ENHANCED INDEPENDENCE OFFER – REABLEMENT SERVICES

Cabinet Date	19 June 2019
Adult Social Care Commissioning **Adult Social Care Delivery**	Cllr Roger Wilson Cllr Kathy Williams
Key Decision	Yes
Background Documents	Care Act 2014 Community Care (Delayed Discharges etc.) Act 2003 LAC (DH) (2010) 6: The Personal Care at Home Act 2010 and charging for reablement.
Location/Contact for inspection of Background Documents	http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted http://www.legislation.gov.uk/ukpga/2003/5/contents https://www.gov.uk/government/publications/lac-dh-2010-6-the-personal-care-at-home-act-2010-and-charging-for-re-ablement
Main Consultees	In undertaking the work to date to redesign Reablement Services for the future there has been considerable internal engagement and working in co-design with system partners, including: ▪ Gloucestershire County Council: • Adult Social Care Teams • Strategic Finance • Commercial Team • Brokerage • Information & Performance Management ▪ Gloucestershire Clinical Commissioning Group ▪ Gloucestershire Care Services NHS Trust ▪ Joint Commissioning Partnership Executive (JCPE) ▪ Joint Commissioning Partnership Board (JCPB)

Planned Dates	June 2019	Complete detailed service specifications for the components of the future Reablement Service and short-term bed capacity to support commissioning and commercial negotiations to vary contracts and commence operationalisation of future pathways.
	June 2019	Commence engagement and consultation with core Reablement Staff employed by the Council regarding service configuration and working patterns required to implement Home First and Reablement Services.
	August 2019	Specifications agreed with service Lead Providers.
	November 2019	Home Based Pathway go-live.
	March 2020	Bed Based Pathway go-live.
Divisional Councillor	All	
Officer	Kim Forey, Director of Integration Email: kimforey@nhs.net	
Purpose of Report	To develop and agree with Gloucestershire Care Services NHS Trust a new reablement service in Gloucestershire to support people thereby allowing them to remain independent in their own homes (the "Reablement Service").	
Recommendations	That Cabinet authorises: 1. The Director of Integration, in consultation with the Cabinet Members for Adult Social Care Commissioning and Adult Social Care Delivery, to work with Gloucestershire Care Services NHS Trust (GCS) as the preferred single lead provider in reconfiguring and expanding the Home Based components of the Reablement Service; including the establishment of a Home First offer that supports discharge from hospital. 2. The continued utilisation of Gloucestershire County Council (GCC) employed reablement workers (currently managed by GCS under existing Section 113 arrangements) as the core staff that will deliver the higher levels of home-based reablement activity including the proposed new Home First service. 3. The implementation of additional staffing capacity to deliver the Home-Based activity described in paragraph 1 above will be achieved through recruitment to currently established GCC roles (with potential additional capacity to be commissioned by GCS under Lead Provider arrangements). 4. To adopt the Enhanced Independence Offer Operating Model outlined in section 3.3 of this report ('the Model) to enable people to remain independent for longer in their own homes. This will enable the reconfiguration of short-term bed capacity, under existing contracts with	

	third party suppliers, into ring fenced units that will provide capacity across the County. This will be optimised for the predicted reduction in reablement and assessment activity as more people receive support at home. Provision at Great Western Court will continue alongside the Enhanced Independence Offer Operating Model outlined in section 3.3 of this report (the "Model"). 5 The targeting of existing GCC reablement services and funding in support of the proposed Model, whilst noting that the final configuration of reablement services will be determined by the Joint Commissioning Partnership Board once NHS as well as GCC's Adult Social Care demand and benefits are taken into account.
Reasons for recommendations	This proposal will allow the implementation of the principles and future operating model described in the "Enhanced Independence Offer – Reablement Strategy for Gloucestershire" (the "Strategy"). This will be key to delivering the benefits detailed in Section 2 of this report.
Resource Implications	The proposed Model would make better use of existing Council expenditure on reablement and domiciliary care provision enabling the achievement of MTFS savings. It also creates the potential to enhance service delivery to meet wider Health and Social Care system needs funded through reduced use of acute hospital services and the need for residential care. The final shape and scope of this joint service would thus, if approved, be determined by the Joint Commissioning Partnership Board.

