Agenda Item No: 4

ADULT POSITIVE CHALLENGE REABLEMENT WORKSTREAM

To:	**Adults Committee**
Meeting Date:	**4 July 2019**
From:	**Service Director: Adults and Safeguarding**
Electoral division(s):	**All**
Forward Plan ref:	**N/A** *Key decision:* **No**
Purpose:	**To provide an update on the Adult Positive Challenge programme with an in-depth look at the Targeted Reablement work stream, and to provide an update on the development of key metrics to monitor progress.**
Recommendation:	**The Committee is asked to consider the content of the report and note the work underway in the Reablement work stream.** **The Committee is asked to note the progress on tracking the impact of the programme and benefits achieved so far.**

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1. BACKGROUND

1.1 The Adult's Positive Challenge Programme vision is that by 2023 local people will drive the delivery of care, health and wellbeing in their neighbourhoods, delivering a financially sustainable service which will enable a neighbourhood approach which supports more people to live independent and fulfilling lives for longer.

1.2 The Adults Positive Challenge Programme has eight work streams in total which all interact positively with each other in order to deliver the overall change, outcomes and financial benefits;

- Neighbourhood Based Operating Model
- Increasing Carers Support
- Embedding Technology Enabled Care (TEC)
- Changing The Conversation
- Commissioning
- Targeted Reablement
- Learning Disability Developing An Enablement Approach
- Review of Panels

Funding of £3 million has been identified by General Purpose Committee to support transformation proposals to deliver these work streams.

1.3 There are regular updates for Committee scheduled to provide detail on progress on the Adult Positive Challenge Programme. This update provides a deeper dive insight into the work being undertaken in the Targeted Reablement work stream and also provides an update on progress in developing key metrics which to monitor the impact of the programme.

2. MAIN ISSUES

2.1 <u>Targeted Reablement</u>

2.1.1 Targeted Reablement is one of the work streams within the Adults Positive Challenge Programme. For 2019/20 the overall financial benefits delivery target from Cambridgeshire is £3.8 million, with the reablement work stream targeted to achieve around £1.3 million of that total.

2.1.2 The diagram below shows how targeted reablement sits within the wider Adults Positive Challenge programme.

2.1.3 The provision of reablement services is covered by The Care Act 2014 Care & Support Statutory Guidance, Section 2, Preventing, reducing or delaying needs.
This states that local authorities, with social care responsibilities, must provide or arrange services, resources or facilities that prevent, delay or reduce individual's needs for care and support, or the needs for support of carers.

2.1.4 Reablement services are a key element of delivering on this agenda. The act states that where reablement is required, it must be provided free of charge for a period of up to 6 weeks and applies to all adults, irrespective of whether they have eligible needs for ongoing care and support. The Act states that whilst the local authority does have the power to charge for this where it is beyond six weeks, local authorities can consider continuing to provide beyond six weeks free of charge if there are clear preventative benefits to the individual.

2.1.5 The primary objectives of the reablement services across Cambridgeshire & Peterborough are to:

i. Enable individuals to remain living in the home, and community, of their choice for as long as possible whilst maintaining their optimum level of independence
ii. Provide personalised, time limited support for individuals which helps them to meet their aspirations and agreed goals, supports carers, and allows them to exercise choice and control.
iii. Deliver targeted, outcome focussed, interventions that prevent and reduce the need for long term care and support in line with comprehensive service criteria
iv. Facilitate discharge from hospital at the optimum time for the individual thereby reducing delayed transfers of care within the acute and community hospitals
v. Ensure that ongoing care needs upon discharge from reablement are at the point when the individual has reached optimum levels of independence.
vi. Reducing costs for the Councils in terms of managing demand through Adult Early

Help where reablement is the default before any long term care is considered.

vii. Reducing the financial cost to the Councils where reviews of service users have identified that a period of reablement may achieve a reduction in their existing care package or reduce the need for increased purchased care provision

2.1.6 Supplementary services are those which are delivered by the reablement services but are in addition to the standard reablement offer. These services include:

i. **Domiciliary Care** prior to and/or following a period of reablement whilst ongoing domiciliary care is sourced (referred to locally as "bridging"). This would be chargeable.

ii. **Reablement Flats** specialist care facilities for those who meet the reablement criteria.

2.1.7 The Reablement services in Cambridgeshire and Peterborough are working successfully with many people supported to retain longer term independence and maximised outcomes. However current data to show levels of independence after Reablement suggests that Reablement are working with a cohort of people who may be more capable, or who could recover without reablement support. This would suggest we could target resources on those who would benefit most and therefore provide a higher demand management impact. This provides evidence for potential improvements that will increase the impact of Reablement by targeting the service towards specific cohorts.

2.1.8 The Reablement work stream is addressing this issue by focussing on maximising outcomes, aligning capacity to clients who will benefit the most, and creating a consistent Reablement model across Peterborough and Cambridgeshire. The proposed changes will increase the impact of the Reablement service.

