ADULT AND COMMUNITY SERVICES SCRUTINY FORUM

FINAL REPORT

EARLY INTERVENTION AND RE-ABLEMENT SERVICES

April 2012

HARTLEPOOL
BOROUGH COUNCIL

CABINET

30 April 2012

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Report of: Adult and Community Services Scrutiny Forum

Subject: FINAL REPORT INTO EARLY INTERVENTION AND RE-ABLEMENT SERVICES

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1. PURPOSE OF REPORT

1.1 To present the findings of the Adult and Community Services Scrutiny Forum following its investigation into Early Intervention and Re-ablement Services.

2. BACKGROUND INFORMATION

2.1 23.8% of the Hartlepool population have long term illness (compared to 17.6% across England). People are living longer with more complex health conditions, with less younger people to provide care and support and shrinking resources. It is expected that by 2030, in Hartlepool, there will be a 68% increase in people with dementia and a 34% increase in people with long-term conditions.

2.2 The Comprehensive Spending Review and 2011/12 National Health Service (NHS) Operating Framework announced significant levels of funding in 2011/12 and 2012/13 to develop local re-ablement services.

2.3 Social care funding allocated to NHS Hartlepool (which must transfer to the local authority for investment in social care services to benefit health and improve overall health gain) equates to £1.3 million in 2011/12 and £1.2 million in 2012/13. Re-ablement funding (which is within Primary Care Trust baselines and needs to be spent on jointly agreed priorities / plans) is approximately £320,000 in 2011/12 increasing to £640,000 in 2012/13.

2.4 Plans for the £1.3M social care funding for 2011/12 have been agreed and include:-

(i) Commissioning services that provide low level support and prevention to maintain people within their own communities (including welfare notices, luncheon clubs, handyperson service, fuel poverty advice and a home visiting service);

(ii) Increased capacity within existing re-ablement services including Occupational Therapist and Occupational Therapy Assistant posts, Re-ablement Officers and Contact Officers;

(iii) Maintenance of existing transitional care provision to facilitate hospital discharge; and

(iv) Maintenance of existing support for carers services

2.5 Plans for the £320K re-ablement funding for 2011/12 have also been agreed and include:-

(i) Commissioning services that provide low level support and prevention to maintain people within their own communities (including welfare notices, luncheon clubs, handyperson service, fuel poverty advice and a home visiting service);

(ii) Care home liaison support for people with dementia; and

(iii) Development of community nursing services based on the 'virtual ward' model to prevent unnecessary hospital admissions and readmissions

3. OVERALL AIM OF THE SCRUTINY INVESTIGATION

3.1 The overall aim of the investigation was to examine and explore early intervention and re-ablement services provided in Hartlepool.

4. TERMS OF REFERENCE FOR THE SCRUTINY INVESTIGATION

4.1 The Terms of Reference for the Scrutiny investigation were as outlined below:-

(a) To gain an understanding of early intervention and re-ablement services, how they contribute to maintaining people's independence and what a positive outcome looks like;

(b) To explore how early intervention and re-ablement services are currently being delivered in Hartlepool;

(c) To consider research carried out by the University of York into the long-term impact of re-ablement service and how this might influence future delivery in Hartlepool; and

(d) To explore options for service provision in the future given the current budgetary pressures and potential for NHS funding to cease in March 2013.

5. MEMBERSHIP OF THE ADULT AND COMMUNITY SERVICES SCRUTINY FORUM

5.1 The membership of the Scrutiny Forum was as detailed below:-

Councillors Cranney, Griffin, Lawton, Loynes, A Marshall, Preece, Richardson (Vice-Chair), Shaw (Chair) and Shields.

Resident Representatives: Christine Blakey, Evelyn Leck and Michael Unwin.

6. METHODS OF INVESTIGATION

6.1 Members of the Adult and Community Services Scrutiny Forum met formally from 18 July 2011 to 19 March 2012 to discuss and receive evidence relating to this investigation. A detailed record of the issues raised during these meetings is available from the Council's Democratic Services.

6.2 A brief summary of the methods of investigation are outlined below:-

(a) Detailed officer reports supplemented by verbal evidence;

(b) Presentations by officers supplemented by verbal evidence;

(c) Verbal Evidence from the Member of Parliament for Hartlepool;

(d) Verbal evidence from the Authority's Portfolio Holder for Adult and Public Health Services;

(e) Presentations from North Tees and Hartlepool NHS Foundation Trust, NHS Tees and Tees, Esk and Wear Valleys NHS Foundation Trust enhanced by verbal evidence;

(f) Presentation from the Professor of Social Care at the University of York enhanced by verbal evidence

7. FINDINGS

DEFINING EARLY INTERVENTION AND RE-ABLEMENT SERVICES

7.1 Members were very pleased to receive evidence from the Member of Parliament (MP) for Hartlepool; the Portfolio Holder for Adult and Public Health Services; and officers from the Child and Adult Services Department in relation to defining early intervention and re-ablement services.

<u>Evidence from Iain Wright, MP</u>

7.2 The MP informed Members that early intervention and re-ablement services are an important social issue and there is a need to design and improve

services now in order to be able to offer social care services to people as they get older. Members were informed that the country is expecting to see a rise in Alzheimer and dementia cases.

7.3 Hartlepool has an increasingly ageing population in comparison to other areas of the country and it is therefore expected that there will be an increase in demand for social care services in the next twenty years. The MP referred to Hartlepool's population pyramid, which shows that Hartlepool has a much older population than most towns, with the majority of people between 45 and 55 years old in comparison to the average age in other towns of 35 to 45 years old. In years to come there will be an increased demand on service provision therefore it is essential that early intervention and re-ablement services are effectively in place to try and reduce the need for high level support services which in turn will reduce financial pressures.

7.4 The MP was pleased to say that Hartlepool provides a high standard of social care and the services currently provided have matured as they have developed over many years, and the MP commended Elected Members and Officers for their hard work. Some neighbouring authorities are only now starting to develop services of a similar nature.

7.5 Members were very interested to hear that it is essential that early intervention and re-ablement services promote independence. The MP highlighted that there is emerging evidence to show that early intervention; quick identification; assessment; and well planned routes are all essential in enhancing a person's quality of life.

7.6 One of the main areas that the MP spoke about was partnership working and how organisations should be working together to deliver services. Hartlepool already has good working relationships with partners, for example, when people are discharged from hospital. However, one of the most important issues is that monitoring of patients should take place at regular intervals to prevent future hospital admissions. It was suggested to Members that procedures should be in place to look at people's housing situation, transport requirements, and the additional help needed to meet their needs in order to ensure that the transition from hospital is effectively and efficiently managed. This would require all organisations /agencies to work together to provide a joined up approach. However, the MP strongly emphasised that hospital admissions should be avoided in the first place and investment in preventative services can help achieve this. The MP quoted a speech from the Secretary of State for Health:-

'If an elderly person has a fall, for every hour he / she stays on the floor, an extra 24 hours in hospital is required'.

