NORTH YORKSHIRE COUNTY COUNCIL

CARE AND INDEPENDENCE OVERVIEW AND SCRUTINY COMMITTEE

REPORT OF THE CORPORATE DIRECTOR – HEALTH AND ADULT SERVICES

24 April 2014

Proposal for a new Health and Social Care Integrated Reablement and Intermediate Care service for North Yorkshire

The START/Re-ablement Service and proposals to develop and integrate with Health Intermediate Care Services in North Yorkshire

1.0 PURPOSE OF REPORT

1.1. To report to the Members of the Overview and Scrutiny Committee regarding the performance of the START/Re-ablement Service and proposals to develop and integrate with health Intermediate Care services in North Yorkshire.

2.0 BACKGROUND

2.1 The START/Re-ablement service was established in 2010 and has been very successful. However changes in the health and social care fields along with a review of the services have indicated that further refinement and development is need.

Health and Social Care integration is a key tenet of the Health and Social Care Act 2012 and is central to the new Care Bill which becomes law in 2014. Integration provides joined up services to the public and improved outcomes whilst delivering financial efficiencies to health and social care organisations.

The proposed new service also forms part of the County Council's agenda on prevention as it equips people with key skills to enable them to stay at home independently for longer.

2.2 The County Council is working in partnership with the 5 Clinical Commissioning Groups (CCGs) to develop new health and social care integrated Reablement and Intermediate Care services for North Yorkshire.

2.3 This report outlines the proposal for a new integrated health and social care Reablement and Intermediate Care service for North Yorkshire.

3.0 CURRENT START SERVICE MODEL

3.1 The START (Short Term Assessment and Reablement Team) service has been operational since September 2010. The service was initially piloted in Selby before being incrementally rolled out around the other areas of the county. START offers a service for up to 6 weeks, and focuses on supporting people to regain skills of daily living, maximising the use of telecare, directly providing a limited range of equipment and signposting to universal services. For some people it may be a very short intervention of only a few days, whilst others may need 6 weeks to optimise their independence, as of February 2014 the average duration of a START episode is 5 weeks. This is developed as part of an outcomes focussed support plan with individual and their family and/or carer.

3.2 The aim of the outcomes focused support plans is to reduce the need for on-going personal care support rather than simply doing tasks on a person's behalf. People who do need an on-going service receive this via a personal budget, Direct Payment or an independent sector service purchased on their behalf.

3.3 The START Service has been successful in positively impacting upon people's lives. **Appendix A** illustrates the improvement to the START service from September 2010 to February 2014. The key headlines are that:-

- Over the period 10829 episodes of START have been delivered to 8564 service users (Graph 1)
- There has been a steady increase to 300 plus episodes per month (Graph 1)
- Around 21% need a further episode (Graph 2)
- 22% do not complete a period of Re-ablement. The reasons for this appear in Graph3. It is relevant that the bulk of these are admissions to hospital
- Currently 70.8% of service users have a nil or reduced on going service. Of these 60.6% receive a nil on going service. (Graph 4 & table)
- Start is well liked by service users with on average 72% of users giving it the highest approval rating of excellent (Graph 5)
- Nationally START has helped to embed a re-abling culture with 85.9% of those discharged from hospital into a reablement service remaining at home 91 days later (Graph 6)

3.4 Although START has been successful there are still inconsistencies in the way it is delivered across North Yorkshire, the proposed integrated reablement and intermediate care service aims to address this inconsistency so that all residents get the same level of service no matter where they live in

the County. The proposed new service will also respond to Central Government policy regarding the integration of health and social care services.

4.0 CURRENT INTERMEDIATE CARE SERVICES IN NORTH YORKSHIRE

4.1 Intermediate care is for people over the age of 18 who have been assessed as being medically stable, do not require hospital care and have short term therapy goals that are achievable within 6 weeks of entering the service. The service is provided on a short term basis either within a service user's home or within a designated residential home. Intermediate Care is targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, or long term residential care.

