Croydon Council

For General Release

REPORT TO:	**Adult Social Services Review Panel** **1st July 2015**
AGENDA ITEM NO:	**7**
SUBJECT:	**Reablement and Personalisation**
LEAD OFFICER:	**Paul Greenhalgh, Executive Director of People**
CABINET MEMBER:	**Councillor Louisa Woodley, Cabinet Member for Children, Young People and Learning**
WARDS:	**All**

CORPORATE PRIORITY/POLICY CONTEXT:

Reablement has been influenced by key strategic developments in health and social care, specifically by the introduction and development of "personalisation". The 2006 government White Paper Our Health, Our Care, Our Say set out four main goals for health and social care of:

- Better prevention services and earlier intervention
- Giving people more choice and a louder voice
- Tackling inequalities and improving access to community services
- More support for people with long term needs.

These goals have been taken forward and enacted through the Better Care Fund (launched April 2015) and The Care Act (April 2015) which have moved focus from being on service delivery and service outputs, to the identification and achievement of individual client outcomes.

These principles have been reflected in the development of the Croydon Council Croydon Challenge Programme, and influenced thinking about how services in the borough should be shaped in the future to best meet the needs of the citizens of the borough.

FINANCIAL IMPACT

Since April 2011 there has been a 66% growth of scheduled hours of brokered domiciliary care within the Older People cost centres.

Approximately 70% of all new domiciliary packages of care are as a result of a hospital discharge. There has been an increase of about 25 additional people per month discharged from hospital to a new episode of social care in this period. This is therefore a key driver of growth in demand and cost.

Reablement is an important initiative in responding to the increasing demand and financial pressures faced by the Council. When considering the potential impact of reablement it should be noted that 35% of clients starting new episodes of care stay in service for more than 3 months, and of this number 75% (i.e. 26% of total) stay for more than 12 months. This means that successfully targeting work with individuals in the first 3 months following hospital discharge could lead to significant savings.

FORWARD PLAN KEY DECISION REFERENCE NO.: N/A

1. RECOMMENDATIONS
This report recommends that the Adult Social Services Review Panel:
1.1 Note progress made in the development of Adult Social Care reablement offer and its focus on taking forward personalisation through its focus on the delivery of outcomes for the individual.

2. EXECUTIVE SUMMARY

2.1 Reablement (including the wider hospital avoidance and discharge services) is a pivotal part of the Council's current transformational agenda, both in terms of improving outcomes for patients/customers, and for the delivery of efficiency to both health and social care budgets. It is essential that the Council reablement offer fits into this wider holistic development of health and social care services.

2.2 The introduction of the Better Care Fund and the Care Act has reinforced the responsibilities of all social care and health organisations to work together to provide integrated, seamless service delivery that enables individuals to be independent within their own home and community. The role of personalisation is central to the approach required in the planning and delivery of care, with the key tenet being to take an outcomes based approach which shape services around the individual.

3. DETAIL OF YOUR REPORT

What is Reablement?

3.1 There is no single, straightforward definition of 'reablement' and as a consequence no single model of reablement in the UK. However the core of what reablement is in Croydon is best summed up as follows:

> *'….. reablement is to work with individuals who have support needs to rebuild their confidence, support the development of daily living skills and promote community access and integration.'*
>
> (Reablement for All Best Practice Framework, report by the Social Work Co-operative for the North East regional Improvement and Efficiency Partnership, 2010)

3.2 Even though there is no single definition, there are several essential elements that are defining features any reablement service and which have been built into the Croydon Reablement offer:

- Reablement is about helping people to do things for themselves, rather than doing things to or doing things for people.
- Reablement is time-limited; the maximum time that the user can receive

reablement support is decided at the start. In most reablement services, this is for up to six weeks, but in exceptional circumstances this can be up to 12 weeks.

