Report to:	**Adult Social Care and Community Safety Scrutiny Committee**
Date:	**6 September 2012**
By:	**Director of Adult Social Care**
Title of report:	**Adult Social Care Reablement Update**
Purpose of report:	**To provide an update and progress report in respect of the development of integrated reablement services within East Sussex.**

RECOMMENDATIONS

The Committee is recommended to:

1. Consider and comment on the progress achieved to date in respect of integrated reablement services.

1. Financial Appraisal

1.1 Historically, domiciliary intermediate care services have been funded by block contracts with an annual value of £7.3m across East Sussex and delivered separately by East Sussex County Council Directly Provided Services (DPS) and East Sussex Healthcare NHS Trust (ESHT).

1.2 Additional investment (£742,000 in 2012/13 and a further £400,000 in 2013/14) has been made available to build capacity and support the development of new capabilities described in the jointly delivered specification for the integrated reablement service. This additional investment has been funded for two years from national reablement grants, after which time the service is expected to reach financial sustainability through savings generated by reduced demand on secondary and social care.

1.3 Nationally it has been possible to model the cost effectiveness of intermediate care and reablement services. In East Sussex, detailed local modelling will be undertaken using the experience of the new integrated reablement service to assess the potential financial impact and possible savings in the following areas:

- Reduction in nursing and residential care placements
- Maintain and achieve up to 50-60% of service users going on to receive no further intervention
- Prevented admission rates against the 60:40 step up, step down ratio, results in lower attendances at secondary care/admissions of short lengths of stay

1.4 The effectiveness of reablement within the DPS is detailed in Appendix 1. In 2011/12 the percentage of clients not requiring ongoing care on discharge was 49%, an increase of 9% compared with 40% for 2010/11. The percentage of users with reduced care was 11%, suggesting they are progressing towards independent living (with reduced packages of care).

2. Background

2.1 In July 2010 the joint (health and social care) Intermediate Care Board agreed a three year plan to develop reablement services. At the heart of the plan was the commitment to integration between health and social care to deliver high quality services in a seamless, person centred pathway.

2.2 In April 2012, the Integrated Care Network and the Joint Commissioning Board agreed to commission East Sussex County Council's DPS Reablement Service and East Sussex Healthcare NHS Trust's Community Therapy Services to deliver a new Joint Community Rehabilitation Service (JCRS).

3. Joint Community Rehabilitation Service

3.1 The JCRS commenced in April 2012 with the following aims:

- To temporarily support individuals within their own homes to regain and maximise independence through personalised rehabilitation and reablement.
- To provide a seamless service to clients, combining health and social care services.
- To develop an increased culture and ethos of personalised care, supporting clients to regain independence and wellbeing appropriate to their individual circumstances.
- To provide a county wide service, ensuring consistent coverage whilst retaining a locality focus.
- To create enhanced capacity and capability to enable appropriate response and access to facilitate early discharge and prevent admissions to acute hospitals.

3.2 The service specification brings together NHS domiciliary rehabilitation, specialised rehabilitation and adult social care reablement services under a single client centred, outcome based pathway detailed in Appendix 2.

3.3 The service specification expects combined capacity to increase from supporting 7,880 (new and existing) clients per annum to 10,012 by the end of the third year – an increase of 10% each year. These projected volumes are based on activity analysis of the current services and represent the additional demand required on community intermediate care across the system.

3.4 In Quarter 1 of 2012/13 the JCRS has supported 1,392 new clients through reablement. 65% of those required no further support or care following the reablement intervention. A breakdown of activity against the key performance indicators is contained in Appendix 3.

3.5 The service has been jointly commissioned by NHS and Adult Social Care for 3 years, from April 2012 to April 2015, and is delivered by several teams aligned to GP consortia boundaries, as a forerunner for Neighbourhood Support Teams, to be implemented from October 2012. Progress on the full implementation of the JCRS is detailed in Appendix 4.

3.6 In addition to the enhanced capacity, there are a number of key differences between the previously separate services and the JCRS, as follows:

- It defines a patient focused integrated pathway, across disciplines within health and social care, removing the existing organisational and cultural boundaries between rehabilitation and reablement.
- The model promotes inter-professional working within a single assessment framework.
- Referrals will be based around the identification of achievable goals towards independent living.
- The service is available 7 days a week, 8am to 8pm, with some elements extending to 10pm.

