

<b>ADULTS AND HEALTH SCRUTINY COMMITTEE</b>	<b>AGENDA ITEM No. 7</b>
<b>11 JULY 2023</b>	<b>PUBLIC REPORT</b>

Report of:	Stephen Taylor, Executive Director Adults	
Cabinet Member(s) responsible:	Councillor Fitzgerald, Leader of the Council	
Contact Officer(s):	Belinda Child – Head of Housing, Prevention & Wellbeing Laura King – Reablement Team Manager	07920160731 07785521368

**REABLEMENT OVERVIEW REPORT**

<b>RECOMMENDATIONS</b>	
<b>FROM:</b> Executive Director Adults	<b>Deadline date:</b> N/A
<p>It is recommended that Adults and Health Scrutiny Committee:</p> <ol style="list-style-type: none"> <li>1. Have regard to the content of the report and support the increased use of reablement service to support people to live independently, and therefore reduce care and support costs across adult social care.</li> </ol>	

**1. ORIGIN OF REPORT**

1.1 The report of the use of reablement was requested by the Committee.

**2. PURPOSE AND REASON FOR REPORT**

2.1 The provision of reablement services is covered by The Care Act 2014 *Care & Support Statutory Guidance, Section 2, Preventing, reducing, or delaying needs.*

This states that local authorities, with social care responsibilities, must provide or arrange services, resources or facilities that prevent, delay, or reduce individuals' needs for care and support, or the needs for support of carers. Reablement services are a key element of delivering on this agenda. The act states that where reablement is required, it must be provided free of charge for a period of up to 6 weeks and applies to all adults, irrespective of whether they have eligible needs for ongoing care and support. The act states that whilst the local authority does have the power to charge for this where it is beyond six weeks, local authorities can consider continuing to provide beyond six weeks free of charge if there are clear preventative benefits to the individual.

This report gives an overview of the service and is for information.

2.2 This report is for the Adults and Health Scrutiny Committee to consider under its Terms of Reference Part 3, Section 4 - Overview and Scrutiny Functions, paragraph No. 2.1 Functions determined by Council –  
4. Adult Social Care; and  
5. Safeguarding Adults.

### 3. **TIMESCALES**

Is this a Major Policy Item/Statutory Plan?	<b>NO</b>	If yes, date for Cabinet meeting	N/A
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### 4. **BACKGROUND AND KEY ISSUES**

#### 4.1 **Introduction**

The provision of reablement services is covered by The Care Act 2014 *Care & Support Statutory Guidance, Section 2, Preventing, reducing, or delaying needs.*

The service operates 365 days a year between the hours of 06:30-22:30 and provides support visits to individuals based on their individual needs, this can range from 1 visit per day up to 4 visits. In periods of hot weather alerts these visits will increase to support the care and support needs of our individuals to ensure nutrition and hydration needs are supported.

The Reablement service sits within the Adults Early Intervention and Prevention offer. This a holistic 'one-stop shop' approach for clients which looks at both their ability to carry out activities of daily living and their physical home environment. This includes Adult Early Help, Reablement, Therapy Services (including TEC (Technology Enabled Care) and Sensory impairment), Housing Programmes, Care and Repair Home Improvement Agency and Older People's Day Services.

Referrals into the service is through the Adult Early Help team for people living in the community who are declining in their ability to remain independent, due to illness or injury. Referrals are also received from Adult Social Care Review and Long-Term teams for people where further improvement could be supported through a period of reablement support. Individuals who are supported by the hospital admission avoidance team are referred directly and the team support people to return home from the emergency department within a few hours. Referrals are received from the Hospital Discharge team directly to reablement, therefore enabling a timely discharge back home. The reablement team provide a holistic assessment, which is part of the wider early intervention and prevention offer, including TEC (Technology Enabled Care), aids and adaptations, environmental home assessments, handyman service, LEAP (Local Energy Advice Partnership) referrals, and onward referrals to the voluntary support sector

Individuals are identified, both in the community and in hospital, who would benefit from a short-term, targeted programme of reablement, and / or reassessment, to maintain or enhance their level of independent function in daily living activities and reduce their need for statutory services. This will include activities in the wider community where necessary and appropriate.

#### **Aims of the Service**

The aim of the service is to achieve the following through person centred goal setting with each individual client:

- Enable individuals to remain living in the home, and community, of their choice for as long as possible whilst maintaining their optimum level of independence, relearning lost skills

- Provide personalised, time limited, support for each individual as decided by the service which meets the goals for each individual, and their carers, and allows them to exercise choice and control
- Deliver targeted, outcome focussed interventions that prevent and reduce the need for long term care and support
- Facilitate discharge from hospital at the optimum time for the individual thereby reducing delayed transfers of care within the acute and community hospitals therefore reducing the risk of further deconditioning within these settings.
- Ensure that assessed care needs upon discharge from reablement are at the point when the individual has reached their optimum level of independence
- Reducing financial burden for the Council where the social care review team have identified that a period of reablement may achieve a reduction in a clients existing care package or reduce the need for increased purchased care provision
- Deliver supplementary services as agreed with commissioners, primarily domiciliary care prior to and/or following a period of reablement whilst long term care is sourced. This is known locally as “bridging” and is chargeable.

