Warwickshire People Group

Social Care & Support

Reablement Strategy

2013 – 2015

Contents

Executive Summary……………………………………………………..2

Introduction and Purpose……………………………………………….5

Scope of the Strategy…………………………………………………12

Vision and Key Principles of the Strategy………………………………15

1. Access & Eligibility…………………….....................................15
2. National & Local Drivers…………………………………….....17
3. Health Alignment……………………………………………...19
4. Maintaining & Maximising Independence…………………..... 21
5. Cost Efficiency………………………………………………...22
6. Five years and onwards………………………………………...23

Delivering the Vision…………………………………………………...26

Executive Summary

The Putting People First concordat 2007 The Health and Social Care Act 2012 and the recently published 'Caring for our Future' White Paper July 2012 all have a golden thread of 'prevention and personalisation' running through them. Local Authorities and now health services understand that by investing in a drive towards personalisation, customers and practitioners have welcomed the focus of a 'person centred approach'. It takes the concept of support towards genuine and powerful choice and control for the person on the receiving end. The evidence is also clear that by investing in preventative services, dependency on long term institutional services will reduce, thus reducing cost. Warwickshire County Councils Reablement Service has been developing and refining its delivery since November 2010. The consistent aim of reablement is to offer personalisation, choice; control and independence to the customer in receipt of the service, whilst also delivering savings on spend within social care.

The next two to five years will be a challenging time for all social care services. Reablement will continue to play a key role in maximising a person's independence and preventing them from requiring statutory provision/institutionalised support. It is vital that the service has some plan and structure for development to ensure that it remains a viable cost saving option for the County Council in the future. Therefore this Reablement Strategy will underpin the future delivery of the Reablement Service within Warwickshire County Council. We are already seeing evidence that home care packages are reducing and that residential care admissions have decreased within Warwickshire and there is confidence that reablement has had a key influence on these changing trends.

We already know the following performance information about the Reablement Service within Warwickshire from 2011 to 2012 (which will play a key role in the development of the strategy)

- The service had **2300** referrals to the Reablement Service. Referrals have been low from mental health, learning disability and the Adult Reviewing Team.
- **92%** of the referrals into the service were deemed appropriate against the current eligibility criteria
- **74%** of customers achieved one or more outcome and achievement within their reablement programme
- **62%** of customers were not in care at 91 days post reablement service

This performance information assists to provide the baseline for an emerging strategy. It enables us to evaluate what is going well, what requires more focus and what areas of service development require priority for the next two to five years.

The Reablement Strategy will prioritise accessibility & eligibility. By maintaining a sensible eligibility and accessibility criteria, the service will be able to continue to achieve its target of preventing the need for a person to require an on-going support package that is expensive, long term and creates a culture of dependency. Eligibility will continue to develop as a result of the reablements partnership work with health. Reablement will also begin to target areas such as stoke, long term conditions, customers at review, learning disability, dementia and mental health. Warwickshire's approach to eligibility and accessibility for reablement will continue to meet social cares fair access to care criteria. This will ensure that all customers that access the service have an identified social care need. Accessing against FACs also assists to meet the council's transformation programme savings. On-going pressure to continue to achieve savings is heavily placed on reablement. This is due to its national and local profile for achieving long term independence and reducing the need to commission high cost long term packages of care and support.

The savings targets for reablement within the Warwickshire transformation programme are reflected as being on track for being achieved, primarily because social care and support are under spending. The caveat to this is that Learning Disability access to the service is not yet fully live and that it is difficult to accurately determine savings wholly attributable to Reablement. Consideration must also be taken for the plans and vision that are contained within this strategy that will have an influence in continuing to achieve savings targets.

The vision for delivering the Reablement Strategy is underpinned by the following key priorities that are all influenced by the changing landscape locally and nationally.

Deliver cost efficiencies in order to meet current and future demand within existing resources
Within the current and future financial and political climate, both health and social care economies are tasked to provide best value services for the local population, within agreed budgetary constraints.

Improve quality & maximise independent living
Maximise people's potential to live independently in their chosen community by giving them access to the reablement service

Decrease the number of people unnecessarily admitted to long term care following a hospital stay
Assessment and decision making about peoples long-term care needs will only be made only after they have had the opportunity for rehabilitation, recuperation and recovery

Prevent hospital admissions and support timely discharges
Individuals will receive their care in the right place, at the right time.

Improve the skills and competencies of the reablement work force
Investing in workforce development will ensure reablement has the right skill mix of staff. This in turn will maximise throughput, volume and quality within the reablement service

Performance management and KPI development
Monitor and evaluate quality, provide accurate reporting data and to inform future commissioning intentions.

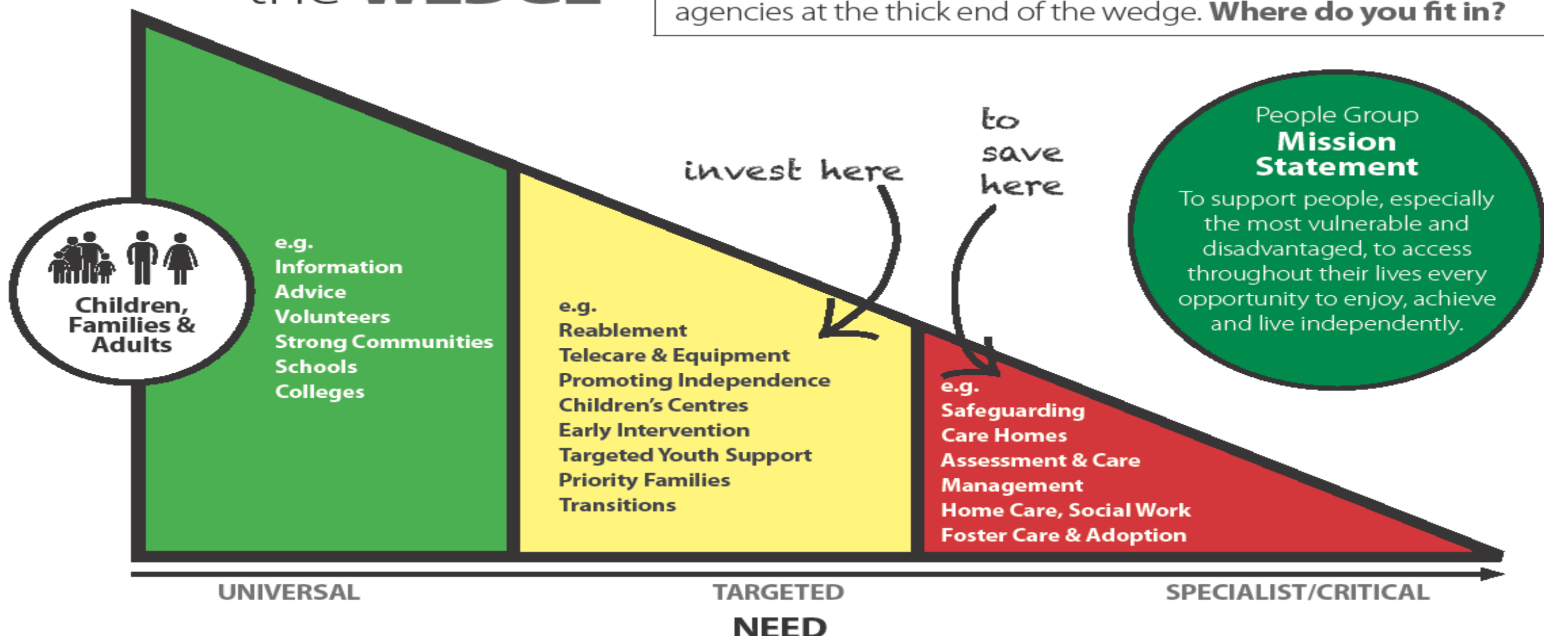
This strategy details how the vision for the Reablement Service will be achieved within Warwickshire County Council within the next two years. The strategy will also include some key development areas that may need to be considered over the next five years, as the landscape for social care continues to change. These developments for the longer term are perhaps more radical and include the need to think about outsourcing reablement to the external market. Another consideration is developing a social enterprise to save money in the long term.

