ASC & Housing Overview & Scrutiny Committee	Agenda Item 23

Subject:		**Reablement**		
Date of Meeting:		**3 September 2009**		
Report of:		**Director of Adult Social Care and Housing**		
Contact Officer:	Name:	**Karin Divall**	**Tel:**	**294478**
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Key Decision:	No			
Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 In January, ASC & Housing Scrutiny Committee received a presentation about reablement and how it was being trialled within our homecare services. Scrutiny was updated about work that is happening nationally to implement re-abling homecare and the results of evaluation carried out across a number of authorities that showed very good outcomes for people who received re-abling homecare as opposed to traditional homecare.

1.2 Reablement is defined in Brighton & Hove as “Services for people with poor physical or mental health. To help them maximise their independence by learning or re-learning skills necessary for daily living.

1.3 Scrutiny asked for a further update and this report provides a summary of the progress made and outcomes achieved to date.

2. Recommendations

2.1 To note the progress made with rolling out Reablement.

2.2 To provide comments on any further developments that would provide improved service delivery.

3.0 RELEVANT BACKGROUND INFORMATION

3.1 Phased implementation of reablement took place with one team of about 20 Homecare worker volunteers, working alongside Care Managers and OTs. This joint assessment and provider team underwent a comprehensive training programme and work started in October 2008. This team took work from the Adult Social Care Access Point.

3.2 Building on this success plans are now underway to roll out reablement across the remaining in-house homecare service, and consultation with staff and unions is underway.

3.3 The success of this approach in Homecare then led to the strengthening and expansion of assessment for reablement and a proposal was developed to create a new team "Community Solutions" which included OTs, OT Assistants and Care Managers, and a Technician and a van. This team undertook a comprehensive training programme and on 30th March they started to take referrals from Access point. This new team carries out all the assessment work and provides equipment and enabling homecare for a period of up to six weeks.

4 PROGRESS UPDATE; HOMECARE- Independence at Home team.

4.1 For the period from 6Th Oct 2008 to 6th April 2009, 57 referrals were received by the Independence at Home team, of these, 48 people received reabling care, 24 people also received equipment.

4.2 The average length of service for those who completed their reabling care programme was 6 weeks (this is consistent with other reablement sites nationally).

4.3 The majority of people (38%) took between 4 and 6 weeks to complete their reablement.

4.4 163 items of equipment were prescribed, 24 people received some type of equipment as part of their reablement programme. Staff reported that having easy access to equipment increased the effectiveness of the service.

4.5 The success rate for those 48 people who received reabling care has been very high. 17 people needed no further care package and 12 people reduced their care hours. This amounted to an overall reduction of 123.75 care hours per week with an estimated saving of £2065 per week.

4.6 Service user feedback gave a generally positive response with most people being "extremely" or " very" satisfied, and nobody being less then "quite satisfied" with the service overall.

4.7 Service users were asked about the different elements of reabling care and asked to rate what had made a real difference to their lives. The aspects that scored highest were:

- equipment that helped with personal care tasks and
- care workers support with food preparation

4.8 Continuity levels were examined for a small sample of service users (7), this indicated that during the day, continuity was good. However evening calls were less consistent due to high staff vacancy levels on the evening service.

4.9 Five transitional care flats at New Larchwood were included in the pilot. 7 people were admitted during Phase 1, of these, 3 people with the intention of returning home, 4 with housing needs. Only 2 people needed the reabling care service. In both cases the level of care provided reduced significantly and remained at this lower level following reablement.

4.10 The service is entering a consultation phase with a view to transferring all staff to the reabling care service with new rotas that are designed to maximise continuity of care.

