Agenda No 5

# Adult Social Care and Health Overview and Scrutiny Committee – 25th October 2011

# Reablement : Data on demand for the service

## Recommendations:

The Overview and Scrutiny committee are asked to:

1. Consider and comment on the information presented on demand for the reablement service
2. Recognise the report on the Evaluation of the Home Care Reablement Service (Cabinet 8th September 2011) for context and further information
3. Continue to support the development of Reablement

## 1. Introduction

This report provides the data and narrative on customer demand and eligibility for reablement, including:

- how many customers accessed the service
- how many customers bypassed reablement
- how many customers who were eligible for reablement did not receive a service upon their hospital discharge.

## 2. Background

2.1 The Warwickshire Reablement Service was launched in March, 2010, initially in Nuneaton and Bedworth. Via a phased roll-out, it became available countywide since November 2010. The phased roll-out was linked to the changes in the council's long term home support service and the transfer of some customers receiving council provided home support, to the independent sector. The phasing also enabled learning and intelligence from the initial stages to be applied and build into improved practices and processes, as the service established a countywide presence.

2.2 The Reablement Service currently receives around **40** referrals a week and accepts around **30** customers per week, equating to around **162** customers receiving the service at any one time.

2.3 It delivers approximately **1,628** hours of reablement home care support per week.

2.4 42% of customers at any time have higher level needs requiring the input of an Occupational Therapist.

2.5 Current criteria reflect the need to safely utilise the capacity available. The current criteria incorporates countywide access to the Reablement Service to anyone who currently does not receive a home care service, has a substantial or critical FACs eligible need and has a physical impairment. However, as capacity allows, people with existing home care packages are considered in hospital discharge situations, to enable maximum opportunity to facilitate timely discharges and positive outcomes.

2.6 The outcomes from the developing service have been extremely positive. An analysis of the activity between 1.11.2010 to 31.01.2011 indicated that approximately **71%** of service users who have received the service, have left no longer needing ongoing homecare provided by Adult Social Care.

This compares favourably with the national research evidence on reablement services.

2.7 It is important to note that these indicators, which reflect national research practice, only capture the raw data with respect to whether a person does or does not receive an ongoing home support package. It does not capture whether service users were readmitted to hospital, entered residential care, deceased or in receipt of a direct payment. To gain improved quality of management information with respect to these indicators, work is being undertaken both internally and with health colleagues, for example, to access hospital admissions within this period.

1.8 The longer term objective from April 2012, is to have widened the access criteria to provide the Reablement Service to as many eligible people who would benefit as possible. National research evidence has been used to identify a criteria which reflects the cohort of people who will benefit from the Reablement Service, for example, early identification that there is potential for improved outcomes. This development will reduce long term social care need, as well as support the reduction of inappropriate hospital admissions as well as contributing to timely hospital discharge support. This will mean that all eligible people are supported to regain / retain their maximum independence in their own home through the intensive support of reablement home carers and therapy intervention by occupational therapists, usually for a period of up to 6 weeks.

