

REPORT

Decision required

To: The Health and Wellbeing Board

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Title of Report: Reablement Development in North Tyneside

1.0 Purpose of Report

1.1 This report updates the Health and Wellbeing Board on the progress and current position in relation to the Reablement Service in North Tyneside

2.0 Recommendations for the Shadow Health and Wellbeing Board

2.1 The Board is asked to note the progress made so far and agree the approach to rollout, including joint working with PCT colleagues, of the additional reablement government funding of £307,000 for North Tyneside.

3.0 Information

3.1 What is Homecare Reablement?

Homecare Reablement seeks to improve choice and quality of life for adults who need care or support. Evidence shows that focused timely bursts of therapy, intermediate care or homecare can either prevent hospital admission or post hospital transfer to long-term care, or appropriately reduce the level of ongoing home care support required. Benefits include maximised independence and minimised whole life cost of care. Social Care and Health services will always need to make best use of limited resources. Demographic projections also show an increasing demand on all models of care. The approach needs to ensure that the lowest appropriate level of intervention is provided set within an active and ongoing assessment process to balance risk against 'quality of life' for adults who need care. Other initiatives such as assistive technology will also play a significant part in supporting people at home.

3.2 Care Services Efficiency Delivery (CSED) Research

Homecare Reablement Models support a number of priority agendas including Prevention & Early Intervention, Efficiency and Personalisation – through promoting independence, choice & control. The evidence base for this model as demonstrated

through CSED research including the “Retrospective Longitudinal Study” identified the following results through evaluation:

- 53% to 68% left reablement requiring no immediate homecare package
- 36% to 48% continued to require no homecare two years after reablement

These results emphasise the benefits of operating best practice in delivering a reablement service. In addition, the evidence base regionally has been supported by the “Regional Business Case” and “Best Practice Framework” developed with the Social Work Co-Operative and supported by CSED.

North Tyneside Adult Social Care benefitted from funding from the North East Improvement and efficiency Programme (NEIEP) for a project manager and external consultancy on marketing the service across health and social care.

3.2 Aims and Objectives of the Reablement Project:

The reablement project was a continuation of work to transform the in-house Home Care Service into a Reablement and complex care service. This is closely linked with Intermediate Care and the Personalisation/Self Directed Support pathway to provide a seamless service for service users.

The main objectives were as follows:

1. To develop and implement a reablement model for North Tyneside, which is inclusive of users, carers, independent and voluntary sector providers, to facilitate early discharge from hospital, prevent hospital admission, minimise dependency upon long term care packages or institutional care, to integrate and further build upon the work of the intermediate care team with reablement as a continuum of that pathway.
2. Work cohesively with care management and the intermediate care teams to maximise independence through good rehabilitation and reablement techniques.
3. Involve the contracts and quality monitoring team to work with providers to ensure support plans are maintained at the level of functionality that has been agreed on transfer from reablement.
4. Support the review process with care managers to ensure packages of support are not increased without opportunities for further reablement intervention.
5. Initiate work to review contracts and develop specifications with the Contracts and Quality Monitoring Team to reflect new ways of working and capture reablement outcomes with the independent sector.

3.3 Reablement Pathway

The reablement pathway has been mapped across health and social care with Assistive Technology embedded in the process as part of the wider Personalisation/self directed support pathway, accessed via the simple point of access (one entry point for the service). The pathway draws upon the existing North Tyneside model for intermediate care and ensures joint screening, via an extended multidisciplinary team, so that the person receives the most appropriate intervention at the right time. This model involves referrals and re-referrals from all specialisms via hospital discharge as well as community routes. It allows for service users to be re-referred into the pathway if their abilities “dip” after transfer to independent sector/direct payment support.

3.4 Project Implementation

Phase 1

- A new staffing structure was introduced in November 2009, reducing the existing 500 staff down to 150, split between the four geographical areas of N Tyneside.
- The emphasis was changed from home care to reablement by encouraging a “do with” rather than “do for” attitude; staff were renamed Home Support Workers and re-graded from scale 4 to 6 to reflect the highly complex/specialised skills of the transformed service, including use of assistive technologies, assessing and fitting of basic equipment.
- The Intermediate Care Rapid Response team were integrated within the Home Support Reablement Team, to raise the skills of the home support staff, whilst continuing to work with the multi-disciplinary assessment team, enabling a greater frontline resource across the health and social care system.
- The block contracted independent sector home care providers were initiated as part of the transformation of Adult Social Care resulting in the contracting of 6 providers to give a choice of two in each of the four areas of North Tyneside.
- Current in-house service users have been consulted and reviewed; where appropriate, the ongoing package of care has been transferred to independent care agencies, leaving only a small number of very complex cases in house.

