

Responsive Integrated Assessment Care (RIACT) and Reablement Teams

Adults Scrutiny

October 2022



DARLINGTON
Borough Council

Introductions

- Linda Thirkeld, Head of Service
- Geraldine, Service Manager
- Carmel Reilly, Team Manager RIACT



Overview

The RIACT transformation project aims and objectives:

1. Develop and implement a more appropriate responsive service to deal with the increasing demand.
2. To evidence the improved outcomes for individuals.

An external consultant with an expertise in Reablement mapped the service from end to end with a plan for DBC to implement.

The new structure gained approval in January 2020 and the following changes were implemented

- New structure using Reablement Co-Ordinators rather than social workers for the Reablement journey
- New functional assessment
- A formal review process to track the individual's journey, to move them through the service seamlessly at an appropriate pace
- Extensive training for staff to focus on the strength-based approach with the individual
- A new service specification
- Improved range of small equipment which is immediately available to staff
- Twice weekly meeting to track progress of people on the service (both via the internal service and via external providers)
- New staffing Rota to ensure the service was staffed at peak times
- Improved Capacity (more people on the in-house service)
- Introduction of customer feedback and a wide range of performance measures



Care is more than toilet rolls and bed baths.



Colleagues from adult social care including Rachael standing at the back

“ I wish I could give my 16-year-old self a shake and steer myself down the path of adult health and social care sooner. ”

incredible relationships w
for, for them I may be th
speak to for a couple of
lifeline for them.
I wish I could give my
shake and steer mys
of adult health and
then again, I believ
to where I am now
had the journey
straight forward
could not be h
“I feel I have
than I would
proves that
change.
My advi
into a
woul
real
fo

new opportunity with the council.”
As a reablement coordinator, my role now is
to assess those that have been in hospital,
for short term support, with the aim of
regaining independence, enabling them
to remain in their own homes and where
possible reducing the need for long term
support. Every day is different for
writing assessments to understa

Meet Rachael, a reablement coordinator with the reablement team at Darlington Borough Council. We asked Rachael to tell us about her journey into her career and if care was always something she wanted to do.
“When I left school, I had no real idea of what I wanted to do when I was an adult! I suppose I was more focussed on making money – this led me to work in retail for six years until I realised time was ticking and I’d become the adult I had envisioned, and I hadn’t progressed in terms of a career. I stumbled into a job with a care agency, something I never envisaged myself doing to be honest. I was desperate to leave retail, so this was hasty option, but something I am so glad I did! Within my role as a carer in the community I was able to learn so much on the job, the experience was honestly invaluable, I was also able to gain qualifications like my level 2 and 3 in adult health and social care among other qualifications. The fact I was learning and earning made such a difference and opened my eyes to the opportunities in front of me. Fast forward a few years and I was still within the care industry, now working in residential care – so in a care home. I was at home throughout the Covid period



Welcome to the team



DARLINGTON
Borough Council

Structure & welcome to the team

The team sits in two parts:-

Internal Reablement Service which is the direct delivery arm of the service and is now based at the town hall.

- Team Leader, 6 Reablement Coordinators , 23 Support workers
- Support workers work : 7.30 till 10pm 7 days a week
- Reablement co-ordinator's work 8am till 8pm 7 days a week

RIACT - The staff who deal with the assessment and support planning for complex cases that require ongoing support : 8.30 till 5pm Monday to

based at Hundens lane co located with Health

- Team manager , Senior Practitioner,
- 6 Social Workers - 2 social workers based at DMH
- 2 Community assessment officers, 2 occupational therapist
- Both teams work together to facilitate speedy and safe hospital discharge, short term rehabilitation and any long term support needs following a period of reablement, including provision of assistive technology and equipment.



CASE STUDY Thank you for giving me my life back

Like many elderly people, Henry Barnes did not want to leave his home for care. He was able to stay in his home for as long as possible, but after a fall he was unable to get up and needed help. He was eventually admitted to hospital and after a long stay he was discharged. He was then able to return to his home with the help of the Reablement Service. He is now able to live independently and is happy to be back in his home.

