Reablement Service Specification for Cambridgeshire & Peterborough

Service	Reablement Services
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1.0 Introduction

1.1 This Service Specification covers the delivery of reablement services to adults, primarily focused on older people and adults who meet demand management criteria, across both Cambridgeshire and Peterborough. It is presented as a generic specification focussing on the aims of the service and the outcomes expected from reablement interventions without being prescriptive about the models of service delivery used to achieve those outcomes. The specification provides a basis for service delivery in relation to all elements of reablement, and includes key performance metrics against which services will report so as to achieve aligned and consistent outcome reporting across the two local authorities.

2.0 The Care Act 2014

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.

3.0 Service Objectives

3.1 The primary objectives of the reablement services across Cambridgeshire & Peterborough are to:

i. 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

ii. 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

iii. Deliver targeted, outcome focussed interventions that prevent and reduce the need for long term care and support in line with comprehensive service criteria

iv. Facilitate discharge from hospital at the optimum time for the individual thereby reducing delayed transfers of care within the acute and community hospitals

v. Ensure that assessed care needs upon discharge from reablement are at the point when the individual has reached their optimum level of independence

vi. Reducing financial burden for the Councils where reviews of service users have identified that a period of reablement may achieve a reduction in their existing care package or reduce the need for increased purchased care provision

vii. 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

viii. Work in partnership with key teams and stakeholders, both internal and external

ix. Strive to achieve outstanding CQC outcomes

x. Deliver statutory requirements and report on Key Performance Indicators (Care Act, CQC, NICE Quality Standards). See Appendix B.

3.2 In seeking to achieve positive outcomes for all customers, and their carers, the reablement service will take an holistic approach to assessment and goal setting which not only involves the person and their family / carers but also aims to consider the benefits of accessing wider, preventative services such as technology enabled care, therapy services, housing related support, housing services and community navigators.

3.3 Partnership Working and Key Interface Relationships

The Reablement Service is seen as an essential element in the delivery of preventative services so will need to work collaboratively with other teams across health and social care including:

- Adult Early Help
- Technology Enabled Care & Sensory Services
- All social Care community teams
- Neighbourhood Teams in CPFT
- Occupational Therapy services – in-house and CPFT
- Intermediate Care
- Acute Discharge Teams
- Enhanced Response Service
- Housing Teams
- GPs & District Nursing Support
- Brokerage
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4.0 Service Criteria

4.1 Reablement services will be provided where the person has given consent or it has been identified as part of a Best Interests decision The decisions of the Reablement service should be respected by all disciplines and are final. An explanation of why a case has not been accepted in the Reablement Service will be provided. The service user should follow the most appropriate pathway to meet their needs. Availability of capacity should not dictate the appropriate pathway for individuals, we aim for safe and appropriate discharges to avoid unnecessary readmissions. Reablement services will focus on efor people to maintain independence and delay the need for longer term care and support. For an individual to be eligible to receive reablement, they must meet the following criteria:

i. The person is over the age of 18 and resides within the local authority boundaries of Cambridgeshire or Peterborough (ie pay their Council Tax to PCC, or one of the five District Councils in Cambridgeshire)

ii. It is identified that the person would benefit from a short-term, targeted programme of reablement, and / or reassessment, in order 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

iii. There is potential for the person to learn or re-learn skills necessary for daily living which may have been lost through deterioration in physical or cognitive functioning. This will include referrals from teams where an individual may benefit from some short term intervention to increase their independence and potentially reduce their care and support package or reduce/prevent the need to increase the package of care

iv. The provision of care and support by the reablement service will mean that the person's risk of admission to hospital (or a care home) may be reduced

The Reablement Service may also support individuals if the following criteria are met:

- Reablement need to act as Provider of Last Resort where there is a lack of independent sector domiciliary care capacity. This includes referrals from communities and from hospitals.

- Short term reablement required for an informal carer, or for the service user if the carer cannot provide their care

NB: In Cambridgeshire, the Reablement service provides care and support to prisoners within HMP Littlehey which has a significant number of older prisoners. Support is provided to prisoners who meet the eligibility criteria for statutory services.

