

Joint Reablement and Intermediate Care Strategy for Wolverhampton

2014- 2016



**Wolverhampton City
Clinical Commissioning Group**



Foreword

This strategy details the reablement and intermediate care intentions of Wolverhampton's health and social care economy.

Our aim is for the principles, outcomes and metrics to instil a preventative philosophy, which will require a change of investment and approach in order to maximise opportunities for independent living.

The plan describes our key development areas in response to this changing landscape and supports the ambition of our Better Care Fund, which is to deliver the Right Care in the Right Place at the Right Time.



**Wolverhampton City
Clinical Commissioning Group**



Introduction

In the summer of 2011, Wolverhampton launched its first Reablement Forward Plan, articulating its commissioning intentions with regard to reablement activity over the following two years. Over this time, there have been significant changes across the health and social care economy, not least the implementation of the Health and Social Care Act 2013.

In response to these changes and through discussions at the Adult Delivery Board, health and social care partners have identified the need to expand the reablement plan to include health based intermediate care services.

The purpose of this refreshed document is to expand the scope of the original plan by including intermediate care; updating the governance and outcomes framework to reflect the changing priorities, and set the framework for the construction and delivery of work programmes going forward. The document also highlights a number of best practice examples and articulates a Principles Framework that will guide reablement and intermediate care activity in Wolverhampton for the next two years.

What is Intermediate Care?

The Department of Health released the original Intermediate Care guidance in 2001 and released updated guidance, Intermediate Care – Halfway Home, in 2009 which sets out the national requirements for intermediate care. This guidance provides the following definition for Intermediate Care:

“Intermediate Care is a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long term residential care, support timely discharge from hospital and maximise independent living”

Intermediate care services can be defined as meeting the following criteria:

- They are targeted at people who would otherwise face unnecessary prolonged hospital stays or inappropriate admission to acute inpatient care, long term residential care or continuing NHS inpatient care
- They are provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery
- They have a planned outcome of maximising independence and typically enabling patients and service users to resume living at home
- They are time limited, normally no longer than six weeks and frequently as little as one to two weeks or less

What is Reablement?

The term reablement defines the use of timely and focussed intensive therapy and care in a person's own home in order to enable them to remain or return to living independently. This approach focusses on optimising people's independence with the lowest appropriate level of ongoing support and care.

National and Local Guidance and Research

In the context of a 26% contraction of public sector budgets, there are a number of factors driving the further development of reablement and intermediate care activity.

First and foremost, maximising independent living is a vital component of improving the health and wellbeing of the population and raising the quality of services people receive. Intermediate care and reablement activity is seen as being central to providing timely, appropriate, enabling and empowering care to individuals

The conclusions reached by the Care Services Efficiency and Delivery Programme from their national studies (CSED, 2007 & 2010) have had the biggest influence on the development of reablement activity. These can be summarised as follows:

- Domiciliary reablement delivers a 60% reduction in on-going social care service usage (and cost)
- Two thirds of reablement users required a reduced or no service response after their reablement intervention.
- Two thirds of reablement users were still managing without a service two years after their reablement intervention
- One third of those who needed an on-going package had reduced or maintained that package.

In addition, the Social Care Institute for Excellence (SCIE 2012) reached the following conclusions from its review of the reablement research:

- Reablement leads to improved health and wellbeing
- Reablement improves outcomes and reduces expenditure on on-going support
- There is no single leading delivery model
- Government investment in reablement could lead to more joint working and funding between health and local government
- Assessment and goal planning are integral to people achieving their individual aims
- Occupational therapists have a key role in the provision of reablement and can assist in on-going reablement activity for people with complex conditions
- More evidence is needed on how reablement influences outcomes in different models of delivery
- Research suggests that customer satisfaction can be high from a well-run reablement service

In January 2013, the University of Birmingham hosted a Social Care Evidence in Practice workshop on the topic of reablement. This workshop reported on the first phase of an academic study, which included a survey of Directors of Social Services followed by interviews with identified intervention leads. It delivered the following research headlines:

- 4 out of 9 studies available nationally have been produced or commissioned by CSED - the national promoter of reablement
- There is much repetition of data from key studies and the volume of research is extremely limited
- The long-term nature of the studies is very limited – a 2 year follow up was never carried out
- There has been very little focus on a variety of user target/sub groups: for example, people with dementia
- The cost impact for carers has not been considered in any of the studies

The overarching conclusions from this workshop were:

- Reablement activity has large upfront costs
- Reablement is more expensive than traditional home care but leads to reduced service usage and better individual outcomes
- Reablement is potentially cost effective over time but more research is needed

For such a visible intervention this lack of research evidence highlights a challenge for practitioners in using an evidence base to inform current practice and develop services.

