

REACH INNOVATION



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Reach has now enjoyed 15 years of innovative and effective life as a private sector provider of home-based rehabilitation for Severe Traumatic Brain Injury (STBI). The majority of our referrals have come from insurance companies, a minority from NHS commissioners.

Reach pioneered Home – based Rehabilitation (HBR) which stands in sharp contrast to the older version – residential rehabilitation. Home-Based rehabilitation has a number of key advantages including: rehabilitation is delivered in the clients' home environment, both that of the family and the wider social setting. As skills are learned, or relearned, they can be put into practice immediately in these familiar settings and reinforced on a daily basis; the problem of transferring patients back home, often many miles away, is thus avoided. And family members are not marginalised as is often the case when rehabilitation is well away from the family home. Both arguments apply with even greater force in the cases of adolescents and children. The essential pre-rehabilitation assessment of "Rehab. Needs" is also carried out in the environment in which functional skills have to be restored. Of equal importance, particularly in these cost-conscious times is the inevitably lower cost of Home-Based Rehabilitation. Over the years this has meant savings to purchasers of at least 30%, more usually 50%. And it is much easier to involve the GP and hospital and social services which are already familiar with the STBI patient and/or his family. Such local knowledge is readily possible

with Home-Based Rehabilitation; it is unavoidably much more difficult in the residential format.

By now, we have a significant number of published articles of the effectiveness of residential rehabilitation in reducing the need for care and in getting STBI victims back to work. The results are reasonable on both counts and the general conclusion holds: residential rehabilitation works. And it is particularly indicated for those individuals who display major behavioural problems and/or drug or alcohol addictions in addition to the much more typical cognitive and functional problems. But reach outcome data for adults and children is even more impressive. In the case of adults quantitative data indicates very significant improvements in Personal Care, Mobility, Self Organisation, Productive Employment and Mental Health. Overall, post – rehabilitation the need for care in terms of average hours of care required is reduced by well over a half and around two-thirds return to some form of paid employment or to full time education. The results for children are equally impressive: after rehab. 4 to 5 hrs per day was self – directed (compared to none pre rehab.); all children are significantly more self-reliant in age – appropriate activities including play, homework and school tasks. Equally important – qualitative feedback from schools has been positive in all cases.

KEY BENEFITS OF HBR TO THE PUBLIC SECTOR

1. When the STBI patient is discharged home from an acute NHS unit his/ her physical problems have usually been

dealt with well, barring some residual need for out-patient physiotherapy, speech therapy etc. But the medium term, more usually long term difficulties remain. These include cognitive problems such as memory, perception, planning, organising and execution, functional skills from basic self-care through shopping to money-management and budgeting. Untreated psychological problems including depression, anxiety and specific phobias, and perhaps the most devastating of all to the patient his family and friends, interpersonal skills, from routine conversation to forming and maintaining long-term relationships.

HBR *particularly when begun soon after discharge*, both picks up and works with such problems, considerably mitigating, often obviating them. These are the direct effects of STBI. But there are also indirect effects, including the bewilderment experienced by other family members ("he is not the man I married"; "he is not my daddy any more").

2. Hence, HBR potentiates early discharge (there is no need to "wait until he is ready, the passage of time alone does not produce improvement in the non-physical areas briefly covered above) allowing major cost savings to hard-pressed hospital budgets. And HBR, by producing real gains in functional skills, readily visible to family members, sharply reduces their helplessness and distress – and their requests for a further, and again expensive, re-admission.