MAIN REPORT CONTENTS

1. Background

1.1 In line with the national context, the Council's Adult Social Care function continues to face significant challenges. In Gloucestershire it is estimated that 47,500 people over the age of 45 are living with a long-term condition. This is projected to rise to 77,000 by 2030. The Care Act, which became law in April 2014, sets out a legal requirement for the Council to deliver a better response to service users and their carers, along with a more cohesive strategy to prevent, delay and reduce people's dependency on long-term Adult Social Care.

1.2 Alongside implementation of the Act and the increased demand for better Adult Social Care services, there is a need to deliver services in a more efficient and cost-effective way whilst complying with the statutory requirement to meet a person's identified social care needs.

1.3 In addition to consolidating health and social care law, the Care Act also challenged the Health and Social Care Economies to work in a more integrated way across shared boundaries with co-located or even fully integrated teams and budgets. In "Working together for a better future: supporting closer integration of health and social care" produced by NHS England in February 2018, its Strategy Team published four key themes:

- Right care in the right place – crisis avoidance
- Joining up processes of assessment
- Right care in the right place ongoing care
- Considering the needs of the whole person

Gloucestershire is at the vanguard of the Integrated Care System approach which superseded the Sustainability and Transformation Partnership (STP) aiming to bring together services for people in need with the four aims above at the heart of service development. This Strategy will underpin the above.

1.4 Underpinning the delivery of the Adult Single Programme is culture change, based on a three-tier conversation model (the "Three Tier Conversation Model"). This model is being used successfully by many local authorities in England to cope with increasing levels of demand in accordance with the requirements of the Care Act, using existing resources. This represents a significant change to social work practice and front-line staff are being trained to have a different conversation, favouring one that places the emphasis on an asset-based approach (considering what the person can do for themselves), as opposed to the deficit-based conversation that historically encouraged dependency on social care, thereby preventing independence and people helping themselves. The Three Tier Conversation Model will help people to:

1. Help themselves – tier 1

2. Get help when needed – tier 2

3. Get ongoing support for themselves or for others when needed – tier 3

1.5 The proposed new Model will transform the current tier 2 pathways described above, simplifying care navigation, managing demand more effectively and focusing on people's outcomes through a consistent 'Re-abling' philosophy that helps people remain at home and live independently longer. Reablement is a philosophical approach that focuses on regaining, maintaining or improving those daily skills a person might need to live independently. It will

focus on rehabilitation, covering a person's physical and emotional needs, as well as making sure all professionals look at community solutions for services. This will be undertaken rather than stipulating state provided services that might be introduced too soon and potentially impacting upon a person's independence in a negative way. The proposed new Model compliments wider work across the local Integrated Care System (ICS) such as the Frailty Service and Complex Care at Home, as well as the increased range of support in Primary Care which is being developed through the new Primary Care Networks (PCNs).

2. Potential Service Benefits:

2.1. Simplified discharge pathways for people requiring assessment or additional short-term support will expedite discharge from hospital and result in 58% of people returning home and receiving therapy led support to maximise their potential to live independently for as long as possible.

2.2. Improving outcomes for people receiving Reablement Services to increase the proportion of people being fully re-abled with no requirement for on-going support from statutory services. This will benchmark Gloucestershire positively against the National Audit of Intermediate Care.

2.3. There will be a reduction of 30 of beds required in the future Bed Based Pathway as more service users return home as the default. Home based care is generally more cost efficient and achieves better outcomes for people.

2.4. The proposed Model is expected to have a wider positive impact at a system level, including: 276 fewer long-term Domiciliary Care packages, 6 fewer Residential Care places, 151 fewer Nursing Care places and 197 fewer hospital readmissions. These benefits will help reduce the pressure and costs within Tier 3 services.

2.5. Maximise links to wider council initiatives, including the use of wider local assets where possible that people can access through the Voluntary, Community & Social Enterprise (VCSE) sector and other innovative council initiatives such as '***Your Circle***' *(our self help portal)*

2.6. Support the increased use of digital technologies and short-term support when needed to delay formal care as long as possible.