- Cambridgeshire has a higher proportion of people receiving Reablement than their statistical neighbours (23% compared to comparators 10%). This confirms that the service makes a strong contribution as part of the health and social care system and the capacity to maximise outcomes and increase effectiveness.
- In Cambridgeshire over half of clients going through Reablement services leave without any ongoing care (56%). Although it is positive that clients do not have any ongoing care needs, this could demonstrate that the service is working with clients with low needs who may have recovered anyway, instead of targeting the service to more complex clients who may benefit more.
- A significantly lower proportion of people receiving reablement in Cambridgeshire are already receiving Council funded care and support (4%) than in statistically neighbouring areas (10%). The high number of new clients is due to the service providing a high level of support to the hospitals and providing a discharge pathway and a response the capacity issues within the domiciliary care market. There is a significant opportunity to work with an increased number of existing clients to maximise their independence and reduce current or future dependency on adult social care support. This is supported by the fact that in 2018/19 of the 88 clients with existing Council funded care and support that went through reablement 24 (27%) on completing their period of reablement required no further long term care and support.
- In Cambridgeshire, the service is using a high proportion of hours providing "bridging care", supporting hospital discharge due to the lack of capacity in the domiciliary care market. This was part of the rationale for the expansion of the Reablement service, but reduces the capacity available to deliver reablement to those who might benefit.

Anticipated Outcomes or Impact of the Workstream

2.1.9 The anticipated outcomes for the Reablement workstream are as follows:

1. Improving the quality of life of service users and supporting people to remain as independent as possible for as long as possible
   - Reablement improves independence, prolongs people's ability to live at home and prevents or reduces the need for social care. This opportunity will expand these benefits to existing service users and those with long term conditions such as moderate learning disabilities, supporting them to maximise their independence and reach their potential.
2. Cambridgeshire and Peterborough have a targeted Reablement service that maximises outcomes for clients
   - Reablement reduces, prevents and delays the need for ongoing care by keeping people independent in their homes and reducing the need for long term care and support.
3. All Reablement support is focused on 'reabling' and improving people's outcomes:
   - Every individual has personalised goals set and an action plan that they work towards with Reablement staff to achieve the goals
   - Reablement is not used as a bridging service and staff spend the majority of their time supporting residents to achieve their outcomes
4. Reablement supports the appropriate clients to increase their independence regardless of their entry route
   - Reablement is incorporated into a range of service pathways, including hospital discharge, planned reviews and community referrals.
   - Reablement consideration is incorporated into behaviours and culture so that the service pathways into reablement are followed
5. Reablement are enabled to maximise capacity and increase efficiency of the service
   - Reablement have the training and equipment necessary to perform their roles and provide accurate and consistent performance information
6. There are clear expectations around levels of 'bridging' care in the Reablement service through the creation of a shared service specification
   - Reablement will significantly reduce the volume of bridging to improve outcomes (20% bridging is the target but reliant on commissioning outcomes for domiciliary care)
   - Commissioning will work to stimulate the domiciliary care market

2.1.10 The workstream has designed the following key performance indicators to capture the performance of the workstream:

- RBT 1 Number of people leaving reablement with reduced or no care outcomes
- RBT 2 Number of people leaving reablement with no long term care
- RBT 3 Number of completed reablement episodes
- RBT 4 Number of existing clients receiving reablement
- RBT 5 Percentage of capacity utilised for direct reablement delivery
- Savings attributed to reablement

2.1.11 These KPIs capture the progress on the workstream's key ambitions to:

- Have a more efficient service with a greater proportion of time and capacity to be used directly delivering reablement
- Have a more targeted service which has an increased number of referrals from the communities to reduce the needs of existing service users.
- Have greater parity between CCC and PCC Reablement Services

2.1.12 In order for us to achieve our goal of targeting reablement where it makes most impact there will also be using locally captured qualitative information. For example rather than setting a metric to monitor the number of repeat recipients of reablement with view to setting a limit on how many times the service can be received, we instead wish to have clarity around when a repeat reablement episode is provided in response to a different driver.

2.1.13 Case example
Mrs Smith has a fall at home and is admitted to hospital, she is diagnosed with a urinary tract infection resulting in confusion and ultimately the fall. Mrs Smith is treated in hospital for the urinary infection and has some pain management for severe bruising on her hip from the fall. She is discharged after a week and has some reablement to help her get back on her 'usual' level of independence and confidence in undertaking daily activities. The reablement episode ends with the outcome of no long term care. 4 months later Mrs Smith is admitted to hospital having suffered a mild stroke. She is in hospital for 2 weeks after which time she has regain most of her former functioning ability but she still has slight paralysis on her left side. Mrs Smith is an appropriate candidate for reablement as it will be targeting a new need and the likelihood of success is as high as for anyone in the same situation.

2.1.14 We will be collecting case examples from the reablement services to support our tracking of savings and KPIs in order to really understand the rounded impact of the work stream.