3. As well as psychological and functional benefits, HBR improves the *quality of life* of STBI victims, from a sense of confidence and well-being to a greater likelihood that an existing marriage will survive or better prospects for attaining one in the future. Research studies show that without effective intervention most marriages/partnerships break down after STBI, and, of course this leads to further public sector costs, from psychological help for distressed spouses to legal aid and associated costs.
4. Even when the family manages to struggle on, without discernible improvements there will be recurring crises leading to requests for GP and Social Service interventions. (And those agencies may not have the relevant professional expertise; STBI is likely to be a relatively small part of their respective case-loads). With such referrals reduced there is a further cost-saving, not only in professional time but in the cost of prescribed medication.
5. When the bill for everyday care is met by Social Services (rather than by insurers) it can be enormous: typically, STBI patients need 10 – 12 hours a day in the absence of effective intervention and do so for many years, often for a lifetime. STBI does not reduce life expectancies; the consequences for long-term care for social service budgets are easily appreciated – as are the cost savings in that area achieved by Home-Based Rehabilitation, which enables most clients to function largely independently.
6. Finally, without effective rehabilitation very few STBI victims return to any form of paid employment. HBR returns a significant proportion of clients to paid work, whether directly, or via relevant education and training. Again considerable cost savings in social security benefits are achieved. And once people are working they are paying taxes – a further gain to the public purse. This is where joint commissioning (between

health and social care) in the support of better integration and service delivery can be encouraged.

KEY BENEFITS OF REACH FOR STBI REHABILITATION

1. **Rehabilitation is personal:** each client works one to one with a Personal Programme Assistant (PPA), every programme is tailored to the individual client. The PPA is locally based. PPAs are selected for both human and professional skills (often a first degree in psychology or in a related discipline).

2. A supportive professional structure.

(a) Each PPA is supervised by a Programme Manager – always an occupational therapist with at least 10 years post-qualification experience in neuro-occupational therapy.

(b) Each PM is then supervised by a Senior Programme Manager, who has at least 15 years post-qualification experience in neuro – occupational therapy.

(c) Finally, SPMs report to the Director of Operations – who has over 20 years experience in neuro – occupational therapy, mainly in the private sector.

3. **Other appropriate professional skills:** Reach maintains a panel of neuropsychologists, and educational and vocational psychologists who provide an assessment and consultative service to reach as required.

4. Geographical coverage

Reach offers a comprehensive service over the entire UK, from the extreme southwest of England to the extreme north of Scotland.

THE NHS AFTER MAY 6TH

As the International Herald Tribune put it recently:

"The National Health Service is the third rail of British politics. Britons cherish the historic achievement of bringing decent

medical care within everyone's reach, while complaining regularly about the bureaucratic rigidity.

"Now the new coalition government is proposing a sweeping round of reforms intended to eliminate layers of bureaucracy and deliver better, more personalised care by giving primary care doctors more power over treatment decisions and referrals to specialists."

"The new health secretary, Andrew Lansley, wants to reshape the NHS by wresting commissioning power from managers in primary-care trusts (PCTs) and delivering it instead to family doctors, who are to club together in consortia to purchase care for their patients". And: "Once budgetary control has been handed to GP consortia, the ten strategic health authorities and around 150 PCTs are to be abolished". "These groupings (i.e. consortia) would be able either to purchase care and treatments directly... or to outsource the task to others". (The Economist, 17th July 2010 page 33).

Where do local authorities, with their traditional role of welfare management, including long term care, fit into to this brave new world? A welfare reform bill is promised by the new welfare secretary, Ian Duncan Smith, who has recruited a heavyweight team, including several former Labour notables. It seems the relationship between health and welfare is yet to emerge. For the present those, like reach who offer rehab. services to the public, as well as to the private sector, have already a great deal to take on board, with probably more to come. For example, shortly before May 6th the then Conservative Opposition announced that, once in office, they would publish on the internet, all NHS private sector contracts over 25,000 pounds, inviting competitive tenders. Will this pledge be followed through?

The Economist of August 14th described the Con./Lib. Dem coalition as a "radical force", as new broom follows new broom. We must all, private providers or public sector purchasers, follow unfolding government plans and decisions with great care and adapt accordingly. However we must always keep the patient and their rehabilitation needs at the centre of the focus. ■