3. Proposal

3.1 This proposal is to reconfigure the Reablement Service by implementing the new Model to improve outcomes for people by allowing them to remain at home living independently for longer, simplify the customer journeys through the care system, maximise efficiency and cost effectiveness; ultimately contributing to financial savings by reducing the number of long-term domiciliary and residential packages required. The proposed Model will also build on elements of current good practice and ensure that the three-tier conversations being adopted by the Social Work Teams are fully integrated into new ways of working.

3.2 In reconfiguring the Reablement Service the programme will ensure that aspects of the service are compliant with CQC registration requirements and implements the principles of the latest guidance and best practice recommended for Intermediate Care Services, including Reablement by the National Institute for Health & Care Excellence (NICE)[1], the Local

[1] NICE guideline [NG74], 2017

Government Association (LGA) and the Association of Directors of Adult Social Care (ADASS).

3.3 It is intended that simplifying the Model will improve outcomes by reconfiguring services into 2 clear pathways that will navigate people back to their own homes as the default (with support if required). There will also be short-term beds commissioned in designated units for people with more complex support needs to commence their reablement or assessment of on-going care needs prior to a return home or into a further package of support. Currently there are also several referral routes into home-based services, which also adds to the complexity and inefficiencies. The main referral sources are 42% from acute hospitals, 20% from community hospitals and 38% from the community itself. The proposed new Model will continue to support referrals from these sources in the future but there will be basic rules that ensure:

- The referrer does not make a decision on the most appropriate service
- The referrer ensures the most up to date and relevant information is passed on

An outline of the proposed new Enhanced Independence Offer Operating Model ("the Model") is illustrated below:

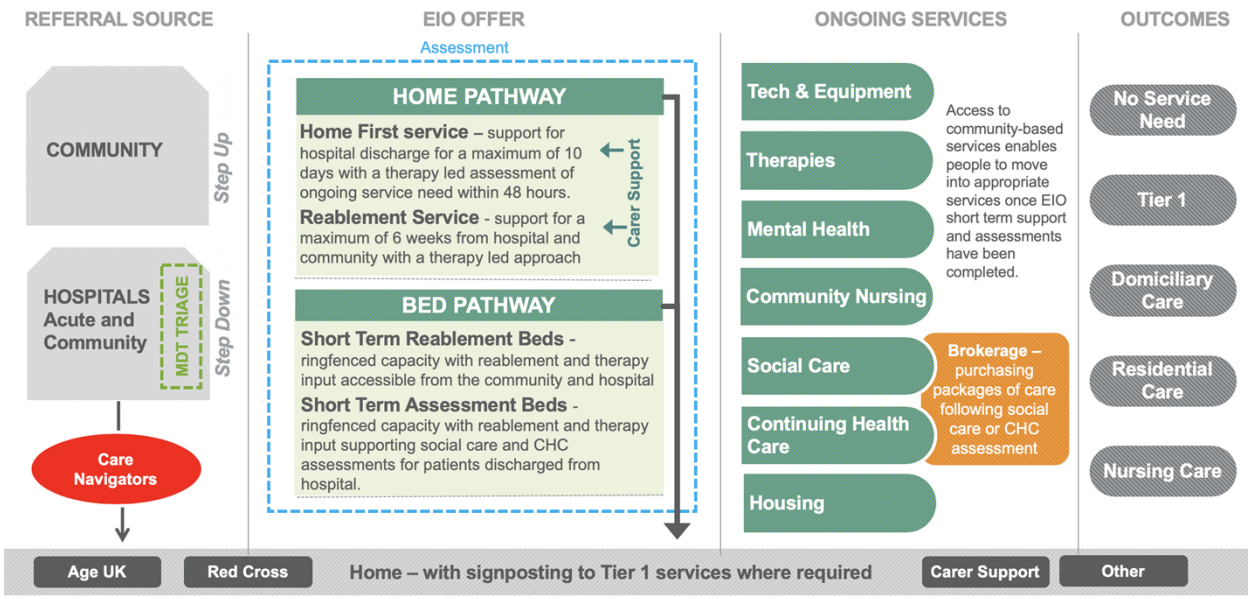

Fig 1. Outline of the proposed new Enhanced Independence Offer Operating Model

3.4 The new home-based pathway will consist of the Home First Service and the Reablement Service, as illustrated above. They will be provided by a lead provider with additional capacity provided from the external domiciliary care sector if required.