Introduction and Purpose

The Social care and support system in England is going through the most comprehensive overhaul since 1948, to make it clearer and fairer to those that use it. The new system focuses on people's wellbeing, supporting them to live independently for as long as possible. Care and support will be centred on people's needs, giving them better care and more control over the care they receive. Support for carers will also improve.

The 'Caring for our future' White Paper sets out our vision for the reformed care and support system. The Health and Social Care Act creates a single modern piece of law for adult care and support, replacing complex and outdated legislation. The landscape is changing significantly and Warwickshire must respond to this change in order to continue to support customers with the right support, at the right time, at the right cost and in the right environment.

Warwickshire's People Group reflects the focus in the wedge below: This wedge encompasses the support and service structure that is being offered to citizens within Warwickshire.



It is envisaged that the principles within the wedge will continue to develop over the next 12 to 18 months as the People Group continues to evolve its priorities around early intervention and prevention. The wedge encompasses the principles of

prevention which reflect recent social care legislation. The wedge reflects that by offering citizens the right information and advice that is universal and accessible, independence is maintained and reliance on statutory services is decreased. The wedge shows that if we invest in targeted interventions, such as reablement, this will assist the citizen to live an independent life within their local community. In turn, this should prevent the need for specialist/critical intervention that is costly and can create a cycle of dependency and institutionalisation.

The on-going development of Warwickshire's Reablement Service provides the platform for the delivery of the wedge principles and current national legislation. Reablement aims to decrease the demand for long term packages of care for customers, by maximising and maintaining independence within a person's own home for as long as possible.

Research in 2010 by the Social Policy Research Unit, University of York and the Personal Social Services Research Unit, University of Kent examined the immediate and longer-term impacts of reablement; the cost-effectiveness of the service; and the content and organisation of reablement services. People who received reablement were compared with a group receiving conventional home care services; both groups were followed for up to one year.

- According to data supplied by local authorities, the unit cost of a typical reablement episode is £2,088. The average cost per hour is £20 and the average cost per hour of customer contact time is £40.

- Reablement was associated with a significant decrease in subsequent social care service use. The costs of the social care services used by people in the reablement group during the 12 months of the study (excluding the costs of the reablement intervention itself) were 60 per cent less than the costs of the social care services used by people using conventional home care services.

- This reduction in social care costs was almost entirely offset by the initial cost of the reablement intervention. The total average cost (including reablement) of the social care services used by the reablement group was £380 lower than the total average cost of the social care services used by the comparison group.

- The reablement group had significantly higher healthcare costs than the comparison group during the first eight weeks of the study. However, more people in the reablement group had been referred to the service following discharge from hospital. These people had significantly higher healthcare costs (mainly arising from further hospital in-patient episodes) during the first eight weeks of the study than people who had been referred to reablement from the community. However, there was no significant difference between the reablement and comparison group in the costs of the health services used during the subsequent ten months of the study. When baseline differences were taken into account, there were also no significant differences in the duration of inpatient stays or the total costs of the healthcare service used when averaged across the two groups over the full 12 months of the study.

- Reablement had positive impacts on users' health-related quality of life and social care-related quality of life up to ten months after reablement, again in comparison with users of conventional home care services

- Effective reablement services require good initial staff training and on-going supervision; clear outcomes for users and flexibility to adapt these as needs change; and prompt supply of equipment. Prompt transfer to home care for those who need it at the end of reablement is essential to maintain capacity in reablement services.

- Users and carers were positive about the impact of reablement on their independence and confidence, although some would have liked more help to improve their mobility and undertake activities outside the home.

Other research conducted by Care Services Efficiency Delivery (CSED) 2010 supports the York and Kent study and has shown that reablement is very beneficial to the person and has positive results compared to a customer going through traditional home care. CSED research also reflects that the long term savings outweigh the initial costs of providing the reablement service to appropriate people. This research has been nationally recognised and is reflected as a key theme in recent social care legislation such as the Putting People First concordat (2007), The Health and Social Care Act 2012 and the recently published 'Caring for our Future' White Paper (July 2012), local authorities and now health services understand that by investing in a drive towards personalisation at the front end, customers and practitioners have welcomed the focus of a 'person centred approach', taking the concept of support towards genuine and powerful choice and control. The evidence is also clear that by investing in preventative services (that may be costly to deliver), dependency on long term institutional services will reduce, so in the long term savings can be achieved as high cost long term packages of care do not need to be commissioned.

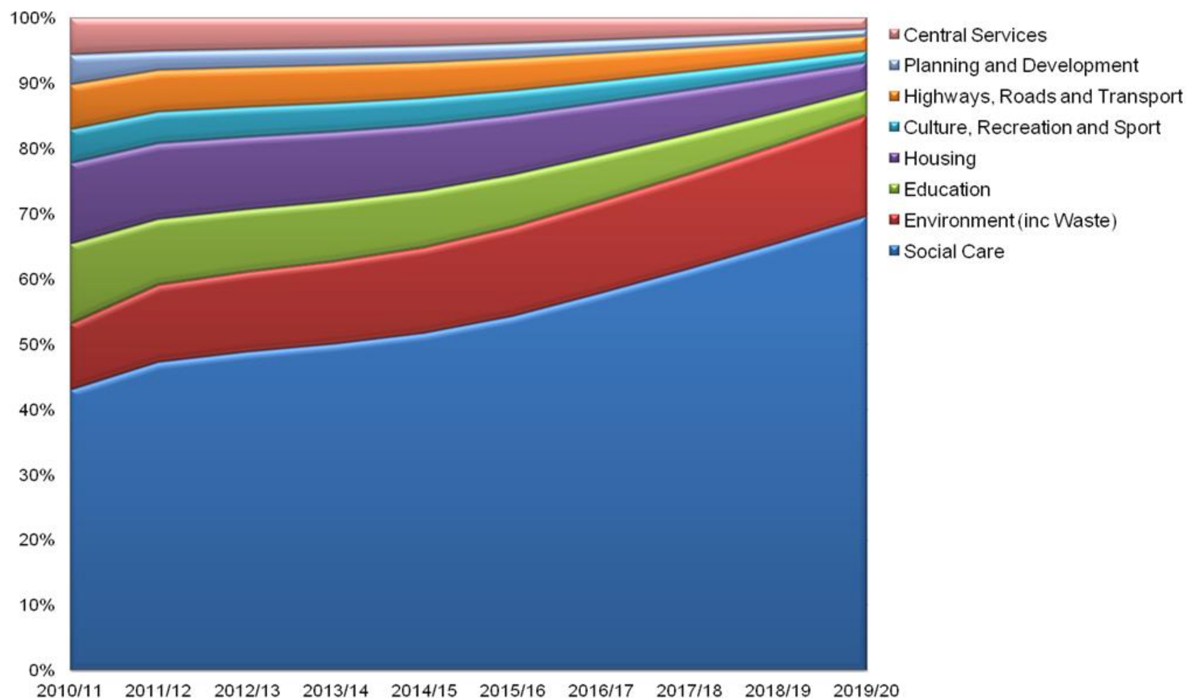
In October 2010, the Department of Health (DOH) made the announcement that additional funding of £70 million would be made available to Primary Care Trusts (PCT) to be used on creating reablement services with local authorities to keep people away from hospital and in their own home. The DOH stated that PCTs could decide how to allocate and spend the funding locally. However, there was an expectation that some of the funding was spent on developing already established reablement services that were available.

Within Warwickshire, the PCT took the decision to undertake a Section 256 transfer of the DOH funding to Warwickshire County Council. A significant element of this funding was to be spent on the reablement service. In 2011/12, funding of £6 million was made available and in 2012/13, £5 million has been transferred to Warwickshire County Council to be spent on the development of the reablement service. This funding is a great move forward for local authorities and has enabled Warwickshire to invest in the on-going development of the Reablement Service. This funding

investment is evidence that the reablement ethos is the driver for drilling down costs and increasing independence and empowerment for local citizens within their own community.