4.2 Intermediate Care services focus on jointly agreed and implemented pathways for people with long-term conditions. There is operational co-ordination between the range of relevant services and initiatives such as telemedicines/telecare, crisis response, stroke rehabilitation, bed-based intermediate care, home from hospital services and Chronic Obstructive Pulmonary Disease (COPD) services.

5.0 INTEGRATED REABLEMENT AND INTERMEDIATE CARE SERVICE

5.1 The key drivers for this proposal for an integrated Reablement and Intermediate Care service are:

- Central Government policy to integrate health and social care services
- the Better Care Fund
- improving health and social care outcomes for people living in North Yorkshire

5.2 The new service will provide efficient, joined up services for service users and patients and will reduce the need for dependence on long term care, reduce admission into hospital and will facilitate well organised, planned and safe hospital discharge seven days a week. When people develop care and support needs, the first priority should be to restore their independence and confidence. The new integrated Reablement and Intermediate Care service will facilitate the development of effective and realistic outcomes that are focussed on independence and will facilitate support plans that are driven by individual needs, wishes and circumstances. People will be empowered to set goals for themselves that include acquiring new skills, or regaining skills that may have been lost.

5.3 The new integrated Reablement and Intermediate Care service will provide support to people in their own homes to enable them to learn or re-learn skills necessary for daily living. This will be achieved through the use of short term intensive support programmes that:

- Maximise independence, choice and quality of life
- Minimise on-going support required

5.4 Better Care Fund (BCF)

5.4.1 The Better Care Fund (BCF) vision is to create a sustainable integrated health and social care economy for North Yorkshire, drawing together community health, social, primary and voluntary care to deliver a more effective and efficient person centred service. This heralds a new era for integrated Health and Social Care in North Yorkshire. This will provide care and support for people in the most appropriate environment to enable them to be healthy, well and independent through 24/7 integrated services. This will increase community based capacity and capability to prevent avoidable demand on the system and to achieve better outcomes for people.

5.4.2 The project will implement the national conditions for BCF which are:

- Protecting Social Care Services (with a health benefit)
- 7 day services to support discharge from hospital
- Data sharing (via the NHS number)
- Joint assessment and lead accountable officer

5.5 Other areas in the country have integrated reablement and intermediate care services. Think Local Act Personal (TLAP) 'What good looks like' is initiative to support councils (including their elected members) to make the best use of their resources and to promote personalisation in a difficult and challenging context. TLAP's aim is to share ideas about how to get better value for people and taxpayers by pooling evidence about what works.

The proposed new service reflects best practice elsewhere in the country and will have the following functions:

5.5.1 Crisis response

- 24/7 Reactive crisis response service provided via multi-disciplinary teams with a single point of access
- Ongoing access to clinical skills/assessment where indicated
- Good co-ordination across agencies, including GPs and ambulance services, to ensure hospital admissions and emergency care homes admissions are avoided and wherever are safe and feasible.

5.5.2 Hospital Discharge

- Successful team working within hospitals and between acute and community based services
- Well planned and organised early hospital discharge that is safe over 7 day working

- Agreed multi agency protocols which reduce length of stay in hospital and improved outcomes for people being discharged

5.5.3 Integrated Reablement and Intermediate Care

- Reablement continuously developed as the default option for all people being referred for a service
- No decisions taken about long term care and support plan until after period of reablement and intermediate care
- Active therapy to promote and maximise independence
- Focus on recovery approach
- Assistive technology and adaptations and community equipment assessed on entry to service
- Agreed and implemented pathways for people with long term conditions
- Operational co-ordination between range of relevant services and initiatives i.e. stroke rehabilitation, COPD, bed based intermediate care (step up/step down)
- SMART targets for people who access the service
- Extend reablement approach to domiciliary care contracts
- Staff trained, equipped and performance managed in a way that maximises the number of people who are fully reabled to maximise independence in their home setting and require little or no further support

6.0 PERFORMANCE IMPLICATIONS

6.1 The following outcomes will be used to measure the impact of the new integrated reablement and intermediate care service on service users and patients.