3.4.1 Home-Based Pathway – Will be therapy led and delivered through a Home First and Reablement Service that begins with up to 48 hours of intensive support and assessment overseen by a lead therapist. During this time decisions will be made regarding need to go onto further reablement for up to six weeks or proceed to Tier 3 for continuing care (statutory assessment) services. Following a maximum of 10 days in the Home First Service those with further reablement potential will transfer into the Reablement Service for up-to six weeks of funded care inclusive of the time spent in the Home First part of the service. Reablement Service users will not perceive a change in their service provision unless it is a reduction in visits based upon an assessment. The pathway is described in more detail at Section 5.5.2 of the Strategy (Appendix 1).

3.4.2 The proposed strategy to implement this service will be to reconfigure and expand the current Reablement Service that is managed by Gloucestershire Care Services NHS Trust (GCS) and utilises the Gloucestershire County Council (GCC) employed reablement workers. This will mean rebalancing and stabilising the correct staffing levels and professional grade ratios to ensure sufficient capacity is in place to support the demand levels predicted through detailed capacity and workforce modelling[2].

3.4.3 Rationale for the Home-Based Pathway approach – The following points highlight the rationale for recommending that commissioners work with GCS and continue to use the current reablement workforce employed by GCC under a Section 113 agreement:

- Supports the development of the ICS and local service delivery including the ISCMs (Integrated Social Care Managers), Integrated Care Teams (ICT) and Primary Care Networks (PCN).

- Unit costs of external providers are higher and the external market has previously failed to respond to provide discharge from hospital services like Hospital to Home across all parts of the county.

- Transfers full delivery and outcomes to GCS thus creating momentum and incentives to improve productivity and performance.

- Reduces the risk of market failure.

- More people will therefore be able to live independently at home with no need for ongoing services.

3.5 Bed-Based Pathway – Will be delivered from 'ring fenced' capacity commissioned to support therapy led reablement or assessment on a short-term basis for a maximum of 6 weeks. It is intended that capacity will be provided in each locality across the county in designated units commissioned from the external care market, with clearly specified requirements to support people rehabilitate and regain maximum independent living skills in order that they can return home. This pathway and bed capacity will also replace the existing Discharge to Assess (D2A) beds that are currently spot purchased across the county to ensure better outcomes for these people.

3.5.1 The reconfiguration of these short-term reablement and assessment beds will be undertaken as part of the Gloucestershire County Council Care Home Strategy. Overall there will be a net reduction in the bed-based capacity required for this pathway as the number of people navigated through the Home Pathway increases. Capacity will also be reconfigured to provide care in each of the Districts across the county, resulting in the delivery of short-term bed-based care being closer to people's usual place of residence. The proposed capacity requirements have been based on predicted demand levels[3] the individual District population density and demographics.

3.5.2 Rationale for the approach – The following points highlight the rationale for recommending that commissioners reconfigure beds as detailed in Section 5.5.6 in the Strategy (Appendix 1).

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[2] Analytical work undertaken by iMPOWER / Caja (2018/19) and validated and verified through the Adult Single Programme key stake-holders.

[3] Analytical work undertaken by iMPOWER / Caja (2018/19) and validated and verified through the Adult Single Programme key stake-holders.

▪ The reconfiguration will provide appropriate levels of predicted capacity at a locality level and better distributed across the county.

▪ The pathway and reconfigured capacity will enable people requiring assessment, or with more complex needs, and unable to immediately return home, to be actively re-abled.

▪ The pathway will reduce delays in hospital and improve outcomes.

▪ The pathway will reduce unnecessary social care and CHC assessments.

3.6 Enablers – There are some key enablers being designed either within the Gloucestershire Clinical Commissioning Group or at a system level that will need to be integrated, as illustrated in the Model in section 3.3 of this report, to ensure the new pathways work effectively.