7.7 If preventative services were all successfully in place, hospital admissions could be minimised. The Council's Head of Service for Social Care informed Members that the challenge was not about discharge but about prevention and how to slow down the numbers coming into hospital.

7.8 The MP spoke about improving early intervention and re-ablement services but in the context of increasingly tight budgets. The MP highlighted the need to maintain the services with a greater emphasis on partnership working. The MP posed a question to the Forum about clarity, asking whether the services should be universal and provided for all or whether targeted services should be provided for specific groups?

7.9 Members were informed that it was vital that people are placed in the most appropriate accommodation which is suitable for their needs. This is reliant on effective management. One of the issues raised by Members was about the need to build houses which are adaptable to people's needs.

7.10 The MP concluded that people want to receive good and improved services. On the whole, the services provided by the Local Authority are better than average and ahead of the game in respect of the national picture. Hartlepool Borough Council is coming from a strong base, as early intervention and re-ablement services have been developing over many years and it is now time to move forward and provide improved services within existing budgets.

7.11 Members questioned the involvement of the voluntary and community sector (third sector) in the delivery of services. With the Government placing more emphasis on this, Members asked the MP about the benefits of third sector involvement in the provision of services and how this involvement could be improved. The MP responded by saying that Hartlepool has a very good voluntary and community sector. It would be for the Local Authority to look at the options of providing services in house, outsourcing to the third sector or outsourcing to the private sector. However, Members expressed concern that large national companies with the capacity and the financial stability could take over large proportions of Local Authority provision and cherry pick the profitable services.

7.12 The Forum highlighted that one of the biggest problems with preventative services is how they are quantified. The MP responded by saying that preventative services have yet to be quantified. Although, substantial amounts of money can be saved by intervening early.

<u>Evidence from the Portfolio Holder for Adult and Public Health Services</u>

7.13 The Portfolio Holder informed Members that there had been a recent announcement by the Government stating that 1.7 billion pounds is available to spend on adult social care. Although, this is seen as a large sum of money, in reality due to demographic pressures, the funding of adult social care is facing a 6 billion pounds shortfall.

7.14 The Portfolio Holder informed Members that 75 – 85% of people now have a personal budget and can therefore choose and pay for their own care package tailored to their individual needs. This model demonstrates that social care is about individual needs based on the services that are needed to enable that individual to live independently at home.

7.15 The Forum was very interested to hear about the telecare / telehealth model and its benefits. The Portfolio Holder was very supportive of telecare / telehealth, as it is a vital way to help people stay at home with the security of knowing that help is on hand 24 hours a day if needed. Members were informed that currently over 700 people receive telecare / telehealth in Hartlepool. One of the issues identified was that the Council and health professionals need to work closely together to identify people who are at risk of major health problems and are likely to be admitted into hospital. Once identified it would be for all partners to proactively work together and offer appropriate preventative services which will avoid the person being admitted into hospital.

7.16 The Portfolio Holder believed that if evidence could be provided detailing the take up of telecare / telehealth in Hartlepool and its effectiveness and usefulness in terms of keeping people independent, then due to its relatively minor cost it should be rolled out to more people.

7.17 Members raised concerns about General Practitioners (GPs) dismissing patients who came to them for help, which later resulted in the patient being admitted to hospital. Members agreed that in more cases than not, the hospital admission could have been prevented if an early intervention service was organised for the patient. The Forum suggested that yearly check ups for people over a certain age would be very beneficial in order to identify health concerns at an early stage. This would allow people the chance to be invited into the surgery, rather than having to make their own appointment. Following on from this, Members agreed that a community based 'matron' system, whereby a nurse goes into the community and discusses social care / health issues with individuals / groups would be a very good idea.

7.18 Members raised concerns about people not knowing who to contact for services in an emergency. It was suggested by the Forum that this type of information needed to be publicised more widely.

7.19 Members explored the issue of funding health services, whether this is through, for example, general taxation or insurance. One suggestion for long term consideration was the option of setting up a system for Hartlepool residents, where people could willingly pay into the scheme and hence have funding to provide and improve services for all. Members thought that this would be very expensive to set up and at this point in time no funding was available but supported the idea of being involved and contributing to a more localised health service.

<u>Evidence from the Child and Adult Services Department</u>

7.20 Definitions of prevention, early intervention and re-ablement services were provided to Members and are as follows:-

Prevention and Early Intervention

7.21 Prevention means different things to different people and it is therefore important to have a clear understanding. The following, while having a broad focus, is helpful in categorising three elements of prevention:

(a) Primary prevention / promoting wellbeing is aimed at people who have no particular social care needs or symptoms of illness. Activity for these people would focus on maintaining independence, good health and promoting wellbeing. Possible interventions could include providing universal access to good quality information, supporting safer neighbourhoods, promoting health and active lifestyles and delivering practical services.

(b) Secondary prevention/early intervention aims to identify people at risk and to halt, or slow down, any deterioration and actively seek to improve their situation. Interventions could include screening and case finding to identify those at risk of specific health conditions or events (e.g. strokes, falls, etc.) or those that have existing low level social care needs.

(c) Tertiary (specialist) prevention is aimed at minimising disability or deterioration from established health conditions or complex social care needs. The focus here is on maximising individual's functioning and independence through interventions such as rehabilitation or re-ablement services and joint management of people with complex needs.

7.22 Members were pleased to hear that low level support is offered to people to keep them at home for longer, some of the low level services include meals delivery, gardening, welfare benefits and debt management.

7.23 Members did feel that there was a communication issue in getting details of these services out to the community and also details of which services could be accessed for free. Members agreed that it would be helpful to know which services were free along with any eligibility criteria that was applied.

Re-ablement

7.24 It was highlighted to Members that there is no dictionary meaning for re-ablement and it has been described in many different ways. One definition that has been developed through work by a number of councils in the North East is:

> *The essence of re-ablement is to work with individuals who have support needs to rebuild their confidence, support the development of daily living skills and promote community access and integration.*

7.25 Members were informed that re-ablement:-

(a) is about helping people to do things for themselves, rather than doing things for or to people;

(b) is time limited, usually for no more than 6 weeks;

(c) is outcome focused; the overall goal being to help people back into their own home or community;

(d) involves setting and working towards specific goals agreed between the individual and the re-ablement team;

(e) is a very personalised approach; the kind of support given is tailored towards the individual's specific goals and needs;

(f) treats assessment as something that is dynamic – you cannot decide an individual's care and support package on the basis of a one-off assessment – their needs and abilities may well change over the period of re-ablement;

(g) assumes that something should change by the end of the re-ablement intervention (i.e. working towards positive change);

(h) builds on what people can already do and supports them to regain skills to increase their confidence and independence;

(i) aims to maximise people's long-term independence, choice and quality of life; and

(j) aims to reduce or minimise the need for ongoing support after the period of re-ablement.

