H.M. (58) 57

NATIONAL HEALTH SERVICE

REHABILITATION IN THE HOSPITAL SERVICE AND ITS RELATION TO OTHER SERVICES

Summary.—The attention of hospital authorities is drawn to those points arising out of the Piercy Committee's Report which call for action on their part or which are of particular concern to them. A copy of a circular sent to Local Health and Welfare Authorities is attached.

1. Earlier guidance on the organisation of rehabilitation in the hospital service, and on co-operation with others engaged in the rehabilitation, training, resettlement and welfare of the disabled, was given to hospital authorities in RHB (49) 36/HMC (49) 26/BG (49) 29, and in HM (54) 89. Since then as hospital authorities will be aware the services provided by all agencies in this field have been reviewed by a Committee under the Chairmanship of Lord Piercy. Their report* in general confirms the advice already given, but it appears to the Minister that it may assist hospital authorities at this stage to bring before them for consideration those matters—dealt with particularly in Chapters II and III of the Report—on which responsibility lies with the hospital service for action and for development as opportunity offers. He recognises that the financial resources of hospital authorities both for capital and revenue expenditure for this purpose are limited, and that staff limitations also exist; but he asks that within the resources available to them authorities will have particular regard to the needs of rehabilitation, not only when drawing up their capital programmes but also when considering the best use of their revenue funds.

Principles of Rehabilitation

2. In the course of their Report the Committee discuss a number of principles which appear to the Minister to be of first importance in any consideration of the part of the hospital service in rehabilitation. These may be briefly summarised as follows:—

(*a*) Rehabilitation must be a single continuous process, beginning with the onset of sickness or injury and continuing throughout treatment until final resettlement in the most suitable work and living conditions is achieved (paragraph 28). At the beginning of the process the emphasis is on the medical aspects, at the end on the work aspects (paragraph 80). It follows that hospital rehabilitation must begin at the first admission to hospital or the first treatment as an out-patient; and that there must throughout the process be the closest liaison between the many different authorities and their

* Report of the Committee of Inquiry on the Rehabilitation, Training and Resettlement of Disabled Persons, Cmd. 9883; H.M.S.O. price 5s. 6d.

To: *Regional Hospital Boards.*
Hospital Management Committees.
Boards of Governors.

staff inevitably taking part in it. It is not possible to rehabilitate all patients to a level at which normal or nearly normal work outside or at home can be performed. Nevertheless the same general principles apply to the management of those patients—especially the elderly—in whom it is possible to achieve only the greatest measure of personal independence in the home that is compatible with their residual disability. Even this partial rehabilitation may, however, have an important psychological effect on these patients and mean a considerable relief in the burden of their home care.

(*b*) Rehabilitation is not to be regarded as the application of special techniques, and still less as a separate medical or other specialty, but above all as a constituent part of the thought and action of all those who are concerned with the treatment of patients and the restoration of disabled persons to their utmost capacity (paragraph 341). The key to the full development of rehabilitation in the hospital service is therefore the attitude of the hospital medical staff (paragraph 41). The British Medical Association and the British Association of Physical Medicine in their evidence emphasised the importance of this "rehabilitation approach" by the medical staff, and considered that although it is accepted and to some degree applied, consultants and others are still slow to consider this aspect of their patients' needs (paragraph 42). It follows that the encouragement of an awareness of this approach among all the staff concerned must be an important part of the hospital authorities' task.

(*c*) Treatment needs to be conceived and planned from the outset, bearing in mind the probable terminal result and its effect on the patient's working capacity and home life (paragraph 41). It should be intensive, planned for the individual patient, and have a background of discipline—this is particularly true of physiotherapy treatment (paragraph 43). It follows that ordered planning and organisation of the use of the hospital's rehabilitation facilities are essential if patients are to benefit to the fullest extent.

(*d*) The hospital is only one among a number of agencies concerned in rehabilitation and, as already said, close personal co-operation of many individuals is essential in the patient's interest. It follows that each hospital authority should do everything it can to promote close personal relations between the professional and other staff concerned—general practitioners, hospital medical staffs, nurses and social workers, disablement resettlement officers, youth employment officers, teachers, and the rest (paragraph 322).

Review of Hospital Facilities

3. With these principles in view, it appears that the first task of Regional Hospital Boards and Boards of Governors should be to review the rehabilitation facilities at present provided and to consider what measures of re-organisation or redeployment may improve the service. Regional Boards may find it convenient initially to concentrate on two or three selected areas in their regions.

4. In undertaking this review Boards may find it advantageous if they have not already done so to adopt the Piercy Committee's recommendation (paragraph 59) to appoint a rehabilitation committee or sub-committee to assist them. As the Report points out, a committee of this kind may be expected to serve a useful purpose in fostering developments and in promoting co-operation with local authorities and local offices of the Ministry of Labour and other Departments concerned. It may also assist in keeping the " rehabilitation approach " before the attention of hospital staff.