Work stream Project Plan

2.1.15 The initial priority of the work stream was to develop a shared specification for CCC and PCC Reablement services. The specification focuses on the aims of the service and the outcomes expected from reablement interventions without being prescriptive about the models of service delivery used to achieve those outcomes. The specification provides a basis for service delivery in relation to all elements of reablement, and includes key performance metrics against which services will report so as to achieve aligned and consistent outcome reporting across the two local authorities. The specification was agreed and signed-off by March Adults Positive Challenge Programme Board. The specification is attached as Appendix 1.

2.1.16 The subsequent focus of the work stream is divided into three key areas:

1. An in-depth review to identify process and practice changes that will reduce bridging.

   This will consider:
   - Referrals data for Cambridgeshire and Peterborough
   - The length of time bridging arrangements are in place

- Whether there are changes to process or practice in the Brokerage Service that could reduce level of bridging.
- Whether changing the conversations that reablement workers have will impact on the level of bridging.

2. A review to identify the opportunities to increase numbers of community referrals

   This will involve:
   - Reviewing the referrals data
   - A series of engagement with teams that could be a source of targeted reablement referrals.

3. Making the best use of resources to maximise reablement impact

   - Taking forward early discussions about how roles and responsibilities could be adapted to better meet the needs of a place based approach in future taking forward the learning from Neighbourhood Cares.

2.1.17 To support the achievement of the outcomes Cambridgeshire will be implementing a new mobile working solution for the reablement service staff. This is anticipated to create improved productivity and release capacity for direct service delivery, and includes the following two systems:

Mobilise: A mobile app which integrates with the Adults Social Care case management system, Mosaic, meaning front line workers appointments, key summary information, progress notes and assessment forms will be available on their mobile device. Any assessment forms or other data entered via the mobile device will be synchronised into Mosaic whenever the device is within range of Wi-Fi or a mobile signal.

Optimise: A dynamic appointment scheduler which follows pre-determined rules based on skills, needs and locality. This will release capacity by reducing the work involved in workers getting changes to their schedules or needing to return to their base as frequently.

2.1.18 Case Examples

The following case examples illustrate how reablement services have delivered outcomes recently:

Case 1
Adult Early Help referred a service user who was having digestive problems. The health issue made it difficult for her to manage her personal care and she was very low in mood due to discomfort. Her husband had his own care package but she did support her husband with meals etc.

The Reablement service were able to motivate and support her. She was given a long handled sponge to help with washing lower legs and feet whilst in the shower. The long handled sponge helped her with the lower half washing when she wasn't feeling well.

Reablement discharged as independent after a total of 10 days of reablement input.

Case 2
Referral from Intermediate Care Team (ICT) who had been delivering 4 calls daily, due to health concerns. Once the service user had stabilised ICT referred to Reablement to assist with lower half dressing including socks.

Reablement started the once daily care and the lead worker identified the need for a sock aid and was able to demonstrate how to use it. The service user managed very well with the sock aid and his wife said it had made a lot of difference as he would always ask his wife to put his socks on.

Reablement discharged as independent after a total of 30 days of reablement input

2.2 How are we measuring impact of the Adult Positive Challenge Programme

2.2.1 The Adult Positive Challenge Programme impact is being measured in a number of ways to reflect the complexity of the programme. We are seeking to ensure that we capture both financial and outcome impacts via both top down monitoring and perhaps more importantly the sharing of individual outcomes from the front line delivery.

Financial Impact

2.2.2 Tracking the financial benefit of this programme is challenging as we are mainly working to avoid or mitigate increases in demand, and so we using a two-pronged approach – tracking savings captured by the individual workstreams, as well as looking at the overall change in forecast spend to validate that those savings are real.