Phase 2

- The Reablement service was re-launched as a free service on 12th July 2010 covering mainly older people and those with a physical disability.
- The Hospital Discharge Social Work Team were involved from the launch date and extra capacity was provided to enable them to remain involved throughout the reablement period. This provides continuity of support in preparation for any ongoing self-directed support plan. The Community Assessment and Support (CAS) teams have been included from late September 2010.
- A joint awareness and training package covering reablement, promoting independence, personalisation and prevention has been developed and delivered in partnership with Community Health colleagues. Most of the in house staff have undergone this training, in preparation for the launch of the free service. This training has been offered free of charge to independent sector agency staff, who have chosen to use a “train the trainers” model and cascade it to their own staff.
- This will ensure common principles and maintenance of the optimum level of independence once service users are transferred into the independent sector, through continuation of reablement techniques and ethos.

Phase 3

- The Electronic Home Care Call Monitoring and rostering system is being piloted with the in house and two independent sector providers from September 2010. This will maximise efficient use of resources and provide real-time monitoring of care delivery.
- An Occupational Therapist post within the Home Care team has been recruited offering assessment, advice and support for reablement plans as well as moving and handling training, advice and support to LA staff and informal carers, ensuring safe handover with continuity of support when in the independent sector.

Future Plans:

- Referrals are FACS eligible and mainly Older People and Physical Disability at present. Specialist implementation for Learning Disability and Mental Health will

follow at a later stage, together with consideration of the "Reablement for All" model, at the point of access, before FACS is applied.

- Consideration will be given to how the current simple point of access, which operates from 8.30am – 4pm at present with intermediate care, can be extended and integrated with the support of out of hours services into a bigger resource, (eventually covering 24hrs).

4.0 What impact will the recommended actions in this report have for North Tyneside?

4.1 Initial findings since the start of reablement on 12th July 2010 are very encouraging:

- Referrals through the simple point of access have significantly increased (722 to the end of October 2010, (246 from 1st July to end of October 2009) with approximately 1700 per year or 33 per week going through reablement.
- 53% of service users going through reablement require no further service at the end of it. (CSED give a figure of 30% for a "good start", 56% "National good performers and 70% "High performers")
- Similarly, CSED also give a target volume of over 5% of over 65s going through reablement. Our figure is just under 4%, i.e. in the mid volumes category of 2 - 5%.
- The hourly rate for reablement is £25 with an average reablement programme costing approximately £989. There are currently 1984 staff hours per week, attributed to the reablement process plus 766 generic support worker hours attributed to rapid response.
- There is an average reduction of 64% in the size of support plans following reablement.
- National Indicator 125 i.e. the numbers of those remaining at home 91 days after discharge from hospital is 88.07% (regional comparators for 09/10 - 78.89%; comparators are Darlington, Gateshead, Northumberland, Redcar and Cleveland, S Tyneside, Stockton, Sunderland)
- Qualitative questionnaires completed by service users have all rated the service "excellent" or "good".

5.0 Please detail those who have been consulted in the production of the report

5.1 Consultation has been ongoing with Health colleagues in the PCT and acute trust as well as independent sector providers of home care and colleagues in the local authority. This has been crucial in the development of the reablement model in North Tyneside.

6. Issue(s) for discussion at the meeting

6.1 The new structure for Adult Social Care will include reablement as key to the personalisation agenda, embedding reablement across all pathways. The reablement service has worked mainly with older people and those with a physical disability and is currently at or near capacity. Further development is required to extend the service to those with mental health problems and learning disability as well as providing a more responsive service, extended out of hours and to those who are not FACS eligible.

The reablement service is now well established. By integrating the teams into a 'reablement service' we have begun to identify further joint working opportunities to support people to remain in their own home safely and independently and are in a position to make appropriate use of the available funding of £306,000 for further development.