The key outcomes of an improved START service will be:

- Reduced permanent admission to residential care
- Remaining out of hospital post hospital discharge
- Improved transfer of care from hospital into community based services
- Improved hospital admission avoidance
- 7 day hospital discharge
- Improved health and wellbeing of patients
- Improved equality of access to high quality care
- Improved patients'/service users' experience of care
- Better utilisation of resources
- Seamless care for patients/service users
- Care is undertaken by the right professionals, at the right time in the right place

7.0 FINANCIAL IMPLICATIONS

7.1 National evidence suggests that by integrating Reablement and Intermediate Care services financial efficiencies are identified that are beneficial to both Local authorities and CCGs whilst improving outcomes for service users and patients.

8.0 LEGAL IMPLICATIONS

8.1 Although integrated Reablement and Intermediate Care services are not a statutory requirement, they reflect intentions the Health and Social Care Act 2012, Better Care Fund plan and the Care Bill 2014.

9.0 EQUALITIES IMPLICATIONS

9.1 A full and comprehensive Equality Impact Assessment is being undertaken with each CCG area.

10.0 CONSULTATION UNDERTAKEN AND RESPONSES

10.1 Public and staff consultation and engagement has been built into the project plan to implement this new service.

11.0 RECOMMENDATIONS

11.1 The Care and Independence Overview Scrutiny Committee is asked to:

i. Note the performance and give comments on the proposal for integrated Reablement and Intermediate Care Services.

Mike Webster
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Procurement, Partnerships & Quality Assurance