Whilst additional funding is key for reablement services development to assist with the changing shape of social care, cost efficiency remains high on the agenda. Warwickshire County Council will continue to be under pressure as the ageing population is set to increase and funding and spending continues to be squeezed. The Comprehensive Spending Review in 2015 and the recommendations within the Dillnott Report will have a significant impact on the expectations of social care provision and spending going forward. Therefore, the on-going investment within early intervention and prevention is vital to keep service costs low and to maximise a citizen's opportunity to live independently in their local community.

The graph of doom that was first used by Barnet Council in May 2011 to reflect the future of Local Government spending is now being widely applied. Warwickshire's version of the graph is as follows:



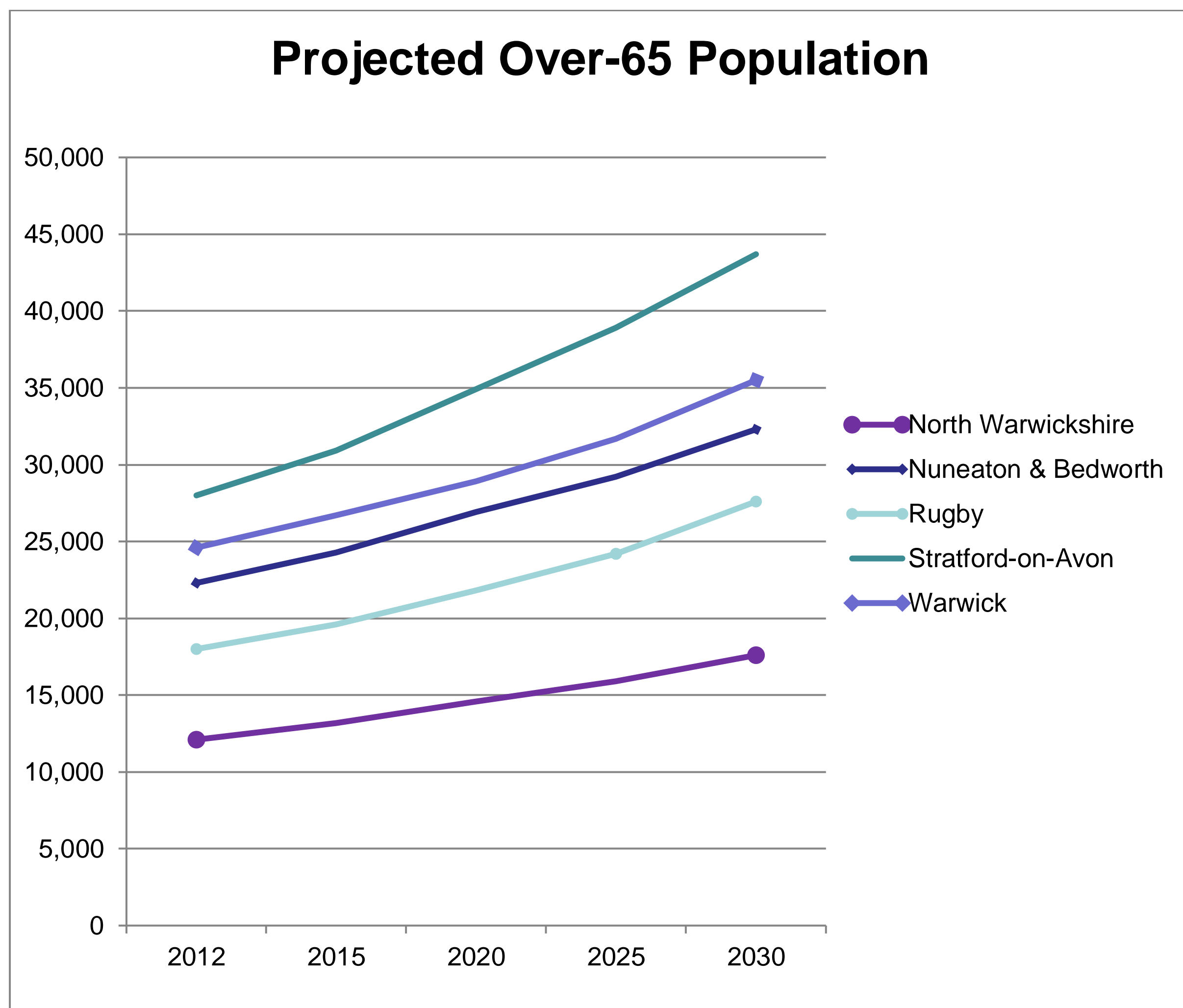
Adult Social Care. Reversing the Graph Of Doom Presentation. Jenny Wood December 2012

We can easily visualise from this that Council's spending on Social Care continues to rise, whilst funding becomes squeezed. This may result in delivering more with less.

As the ageing population grows and the funds decrease, the focus on early intervention and prevention become the foundations on which services are reconfigured. The move away from long term dependency is key and the move towards reablement, rehabilitation and recovery are vital for future sustainability.

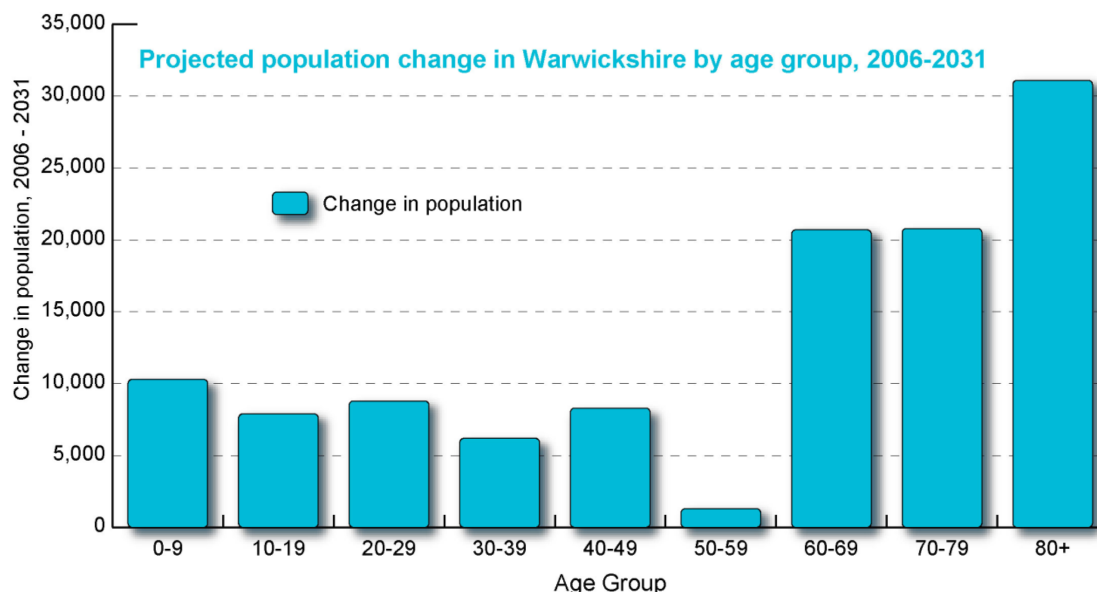
Warwickshire will need to respond to the change in population profile that is predicted, whilst carrying the pressure of on-going funding issues. This population change prediction reflects people living longer. This change will have a significant impact on the way that services and support are commissioned in the future. Reablement will need to respond to this key change in demography and ensure it plays its part in maximising and maintaining a person's independence by steering a person away from statutory provision. The key will be to reduce demand and reduce dependency on traditional models of support that are not beneficial and are financially costly to the customer.

Demography data provides useful information on the way that the population will change over the next 20 years. The table below suggests that the number of people aged 65+ within Warwickshire is projected to increase significantly by 2031 (see table below). This is driven by those residing in Stratford-on-Avon.