4. Wider Reablement Market Development Initiatives

4.1 In addition to the development of the JCRS, a reablement pilot, using two independent sector providers has commenced with the following objectives:

- To gather intelligence on the financial benefits of introducing more reablement into the care pathway.
- Gain a positive culture of focussing on reablement within the Council's Adult Social Care teams.
- Reduce the number of people relying on homecare services in order to live safely in their own homes
- To stimulate the market into providing reabling services as well as traditional homecare.
- To gain an understanding of methods of targeting those that will most benefit from reablement so that we utilise resources to the greatest impact.
- An improved focus on outcomes when commissioning independent providers.

4.2 Using £100,000 from national reablement funds to create additional assessment and therapy capacity, the pilot project will run for one year, and generate savings through the reduction of ongoing care costs. A full evaluation of the pilot will be undertaken in October 2012.

5. Conclusion and Reason for Recommendation

5.1 Significant progress has been made in developing joint reablement services within East Sussex. The additional investment, alongside the integration of health and social care pathways and the use of independent sector provision, means that more people can be helped to live independently in their own homes with little or no health and social care support. As such, reablement is an essential element of the strategy to address the demographic pressures faced within the County in the context of the financial constraints faced by Health and Social Care.

5.2 It is recommended that the Committee continues to review the ongoing development of the Reablement Pathway by receiving an update in a year's time.

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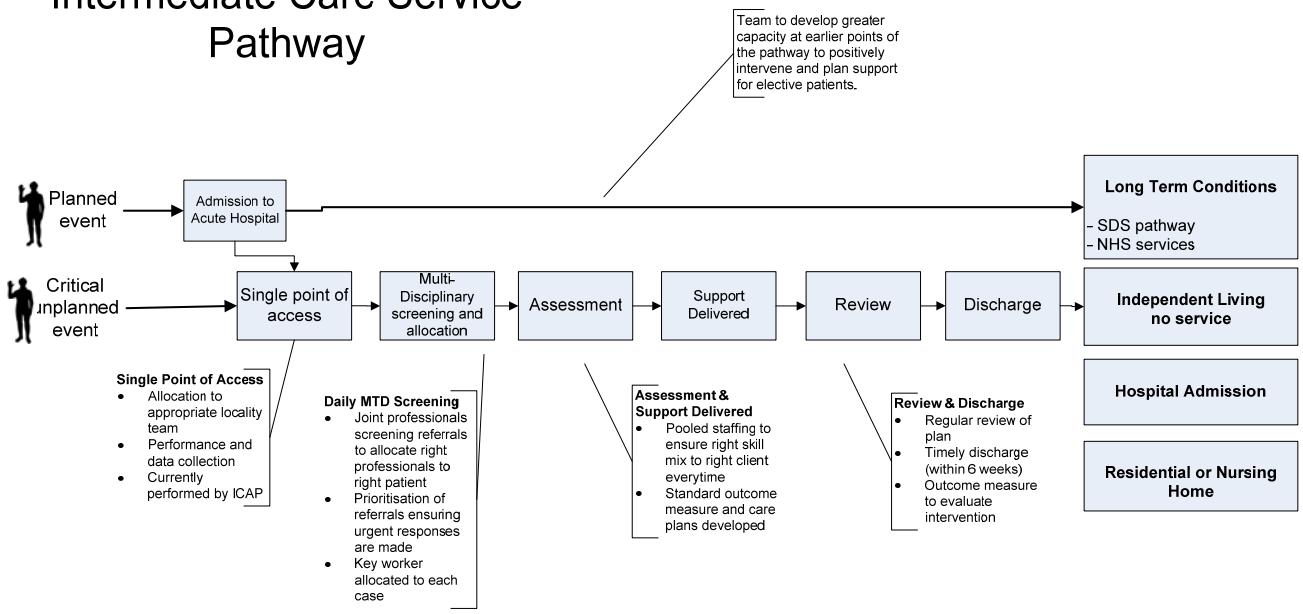
Local Members: ALL Background Documents: NONE

Appendix 1: Countywide Breakdown of Assessed Care Packages for Living at Home Service 2011/12