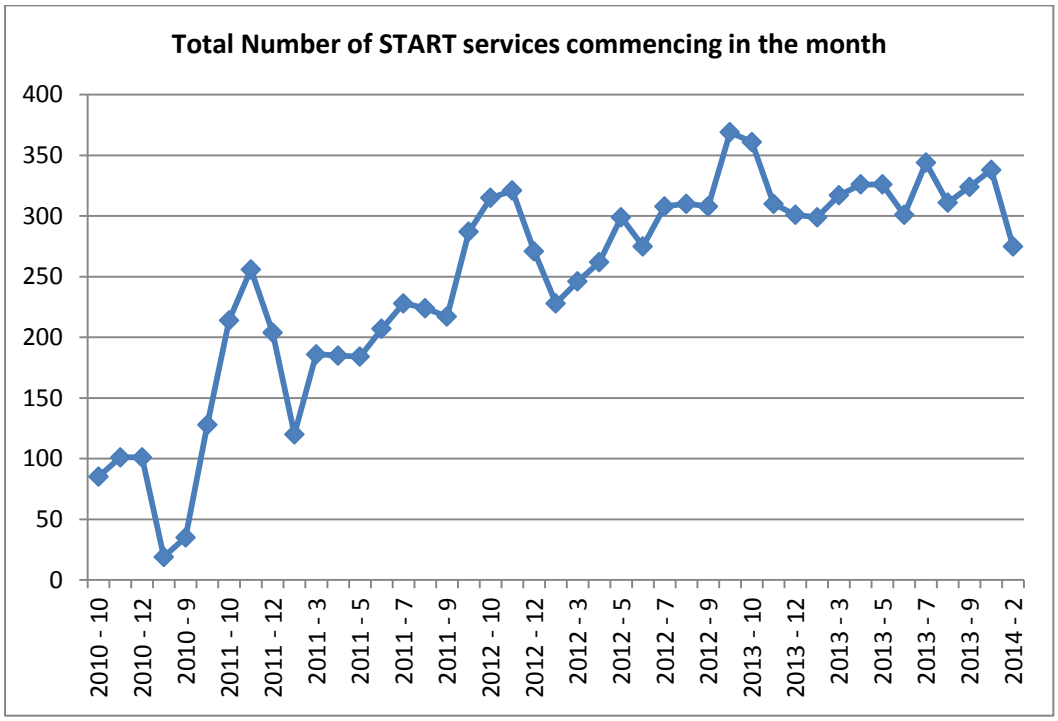
24 April 2014

Appendix A

START Data analysis

Graph 1

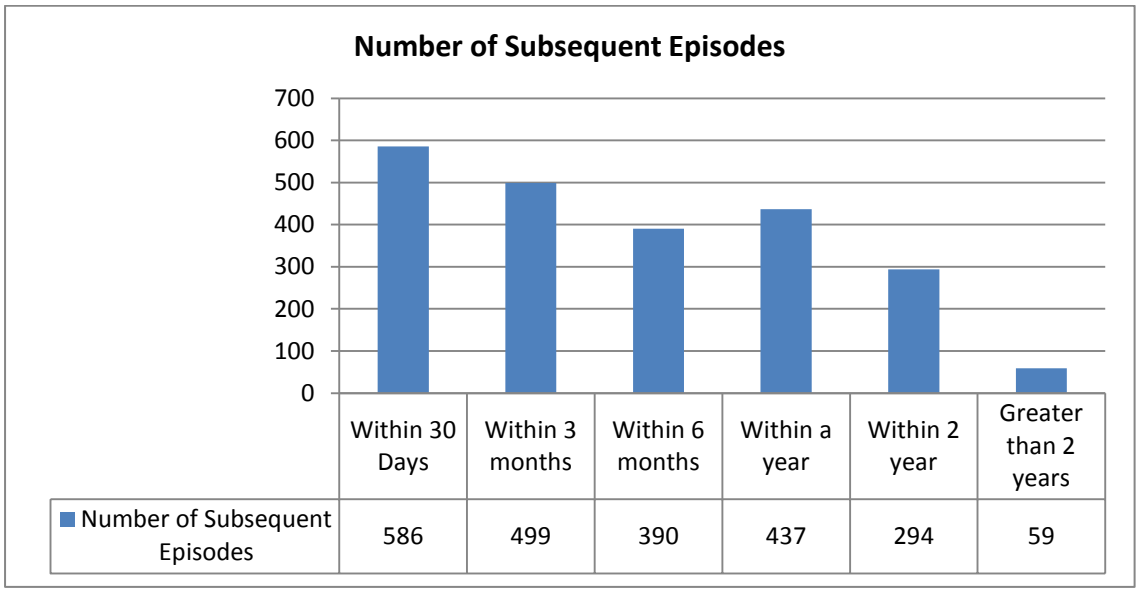
Graph 1 shows the gradual increase in START episodes across all areas from October 2010 to February 2013. Since July 2013 the number of services commencing has been in the main between 300 and 350 per calendar month. The total number of episodes of start is 10829 which represents 8564 service users.



	Episode Type		
	First	Subsequent	Total
Number of Start Episodes	8564	2265	10829
Of which, ceased before planned end date	1918	502	2420

The table above and graph 2 below shows the breakdown of the numbers of start episodes and users. Over the period an average of 22% have ceased before the planned end date (please see graph 3 below for reasons).