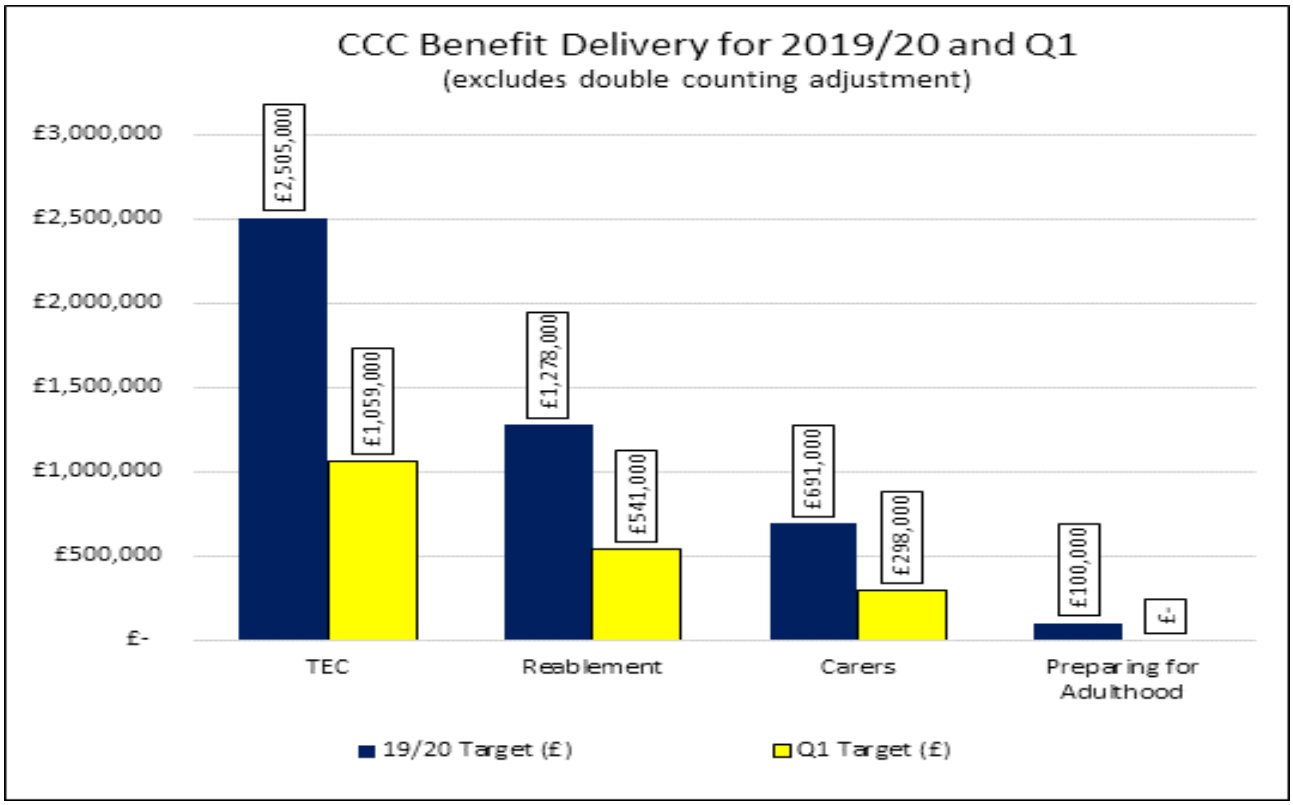
2.2.3 There is a risk of double counting in this approach as a person may receive interventions from several workstreams, such as TEC and Reablement. We have estimated the impact of this as part of the original savings modelling and will adjust for it when tracking savings. The work streams individually have been set targets for cost avoidance which total £4.6 million, which allows for £800k (17%) of double counting overall, and the monitoring of the overall expenditure trajectory will provide further assurance that savings are not over-reported

2.2.4 The estimated profile of the saving is:

2.2.5 Over the first quarter, this process will be refined and tested against actual expenditure information, and will form part of the service forecasts reported to Committee in the Finance and Performance Report bimonthly as well as in the Savings Tracker quarterly.

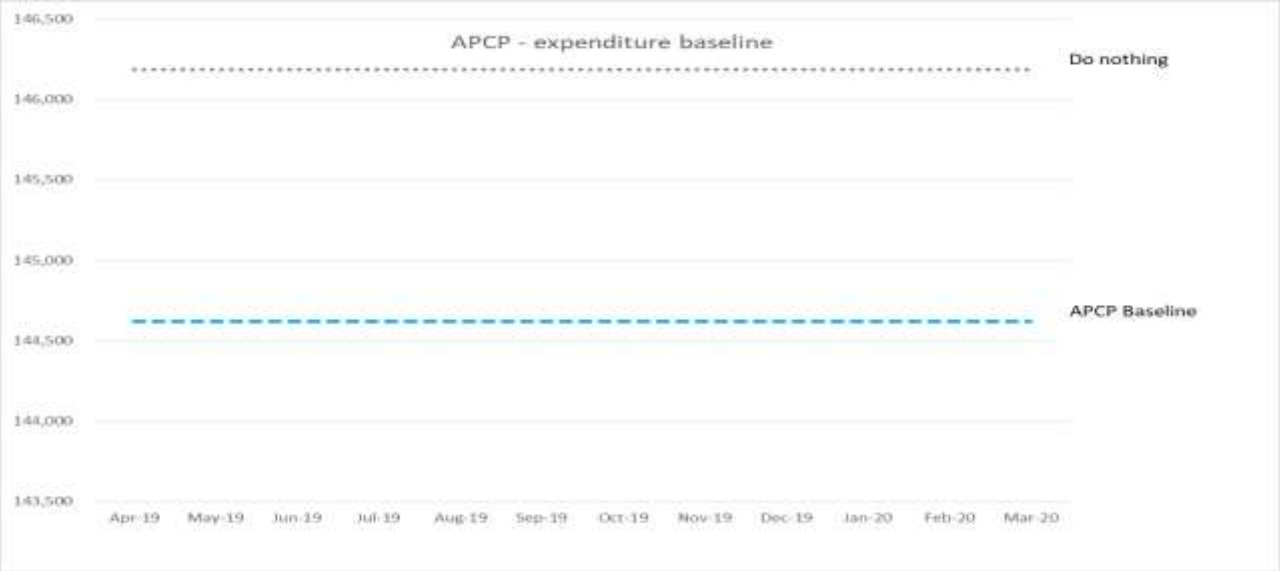
2.2.6 Financial savings delivered by the work streams are captured at individual work stream level using the agreed financial impact criteria, with adjustment made by finance team to mitigate the effect of double counting, where more than one work stream might have affected the benefit.