"I have regained the independence I had wished for"

Henry Barnes is a 75-year-old man who has lived in his home for over 50 years. He has a long history of health problems, including a stroke and a heart attack. He was unable to get up and needed help. He was eventually admitted to hospital and after a long stay he was discharged. He was then able to return to his home with the help of the Reablement Service. He is now able to live independently and is happy to be back in his home.

For more information, visit www.darlington.gov.uk

Key elements of the service/team

- The RIACT Team, based at Hunden's Lane, Rehabilitation Centre. The service offers a short-term goal focused service for up to 6 weeks that assists people who have experienced a deterioration in their physical health. The aim is to develop both confidence and practical skills to maximise independence. The service length is dependent upon the goals set. Often this will be much shorter than the maximum period.
- D2A – Discharge to assess : reablement coordinators are allocated the referral for same day hospital discharge . The coordinator liaises with the ward confirms the individual is medically optimised and transport in place. The coordinator meets the individual at their home and undertakes a functional assessment and deliver support needed at this visit. This is an integral part of our service response as we can more effectively assess an individuals needs in their own home.
- It is a single point of access for all referrals triaged between health and social care. It offers a rapid response which is undertaken by an on-call clinician within a two-hour timeframe. The team operates 7 days per week 8am-8pm.
- The social workers within the team undertakes Care Support needs assessments for those who have need ongoing support following or during the reablement intervention. They also undertake review of long-term care and complex hospital discharges.



Partnerships

We work with:

- Acute Hospitals (Darlington Memorial Hospital, James Cook and others)
- Community Hospitals
- Community Professionals such as
 - RIACT Health staff
 - Physiotherapists
 - District nurses
 - Community psychiatric nurses (CPNs)



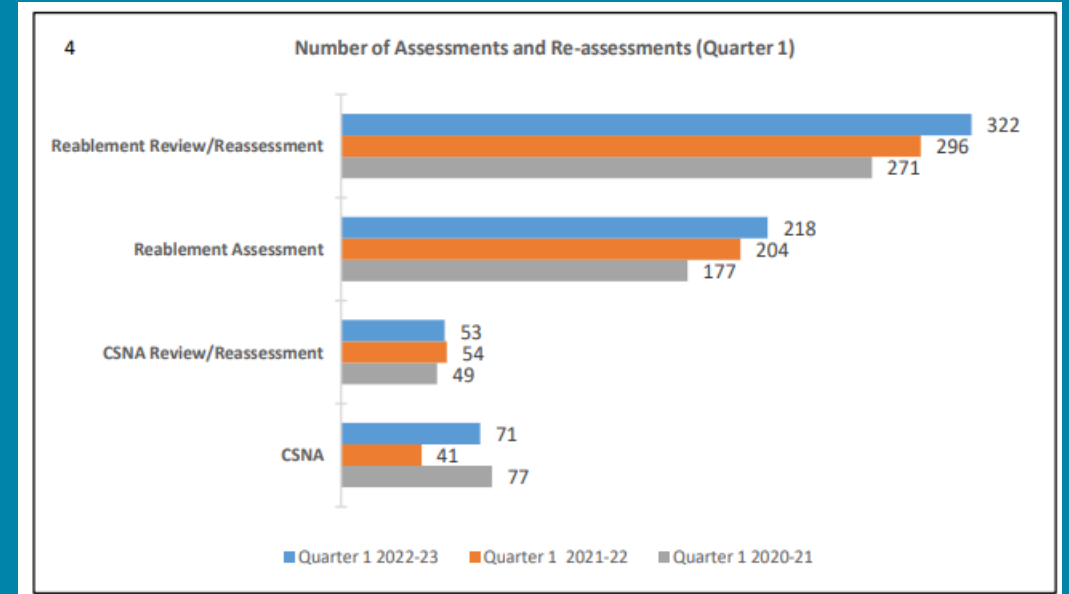
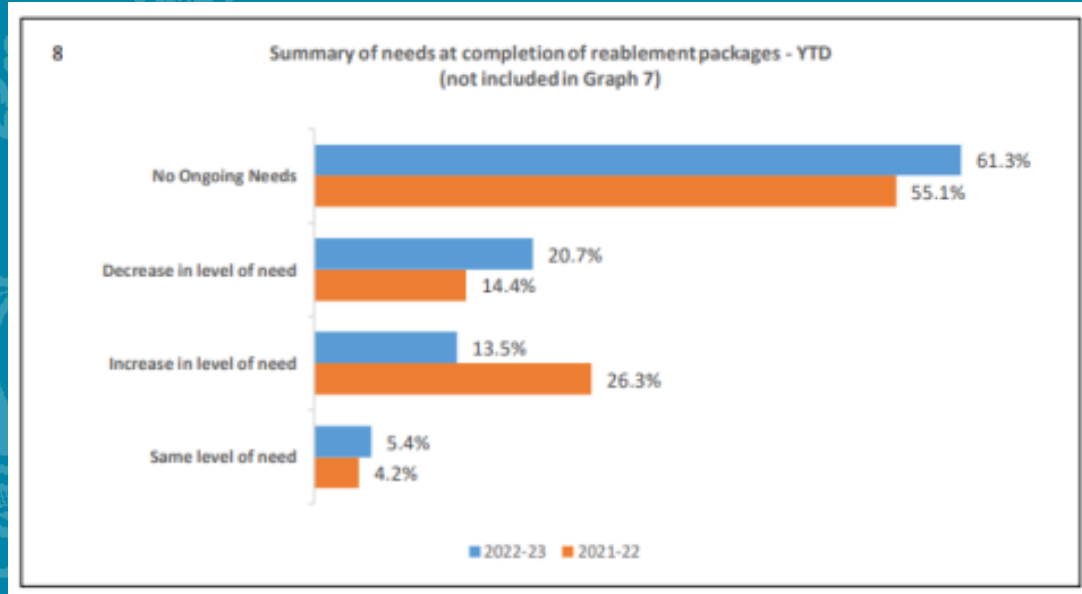
DARLINGTON
Borough Council