USER GROUP		NO OF SERVICE USERS		START		END		AVERAGE DURATION (days)
				Average care package hours (per week)	Range of hours (per week)	Average care package hours (per week)	Range of hours (per week)	
No further homecare package required at end of re-ablement phase		649		9.16 hrs	H = 43.25 hrs L = 3.50 hrs	0.00 hrs	H = 0.00 hrs L = 0.00 hrs	30 days
Assessed homecare package at start reduced by end of re-ablement phase		139		11.25 hrs	H = 25.00 hrs L = 2.50 hrs	6.45 hrs	H = 19.00 hrs L = 1.50 hrs	38 days
Assessed homecare package at start maintained at end of re-ablement phase		186		10.25 hrs	H = 36.00 hrs L = 2.00 hrs	10.25 hrs	H = 36.00 hrs L = 2.00 hrs	33 days
Assessed homecare package at start increased at end of re-ablement phase		31		9.69 hrs	H = 18.50 hrs L = 1.75 hrs	12.64 hrs	H = 36.50 hrs L = 3.50 hrs	40 days
User did not complete re-ablement phase: e.g. referred to other services including LTC or health, declined service once started or died before end of re-ablement phase	**NC – Readmit to Hospital**	59	315	10.09 hrs	H = 38.00 hrs L = 3.50 hrs	9.51 hrs	H = 38.00 hrs L = 3.50 hrs	16 days
	NC – Admit to Hospital	147						
	NC – Admit to Nursing / Residential Home	54						
	NC – Death	13						
	NC – Service Declined	15						
	NC – Other	27						
	Non Starter	133		3.80 hrs	H = 17.50 hrs L = 0.00 hrs	0.00 hrs	H = 0.00 hrs L = 0.00 hrs	0 days
TOTAL		**1453**		**9.25 hrs (average)**	H = 43.25 hrs L = 0.00 hrs	**4.31 hrs (average)**	H = 38.00 hrs L = 0.00 hrs	**26 days (average)**

Appendix 2: Client Pathway

Figure 1. Community Intermediate Care Service Pathway



The model defines a clear pathway, promoting a key worker model to provide continuity of care and contact point for patients and carers and promoting more general support worker roles; bringing together the rehab and reablement support roles.

Specialist services such as ‘Stroke rehab service’ will be incorporated within the service, forming a strong focused arm within Community Intermediate Care Service. The expertise will remain and continue to be enhanced, with greater resource and support to develop assisted/early discharge elements. Rationale is to retain specialist expertise and complement disease pathways where appropriate (e.g. Stroke Pathway, COPD, Falls etc) but still enable lean working or pooling of resources (such as back office admin or support staff) between specialist and generic streams to enable the greatest impact.

The new service utilises and strengthens the single point of access for community services, demanding all referrals are managed through ICAP. This is to support successful links with other community services, and provide straightforward referral from primary or secondary care for health and social care professionals.

It explicitly states that clients living with dementia (diagnosed or not) are not excluded from community Intermediate Care Service, stating the only exclusion criteria is those still under medical care from a consultant.

It clearly defines all the roles required to provide comprehensive Intermediate Care function, from nursing to therapy to personal care input and states training and development requirements.

It provides detailed costings, and performance metrics on which commissioners can use to monitor service delivery.

Promotes good practice in some rehab teams of Assisted discharge Schemes across the whole county and with all acute providers for elective care – proactively engaging clients with the rehab process and support prior to elective interventions enabling greater clarity and communication to clients, shorter acute lengths of stay and shorter length of stay within community intermediate care teams. This should enable Community Intermediate Care service to ‘pull’ through the system as well as react to step down discharge referrals.

Appendix 3: Key Performance Indicators for the Joint Community Rehabilitation Service

Quarter 1 – KPI Activity April – June 2012 – see colour key following page.