Demography

This driver can be summarised as more people to serve with less money. The value of reablement and intermediate care lies in the potential to decrease the demand for publically funded services, whilst at the same time delivering positive quality of life outcomes for service users and patients - in short, doing the right thing for the right reasons.

Older people are by far the largest user group of publically funded services, and this population is growing.

<i>Wolverhampton population aged 65 and over</i>					
	2012	2014	2016	2018	2020
People aged 65-69	11,400	11,500	11,900	11,500	11,300
People aged 70-74	9,600	9,800	9,900	10,500	10,700
People aged 75-79	8,200	8,400	8,400	8,400	8,600
People aged 80-84	6,500	6,400	6,400	6,600	6,800
People aged 85-89	3,800	4,000	4,200	4,300	4,400
People aged 90 and over	2,000	2,300	2,500	2,800	3,100
Total	41,500	42,400	43,300	44,100	44,900

POPPI (2012)

The 2012 National Audit of Intermediate Care shows that users had an average age of 81 with over 42% of the sample being over 85 years of age. An increase in the population for this age group is therefore going to have a significant impact on demand for intermediate care services

According to the last ONS ethnicity estimates, the majority of those aged 65 and over are from a white ethnic background, with very few from a black minority ethnic background (BME) and these are predominantly Asian. Census 2011 data suggests that 32% of the population are from a BME background, 18.1% Asian, more than previous estimates.

In addition, there are 3,100 people with dementia living in Wolverhampton – this figure is set to increase to 3500 people by 2020.

Wolverhampton population aged 65 and over predicted to have dementia					
	2012	2014	2016	2018	2020
People aged 65-69	141	145	148	143	141
People aged 70-74	262	267	271	287	293
People aged 75-79	481	493	493	493	504
People aged 80-84	781	768	768	788	811
People aged 85-89	767	783	822	861	878
People aged 90	597	684	742	829	915
Total	3,028	3,139	3,243	3,401	3,542

POPPI (2012)

Responding to the reablement/intermediate care needs of people with dementia crystallises the level of challenge facing the health and social care economy. For people with dementia living in an institution can be a daily reality. Several observations can be made through the extrapolation of national studies

- A third of people with dementia live in care homes
- Two thirds of the care home population are people with dementia
- One quarter of hospital beds at any one time are occupied by people with dementia
- The inpatient experience for people with dementia has a negative effect on well-being; dementia symptoms and physical and mental health, resulting in poorer quality outcomes when compared to the general population
- One third of people with dementia who are admitted to a general hospital ward never return home and are usually admitted to a care home

Ref
Wolverhampton Joint Dementia Strategy (2011)
Alzheimer's Society (2009)
CSCI (2008)

Intermediate Care Best Practice One– Dementia

Central Lancashire PCT

Ten beds commissioned in a residential home for intermediate care for people with dementia who have been transferred from acute hospital wards. A multidisciplinary team provides support, OT and other therapies, aiming to reskill people to become independent. The team also provides outreach support when people leave linked with a community resource centre providing enhanced day care, drop in, open access and voluntary organisation.

All of this needs to change as articulated in the Joint Dementia Strategy, people with dementia are people first and are entitled to the same rights and opportunities as everyone else. This includes rights and opportunities which maximise the likelihood of regaining or retaining independent living.

Whilst most reablement activity has focussed on older people, the number of people under 65 years of age with moderate and serious disabilities is also projected to increase steadily over the next 20 years (PANSI 2011). This is due to a range of contributing factors: for example, medical advances enabling people to survive life threatening incidents from stroke, road traffic accidents, serious assault, and people living longer with more complex long term impairments,. In addition, many younger disabled people have an increased expectation that they will receive rehabilitation and reablement as part of their journey to recovery or as part of the maintenance of their long term impairment, and want to live more independently and reduce their dependence on care services.