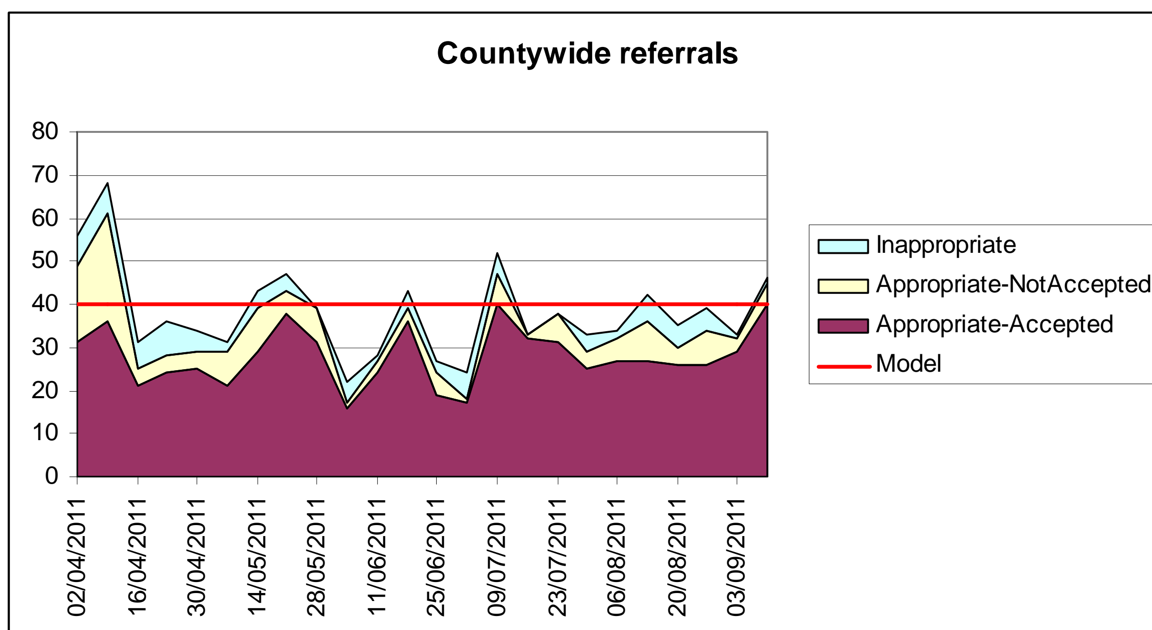
The reduction in long term social care services translates as better outcomes for Warwickshire County Council (WCC) service users, and the realization of cost efficiencies for WCC by reducing the costs of long term social care. Additionally, health partners should experience benefits, in terms of the positive impact on timely hospital discharges and inappropriate hospital admission rates. The development and expansion of the Reablement Service is underway, in order to deliver these objectives.

This report provides information on demand for the reablement service for customers leaving hospital and new customers in the 6 month period April 2011 to September 2011

## 3. Reablement Referrals

3.1 The modelling for predicted referrals into reablement, indicated that countywide across Warwickshire the service should receive **40** referrals per week

The graph below illustrates the Countywide referrals from 02/04/11 to 03/09/11




The predicted number of referrals (40) has largely been realised on average.

Referrals into the service include those who were inappropriate, for example people who were not medically fit, people who were not FACS eligible for service, people with a diagnosis of dementia and people who were unable to participate in a reablement programme.

Referrals also include service users who were accepted into the service based on the referral information, but following assessment by reablement were not appropriate.

This may be due to declining health, because reablement is not able to meet their assessed needs or that the service user has a cognitive impairment which reduces their ability to participate in a reablement programme.

These people remain in reablement until alternative support is identified and provided.

3.2 The table below illustrates in greater detail the Countywide referrals over a 4 week period from 20/08/11 to 10/09/11, which also highlights the fluctuations of referrals on a weekly basis