The graph below shows the target against each workstream.



2.2.7 Overall forecast spend against plan at a service level will be used to triangulate the savings reported by each workstream and give a ‘top-down’ view of how the programme is performing against budget.

2.2.8 To be on track, we would expect the overall forecast spend on care each month to track the blue line:



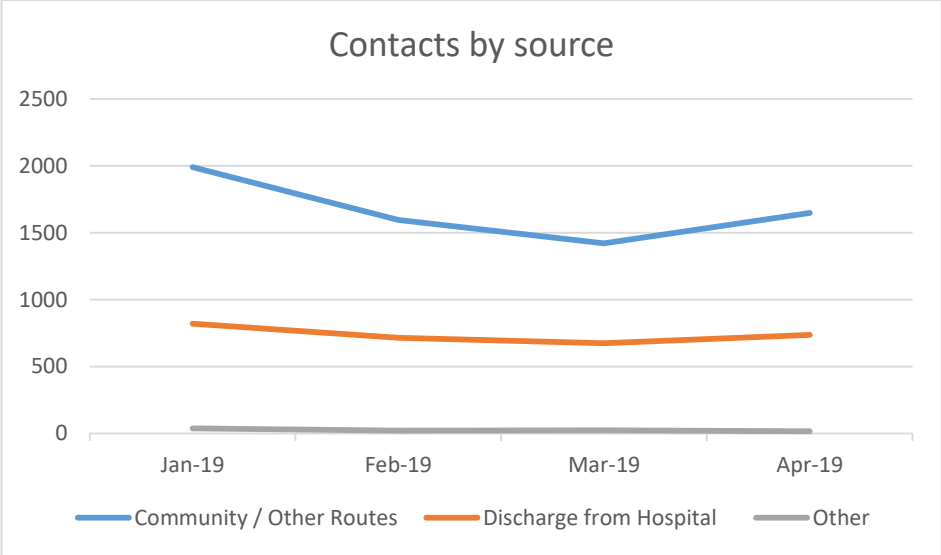
2.2.9 There will be a number of other things impacting on care spend as well as the work of this programme, however, particularly the impact of price increases. We will therefore be tracking an estimate of forecast spend based on original prices as well as overall forecast spend, to try to isolate the impact that this programme is having.

Impact on key service flows

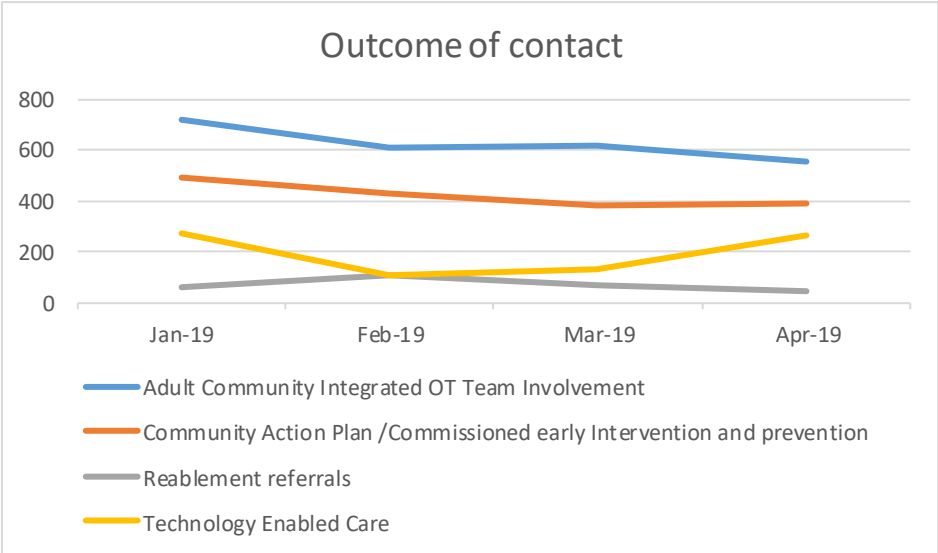
2.2.10 Impact is also monitored by tracking changes in demand activity and flow through adult social care pathways. This is in order to determine whether the action we are taking have the impact in the areas of demand we anticipate.