Source: Predicting Older People Population (POPPI)

This table from the Joint Strategic Needs Assessment highlights the changing trend in age per population and it is clear that the ageing population is growing.



The Kings Fund has also undertaken significant research. 'Time to Think Differently' is a new programme of work aimed at stimulating debate about the changes needed for the NHS and social care to meet the challenges of the future into how the population is set to change. They share key messages that will change the shape of social care in the next 20 years:

- **The population is growing**
  Over the next 20 years (2012-2032), the population in England is predicted to grow by 8 million to just over 61 million, 4.5 million from natural growth (births – deaths), 3.5 million from net migration.

- **More people are living alone**
  By 2032, 11.3 million people are expected to be living on their own, more than 40 per cent of all households. The number of people over 85 living on their own is expected to grow from 573, 000 to 1.4 million.

- **Life expectancy and healthy life expectancy are growing**
  In 1901, baby boys were expected to live for 45 years and girls for 49 years. In 2012, boys could expect to live for just over 79 years and girls to 83 years. By 2032, this is expected to increase to 83 years and 87 years respectively. Healthy life expectancy is growing at a similar rate, suggesting that the extra years of life will not necessarily be years of ill health.

- **The population is ageing**
  The combination of extending life expectancy and the ageing of those born in the baby boom, just after the Second World War, means that the population aged over 65 is growing at a much faster rate than those under 65. Over the

next 20 years, the population aged 65-84 will rise by 39 per cent and those over 85 by 106 per cent.

It is vital that social care is ready and prepared for this change in demography. People living longer will naturally mean people living with age-related conditions, particularly dementia, that may be perpetuated by existing health and social care issues (housing, heating, income). Whilst reablement will not benefit everyone, there is development needed to ensure the service can meet the rising trends in the ageing population, complicated by the on-going funding pressures within the public sector. Hopefully, the Reablement Strategy sets out the detailed vision of how the service will do this over the next two years, whilst considering the longer term outcomes required over the next five years.

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Scope of the Strategy

Defining the scope of the Reablement Strategy is key for its success. The questions that should underpin the strategy are:

- **How do we know reablement works and how do we continue to refine and develop service delivery to secure its sustainability?**
- **How are we confident that reablement saves more than it costs?**
- **How do we develop the service so that it improves and sustains outcomes?**
- **How do we develop the service in a changing social care landscape?**
- **How do we continue to work in partnership with key stakeholders?**
- **What do we need to consider in the long term (5 years) to respond to on-going financial pressures and strategic priorities?**

To ensure that the development and delivery of this strategy is manageable, it is vital to define the boundaries within which this strategy will operate. The Reablement Service is central to the Warwickshire Social Care and Support business unit. Since its introduction in 2010, the service has grown significantly to meet demand and need. The service has also had an impact on the decreases in commissioned home care service and residential home service costs. It also continues to meet its savings targets, as reflected through Warwickshire's Transformation Programme.

Clinical Commissioning Groups, The Arden Cluster, Coventry & Warwickshire Partnership Trust all have a vested interest in the development of the Reablement Service. This is due to its valid contribution to responding to an increasing ageing population by providing support to maintain a person's independence in their local community, with a result of low cost or no on-going support being required. In particular, the Reablement Service has developed a strong relationship with the acute hospitals by providing a flexible service to patients upon discharge. This has resulted in improved flow within the acute hospitals and a decrease in delays of discharge, due to reablement being a responsive, flexible community support service. The service has also no doubt assisted with the decrease in repeat acute admissions, as patients are receiving the right support, in the right place, at the right time. This has enabled the person to become fit and well and to sustain their level of independence in their own home after a period of hospital stay.

Clinical Commissioning Groups have developed their commissioning intentions documents that reflect the golden thread of early intervention and prevention. Therefore, the interest in how the Reablement Service will evolve to meet the need and demand is growing with all key stakeholders, as they can see that, if delivered correctly, the benefits are great and the on-going costs are low.

Whilst Warwickshire Social Care and Support business unit and key stakeholders highlighted above share the vision for development within integration, alignment and

personalisation, the priorities within stakeholder groups can sometimes conflict. Challenges within the organisations, such as financial pressures, organisational priorities, national targets and commissioning intentions for the future are not always the same for each service area. Therefore, it is important that Warwickshire County Council sets the vision and key principles for the development for the Reablement Service. This will ensure the priorities of Warwickshire County Council are central to the Reablement Service development. This in turn secures the focus around delivering savings and increasing the population's independence through early intervention and prevention. It is still acknowledged that the on-going partnership developments with key stakeholders is central to the future sustainability for social care and support but it is important to highlight that the Reablement Service ultimately must provide significant benefits for social care services and people that require social care support, otherwise its existence within Warwickshire County Council is questionable. There is the risk that if the future vision for the service is not clear, then the benefits to social care may become lost, as the service becomes consumed by stakeholders' priorities. Therefore, the scope of the Reablement Strategy is as follows:

- The strategy is designed to ensure that all people that are eligible (have an identified social care need) have access to the Reablement Service, based on their need and requirement to maintain independence within an environment of their choice.

- The strategy will detail the areas for development within the Reablement Service over the next two years. These developments will include joint initiatives with key stakeholders. These initiatives will include improving the transition for a person between acute hospital services and community services, reducing unnecessary hospital admissions, long hospital stays and preventing premature use of long term residential care. The focus will continue to limit the long term requirement for expensive packages of care within social care and support.

- The strategy will make reference to the longer term options that should be considered within the next five years. It is difficult to predict how the social care landscape will look at this time but assumptions based on current evidence and national thinking can be made.

- The strategy will include cost efficiencies, which are key due to the current environment of on-going financial pressures, a growing population and an increase in funding squeeze within the public sector.

- The basic tenant of the development of the strategy has been upon the agreed need to focus upon early intervention and prevention as the key to

reduction on dependency and mitigating the need for on-going support through social care and health services.

- It is important to note that this strategy can only be responsible for the part that reablement will play in maintaining a person's independence. Reablement, in some cases, is just one stop along a customer's journey. Dependencies such as providing the right information, advice and guidance, undertaking safe assessments and discharges from an acute hospital, commissioning appropriate support through the self-directed support model, will all have a vital role to play in how a person accesses reablement and how their independence is maintained within the community post reablement.

Vision and Key Principles of the Strategy

1. Accessibility & eligibility

The vision of reablement is to ensure the service is accessible to the majority of the Warwickshire population that require social care. The service offers targeted intervention to an adult for up to 6 weeks. The intervention will aim to reduce dependency and maximise the person's independence. The service will give the person the required skills, confidence and feeling of well-being to enable them to be in control of their own lives and live independently in a chosen environment (usually in their own home). The service will assist people that may have reablement potential as a result of a long term condition or stroke with the aim of maximising and maintaining the person's independence within an environment of their choice. The service will play a fundamental role in preventing hospital admission or admission to a long term institutional service, such as residential care. The service will work alongside existing providers within the voluntary and private sector to share the ethos of reablement so that any independence that the customer has gained is maintained long term.

The approach to reablement accessibility within Warwickshire ensures that reablement is offered to the people that will benefit most from it. The service will maintain its eligibility criteria which in turn will ensure that people who have the potential to engage in a reablement programme are offered the service at the right time and in the right place. This potential to engage will also ensure that people are able to achieve their self-perceived wishes and goals during their time in reablement. This is currently reflected through performance monitoring where, at the time of writing (Quarter 2 July – Sept 2012), 77% of people that have completed the reablement service have achieved one or more of their own agreed outcomes.