3.6.1 Triage & Navigation – Is being aligned with wider work being undertaken across the local health and care system. Specifically, there is work being undertaken with support from NHS England to ensure that the routes out of hospital for patients returning home works more efficiently. Details of this work are contained in Section 5.5.8 of the Strategy (Appendix 1).

3.6.2 Brokerage – Capacity in brokerage is often required to operate reactively in response to system pressures, particularly in managing Delayed Transfers of Care from hospital; this is in addition to its primary role commissioning longer-term packages of care and shaping and managing the local care market. Effective brokerage and an external care market that is commissioned effectively and able to respond in all parts of the county is critical to the new Model being successful. In particular, the ability of the local domiciliary market to provide care in all parts of the county. Details of this work are contained in Section 5.6 of the Strategy (Appendix 1).

4. Impact on Activity, Capacity

4.1 Work has been undertaken within the Adult Single Programme to conduct detailed analysis of current activity, capacity and workforce to create a baseline from which future projections have been calculated. The baseline has been developed using a consistent time period of sample data where practicable[4]. Future projections have been calculated using a set of validated assumptions about the new pathways and best practice benchmarks where they exist and applied to forward looking projection of 3 years. Summaries of the projected impacts are detailed in Section 4.11 of the Strategy (Appendix 1).

5. Workforce

5.1 The right level and type of workforce will be critical to the delivery of the future pathways and recommendations are based on detailed work to minimise risk to services whilst maximising the use of local resources. A number of options have been considered in making recommendations about the workforce and the need to reconfigure services quickly and have a sustainable service within a finite budget have been the overriding factors that have determined that building on the current Gloucestershire County Council employed workforce is the best option. Details of the current staffing levels and the required future changes are detailed in Section 6 of the Strategy.

[4] Data period for baseline activity, capacity & workforce covers 12 months from August 2017 – July 2018

5.2 Specifically, the planned workforce plan will require that the service continues to utilise the Gloucestershire County Council employed reablement workers (currently managed by Gloucestershire Care Services under existing Section 113 arrangements) as the core of the capacity needed to deliver the higher levels of home-based reablement activity including the new Home First service. There will also be a requirement to secure additional capacity to deliver the predicted levels of home-based activity which will be implemented through recruitment to currently established but vacant council roles, and any additional capacity commissioned by Gloucestershire Care Services under Lead Provider arrangements.

6. The Financial Business Case

6.1 The proposed new Model will make better use of existing Council expenditure on reablement and domiciliary care provision enabling the achievement of savings. It also creates the potential to enhance service delivery to meet wider Health and Social Care system needs funded through reduced use of acute hospital services and the need for residential care. The final shape and scope of this joint service would thus, if approved, be determined by the Joint Commissioning Partnership Board.

7. Risk Assessment

7.1. A full risk register has been developed for the Enhanced Independence Offer (EIO) Cluster and the top 5 risks identified in respect of reconfiguring Reablement Services are as follows:

7.1.1 There are currently issues recruiting and retaining reablement staff, resulting in variation of staffing levels and ability to deliver current services across the county. Having a sufficient and well-trained workforce is crucial to enabling delivery of the new Model, particularly with competition for workforce from other sectors.

7.1.2 Staff and Union relations will impact upon any of the service transformation.. There could also be significant resistance from operational staff to proposed changes.

7.1.3 There is a risk that the simplified pathways will be overwhelmed with referrals, as the system may see reconfigured services as an easy answer to immediate operational issues facing acute hospital discharge. However, predicted future capacity has been calculated using local data and capacity will be capped based on predicted levels of activity and the affordability envelope.

7.1.4 The inability or lack of appetite by the local care market to support either additional reablement worker or personal care capacity in the Home-Based Pathway, and provision of both short-term or on-going Domiciliary Care packages in all parts of the county to support the flow out of reablement services could create issues with system flow. It will be essential that the local care market is shaped and incentivised to be responsive across the county.

7.1.5 Whilst there is a good working relationship between GCS and GCC there is a notice period to enact changes to the current contract. This is low on the risk register.

7.1.6 With so much transformation taking place within the local health and social care sector there is a risk of strategy, policy and procedural misalignment. Whilst this is mitigated through the Integrated Care System approach, good partnership working and consultation, it still remains a low-level risk.