5. The matters which should be the subject of review in connection with the rehabilitation services of each hospital appear to be the following:—

(*a*) *The general supervision and co-ordination of the hospital's facilities*

Experience indicates that there is great advantage in designating one consultant to supervise and organise the rehabilitation facilities at each hospital, selected not primarily because of his specialty but because of his readiness to promote this work, to exercise leadership of the hospital team, and to maintain close liaison with others outside the hospital engaged in rehabilitation and resettlement services, including acting as chairman of the resettlement clinic (see (*c*) below). A consultant charged with these responsibilities will also be in a favourable position to promote the " rehabilitation approach " in all the work of the hospital. Boards are therefore asked to consider the designation of a consultant at every appropriate hospital for this purpose wherever they have not already done so.

(*b*) *The organised use of resources*

The Committee's Report quotes the contrast drawn in the evidence of the British Medical Association between unsatisfactorily organised out-patient clinics and treatment which is " intensive, planned for the individual patient, and has a background of discipline ". This criticism related particularly to physiotherapy, but it is relevant to the whole programme of rehabilitation in hospital; and it implies that the object of re-organisation and redeployment should be to ensure the careful selection of patients, a planned course of rehabilitation in each case, discharge from hospital care as soon as the course is completed, and the closest liaison with the general practitioner and any others who will be subsequently concerned in the resettlement of the patient. The Committee thought that in this way not only would the patient benefit, but treatment might be less prolonged and the staff to that extent relieved.

Particular points to which Boards might direct their attention are:—

(i) Active rehabilitation by purposeful physical methods, including the further development of group exercises, is more important than passive physiotherapy; and additional peripheral clinics under consultant supervision in suitable premises may help to meet the needs of those living at a distance from hospitals with departments of physical medicine (paragraph 43).

(ii) The promotion of the existing trend in the development of occupational therapy towards realistic occupations such as carpentry, metal work and the use of machine tools (a special note on this point in relation to mental and mental deficiency hospitals is included below); and the development of advice and help, particularly to housewives, on how to adjust methods of housework to a residual disability (paragraph 44).

(iii) The fullest use of the trained hospital social worker to provide information for the doctor about the patient's home and work, to assist by advising relatives on home problems, and to ensure that on discharge the patient is in touch with other agencies which can help in employment or welfare, such as the disablement resettlement officer and the local authority services. To help in meeting the shortage of fully trained social workers everything possible should be done to provide clerical or other assistance needed (paragraphs 36 and 46).

(*c*) *The assessment of disability*

This was emphasised by the Committee as an important responsibility of the hospital services (paragraphs 51-8) in ensuring that on discharge each disabled patient receives any help needed. The great majority are fairly easily assessed. Some, however, need help in obtaining new work with or without training, and in adjustment to home life, and for these the disablement resettlement officer, the appropriate officer of the local health or welfare authority, and others concerned should be brought in at an early stage (see also paragraph 6 of circular L.A.16 enclosed). For the more difficult cases it is desirable to arrange for resettlement clinics. The Committee envisaged (paragraph 56) that such clinics should deal not only with hospital patients and those referred by general practitioners but also, exceptionally, with cases referred by disablement resettlement officers or other lay officers.

The Minister is aware that a number of resettlement clinics have already been set up, but it seems doubtful whether they are as widely or as fully accepted as is desirable. They should exist at all major hospitals to serve appropriate areas and hospital groups, as an integral part of the hospital service, and Boards are asked to pay particular attention to this matter.

As the Report indicates (paragraph 55), the resettlement clinic is essentially a case conference of all concerned to advise on the industrial or social resettlement of especially difficult cases. The chair should be taken by a consultant on the hospital staff (normally no doubt the consultant in charge of rehabilitation suggested in paragraph 5 (*a*) above), and those present should include the consultant in charge of the patient and the general practitioner, together with any of the following whose advice may be required: physiotherapist, occupational therapist, almoner or psychiatric social worker, disablement resettlement officer, health visitor, local authority

welfare officer, officer of the National Assistance Board, or any other worker with special knowledge of the patient or his needs. The presence of a doctor with knowledge of local industry may also be helpful.

The value of the resettlement clinic lies not only in assisting hospital staff, general practitioners, and employment and welfare officers to deal with the more difficult cases, but as a focus for the close liaison which is essential in the interests of all disabled patients. It has also an important part to play (as the British Medical Association emphasised) as "a medium for the education of the medical profession in rehabilitation" as well as for the education of others engaged in this work.

