primary Care Rehabilitation

# Return to Work / Education




| **Economic Benefits** | **Who?** |
|---|---|
| Return to Work | DWP |
| Reductions in Healthcare contacts | NHS |
| maximise educational opportunities | DfE |

# Strategic Intent
# Submission to Executive Group

- The current financial impact of ill-health benefits on DWP is approximately £30bn pa.
    - 5% saving with a benefit/cost ratio of 10
    - £1.5bn could be saved with £150m investment
    - spread across DH, NHS, DCLG and DWP – business and TUs?
- The Injury Cost Recovery Scheme
    - Generates £220m pa
    - maximised and divert to trauma rehabilitation.
    - NHS E review of trauma – estimated 8000 people /year requiring trauma rehabilitation, which would cost £95m to provide.

# Rehabilitation

- Must be resourced
- Become a key activity in the new NHS
- Unburden the urgent and emergency care systems
- Enhance national wealth.

# Rehabilitation Must be Resourced

- Will improve important clinical and economic outcomes.
- Bring significant gains:
  - NHS efficiency
  - National economy
- Cross-governmental / society initiative
  - Joint funding of transformation
- Timing – Now
  - New Government
  - Manchester Experiment