Agenda Item 9

Reablement and Bed Based Intermediate Care Services

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Falkirk
Health and Social Care
Partnership

Title/Subject:	**Reablement and Bed Based Intermediate Care Services**
Meeting:	**Integration Joint Board**
Date:	**7June 2019**
Submitted By:	**Head of Social Work Adult Services**
Action:	**For Decision**

1. INTRODUCTION

1.1 This report provides IJB members with an overview of critical priorities for action on reablement and bed based intermediate care services in the period of the Strategic Plan 2019-2022.

1.2 Achievements to date are noted alongside areas requiring increased pace of change. These areas of service activity are critically important to supporting people achieve better personal outcomes through their involvement with services.

1.3 The report describes key principles, success factors and a direction of travel giving a clear line of sight to the creation of a whole system continuum of recovery, recuperation, reablement, rehabilitation and progression.

2. RECOMMENDATION

The Board is asked to:

2.1 note the range of work underway to embed a whole system approach to reablement and intermediate care across the HSCP

2.2 request a report to the IJB providing an option and site appraisal for taking forward the delayed capital project to build a dedicated bed based intermediate care facility.

3. BACKGROUND

3.1. In 2012 the Scottish Government published 'Maximising Recovery, Promoting Independence – a National Framework for Intermediate Care in Scotland.' The National Framework sets out an approach involving a collection of services working to common, shared objectives and principles. Intermediate care is described as a set of 'bridges' at key points of transition in a person's life, in particular from hospital to home (and from home to hospital) and from illness or injury to recovery and independence; helping them achieve their personal outcomes. By its nature in acting as a bridge between locations, sectors and personal circumstances, there must be close connections with mainstream services – whether the acute sector or community based services.

3.2. The above high level approach remains strongly relevant to our context in Falkirk in 2019. As part of the Collaborative Leadership in Practice (CLiP) support provided to Falkirk Health and Social Care Partnership (HSCP) by NHS Education for Scotland (NES), an external coach supported the work of a Reablement Leadership Group (RLG) during 2017/18. The agreed purpose of the RLG was to:

- improve reablement services for service users
- provide leadership for strategic changes – while keeping present services going
- not be a decision-making group, but to develop and recommend strategy and changes to the Leadership Team for approval
- support each other and staff through the changes
- provide thinking space for a group members
- look at innovation for the future.

3.3 The RLG noted that there are two distinct strands of work required in order to effectively embed a Partnership wide reablement approach; ethos and service delivery. On this basis, the group presented a re-defined vision to the Leadership Team, which was approved as follows:

Reablement Ethos	Reablement is a shared approach across the Falkirk Partnership for all service users, which has a focus on independence. *The ethos and principles of reablement would become the normal way of working across all services including Health, Social Care, Housing and external providers. This would include a preventative element, routing people at the earliest opportunity to services which might help them, to prevent deterioration of their condition. As more service users are directed early, to a range of services, from a wide range of providers, it is hoped that fewer would require assessment for formal reablement services.*
Reablement Service Delivery	The Reablement service will begin at the point of assessment and have a focus on independence through the delivery of a short-term person-centred approach by a multidisciplinary team of well-trained staff working with patients, carers and their families. *The reablement service would be offered following an assessment against agreed criteria. This could be, for example, the frailty assessment or the social care intake assessment.*

3.4 Currently the HSCP has engaged the Institute of Public Care, (IPC), based at Oxford Brookes University, as a key partner in taking forward next steps in developing the approach..

3.5 Later sections of this report set out current learning from our links with IPC and implications for setting the strategic direction on reablement and bed based intermediate care services. These services are a key enabler in relation to the implementation of a "Maximising Recovery, Promoting Independence" approach. This model aims to prevent hospital and care home admissions and support Falkirk citizens to remain living at home independently for as long as possible.

4. REABLEMENT IN FALKIRK

4.1. The Reablement Leadership Group, as part of the work facilitated by CLiP, produced a Reablement Pathway for Falkirk, attached in diagrammatic form (Appendix 1). This pathway sets out potential options for a person requesting assistance across the system from initial point of contact. These options offer varying levels of intervention from sign-posting to prevention and early intervention provision through to intensive reablement intervention, bed based intermediate care and rehabilitation.