	KEY PERFORMANCE INDICATORS		TARGET 12/13 Baseline Year 1	QUARTER 1		Apr-12		May-12		Jun-12	
				Totals	%	Totals	%	Totals	%	Totals	%
1	Volume of referrals		N/A	2123		720		793		610	
2	Proportion of referrals that were inappropriate & never seen		N/A	339	15.97%	113	15.69%	136	17.15%	90	14.75%
3	No of clients starting reablement/rehabilitation		N/A	1392	65.57%	456	63.33%	552	69.61%	384	62.95%
4	No of clients ending reablement/rehabilitation		N/A	823	38.77%	148	32.46%	361	65.40%	314	81.77%
5	Referrals source for all clients (identifying caseload classification - step up, down, LTC palliative care etc	**Step up**	N/A	1197	56.38%	390	54.17%	452	57.00%	355	58.20%
		Step Down		926	43.62%	330	45.83%	341	43.00%	255	41.80%
		Dementia		54	4.35%	22	4.77%	17	3.94%	15	4.29%
		Fall		168	13.53%	71	15.40%	57	13.23%	40	11.43%
		LTC		153	12.32%	95	20.61%	41	9.51%	17	4.86%
		Palliative **		21	3.52%	5	2.51%	8	3.57%	8	4.62%
		Stroke *		8	1.34%	4	2.01%	4	1.79%	0	0.00%
6	No of clients that did not complete programme - complete with reasons e.g. readmission etc		10%	58	16.96%	8	13.79%	30	18.63%	20	16.26%
7	Average length of stay (days)		42 Day (6 wks)	24.68		20.3		24.15		29.6	
8	No of hours face to face support per client per week (averaged)		Qtr 4 Audit Only	Qtr 4 Audit Only		Qtr 4 Audit Only		Qtr 4 Audit Only		Qtr 4 Audit Only	
9	Size of support delivered per episode of support per client in hours		Qtr 4 Audit Only	Qtr 4 Audit Only		Qtr 4 Audit Only		Qtr 4 Audit Only		Qtr 4 Audit Only	
10	Primary diagnosis upon referral & reasons for intervention		N/A	Data from Eastbourne only	Data from Eastbourne only						
11	No of people who remain at home following reablement/rehabilitation with no additional ongoing support		55%	222	64.91%	40	68.97%	95	59.01%	87	70.73%
12	Staff utilisation rates, face to face hours (including essential client related admin/phone calls etc - but not travel)		50%		45.89%		44.70%		46.82%		46.15%
13	Percentage of staff trained on joint community rehabilitation/reablement training programme		100%	Not captured until Sept - 12		Not captured until Sept - 12		Not captured until Sept - 12		Not captured until Sept - 12	
14	Rapid response for all referrals	**Low**	N/A	98	17.92%	50	21.65%	28	16.67%	20	13.51%
		Routine		203	37.11%	104	45.02%	52	30.95%	47	31.76%
		Urgent		46	8.41%	21	9.09%	13	7.74%	12	8.11%
		Rapid		42	7.68%	14	6.06%	18	10.71%	10	6.76%
		No data		158	28.88%	42	18.18%	57	33.93%	59	39.86%
15	No of clients with agreed goals (meets CQC outcomes for personalised care)		75%		82.01%		83.40%		78.90%		83.73%
16	No of clients with standardised outcome measure used (to evaluate effectiveness of interventions) Use of therapy outcome measure (TOMS) on referral & discharge capturing levels of : Impairment, Activity, Participation, Wellbeing		N/A		82.32%		82.35%		78.90%		85.70%

Scorecard Key:

*	Only collected from Crowborough & Uckfield to be captured by diagnosis going forward
**	Only collected by Lewes & Weald but all teams to capture in the future
KPI 6	See charts for JCR Eastbourne
	Data only for JCR Eastbourne only
	Only captured for CRS - Eastbourne and Lewes & Weald (% calculated combining both areas total referrals)
	Only CRS Eastbourne figures captured (% calculated from CRS total referrals exc LAHS)
	All areas where data captured
	LAHS only – All areas

Summary against Key performance Indicators for Joint Community Rehabilitation 1st Quarter April – June 2012

KPI 1 & 3	A total of 2123 referrals have been taken over this period of which 1392 started active reablement or rehabilitation over the area. This equates to 65% of the referrals.
KPI 2	A total of 339 referrals were referred to the teams and through the allocation system found to be inappropriate for the JCR; from this total 53% were re-directed to a more appropriate service. This suggests that more information is required on the referral documents which will assist the Integrated Community Access Point (ICAP) to refer directly to a more appropriate team *(See KPI 2 charts for further information).*
KPI 4	Over the whole area 823 clients were discharged from the service. This only includes those clients that started rehabilitation or reablement during this period and does not include those clients that were already within the service at the beginning of April 2012.
KPI 5	56% of total referrals for the whole area were 'Step Up'. The majority of 'Step up' referrals were received from GP s. 'Step Down' referrals from Acute Hospitals accounted for 44% of the total referrals. For Quarter1; Hastings, Rother, Lewes and Wealden received a higher proportion of 'Step Up' referrals compared to the Eastbourne area, which received a higher number of 'Step Down' referrals. *(See KPI 5 charts for further information).*
KPI 6 & 7	Data available from JCR Eastbourne area only. This figure of 58 clients not completing programmes equates to nearly 17% of those discharged from the service. The highest reason for non-completion is readmission or a new admission to an Acute Hospital. The percentage of non completed episodes is calculated against the total discharge figures. The percentage is likely to decrease within future quarters when more discharges have occurred. The discharge figures within this quarter will have been captured where clients have had a short period within the service; of which a number of these would be where a programme has not been completed. The average length of stay is anticipated to rise within future quarters as a larger percentage of programmes are completed.
KPI 8 & 9	To be collected for Quarter 4.
KPI 10	Data available from Eastbourne CRS – The highest primary diagnosis is recorded as musculoskeletal and orthopaedic issues. The main reasons for referrals are mobility and enabling faster discharges from Acute. Within Eastbourne these figures will be affected by the Assisted Discharge Scheme (ADS) and Trauma Assisted Discharge Scheme (TADS).
KPI 11	Data available from JCR Eastbourne only. At 65% these figures are well above the target for the spec of 55%. They need to be treated with caution as only include clients discharged from the JCR during the first quarter.
KPI 12	Data available from LAHS countywide – 46% although below the target figure of 50%; is within the 10% tolerance levels. These figures will be interesting to compare when they are available for all services within the JCR.
KPI 13	To be collected from Quarter 3.
KPI 14	Limited data available from Eastbourne CRS – 16% of referrals were seen urgently or as a Rapid response. 37% have been prioritised as routine to be seen within14 days and 18% of referrals of a low priority. The remaining 29% were not coded.
KPI 15	Data available from JCR Eastbourne only – 82% of clients with agreed goal. Above target of 75%.
KPI 16	Data available from JCR Eastbourne only – 82% of clients with standardised outcome measure recorded.

