ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
HDR2
Scheme name
Reablement
What is the strategic objective of this scheme?
To promote the health and wellbeing of individuals by maximise their level of independence and helping them to achieve identified goals and thus reducing the need for hospital admissions and long term health and social care services.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The Rutland REACH Reablement service consists of a multi disciplinary team including a Registered Manager, Assistant Managers and Co-ordinators, Occupational Therapists, a Physiotherapist, a Social Care Review Officer and Reablement Support Workers and Team Assistants. The team works closely with hospitals, NHS professionals, social care teams and the wider community, in order to provide short and intensive Reablement interventions and practical support to those who are discharged or newly in need of home care or personal support. The aim is to act quickly in order to provide advice and support to maximise independence. • Help people live healthier lives • Help people stay well for longer • Improve the patient experience • Avoid hospital and care home admissions • Improve integration of health and social care • Provide a swift response in providing step down care and support on discharge from hospital.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The REACH service is provided by Rutland County council in conjunction with Leicestershire Partnership who provide the seconded Physiotherapist for the service. The scheme is measured using a number of KPI's including the 'effectiveness of reablement' – this target tracks the number of people who are no longer eligible for an ongoing social care service. The Reach service is managed by the Supporting Independence Team Manager who is responsible for ensuring swift allocation of cases and is assisted by the Registered Manager and Assistant Managers and Co-ordinators who carry out the home assessments, including risk assessments which include the risk of falls. The

Reablement is therapy led to devise Reablement plans to be carried out by the Reablement Workers. Cases are reviewed to establish eligible need and if required brokered on to ongoing services, including direct payments and signposting by the team's Review Officer.

The service fits with the prevention and wellbeing agenda required by the Care Act and is an essential part of discharge planning from hospitals, the service contributes to the step up and step down schemes and will be essential to crisis response and seven day working.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Increase the number of 65's still living at home after 91 days -

- Helps with falls management during recuperation phase to avoid falls and enable to manage appropriately if a fall does occur to avoid the need to dial 999
- Helps with medication compliance.
- Maximise independence and confidence.
- Assess long term social care needs and establish personal budgets and support plans if eligible.
- Help establish direct payments or commission packages of care where relevant and hand over to help maintain achievements made by the individual during the Reablement period.

Reduce the number of delayed transfers of care –

Can be used to reduce the difficult to source care package in some situations.

Reduce total number of emergency admissions –

Prevents accidents in the home such as fires, flooding, hypothermia, medication errors or non-administration of medication – work in an integrated way with all providers including the voluntary sector. Provide equipment and support to improve independence.

Reduce the number of falls –

Ensures a speedier response which could avoid the need for a hospital admission or more serious consequences of a fall if not dealt with in a timely way. A risk assessment is completed with all service users in order to reduce the amount of risks and provide advice and equipment to minimise the occurrence of falls.

Improved patient/service user experience –

Reduced need for invasive and costly care package. Peace of mind. Increased choice and control over lives. The service will identify and work with service users at the optimum time for their rehabilitation and prevent admissions where possible, enabling them to remain within their home as long as they are able and improve discharge times.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Impact	Scheme Assumption

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The cost effectiveness of Reablement is hard to measure due to the preventative nature but evidence indicates that the higher price of short term Reablement is likely to be offset by longer-term savings from reduced social care related needs (Social care institute for excellence research briefing April 2011, Jennifer Francis et al). The best results show that up to 62% of Reablement users no longer need a service after 6-12 weeks (compared to 5% of the control group) and that 26 % had a reduced need for care home hours (compared to 13 % of the control group). One study showed 76% of Reablement users did not need a service up to four months after completion. Furthermore, over two years, the Reablement group were less likely than the control group to use hospital emergency services. Results across services vary due to the different referral criteria applied in different schemes, some people with high needs for assistance on referral to Reablement will not benefit as much as those with lower support needs.

Studies have also focused on the changes in individuals lives. Self perceived health has been found to be a reliable predictor of objective health and overall closely associated with overall wellbeing. Some studies have shown that the perceived quality of life was statistically better among the Reablement group compared with the traditional home care group but results vary.

What are the key success factors for implementation of this scheme?

- Integrated health and social care approach
- Well developed and trained workforce
- Clear access and response rates.