DESCRIPTION OF THE PRACTICE

1. Title of the practice

Reablement and Community Home Support in the North of England (REaCH)

2. Organisation responsible for the practice

Stockport Council, United Kingdom

3. Contact person(s)

Name / E-mail	policy@esn-eu.org

4. Summary of the practice

Stockport Council's in-house Reablement and Community Home Support (REaCH) works with Stockport's district nursing teams and McMillian Nurses to enhance and combine social care and clinical support offered to people at the end of their lives. This approach has enabled more people to die at home and has reduced the number of hospital admissions in times of crisis.

REaCH offers a person-centred integrated clinical and social care support plan. The plan aims to protect people's dignity and treat people with respect during difficult times to make sure their wishes are met and are at the heart of decision-making. This new combined team can meet the holistic needs and choices of the individual, enabling people to die in their place of choice, which for many is their own home.

REaCH offers a personalised, individual package of care to Stockport residents, providing:

- intermediate care;
- reablement (supporting people to regain independence that may have been reduced or lost through illness or disability);
- overnight support;
- end-of-life care;
- short-term assessments;
- supporting people in crisis;
- utilising REaCH's assistant practitioners' skills and working in partnership with social workers, NHS (National Health Service) professionals and the third sector.

The support provided may include:

- personal care;
- practical support;
- well-being visits;
- clinical support;
- signposting to community networks and local services;
- connecting and introducing people to third sector services.

5. National/regional/local context of the practice

When the project started, 70 per cent of deaths in Stockport occurred in hospitals and a lack of capacity in the community was identified as one key reason for this. District nurses are core generalist providers of end-of-life care but often lack the capacity to meet demand.

In 2013, a pilot commenced in one locality to deliver end-of-life care to service users in the last weeks/days of life from an integrated team consisting of the district nursing and REaCH

staff working together to support service users on an end-of-life care pathway. A second team started working together in January 2014 in the Stepping Hill Victoria locality. The pilot aimed to increase the level of support in the community by utilising the existing services and skill base. The project was funded largely by Stockport Council and also by the Better Care Fund.

The service is free to all palliative care service users over the age of 18 living in the Stockport area.

Originally, the REaCH service was predominately a short-term reablement and intermediate care provision. However, the service was required to increasingly cater for people at the end of their life.

6. Staff involved

REaCH aims to increase the capacity of the district nursing service by employing REaCH assistant practitioners who are experienced and able to provide additional support with the same skill level as district nurses. These assistant practitioners are trained and have end-of-life care skills. The district nursing service provides clinical supervision and certifies the competencies of REaCH assistant practitioners. Staff from both services are integrated and located together. The district nursing service receives the referral, assesses users and allocates cases to the REaCH staff.

REaCH staff attend all district nursing contact meetings to discuss cases and agree on the level of support.

7. Target group

Adults in the last few weeks of their lives in the Stockport area.

8. Aims of the practice

REaCH supports individuals in maintaining their quality of life and their chosen level of independence for as long as possible. This is done by ensuring prompt access to aids and adaptations, reordering medication and pain relief by working with the GP and community nurses.

The integrated service is underpinned by the principle of interdisciplinary working and understanding how different roles can best match the rapidly changing support needs for the individual.

The programme emphasises respect for people's wishes and dignity at the end of their life. The interdisciplinary team is brought together to meet all the needs and choices of the individual, with the aim to enable people to die in their place of choice, typically their own home.

9. Issues for social services

Service Integration/ Cooperation across services	x	Service Planning	x	Contracting	

Technology		Skills development (of the workforce)		Quality of services	x
Prevention and rehabilitation	x	Participation of service users		Volunteering	

ANALYSIS OF THE PRACTICE					
10. Status					

Pilot project (ongoing)		Project (ongoing)	x	Implemented practice (restricted areas)	
Pilot project (terminated)		Project (terminated)		Widely spread practice/rolled out	

11. Scope of the practice

Describe the setting of the practice, considering the following criteria:

- *Micro level practice:* practice that involves individuals at local level
- *Meso level practice:* practice that involves organisations or communities
- *Macro level practice:* practice that involves large population groups

Meso

12. Leadership and management of the practice

Description of the leadership of the practice, considering the following criteria:

- *Collaborative management*: shared between large partnerships, often of central, regional and local representation
- *Organisational management*: by one organisation
- *Professional management*: managed by a single person
- *Shared management*: shared with no defined leadership

REaCH is coordinated by monthly meetings of REaCH managers, District Nurse team managers, St. Ann's Hospice management and representatives of the Clinical Commissioning Group (CCG).

We have also been holding daily mixed interdisciplinary team meetings.