- Reablement is outcome-focused: the overall goal is to help people back into their own home or community.
- Reablement involves setting and working towards specific goals agreed between the service user and the reablement team.
- Reablement is a very personalised approach – the kinds of support given are tailored to the individual user's specific goals and needs.
- Reablement often involves providing intensive support to people for a short period.
- Reablement treats assessment as something that is dynamic not static. This approach means that you cannot decide a user's care or support package on the basis of a single, one-off assessment, instead you need to observe the user over a defined period of time, during which their needs and abilities may well change, with a reassessment at the end of the period of reablement.
- Reablement approaches assume that something should change by the end of the reablement intervention; you are working towards positive change.
- Reablement builds on what people currently can do, and supports them to regain skills to increase their confidence and independence.
- Reablement may also involve ensuring people are provided with appropriate equipment and/or assistive technology, and understand how to use it.
- Reablement aims to maximise users' long-term independence, choice and quality of life.
- Reablement aims to reduce or minimise the need for ongoing support after the period of reablement.

Croydon Reablement Services

3.3 Therefore, based on the above the Croydon Reablement service aim is to provide a range of short term interventions designed to either prevent a hospital admission or to regain independence following hospital discharge to enable people to regain functional, practical, and social skills and confidence to enable them to regain independence within their own home and community

3.4 In Croydon, reablement should not be thought of as one service provided by one organisation but a range of coordinated services and a mixture of professionals working with an individual, their carer or wider family, as a “team” to achieve outcomes identified with the individual in a flexible and timely manner to reduce dependency on health and social care paid services.

3.5 The Croydon Council reablement service is a key element of the Croydon Better Care Fund (BCF) Plan and the Council’s Croydon Challenge programme.

Policy Context

3.6 The development of reablement in Croydon has to be placed within the national and local policy context. The focus on moving from a service provision approach measured in terms of activity (time and task), to a person-centred approach based on the achievement on outcomes has been pivotal.

Care Act:

Part 1 of The Care Act 2014 came into force on 1 April 2015. It consolidates and reforms the law relating to adult social care. The Act has been important in articulating that the “*core purpose of adult care and support is to help people to achieve the outcomes that matter to them in their life.*” (Care Act Guidance, Chapter 1).

The Act introduces the concept of “wellbeing” and defines it as including control by an individual over day to day life (including over care and support and the way it is provided). It also includes: living accommodation, contribution to individuals contribution to society, social and economic wellbeing, and domestic, family and personal relationships. As a consequence under the Act local authorities must promote wellbeing when carrying out any of their care and support functions in respect of a person.

This is an important shift as the Act signifies a shift from the provision of particular services to the concept of “meeting needs”. During the assessment process a local authority should consider the most relevant aspects of wellbeing to the individual, and assess how their needs impact on them. Taking this approach will allow for the assessment to identify how care and support, or other services or resources in the local community, could help people achieve their outcomes.

This has to align to the duty that local authorities must carry out their care and support responsibilities with the aim of promoting greater integration with NHS and other health related services. The aim of the Act is for people to receive joined up care that is person centred, and “tailored to the needs and preferences of those needing care and support, carers and families”. This duty is not restricted to local authorities alone and is reflected on the duties placed on the NHS to promote integration with care and support. The focus in the Act is for health and social care to work in an integrated way to reduce risks to

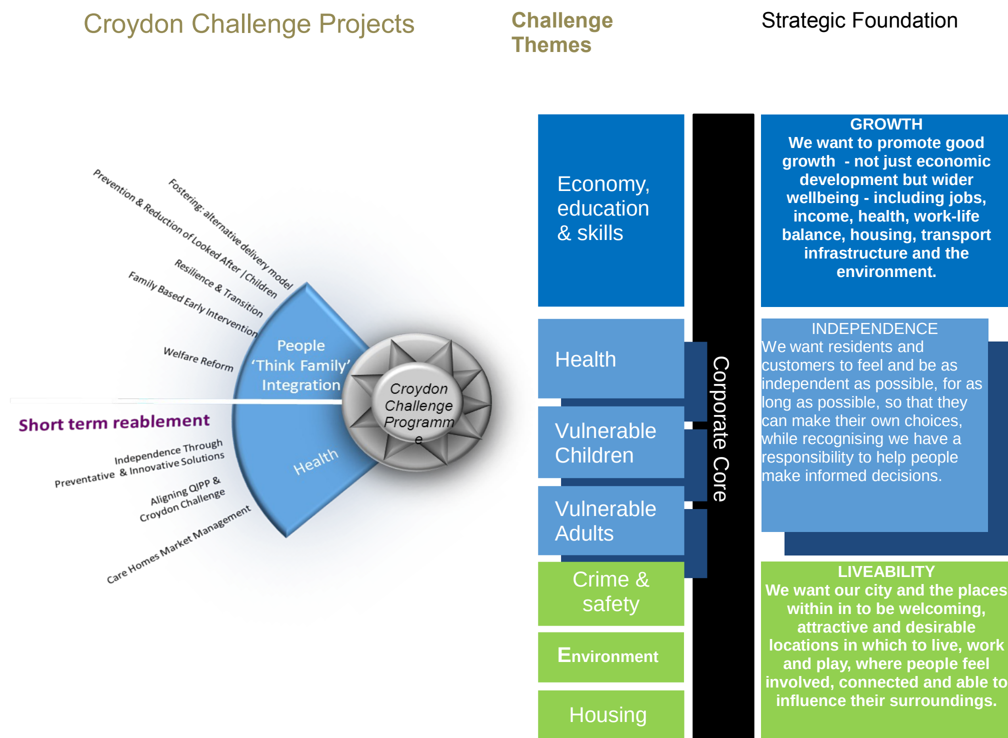
health and “help maintain independence or support reablement or recovery” (Guidance Chapter 9).