Best Practice Two

The **START** (Short Term Assessment and Reablement Team) service in Shropshire provides a short term period of intensive assessment and reablement to people who want to remain living in their own home. The service is managed centrally and delivered from five locations across the county.

Consultation & Outcomes

In June 2013 Helen Sanderson and Associates facilitated a workshop with front-line operational staff from across the health and social care economy. This workshop delivered the following headlines:

- Reablement requires ownership by all partner agencies
- The current governance arrangements need to be revisited to reflect the joint ownership
- An outcomes framework needs to be agreed across all partner agencies with a robust monitoring framework
- Both quantitative and qualitative data needs to be reported – this will ensure that any quality of life outcomes will be captured
- Success stories should be celebrated and disseminated through social media – this will help facilitate a wider cultural shift in relation to aspirational change
- More work is needed with the external market to change culture and practice

The headlines from this first workshop formed the basis of the opening presentation at a second workshop in July 2013 facilitated by the Institute of Public Care. This was a high level strategic workshop attended by Senior Responsible Officers from key partners across the health and social care economy. This workshop delivered the following headlines:

- There is a recognition that reablement delivers improved quality of life outcomes for individuals and financial savings for the public sector
- Health and social care organisations need to align their reablement and intermediate care intentions and work in an integrated way to deliver these outcomes
- More evidence and better understanding is needed about the longer-term benefits of reablement
- More work is needed with the wider market to incentivise reablement and intermediate care activity

**Best Practice Three
Sandwell Reablement Model**

STAR (Short-Term Assessment and Reablement) is a support service that is provided in your own home and focuses on short-term assessment and reablement. The aim is to improve the ability to live independently. We can provide this service to you for a maximum of six weeks until you are able to manage once again, or we have supported you to receive other appropriate services.

Local Market

The Department of Health White Paper 'Caring for our Future: reforming care and support' proposed a new duty on local authorities to promote diversity and quality in the provision of services. This duty includes the requirement for all local authorities to publish a Market Position Statement (MPS) by March 2014. A key part of Wolverhampton's MPS is to deliver the following:

- Worked with the Wolverhampton Clinical Commissioning Group (CCG) to issue a statement about future joint commissioning of integrated health and social care services
- Refreshed the Reablement Forward Plan to provide more details about further developing reablement and prevention in partnership with providers
- Produced a more detailed paper based on the joint health and social care strategy for dementia, which will outline specific expectations and requirements of the market when delivering a range of opportunities for people with dementia and their families

In 2012 Wolverhampton City Council along with Wolverhampton Primary Care Trust (PCT) commissioned Community Gateway to undertake a data gathering exercise with the purpose of understanding the scope of both health and social care reablement and intermediate care locally, regionally and nationally. The following conclusions were identified from this research:

- The external market locally and nationally is still in embryonic form and the economic, effectiveness and efficiency benefits of outsourcing in-house services are far from proven
- The national market is relatively underdeveloped the longest externalisation has been four years and some local authorities have experienced serious difficulties in achieving the quality and reliability outcomes they were seeking from externalisation
- There was considerable variation in the hourly price for externalised reablement services
- In those local authorities that had externalised services, the decision was made either for cost reduction reasons and/or part of a wider Council strategy of commissioning /provider separation

The overarching recommendation from this report is that priority should be given to the development of an integrated reablement/intermediate care model with health and social care Providers. There are clear opportunities within this model for cost reduction, duplication avoidance and improved outcomes for patients and service users.

Best Practice Four

Home care reablement service in Leicestershire found that 58–62 per cent of reablement users had their care package discontinued at first review, compared with 5 per cent of a control group; 17–26 per cent had their care package reduced at first review, compared with 13 per cent of a control group (Kent et al, 2000).

