West Wales Care Partnership
Partneriaeth Gofal Gorllewin Cymru

Integrated Care Fund 2018/19
Project Brief

Project Title	Reablement
Is this a new project or continuation?	Continuation
What alternative delivery concept is being tested?	Older People and Learning Disabilities/Complex Needs
In which financial year will the project complete testing of concept?	Christine Harrison
Which ICF theme does it align with?	
Regional Project Lead/Link Representative	
Local Authority Project Lead/Leads and/or Link Representative/ Representatives	Christine Harrison
HDUHB Project Lead/ Link Representative	
Third Sector Project Lead/ Link Representative	

1. **Background/Rationale:** *(No more than 300 words, including how your proposal (1)* ***tests alternative delivery concepts*** *(2) l****inks with local strategies and plans such as Transforming Clinical Services; Integrated Medium Term Plan; Well Being Plans etc.*** *(3)* ***contributes to regional priorities*** *and (4)* ***supports delivery of objectives within the West Wales Area Plan.****)*

Supports the SSWBA prevention, early intervention and reablement priorities. These are cross-cutting themes that have been taken into account in our Ageing Well Strategy and Learning Disabilities Strategy.

Supports integration of support provided by health and social services and seamless transfer between services. This includes intermediate care options, such as step up / step down beds and the MAST service.

Contributes to the regional priorities set out in the table above.

Supports recommendations identified in the population needs assessment such as:
GENERIC RECOMMENDATIONS
5.2. Prevention and early intervention
3. Build on the considerable foundations in place across the service areas covered in this assessment to ensure appropriate services are available to prevent or delay

the need for ongoing care and support and that the prevention ethos underpins all levels and types of care. Specifically, opportunities should be taken to develop consistent preventative frameworks across services, which build on existing good practice, facilitate transition between children and adult's services and demonstrably reduce the need for ongoing care and support.

5.5. Cooperation, partnership and integration
11. Develop consistent delivery models across service areas and the region, based on a shared strategic vision and the principles within the Act; ensuring common standards to all residents in West Wales.

HEALTH AND PHYSICAL DISABILITIES RECOMMENDATIONS
To improve the mental health and wellbeing of our local population through improved promotion, prevention and timely access to appropriate interventions.

Greater flexibility to deliver step up and down provision to respond to changing needs and a greater focus on mental health provision.

2. **Purpose: What will you do and how will you do it?** *The proposal should support at least one of the aims identified within the Welsh Government* Guidance *for use of the ICF. Please outline how your service would meet a particular Aim (or Aims).*

ICF Aim	Description of how your proposal will meet the Aim(s)
Prevention To arrange the provision of preventative services to prevent or delay the development of care and support needs.	Provision of reablement intervention in most cases results in the service users living independent of long term domiciliary care support. To support the flow of people through the service two reablement assessors have been appointed and these roles will continue. These assessors ensure that transfers of care and exits with no long term care are facilitated in a timely manner to ensure reablement capacity is focussed on the core intervention.
ii. establish a more proactive approach, seeking to identify those people at risk of becoming 'stuck' within secondary care with a resulting impact upon their ability to return to independent living;	Reablement is not only provided in response to an assessment of need following a hospital stay or acute episode in the community, it is also provided following a review of service user needs. This ensures that where possible people are supported to live as independent of long term care as possible. The reablement assessors work with service users and the reablement provider to ensure good outcomes in line with assessed needs.

ICF Aim	Description of how your proposal will meet the Aim(s)
iii. establish preventative intervention to help avoid unnecessary hospital admissions or inappropriate admission to residential care as well as preventing delayed discharges from hospital;	People who suffer an acute episode in the community or who attend A&E are assessed by health and social services professionals and where appropriate are referred to the reablement / rapid response services to avoid unnecessary admission to hospital. Regular monitoring of patients for whom there is a risk of delaying their discharge provides an opportunity to consider the provision of reablement to facilitate a safe discharge. Regular monitoring of those in receipt of reablement ensures service users move on to either independent living or appropriate services as soon as the reablement intervention goals have been achieved.
iv. increase the capacity of reablement and rapid response services to better meet demand (including night time and weekend services);	This supports access to reablement 24 hours and 7 days a week. It also supports capacity within the step up / step down services. The reablement assessors monitor and promote service user flow through the service minimising delays in transfers of care.

3. **Outcomes:** *Please list which of the outcomes from the regional outcomes framework attached will your proposal contribute towards and how it will do so (minimum of 1, maximum of 3.)*

Regional Outcome(s)	Description of how your proposal will meet the Outcomes(s)
Citizens get the right care and support, as early as possible.	Health and social services professionals can refer directly to the brokerage service and the rapid response element ensures quick access where required. Reablement assessors work closely with the service user and provider to ensure the right reablement support is provided.
Percentage of people whose care and support has helped them have a better quality of life.	Reablement support helps people to identify and attain reablement goals set as part of their assessment of needs. This facilitates independence with improved quality of life.

4. **Implementation Timescales –** *please indicate the following:*

When will project development commence?	This is ongoing.

When will initial expenditure commence?	This is ongoing.
When will staff recruitment commence (if required)?	This is ongoing.
When will project delivery commence?	This is ongoing.
Expected date of completion of project concept testing.	
Expected date of project review/embedding learning into mainstream practice or termination.	

5. **Amount Requested** (*include detailed breakdown of costs and if revenue or capital*)

2 x Reablement Assessors £69,790 these will be spread evenly over the year as they are existing posts.

Reablement service provision - £275,264 (Majority of the total cost of this service is funded by PCC.

6. **Proposed Performance Indicators:** *(What will it enable you to achieve in addition to what you are doing now. i.e. how many additional participants/outcomes? Please refer to ICF 17/18 C)*

Performance Indicators	
How much will you do? (Quantity)	**How well will you do it? (Quality)**
The number of people who have completed a period of reablement. The number of people in reablement on the last day of the period. The number of people who are supported in reablement on the last day in the period. The average no. of weeks for a reablement intervention.	The % of people who leave reablement with no long term domiciliary care needs. The % of people who leave reablement with reduced long term domiciliary care needs.
How will people be better off as a result? (Quality and Quantity of effect)	
20a - % of adults who completed a period of reablement; and have a **reduced** package of care and support 6 months later 20b - % of adults who completed a period of reablement; and have **no** package of care and support 6 months later	

7. **Sustainability:** *After testing and review, how will successful concepts be incorporated into either mainstream delivery, IMTP, TCS, Area Plan or Well-Being developments and what is the exit strategy? (no more than 100 words*)

This service is part funded by ICF to support integrated working and to maintain links with other intermediate care services. This is evidenced by the capacity available to support referrals from health professionals.

9. **What are the implications if this business case isn't supported?**

There will be less capacity in the service to support integrated working.

10. **Please provide supporting evidence of engagement with key stakeholders, in the development *or* delivery of the project, particularly 3rd sector and community partners when alternative delivery concepts are being tested.**

11. **Please ensure a completed 12 month budget profile is attached.**