7.26 The re-ablement approach encourages people to do more for themselves with help, for example, to cook their own meals. Other services, such as telecare provide reassurance to people, knowing that someone is at the end of the phone, if needed. Two telecare testimonials, shown overleaf, were presented to the Forum, which highlighted how this service has dramatically improved people's lives.

Telecare Testimony 1

Telecare Testimonials

KW is 49 years old and suffers from Multiple Sclerosis. KW said of the Telecare service "I realise that since I have had Telecare installed I feel a lot safer. I live alone and before only had my father to rely on. The service gives piece of mind for me and my family."
KW also gave an example of how the service helped her "Once I went out into the garden in my wheelchair and got stuck in the mud. I pressed my lifeline button and got a very quick response. If I did not have Telecare I would have been stuck there for six hours until my care worker was due."

Telecare Testimony 2

Telecare Testimonials

BS is 84 years old and has problems controlling her blood pressure along with mobility problems. BS said of the Telecare Service "My family have piece of mind. We have no complaints at all with the service. The staff are really nice and could not be any better."
She also gave an example of how the service helped her "Before Telecare was installed I had fallen a few times in the house. One time I was on the floor for seven hours before anyone came. Since Telecare was installed I now have my pendent and falls detector and feel safe because of the service."

7.27 Members of the Forum were informed that The Department of Health published a *Revision to the Operating Framework for the NHS in England 2010-11* in late 2010 that described some changes to payments for readmissions to hospital. These changes were linked to additional funding for re-ablement and the Department of Health widened the meaning of re-ablement to include *"…recovery following an acute hospital episode,*

rehabilitation and home care re-ablement in the sense of getting the person back to the position, or improving upon, the position that they were in before the acute hospital phase (whether that be returning to employment, returning home, etc).”

8. HOW EARLY INTERVENTION AND RE-ABLEMENT SERVICES CONTRIBUTE TO MAINTAINING PEOPLE’S INDEPENDENCE AND WHAT A POSITIVE OUTCOME LOOKS LIKE

8.1 Members were very interested to hear how early intervention and re-ablement services contribute to maintaining people’s independence and welcomed evidence from the Child and Adult Services Department.

Evidence from the Child and Adult Services Department

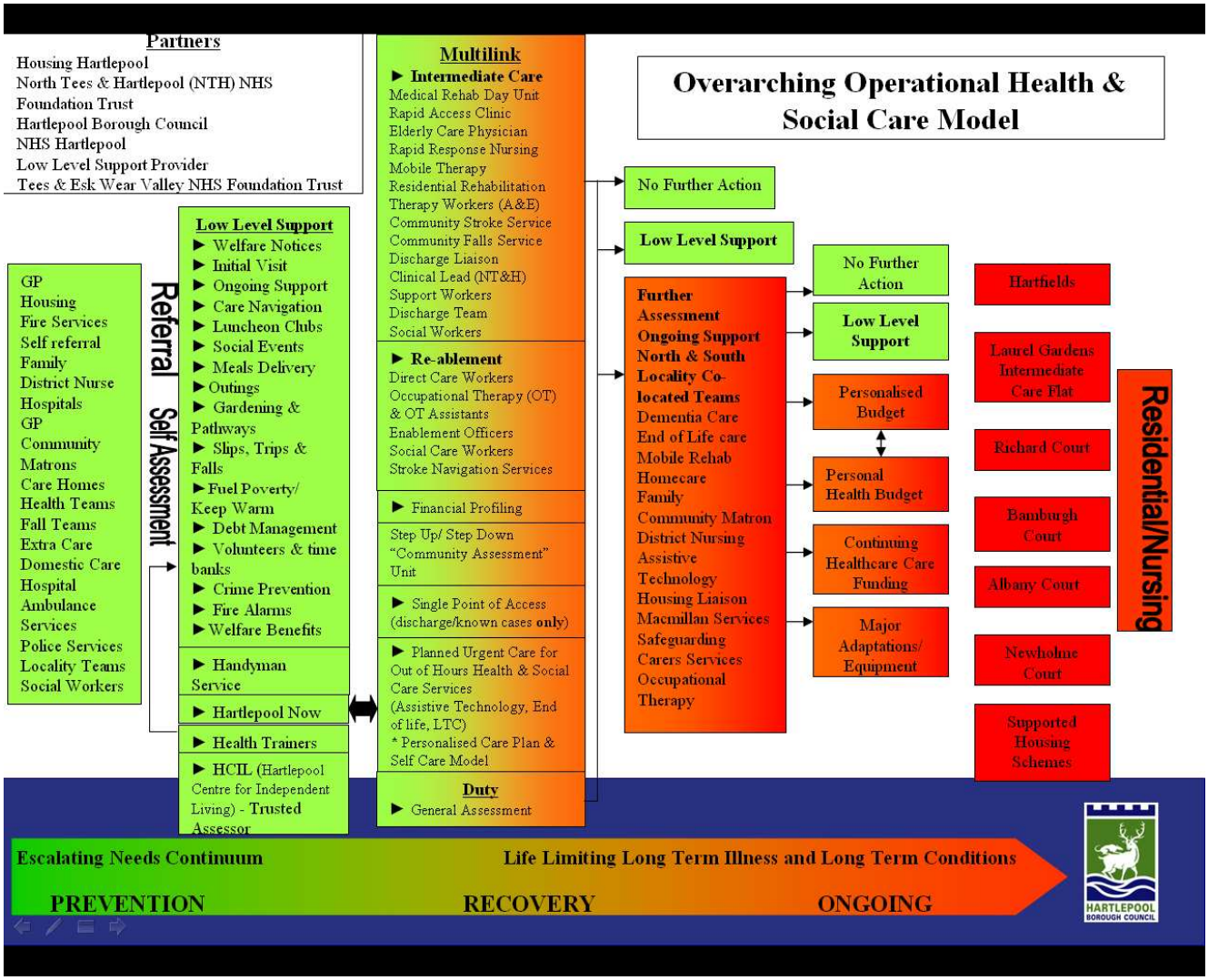
8.2 The Forum was informed that the evidence for the effectiveness of early intervention / preventative approaches is growing stronger. Evidence from the national evaluation of the Partnerships for Older People Projects (POPP) programme and other initiatives has demonstrated that people have been able to achieve one or more of the following: increased choice and control; improved health and emotional wellbeing; maintaining personal dignity and respect and were able to make a positive contribution to the community in which they live.