Warwickshire's Reablement Service eligibility will continue to make a clear distinction from intermediate care (IC) and rehabilitation which is key to assist with its effective service outcomes. This is reflected in the DOH *'Intermediate care half way home'* 2009 guidance which confirms that IC and reablement should complement each other and not duplicate service delivery. The guidance goes on to quote that IC is a function that is clinically lead and assists to rehabilitate a person from a medical episode. Reablement is defined as a community-based service that responds to the social care and holistic nature of a person's daily living, thus maintaining a person's independence within their community. Reablement is also defined as being accessible to a wider cohort of people and does not just dedicate service delivery to people that have been in hospital. The reablement service within Warwickshire works closely with IC teams and this relationship will continue to develop. This enables a person to receive reablement following their period of IC support to ensure that reablement will be beneficial to them once their medical episode is complete. It ensures they are well enough to participate in a programme to maximise and

maintain their independence. Thus, one service complements the other and a clear distinction is developed and maintained.

Warwickshire's approach to eligibility and accessibility for reablement will also ensure that the Council's Transformation Programme savings targets continue to be adhered to. On-going pressure to continue to reflect savings is heavily placed on reablement, due to its national profile for achieving long term independence and more locally due to its high cost of service delivery (approx. £1000 per week per person within Warwickshire).

By maintaining a sensible eligibility and accessibility criteria, the service will be able to continue to achieve its target of preventing the need for a person to require an on-going support package that is expensive, long term and creates a culture of dependency. It is important to emphasise that the eligibility and accessibility criteria within reablement are very important within the health alignment and integration plans within Warwickshire. Whilst the service aims to complement and assist its key partners and stakeholders within health, it is crucial that those that are referred to reablement will be able to experience personal results. If a person is still experiencing a medical episode and is not perceived as well enough to participate, then the experience of reablement will not be a positive one. This will also have a negative impact on savings and outcomes for the service, as it will be more likely that the person will require an on-going costly service and less likely they will have achieved their personal outcomes as a result of receiving a reablement service.

Reablement in Warwickshire will be accessible to a person that has experienced a stroke or who is living with a Long Term Condition. Work is underway to evaluate how reablement needs to tailor its service delivery to ensure that best outcomes are achieved for a person post-stroke. Timeframe for service delivery may be extended to 12 weeks for a post-stroke customer to ensure that potential is achieved.

Reablement in Warwickshire will support a person that is living with a Long Term Condition. Reablement will strive to tailor its service offer to assist someone to self-manage their Long Term Condition in their own home with the aim of maintaining their independence and dignity whilst living with their condition. This may result in the need for specialist training for reablement staff to ensure that support can be delivered in an effective and non-obtrusive way. It will also involve Reablement working closely with primary and secondary care partners to identify the right support, in the right place, at the right time. The use of Assistive Technology will be a natural part of the Reablement Service offer to assist a person to self-manage their condition

Reablement in Warwickshire will be accessible to a person that has a learning disability, early stages of dementia or a mental health problem. Work is underway to evaluate how reablement can respond and assist people within these groups. For example, support will need to be tailored if reablement staff are supporting a

customer with dementia. The aim will continue to be to maximise a person's independence within their own home, however the delivery of the service offer may require higher intensity, due to the characteristics of dementia. It is also vital that reablement complements current established support mechanisms that a customer already has in place. For example, a person experiencing mental health problems may already have a number of statutory services that are supporting them. The Reablement Service offer must be developed sensitively and in partnership with the established support services and customer to ensure duplication does not occur.

This is also the case for a person with a Learning disability. Reablement will work to assist the person to achieve independence, particularly if a person's support package requires increasing. Reablement will work alongside the established support providers to offer a service that will prevent the need for an on-going increase in support and may even reduce the overall support that a person is receiving. Services such as Warwickshire Employment Services Team (WEST) and Supporting Independence Service (SIS) will work closely with the Reablement Service to ensure that a person with a Learning Disability is having all of their needs met. An example of this may be that a person accesses WEST to maximise their employment potential. They may also access SIS who will assist them with using transport to get to and from their place of work. Finally, they may also access reablement that will assist the person to undertake their daily living tasks independently in their own home (washing, dressing, meal preparation). This will enable the person to access their place of employment. Thus one support service complements the other and there is no duplication occurring within the customer's journey.

2. National & Local Drivers

The key driver for adult social care continues to be to deliver personalised services. The principle of supporting and maximising independence continues to be embedded across all areas of adult social care; facilitating self-support wherever reasonably possible. This includes working with people to enable them to access local community networks and services and other non-statutory forms of support. Warwickshire's Reablement Service reflects a number of the six strategic themes for the People Group:

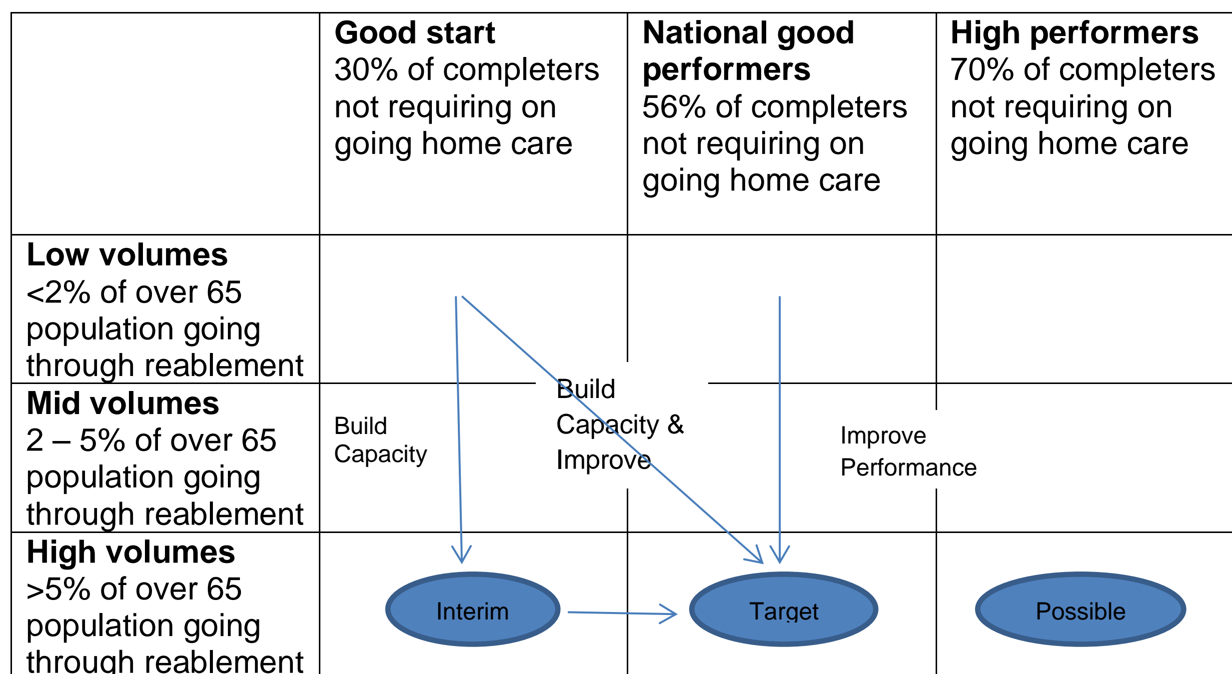
- Personalisation
- Integration / Collaboration
- Early Intervention

These themes require further development and refinement within the Reablement Service to ensure that the themes are responded to. The accessibility of the service must be considered so that the volumes of people are high and in turn the benefits of personalisation, integration and early intervention are felt by those that have experienced a reablement journey.

Gerald Pilkington Associates (‘Home Time’ Pavilion conference 6th Sept 2012) expects that Councils should be expecting reablement as a service offer to 100% of customers that come through the ‘front door’. He believes that this is the only way that the service will see the benefits of its own costs.

Gerald proposes that any reablement service needs to go through a period of maturity to enable it to continue to function and the target is high volumes of customers and high percentages not requiring on-going support post reablement.