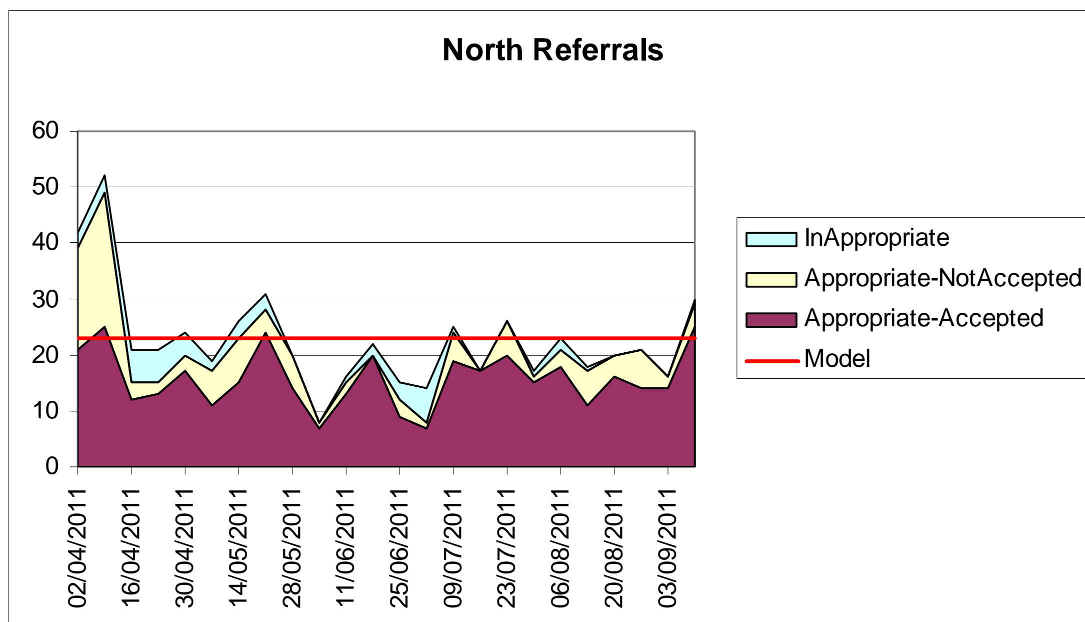
Warwickshire County Council

| Week Ending | Appropriate | Appropriate-Accepted | Appropriate-Not Accepted | Inappropriate | Total | Model |
|---|---|---|---|---|---|---|
| 20-Aug-11 | 30 | 26 | 4 | 5 | 35 | 40 |
| 27-Aug-11 | 34 | 26 | 8 | 5 | 39 | 40 |
| 03-Sep-11 | 32 | 29 | 3 | 1 | 33 | 40 |
| 10-Sep-11 | 45 | 40 | 5 | 1 | 46 | 40 |
| Average since Apr 2011 | 34 | 28 | 6 | 4 | 38 | 40 |

3.3 The Countywide referrals are further broken down into North and South localities .

The predicted referrals for the **North** were **23** per week

The graph below illustrates North referrals from 02/04/11 to 03/09/11




The predicted number of 23 referrals per week has been realised.

In May 2011 and July 2011 the North received significantly fewer referrals for a short period of time. This was due to the cumulative affect of ward closures at George Elliot Hospital, when patients were discharged into Intermediate Care and bypassed reablement.

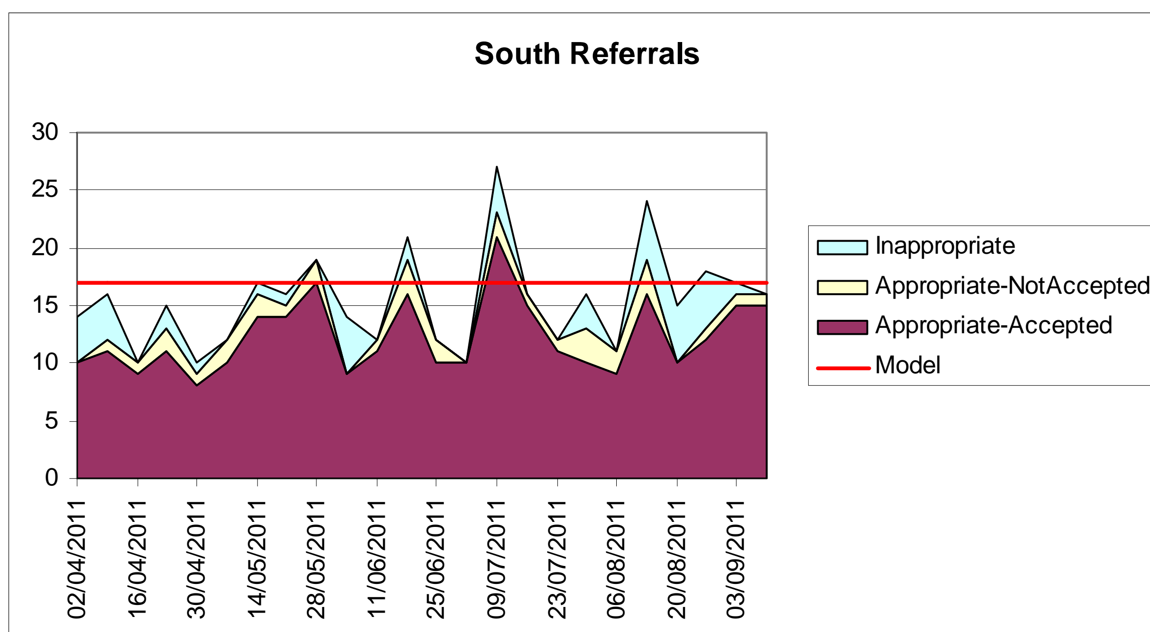
3.4 The table below illustrates in greater detail the North referrals over a 4 week period from 20/08/11 to 10/09/11, which also highlights the fluctuations of referrals on a weekly basis :