4.2 Exclusion Criteria:

i. The person has a rapidly deteriorating condition or prognosis, that cannot be met by the reablement service and would be best met by health services – either Intermediate Care or NHS Continuing Health Care

ii. The person has a health need that requires a specific clinical rehabilitation programme or Intermediate Care including:

- unstable medical condition requiring medication review eg unresolved delirium; diabetes; pain control,
- fractures where it is on the dominant side and / or precautions need to be observed.
- those people where there is specific medical advice that they must be non-weight bearing for a specific period of time and unable to participate in a Reablement programme
- those who should be on specialist rehab pathway, such as neuro rehab, stroke rehab and amputee rehab

iii. The person requires care and support while their family carers are on holiday

iv. Adults who are homeless and do not have suitable accommodation for a Reablement programme to take place. If there is no suitable accommodation, consideration will be given as to whether the person is suitable for accommodation through the Out of Hospital Project. Reablement will undertake an assessment to determine whether the accommodation offered is suitable for the provision of a reablement programme. An exit plan will need to be considered and planned to support the decision to accept.

v. Adults who have No Recourse to Public Funds (NRPF). The referring professional must have checked the status of individuals if they have reason to query access to public funds. (If the individual has care and support needs, a Human Rights Assessment will need to have been completed as the L.A. may have a duty to support regardless of whether the adult had NRPF).

vi. People who are unable to engage in a reablement intervention due to severe cognitive impairment where reasonable adjustments have not been successful and / or are not engaged in a programme of rehabilitation support.

These are typical exclusions. Exceptions may be allowed at the discretion of the Registered Manager.

4.3 Access to the Services

Entry routes into the services will ensure that individuals can easily be referred to complementary prevention and early intervention services. This is achieved at PCC through the Home Services Delivery Model and through CCC's prevention and early intervention offer.

Entry into the Reablement Services will be efficient and effective with main routes of referral being via hospital discharge teams, Adult Early Help and other routes, as agreed locally.

5.0 Hours of Operation & Geographical Areas Covered by the Service

5.1 Reablement services operate on a 7-day basis between the core operating hours of 7am and 10pm and can accept referrals during this time. The services operate 'on call' and 'out of hours' cover.

5.2 Reablement services will be available within the local authority boundaries of Cambridgeshire County Council and Peterborough City Council.

5.3 The reablement services will be expected to provide cover across local authority boundaries for each other if they have capacity to do so.

6.0 Delivery of the Service

6.1 Following triage of referrals, the Reablement Service will work with the individual (and their family carers if required) to identify and jointly agree outcome focussed goals.. An initial assessment will be completed to identify needs and how Reablement interventions will be delivered to work towards achieving desired outcomes. This assessment will be completed by whichever member of the team is deemed to be the most appropriate.

6.2 The service will ensure that there is ongoing monitoring of outcomes against assessed need and set goals with the aim of maximising the service user's independence. Adjustments to be made to the goal plan whenever necessary.

7.0 Completion of Reablement Intervention and Ongoing Care Management

7.1 The Reablement Service will work with the individual, and their family / carers / significant others where appropriate, to determine the most appropriate point of exit from the service. This will be undertaken in a timely and planned manner, with all relevant partners and agencies kept informed throughout.

7.2 The period of Reablement will be deemed to be complete in the following circumstances:

i. The individual is discharged with no ongoing support needs identified. Where required, the person will be provided with appropriate information, advice and guidance on prevention and early intervention services should they be needed now or in the future

ii. The individual requires ongoing care and support from Adult Social Care Services. The Reablement Service will complete a statutory assessment of the individual's ongoing care and support needs in line with the requirements of The Care Act. An outcome focussed Care & Support Plan will be agreed with the individual before ongoing care and support is sought

iii. The individual requires ongoing care and support but their assessment has deemed them to be a self-funder. In this situation, people will be provided with information and advice with regard to sourcing their own care and support

iv. The individual requires other ongoing support other than that provided by Adult Social Care – eg wider support services, including voluntary sector

support. The Reablement Service will provide a summary of care and support needs that can be passed to relevant others

8.0 Workforce Development & Training Needs

8.1 The reablement needs of individuals will be met by staff who are appropriately trained and are well supervised. Reablement staff will receive appropriate development opportunities to ensure they carry out their role effectively and are supported to keep key skills and training up to date.