Better Care Fund:

In Croydon, we have been working for several years prior to the Act with our health partners to develop partnership working and the development of more joined up services for the individual. The development of reablement in the borough started under the Council’s Reablement and Discharge programme which was funded from the Section 256 funding from the Department of Health and which has been continued under the Better Care Fund introduced in April 2015.

Croydon Challenge:

The requirements of both the Care Act and Better Care Fund are reflected in Croydon Council Corporate strategy. The Croydon Challenge programme and the development of the Croydon Council operating model have independence, resilience and integration as core drivers.



Reablement sits alongside other key Croydon Challenge initiatives that recognise the interdependency between health and social care services and the need to work together in better ways to serve local people so they experience well-co-ordinated care and support which is truly person-centred and helps them maintain independence into later life. The programme challenges services to work together to prevent issues arising and in doing so enable individuals to develop their self-resilience, maintain their independence

and self-management of their health.

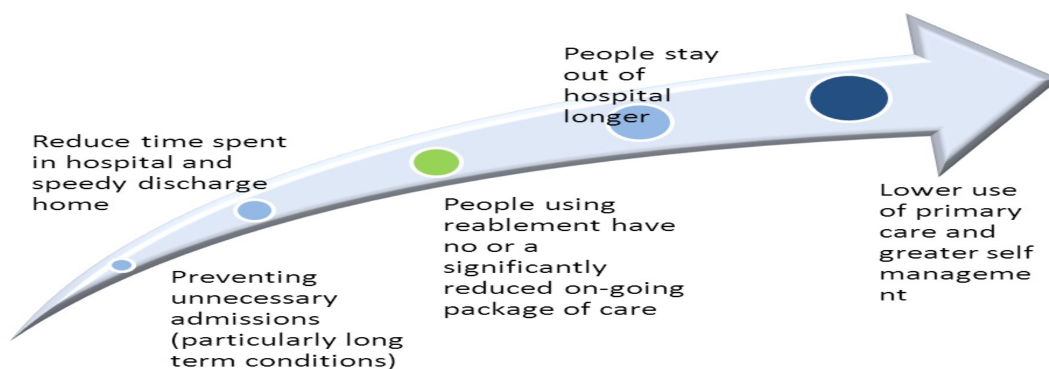
Client Outcomes and Efficiencies - Shared Benefits

3.7 Reablement in Croydon has been developed in line with the national and local policy with a focus on how we can work with the individual to help achieve their outcomes to define for themselves what that means and then work with them to help them achieve those goals.

3.8 The service has been based on a number of key principles which has shaped it to date and will continue to be central as the reablement continues to develop:

- Integrated: services to be provided in a joined up way, for organisations to coordinate and provide a seamless provision of care.
- Timely: Service to be provided as early as possible, with timely adjustments to care packages with updated goals.
- Flexible and adaptable: care package and goals reflect current circumstances, and help people plan for the short, medium and long term.
- Regular coordinated reviews that look at progress across a whole reablement plan, and where issues can be looked at together, and next steps and goals agreed

3.9 In taking a person centred approach in Croydon it is believed that not only will there be benefits to the individual but also potential benefit to the wider health and social care system through efficiencies and released capacity through hospital avoidance, and reducing pressure on social care budgets.