Gerald reflects this in a diagram:



	Good start 30% of completers not requiring on going home care	**National good performers** 56% of completers not requiring on going home care	**High performers** 70% of completers not requiring on going home care
Low volumes <2% of over 65 population going through reablement			
Mid volumes 2 – 5% of over 65 population going through reablement			
High volumes >5% of over 65 population going through reablement	Interim	Target	Possible

Gerald goes on to state that the national average of customers not needing on-going care post reablement is currently 55% and that there is potential for increasing this percentage to at least 60%. However, the volume of customers’ needs also increase for this to be achieved. He sets this goal as possible to achieve and in turn it reflects a Reablement Service that is a high performer. So, in summary, volumes of customers into reablement will in turn result in high performance and results for the service.

Within Warwickshire (Quarter 2 Sept 2012), 59% of customers do not need on-going care post reablement. This is extremely positive and is above the national evidence base for Reablement Services. However caution must be taken, as the content of this strategy could have a significant impact on that percentage. If eligibility is expanded fully to specialist areas, such as Mental Health, Dementia, Stroke, Long Term Conditions and Learning Disabilities, it is highly likely that a person post reablement will require some form of care on a long term basis. The caveat to this is that reablement intervention should have reduced the intensity of this support.

Within the ‘Home Time’ conference (Pavilion Sept 6th 202), Gerald reflects on reablement services being extended to specialist groups and not just continuing to concentrate on the frail elderly. He is supportive of this extension but makes it clear

that services need to secure the efficiencies within the main reablement service before stretching resource to project manage other developments. This is a vital factor that Warwickshire plans to adopt when considering the extension of reablement.

It is also interesting and helpful to make comparisons to other councils that have developed reablement services over the past three years. Common themes and trends of service delivery are a vital guide to assist in steering the future for Warwickshire Reablement Service, as it enables assessment of what works and what is not effective when developing the service. The Councils with Social Service Responsibility (CSSR) Scheme Update on Reablement Services was published in April 2012 (http://www.geraldpilkingtonassociates.com/news.html). This directory (Warwickshire is included) update clearly evidences the Councils' desire to continue to refine and develop their reablement services, to continue to meet the developing landscape where personalisation and early intervention is key, whilst managing sustainability and cost efficiencies.

The directory evidences the following trends within the CSSR reablement services:

- 17% of the services support people from hospital. The vast majority feature community and hospital referrals.
- 67% operate on a deselective basis. However, as experience grows, these Councils are refining their reablement criteria and eligibility. For example, closer scrutiny around people with larger packages and or requiring 'double up' care provision to question if they can really benefit from reablement.
- 71% are funded solely by the council, whilst the rest are jointly funded by health and the council. Despite the drive for integration between health and social care, none of these services have indicated a newly created funding agreement with health.
- Outsourcing of reablement - 110 services remain in house, whilst 24 services are not outsourced and a further 5 are a mix of in house and outsourced services. Interest in outsourcing seems to be increasing as councils try to find creative ways to maintain cost efficiencies within the service delivery.
- 69% use FACS eligibility criteria on entry into the reablement service.

This strategy not only covers accessibility and eligibility but also acknowledges that other factors such as sustainability, cost efficiency and competence of workforce are key foundations that must be in place before extension of the service is considered. A clear incremental implementation plan will be developed following the Reablement Strategy that will reflect the planned developments for the next two years.

3. Health Alignment

The vision for reablement is to play a pivotal role in developing pathways with health to maximise a person's independence and to provide support within a non-acute environment. The culture of a hospital stay needs to change and a person should only 'be treated' in hospital. The journey of active convalescence for the customer should take place out of the hospital environment, where the individual is central to the support service offer. This enables key decisions about a person's

support to be made within a positive environment, which is likely to reflect a realistic picture of the customer's needs, rather than being assessed within the confines of an institutionalised environment, such as an acute hospital.

Against a background of a series of early service integration pilots in Warwickshire, senior leaders from Warwickshire County Council, South Warwickshire Foundation Trust, NHS Warwickshire PCT and South Warwickshire Clinical Commissioning Group met to discuss the way forward towards integrated / aligned services for older people. The outcomes of these discussions lead to the development of a shared purpose for integrated working. The foundation of the new model of aligned working is defined by the development of three new 'Discharge to Assess' pathways. The aim is to establish three clearly understood pathways of care. A patient is identified for the appropriate pathway, which will depend on the complexity of need of the patient. The aim is to discharge the patient from the acute environment and provide an assessment for any on-going support requirements in a non-acute environment, such as the person's own home or a residential care or nursing care setting. Reablement will offer a service to the patient once they have been discharged from the acute environment if this is deemed appropriate through the person's assessment. The Reablement Service will also offer support to a customer once they have been through an active period of convalescence within a residential home, with the aim of enhancing their journey to independence within the community and ideally within their own home. This will impact on referral numbers into reablement, so the service will need to be ready to receive a potential increase in numbers into the services.

This alignment also requires careful development against the Reablement Service eligibility and accessibility as we must continue to ensure that only those that will benefit from a period of reablement are referred into the service. The development of the electronic navigation tool that is under development should assist with ensuring appropriate referrals into reablement through the Discharge to Assess model. This electronic navigation tool, used by acute hospital discharge teams once the patient is ready for discharge, enables consistent information to be gathered regarding the person's current health and social care status, which in turn enables the navigation tool to categorise the patient into the most appropriate community based service. This will assist with flow and timely discharges, as the Hospital Social Care Teams are not referred to within this pathway, instead the acutes are empowered to make a direct referral into reablement and have the electronic tool to ensure consistency of information can be forwarded that can act as the basis for any on-going assessment within the Reablement Service.

This navigation tool will develop throughout Warwickshire with the aim of maximising referrals from hospital into the Reablement Service, whilst ensuring that the referral is an appropriate one. Eventually, the navigation tool will be used to navigate patients to support the timely, safe and effective discharge of people with Long Term Conditions. A Common Care Plan across Intermediate Care, Reablement and

Supported Living staff and Health Community staff, Virtual Ward staff and Social Care and Support staff will also be developed within the navigation tool. Finally, an assessment and decision support tool kit which is shared across Health and Social Care (including, for example, Dementia early assessment tool, Nutritional tool, Falls Assessment tool, Quality of Life outcome tool) and supports the consolidation of compatible assessment information will also be developed. All of these developments within the navigation tool will assist the Reablement Service with throughput, volume and general flow, as information received will be consistent and assessments will be trusted and the need for duplication will be prevented.

4. Maintaining & Maximising Independence

The vision for reablement is to keep people at home for as long as possible post-reablement with little or no on-going support. This enables a person to live independently in an environment of their choice, which promotes feelings of well-being, achievement and self-worth. This will be evidenced through key performance indicators that measure targets and outcomes of reablement. The Adult Social Care Outcomes Framework (ASCOF) for 2013-14 has been launched by the State. The framework has been strengthened with new measures and has been further aligned with the NHS Outcomes Framework and the Public Health Outcomes Framework, supporting all parts of the health and care system to work together to support people to live better for longer. The ASCOF for 2013-14 will support councils to rise to the challenge of delivering main White Paper priorities by providing a clear focus for local priority setting and improvement and by strengthening the accountability of councils to local people.

Outcome 1 (Enhancing the quality of life for people with care and support needs) and Outcome 2 (Delaying and reducing the need for care and support) will be of particular focus for reablement's development and will be a valuable reflection of how the service is developing within its aims and objectives. One key area of delivery that the service must focus on is the 'revolving door' issue. Whilst the current performance levels are good (as outlined in page 2) with the percentage of people maintained at home post 91 days of receiving reablement, there is significant improvement needed for repeat admissions into reablement. This also relates to repeat admissions to the acutes, where a person's reablement programme may have been disrupted due to the customer requiring a return to hospital due to illness or injury. The service needs to target specific areas of service delivery within the service offer, such as falls prevention, that will contribute to maintaining a person's independence in the community and minimize the risk of readmission into hospital.