8.2 The service will ensure that:

i. All staff operate with an enabling ethos that promotes as much independence as possible for the individual. It is expected that support staff will be given the opportunity to learn from, and will be supported by, qualified members of the team, eg Occupational Therapists and Social Workers , as part of ongoing training and development
ii. All staff receive appropriate induction at the start of their employment in line with the Skills for Care, Care Certificate
iii. All staff undertake mandatory training in line with CQC Fundamental Standards and keep these updated
iv. All staff are supported to acquire further skills and qualifications that are relevant to their role and the needs of the service
v. All staff receive appropriate supervision by a suitably experienced and qualified person and records are kept in line with council policies
vi. All support staff receive an annual performance appraisal review in line with requirements of the council
vii. All staff are managed in line with council policy and procedures

9.0 Adherence to Key Legislation, Policies and Standards

9.1 The Reablement Service will:

i. Maintain registration with the Care Quality Commission (CQC) and must meet the Fundamental Standards
ii. Comply with the requirements of The Care Act and the associated Care & Support Statutory Guidance
iii. Comply with the NICE Quality Standard *Intermediate care including reablement* (Aug 2018) www.nice.org.uk/guidance/qs173
iv. Adherence to national and local policies relating to specific areas of service delivery including :
    - Equality & diversity
    - Data protection
    - Safeguarding

Appendix A:

Short & Long Term Support (SALT) Annual Statutory returns to Dept of Health

Individuals will be reviewed throughout the delivery of the support. If someone is initially deemed eligible for reablement and circumstances change, this may result in early cessation of the service .

Early cessation describes a circumstance where the period of short term support was forced to be cut short in an unexpected way. It can occur because of unexpected changes in client health, such as if the person suffers a stroke or other sudden event that means the short term support to maximise independence (ST-Max) is no longer appropriate. Clients may be forced to return to hospital with an uncertain discharge date, causing the suspension or termination of the ST-Max support. In some instances the client may move (or be moved) out of the local area, perhaps to live under the care of relatives. Or relatives may decide mid-way through the period of support to take over that support etc. forcing the end of ST-Max. The client themselves may decide to end the support themselves, on the grounds that they do not need it.

'Early cessation' does not simply mean that support has ended prior to a standard service period, such as 4 or 6 weeks.

The categories of early cessation are as follows:

i) Early Cessation of ST-Max
   Early cessation of service (not leading to long term support) - NHS funded care/End of Life/ deceased. This sequel shows explicitly that further health care or palliative care was needed, or that the client died before ST-Max was completed.

ii) Early Cessation of Service (not leading to long term support) – other reason. This sequel should be used for all other instances of ST-Max ending early where long term social care support does not result. For example, the client may move (or be moved) out of the local area, perhaps to live under the care of relatives. Or relatives may decide mid-way through the period of support to take over that support, forcing ST-Max to end.

iii) Early Cessation of Service (leading to long term support)

This is used if a client's short term support ended early and provision of long term services followed

Appendix B: Key Performance Indicators

Financial measures – check with Anna and agree how these should be stated here…

Re 3,4,5,& 6 the Independence and Wellbeing Group need to agree if these are still appropriate or whether there are other measures that are more relevant…

No.	Measure	Notes
1.	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	**Statutory Measure** Both PCC and CCC measure all-year round. PCC measure for **all individuals** who receive reablement support. CCC only measure for those who are discharged from hospitals (not community referrals).
2.	Outcome of short-term services: sequel to service (Proportion of clients leaving ST-Max who do not go onto receive long-term support)	**Statutory Measure**
3.	Number of people leaving reablement with reduced care or no care outcomes	Key Performance Indicator for Adults Positive Challenge Programme
4.	Number of "existing" clients receiving reablement	Key Performance Indicator for Adults Positive Challenge Programme
5.	Percentage of capacity in reablement utilised for direct reablement delivery	Key Performance Indicator for Adults Positive Challenge Programme
6.	Operational and Management Reporting for the efficient running of the service.	

Risks and Dependencies

Staffing levels

Vacancy levels

Equipment service impacts on lengths of stay in Reablement.