People Scrutiny Committee

In-Depth Scrutiny Project

PEOPLE SCRUTINY COMMITTEE

IN-DEPTH SCRUTINY REVIEW 2019/20

REABLEMENT SERVICES

1. Introduction

1.1 This report explores the challenges facing the Reablement Service of Southend-On-Sea Borough Council, particularly in light of the Council's response to the COVID-19 pandemic of early 2020, which placed new demands and pressures on existing health and social care systems.

1.2 Reablement is a term applied to describe an assessment and interventions provided to people in their home (or care home) aiming to help them recover skills and confidence and maximise their independence. For most people interventions last up to 6 weeks.

1.3 When someone is discharged from hospital, they may need help to manage at home. Such support is often provided by the Reablement Service. An effective Reablement Service is beneficial for our residents and the National Health Service (NHS) as it assists individuals to lead full and independent lives whilst reducing the overall cost of long-term provision. Reablement can play a decisive role in helping people to regain their independence and maximise their health and wellbeing following hospitalisation or ill-health. It can also reduce the amount of time a person needs to stay in hospital, therefore aiding faster recovery.

1.4 The provision of an effective Reablement Service is not only beneficial to clinical outcomes and residents' health and wellbeing, but also can help to ease the financial and capacity pressures placed on local authorities and the NHS through decreasing the need for hospital admission, decreasing the need for long-term care packages, and appropriately reducing the level of ongoing home care support required.

1.5 I would like to thank all councillors, co-opted members, officers and external organisations for their contribution to the in-depth review.

Councillor Fay Evans
Chair of the In-Depth Scrutiny Review Project Team

2. Background

2.1 Reablement is a short-term personalised service usually provided at home (or other community setting), to aid recovery after discharge from hospital, enabling adults to maximise their optimum level of independence. Reablement seeks to enable people to do things for themselves rather than the traditional home care approach of having things done for them. For example, if someone has had a fall needing hospital admission, they may not be physically capable of coping with daily tasks such as washing, dressing and domestic tasks.

2.2 Reablement focusses on a person's wellbeing by building on their strengths. It supports them to regain confidence, self-esteem, and motivation and develops outcomes to learn or re-learn the skills needed for everyday life, such as:

- personal care.
- dressing.
- toileting.
- nutrition.
- meal preparation.

- domestic and cleaning tasks.
- washing.
- falls avoidance.
- managing medication.

2.3 Reablement also considers what equipment, adaptations, and assistive technology may help the adult to maintain their independence and teaches them how to use these to support themselves.

2.4 There is strong evidence that reablement services lead to improved outcomes and value for money across the health and social care sectors. Home is the most appropriate place for recovery for nearly all people discharged from hospital. This is not a new approach and reablement services offered by the Council are provided at no cost to the individual. However, reablement services may not be suitable for those that require a higher level of care and are only available to people that can consistently participate in reablement and have the potential to benefit from a reablement programme.

2.5 The Local Government Association (LGA) has previously found ('Efficiency opportunities through health and social care integration: Delivering more sustainable health and care' (June 2016)) that:

'Discharge planning to maximise independence would save money and improve outcomes. For nearly a quarter of people who were discharged from hospital with a care package, a preferable pathway was identifiable that could have delivered better outcomes at lower cost. Given that a significant subset of these pathways results in costly long-term residential placements this is of particular significance. Practitioners taking part in the study estimated that 59 per cent of long-term residential placements resulting from an acute hospital admission could be delayed or avoided.'

2.6 The identification of the Reablement Service for in-depth scrutiny review arose from concern at the Council's performance against the Adult Social Care Outcomes Framework (ASCOF) and national performance indicator (ASCOF2B2), which measures the proportion of older people (65 and over) who were offered reablement services following discharge from hospital. The identification of the Reablement Service for review also arose from concerns with regard to how data informing the Council's performance against the ASCOF2B2 performance indicator was recorded. At that time, the Council's performance figures reported in June, July and August 2019 were:

June 2019	64.5%
July 2019	61.6%
August 2019	63.7%

2.7 The ASCOF Framework is used both locally and nationally to set priorities for care and support, to measure progress and strengthen transparency and accountability. The framework measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode, by determining whether an individual remains living at home 91 days following discharge (the key outcome for many people using reablement services). It also captures the joint work of social services, health staff and services commissioned by joint teams, as well as adult social care reablement, to

- delay and reduce the need for care and support; and
- to ensure that when people develop care needs, the support they receive takes place in the most appropriate setting and enables them to regain their independence.