Additional Facilities

6. Although the first step suggested by the Committee was for a review and redeployment of existing resources, they recognised that any such review might be expected to reveal the need for additional physical facilities; and Boards will need to consider how far any developments can be given priority within the resources available to them. All developments should of course be planned having regard to the facilities provided by the industrial rehabilitation units of the Ministry of Labour (a list of which is appended), of which the fullest use should be made by the hospital service in suitable cases.

7. The kinds of development likely to arise appear to be:—

(*a*) The provision of adequate space for active physiotherapy (group exercises, etc.). In many instances this should be possible without elaborate or expensive building or equipment.

(*b*) The similar provision of space and equipment in occupational therapy departments for simple factory work, and for training the disabled housewife and others in their adjustment to home life.

(*c*) The provision of some residential rehabilitation accommodation, particularly to serve rural areas. As the Committee pointed out (paragraphs 48-9), the main need is for out-patient facilities; but the miners' rehabilitation centres and other units have shown the value of residential centres for selected patients. Planned convalescence of a more active nature at some existing convalescent homes may help to meet this need.

8. The Committee also proposed (paragraphs 91-3) the provision on an experimental basis of comprehensive rehabilitation and assessment centres. The planning of centres of this kind is under discussion with the Ministry of Labour, and if and when it is decided to proceed an approach will be made by the Minister to individual boards with proposals for action.

Co-operation with other Services

9. The need for the closest liaison at all stages with other authorities and officers engaged in the continuous process of rehabilitation was emphasised by the Committee throughout its Report, and has already been mentioned above. Boards and Committees should have particular regard to the following points raised in the Report:—

(*a*) The general practitioner in relation to the disabled even more than to other patients has a leading part to play and must be

kept fully informed. He should be put in a position to reduce to a minimum subsequent recall to the hospital for follow-up. The Committee drew special attention to the importance of prompt reports on discharge (paragraph 112), and hospital authorities are asked to look again at their arrangements in this respect.

(*b*) Similarly prompt and full information should, with the patient's consent, be given to the appropriate officers of the local health and welfare authority when that authority's services will be required after discharge.

(*c*) The value of early contact with the disablement resettlement officer or local authority officer concerned before the patient's discharge, and of the resettlement clinic for the more difficult cases, has already been mentioned above.

(*d*) The Committee recommended (paragraph 160) that specialist medical advice should be available to disablement resettlement officers and Disablement Advisory Committee Panels on especially difficult cases. These may be referred to the hospital service through the patient's general practitioner, or may exceptionally be referred direct to the resettlement clinic; and arrangements are also being made for the advice of the Minister's Regional Medical Officer to be available, and patients may be referred to the hospital service by him.

(*e*) The Committee also recommended (paragraph 89) that Regional Boards should make available specialist services (including psychiatry) to industrial rehabilitation units at the request of the Unit Medical Officer, wherever possible by linking a particular hospital with a neighbouring unit. Normally it may be expected to suffice if arrangements can be made to cover the reference of the patient (with the agreement of his general practitioner) by the Unit Medical Officer to the appropriate specialist out-patient clinic session. In the case of psychiatric advice, however, the Ministry of Labour have found from experience that it is much more satisfactory if regular clinic sessions can be held at the industrial rehabilitation unit itself. The Minister understands that in some areas satisfactory arrangements to this end have already been made. In others Boards may expect to be approached by the Regional Office of the Ministry of Labour, and in that event are asked to arrange accordingly.

(*f*) The Committee drew attention (paragraphs 247 and 277) to the need for educational facilities in hospital for children and for younger tuberculous patients. Boards and Committees are therefore reminded of the advice given in HM(56)81 on this matter, and particularly of their responsibility in bringing to the notice of local education authorities the educational needs of patients in hospital.

Special Points

10. *Tuberculous patients.* The Committee emphasised the special importance of carefully planned convalescence and the gradual extension of activity for tuberculous patients, and the special risks of excessive strain to the patient and infection to others with whom he may work (paragraphs 278-80); and Boards are asked to have special regard to co-operation between the chest physician and the disablement resettlement officer for this purpose. As Boards may be aware, enquiries are

made from time to time in selected clinics as to the need for additional part-time training to be provided by the Ministry of Labour (paragraph 278).

11. *Mental and Mentally Defective Patients.* The Committee commended the arrangements made in some areas for suitable mental or mentally defective patients to attend courses at industrial rehabilitation units before discharge from hospital (paragraph 293). Regional Officers of the Ministry of Labour are considering how far these arrangements might be made at other units, and hospital authorities which may be approached by those officers are asked to co-operate in courses of this kind. The provisions of Section 28 of the National Health Service (Amendment) Act, 1949, do not apply to patients attending such courses, as the payments made to them do not constitute payment for remunerative employment, and no recovery of expenses should be made by hospital authorities. It is accordingly proposed that in future no lodging allowance should be paid to in-patients attending industrial rehabilitation units, and the Regional Officers of the Ministry of Labour will be taking up this matter with hospital authorities on current cases in order to arrange a convenient date for ceasing payment.