2.2.11 The graphs below illustrate the key service flows we are tracking.

Contacts by source



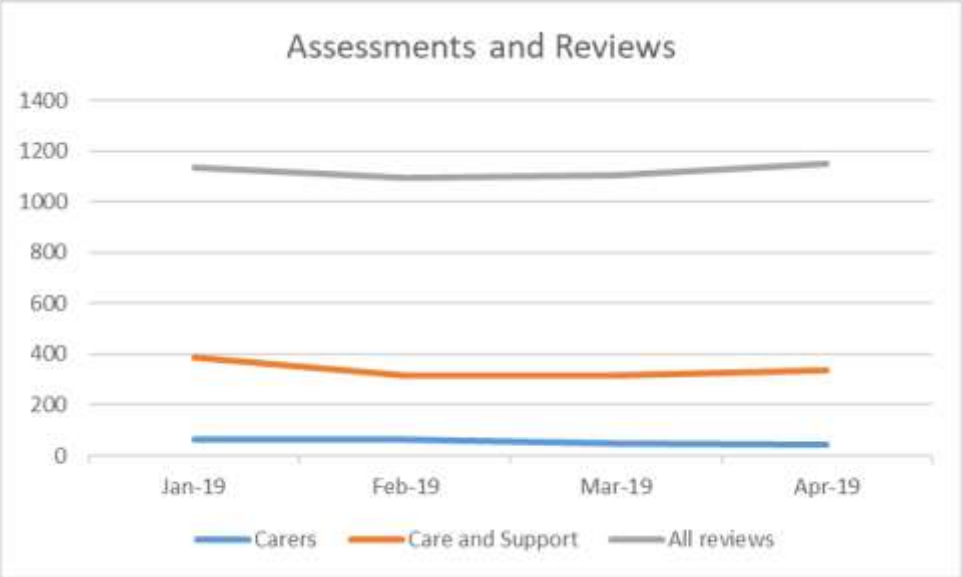
2.2.12 Other referrals include self-funders with depleted funds, transitions and hospital diversion. Contact outcomes – the outcome following the intervention at the initial contact. The outcome expected from the programme would be over time to see a decrease in community contacts as residents find support options for themselves via alternative routes, including on line information and Community / VCS organisations. The trend for community contacts, the blue line in the graph above, has been downwards from January 2019, all be it with a slight increase in April.



2.2.13 The graphs illustrates only the outcomes which are specifically impacted by the programme. There has been a decrease in contacts passed through to Occupational therapy but an increase in contacts referred on the TEC. Community Action Plans and commissioned early

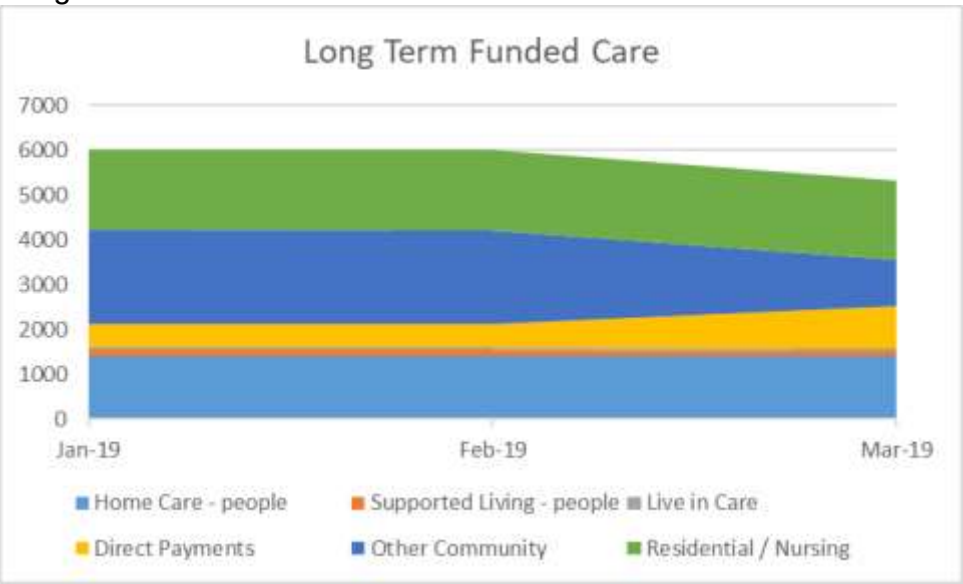
intervention and prevention outcomes are down, as are reablement outcomes. Overall we would expect to see an increase in TEC and Reablement outcomes, although a decrease in Community Action Plans might be evidence of residents and communities determining their own solutions without making contact with the Council.

2.2.14 Assessments and Reviews



2.2.15 The graphs illustrates and the position on carers assessments in blue, care and support assessments in orange and reviews in grey. Showing a general decrease in assessments and a slight increase in reviews in line with the programme. The position on carers assessment is quite static but mostly reflects the position prior to the carers work stream entering the delivery phase.

2.2.16 Long Term Funded Care



2.2.17 The graph illustrates that overall the number of people receiving long term Council funded care is down, in line with the goals of the programme. Some of the decrease in “other

community" and increase in "direct payments" is likely to reflect some data quality changes where direct payments had been previously captured as other community.

KPIs – To track key work stream impact

2.2.18 Key Performance Indicators have been identified to track whether the changes implemented by work streams are having the impact on activity or outcomes that is expected. Some of these KPIs are collected currently and others are being developed as part of the implementation of changes themselves.

2.2.19 At this stage three of the work streams are mobilised to an extent that impact can be tracked in operation. These are:

- Changing the Conversation
- Technology Enabled Care
- Targeted Reablement

2.2.20 Although the carers work stream is mobilised in respect of the transfer of operational staff back into the Council the fact that recording has only just changed from April has impacted the availability of the metrics for the beginning of the financial year.