2.8 The Council's performance against the ASCOF2B2 indicator, (the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into

reablement/rehabilitation services) since the period prior to the escalation of the COVID-19 pandemic, was as follows:

February 2020	70.8%
March 2020	81.7%
April 2020	80.2%
May 2020	81.3%
June 2020	77.6%

2.9 The Council's monthly target for its performance against the indicator during this period was for 80% of people to still be at home 91 days after their discharge from hospital

3. Framework of the Review

3.1 At its meeting on 9 July 2019, the People Scrutiny Committee agreed (Minute 172 refers) that an in-depth scrutiny review be undertaken to consider the appropriate use of reablement services by the Council, as part of its work programme for 2019/20.

3.2 The Committee agreed that the framework for the review should be:

"The appropriate use of reablement for older people (65 and over) when discharged from hospital, to maximise the number of people at home after period of 91 days."

3.3 The scope of the review was to consider:

- whether the current service offered accessible and effective care, delivered to the right people, in the right place and at the right time.
- how the service was delivered.
- the experience of residents who used the service.
- the views of partner agencies and the level of integration; and
- relevant comparative information.

3.4 The review was set within the context of the Council's 2050 ambition and priorities and the following proposed outcomes for the project were agreed:

- increased awareness of the reablement offer and the intention to promote health, wellbeing, dignity and social inclusion through focused work to maximise independence and reduce the need for longer-term support.
- assurances that the reablement offer supports the appropriate people to maximise their level of independence and to recommend changes to the offer as appropriate; and
- assurances that the use of reablement supports the relevant outcomes outlined in the 2050 ambition.

3.5 Progress with regard to the review was achieved in the first half of the 2019-20 municipal year, including the development of an action plan, the receipt of relevant presentations and the holding of appropriate site visits. However, the completion of the projects was subsequently delayed from late-2019 as a result of a number of issues including reduced officer capacity in key service areas.

3.6 From March 2020, the impact of the COVID-19 pandemic also further delayed activity with regard to the completion of the review, reflecting the Council's approach to the handling of the pandemic, including the necessary focus on priority activities and the delivery and implementation of the Coronavirus Act 2020 (see paragraph 6.6), which changed the lead responsibility for all discharges from hospital to Health. In addition to the dedication or redeployment of officer capacity that would have supported the reviews towards key service

provision and the adoption of ongoing remote working and meeting arrangements for councillors and a significant number of the Council's employees. As a result, it was not possible for the in-depth review to be completed by the end of the municipal year.

4. Methodology

4.1 The review was undertaken on behalf of the Scrutiny Committee by a Project Team comprising Councillors F Evans (Chair), A Dear, D Garne, M Borton, C Nevin, A Chalk, I Shead and A Thompson. Mr T Watts of the Southend Carers Forum was co-opted as a member of the Project Team.

4.2 The Project Team was supported in its investigations by relevant officers including Sarah Baker (Director of Adult Social Care), Lynn Scott, (Head of Adult Social Care), Gemma Czerwinke (Service Manager (Adult Social Care)) and Fiona Abbott/Steve Tautz (Project Coordinators).

4.3 The Project Team met on three occasions between July 2019 and September 2020.

4.4 The project was undertaken using an evidence-based approach to the consideration of a range of options, through a mixture of desk top research, informative presentations and site visits, that supported our understanding of the provision of reablement services and the experiences of residents that use the services. All such site visits were undertaken prior to the escalation of the COVID-19 pandemic.

Community Development Team

4.5 On 29 October 2019, the Project Team received a presentation on the services provided by the Community Development Team and the role of social workers in GP surgeries and other health teams.

Community Site Visit

4.6 We also undertook site visits to the Pall Mall Surgery and Jordan's Sheltered Housing Hub on 29 October 2019.

Assessment Bed Site Visit

4.7 On 29 October 2019, the Project Team also visited Priory House to receive an overview of the assessment bed arrangements designed to help people become independent and to offer the skills and support they need to return to their own homes. We also received relevant performance data with regard to the ASCOF2B2 indicator in relation to Priory House and other establishments within the Borough that provide assessment bed facilities.

4.8 At our visit, the Project Team was also provided with a tour of Priory House so that members could meet staff and residents. We also considered a case study relating to the work of Priory House and received a presentation on the role of therapists and the importance of home visits.

Hospital Site Visit

4.9 On 30 September 2019 members of the Project Team visited Southend University Hospital Foundation Trust to receive an overview of the work of the Hospital Social Work Team and the Integrated Discharge Team. The Project Team also visited Windsor Ward and Princess Anne Ward at the Hospital to observe ward-based Multi-Disciplinary Team (MDT) (including reablement workers, health and care providers, occupational therapists and physiotherapists etc.) working.

4.10 The Project Team wish to extend its thanks and appreciation to each of the agencies and organisations that facilitated its programme of site visits.