8. Options and Officer Advice

a) Option 1 Do nothing

Do nothing is not an option in Gloucestershire due to increasing demands on statutory services across the county and ensuring that GCC continues to execute its responsibilities.

b) Option 2 Cabinet approves the recommendations as set out in this report.

The proposals detailed in this document and the accompanying Strategy have been developed following a detailed review of current services. The proposed Enhanced Offer makes the best use of resources and will improve outcomes for citizens.

Officer advice: Approving the recommendations detailed in this report, that are based on detailed future activity and financial modelling, will enable GCC to work in partnership with local partners as part of the Gloucestershire Integrated Care System to enable people to remain living independently, at home, for longer.

9. Equalities considerations

9.1 A Due Regard Statement has been completed and has found the impact of these proposals to be positive across most characteristics, with opportunities to improve service provision. Cabinet Members should read and consider the Due Regard Statement in order to satisfy themselves as decision makers that due regard has been given.

10. Performance Management/Follow-up

10.1 A robust performance framework will be developed as part of the contractual arrangements, offering clear oversight of these services. In principle it will focus on improving compliance with published policy, standards, guidance and best practice, including**:**

- Intermediate care including reablement Quality Standard. QS173 NICE
- Intermediate care including reablement NICE Guidance. NG74
- NICE Quality Standard. QS136
- NHS Five Year Forward View (Oct 2014)
- Intermediate Care Beds review (2017)
- NHS England Commissioning guidance for rehabilitation, NHS England (March 2016)
- The King's Fund making our health care systems fit for an ageing population (2014)
- Rehabilitation is everyone's business: Principles and expectations for good adult rehabilitation Version number: 1.0 First published: (June 2015)
- National dementia strategy (DOH 2009)
- Intermediate Care – Halfway Home Intermediate Care, (2009, Updated Guidance for the NHS and Local Authorities)
- Putting People First (A shared vision and commitment to the transformation of Adult Social Care 2007)
- The Care Act 2014

Report Title	Enhanced Independence Offer – Reablement Services
Statutory Authority	Care Act 2014 Community Care (Delayed Discharges etc.) Act 2003 LAC (DH) (2010) 6: The Personal Care at Home Act 2010 and charging for reablement.
Relevant County Council policy	
Resource Implications	The proposed Model would make better use of existing Council expenditure on reablement and domiciliary care provision enabling the achievement of savings. It also creates the potential to enhance service delivery to meet wider Health and Social Care system needs funded through reduced use of acute hospital services and the need for residential care. The final shape and scope of this joint service would thus, if approved, be determined by the Joint Commissioning Partnership Board.
Sustainability checklist:	
Partnerships	The council is seeking to develop this service for people requiring short-term support on discharge from hospital or step-up from community and has been developed with local NHS commissioners and provider partners.
Decision Making and Involvement	ASP Governance.
Economy and Employment	This strategy will seek to build on the current reablement workforce, sustaining local care jobs and encouraging career development in the local care sector.
Caring for people	Provision of this strategy supports Gloucestershire County Council to meet its statutory obligations under Care Act 2014.
Social Value	This strategy aims to help people remain in their place of choice, living independently for as long as possible.
Built Environment	N/A
Natural Environment' including Ecology (Biodiversity)	The council will ensure that any impact on the natural environment is minimised.

Education and Information	N/A
Tackling Climate Change	Carbon Emissions Implications? Neutral Vulnerable to climate change? Maybe
Due Regard Statement	Has a Due Regard Statement been completed? Yes Yes - considerations included in main body of report A copy of the full Due Regard Statement can be accessed on GLOSTEXT via http://glostext.gloucestershire.gov.uk/uuCoverPage.aspx?bcr=1 Alternatively a hard copy is available for inspection from Jo Moore, Democratic Services Unit, e-mail: jo.moore@gloucestershire.gov.uk.
Human rights Implications	Improve the Human Rights for Gloucestershire's vulnerable and older people requiring short-term support to help them live independently.
Consultation Arrangements	HR are engaged regarding staff consultation in respect of any changes to Reablement staff terms and conditions. Public representation will also be identified for the Delivery Board.