2.2.21 The following KPIs are already in place and being monitored.

Changing The Conversation

2.2.22 The work stream recognises that much of the current review activity currently is the result of responding to unexpected events. These reviews are difficult to plan for and at the time of a health or family crisis it is not always best time to have a strengths and asset based conversation which leads to an innovative and flexible care and support plan. The work stream aims to change the model of how we target reviews, to plan in reviews more flexibly linked to the potential for changing support needs for the individual concerned. Getting this right should lead to an increase in planned reviews and a decrease in unplanned (crisis response) reviews.

Metric	Outcome	Monthly Ave	Latest	Monthly Trajectory	Annual Trajectory
CTC1. Number of unplanned reviews	Decrease	28	53		
CTC2. Number of reviews where planned / unplanned status is unknown	Decrease	963	977		

2.2.23 The reviews indicators CTC1 and CTC2 are currently reflecting the case migration into Mosaic. As all first reviews have to be recorded as an assessment these cannot indicate whether the review was planned or unplanned, hence the large number recorded in indicator CTC2 as unknown. Over time this should reduce to minimal numbers, whilst indicator CTC1 increases and then stabilises / reduces reflecting our overall goal to better target planned reviews in order to prevent unplanned reviews arising for client crisis.

2.2.24 **Technology Enabled Care**

Metric	Outcome	Monthly Ave	Latest	Monthly Trajectory	Annual Trajectory
TEC1.Number of TEC referrals	Increase	264	352		
TEC2.Number of items of telecare technology issued that facilitates independence	Increase	380	484		

2.2.25 The TEC promotion carried out has significantly increased the number of referrals to the service and subsequently the number to items of TEC issued.

2.2.26 **Targeted Reablement**

Metric	Outcome	Monthly Ave	Latest	Monthly Trajectory	Annual Trajectory
RBT1. Number of clients completing reablement with reduced / or no ongoing long term care and support	Increase	126	148		
RBT2. Number of clients completing reablement with no ongoing long term care and support	Increase	114	128		
RBT3. Number of clients completing reablement within the month	Increase	200	204		

2.2.27 Measures RB1 and RB2 both evidence the impact of reablement in relation to long term care and support need. In total 148 people completed reablement with either reduced care and support needs (20) or no further care and support needs (128), both higher than average and on an increasing trajectory. As we see an increase in the numbers of people with existing care and support plans be referred into and benefitting from reablement we expect to see a slight swing in the balance between those ending with reduced and no care and support needs. However overall numbers (RT1) should increase.

2.2.28 RBT3 shows the numbers of all clients completing a period of reablement. This is in order to track whether the capacity within reablement is being used to sustain growth in the service. In April the number dipped slightly from 211 to 204, reflecting the amount of capacity being used for bridging, it remained higher than the monthly average however, indicating that we are moving in the right direction.

The following KPIs are in the process of being implemented

2.2.29 **Changing the Conversation**

Metric	Outcome	Comments
CTC3.Proportion of new client contacts where the recorded outcome is long term support (under development)	Decrease	The reporting of these metrics has been constrained by the migration to the new Mosaic care management system and the need to finalise migration of care package information in order to report on some indicators. A report to track outcomes at the front door is being developed to track outcomes from front door contacts.
CTC4. Proportion of audited cases where community assets are evidenced as part of the care and support plan (under development)	Increase	There is a new monthly Team Manager audit which will capture information for indicator CTC4, around evidence of community assets as part of care and support plans.

2.2.30 **Technology Enabled Care**

Metric	Outcome	Comments
TEC3. Number of referrals for double up reviews. (under development)	Increase	The third key metric seeks to track the work the team does around high cost double up packages, this is an indicator that will be able to be reported once care packages data is migrated to Mosaic in order to clearly match referrals to double up (2 carer) packages were in place.

2.2.31 **Reablement**

Metric	Outcome	Comments
RBT4. Number of existing clients receiving reablement (under development)	Increase	Measure RBT4 will allow tracking of how may clients already in receipt of long term care and support are referred into the service, either to reduce back the care and support provided in excess of need, or to prevent further deterioration. In 2018/19, 88 existing clients went through reablement, 24 of those completed reablement with all long term support ended, due to having no ongoing eligible needs
RBT5. Percentage of capacity utilised for direct reablement delivery.	Increase	Measure RBT5 will allow tracking of how much of the available reablement capacity is used to deliver reablement versus “bridging” domiciliary care. This will enable the goal of ensuring reablement capacity is focussed on delivering the right type of care to be tracked.