Appendix 4: JCR Key Milestones

Joint Community Rehabilitation Service

Highlight report: 09 Aug 2012

Activities completed in this period

- Further GP forums attended
- Letter sent to all East Sussex GP practices re: new service and referral process
- Internal E-updates re: new service to all ASC and ESHT staff
- Implementation of recording against KPIs in all areas
- First quarter Balanced Scorecard published
- Mapping of existing NHS/ASC training complete
- New admin staff in place in 2 localities
- 2 ASC staff seconded to NHS teams to gain specific experience of rehab and competencies, and shadowing of therapy staff in each
- Demonstration of interim IT system
- JCR staff newsletter produced
- EIA signed off

Activities planned for the next period

- Attendance at further GP forums
- Financial Memorandum of Understanding signed off
- Therapy advert out on NHS jobs
- Remaining community referrers informed of changes to service and referral process
- First JCR newsletter signed off
- Service information working group and referral pathway workshop held
- Drafting of governance agreement
- Training planning meeting held and draft 'to be' programme designed
- First testing of interim IT system
- ICAP service developments in progress
- Visits to other authorities with integrated reablement services booked

Milestones

Eastbourne teams co-located	Apr 12 ✓
Staff consultation completed	May 12 ✓
Staff engagement workshops	Jun 12 ✓
Project Manager in place	Jul 12 ✓
Eastbourne teams jointly allocating	Jul 12 ✓
EIA, spec and KPIs signed off	Jul 12 ✓
GPs advised of key changes to service	Jul 12 ✓
1st Quarter Balanced Scorecard	Jul 12 ✓
Client & referrer docs aligned	Sep 12
Start of integrated training	Sep 12
Interim IT system implemented	Oct 12
7 day working begins	Oct 12
Hastings & Rother teams co-located	Dec 12
Lewes, Havens and High Weald Teams co-located	Dec 12
Operational recording docs aligned	Jan 13
Communication of change to other key stakeholders	Jan 13
End of first year report	Apr 13
Operational policies, procedures and guidance aligned	Sep 13
All staff completed new training programme	Sep 13

Issues

- Delay in securing/confirming accommodation significantly impacting timescales for co-location
- Implementation of interim IT system delayed by technical hosting/deployment issues

Key overarching risks/issues identified

#	Description	I	P	S
1	Delay in securing accomm	4	3	12
2	Staff working to different operational policies	5	2	10
3	Staff work to different IG procedures	5	2	10
4	Failure to implement fit for purpose IT system	4	3	12
5	Untimely assessment	2	3	6
6	Failure to effectively communicate changes	4	1	4
7	Staff resist/don't engage with changes	5	1	5
8	Incomplete referrals	3	3	9
9	Recruitment delays	4	1	4
10	Staff working on different terms	1	5	5
11	Partner wishes to pull out	5	1	5
12	Nursing Home referrals	3	2	6
13	EIA requirements	2	2	4
14	Not all referrers informed of changes	1	3	3

Latest Document Versions

Detailed Project Plan	v 12
Key Milestones	v 11.1
High Level Milestone Plan	v 11.1
Risk Log	v 3.3
Working Groups	v 16.1
Comms Plan	v 5

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