8.3 Research suggests that re-ablement has a positive impact on people’s quality of life, for example improved general health, self care, activities and mobility. Increasingly, research is showing that re-ablement services are effective in increasing users’ independence and reducing their need for ongoing support after the re-ablement intervention.

8.4 The key features of re-ablement are helping people to do things for themselves, rather than doing things for or to people; time limited support, usually for no more than 6 weeks; being outcome focused; the overall goal being to help people back into their own home or community; and building on what people can already do and support them to regain skills to increase their confidence and independence.

8.5 A social care system needs to be in operation that is efficient and effective, Members were shown an overarching health and social care model which will provide this efficiency and effectiveness, as detailed in diagram 1 below.

Diagram 1 Overarching Operational Health and Social Care Model



8.6 Members were informed that clear leadership is essential with vision, values and direction of travel clearly identified. It is essential to maximise efficiency and control cuts by preventing need, encouraging self support and supporting carers through removing duplication and redesigning processes. In order to do this, one option could be to create strategic partnerships, for example collaborate and share resources; integration of health and social care and social enterprises.

8.7 Members were informed of the potential outcomes of the model, which are as follows:

(a) Increased number of people helped to recover from serious illness and injury;

(b) Increased number of people managing their own care & support and in control of what, how and when this is delivered;

(c) Less dependency on intensive services due to earlier and targeted intervention;

(d) More people will be physically active and live independently as there will be a delay and reduction in the need for care and support;

(e) Fewer avoidable acute episodes by better management of the condition;

(f) Reduction in emergency bed days associated with repeat acute admissions by more timely and co-ordinated discharge;

(g) Re-organisation of pathways and removal of professional boundaries;

(h) Prevention and targeted support helping people to stay independent and connected to their communities as good information and advice is made available and access to universal services is promoted; and

(i) Clinicians, other professionals, local Councillors and the 'public' are brought together to develop neighbourhood approaches.

8.8 Members were supportive of the new model as it has been developed based on best practice and previous experiences. Members acknowledged that one of the keys to the success of this model is the voluntary and community sector. The model was based around the idea of being a good neighbour and supporting the community and Members agreed that this ethos should continue. The model provides for a co-ordinated approach with all partners.

8.9 It was felt by Members that offering training courses / apprenticeships in social care to young people would create jobs to help the local economy and also provide the social care sector with an increased work force. The Head of Service for Adult Social Care informed Members that social care traineeships were offered but it was found that once trained they moved quickly to other posts which created the issue of back filling of posts. However, it is believed that there is a need to invest in the workforce and take this issue forward as a Local Authority and develop alongside partners.

9. HOW EARLY INTERVENTION AND RE-ABLEMENT SERVICES ARE CURRENTLY BEING DELIVERED IN HARTLEPOOL

9.1 The Forum was keen to examine how services were currently being delivered in Hartlepool and therefore was pleased to receive evidence from Connected Care, North Tees and Hartlepool NHS Foundation Trust and Tees, Esk and Wear Valleys Foundation Trust.

Evidence from Connected Care

9.2 Members received evidence from Connected Care in relation to the Supported Access to Independent Living Service (SAILS). Connected Care brings together a wide range of services, activities and initiatives which are

delivered through a range of partner organisations within Hartlepool. The majority of services focus on meeting the needs of the frailest individuals with the highest level of need, in accessing extra support which helps improve their quality of life and their ability to live independently. The SAILS service in essence is a good neighbour scheme, helping people live independently and engaging people in social activities, for example luncheon clubs. A wide range of practical and social services are provided to help vulnerable elderly people live safely in their own homes. Members were informed that since November 2011, six luncheon clubs were handed over from the Council and the number of clients accessing the existing luncheon clubs was 102. Three new luncheon clubs have started with 45 people accessing the clubs. The Forum queried how people accessed the luncheon clubs and were informed that new transport projects were currently under development. Connected Care is determined to work in partnership with organisations to order to further enhance services. Access to services is a right and it is about reducing the barriers to those services.

9.3 Other low level support services offered through the SAILS project include hospital visits, shopping, meal delivery services and general support. There is also a handyman service that offers "that little bit of help", which works on a Town wide basis with 711 clients currently and 1251 jobs completed.

9.4 Members welcomed the introduction of welfare notices, where any individual can refer a person, who they think may need some extra help or support to SAILS. The Forum was of the opinion that welfare notices should be promoted at every opportunity, for example, through the Council's magazine, Hartbeat, the Hartlepool Mail, libraries, resident associations and community groups as they are an excellent initiative. It was felt that welfare notices are not advertised well enough but noted that the notices have only been in place since November 2011 and further awareness raising and publicity is planned.

9.5 Members were very pleased to hear about the winter warmth initiative which cleared snow and ice from 289 pathways and sheltered accommodation schemes throughout the winter. The initiative also provided for a number of drop in sessions across the town (in partnership with Manor Residents Association and West View Advice & Resource Centre) to provide advice and guidance.

9.6 A housing intervention scheme is also offered in the Owton area which works with the most difficult families and individuals on a one to one basis and liaises with Joint Action Group (JAG), housing providers, police, probation service and prisons.

9.7 Members were informed that Connected Care work in partnership with a range of organisations including Manor Residents Association, Wharton Trust, Hartlepool Mind and Hartlepool Carers and work with a range of groups to work up funding applications.

Evidence from North Tees and Hartlepool NHS Foundation Trust and NHS Tees

9.8 Members were informed about the Multi Link service which is provided by the Council and the Trust. Multi Link is an intermediate care team which comprises rapid response nurses, social workers, discharge liaison team, occupational therapists and physiotherapists who are there to help adults in Hartlepool. The aim of the team is to:-

(a) support people so that they can remain at home during an illness or following an accident;

(b) make sure people get the right care to support a safe and timely discharge from hospital; and

(c) plan a range of services and therapies with individuals and family members that help the person recover at home;

9.9 The Multi Link team has received national recognition as providing excellence and best practice in terms of flexible working across multi agency boundaries and improving the quality of the patient journey ('Framing the Contribution of Allied Health Professionals: Delivering High Quality Health Care – Department of Health – October 2008).

9.10 Members raised concerns about the patient discharge procedures and how not all staff had the same message on the procedures. Similar complaints had been received by Hartlepool LINk, particularly in relation to a lack of discharge planning and information sharing.

9.11 It was highlighted that there are good discharge liaison teams in place but information was not being shared across teams / departments until discharge. Members felt that the discharge should be started to be planned for at the time of the admission but this is not always happening.

9.12 It was clear that as far as was possible, the patient should be the first to know about their hospital discharge and the assistance they would receive when returning home. Patient confidentiality needed to be maintained, yet there seemed to be many incidences where nurses and social workers were talking to their family rather than the patient. Many may have very good reasons for not wanting their family to know the full details of their care package. It was a difficult balance but one that needed to be acknowledged.