13. Engaging stakeholders in the practice

Description of the engagement of stakeholders, considering the following criteria:

- *Individual practice*: individuals have sought practice change
- *Network approach*: one or more organisations develop a network
- *Collaborative approach*: large collaboration with relevant stakeholders

Stakeholders were invited to a recent 'task and finish' workshop which provided an overview of the REaCH programme, with first-hand accounts from service users. We have two DVDs, one of which was supplied by a service user's son, and the other one was contributed by a service user and his wife.

14. Involvement of service users and their families

Description of the involvement of service users, considering the following criteria:

- *Team involvement: service users and carers were part of the practice team*
- *Consultative: a consultative body of users was set up for an on-going dialogue and feedback*
- *Involvement in care: person-centred approaches to care/support*

Service users are involved in the review of REaCH with a feedback sheet where they can provide their opinion on the service.

15. Costs and resources needed for implementation

Description of how the practice is financed, considering the following criteria:

- *Within existing resources: staff time and other resources are provided 'in-house'*
- *Staffing costs: costs for staff investment*
- *Joint/Pooled budgets: two or more agencies pool budgets to fund services •
  Funded project: external investment*

The project received funding largely from two sources: Stockport Council and the Better Care Fund.

GBP 100,000 from the Better Care Fund.

GBP 400,000 from Stockport Council.

The funding was required for the following:

- co-ordination of District Nurse teams and REaCH teams;
- a six-week 'Compassionate Care' training module provided by St. Ann's Hospice;
- improvement of the communication between the local clinical commissioning group (CCG) and people at the end of their life.

The assistant practitioners' clinical skills were an important resource for the success of the project.

It was identified that there were cases where some service users had too many visits and double ups when not required. Addressing this will improve the efficiency of the project.

16. Evaluation approaches

Description of the evaluation method of the practice, considering the following criteria:

- *Multi-method: use of both a qualitative and a quantitative approach*
- *Single method: qualitative or quantitative approach*
- *Audit: looks at data sources such as existing medical records, and/or other routinely collected service data.*
- *Informal: refers to in-house service evaluation using locally designed tools and/or collecting opportunistic feedback*
- *No evaluation*
- *An evaluation is planned*

| | Timelines which recorded the delivery of care packages were drawn up. It was reflected on these by looking at the number of visits, by what professional and with what impact. |
| Feedback from service users in the form of letters and cards was referred to. |
| The REaCH system monitors a number of criteria, such as the number of new referrals, average time of support, number of visits, outcome (place of death), date of referrals and area. |
| The data collected has been analysed to examine where referrals originate from, the number of visits and the outcome for each package of care. |

17. **Measurable** effects of the practice and what it has achieved for…	
Service users	Statistical evidence has demonstrated that 92 per cent of people on the pilot (56) have been able to die at home. Prior to the pilot commencing, 70 per cent of people died in hospital. This demonstrates that the end-of-life pilot has made a significant impact in enabling people to choose to die at home.

Formal caregivers	n. a.
Informal carers	n. a.
Organisations	n. a.
Other	n. a.

18. **Anticipated or 'aspirational'** effects of the practice and what it has achieved for… *This category can include outcomes which are not documented, quantified or properly evaluated. They can include such elements as improved knowledge, quality, workforce, etc.*	
Service users	The aspirational impact is that by enabling people to stay at home at the end of their life and catering to their wishes, they will be more satisfied and comfortable than if they were in a hospital.
Formal care givers	n. a.
Informal carers	n. a.
Organisations	By allowing more people to stay at home, there will be less burden on under-pressure hospital facilities.
Other	n. a.
19. How the practice has changed the way the service is provided (lessons learned)	

Three main lessons learned:

- Good quality care planning is required.
- Person-centred plans are essential.
- Holistic support from clinical and social skills teams is necessary.

20. Sustainability of the practice

Description of whether the practice is sustainable, considering the following criteria:

- *Potential for sustainability:* practice was newly started or is ongoing/not yet mainstreamed. How could the practice be sustained (in terms of resources)?
- *Organic sustainability:* service users have been empowered to take the practice forward
- *Established:* the project has been operational for several years

The project leaders are seeking to secure future funding and greater integration of teams for the practice to continue in the future as a result of its success thus far.

21. Transferability of the practice

Description of whether the practice has been transferred, considering the following criteria:

- *Transferred:* transfer to other regions, countries, service user groups, etc.
- *Potential for transferability:* there is interest from the outside; elements of the practice have been taken up and used elsewhere; material for transferability (for ex. training material) has been developed

Important transferable aspects of the project which have been identified are the need for person-centred plans and the cooperation of clinical and social staff to provide holistic support.

When assessing how transferable the practice is, it is important to note that the project depended on large numbers of trained assistant practitioners within the teams.

22. Further information

[ADASS: Ambitions for palliative and end of life care: a national framework for local action 2015-2020](#)