The Reablement Service needs to develop its focus around hospital admission prevention. Business Intelligence data suggests that since the Reablement Service went live in Warwickshire in 2010, referrals from the community teams have been low. More work is required around this to ensure that all eligible for Reablement are able to access it without becoming reliant on statutory provision too early. Direct

referrals into reablement from the Customer Contact Centre may enable this aim to be achieved. We must ensure that all customers that may benefit from a period of reablement are offered it before being offered a high cost service package of support that will instill dependency. This is a reflection of the People Group's Wedge application of service and support provision. The front door for customers' needs to be focused on advice, information, assistance (in any form from third sector, assistive technology, local businesses) to reflect early intervention and prevention and reablement should be used as a method for reversing people away from social care and support and towards a life of empowerment, independence and choice within their own community.

Focus also needs to be developed to enhance the customer's journey once reablement is coming to completion. Many customers will require an ongoing support package to respond to any longer terms requirements they may have post-reablement. The aim is to begin the customer's self-directed support process pre-reablement exit. This will reduce the number of 'hand offs' that the customer experiences and enables them to have the opportunity to take control of their ongoing support need through a personal budget or direct payment. At present, a high number of customers are placed onto a temporary support package whilst they wait for their self-directed support process to begin. This creates dependency and can be very destructive for the customer, whilst also reflecting high costs to social care.

5. Cost Efficiency & Sustainability

The vision for reablement is to deliver the service in a cost effective way that secures its stability in an ever growing period of financial uncertainty. This will involve streamlining the service to ensure the assessment process within reablement is lean and does not reflect duplication of assessments that have already been completed. Staffing capacity will be utilised fully to ensure that costs of the service reflect maximum service activity.

Until the funding picture becomes clearer in 2015, we will continue to do whatever we can to deliver the best outcomes for our customers within the Reablement Service, whilst continuing to meet savings targets.

Development is required to ensure that the reablement model of delivery within Warwickshire remains cost efficient and that the service costs do not outweigh the savings targets. It is also important to develop a service that is efficient in operation and that the unit cost is comprised of constructive contact time with customers. Detailed modelling is needed to plan the services future. This needs to incorporate from a cost perspective:

- Predicted service volumes and throughput once eligibility and accessibility is refined.

- Staffing establishment requirement to meet predicted level of need within the service.
- Consideration of utilising existing staffing resource within social care and support and reconfiguring these groups into the Reablement Service.
- Refining working practices to ensure constructive and effective work force.
- Development of working protocols and processes with other services (health, SIS, WEST, internal social work teams) to ensure that reablement is not duplicating service delivery and vice versa. This has cost benefits and personal benefits to the customer in terms of their journey through social care and support

Once the cost efficiency modelling is complete, a clearer picture will emerge regarding the Reablement Service's future. It will make clear what is required to make the service sustainable going forward in a period of significant financial and demographic pressure over the next two years. We can evaluate if the best model for delivering reablement remains in house within the authority and seek to explore any alternative models that may be more cost effective in the future.

6. Five years and onwards

It is vital to consider the medium to long term future of the Reablement Service. It is likely that the social care ethos for delivering prevention and early intervention support will continue to develop.

This strategy has outlined the funding pressures that will continue within the public sector and the expectation alongside this pressure of finding creative and innovative ways to keep people away from statutory provision. With demographics changing, resulting in an ageing population, the principles of reablement are likely to be the central focus for assisting people to live an independent life in their local community for as long as possible. This strategy has outlined how it plans to refine the model of delivery through eligibility and accessibility, whilst monitoring closely the costs of service delivery against the benefits and results within savings targets. The principle of providing more for less is imminent and the cost of reablement staffing may begin to outweigh the savings targets and the performance results expected. Difficult and challenging options must be considered for the future model, to ensure it is sustainable going forward.

Gerald Pilkington Associates ('Home Time' Pavilion conference 6th Sept 2012) explains that many councils that directly provide a reablement service are trying to seek cost efficient ways to deliver the service in the future and outsourcing the service is a realistic option. He says that councils must consider why and how they will outsource and it is crucial that the benefits outweigh maintaining the status quo of direct authority service delivery.

He sees that there are three elements that must be achieved to make the outsourcing successful:

1. Reduced cost of delivery
2. Improved performance
3. Greater capacity

He goes onto say that commissioning intentions must be central to outsourcing and that external providers must be held contractually accountable to ensure all of the above three elements are consistently met through service delivery and development.

There is evidence available from those local authorities that have outsourced their Reablement Service. CSED obtained a list of these authorities and emailed specific questions regarding their experiences of outsourcing. Common themes from these are as follows:

- The delivery of service within the external market has been successful overall and good results are evident regarding people remaining independent following their time in reablement.
- Service delivery is cheaper.
- Flexibility to integrate the outsourced reablement service with intermediate care teams to provide an enhanced customer journey.
- Relationships vary between council-owned staff (Occupational Therapists and Social Workers) and the external reablement service providers.
- Performance monitoring varies with external reablement service providers so results of the outsourcing are sometimes difficult to capture or evaluate.
- TUPE of staff must be carefully considered as this has the potential to impact on financial sustainability for the authority and the new service provider.
- It is important that the external reablement service provider does not have a conflict of interest. If the provider is responsible for also delivering on going traditional domiciliary care, there may be a vested interest to maintain a person's support post reablement. Therefore, a block contract purely for the delivery of reablement should be commissioned.

There is also evidence of local authorities entering into creative contracts as Local Authority Trading Company's (LATC) to deliver reablement services. Essex Cares[1] is fully owned by Essex Council, which set it up in 2009 to run that authority's home care, day care, equipment and employment support services. Unlike an in-house council service, it can trade commercially, develop new services and accept business from direct payment and self-funders. It made a profit of £3.5m in 2010-11 and paid a dividend back to Essex Council as the sole shareholder and its 2010-11 annual report announced plans to expand into running services provided by other local authorities. Since becoming the first council social care trading company in

[1] Community Care Magazine Article July 2012

2009, a number of other authorities have followed in Essex's footsteps, including Croydon and Barnet in London, and Wokingham.

Finally, a longer term more radical approach to reablement is to follow the Wiltshire model of social care. Professor John Bolton (‘Home Time’ Pavilion conference 6th Sept 2012) outlines their outcome based model which is named Help to Live At Home (H2LAH). This has taken two years to establish. The Wiltshire social care system has adopted a ‘reablement based’ approach to service and support. This results in a stand-alone Reablement Service not being required. In summary the model reflects all assessments being outcome focused, with the aim of retaining the customer’s independence. Providers receive payment by results and are fined by the commissioning authority if their performance results are below target. By being rewarded financially for results, reinvestment into workforce and quality can take place, which in turn enables results to be sustained. As result of this, outcomes based model, Wiltshire has reported a reduction of £1 million on domiciliary care during the first 6 months of the full operation of their new service. This is equivalent to 3% reduction of spend.

Implementation of the Wiltshire model requires the complete review of Warwickshire’s social care and support delivery, however this review may be achievable over the next five years and as evidence is already positive from an authority that has successfully achieved this, serious consideration should be taken to develop this for the future.

Delivering the vision

It is important that any strategy reflects how visions and key principles will be delivered. Two case studies are outlined to reflect how the Reablement Service vision will look in working practice. These case studies incorporate the principles within this strategy and show how, if applied, they can benefit the Warwickshire citizen to maintain their independence within their own home

Case Study 1: BETTY

Betty visits her GP as she has been having recurrent pain in her hips following a recent fall. An x ray reveals bad bruising but no long term damage. She tells her GP that this pain is causing her difficulty with daily living tasks, such as washing and dressing and that she is feeling less confident with her mobility. The GP gives her a prescription for the pain and makes a referral for Betty to Warwickshire County Council's Reablement Service. This just takes a telephone call to the Contact Centre who refer Betty straight through to Reablement.

The next day, the Reablement Team visit Betty and undertake an initial assessment. This identifies a service offer for Betty and focuses on daily living tasks – to wash and dress independently, falls prevention to prevent recurring falls, medication support, access to local community activities and money management.

The Reablement Support Workers assist Betty to achieve her goals within the service offer. Betty has the opportunity to access Age UK services and begins to feel part of her local community again. The Reablement Occupational Therapist prescribes a shower rail and a trolley to assist Betty to mobilize safely in her own home. The Occupational Therapist also prescribes 'good practice' guidance for Betty to promote safe movement to limit the risk of falling.