9.13 Examples of the types of services / interventions available were highlighted to Members and are shown below:-

Diagram 2 Types of services / interventions available

Continence care Assistance with dressing/undressing Transfers: bed, chair, toilet Phlebotomy: deliver to path lab Meal preparation Blood pressure monitoring Blood glucose monitoring Urinalysis monitoring Temperature monitoring	Mobility practice Transfer practice Order and fit assistive equipment Pain monitoring Falls risk assessment and removal of hazards Plaster cast care Oxygen sats monitoring Mouth care, bathing, foot care

9.14 The case studies below highlight the benefits of multilink services:-

Multi-link Case Study 1

- Mr B a 91 year old man, lives alone but previously independent. Fell at the weekend due to tripping on a pavement. No bony injury but soft tissue damage significantly reduced mobility.
- The Rapid response team arranged for him to sleep downstairs and rapid assessment support workers risked assessed home and with consent removed tripping hazards. Rapid Assessment Support Worker (RASW) discussed Care Call and organised upon return to base.
- RASW visited twice per day over the weekend to assist with activities of daily living and meal preparation plus nutritional advice.
- RASW reviewed wounds and changed simple dressings with Rapid response nurse direction.
- RASW reviewed support needs and handed over to Intermediate care for further rehabilitation.
- Independence gained after 3 weeks of intermediate care.

9.15 North Tees and Hartlepool NHS Foundation Trust are in the process of developing a 'Community Renaissance' model (as shown in diagram 3), where services respond proactively to the changing health needs of the local population. Significant progress has been made in developing the model. Community Renaissance includes:-

(a) Managing people with long term and complex conditions in their own homes;

(b) Supporting people by integrated multi-agency teams working with GP practices in a more integrated way, providing care closer to home;

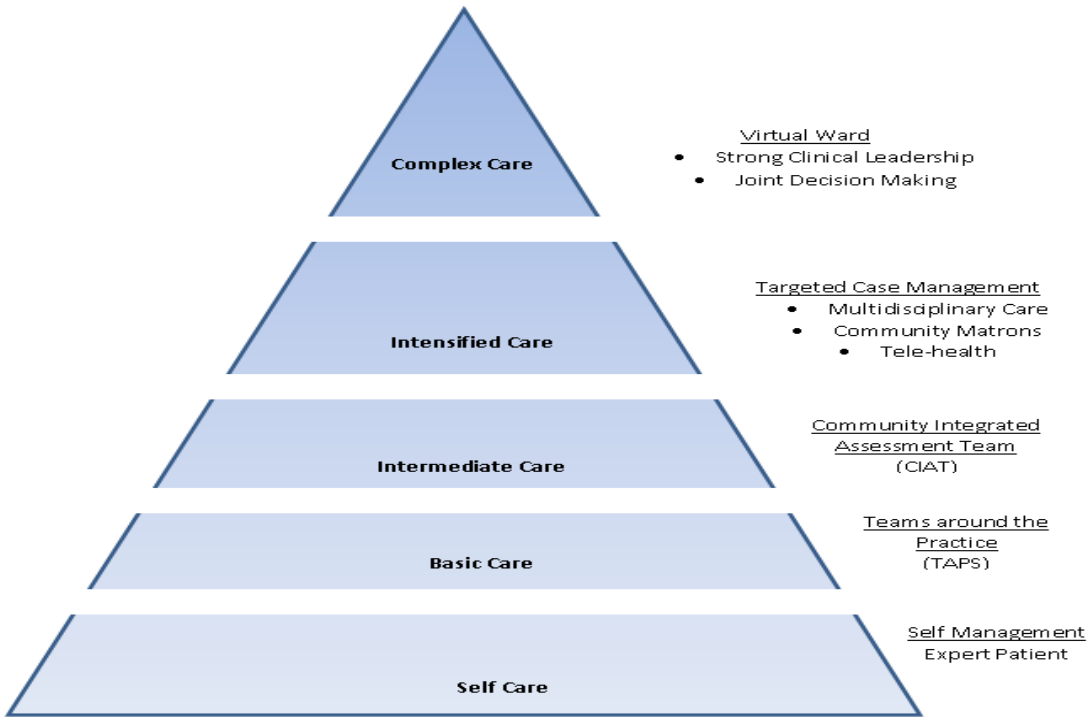
(c) Increasing the number of people supported by technology such as telemedicine / telecare; and

(d) Helping people to leave hospital safely and quickly or supporting them at home via a range of integrated intermediate and re-ablement services.

9.16 The Trust is working towards an integrated single point of access and a Community Integrated Assessment Team, with the aim to have this system live by April 2012.

9.17 Members were informed that the key to successful delivery is close partnership working with local authority providers.

Diagram 3 The Community Renaissance Model



9.18 Members welcomed this new model but felt that the term 'Community Renaissance' was not a term that people would understand and relate too**.**

Evidence from Tees, Esk and Wear Valleys NHS Foundation Trust

9.19 Members were informed that Tees, Esk and Wear Valleys NHS Foundation Trust provide a range of metal health, learning disability and substance

misuse services. In relation to re-ablement services, the trust provides services to older people with mental health needs. It was highlighted to Members that within the Department of Health publication 'Ready to go? Planning the discharge and the transfer of patients from hospital and intermediate care (2010) it states that:-

> "All too often, older people are encouraged to make a permanent decision to enter a care home before they have reached their full potential. Unfortunately, this is often the only option considered for many people with dementia".

9.20 The Half Way Home guidance published by the Department for Health (2009) identified that intermediate care services should be accessible to older people with mental health needs, where there is a "goal that could be addressed within a period of weeks". It is recognised that some people may need flexibility to extend their period of intermediate care past the prescribed 6 week period.

9.21 Members were informed that there are a number of myths surrounding dementia and mental health, for example, that people must have physical health needs/problems to access re-ablement or intermediate care services. Members were informed that mental health services need to challenge the myths and work closely with main stream services to reduce stigma and support equal access. Members welcomed initiatives and ideas to support equal access and reduce misconceptions.

9.22 In terms of funding for Tees, Esk and Wear Valleys NHS Foundation Trust, £50k has recently been allocated, but it is non-recurring funding. The plans for this money are to provide a service at basic advice and liaison level, with the aim of supporting mainstream health and social care teams across Hartlepool to include people with dementia in rehabilitation/re-ablement. The focus of the service will be to:-

(a) Improve access to mainstream intermediate care/re-ablement service provision for those with dementia;
(b) Help to prevent premature admission to long-term care;
(c) Reduce the access of long-term residential care following short-term provision;
(d) Provide timely, individually tailored, specialist support for those with dementia in intermediate care phases of their patient journey; and
(e) Promote independent living for those with dementia (home environment where possible, and with either no or the least intrusive support package necessary).