Graph 2

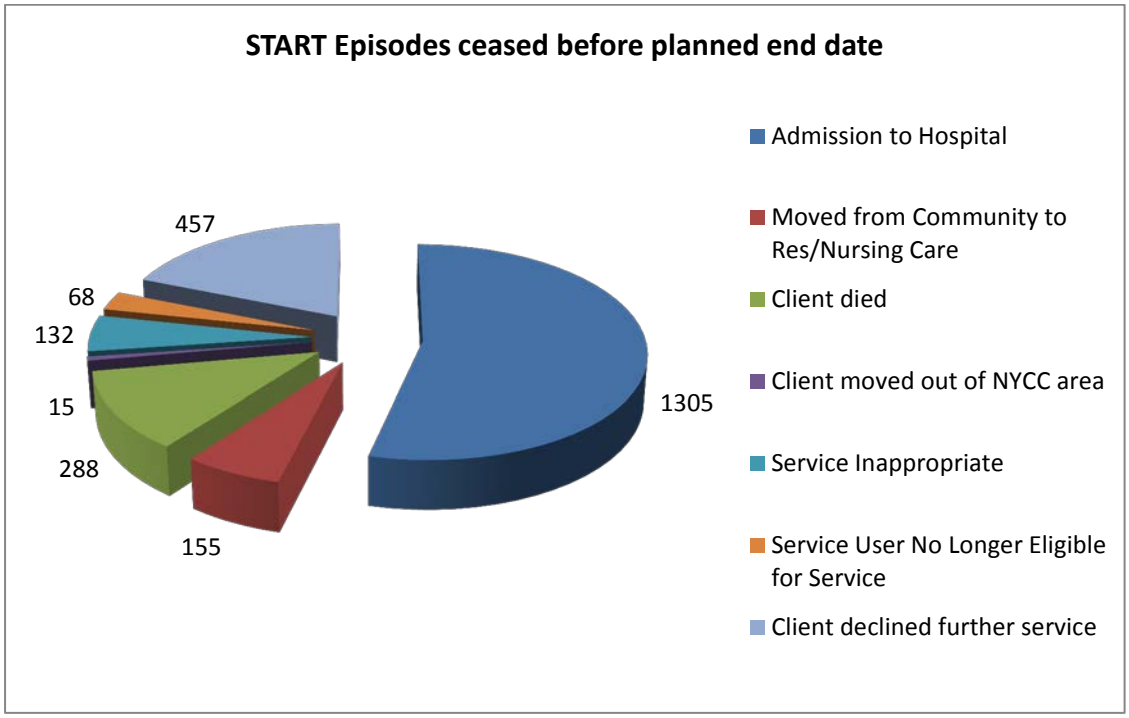


21% of all start episodes are repeated episodes.

A number of users who successfully complete a START episode have subsequent episodes some can be seen as extensions of the initial episodes and take place quite quickly after the first. Some are due to relapse of the original condition and others are new episodes of care.