The Reablement service is also commissioned to be the Provider of Last Resort where there is a lack of independent sector domiciliary care capacity. This includes requests from adult social care teams and from hospitals.

### **Compliments**

The Reablement service receives daily feedback and compliments from both clients and their families. The following a small selection from the last few months:

*“All of the staff who visited were polite, courteous, and respectful and played a large part in boosting my confidence with encouragement, enabling me to now do things independently. My life also benefits greatly from their presence”*

*“Equipment very helpful. Lots of good advice and techniques given which has really helped me to learn to do things again myself. Encouragement given, routine established. Liked seeing people”*

*“I found it very comfortable with the nice people that came to me. They eased me into things I thought would be difficult for me, but it was easier to get back into the routine of my everyday life”*

*“Time to listen. They understand why I was feeling anxious and supported me well. Friendly, polite and respectful of my home. Thank you”*

*“Lesley my OT assistant was very helpful, encouraging confidence with negotiating tasks in the house and ordering equipment to facilitate this. My main focus was to use the stairs as I got stronger and eventually the use of the upstairs shower, independently. This she enabled, over visits Lesley was very easy to talk to. Took time to appreciate my difficulties and how they improved to the point of my re-enablement confidence”*

*“Before accepting Reablement, I had lost confidence in myself and this was affecting such things as my mobility. Now I feel a boost to myself confidence and my outside mobility has also improved”*

### **Example Case Study**

Client X was referred through a hospital discharge. They had been in Hospital for 42 days

and had no previous support in the community and lived alone. Client X had been admitted into hospital due to sepsis, acute kidney injury, chronic kidney disease and confusion. Client X had a long past medical history including exacerbation of chronic obstructive pulmonary disease, severe pulmonary hypertension, obstructive sleep apnoea. He had a CPAP (continuous positive airway pressure) machine at home and suffered Type 2 diabetes.

The initial Reablement support provided was 3 calls per day to support with washing, dressing, preparing meals and medication support. At the time of the assessment Client X worked with the reablement practitioner and agreed to goals of bathing, showering, dressing, meal preparation and drink preparation. It was also identified that a reminder clock for medication could support an increase in independence. Client X received weekly monitoring visits by the reablement Care Support Worker. Following the first review Client X was seen to be consistently achieving their Lunch time goals, therefore the lunch call was ended, leaving in place a morning and the tea-time call to continue to work on personal care goals.

It was also evidenced, that the reminder clock was having a positive effect and Client X was identified as independent with his medication routine and by the second monitoring visit in Week 3, Client X was identified as meeting all his goals consistently and it was agreed to end the reablement support.

Client X had received reablement support for approximately 3 weeks before they were able to regain their baseline level of independence

### **Performance during 2022/23**

- Referrals received 1,185
- The team completed 29,000 support visits and delivered over 20,000 hours of support
- 78% of clients the team supported achieved full independence following their reablement support
- The current Independence rate for the reablement service is 79.5%

The last Full CQC (Care Quality Commission) Inspection of the service was carried out in August 2017, a rating of 'Good' was awarded.

### **Service developments**

Working with our Public Health and Healthy You colleagues, an opportunity was identified for the service to incorporate Strength & Balance Exercises into the goal setting for appropriate clients. This has led to the Senior Clinical Exercises Specialist within the Falls Prevention Team to provide the Reablement Practitioners with training to provide goals related directly to the appropriate Strength and Balance exercises for clients appropriate to their needs. The second phase of this training which started in May 2023 will provide additional training and knowledge to our Reablement Workers. This will support their knowledge and ability to promote confidence to clients during their support visits, increasing the promotion of individuals overall strength, stamina, and balance, to reduce their risks of falls.

One of the challenges the team faces is the recruitment of Reablement Support Workers. As part of our recruitment campaign, we have teamed up with the council's communication team to produce a short film, highlighting the work our reablement staff do with the clients. Once this work has been completed, this will be shared on all social media platforms and used to bring to life the fantastic work provided by the service and the job satisfaction felt by staff to support the recruitment of workers into this vital role.

## **5. CORPORATE PRIORITIES**

5.1 *Consider how the recommendation links to the Council's Corporate Priorities:*

1. *Prevention, Independence & Resilience*

- *Educations and Skills for All*
- *Adults*
- *Children*

*Further information on the Council's Priorities can be found here - [Link to Corporate Strategy and Priorities Webpage](#)*

## **6. CONSULTATION**

6.1 There has been no consultation, this is a city- wide offer.

## **7. ANTICIPATED OUTCOMES OR IMPACT**

7.1 The reablement service as an element of one of the Council's corporate priorities; Prevention, Independence and Resilience.

## **8. REASON FOR THE RECOMMENDATION**

8.1 To provide Early Intervention and Prevention, helping and supporting Peterborough residents to remain independent and connected in the local communities.

## **9. ALTERNATIVE OPTIONS CONSIDERED**

9.1 *N.A.*

## **10. IMPLICATIONS**

### **Financial Implications**

10.1 This is an information report.

### **Legal Implications**

10.2 This is an information report.

### **Equalities Implications**

10.3 The service covers all clients and groups attached within the reablement service specification.

## **11. BACKGROUND DOCUMENTS**

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985

11.1 None.

## **12. APPENDICES**

12.1 Appendix 1 - CCC&PCC Reablement Service Specification – June 2022

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