9.23 In order to delivery this agenda there will be a rolling programme of training and 1:1 co-working for staff working in the intermediate/re-ablement services to:

(a) Aid management and understanding of behaviours which challenge others;

(b) Enhance two way communications with a person who has dementia;
(c) Increase knowledge of the different types of dementia;
(d) Increase understanding of physical health issues and dementia;
(e) Increase understanding of the importance of adequate nutrition and hydration;
(f) Increase understanding of the use of meaningful activity for those with dementia; and
(g) Increase awareness of functional mental health problems in addition to dementia, in particular depression

9.24 Members heard that funding from the Primary Care Trusts had already been received for the Middlesbrough and Redcar and Cleveland localities where a similar approach had been implemented so there was an opportunity to learn from experiences South of Tees. So far they have learnt that the provision of specialist mental health advice and liaison for those with confusion and/or dementia is valuable in helping service users gain improved access to and use of mainstream services. Only two people known to the project were deemed inappropriate for mainstream intermediate care bed use. This was based on their level of need, not diagnosis of dementia. The project was successful in preventing admission to long term care, helping people return to their home environments, and in training staff to be more aware of the potential of those with dementia. Of all referrals 61.5% returned home, only 13% went into permanent care and only 3 short term care placements became permanent (6% of referrals).

9.25 Members questioned how voluntary and community sector organisations could help the re-ablement agenda. Members were informed that the Trust has good working relationships with the voluntary and community sector organisations but do need to extend those links. Members agreed that the links with the voluntary and community sector organisations needed to be publicised more, and suggested advertising voluntary and community sector groups on, for example, leaflets and posters.

10. RESEARCH CARRIED OUT BY THE UNIVERSITY OF YORK

10.1 The University of York carried out a study into 'Home Care Re-ablement Services: Investigating the Longer Term Impacts' and Members were very pleased to receive evidence on the findings of the study from Professor Caroline Glendinning.

Evidence from the University of York

10.2 Members were informed that the study focused on providing evidence on the longer term impacts of home care re-ablement, by comparing outcomes for re-ablement users with those of conventional home care service users; identifying factors affecting the level and duration of benefits for service users; identifying impacts on and savings in the use of social care and other services that could offset the costs of re-ablement; and describing the content and unit costs of re-ablement services.

10.3 The study focussed on five Councils using a re-ablement approach and five Councils using conventional home care, users were interviewed and then re-interviewed 9-12 months later. The outcomes measured focused on health, quality of life and social care outcomes.

10.4 It was highlighted to the Forum that home care re-ablement services are focused around a distinctive ethos of 'doing with'/watching and encouraging, rather than 'doing for' and Members supported this. Examples used included, personal care, meal preparation, practical help, promoting medication, confidence building and advice and information. The Professor explained how home care re-ablement services are organised through dedicated re-ablement teams and highlighted the risks of a mixed approach, for example, staff delivering home care and re-ablement services could dilute the re-ablement approach.

10.5 Assessment and reassessment is essential and it is important for the user to define their goals. The Forum queried the average time spent with individuals in the home by Re-ablement Officers. The Professor indicated that throughout the study information was collected on the average duration of visits and duration times varied dependent upon individual needs but a flexible approach was required.

10.6 Members were interested to hear about the user and carer prospective of re-ablement services. The Professor emphasised that there was little initial understanding of the aims of re-ablement, however, after receiving the service users reported greater confidence, independence and motivation. Regular monitoring and frequent visits by re-ablement workers increased confidence and motivation, especially from people who had been discharged from hospital or recovering from accidents or illness. Some users would have liked more help with mobility and activities outside the home and carers would have welcomed more advice on how to maximise users' independence.

10.7 Members questioned whether there were various perceptions at a local level in relation to the differences between home care services and re-ablement services. It was emphasised by the Professor that all staff including carers and users of the service need to be clear about the vision and purpose of re-ablement to avoid any misunderstanding of its purpose.

10.8 The Professor highlighted that there are many factors that contribute to success in home care re-ablement, both internal and external factors. The internal factors included service organisation, which requires careful assessment and reassessment; user focussed care plans; flexibility; rapid access to equipment / Occupational Therapist expertise; and access to other specialist skills such as physiotherapy. Training and supervision was considered as a success factor along with the reinforcement of the re-ablement 'ethos'. In relation to the wider factors there should be a strong, shared vision of the service amongst all staff including adult social care teams and hospital discharge staff. Members were informed of the assessment process following discharge from hospital and the importance of

Senior Re-ablement Officers undertaking assessments in the home in addition to hospital based assessments was emphasised.

10.9 Members raised concerns about how care workers could be recognised and supported in their role as part of this process. The Professor acknowledged the time constraints placed on care workers was largely as a result of contract arrangements with providers. These issues can be addressed through the contracting process and increasing the focus on outcomes. The advantages of re-ablement services as opposed to standard home care services were emphasised.

Costs of Re-ablement Services and Traditional Home Care Services

10.10 The findings of the study indicated that re-ablement had positive impacts on health related quality of life and social care outcomes compared with conventional home care services. A typical re-ablement period (39 days) cost £2,088, which is considerably higher than conventional home care. However, re-ablement was associated with a decrease in social care service use.

Key Findings of the Study as outlined in 'Research Works' (2011)

10.11 The key findings of the study were outlined to the Forum, which were:-

(a) That there were no net cost savings to health and social care in the first year of re-ablement, compared with conventional home care. Members were informed that home care re-ablement is almost certainly cost effective because of the improved outcomes for users.

(b) Re-ablement was associated with a significant decrease in subsequent social care service use. The costs of the social care services (excluding the use of re-ablement itself) used in the 12 month study period by people in the re-ablement group were 60 percent less than the costs of the social care services used by people in the home care group. However, these lower costs were almost entirely offset by the higher cost of re-ablement intervention. The average total (including re-ablement) cost per person of the social care services used by the re-ablement group was just £380 lower than the costs of the social care services used by the comparison group.

(c) Improvements in users' health related quality of life and social care related quality of life was evident up to ten months after re-ablement care, in comparison with users of conventional home care services.

(d) Taking into account any differences between the two groups at the start of the study, there was no significant difference in the average costs of healthcare services used by the re-ablement and comparison groups over the full 12 months.

11. OPTIONS FOR SERVICE PROVISION IN THE FUTURE GIVEN THE CURRENT BUDGETARY PRESSURES AND POTENTIAL FOR NHS FUNDING TO CEASE IN MARCH 2013

11.1 Members received evidence from NHS Tees and the Child and Adult Services Department on the options for future service provision and funding.