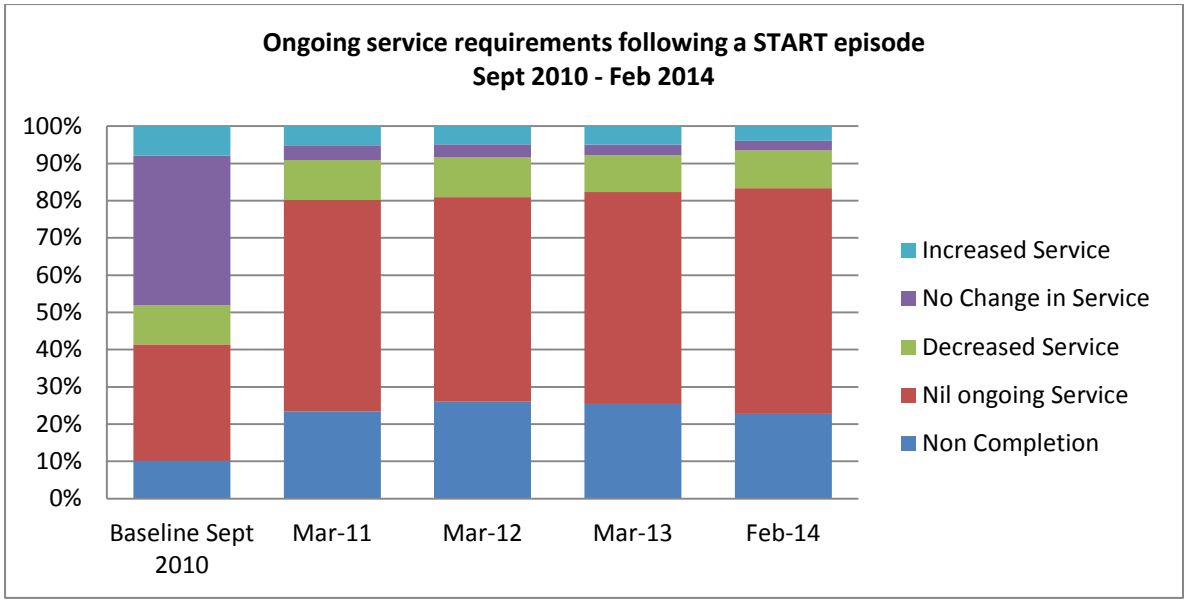
Graph 3

Graph 3 shows the reasons why some START episodes cease before the planned end date. Of the 2420 episodes the bulk are for medical reasons, either admission or readmission to hospital care. This figure could be reduced with greater integration with community health teams. A further 155 are admitted to residential care, again this is a group of clients who through more intense rehabilitation could be kept in the community. Finally there are a group of clients who decline further services, even though START is free for the first 6 weeks of service.



Graph 4

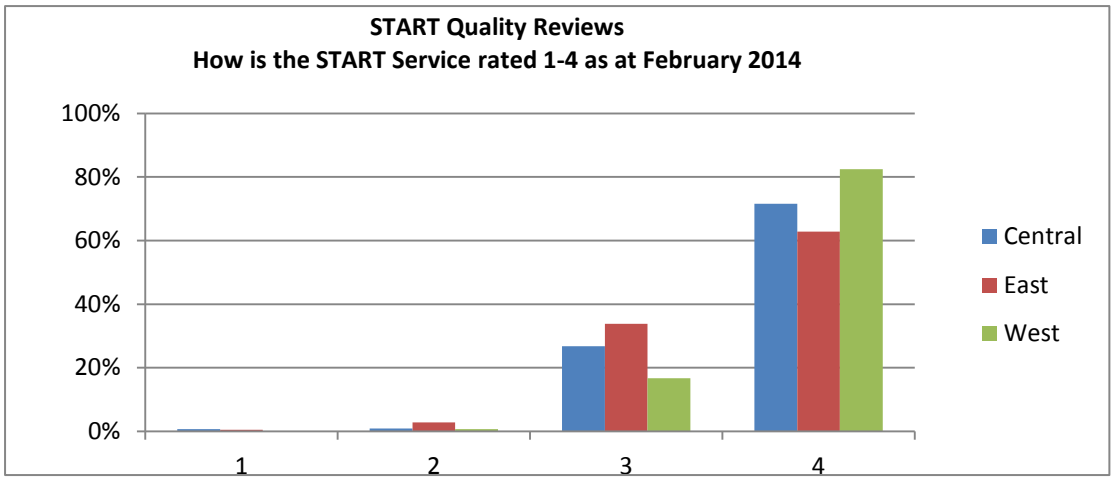
Graph 4 and the associated table plot the progress of START from the initial baseline study in September 2010 to date. The key changes are a significant reduction from no change in services, to a position where services are no longer required (nil on-going service 60.6% Feb 2014) Only 586 (5%) require a subsequent episode with in 30days. The numbers of service users requiring an increase package of care has reduced to 3.9% from 7.9%. However the number of non-completions has risen due to the policy of ensuring all service users have access to START services and not automatically passporting them on to long term services.



START	Non Completion	Nil ongoing Service	Decreased Service	No Change in Service	Increased Service
Baseline Sept 2010	10.1%	31.3%	10.5%	40.2%	7.9%
Mar-11	23.4%	56.8%	10.7%	4.0%	5.1%
Mar-12	26.0%	54.9%	10.7%	3.5%	4.9%
Mar-13	25.4%	56.9%	9.9%	2.8%	5.0%
Feb-14	22.7%	60.6%	10.2%	2.6%	3.9%

Graph 5

Graph 5 Is taken from the START review given at the end of each episode of START on average 72% of start users giving START the highest approval rating of excellent (4) .



Graph 6

Graph 6 Shows the national impact that the START service has in maintain people at home 91 days after discharge. At 85.9% North Yorkshire is a top quartile performer.