Within four weeks, Betty's confidence has returned, she is fully independent once more with her daily living tasks, including medication management, and she has some on-going support from Age UK to access her local community. She has met all of her goals and outcomes set within her Reablement Service offer.

Case Study 2: FRED

Fred was admitted to hospital following a stroke. The Hospital Discharge Team identified that Fred would be eligible for Reablement so they completed the navigation tool using their iPads. This resulted in a direct referral to reablement and the service confirmed within two hours of receipt of the referral that Fred could access the service the following day.

Fred was discharged the next day and was greeted at home by the Reablement Team. A 12 week service offer was created with Fred and it focused on developing independence with his daily living tasks, such as washing, dressing,

meal and drink preparation, medication, mobility and transfers. Reablement Support Workers worked in partnership with the Stroke Early Supported Discharge Team to ensure Fred's independence levels were promoted in all areas of his life. Reablement intervention complemented the therapy and nursing input from the Early Supported Discharge Team to ensure all of Fred's needs were met.

After 12 weeks, Fred's independence increased in all areas. He uses an automated pill dispenser to administer and self-manage his medication. At the eight week review, it was identified that Fred needed on-going support, so the Reablement Community Care Worker visited Fred following his review to begin the creation of his self-directed support questionnaire. Once complete, this was evaluated through the Resource Allocation System (RAS) and a funding amount agreed. Fred decided to take his funding as a direct payment and employs his good friend and neighbour to assist him with his on-going support needs.

The following areas detail how the key areas of the strategy will be delivered:

Improve quality and maximise independent living
Maximise people's potential to live independently in their chosen community by giving them access to the Reablement Service • Ensure that reablement eligibility maximises access into the service, all cases to be assessed on a case by case approach. • Develop a person-centred 'menu based' approach to service provision. This aims to respond to the holistic requirements of the customer and prepares them for an independent life post reablement. • Integrate reablement into the customer access model (see next bullet point). • Ensure customers are offered a self-directed support assessment at reablement exit point so that dependency on a temporary package does not occur. • Invest in Assistive Technology to support people to remain in their own homes and ensure that telecare and telehealth become an integral component of the reablement service offer. • Reablement to be offered as an 'additional service' to customers that have had an increased package identified. Reablement will work alongside existing support providers (to include WEST and SIS) to prevent permanent package increases. • Reablement to be offered to customers at their annual review where appropriate. • Ensure reablement is inclusive in nature and reflect equality requirements by offering support to people with Learning Disabilities, Mental Health needs, people with long term conditions, people with dementia, people that have experienced a stroke • Fully maximise the process of 'trusted assessment' so that the customer entering into reablement does not experience a duplication of assessment just to inform differing organisations of the same information.

Decrease the number of people unnecessarily admitted to long term care following a hospital stay

Assessment and decision making about people's long-term care needs will only be made only after they have had the opportunity for rehabilitation, recuperation and recovery

- Reablement to undertake a key role within the Discharge to Assess Pathway that is under development within the acute hospitals.
- Ensure that no one is transferred directly from an acute ward to long-term residential care without being offered a period of Intermediate Care and Reablement.
- Ensure that assessment, review and decision making takes place in a non-acute environment, following the opportunity for rehabilitation, recuperation and recovery. The effect of this intention will be to reduce the current number of individuals who are admitted to long-term bed based care directly from hospital. It will also have the potential to reduce the on-going financial requirement of statutory organisations.
- Implement and refine a unified navigation process (eCAT) at point of discharge which is trusted by all with appropriate information shared between partners

Prevent hospital admissions and support timely discharges

Individuals will receive their care in the right place, at the right time.

- Maximise reablement referrals at the front door stage for customers, maximising the direct referral links from the corporate Customer Support Centre into the service.
- Reablement will undertake a key role within the Discharge to Assess pathway under development within the acute hospitals. This will ensure that timely discharges from an acute setting into reablement can take place
- Direct access into reablement from the acute hospitals to be maximised to decrease the requirement for unnecessary assessments.
- Develop pathways to scope the benefits of primary care services having the ability to access reablement directly.
- Engagement with the CCG's so that reablement continues to be offered by Warwickshire County Council as a service to prevent admission into an acute setting.
- Undertake key developments to refine the reablement service offer to reduce repeat admissions into reablement within a 12 month period

Improve the skills and competencies of the reablement work force

Investing in workforce development will ensure reablement has the right skill mix of staff. This in turn will maximise throughput, volume and quality within the reablement service

- Reconfigure the Hospital Social Care Teams to be utilised in reablement to assist with the volumes and throughputs of referrals, once the Discharge to Assess pathway is established.
- Develop the assessment process within the service to offer the customer a menu type approach to service provision that is tailored to their goals and aspirations.
- Offer clinical reasoning support to Reablement Assessment Officers so that they can be fully skilled and experienced to tailor a support plan to each reablement customer.
- Offer specialist training (LTC, Stroke, and dementia) to ensure the service can appropriately respond to all customers that access reablement. This will ensure that the customer receives the maximum potential of the reablement service.
- Ensure that staff provide consistent advice and guidance on all aspects of the reablement service, from screening into the service, to review process during the reablement journey.
- On-going training for staff on FACs to ensure this appropriately applied at reablement entry and exit.
- On-going training on 3rd sector support so that customer is appropriately signposted if their needs are low to moderate post reablement.
- Training on the application and process of Self Directed Support and Individual Service Funds so that staff can promote these processes in readiness for them to be offered post reablement.
- Training on the application of Direct Payments, so that staff can promote this service in readiness for it to be offered post reablement.
- Training on the telecare and telehealth to ensure it is embedded within the reablement service offer.
- Review the current Home Carers' contracts to ensure they are being used effectively within the service.
- Refine clear protocols within the service to ensure that all staff are adhering to set standards within service delivery. To include the promotion of mobile working and IT equipment to assist with assessment throughput.

Performance management and KPI development

Monitor and evaluate quality, provide accurate reporting data and to inform future commissioning intentions.

- Develop and implement a robust performance management framework to ensure that future Reablement provision meets identified needs and achieves desired outcomes.
- Engagement with SWFT to develop the Arden Cluster dashboard that will report on flow, volume and throughput to analyse the effectiveness of reablement within specific pathways.
- Customer survey engagement to reflect and review service delivery and standards.
- Operational and service delivery targets to be discussed and applied through staff supervision to ensure targets are being met to reflect Reablements on going KPI development (for example number of referrals made to Assistive Technology, number of assessments and reviews undertaken per week.

Deliver cost efficiencies in order to meet current and future demand within existing resources

Within the current and future financial and political climate, both health and social care economies are tasked to provide best value services for the local population, within agreed budgetary constraints.

- Ensure that Reablement continues to meet its savings targets as set by the Transformation Programme.
- Undertake a full LEAN process of the current pathway within Reablement with the aim of reducing bureaucracy and increasing assessment throughput.
- Undertake a full review of reablement staffing to ensure volumes reflect service delivery need.
- Ensure cost effective service delivery and monitor outcomes of Intermediate Care and Reablement service to ensure that the service meets the desired outcomes of the individual and their carers.
- Ensure there is a robust financial monitoring framework which links service delivery to ensure that the service is delivered within the defined budget.
- Engage with acute hospitals to develop the financial tool to monitor joint initiatives such as Discharge to Assess pathway
- Pilot the use of hand held devises for reablement front line workers so that roster changes can be updated automatically and contact time can be monitored and maximised.

Five year programme consideration
As the social care landscape changes, questions need to be asked as to whether the delivery of the Reablement Service should be maintained within the Local Authority • Consider options for outsourcing the service. • Further research required on need and demand trend for reablement • Further research required on the results experienced by other local authorities that have already outsourced reablement. • Commissioning intentions must be clear to ensure external market can respond. • Further research required into the development of outcome based model of social care delivery.