12. Most mental deficiency hospitals and some mental hospitals already arrange for some patients to go out by day to suitable work at factories or other places of employment. The Committee recommended (paragraph 296) that hospital authorities should pay particular attention to the possibility of providing accommodation for such patients in annexes convenient to their work rather than in the main hospital. The Royal Commission on the Law relating to Mental Illness and Mental Deficiency has subsequently pointed out in paragraph 623 of its report (Cmnd. 169) that hostels separate from the main hospitals will be needed for this purpose within the hospital service even apart from any provision which may in future be made by local authorities of residential hostels for patients who could be discharged from hospital care if they had a suitable place in which to live. The Minister hopes that Hospital Boards will continue to bear in mind the usefulness of such annexes or hostels when planning for future development.

13. Some hospitals have also arranged for simple factory work to be sent by industrial firms to be done at the hospitals by patients who are not yet fit to leave the hospital by day, or where the hospital's geographical position makes it difficult to find suitable outside employment. This has been found valuable both for long stay patients and for those for whom this may be a stage towards early discharge from hospital care, but it should be organised in such a way as to avoid unfair competition with normal sources of labour. The Committee suggested (paragraph 297) that such schemes are worthy and capable of extension to other hospitals. The Minister has recently received more detailed advice on this subject from the Standing Mental Health Advisory Committee, who have also recommended the development of such schemes as an important contribution to the effective rehabilitation of patients. The Advisory Committee suggest that such schemes should be contained in separate units within the hospital in which hours, pay and working conditions should be as similar as possible to those in outside industry, so that the patients, while still within the shelter of the hospital, may become accustomed to normal working conditions and to handling their own

money. Patients should be encouraged and enabled more than hitherto to buy their own clothes and pay for their own outings rather than have these things provided for them. The Committee also suggest that for subnormal patients and others unlikely to be discharged the unit might conform to a less exacting pattern, and that such patients might work partly in the unit and partly on other occupations in the hospital. They point out that industrial schemes in some hospitals have been hampered or have failed to develop because firms could not provide enough suitable work or could not provide it regularly, much of the work being of a seasonal character, so that mixed programmes are required to maintain regular employment for the patients. They recommend that responsibility for organising a continuous industrial scheme in any hospital should be given to a specially designated officer, one of whose main tasks would be to arrange with firms in the area to maintain a regular flow of work of a suitable kind. In addition to having the qualifications necessary for this purpose, he should also have the qualities required to deal with these particular groups of patients. Although the professional training of occupational therapists would be invaluable, the Advisory Committee consider that they might not ordinarily possess the wider knowledge and experience necessary for dealing with the industrial side; if a particular occupational therapist or member of the nursing staff had the necessary qualifications and experience, however, the Committee suggest that he should be employed whole-time on this work. The Minister would be glad if Hospital Management Committees of mental and mental deficiency hospitals will consider the possibility of introducing schemes of this sort if they have not already done so.

Reports on action taken

14. The Minister proposes in due course to call on Boards for reports on the action taken following this memorandum, and for particulars of any new or experimental developments of particular interest.

MINISTRY OF HEALTH,

SAVILE ROW,

LONDON, W.1.

10*th July*, 1958.

93287/21/68/6.

LIST OF INDUSTRIAL REHABILITATION UNITS IN ENGLAND AND WALES

BIRMINGHAM
255 Holyhead Road,
Handsworth, Birmingham, 21.
Northern 1998 and 2246

BRISTOL
Vassall Road,
Fishponds, Bristol.
Fishponds 53241

CARDIFF
14-15 Buildings,
Curran's Road, Cardiff.
Cardiff 28351

COVENTRY
Torrington Avenue,
Tile Hill, Coventry.
Tile Hill 66634

DENTON
Windmill Lane,
Denton, Manchester.
Denton 2663-5

EGHAM
'Woodlee',
Egham, Surrey.
Egham 880

FELLING
Green Lane, Felling-on-Tyne,
Gateshead, 10, Co. Durham.
Felling 82285

HULL
Chamberlain Road,
Hull.
Hull 34730 to 34739

LEEDS
Dewsbury Road,
Leeds, 11.
Leeds 76074

LEICESTER
Thurmaston Road,
Humberstone Lane, Leicester.
Leicester 67054 and 67073

LONG EATON
Wilsthorpe Road,
Long Eaton, Nottingham.
Long Eaton 880

SHEFFIELD
Richmond Park Road,
Sheffield.
Sheffield 41261

WADDON
Stafford Road, Waddon, Croydon, Surrey.
Croydon 6191

Note: Egham is a fully residential unit. Leicester is partly residential: other units can usually arrange lodgings for those coming from a distance.

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