Best Practice Five Hertfordshire Council's Model

A review of the rehabilitation model which although was performing well was high in costs, led to service changes that included payment by results and improved outcomes. Investment was also made in commissioning a new electronic home care monitoring system. A new service specification tied into payment by results was to ensure that hourly cost was reduced along with improved contact time

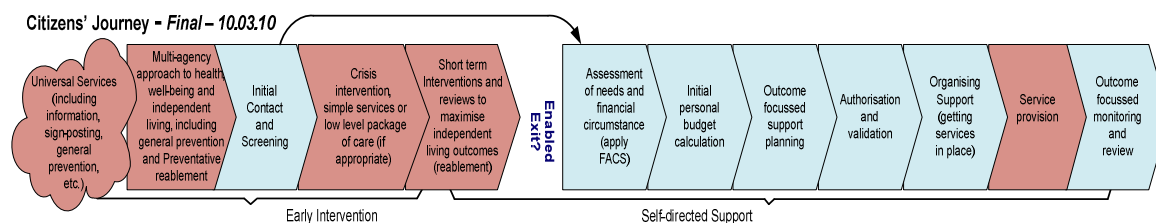
68% of referrals from community and hospital go through rehabilitation

65% of people have no on-going needs

Hourly cost has reduced from £70 to £45

Citizens and Patients Journey

Through its Putting People First Programme, Wolverhampton has developed a Citizen's Journey, which embraces a broader definition of reablement and embeds independent living principles at every stage.



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Underlining the continuum link between reablement and prevention, a broader strategy approach for reablement has been developed that takes into account all aspects of the Citizens Journey and includes three aspects of a prevention definition:

- **Universal Prevention/Promoting Wellbeing**

This is aimed at people who have no particular social or health care needs. The focus is on maintaining independence, good health and promoting wellbeing. Interventions include combating ageism, providing universal access to good quality information, supporting safer neighbourhoods, promoting health, social inclusion and active lifestyles, delivering practical services etc. These activities form part of Universal Services outlined in the Wolverhampton Citizens' Journey

- **Targeted Prevention/Maintaining Independence and Social Inclusion**

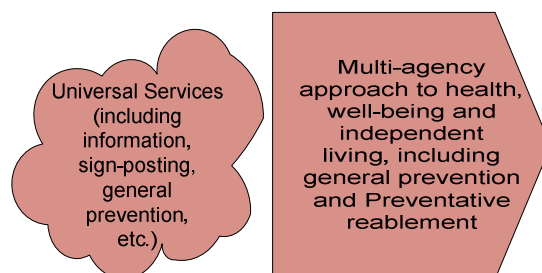
This is aimed at identifying people at risk in the community through targeted prevention to halt or slow down any deterioration and actively seek to improve their situation. Interventions include community support and case finding to identify individuals at risk of specific conditions or events or that they have existing low level social care needs.

- **Reablement Prevention/Independent Living**

This is aimed at minimising disability or deterioration from established health conditions or complex social care needs. The focus is on maximising people's functioning and independence through interventions such as rehabilitation/reablement services and joint case management of people with complex needs.

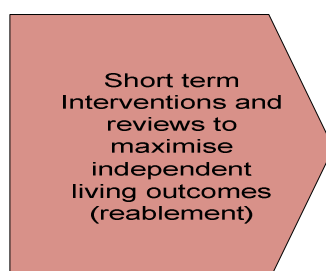
Supporting this broad continuum approach, CSED identified the importance and benefit of delivering bursts of reablement activity at transition points in people's lives in order to enable (re-able) independent living to be maintained or regained (2007; 2010). This Strategy has utilised the Citizen's Journey identified the critical transition Blocks most likely to deliver independent living outcomes:

Citizen's Journey; Blocks 1 & 2



Blocks 1 & 2 are identified as critical early stage intervention reablement opportunities. These have been overlooked by most local authorities in their single strand domiciliary reablement response, but delivering a reablement philosophy and approach at this earlier stage reduces and minimises the likelihood of crisis situations developing in the first place and the subsequent need for on-going service interventions.

Citizen's Journey; Block 5



Block 5 is important because it is at this point that citizen's potentially become customers and users of services. This Block represents a short-term targeted reablement intervention that has been the focus of most local authorities. This Strategy advocates that this intervention is offered before or as a core part of the assessment process. This pre-assessment intervention will be delivered free of charge.