5. The Impact of COVID-19

5.1 Since the commencement of the scrutiny project, the United Kingdom has faced one of the biggest challenges ever encountered in public health and social care provision, the ongoing COVID-19 pandemic. The impact of the pandemic has resulted in changes to the Council's delivery of reablement services and the scope of the ongoing project. Performance against the ASCOF2B2 indicator dipped as a result of the changing landscape for the delivery of reablement services brought about by the pandemic.

5.2 At its meeting in July 2020, the Project Team received a presentation on how the impact of the COVID-19 pandemic had affected the delivery of reablement services and how the approach to the handling of the pandemic affected the scope of the ongoing project.

5.3 The ongoing impact of the COVID-19 pandemic has restricted the ability of the Project Team to conduct the review fully in accordance with the scope and project plan agreed at the commencement of the project. Although we have received information and presentations on how the Council traditionally delivers reablement services, some elements of service delivery have by necessity changed as a result of the response to the pandemic. Additionally, whilst we welcomed the favourable experience of residents who had used the service as part of our programme of site visits in 2019, we have not been able to further assess satisfaction with the service since the escalation of the pandemic and the introduction of the Coronavirus Act 2020.

5.4 However, even in light of the pandemic, we consider that the current service continues to offer accessible and effective care, delivered to the right people, in the right place and at the right time. Social care staff have continued to work at a high level of integration with health care professionals and relevant comparative information showed improvement against the ASCOF2B2 performance indicator at the height of the pandemic.

6. Coronavirus Act 2020

6.1 The Coronavirus Act 2020 was enacted on 25 March 2020 and made provision for the Government to respond to the emergency situation and manage the effects of the pandemic. The Act, which is time-limited for two years, set out a number of provisions that were relevant to the scrutiny project and sought to relax regulations in order to ease the burden on healthcare services during the pandemic.

6.2 Although the provisions of the Act are intended to be temporary, it is clear that the Government remains mindful of the impact of the 'second wave' of the virus that is currently being experienced.

(a) Care Act Easements

6.3 The Care Act Easements were intended to assist in managing the predicted rapidly growing pressures as more people needed support because unpaid carers were unwell or unable to reach them, and as care workers were having to self-isolate or unable to work for other reasons. The Care Act Easements enable local authorities to streamline present assessment arrangements and to prioritise care so that the most urgent and acute needs were met.

6.4 The easements took effect on 31 March 2020 and will be in place for a period of two years (reviewed every six months), and should only be implemented by local authorities where this

is essential in order to maintain the highest possible level of services during the COVID-19 pandemic.

6.5 At the present time, the Council has not sought to implement any of the provisions arising from the Care Act Easements. A comprehensive report of the Executive Director (Adults and Communities) that presented a framework setting out how the Council would implement the provisions set out within the Care Act Easements, was considered by the Cabinet at its meeting on 28 July 2020.

(b) Discharge Requirements

6.6 The Coronavirus Act 2020 also set out how health and care systems and providers should change hospital discharge arrangements and the provision of community support during the coronavirus pandemic. This aspect of the Act was the key factor and the most significant operational change for the provision of Adult Social Care by the Council and the area most likely to have an impact on the performance of the Reablement Service.

6.7 The requirements focus on ensuring that acute and community hospitals discharge all patients as soon as they are clinically safe to do so. Transfer from the ward must happen within one hour of that decision being made to a designated discharge area. Discharge from hospital must happen as soon after that as possible, normally within two hours. The Government agreed that the NHS would take the lead on all discharges and fully fund the cost of new or extended out-of-hospital health and social care support packages. This applies for people being discharged from hospital or who would otherwise be admitted into it, for a limited time, to enable quick and safe discharge and more generally reduce pressure on acute services.

6.8 Discharge requires teamwork across many people and organisations and the funding and eligibility blockages that currently exist cannot remain in place during the COVID-19 emergency period. A 'Discharge to Assess model has been implemented across England as a default pathway (with alternative pathways for people who cannot go straight home), as staying in hospital for longer than necessary has a negative impact on patient outcomes. The Discharge to Assess model ensures that patients are given the chance to continue their lives at home, which is important for their long-term wellbeing.

6.9 Only a small number of relevant officers remained in hospital settings for discharge purposes, with other staff being transferred to social care assessment roles. The Project Team was most encouraged to be advised that many innovative arrangements for the handling of discharge arrangements were proposed by staff.

7. Current Position

7.1 The COVID-19 pandemic continues to have a significant impact on the delivery and performance of reablement services by the Council.