Performance

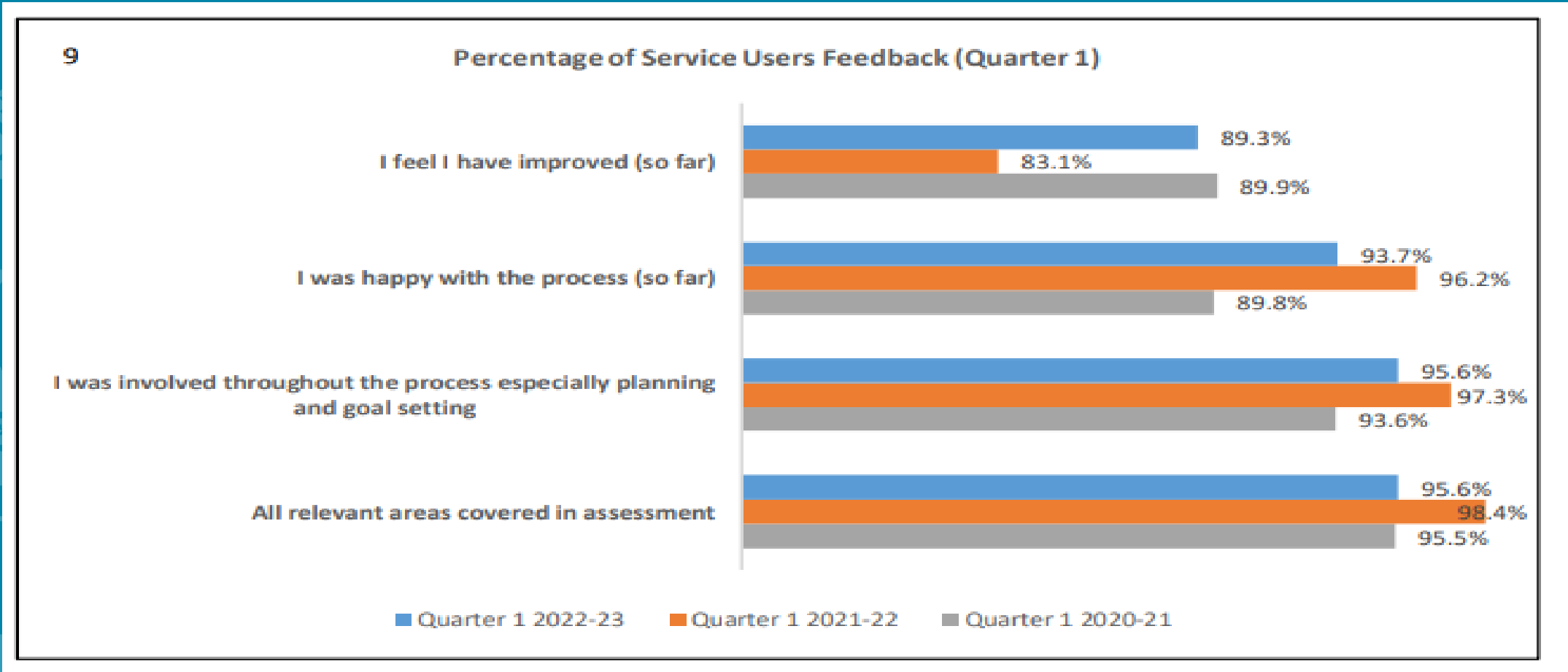
- Hospital discharges to RIACT
- 993 21/22
- 840 20/21
- Average per month increased from 70 to 83
- The percentage of Reablement Assessments completed within 2 days is consistently achieved therefore there have been no delays in hospital discharges.
- Since April 2021, the proportion of older people who are still at home 91 days after discharge from hospital into Reablement/rehabilitation services was 84.1%.
- The proportion of older people still at home after discharge from hospital in April 2021 was 88.9%. However, our performance continues to be higher than both the regional and national average for this metric.