Intermediate care fits into block 5 of the Local Authorities citizens journey but focusses on people who have a health need. "Halfway Home" states that the services that might contribute to the intermediate care function include:

- Rapid response teams to prevent avoidable hospital admissions for patients referred from Primary Care, A&E and other sources
- Acute care at home from specialist teams including some treatment such as administration of intravenous antibiotics
- Residential rehabilitation for people who do not need 24 hour consultant led medical care but do need a short period of therapy and rehabilitation ranging from one to eight weeks
- Supported discharge in a patient's own home with nursing and/or therapeutic support to allow recovery at home
- Day rehabilitation for a limited period in a day hospital or day centre possibility in conjunction with other forms of intermediate care support.



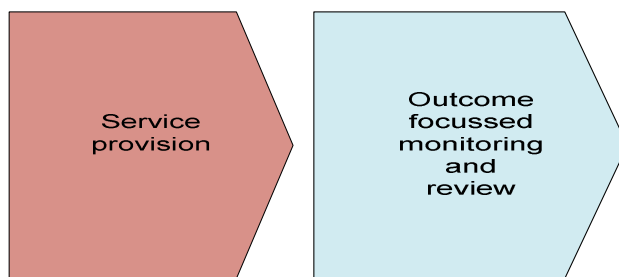
Best Practice Six

Wiltshire developed their 'Home to Live at Home Service' for older people and others who remain at home. Wiltshire has focused on outcomes that older people may wish to gain while at home. The responsibility for delivering an outcome based service has been driven by Personalisation agenda. The model created was a single entity that comprises of integrated equipment and telecare service and an out of hours response service.

A key aspect of this approach is to view the care delivery as a function which can be provided by a wide variety of community services and not stand alone teams.

Ideally the intermediate care and reablement activity across Wolverhampton would be integrated health and social care services. As a minimum the services will need to be aligned across health and social care and partnership agreements will need to be in place to ensure effective flow between the agencies preventing delays in transfer of care. The aim is to move towards a broader view of intermediate care with specialist health care services falling under an umbrella of bridging services between hospital and home and from illness to recovery.

Citizen's Journey; Blocks 11 & 12



Blocks 11 and 12 are identified as critical reablement intervention points.

Assertive outcome focussed reviews that are timely and include the potential for targeted reablement intervention are critical to the successful application of a person centred reablement philosophy and approach.

Developing a broader perspective, this plan also incorporates a range of health outcomes:

- An avoidance of unnecessary hospital admissions
- An increase in earlier hospital discharge
- Reduction in the length of hospital stay
- Increase in the number of independent living discharge route
- A decrease in the rate of readmissions following in-patient treatment
- The diversion away from hospital admissions
- An alignment to other strategies

In line with national evidence, numerous reviews have been undertaken which recognise that:

- A number of acute hospital beds are inappropriately occupied for long periods by a relatively small number of predominately older people who frequently have complex needs which could be more appropriately met in different care settings
- There is an increasing demand from people themselves that, wherever possible, care should be provided at home or as close to home as possible

Intermediate Care Best Practice Seven – Third Sector Involvement

British Red Cross's Care in the Home scheme is a third sector voluntary scheme that has a number of strands. The emergency admissions avoidance strand works with people who have a long term condition and need support to be able to stay in their own home.

Volunteers on the A&E discharge programme transport patient's home from hospital, settle them in, make a risk assessment, tell neighbours and relatives that the person is home, check on pets and help prepare a meal. A follow up home visit is made the next day. (HSJ, 2011)

Intermediate Care Best Practice Eight– Co-ordinated Care Bristol

The Intermediate Care service is managed under one umbrella and includes:

- Rapid response team to prevent admission to acute care
- Rehabilitation in peoples own home
- “Reconnect service” to facilitate discharge for people who need short term input but no therapy
- “React teams” working at the front of the hospital to prevent admissions
- In reach nurses to wards to identify patients who could be discharged to intermediate car
- Access through a single point of access.

Following the intervention 80% of people remained in their own homes.

(Halfway Home, 2009)

In summary, this plan promotes an all en-compassing philosophy and approach, including all adults and advocates that the single strand time limited domiciliary reablement focus applied by most local authorities is unnecessarily limiting and fails to recognise the true experience and needs of potential customers.