4.2. Where the Partnership has operational responsibility for the management of services that support the reablement service delivery, strands of work have been taken forward aligned to this pathway. Some of these are described in this section of the report.

4.3. Partnership Funding has also facilitated a range of services that prevent avoidable admissions or support discharge. Many of these projects have a reablement focus and align to the reablement pathway, including the Rapid Access Frailty Clinic, Enhanced Discharge at Falkirk Community Hospital (FCH) through funding for four rehab assistants, Summerford House and Allied Health Practitioners (AHP) capacity across the Falkirk area.

4.4. The Board will note that the Partnership Funding report presented as a separate agenda item, describes a detailed review of projects currently underway. This involves a review of projects by thematic areas, to review their progress against outcomes and transformational change achieved during the funded period. This will provide an opportunity to explore further opportunities for collaboration, and to identify any duplication and areas of improvement.

4.5. It will be important that a robust review of projects is undertaken, with particular emphasis on continuation of funding being dependent on their contribution to supporting the delivery of the IPC model set out in section 5 of this report. The review recommendations will be presented to a future meeting for consideration.

Reablement in the Community

4.6. In 2017 the HSCP set up a Discharge to Assess pilot to address issues supporting people's timely discharge home from hospital. This service has now evolved in to the Reablement Project Team, which focuses on supporting people being discharged from hospital, based upon the Home First principle and learning from

the Discharge to Assess approach. This work has involved the commitment of significant resources from Council services (OT and home care) and from NHS FV (ReACH team).

4.7. The above work is complemented by promotion of a range of early intervention, prevention and self management initiatives. Joint programmes are underway between NHS FV AHP's and the Community Trust, for example falls prevention programmes and strength and balance classes. Board members have received previous briefings on the Living Well Falkirk website, a partnership with ADL (Activities of Daily Living) Smartcare, offering access to the public to self assessment and a wide range of information, techniques and equipment solutions supporting self management.

4.8. The reablement approach sits within a continuum of a range of rehabilitation services delivered via the ReACH team and Council AHP inputs and by work across agencies on falls prevention.

Bed Based Intermediate Care in Falkirk

4.9. The National Framework for Intermediate Care sets out the expectation that some people who are clinically ready to leave hospital may be still unable to return directly to their own home. The person may benefit from a period of time being supported with their continuing recovery, reablement and/or rehabilitation, requiring the availability of 'step down' bed accommodation. The Framework also envisages that some people living in the community may benefit from a move to such a resource, known as a 'step up' bed.

4.10. The IPC model developed by Professor John Bolton concurs with the National Framework in highlighting the need for bed based, intermediate care as one component of an effective whole system approach.

4.11. At the inception of the Partnership, Social Work Adult Services adapted 10 beds in Summerford House to use as bed based intermediate care placements. The remainder of the beds provided residential care and short break provision. The facility was not intended to be a long term solution given the dated physical environment and the ability of the building to be adapted to deliver bed based intermediate care. The Council supported a circa £3.7million capital build project to replace Summerford House and provide intermediate care facilities to deliver the strategic vision for people to be supported and enabled to remain at home.

4.12. In the interim, to enable a balance of home and bed based reablement services in the system, the Partnership has continued the incremental adaptation of service at Summerford House. There are now 20 beds available for bed based intermediate care, with a maximum of 18 beds having been in use for this purpose.

4.13. Through benchmarking with the IPC model for whole system flow (Appendix 2) including previously submitted Partnership Funding evaluations, it has been evidenced that to date the service offered at Summerford does not achieve optimal

use of the intermediate care beds. Average length of stay at Summerford is longer than would be expected, which reduces the number of people able to benefit from the service is low. This is a performance challenge which could be anticipated in the early stage development of the model, but which must be addressed in the next stages of development of the service. The resource is scarce and must be used effectively and efficiently.

4.14. For 4 years there has been in place an outline plan to commence a capital programme to build a dedicated bed based intermediate care facility. Capital spend has been allocated to this project by Falkirk Council throughout this period, remaining available to the present date.