Outcomes



Customer Feedback



People's stories

- **Case Study 1**

- Paul is 81yrs old and lives with his wife in their own home. They have a very supportive family including daughter who visits regularly. Paul experienced a stroke and initially was very unwell in hospital. Prior to the stroke Paul enjoyed spending time with his family, going for meals and family outings. Being with his family is very important to Paul. Due to the complexity of Pauls needs the assessment was completed by a Social Worker.
- Initially Paul was in hospital and as he started to recover from the stroke he was assessed by the Stroke and Neuro physiotherapist it was identified Paul would benefit from more intensive rehabilitation, and he was transferred to an NHS rehabilitation bed. At the end of the rehab period it was identified that Paul did have the potential to improve further and he was discharged home with Reablement support 2 support workers 4 x daily. A multi disciplinary team approach was taken including, housing, occupational therapist.



People's stories

- **Case Study 2**

- Alan is an 88yrs old who until recently was living with his wife, at home. Alan and his wife were admitted to hospital both testing positive for COVID and sadly his wife passed away whilst in hospital. Alan was referred into the Reablement Team from Hospital for assessment of his care needs. Alan was seven days post COVID on discharge from hospital.
- Alan has great support from his family however due to work commitments they were unable to provide increased level of support. Alan and wife had developed a routine at home, and she provided support with medication and meal provision. Alan recognised his limitations and felt he required support in these areas. Alan was keen to return home however this was a difficult transition for him as it would be the first time in his married life that he was going to be living on his own. The reablement support included both support around personal care, medication and meal prep and at the end of the service Alan learnt new skills as well as regaining his independence.



What people tell us

Card : Just wanted to say a big thank you to all you lovely people who's cared for me over these past weeks . I feel I have made some friends not just carers. I have looked forward to your visits and shall miss you all as will my son who says he will miss our chats , so keep up the good work you do it so well . My very best wishes to you all thank you

Home Made Thank you card : Thank you for all your help and support we both needed your time and cheerful faces my husband I am sure will continue to make progress as he has had such a good start with your service. You are STARS.

Card : To all those who have cared for me over the last weeks thank you with all good wishes

Card : To Kim and your fab team with warmest wishes and a thousand thanks . Thank you for all your care given to my mum you have been brilliant we will miss you all. Thank you

Feedback from service users husband to Occupational Therapist : Giving a massive thank you to the reablement coordinator and team for all their amazing support. Husband was very pleased with the service

Direct feedback : Girls are lovely and appreciate everything they have done and don't know what they would do without them.





Any questions



DARLINGTON
Borough Council