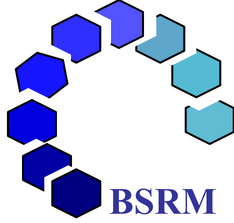


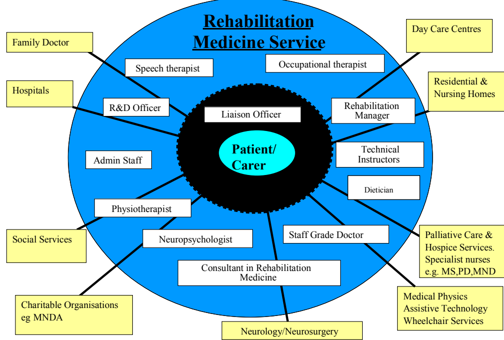
Northern Lincolnshire and Goole Hospitals NHS Trust NHS

Community Orientated consultant led model of Rehablitation Medicine

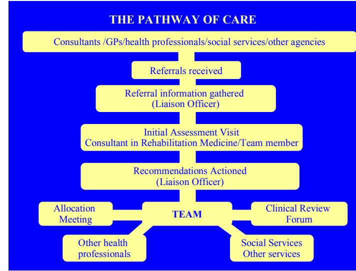
Dr Ita Molloy (Consultant in Rehab. Medicine), Dr K.M. Bo, Jeanette Markham & the team members

Supporting patients with changing needs in their own environment, providing education & self management skills is difficult but cost-effective.

Structure

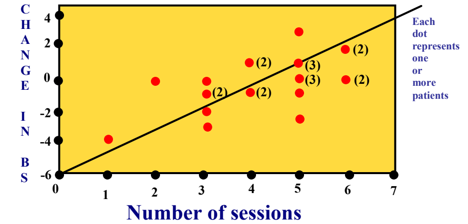


Processes



Outcome (testing)

The Association between number of MS group sessions attended & change in Barthel Score (BS)



Other Team Activities Around The Patients

Individual Rehab	Group Work	Liaison with other teams	Accessing	Specialist Referrals and Management	Production of Information for	Special Interest Groups	Research and Audits
Follow-up medical assessment	MS	Primary Care	Equipment/ Assistive Technology	Territory referrals	Social Service Care Management	MND	NSF QR
Speech & Lang . ther.	Head Injury	Wheelchairs	Continuing Care	Rehabilitation programmes	Compensation Claims	MS Support	Service Evaluation
Occupational Therapy	Neuro	Child Health	Respite	Back to Work Progam	Housing applications	Headway	MS Society Success Award
Dietetics	Parkinsons	Learning disability	PACT*	Independent living	Medical Reports (eg Works)	Head Injury Carers Group	BSRM Standards of Care
Physio-Therapy	Younger Adults	Palliative Care	Education	Spasticity Clinic	Information for patients & professionals		Young Adults
Neuro-Psychology	Continence/ tissue viability	Housing	Direct Payment				Ms Group Education
Rehab Assistants							MND International Symposium

Yorkshire HULL
R I V E R H U M B E R
Goole
North & Northeast Lincolnshire
Scunthorpe Grimsby Brigg

Background

Provides comprehensive services
Population 410,000
Developed from 1 Dr. & 1 secretary (part time) in '94 to fully staffed (20) community team, base, gym, general& special OPD,14 bedded Goole Neuro-Rehab Centre (GNRC) in Aug '07
Use IT System one & voice recognition reports available to team online. All reports are sent to patients.

Development

Based on

Consultation with patients, carers, staff
Influenced by Living Option Guidelines
Influenced by WHO concept of Community Based Rehabilitation

Innovation

Care pathways & activities linked to patients
All reports sent to patients & carers
Liaison officer maintain team/patient communication & provides case management
Team assistants provide a personable non- clinical approach to patients & carers

Clientele—mainly as in NSF for LTC
a. Sudden onset (e.g. ABI)
b. Intermittent & unpredictable (e.g. early MS)
c. Progressive (e.g. PD, MND, late MS)
d. Stable (e.g. post Polio $, adult CP)

Seamless service provision (within P°,S°,T° care)
Most activities happen in patients home
Age range 16-65 and + if there is rehabilitation potential

No time limitation (from diagnosis to death)

CRF—client led MDT, multiagency meeting at patients preferred environment (usually at home))
Weekly Allocation Meetings (discussion of active caseloads with additional learning, coordination & communication)
Group work, combined therapy/support group for patients (e.g. MS, PD)
MND SIG; Supports local& regional development of good clinical practice, including research & audit

R&D officer appointed leading to collaboration & publication with Leeds, Sheffield, MNDA e.g. young adults, *MS group evaluation*, carer strain on MND carers

Caseload 220 new referrals in '06

Active patients discussed weekly — 40 in'00, 90 in '06

As alternative 'outcome' recommendations at home visits & actions at Clinical Review Forums (CRFs) all agreed with patient/carer.

Recommendations agreed by patients at CRFs & actioned by team before next CRF — 98%

Referral to out of area specialist unit — 14 in '95 to 5 in '04

Working with private sector to open GNRC in August '07

Participate in HYMS curriculum development & teaching 4th yr. medical students in CNS & Musculoskeletal blocks.

Acute bed days reduction (RMS patients) from '96 to '00 — 79%

Compliance with NSF Long-term Quality requirements(5) — excellent

National MNDA patient survey — very much satisfied in local area

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