3.5

| Week Ending | Appropriate | Appropriate-Accepted | Appropriate-Not Accepted | Inappropriate | Total | Model |
|---|---|---|---|---|---|---|
| 20-Aug-11 | 20 | 16 | 4 | | 20 | 23 |
| 27-Aug-11 | 21 | 14 | 7 | | 21 | 23 |
| 03-Sep-11 | 16 | 14 | 2 | | 16 | 23 |
| 10-Sep-11 | 29 | 25 | 4 | 1 | 30 | 23 |
| Average since Apr 2011 | 21 | 16 | 5 | 3 | 23 | 23 |

The predicted referrals for the **South** were **17** per week

The graph below illustrates South referrals from 02/04/11 to 03/09/11




On average, the modelling of 17 referrals per week is just below this prediction.

The table below illustrates in greater detail the South referrals over a 4 week period from 20/08/11 to 10/09/11, which also highlights the fluctuations of referrals on a weekly basis

| Week Ending | Appropriate | Appropriate-Accepted | Appropriate-NotAccepted | Inappropriate | Total | Model |
|---|---|---|---|---|---|---|
| 20-Aug-11 | 10 | 10 | | 5 | 15 | 17 |
| 27-Aug-11 | 13 | 12 | 1 | 5 | 18 | 17 |
| 03-Sep-11 | 16 | 15 | 1 | 1 | 17 | 17 |
| 10-Sep-11 | 16 | 15 | 1 | | 16 | 17 |
| Average since Apr 2011 | 14 | 12 | 2 | 3 | 15 | 17 |

## 4. Referrals by Source

4.1 Currently, referrals are received directly into reablement from Community Social Work Teams (OPPD) or Hospital Social Care Teams (HSCT).

The referrals from the HSCT are generated by a referral to them by ward staff, who have identified that a patient will require some element of social care support upon discharge from hospital.

The Customer Contact Centre will receive initial queries from GP's, District Nurses, family members, or the service user themselves, and the contact centre will forward these onto the relevant OPPD team for them to contact the service user for further information and generate a referral to the appropriate service.

**North**
In the North, between 02/04/11 and 03/09/11 there were **544** referrals into reablement.; of these **377** went on to receive a reablement service .

42% of referrals in the North came from the HSCT
36% of referrals in the North came from OPPD

Total referral numbers and percentages

| | Friend/Relative | HSCT | OPPD | Other | PHILLIS | Total |
|---|---|---|---|---|---|---|
| **Appropriate** | 0 | 213 | 183 | 83 | 17 | 496 |
| **Inappropriate** | 0 | 17 | 18 | 11 | 2 | 48 |
| **Total** | 0 | 230 | 201 | 94 | 19 | 544 |

| | Friend/Relative | HSCT | OPPD | Other | PHILLIS | Total |
|---|---|---|---|---|---|---|
| **Appropriate** | 0% | 43% | 37% | 17% | 3% | 100% |
| **Inappropriate** | 0% | 35% | 38% | 23% | 4% | 100% |
| **Total** | 0% | 42% | 37% | 17% | 3% | 100% |

The referral source which lead to a Reablement service being provided, (and shown as a percentage)

| Friend/Relative | HSCT | OPPD | Other | PHILLIS | Total |
|---|---|---|---|---|---|
| 0 | 164 | 136 | 63 | 14 | 377 |

| Friend/Relative | HSCT | OPPD | Other | PHILLIS | Total |
|---|---|---|---|---|---|
| 0% | 44% | 36% | 17% | 4% | 100% |

4.2 **South**
In the South, between 02/04/11 and 03/09/11 there were **373** referrals into reablement; of these **305** received a reablement service .

