Havering
LONDON BOROUGH

INDIVIDUALS OVERVIEW & SCRUTINY SUB COMMITTEE

Subject Heading:	Reablement Update
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Policy context:	Supports priorities in the Joint Health & Wellbeing Strategy: • Better integrated support for people most at risk • Quality of services and patient experience
Financial summary:	No financial implications

The subject matter of this report deals with the following Council Objectives

Communities making Havering	[x]
Places making Havering	[]
Opportunities making Havering	[]
Connections making Havering	[]

SUMMARY

This report provides an update on the service delivery and performance outcomes of the Reablement Service delivered by Essex Cares Limited.

RECOMMENDATIONS

That members note the information presented in this report.

REPORT DETAIL

Background

Reablement is the active process of supporting an individual to regain skills, or gain new / alternative skills and confidence to enable them to remain living independently or with less support in their own home.

The Reablement service was recommissioned in 2018/19 with the new contract being awarded to Essex Cares Limited (ECL) and commencing in April 2019.

The previous recommissioning exercise which was undertaken in 2017, whereby London Borough of Havering (LBH) worked in partnership with Havering Clinical Commissioning Group (CCG) and North East London Foundation Trust (NELFT) to design a new integrated approach to reablement, ensuring a reduction in duplication and a greater focus on outcomes for the service user. There was a specific focus on delivering an integrated model of care with the rehabilitation service provided by NELFT (separately commissioned through the CCG) ensuring that people receiving both services experienced a joined up and coordinated service whilst driving efficiencies across the system.

In addition to the integration with rehab there were some other key changes to the service that were developed as part of the system wide design process. They included:

- Direct referral to the service from hospital therapists, eliminating duplication of assessment inherent in the previous process – this was in line with the Trusted Assessor model
- Contractual requirement to complete a reablement assessment at the service users home within 24 hours consistent with a ‘Home First’ approach
- A requirement to continually review progress against goals and a more in depth review at approx. 4 weeks to determine if further care is required post reablement.

The new design was very effective in enhancing quality, improving outcomes and ultimately supporting people to remain independent in their own home.

The new service

The most recent recommissioning exercise was an opportunity to review the successes of the new integrated approach and build on the design in line with council and system priorities such as HomeFirst and Better Living.

In terms of the specification for the service there were no significant changes but a greater emphasis on integration with key services on the intermediate care pathway and better connections with the community.

Performance – (data as of Dec 2019)

The service is commissioned to deliver approx. 1300 episodes of reablement per year, 108 per month.

The service has received an average of 154 referrals per month and accepted an average of 110.

There have been 182 joint reablement and rehabilitation cases

520 people have been supported to access other community services

KPI	Total Average (April-Dec 19)
% of referrals responded to within 1 hour	96%
% of assessments completed within 24 hrs	99%
Ongoing care hours reduced at the end of reablement period	517.52 (per month)
% of completed reablement packages which required no further care	92%
Average score of customers who completed satisfaction survey at the end of reablement period	93%

Service user outcomes

% of people fully or partially meeting their goals agreed at initial assessment:

Health & medication Management – 93%
Mobility – 90%
Accessing the community – 65%
Looking after yourself – personal care – 88%
Looking after yourself – home skills – 79%
Support Networks – 93%

Challenges

There are some challenges with the service which are being continuously worked through with system partners. The key challenge, specifically over the winter period is capacity – as the performance figures show, the demand for the service far exceeds the commissioned activity. The provider has been able to respond well to demand in general but there has been a requirement to purchase additional capacity from other providers to ensure the patient flow at the hospital isn't affected.

There are many things which are affecting the provider's capacity which include the number of failed discharges they experience from the hospital and the number of people/families refusing the service at the first visit. This is being managed with system partners to minimise impact in future months.

System partnership working
Since the new service commenced in April 2019 the partnership working across the system has developed significantly which has positively impacted all areas of the service.

Quarterly stakeholder meetings are held with representation from ECL, BHRUT, LBH community team managers and NELFT. This has become a transparent and constructive forum to deal with issues any of the partners are experiencing. Feedback regarding this meeting is extremely positive and it has enabled continuous refinement of the pathway and processes.

ECL have worked in partnership with LBH and BHURT to undertake a pilot to test the 'Home First' concept which ensures no decisions about care are made while the person is in an acute environment. ECL have supported this by providing a therapist to meet the service user in their home following discharge to undertake their functional assessment. The outcomes of the first phase of this pilot have been very positive with a reduction in bed days, care hours, equipment and ongoing therapy needs. Phase 2 of the pilot is due to commence on 1st March.

Future service plans
Following the Home First pilot it is envisioned that this becomes the default discharge pathway for all patients in the hospital which should see a reduction in demand from the hospital due to people being assessed in their own home. This will release some capacity in the service to allow more referrals from the community. The potential for improved outcomes is significant as currently almost all people referred to reablement from the community do not require further care at the end of the service period.

There are plans to explore integrating reablement into the Locality plans focusing on delivering services at locality level across the borough and also further developing connections with community services.

IMPLICATIONS AND RISKS

Financial implications and risks: None applicable to this report

Legal implications and risks: None applicable to this report

Human Resources implications and risks: None applicable to this report

Equalities implications and risks: None applicable to this report