Intermediate Care Best Practice Nine – Joint Commissioning Tameside and Glossop

There is a jointly commissioned intermediate care service with a single point of access, 7 days a week between 8am and 10pm. The service receives over 200 referrals per month which are associated with avoiding hospital admissions and facilitating hospital discharge. 85% of those who received a service were discharged to their own homes and 60% required no further support.

(Halfway Home, 2009)

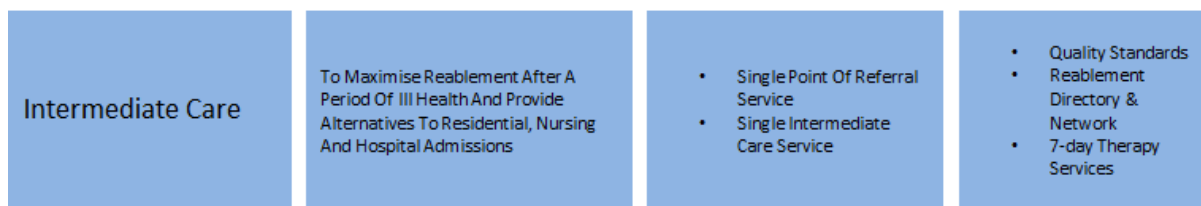
Better Care Fund

The Better Care Fund will ensure that the Wolverhampton health and social care economy is working in an integrated way to deliver the most efficient and effective response to the needs of all users and patients. It recognises and protects early stage interventions and the contribution they make to restoring and maintaining independence; reducing unnecessary hospital admissions; facilitating discharges back home and improving the quality of care for all.

Health and Social Care partners have agreed a vision for the delivery of the Better Care Fund under the heading ‘Wolverhampton, One Ambition, Working as one, for Everyone’.

Strategic Objective	One Ambition	Working as One	For Everyone
What Are We Trying To Do?	Single Plan Sharing everything Prevention & Recovery	Integrated Pathways All Partners Working Together Shared Sustainable Outcomes	Each Individual Keeping People Well Self-caring Communities
	Right Care	Right Place	Right Time

This vision will be delivered through the Plan on the Page shown in Appendix Three, including the following focus on intermediate care:



Principles Framework

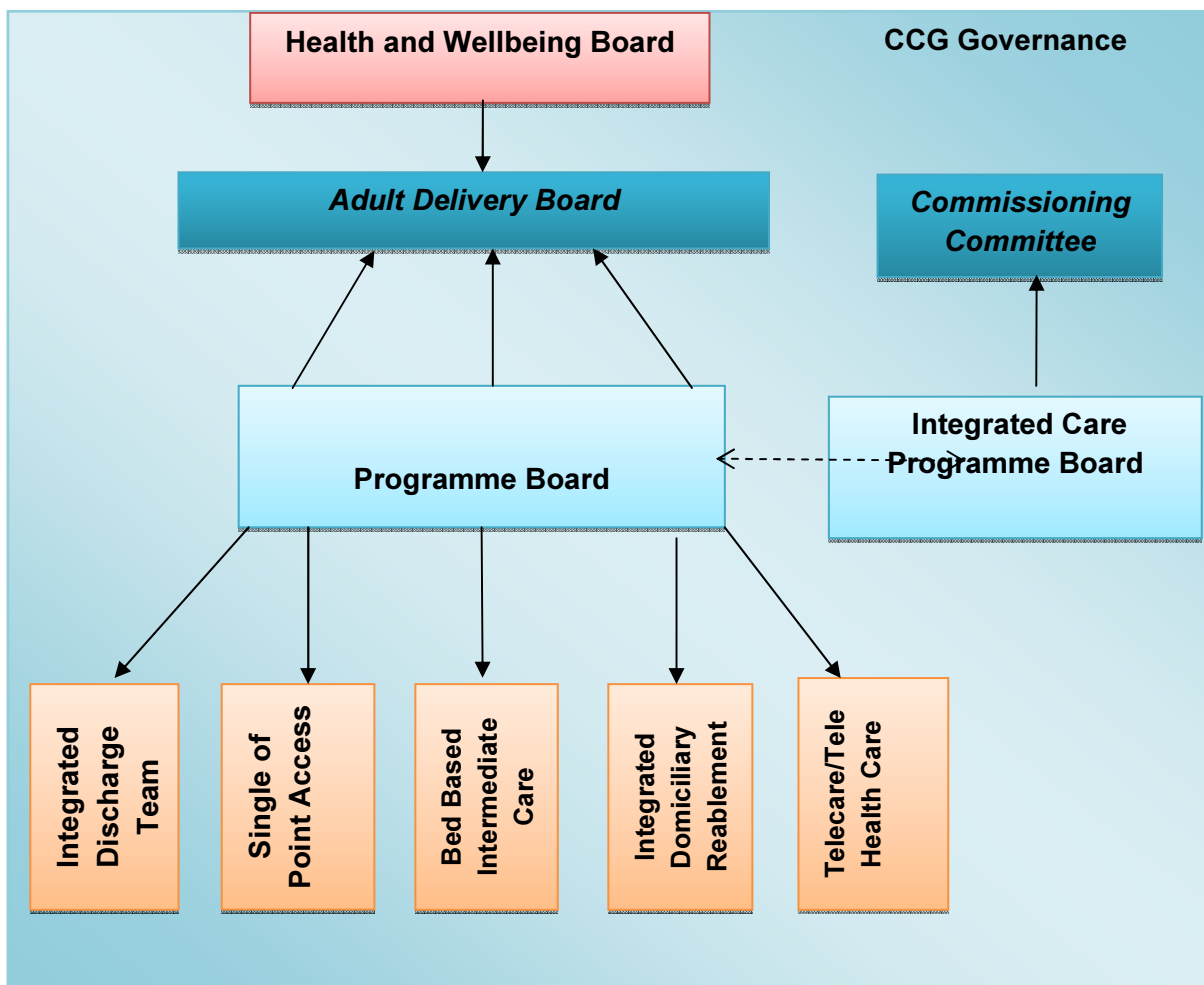
In order to deliver this Reablement/ Intermediate care strategy the Adult Delivery Board has agreed the following principles framework:

<p>Principle One People with dementia will have full access entitlement to all reablement /intermediate care services and opportunities</p>	<p>Principle Two This reablement / intermediate care strategy plan will apply to all adults with reablement/intermediate care needs</p>
<p>Principle Three Providers of care from all sectors are recognised as partners in the delivery of reablement and intermediate care activity, and engagement will take place with these partners at all stages of the commissioning process</p>	<p>Principle Four Reablement and Intermediate Care will be an aligned, integrated, all-encompassing philosophy and approach that is reflected in all customer pathways and journeys</p>
<p>Principle Five Reablement and intermediate care will focus on building, improving and maintaining self-esteem and wellbeing</p>	<p>Principle Six Reablement and intermediate care activity will be a way of delivering person centred outcomes</p>
<p>Principle Seven No long term decision will be made for an older person when they are in a crisis. Help and support will be provided to work through the crisis before determining any longer-term outcomes</p>	<p>Principle Eight Reablement and intermediate care activity will be regarded as business as usual or, in short, it's ‘what we do around here’</p>
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Governance and Next Steps

