APPENDIX 2

Reablement Plan - supportive of Hospital Discharge

1) Introduction

Funding for re-ablement services has been incorporated within recurrent PCT allocations in 2011-12 and 2012-13. The local allocation has been confirmed for Shropshire for 2011/2012 as £866,000.

In Shropshire, the PCT and Local Authority worked closely to agree the plans for the Reablement Allocation.

Details of the Reablement Plan are detailed below.

2) Agreed Schemes for Reablement

There are four elements agreed for the use of this allocation:

Scheme	Totals £
Shrewsbury Rehabilitation Scheme	510,000 (see cost breakdown below)
Stroke Early Supported Discharge Scheme	160,000
START – Supported Discharge (Short Term Assessment and Reablement Team)	160000
British Red Cross – Extension of Home From Hospital Scheme	13,500
TOTAL PROPOSED EXPENDITURE	**843,500**
TOTAL ALLOCATION	**866,000**
CONTINGENCY	**22,500 *** * GP feedback during the development of the plan for the Shrewsbury Rehabilitation Scheme indicated that a contingency fund of circa £20,000 would be advisable to ensure sufficient session allocations as the scheme develops in the year.

3) Further detail on each scheme

3.1 Shrewsbury Rehabilitation Scheme (Isle Court)

The Service objective is to facilitate the transition to functional independence so that the patient may return to his/her usual place of residence within a pre-defined period of time. In turn this outcome will achieve one or more of the following;

- support for the transition from hospital to home
- avoidance of preventable or premature admission to long term residential or nursing home care
- avoidance of unnecessary re-admission to hospital

Referrals are made via the Joint Interface Team following clear admission criteria to ensure that the service is targeted appropriately for a four week time limited period for clients who are registered with a Shrewsbury and Atcham GP or neighbouring areas. Patients are identified who have the capacity to take part in rehabilitation and who are clinical stable and will benefit from this planned intervention.

The provider responsibilities have been detailed in the Service Specification to ensure that Morris Care (Isle Court Provider), the Community Provider (NHS), Joint Interface Team and Social Care have clear roles and remits in relation to care and liaison.

The Shrewsbury Rehabilitation Scheme is a new pilot making use of a modification of an existing contract with Morris Care for Isle Court beds and building in the wrap around support required to enhance the bed provision into a targeted reablement service. If this service was continued beyond the first pilot year, contracting options would be revisited and the appropriate procurement and funding route secured for future provision.

3.2 Stroke Early Supported Discharge

This is a continuation of an existing scheme, funded through the initial Reablement allocation provided in Winter 2010. The overall aim of the scheme is to support appropriate patients following stroke to achieve their full potential for rehabilitation in a non acute environment allowing the patient to make a safe transition earlier and avoiding readmission. The benefit is seen in reduced lengths of stay and avoidance of readmissions.

The service provides a specialised and co-ordinated service to improve independence and functional ability using a time specific patient goal setting methodology. Patients have contact within 24 hours of discharge and a personal care plan produced based on individual needs, incorporating the evidence-based minimum for therapy based on RCP Stroke Guidelines. The service input length is tailored to need and varies between 2 to 6 weeks.

In order to meet stroke national standards, NICE guidelines and BASP guidelines the community hospital had to employ neuro / stroke specialist rehab staff to plan and deliver care for the initial pilot. Staff were brought in from a combination of areas including specialist locums, nursing agencies, Community IDT teams and SaTH stroke unit. Additionally some of the community provider part time staff worked extra hours to cover the therapy demands of

the extra four stroke beds. Community provider staff were given time away from their own clinical duties to shadow these specialist staff and attend stroke training so this also has benefits for the skill base of the in-house workforce.

3.3 START – (Short Term Assessment and Reablement Team) START Supported Discharge (SSD)

This is a continuation of the prototype enhanced START scheme which was initially funded via the Reablement monies received in Winter 2010.

This included the establishment of a team, to work with the Joint Interface Team, to facilitate safe discharge from the acute hospitals for individuals who require social care support and are medically fit for discharge.

The team comprises START Assistants who are frontline reablement workers who work with individuals in their own home to maximise independence with daily living tasks, a START organiser who co-ordinates and schedules visits and provide supervision, a link Social Worker based within JIT and a secretary.

The team aim to discharge patients within 24 hours and where possible on the same working day. They provide a period of reablement support for up to 6 weeks.

The project has highlighted areas for improvement within the entire discharge pathway, as START has been able to offer an immediate response it has highlighted other areas where delays are caused, e.g. equipment provision, waiting for medication (TTO's) and transport. It has also highlighted that ward staff do not always prioritise discharge, we have had examples where because arranging the discharge has become challenging ward staff have postponed the discharge over the weekend. These issues are being addressed.

It has provided some very good evidence on the capacity for START Assistants, and whereby in other areas we can expect to see a 1-1 ratio (staff to SU), in START supported discharge this is up to 3-1 ratio. All of the performance has been achieved with only 5 x25hrs operational staff and 2 x 37hr Key workers who are not scheduled onto the main START rota, so they are able to pick up immediate discharges.

It has also demonstrated increased efficiency when good comprehensive MI plans are completed by the SW and SU, regular progress reviews are completed and dedicated SW worker with the team to move cases on. Average duration in START supported discharge is much reduced to other areas (Minimum duration 1 day - Maximum duration 54 days = average duration 16 days)

3.4 British Red Cross – Further Enhancement of Home from Hospital Scheme

This is a further enhancement of a voluntary scheme. This builds on a core contract already in existence between the PCT and the voluntary sector provider and the capacity building enhancement already secured by the initial Reablement funds in Winter 2010.

This proposal extends the service further with a specialist intervention for people with dementia and their carers at home. The service will provide care to people who without help would be at risk of admission or readmission, or to facilitate timely discharge from hospital. Evidence during the year 2010/2011 shows that there are regular occasions when the transfer of care or discharge is delayed due to the need for care for people with dementia, or

the breakdown of care in the home, which could be avoided with this targeted, low level intervention.

The proposal includes a commitment to work with the Alzheimers Society to provide a range of support in a six week period, which could include light housework, assistance with meals, shopping, prescriptions, short term respite for carers, check and chat phone calls, transport and escort, pendant alarms and emotional support. This is based on the existing successful model already being used by the organisation locally and nationwide.

The proposal has been discussed with commissioners and agreement reached for further liaison with mental health teams and the dementia lead in particular to ensure the most beneficial interventions and approach are taken and teams are aware of the service.

4) Monitoring and Evaluation of Outcomes

Each Scheme is required to submit returns showing outcomes and measures achieved in addition to expenditure and forecast costs in order to ensure that finance are able to track the use of the allocation and complete central returns.