Evidence from NHS Tees

11.2 Members welcomed evidence from NHS Tees on their role. The Forum was informed that in October 2012 the Department for Health announced funding for re-ablement linked to hospital discharge. The funding received for Hartlepool in 2011/12 was £243,000 and for 2012/13 was confirmed as £600,000. Beyond this period, any savings made from reducing hospital activity would be re-invested into projects that are proven to make a difference. The Forum questioned how services can be quantified and a monetary value placed upon them. Members were informed that all packages of care have a 'tariff' and if activity levels are analysed and admissions reduced, the money saved from these admissions can then be fed back into other services.

11.3 Members were informed that Commissioners need not reimburse hospitals for admissions within 30 days of discharge following a planned admission with locally agreed thresholds for other readmissions. The savings made need to be invested to support improved outcomes through re-ablement and post discharge support. The Department for Health said that 'Primary Care Trusts should develop local plans in conjunction with Local Authority and Foundation / NHS Trusts and community health services on the best way of using this money to facilitate seamless care for patients on discharge from hospital and to prevent avoidable hospital readmissions'. Members were reassured that appropriate safeguarding checks were in place when commissioning services.

11.4 In response to this, NHS Tees set up a partnership group involving local authority and health partners which developing plans for schemes to help support re-ablement for 2011/12, and are now working on agreeing plans, by April 2012, for 2012/13.

11.5 In terms of next steps, Members welcomed the continued monitoring and measuring of plans to ensure that they are making a difference, and assessing what works well and what should be continued in the future.

11.6 Members were informed that from the end of March 2013, Clinical Commissioning Groups will take on full responsibility for re-ablement. However, Clinical Commissioning Groups are involved now in order to understand and assess what works well and how to further improve pathways to ensure more people remain independent.

Evidence from the Child and Adult Services Department

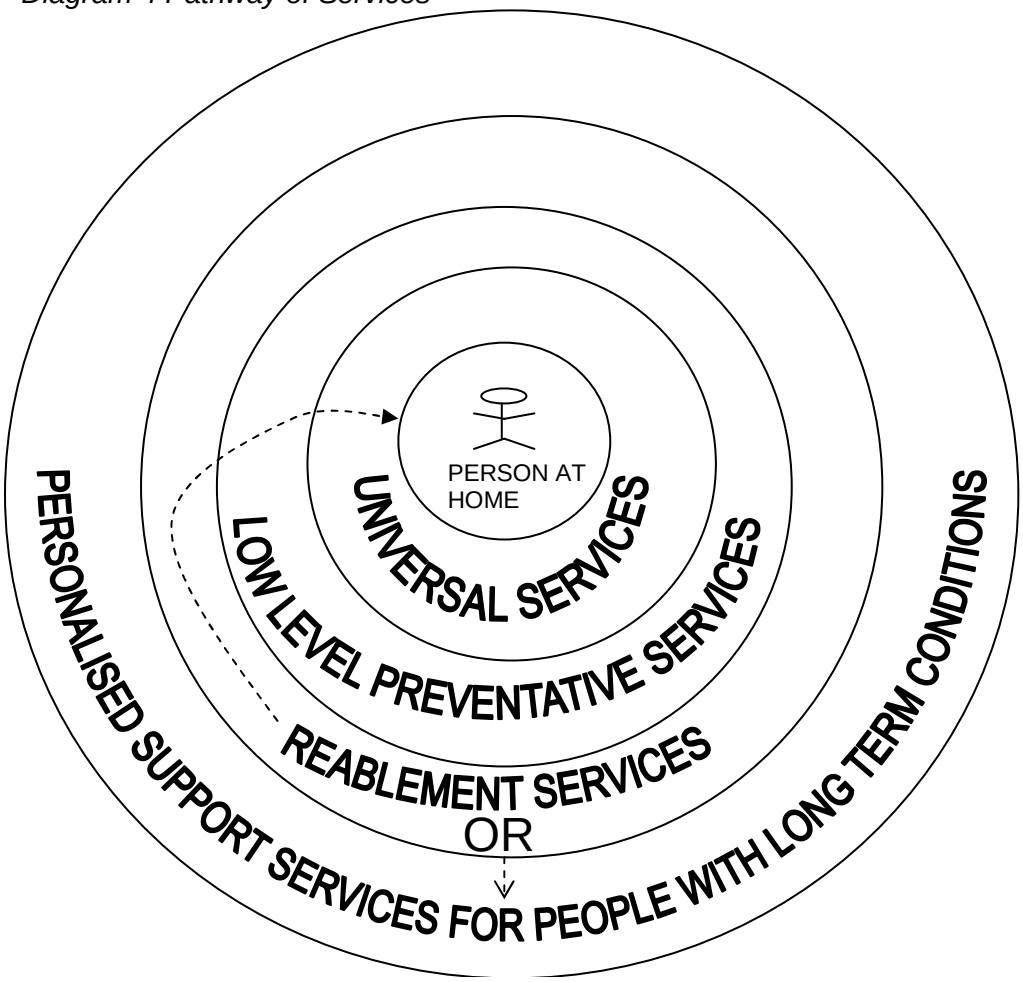
11.7 Members were informed of an announcement in the 2012/12 NHS Operating framework in November 2011 indicating that NHS funding for social care services would be continued for a further two years until March 2015, meaning that future funding of such services is a less immediate concern.

11.8 Therefore, the future for Adult Social Care and re-ablement services is based on the vision 'that the services and support that the Council commission, enable or provide will be more personalised, more preventative and more focused on delivering the best outcomes for people". The vision is based on six key principles, which are:

(1) PREVENTION: keeping people well and safe in their own homes
(2) PERSONALISATION: person-centred services and outcomes
(3) PERSONAL BUDGETS: people can chose what to spend from their own pot of money
(4) PLURALITY: people can chose from a range of different services
(5) PARTNERSHIP: people and organisations work together
(6) PRODUCTIVITY: efficient services that give value for money

11.9 Diagram 4 below illustrates how all the services fit together.

Diagram 4 Pathway of Services



12. CONCLUSIONS

12.1 The Adult and Community Services Scrutiny Forum concluded:-

(a) That the developing early intervention and re-ablement services are first class, however, communication and information sharing between services still remains a barrier and often leads to poorly co-ordinated hospital discharge procedures;

(b) That due to an ageing population, early intervention and re-ablement services are essential in order to reduce pressure on services, as intervening early saves money in the long term;

(c) That the Council has a duty to deliver these key early intervention and re-ablement services in order to safeguard vulnerable adults;

(d) That where appropriate the person receiving the service(s), should always be spoken to first in relation to their care package before any family members;

(e) That welfare notices are an excellent initiative and need to be promoted as widely as possible, along with low level support services, such as gardening and meal preparation;

(f) That re-ablement services are about helping people remain independent; therefore it is about encouraging and helping people rather than actually doing the job for them;

(g) That staff and users of the service need to be clear about the purpose of re-ablement in order for it to be effective;

(h) That working with partner organisations, including the voluntary and community sector is the key to delivering effective and efficient services;

(i) That services should be built around an individual's own needs and that appropriate accommodation should be provided and adaptable to a person's own needs;

(j) That community spirit and 'good neighbours' are key elements of support for those people who do not have family members who can offer their support and this should be encouraged / promoted, where possible;

(k) That funding for health care was an area to be further explored and Members supported the idea of being involved and contributing to a more localised health service; and

(l) That it is difficult to retain trainees in social care once qualified and options to improve retention should be explored.