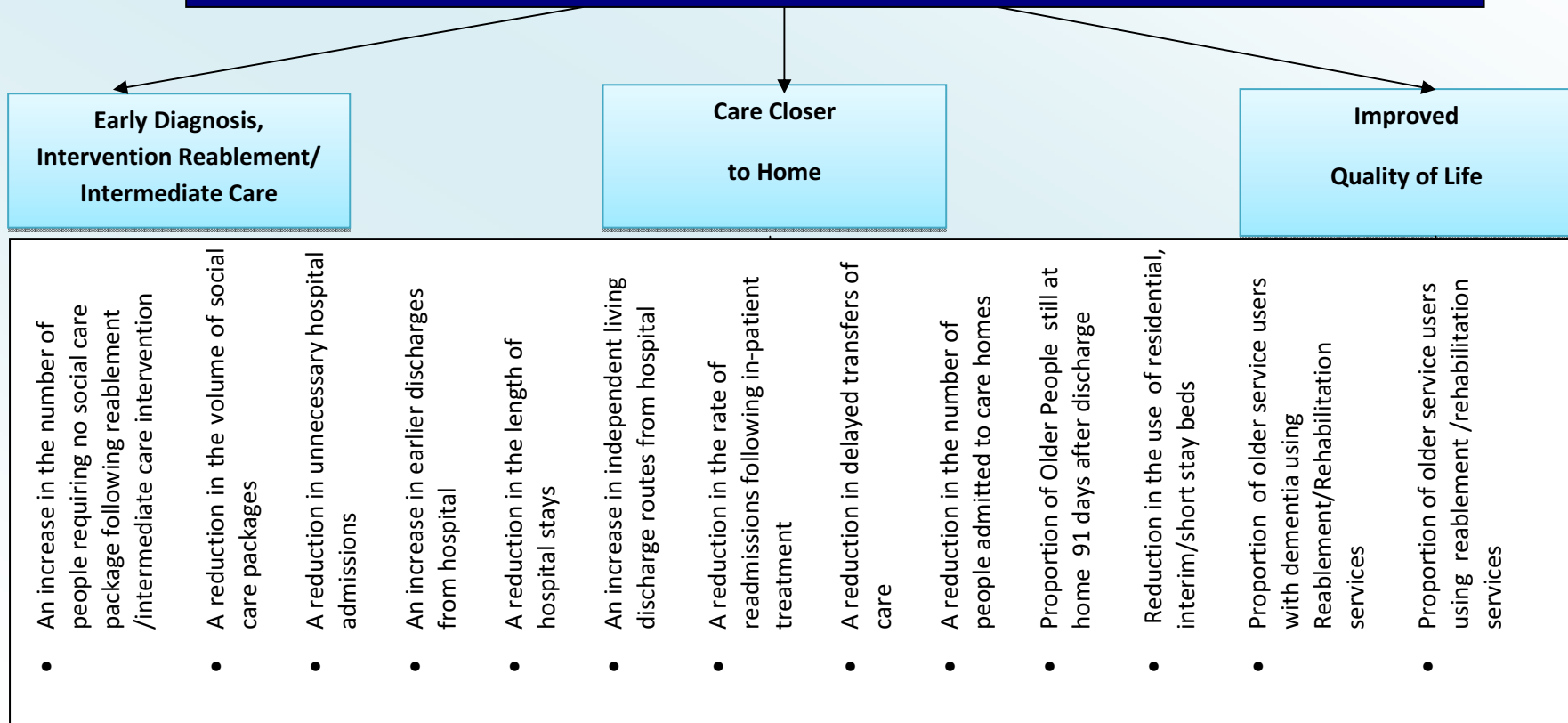
As shown in the governance structure below, the responsibility for delivering the overarching work programme will rest with the Intermediate Care Programme Board, which will be made up of subject matter experts from across all agencies and chaired by the Joint Commissioning Unit (JCU). The work programme will be broken into key projects and delivered through a project management approach by a number of Task and Finish Groups. The Intermediate Care Programme Board will work alongside the Integrated Care Programme Board within the CCG. Clear channels of communication will be put in place to ensure no duplication of work occurs.

Appendix One



Both the programme and the projects will be delivered in line with the overarching messages from the refresh workshops and the agreed hierarchy of outcomes framework – see Appendix Two.

Reablement /Intermediate Care Hierarchy of Outcomes To Enable Independent Living



Reablement /Intermediate Care - Plan on a Page



- #### 13 Metrics
- An increase in the number of people requiring no social care package following reablement/intermediate care intervention
 - A reduction in the volume of social care packages
 - A reduction in unnecessary hospital admissions
 - An increase in earlier discharges from hospital
 - A reduction in the length of hospital stays
 - An increase in independent living discharge routes from hospital
 - A reduction in the rate of readmissions following in-patient treatment
 - A reduction in delayed transfers of care
 - A reduction in the number of people admitted to care homes
 - An Increase in the number of Older People still at home 91 days after discharge
 - Reduction in the use of residential, interim/short stay beds
 - An increase in the number of people with dementia using Reablement/Rehabilitation services
 - An increase in the number of people using Telecare/Telehealth

Principles of Framework	
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