4.11 Some service user comments were:

- I couldn't do anything for myself (wash, dress) they were wonderful, I couldn't fault them. They gave me my confidence- I honestly thought I was finished as a person but they gave me that back. They showed me ways to do things despite being paralysed in one arm and hand. Positive feedback from carers was very important. I wouldn't be where I am now if it wasn't for them.
- They watched over me and just let me get on with it but that gave me the encouragement I needed.
- They explained what I should be able to do. Couldn't ask for anything better. Helped me to be able to cook on my own. Very very helpful

5. PROGRESS UPDATE COMMUNITY SOLUTIONS

5.1 The success of reablement in our homecare services then led us to trial reablement as a way of working for assessment staff, and the aim of the Community Solutions Team is to support people to maintain or increase their independence using resources such as Independence at Home Team re-abling care; Telecare; Carelink; Voluntary Organisations; Friends and Family etc

5.2 The Community Solutions Team is now established with a multi-disciplinary workforce consisting of ; 4 x Occupational Therapy Assistants (OTA), 3 x Care Managers (CM), 3 x Occupational Therapists(OT), 1 x Senior Practitioner and x1 Team Manager.

5.3 Since 31st March 2009 Community Solutions have been taking referrals from the Access Point for people who are new to Adult Social Care or whose case had been closed and they had returned for further services.

5.4 As of the 17th July 2009 the Community Solutions Team have taken approx 75% of all new cases referred through Access Point that required a Community Care Assessment i.e 276 cases out of a total of 350 cases. The other 25% being referred back to traditional services.

5.5 In June 2009 95% of all assessments were completed and services provided within a four week period with cases being allocated within one week from referral from Access Point.

5.6 Currently over 80% of clients receiving a package of care will have gone through the Independence at Home Team to receive re-abling care in order to maximise the person's independence prior to purchasing a service from an Independent Provider.

5.7 Care Managers within the Team have stated that previously where they may have set up a package of care to support a person whilst they waited for an Occupational Therapy Assessment they are now able to prescribe this equipment themselves or joint work alongside an OT within Community Solutions which often results in no package of care being set up at all.

5.8 The OTA's & Care Managers have undergone comprehensive training to provide a more responsive service which combines the skills of both the Care Manager & OTA with a focus on Outcomes for that person eg An assessor within the team has the tools to assess and provide re-ablement support plans which may include for example a Reablement Action Plan for meal preparation and personal care; for support to access the local shops and also the prescription of Daily Living Equipment to support the persons functional abilities ie Perching Stool.

5.9 This approach has proved very effective and has reduced the number of referrals to different teams for the same person. Previously this would have been referred to two different departments in Adult Social Care; Occupational Therapy Team for equipment needs and Older Peoples Community Assessment Team or Physical Disability Assessment Team for care needs.

5.10 All Community Solutions Staff are now trained as Enhanced Trusted Assessors (this includes Sensory Equipment).

5.11 As the combined skills of both OTA's and Care managers has been recognised as a more 'complete' role a new post of Independent Living Officer is being developed and has gone to Community Solutions Staff for consultation.

5.12 It is expected that the Community Solutions Team will expand proportionately to enable them to take 100% of all new cases coming through from Access Point and to provide a toolkit of resources to ensure more positive outcomes for people.

6. CONSULTATION

6.1 None

7. FINANCIAL & OTHER IMPLICATIONS:

7.1 Financial Implications:

Finance Officer Consulted: *Date:*

Legal Implications:

7.2

Lawyer Consulted: Date:

Equalities Implications:

7.3 Reablement services are working mainly with older people and the services have demonstrated improvements in people's well-being and independence.

Sustainability Implications:

7.4 The work of the team is for a period of up to six weeks and aims to increase people's independence and support people to live in their won homes.

Crime & Disorder Implications:

7.5 Reablement aims to improve people's confidence and independence and improve their access to social and community activities all of which improve people's feeling of security.

Risk and Opportunity Management Implications:

7.6 If we do not continue to develop reablement then we will not be in the best possible position in order to manage increased service demand and expectations in the future.

7.7 The local authority has received funding to implement "Personalisation" and a failure to roll out reablement will mean that we do not deliver the required transformation of services.

Corporate / Citywide Implications:

7.8 Reablement services work across the City

8. EVALUATION OF ANY ALTERNATIVE OPTION(S):

8.1 The alternative would be to continue to deliver traditional services, this would mean that we could not meet increasing demand and expectations.

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