4.15. Extensive scoping work was carried out at FCH exploring the potential for the new facility to be built there. The preferred site at FCH has been identified, however agreement with NHS FV has not been reached for this proposal to proceed to commencement of works. The strategic importance of bed based intermediate care is such that it is at this point imperative the partnership determine an agreed course of action regards commencement of this capital project, whether at FCH or other site as outcome of option and site appraisal.

4.16. Delay in taking forward a planned replacement capital build project has prevented the envisaged early closure of Summerford. It remains the case that a planned move out of Summerford cannot be scheduled because it has not been possible to put in place a plan for a replacement building.

Community Hospitals

4.17. There is currently a pathway for people who are inpatients in Forth Valley Royal Hospital to move to the community hospitals in Falkirk and Bo'ness. AHP resource is available at Falkirk Community Hospital but not at Bo'ness Community Hospital. Given the overlapping nature of reablement and rehabilitation, there is a necessity for the Partnership to take a strategic perspective on the opportunity to develop the contribution of the beds at both Community Hospitals to a whole system model. This is an area which can be the subject of further exploration and a future report to the Board.

Reablement training programme

4.18. To underpin reablement across the whole system it will be necessary to have an extensive training programme in place. Work has begun to design a rolling programme for staff across the health and social care partnership including external home care providers. Links have been made with Forth Valley College in relation to potential for Social Care Officers and Senior Carers to undertake an SVQ module in Reablement. The challenge is to explore new roles and approaches, building upon collaborative relationships and learning organisation principles.

5. NEXT STEPS TOWARDS A WHOLE SYSTEM APPROACH

5.1. Our joint work with IPC and Professor John Bolton has involved mapping whole system flow (Appendix 2). While further work is required on our data, the early benchmarking indicators suggest that on key measures, such as numbers of people going directly from hospital to care home or taking up continuing home care without having had the opportunity of reablement, our figures are higher than would be expected.

5.2. There is significant further progress to be realised from maximising recovery, recognising the importance of enabling the person's recovery in parallel with or where necessary, as a precursor to promoting independence. A key principle which requires to be embedded is that no one should have their long term care needs assessed while they are in crisis and in acute hospital care.

5.3. At the IJB meeting on 7 December 2018, the Chief Officer tabled a report on Whole Systems Working: Unscheduled Care and Delayed Discharge. That report noted the requirement to adopt a Home First principle across the system as the default response in both acute and community settings. Consistent with the Home First principle the Promoting Independence approach is founded on building a number of key interventions set out as follows:

- Recovery
- Recuperation
- Reablement
- Rehabilitation
- Progression.

5.4 Professor Bolton has presented this model, under the banner of Promoting Independence at workshops of Partnership staff and stakeholders in February and March and May 2019, including to the IJB on 1 March 2019.

5.5 There was general recognition that the strategic approach set out by Professor Bolton is congruent with the earlier work of the Reablement Leadership Group and the vision for Falkirk which delivers positive outcomes for citizens. The whole system approach to "Maximising Recovery, Promoting Independence" will support the delivery of the Strategic Plan.

5.6 As the partnership moves into localities broader opportunities will develop in relation to reablement in the community with NHS AHPs and community nursing staff. This will be founded upon a multi-disciplinary service system which can be responsive at the locality level to crises thus preventing hospital or care home admissions.

5.7 Given the Partnership priority to expedite hospital discharge the focus for the Reablement Project Team has been the hospital population. However, it is equally important to prevent hospital admission, promote independence and reduce reliance on formal services within the community. There is, therefore, work on-

going to mainstream the Reablement model across localities. 3 additional Occupational Therapists posts have been funded (one per locality) to build capacity to deliver responsive reablement assessments to support people to remain living at home.

5.8 As noted earlier in this report, significant delay has arisen in formulating an implementation plan for the capital programme new build project to replace Summerford House. A whole system approach to planning around the future bed model for bed based intermediate care requires consideration to be given to the the future role and deployment of the community hospital bed base and the related professional inputs from AHP, primary care and social care. The immediate question of the planning for the Summerford replacement facility is addressed in the recommendations section of the present report, suggesting the need for a specific report to the IJB on options and site appraisal supported by Falkirk Council's Development Services.