The Reablement Journey

3.10 The focus in the development of Reablement in Croydon has been on people (with eligible social care needs) who have been discharged from hospital. This has been for just reason as 70% of new social care packages result of from (mainly) older people requiring support after receiving acute care following treatment. Coupled with the Council's commitment to support people at home and reduce admissions to residential care the impact has been to see increasing pressure on adult social care budgets.

3.11 In order to respond to this increasing demand Croydon has developed its reablement service and in doing so has recognised the importance for reablement planning to start as early as possible after a patient has been admitted to hospital and being identified as having social care needs. In order to support hospital staff and enable effective discharge and reablement planning there has been BCF investment in additional social work capacity in the Adult Care Team (ACT) working in Croydon University Hospital with the specific aim of improving coordinated discharge and reablement planning through the social care assessment process.

3.12 In order to deliver coordinated reablement interventions with the individual after they have been discharged the Council has established additional social work and Occupational Therapy capacity within the Short Term Assessment and Reablement Team (START). The purpose of these workers is to ensure the outcomes identified through the work of ACT are translated into a detailed reablement plan, and ensure that this plan is implemented and regularly monitored, and adjusted as appropriate and at the right time.

3.13 In April 2015 the Council introduced specialist reablement domiciliary care "lot" made up by 10 agencies commissioned through the Council's domiciliary care integrated framework to provide a range of community and home based enabling support to help a patient regain their confidence and independence.

3.14 In order to achieve an individual's reablement goals a number of services may be needed to contribute. For example, there may be a need for input to help regain functional abilities, and therefore the professional skills of an occupational therapist required. In addition, support to assist in and help with the rediscovery of skills within the home to regain independence may need skilled domiciliary care support. Building confidence to access to community services and facilities again may require some targeted outreach work. The aim of Croydon Reablement is to ensure that even though there may be a number of services involved the individual has one reablement coordinator that works with them to ensure they work together to achieve the outcomes important to the individual.

Case Study

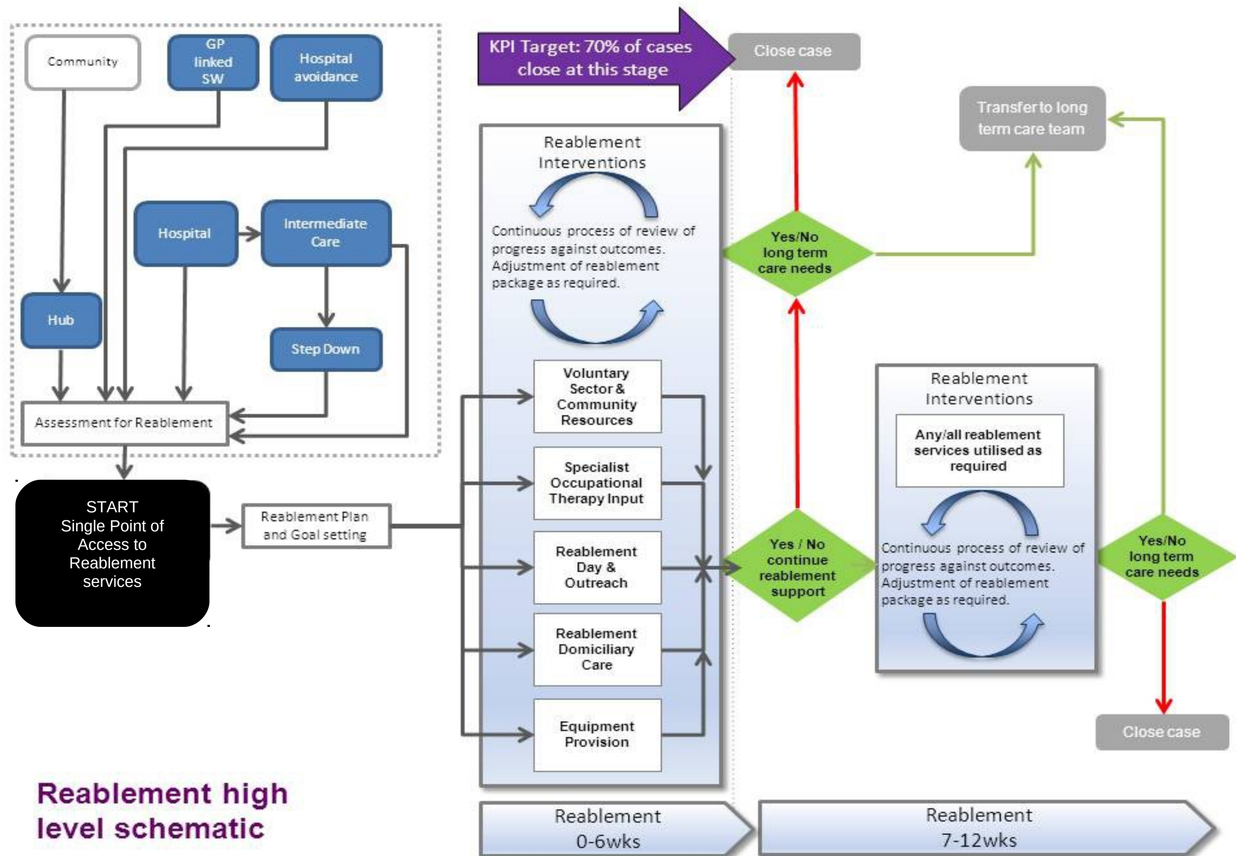
Mrs. W was an 84 year old client who was referred to the service by Croydon University Hospital A&E care management after having a fall, which injured her right shoulder. Mrs W was lacking in confidence, not able to do personal care or leave the house after the fall. Her planned outcomes were to get back to being more functional at home and to re-establish links with her social networks.

