

Community Rehabilitation: a partnership model

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Community Rehabilitation (CR)

- CR is concerned with helping or facilitating an individual to achieve their personal goals and integrate back into their community. It is an active process of partnership between an individual and other agencies to overcome or circumvent difficulties, to develop new strategies and new interests if existing activities are no longer possible.
- Co-ordinated service planning should ensure that suitable services are available within a reasonable traveling distance. In rural areas, this may involve the establishment of satellite services or peripatetic teams to reach isolated locations¹
- Models of community rehabilitation include hospital outreach teams, primary care teams, community based teams (disease or symptom specific), individual community based practitioners working alone or with local teams & resources (partnership)
- Why *community* rehabilitation? It provides "Convenient access to high quality services...Care in the most appropriate setting ...Shifting care closer to home is one of the pillars that supports our vision of improved community health and social care..." *Our Health Our Care Our Say 2006*²

Background

A report on community rehabilitation services in Northumberland and North Tyneside demonstrated significant gaps in service provision, especially in rural areas³. This problem is evident in county Durham which similarly covers a large rural area.

Community rehabilitation and outreach services have been provided for over 10 years. Specific initiatives have been developed by the Centre such as the Newcastle Community MS Team (302 clients) and Northumberland Head Injury Service (150 clients). In 2006 the consultant covering Northumberland saw 176 patients in community clinics or home visits for assessment and treatment.

Resources are no longer available to develop new diagnosis specific teams in localities, and future developments must use existing resources in innovative ways. No one should be excluded from rehabilitation because of their postcode.

The partnership model is being developed to combine central and local expertise to provide a high quality rehabilitation throughout the region.

Community Rehabilitation: Partnership Model

The expertise of a local community team with its awareness of community needs, local social services and local resources joins with a specialist from the Centre for Neurological Rehabilitation to form a specialist multi-disciplinary assessment and treatment resource, providing a clinic and home visits. Administration is kept to a minimum through close liaison between clinics. Costs are shared as outlined in the North Northumberland Clinic (below). There is potential to expand into other geographical areas through this careful use of resources and avoid the "post-code lottery"

Medical Reviews (Durham County)

This service was established by Dr Nicky Chater

An audit of community medical reviews Feb – April 07:

Average of 2 sessions per week

62 community reviews in County Durham ± MDT assessment

8/62 (13%) cancellations/DNA

12/55 (22%) new referrals

28/62 (45%) domiciliary visits

MS (36/55, 65%), Stroke (10/55, 18%), TBI (4/55, 7%)

Outcome: Bot Tox therapy (24/62, 39%), referral (15/62, 24%), therapeutic change (19/62, 31%)

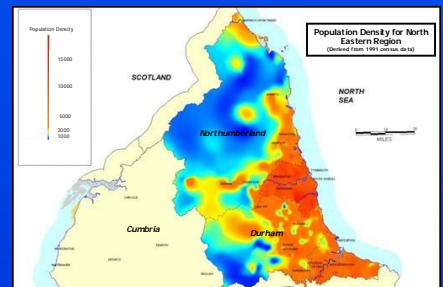
North Northumberland Clinic

Liaison between: NTW Trust – Rehabilitation Consultant;
Northumberland Acute Trust – premises;
Northumberland Care Trust – Local rehabilitation team and MS nurse who is also part funded by MS Society and MS Research and Relief;
PCT – Continence advisor.
Meet once a month to provide an assessment and treatment and home visits.

Planning and appointing of MS nurse took two years.

First clinic March 2007.

March – May 07 Nine people seen in clinic for m/d assessment, Botulinum toxin, full continence assessment, and one home visit to patient unable to leave house. Comment from lady with SP MS who has not been able to access services, "It's great coming here and seeing everyone on the one day. I couldn't travel any further"
Comment from physiotherapist on home visit "It makes such a difference doing a joint assessment and planning together here at home"



Northumberland has a population of over 307,000 and covers 5000 square kilometres. County Durham has a population of over 493,000 and covers almost 2700 square kilometres..

Conclusion

Future developments will only occur through reorganisation of existing resources. This proposed model of partnership working gives a specialist multi-disciplinary team that is formed for a specific purpose whilst continuing with its existing roles. In so doing it fulfils one of the aims of the NSF Long Term Conditions(2005) to promote quality of life and independence by ensuring that people with long-term neurological conditions "receive co-ordinated care and support that is planned around their needs and choices"
We propose that this model of providing high quality specialist rehabilitation to people who are excluded from accessing regional centres because of geography or frailty, should be further developed and evaluated. Our plans include taking client and professional feedback; exploring activities in other parts of the UK; analysing the specific factors that facilitate this model; and reviewing disadvantages and advantages.

References

1. BSRM Standards for specialist in-patient and community rehabilitation services <http://www.bsrm.co.uk/ClinicalGuidance/Standards.PDF>
2. Our Health Our Say 2006 <http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/>
3. MacFarlane R, Turner K, Chandler BJ, Chandler CS. Delivering Health Care Services Across the Rural-Urban Boundary: A case study from North Tyneside and Northumberland. European research in regional science series, Number 12: Rural Services and Social exclusion. Editor Higgs G. Pion Ltd London, 2003.