57% of referrals in the South came from HSCT
40% of referrals in the South came from OPPD


Warwickshire County Council

Total referral numbers and percentages

| | Friend/Relative | HSCT | OPPD | Other | PHILLIS | Total |
|---|---|---|---|---|---|---|
| **Appropriate** | 2 | 200 | 121 | 6 | 0 | 329 |
| **Inappropriate** | 0 | 14 | 28 | 2 | 0 | 44 |
| **Total** | 2 | 214 | 149 | 8 | 0 | 373 |

| | Friend/Relative | HSCT | OPPD | Other | PHILLIS | Total |
|---|---|---|---|---|---|---|
| **Appropriate** | 1% | 61% | 37% | 2% | 0% | 100% |
| **Inappropriate** | 0% | 32% | 64% | 5% | 0% | 100% |
| **Total** | 1% | 57% | 40% | 2% | 0% | 100% |

The referral source which lead to a Reablement service being provided (and shown as a percentage)

| Friend/Relative | HSCT | OPPD | Other | PHILLIS | Total |
|---|---|---|---|---|---|
| 2 | 192 | 105 | 6 | 0 | 305 |

| Friend/Relative | HSCT | OPPD | Other | PHILLIS | Total |
|---|---|---|---|---|---|
| 1% | 63% | 34% | 2% | 0% | 100% |

## 5. Access for new customers

5.1 Previously, our analysis estimated that not more than 35% of new service users in AH&CS had the opportunity to receive reablement in the first instance.

Since March 2011, **570** people started a home care service, who were new service users, of these, **240** received reablement prior to starting their ongoing home care service

Therefore, **42%** of new home care service users received reablement first, which is an improvement on the 35% previously reported

## 6. Future Developments

6.1 The current eligibility criteria does limit access into the service. From October 2011 through to April 2012 there is a phased implementation countywide of revised eligibility criteria which will essentially enable the reablement service to be offered to as may eligible people as possible.

We predict 79 referrals per week countywide with the revised eligibility criteria.

Through learning throughout implementation, we have identified that typically 80% of people referred into reablement actually go on to receive a service, therefore we should expect to see 63 people per week. This has taken into account a 20% reduction for those service users who are not suitable for reablement

| District | 2009 Customer base | New OPPD | New HSCT | New Total | Restarts HSCT | Increases OPPD | Total |
|---|---|---|---|---|---|---|---|
| North Warwickshire | 350 | 4 | 3 | 7 | 3 | 4 | 14 |
| Nuneaton & Bedworth | 737 | 5 | 5 | 10 | 5 | 5 | 19 |
| Rugby | 444 | 3 | 3 | 7 | 3 | 3 | 12 |
| Stratford | 617 | 4 | 4 | 7 | 3 | 4 | 15 |
| Warwick | 680 | 4 | 6 | 10 | 5 | 4 | 19 |
| **County Total** | **2828** | **20** | **20** | **40** | **18** | **20** | **79** |

| District | Table to show that, typically 80% of the above are suitable to receive a Reablement service<br>Referrals leading to Reablement |
|---|---|
| North Warwickshire | 11 |
| Nuneaton & Bedworth | 15 |
| Rugby | 10 |
| Stratford | 12 |
| Warwick | 15 |
| **County Total** | **63** |

| Area | Number / week |
|---|---|
| North | 36 |
| South | 27 |
| | |
| **Total** | **63** |

6.2 Joint Developments with Health Partners

Work has already commenced with health colleagues from both primary and secondary care to ensure that a collaborative model of intermediate care, reablement and community services is developed. The expectation is that referrals will come into reablement directly from intermediate care teams, to support timely hospital discharges and ensure a persons assessed needs are met by the service best placed to meet those needs.

Trusted assessments have been developed with health colleagues, and when established will support direct access into the service from hospitals. A suite of reports is being developed which will provide qualitative data on numbers of people referred into reablement directly from wards and from Intermediate Care Teams.

This forms part of the ongoing development of the service, building on the success to date and the positive outcomes for service users and the organisation thus far.

## Background Papers

| Cabinet 8 September 2011 – Evaluation of the Home Care Reablement Service |
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Report Author: Joanne Allen

Head(s) of Service: Jenny Wood

Strategic Director(s): Wendy Fabbro

Portfolio Holder(s): Cllr Mrs Izzi Seccombe