5.9 The Partnership stands at a critical juncture in the journey towards health and social care integration. The implementation of the locality model, renewal of community hospitals model and the unscheduled care improvement programme present critical opportunities for improvement.

6. CONCLUSIONS

6.1 The Strategic Plan 2019-2022 commits the Partnership to development of self management as a key outcome for people using our services and supports. This is reflected in the development of an evolving model for reablement which supports post acute care. This report sets out next steps in regard extending the reach of reablement comprehensively to meet need identified outwith the hospital setting.

6.2 Strategic planning is also concerned with delivering improvement on the delayed discharge agenda. This improvement trajectory will be supported by the direction of travel set out, involving considering anew the contribution of the range of resources from professional inputs, through to social care beds (Summerford) and NHSFV beds (community hospitals).

6.3 The IJB has supported the "Maximising Recovery, Promoting Independence" model for the HSCP to implement. It is essential that both partners fully adopt and support implementation to ensure this is taken forward as a priority and with pace.

Resource Implications

The development of a whole system approach to reablement and bed based intermediate care provides an opportunity for alignment of resources with strategic outcomes.

Impact on IJB Outcomes and Priorities

The report sets out a whole system approach to "Maximising Recovery, Promoting Independence" will support the delivery of the Strategic Plan.

Legal & Risk Implications
There is financial risk associated with continuing delay on the intermediate care capital build programme.

Consultation
This will be incorporated in to the delivery arrangements to take forward this work.

Equalities Assessment
This will be undertaken as required.

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List of Background Papers:

Appenedix 1 : Reablement Pathway

REFERRALS FROM:-

- Community
- Professionals
- Carers
- Hospital
- Patient Self-Referral
- Scottish Ambulance Service

STAFF & FUNCTION:-

Access
Points to HSCP Falkirk

REQUEST FOR ASSISTANCE POINTS

FUNCTION:-

- Information Gathering (access current info)
- Screening
- Triage – Level of urgency/priority
- Signposting & referral
- Ability to make appointment

Level 3 (2 -4 HOUR

URGENT RESPONSE:-

- ECT
- RPT
- Crisis Care

OUTCOME ACHIEVED

REFERRAL TO LEVEL 2 OR LEVEL 3

Level 2

LEVEL 2 RESPONSE:-

Locality Team Response: District Nurse, Community Care, REACH

Intermediate Care: Summerford, Community Hospital

Support at Home: ECT, Night Service, MECS, TEC

Specialist Team: Sensory Team, Dementia Outreach Team, Immediate Mental Health Team, Learning Disability etc.

Other Input as required: GP, Pharmacy, CPN, Dietician etc.

Goals Set:
* 6- week intervention review; monitor
* May only need a short-term intervention e.g. physio
* Reablement intervention is a collaborative team approach led by assessment of what the person wants to achieve.

OUTCOME ACHIEVED

LEVEL 3 RESPONSE

- Ongoing Reablement Support
- Ongoing Care & Support at Home Review
- Ongoing health intervention e.g. DN/CPN
- Ongoing REACH

OUTCOME ACHIEVED

- **Long Term Care**

Level 1

LEVEL 1 RESPONSE:-

SIGNPOSTING

- **GP/NHS24**
- **Welfare Benefits Advisor**
- **Attendance at Living Well Clinic**
- **Housing**
- **Carers Centre**
- **Palliative Care**
- **Falls Classes**
- **3rd Sector Input**
- **Seen by targeted appropriate professional**

PROVISION OF TELEPHONE ADVICE

SCHEDULE APPOINTMENT

LIVING WELL CLINIC

REACH

TELECARE / MECS

OUTCOME ACHIEVED

REFERRAL TO LEVEL 2 RESPONSE

Discharged NFA
500

Admitted to Hosptial
1,000 (over 65's)

"Effective Assessment"
Right time, Right type, Outcome focused

"Low-level" support (eg follow-up from therapist or District Nurse)
200

Discharged requiring further support
300

"Effective Commissioning"
Understand demand
Commission the "right" provision
Focus on recovery and recuperation
Review performance

Intermediate Care

Short-term Reablement based residential care bed with theraputic and nursing support
50

Domiciliary Support
(eg Reablement based)
250

On-going Domiciliary Support
90

Residential Care
10