7.2 In order to manage the authority's approach to the handling of the pandemic and to comply with the changing legal landscape brought about by the Coronavirus Act 2020, the Adult Social Care Department make swift and significant changes to its current provision of services, including:

- all teams moved to a model of 'A' and 'B' Teams, with as many staff as possible able to work remotely and undertake assessments on a virtual basis.
- all teams embraced new ways to assess and support the community using technology and connecting closely with staff from other departments and other organisations.
- Occupational Therapy enhanced the Reablement and Assessment Bed Service, taking a lead role in reducing need for long-term care for people facing acute phases

of illness. Digital technology was used to support home assessment and to ensure that medical equipment was delivered and safely installed.

- the protection of clinically extremely vulnerable people with underlying severe health conditions (Operation Shield) was co-ordinated by the Community Development Team and many staff provided support for the COVID-19 helpline established by the Council.
- a unit of 13 specialist beds was established at Priory House to manage patients from Southend Hospital who had a COVID-19 positive status, who could not return to their normal place of residence.
- the use of digital offers from day-care providers including Project 49, to support people to remain connected and included whilst they were unable to physically attend day opportunities.
- close monitoring of social care demand and financial and practical support to support providers to manage capacity.
- robust support for care providers around infection control, by supporting the provision of relevant personal protective equipment (PPE), offering infection protection control advice and maintaining regular contact and communication channels.

7.3 The Hospital Team faced the biggest changes following the revisions to the Discharge Requirements. The team were located into the community pathways of a 'Discharge to Assess Model', with only a small number of staff remaining at the hospital to ensure safeguarding and complex case management responsibilities were met. A 'hot site' for COVID-19 positive patients was established at Basildon Hospital.

7.4 The care homes within the Borough acted extremely responsibly during the period of the pandemic. It remains generally the situation that visitors are not permitted within the care homes.

8. Hospital Team and Intermediate Care

8.1 The Discharge to Assess Model set out in the Discharge Requirements has a focus on specific pathways that people will be discharged into when deemed clinically stable. Although discharge into a specific pathway is determined by health professionals, social care staff are involved in the consideration of relevant discharge decisions.

Pathway 0

Simple discharge with no input required from health and/or social care, although relevant advice provided.

Pathway 1

Support to recover at home. Able to return home with support from health and/or social care through a 'Home First' approach.

Pathway 2

Rehabilitation in bedded setting.

Pathway 3

There has been a life-changing event. Home is not an option at point of discharge from acute care. Patients within this pathway were generally transferred to Brentwood Hospital.

8.2 Staff within the Hospital Team and the Intermediate Care Team were aligned to the pathways. New Multi-Disciplinary Teams were formed with health staff and Essex

Partnership University NHS Foundation Trust. Two managers support the pathways, with one focusing on Care at Home and the other on the Acute and Bedded Settings. Priory House and care agencies were supported in setting up specialist teams to manage people with a COVID-19 positive status and social workers provided supported through each of the pathways.

8.3 The Project Team recognised that people discharged into Pathway 0, whilst requiring no formal support or assistance from health and/or social care, might be reliant on the support of 'unpaid care' through family and friends etc. We were pleased to note that Southend Association of Voluntary Services (SAVS) made direct contact with all patients discharged into Pathway 0, to provide assistance and guidance where necessary.

8.4 The Project Team was advised that robust information arrangements are in place between the health and social care teams, so that all discharges into specific pathways are communicated to social care, and that flexibility exists in the pathway approach to transfer people between different pathways should this be necessary. The creation of the MDTs around each of the pathways has been critical to the success of this approach and also serves to address any identified safeguarding issues, although it is still too early to indicate whether the approach has delivered improved outcomes.

8.5 However, the experience of responding to COVID-19 has demonstrated the importance of reablement services that are centred on the individual and which provide safe, proactive care that maximises independence and wellbeing.

8.6 With the focus on care at home and reablement services, the performance of the ASCOF2B2 indicator has improved, with a clear vision to improve the outcomes for people.

9. Recommendations

9.1 We consider that the review was undertaken within the context of the Council's 2050 ambition and priorities and that, whilst allowing for the impact of the COVID-19 pandemic, the proposed outcomes for the project have been achieved, albeit in a markedly different context to that originally established in July 2019 when the scope of the project was determined.

9.2 At the present time, we do not therefore consider that it is appropriate to make recommendations as to the future operation and management of the Reablement Service, given the changes to service provision brought about by the Coronavirus Act 2020 and the ongoing implementation of relevant provisions (particularly revised discharge arrangements) of the Act.

9.3 However, we do recommend the following:

(a) That performance against the ASCOF2B2 indicator continue to be reported as part of the Council's regular corporate performance report; and

(b) That, on the relaxation of the relevant provisions of the Coronavirus Act 2020 and with regard to the Council's ongoing performance against the ASCOF2B2 indicator at that time, consideration be given to the identification of measures to further improve the delivery of reablement services by the Council, if required.