13. RECOMMENDATIONS

13.1 The Adult and Community Services Scrutiny Forum has taken evidence from a wide range of sources to assist in the formulation of a balanced range of recommendations. The Forum's key recommendations to the Cabinet are as outlined below:-

(a) That the Council implements a co-ordinated approach and in doing so:-

(i) works with partner organisations and the voluntary and community sector to deliver and promote early intervention and re-ablement services including the use of welfare notices and low level support services; and

(ii) identifies as a key priority, the importance of prevention across all Council services

(b) That the Council works closely with healthcare professionals to prevent future hospital admissions by:-

(i) developing an early identification process for people who are at risk of major health problems;

(ii) regularly monitoring patients and exploring the patients individual needs in depth; and

(iii) ensuring the transition from hospital is effectively and efficiently managed by improving communication across all discharge services

(c) That the Council explores the potential to offer further apprenticeships in social care in the challenging financial climate, and explores how incentives could be used to retain trainees once qualified.

ACKNOWLEDGEMENTS

The Committee is grateful to all those who have presented evidence during the course of our investigation. We would like to place on record our appreciation, in particular of the willingness and co-operation we have received from the below named:-

Hartlepool Borough Council:

Councillor Ged Hall – Portfolio for Adult and Public Health Services

Jill Harrison – Assistant Director - Adult Social Care

Phil Hornsby – Head of Service – Adult Social Care

John Lovatt – Head of Service – Adult Social Care

External Representatives:

Ward Councillors

Iain Wright - Member of Parliament for Hartlepool;

Hartlepool LINk

Hartlepool Carers

50+ Forum

NHS Tees

Tees, Esk and Wear Valleys NHS Foundation Trust

North Tees and Hartlepool NHS Foundation Trust

Professor Caroline Glendinning - University of York

Local residents

Photograph on front cover courtesy of www.careimages.com

COUNCILLOR JANE SHAW
CHAIR OF THE ADULT AND COMMUNITY SERVICES SCRUTINY FORUM

April 2012

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BACKGROUND PAPERS

The following background papers were consulted or referred to in the preparation of this report:-

(a) Report of the Scrutiny Support Officer entitled 'Scrutiny Investigation Into Early Intervention And Re-ablement Services – Scoping Report' presented to the Adult and Community Services Scrutiny Forum of 18 July 2011

(b) Report of the Scrutiny Support Officer entitled 'Early Intervention and Re-ablement Services – Setting the Scene – Covering Report' presented to the Adult and Community Services Scrutiny Forum of 15 August 2011

(c) Presentation of the Head of Service entitled 'Setting the Scene – Prevention, Early Intervention and Re-ablement' delivered to the Adult and Community Services Scrutiny Forum of 15 August 2011

(d) Report of the Scrutiny Support Officer entitled 'Early Intervention and Re-ablement Services - Evidence from the Member of Parliament for Hartlepool and the Authority's Portfolio Holder for Adult and Public Health Services - Covering Report' presented to the Adult and Community Services Scrutiny Forum of 15 August 2011

(e) Report of the Scrutiny Support Officer entitled 'How Early Intervention and Re-ablement Services are Currently Delivered in Hartlepool - Covering Report' presented to the Adult and Community Services Scrutiny Forum of 12 September 2011

(f) Joint presentation of the Child and Adult Services Department and North Tees and Hartlepool NHS Foundation Trust entitled 'Early Intervention and Prevention – Current Arrangements' delivered to the Adult and Community Services Scrutiny Forum of 12 September 2011

(g) Report of the Scrutiny Support Officer entitled 'Early Intervention and Re-ablement Services – Evidence from York University' presented to the Adult and Community Services Scrutiny Forum of 16 January 2012

(h) Presentation of the Professor of Social Policy entitled 'Home Care Re-ablement Services: What do they do? What impact do they have?' delivered to the Adult and Community Services Scrutiny Forum of 16 January 2012

(i) Report of the Scrutiny Support Officer entitled 'Supported Access to Independent Living Service (Sails) - Covering Report' presented to the Adult And Community Services Scrutiny Forum of 20 February 2012

(j) Presentation of Connected care entitled 'Who cares North East – Connected Care' delivered to the Adult and Community Services Scrutiny Forum of 20 February 2012

(k) Report of the Scrutiny Support Officer entitled 'Early Intervention and Re-ablement Services - Delivery of Services - Covering Report' presented to the Adult and Community Services Scrutiny Forum of 20 February 2012

(l) Presentation of North Tees and Hartlepool NHS Foundation Trust entitled 'Early Intervention and Re-ablement Services' delivered to the Adult and Community Services Scrutiny Forum of 20 February 2012

(m) Presentation of NHS Tees 'Re-ablement – The Role of NHS Tees' delivered to the Adult and Community Services Scrutiny Forum of 20 February 2012

(n) Presentation of Tees, Esk and Wear Valleys NHS Foundation Trust entitled 'The Re-ablement Agenda – Tees, Esk and Wear Valleys NHS Foundation Trust Contribution' delivered to the Adult and Community Services Scrutiny Forum of 20 February 2012

(o) Report of the Scrutiny Support Officer entitled 'Early Intervention and Re-ablement Services: Moving Forward Together: A Vision For Adult Social Care in Hartlepool - Covering Report' presented to the Adult and Community Services Scrutiny Forum of 20 February 2012

(p) Presentation of the Assistant Director of Adult Social Care entitled 'Moving Forward Together' delivered to the Adult and Community Services Scrutiny Forum of 20 February 2012

(q) The University of York, Research Works - The Organisation and Content of Home Care Re-ablement Services (2010),

(r) The University of York, Research Works – Home Care Re-ablement Services: Investigating the Longer-Terms Impacts (2011)

(s) Department of Health, Framing the Contribution of Allied Health Professionals: Delivering High Quality Health Care (2008)

(t) Department of Health, 'Ready to go? Planning the Discharge and the Transfer of Patients from Hospital and Intermediate Care (2010)

(u) Department for Health, Half Way Home Guidance (2009)