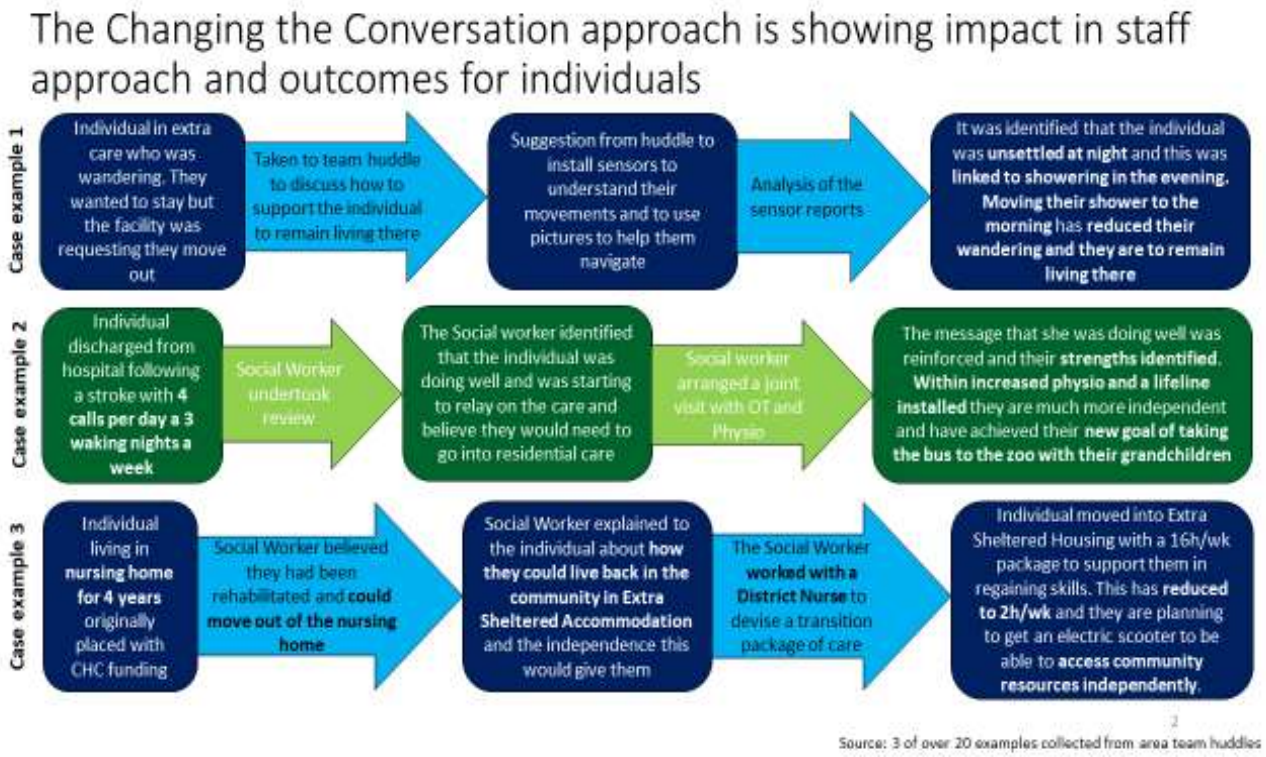
Locally collected outcomes to track impact on individuals

2.2.32 One of the key elements of the Adult Positive Challenge Programme is bringing practice challenge and reflection into everyday working practice. As such Managers and workers are encouraged to collect and share their successes.

2.2.33 To support this a tool has been created for Huddles to capture specific cases where they feel a real difference has been made.

2.2.34 There is also a tracker for Team Managers to use to track cases they are aware of that have resulted in better outcomes due to a specific strengths and asset based approach.

2.2.35 The case studies below are examples of case specific outcomes which have been identified.



3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 A good quality of life for everyone

The Adults Positive Challenge Programme and Reablement services actively seek to improve quality of life for recipients by enabling them to remain independent and in control of their own lives as far as possible, whilst providing helpful advice and training to effectively support the mitigation of risk.

3.2 Thriving places for people to live

There are no significant implications within this category.

3.3 The best start for Cambridgeshire's Children

There are no significant implications within this category.

4. **SIGNIFICANT IMPLICATIONS**

4.1 **Resource Implications**

The report above sets out details of significant implications in paragraph 2.2.2 to 2.2.7

4.2 **Procurement/Contractual/Council Contract Procedure Rules Implications**

There are no significant implications within this category.

4.3 **Statutory, Legal and Risk Implications**

There are no significant implications within this category.

4.4 **Equality and Diversity Implications**

There are no significant implications within this category.

4.5 **Engagement and Communications Implications**

There are no significant implications within this category.

4.6 **Localism and Local Member Involvement**

There are no significant implications within this category.

4.7 **Public Health Implications**

There are no significant implications within this category.

Implications	**Officer Clearance**
Have the resource implications been cleared by Finance?	Yes Name of Financial Officer: Stephen Howarth
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Yes Name of Officer: Gus De Silva
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Yes Name of Legal Officer: Fiona McMillan
Have the equality and diversity implications been cleared by your Service Contact?	Yes Name of Officer: Charlotte Black

Have any engagement and communication implications been cleared by Communications?	Yes Name of Officer: Mathew Hall
Have any localism and Local Member involvement issues been cleared by your Service Contact?	Yes Name of Officer: Charlotte Black
Have any Public Health implications been cleared by Public Health	Yes Name of Officer: Tess Campbell

Source Documents	**Location**
None	