A one to one programme with a staff member was agreed for completing the daily living tasks and her personal shoulder exercise programme. At the beginning a staff member assisted Mrs .W with some personal care, but this was only needed for three weeks. A weekly record was completed of all the objective activities that had been set for Mrs W that continued until the end of her programme

It was agreed that Mrs. W would be discharged at 6 weeks as she said “that she felt she had achieved some improvement with her daily living skill, and now able to manage her personal care independently, which she felt was due to her improvement in her shoulder movement.”

felt able to take over his wife’s care and the reablement plan came to an end. The planned multi agency discharge and the initial support was enough to support both Mrs J and her husband to remain living independently in their home.

3.15 The Croydon Reablement service schematic below illustrates the journey that an individual would be supported through from identification of need through to completion of their reablement plan. The need for continuous review is crucial and is proving a challenge with the volume of clients (average 84 per month) now being referred to reablement.



3.16 Whilst the focus to date has been predominantly on post hospital discharge support, there is a need to develop reablement as an early intervention to prevent or delay hospital admission and maintain independence within the home. Whilst referrals are received from the community older people social work teams and the social work team attached to the six G.P Networks the figures in comparison to hospital discharge are relatively small.

Performance

3.17 Reablement services in Croydon have been working within the context of increasing focus on Croydon University Hospital performance against the national accident and emergency waiting time target (4 hour wait) and the consequent pressure on beds required following a decision to admit. There are three key national indicators that need to be considered in reviewing the performance of Croydon Adult Social Care in enabling people to come home and in remaining at home following discharge. The three are linked as the process for reablement starts in hospital and flows into the community:

- **ASCOF 2C Part 2: Delayed transfers of care from hospital which are attributable to adult social care per 100,000 population.**

Once again Croydon has performed extremely well with social care coded delays (1.8 per 100,000 population) being below both our comparator group average, London average, and well below the national average. The Adult Care Team have achieved this in the face of increasing bed pressure on Croydon University Hospital resulting in increasing demand for the team to undertake social care assessments and facilitate discharges.

Comparator Average:	2.0
London Average:	2.3
England Average:	3.1

The continued of success social care discharge performance has been an important factor in the improvement in the performance against Delayed Transfer of Care (Delayed Days) from Hospital per 100,000 population in Croydon from 162.9 days in 2013/14 down to 128.3 days in 2014/15. This is a joint health and social care indicator.

- **ASCOF 2B Part 1: Proportion of Older People (65 and over) who were at home 91 days after discharge from hospital into reablement/rehabilitation services (successful reablement)**

Performance in Croydon has improved from 2013/14 where 85.2% of people discharge from hospital was still at home 91 days after Discharge. This has risen to 87.7% in 2014/15. This improved performance should be set against a challenging year with patients being discharged earlier than in previous experienced and as a result with higher care and support needs; as testified with the rise in higher cost domiciliary care packages.

