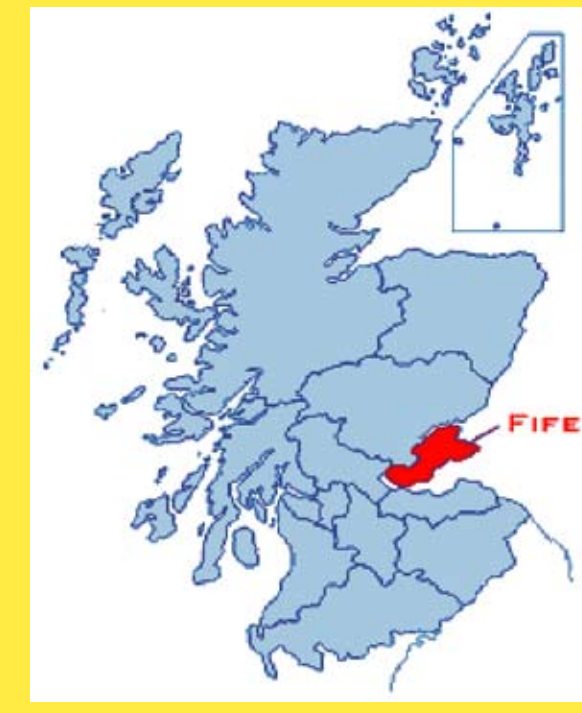


Introduction

Fife Rehabilitation Service (FRS) was established in 1992 following the appointment of Fife's first and to date only Consultant in Rehabilitation Medicine. The service has historically been managed within the Primary Care Trust but is now part of one of three Community Health Partnerships which replaced the Trust following re-organisation of the health services in Scotland in 2005. FRS has been based at the Sir George Sharp Unit in Cameron Hospital since September 1995.

The aim of the service is to provide assessment and rehabilitation to those with disability due to a neurological cause, primarily in the 16-64 age group. This is done on an in patient, out patient or community basis. The main diagnostic groups referred are acquired brain injury, including both traumatic and stroke and multiple sclerosis.

In patient referrals come primarily from the 2 acute hospitals in Fife and the neuroscience centres in Edinburgh and Dundee. Out patient referrals are mainly from the GPs within Fife and from other medical specialties - in particular, the 4 neurologists who do clinics within the Fife hospitals.



Kingdom of Fife

- Population 355,000
- Central and West Fife former mining communities
- NE Fife more rural and agricultural with number of fishing villages in East Neuk
- Industries now based on new technologies
- Edinburgh across Forth to south
- Dundee across Tay to the north
- 2 acute district general hospitals in Kirkcaldy and Dunfermline both part of the acute division of NHS Fife
- 3 Community Health Partnerships in Fife
- Number of community hospitals
- One district Council.

Sir George Sharp Unit

- Based in Cameron Hospital, formerly the chest and ID hospital for the county
- 12 bed active rehabilitation ward
- Out patient clinic area
- All therapy areas including large gymnasium
- Office accommodation for staff
- Administration area including medical records.



Specific aspects of the service

Acquired Brain Injury Service

- Includes Acquired Outreach Nurse
- All ABI patients seen to provide information to patients relatives and carers
- Inpatient, outpatient and home and community based programmes
- 90% of all inpatient admissions
- 90 new referrals to outpatient programmes per year
- Understanding Brain Injury groups run by Outreach Nurse and Clinical Psychologist.

Multiple Sclerosis Service

- Mainly outpatient and home and community based
- On average 60 new referrals per year
- Increasing caseload of patients under review
- 50% of all outpatients under review have MS
- 80% of those with MS in Fife have contact with FRS
- MS Nurse Specialist
- MS Nurse for disease modifying therapy linking with prescribing neurologist
- Newly Diagnosed Group (link with MS Society)
- Fatigue Management Group
- FRS has a Measuring Success Award for MS services from MS Society 1999.

Inpatient Rehabilitation Programme

- 12 bed active rehabilitation ward
- 50-60 admissions per year
- 90% have a diagnosis of acquired brain injury
- 75% admitted within 1 week of assessment
- 96% are discharged home
- Median length of stay 26 days
- FIM/FAM used as outcome measure
- Over 80% of patients are independently mobile at discharge
- Less than 10% are unable to mobilise at discharge.

Continuing Care Service

- 9 beds at Glenrothes Hospital
- For very severe brain injured i.e. vegetative or low awareness state
- Slow stream rehabilitation
- Aim for discharge to community if possible

Vocational Rehabilitation

- Developed in collaboration with Occupational Health Department
- Head OT based in occupational health but line managed in FRS
- Availability of standardized assessment tool VALPAR
- 38% of TBI patients admitted for in-patient rehabilitation from Jan 04 to Dec 05 returned to full time gainful employment or further education.

Young Disabled School Leavers Service

- Fortnightly OP Clinic
- Aimed at those with physical disability in mainstream education
- Referrals from paediatric and community services
- Aim to facilitate transition into adult service
- Approx 10-15 new referrals per year
- Main diagnostic groups are CP (36%), TBI (18%), muscular dystrophy (14%) and spina bifida (14%)
- Quarterly meetings with Education and SW departments
- Establishing link with one of main FE colleges

Total interdisciplinary team staffing for all aspects of service



- 1 WTE consultant in rehabilitation medicine
- 1 WTE associate specialist
- 17.8 WTE for 12 bed active rehabilitation ward
- 3 WTE specialist nurses
- 4 WTE physiotherapists
- 4 WTE occupational therapists
- 2.8 WTE SALT
- 1.4 WTE clinical psychology
- 1 WTE dietitian
- Weekly link with social work for in patients
- Nursing staff for 9 bed continuing care part of 24 bed GP admitting ward
- Pharmacist attends in patient meeting fortnightly.

Environmental Control Assessment

- FRS responsible for EC assessment
- Average 2-3 new installations per year
- Limited budget
- Will offer advice and assessment
- No local bioengineering service only access to regional service

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CARF accreditation

In 2003 FRS became the first hospital based service in the UK to apply for accreditation by the Commission for Accreditation of Rehabilitation Facilities (CARF) for its in patient and brain injury services and were successful in gaining the maximum 3 year accreditation retaining this in 2006.