Comparator Average:	84.6%
London Average:	88.1%
England Average:	82.5%

- **ASCOF 2A Part 2: Permanent Admissions of Older People (65 and over) to Residential and Care Homes, per 100,000 population**

A key purpose of reablement is to enable independence and self-care within a person's home, and the success of reablement services has contributed to the improved performance against this indicator. In 2014/15 there were 408.6 admissions per 100,000 population into residential and care homes compared with 421.3 admissions per 100,000 population in 2013/14. This performance compares well with the London and England averages, and is almost on par with our comparator group.

This performance is notable as it should be considered against a pattern of earlier discharge from hospital, increasing acuity and the consequential increase in social care support need of patients post discharge (as evidenced by increase in domiciliary) , and an ageing population.

Comparator Average:	405.2
London Average:	454.0
England Average:	650.6

4. CONSULTATION

4.1 Croydon Council Adult Social Care is committed to ensuring that regular communication and engagement with our population, the wider health and social care community and our local stakeholders to maintain public trust and confidence in services for which we are responsible. The development of Reablement has drawn on strategies that have been subject to consultation and engagement with stakeholder groups nationally and through the development of the Croydon Better Care Fund Plan. Its aims are also in line with the outcomes defined by stakeholders in the consultation for Outcomes Based Commissioning.

4.2 START will be undertaking regular surveys of clients who have received reablement in order to gain their feedback and suggestions on how the services provided can improve.

5. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

5.1 Revenue and Capital consequences of report recommendations

	Current year	Medium Term Financial Strategy – 3 year forecast		
	2015/16	2016/17	2017/18	2018/19
	£'000	*£'000*	*£'000*	*£'000*
Revenue Budget available	1,013	1,013		
Expenditure	1,013	1,013		
Income				
Effect of decision from report				
Expenditure				
Income				
Remaining budget	0	0		
Capital Budget available				
Expenditure				
Effect of decision from report	0	0		

Expenditure				
Remaining budget	0	0		

5.2 The effect of the decision

No decisions arise from this report.

5.3 Risks

The funding for Reablement services in Croydon comes from the Croydon Better Care Fund. This funding covers staffing and running costs (circa £243,000) and a contribution to non- chargeable domiciliary care packages for the first six weeks post hospital discharge (circa £771,000). If this funding was not available then there would be a risk to the continuation and development of the Council's reablement service with impact on the Adult Social Care Croydon Challenge reablement efficiency.

5.4 Future savings/efficiencies

The Croydon Challenge efficiency target for reablement as a result of reducing long term dependency on domiciliary care packages is £324,000 for 2015/16 and 2016/17

(Approved by: Lisa Taylor, Head of Finance and Deputy Section 151 Officer, Corporate Resources)

6. COMMENTS OF THE BOROUGH SOLICITOR AND MONITORING OFFICER

The Solicitor to the Council comments that there are no additional legal issues arising from the content of this report.

(Approved by: J Harris Baker, head of social care and education law, on behalf of the Borough Solicitor & Director of Legal & Democratic Services)

7. HUMAN RESOURCES IMPACT

An important part of this programme is to actively engage and consult with key stakeholders to shape the options and solutions. As such any HR implications will be identified as the programme is developed further and will be managed in accordance with Council policy and employment legislation.

(Approved by: Deborah Calliste, HR Business Partner, on behalf of the Director of Human Resources)

8. EQUALITIES IMPACT

8.1 The Croydon Reablement services is resourced from the Better Care Fund and from existing Council revenue funded services and is such not new funding. Reablement is included in the Croydon Better Care Fund which has already been approved by Health and Wellbeing Board.

8.2 Any new initiatives that are commissioned will be subject to an Equalities impact assessment where it has been assessed as being required.

8.3 Description of population groups to be covered by Better Care Funding is included in first section of the draft Better Care Fund draft submission submitted to Board.

9 ENVIRONMENTAL IMPACT

9.1 There is no environmental impact to be considered from this report.

10 CRIME AND DISORDER REDUCTION IMPACT

10.1 There are no crime and disorder impacts to be considered from this report.

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BACKGROUND DOCUMENTS: None