Report to the Health and Adult Social Care Select Committee

Title:	Adult Social Care Transformation - Regaining Independence (Tier 2)
Committee date:	Tuesday 2 July 2019
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Purpose of Agenda Item

1. This report provides an update on Tier 2 of the Better Lives Transformation Programme. Previous updates were provided to HASC on 28th November 2017 and 24th July 2018.

Background

2. The Better Lives Transformation Programme is supporting the delivery of the Better Lives Strategy. This is the strategy for the future of adult social care services in Buckinghamshire. A detailed diagnostic of the service and opportunities for transformation was undertaken in 2017 which set the overarching framework for the programme and its content.

3. The Transformation Programme is organised into three tiers:
   - Living Independently (Tier 1) – update provided to HASC on 19th March 2019
   - Regaining Independence (Tier 2) – this update to HASC on 2nd July 2019
   - Living with Support (Tier 3) – update due to HASC on 24th September 2019

4. Regaining Independence (Tier 2) is focused on working with people and their families to help the individual gain or regain the skills they need to live independently by supporting them in the short term, expecting that wherever possible people will support themselves in the longer term.

5. We know that this approach can prevent longer term needs from developing. And that when people experience a crisis in their lives, we will work with them and

their families to manage the crisis, helping them to become better able to deal with issues in the future.

6. There are two substantive work streams within this tier:

   - Short Term Intervention: Improving and broadening our short term intervention offer to support the individual gain or regain the skills they need to live as independently as possible. We have established a portfolio of projects which will integrate BCC, BHT and CCG services to support short term interventions which will support people to live as independently as possible. These projects include developing a new Short Term Intervention Service (starting with reablement and intermediate care in the community), a Single Point of Access (SPA) for referrals into these services and integrated discharge from hospital service including a Discharge to Assess Pathway (D2A)

   - Preparing for Adulthood (PfA): creating a single integrated service with Children's Social Care to support children and young adults in receipt of social care support; and smooth the transition from Children's Service to Adult Services with the objective of supporting those young people to live as independently as possible. The focus is on children and young people (and their families) whose needs are such that they will be progressing into Adult Social Care.

7. Tier 2 has been the most challenging portfolio of projects in the Transformation Programme. This is principally because all of these projects have required close partnership and the compound effect of collaborating with a different Directorate or organisation with competing priorities can slow progress. That said, there is now concrete progress being made across all Tier 2 projects.

Integrated Care System

8. In June 2017, Buckinghamshire was announced as being one of the first wave of Accountable Care Systems, now known as the Integrated Care Provider (ICP), to deliver improvements to local health and care through joining up services in place of what has often been a fragmented system. The County Council's *Better Lives* Adult Social Care Strategy 2018-2021 is directly aligned to and supports the delivery of the ICP Operating Plan outcomes.

9. Specifically, the Better Lives transformation programme supports two of the ICP priorities:
   - Population Health Management – will help people to stay healthy, live independently and avoid getting unwell
   - Integrated Primary & Community Services – will support individuals who are unwell by providing care at home or in the community. Tier 2 aligns most directly with this ICP priority which is governed through the ICP Integrated Care Board.

WORK TO DATE AND PRIORITIES FOR THE NEXT PERIOD

SHORT TERM INTERVENTION SERVICES AND CRISIS SUPPORT

10. Until very recently, the substantive focus has been on aligning the BCC Reablement and Occupational Therapy (OT) Teams with the BHT[1] Rapid Response & Intermediate Care (RRIC) service with the intention of bringing them together to form a single short term intervention service for Buckinghamshire.

11. Work undertaken in the last 12 months has included:
    - Designing 3 pathways to be able to better meet patient needs – admission avoidance, supported discharge, extended support – Appendix A
    - Introduced Trusted Assessor pilots, single set of paperwork, Community OT pilots, development of a single communications plan and recruitment/retention strategy
    - Designed a Single service specification including referral criteria – Appendix B
    - Agreed an integrated performance framework with a single dashboard bringing together activity and performance data from both the BHT and BCC services – Appendix C
    - Healthwatch undertaking qualitative user engagement – this demonstrated that the experience of people using both the BCC and BHT service can be very inconsistent and identified some specific areas for improvement – the full report can be viewed on the Healthwatch Bucks website here.
    - Developed a draft business case for a single service

12. However, despite the achievements of this past period, it became clear that a truly integrated service would require longer time to achieve as there are some differences between the respective services which cannot be swiftly reconciled; and there is improvement work to be undertaken within the relevant BCC services preparatory to any further integration. Therefore, whilst creating the integrated single service with BHT remains the ambition, our short to medium-term focus is on bringing together our own two short term intervention services (Occupational Therapy and Reablement), developing a new service model to improve outcomes and productivity and invest in cultural change and workforce development (as well as recruitment and retention) to support staff with the right tools and capabilities.

13. In addition to the service improvement activity, £264k saving was delivered against a target of £460k in 2018/19 through effective reablement supporting some individuals' to live more independently and so reducing the amount of home care required. This was significantly short of the target of £460k and a priority going forwards is to increase the volume of appropriate referrals into the service and forms part of the improvement plan.

[1] BHT is Buckinghamshire Healthcare Trust. The BHT RRIC service includes reablement, physio and occupational therapy.

Short term intervention and crisis support - priorities for the next period:

14. The priorities for the next period are to create a BCC Short Term intervention service. A project manager has been appointed who will be responsible for taking forward the improvement plan. A new management structure for the short term intervention service is being developed as part of a wider restructure of Adult Social Care Operations

15. The improvement plan which is being developed will include:

- Staff engagement and co-design (all staff have already been briefed of the service intention)
- Developing the new service model which will include co-design with staff and detailed customer journey mapping with service users to properly understand the service from the user's perspective (Healthwatch Bucks will be undertaking a re-run of similar qualitative interviews later this year to test out the improvements from the user's perspective
- Cultural change and work force development so that staff understand the "why" and "what" of the change and are provided with the right skills and capabilities for the new service
- Recruitment and retention – staff turnover and hard to fill posts are one of the biggest contributors to disrupting service performance and providing the service at the most timely point to the client
- Identifying any investment requirements, whilst continuing to work with BHT on alignment and the longer term
- Increase the quantity of community referrals (i.e. non- hospital discharges) and for people with disabilities
- Reduce the number of "inappropriate referrals" as this is a waste of both the client's time and BCC's.
- Learn from good practice elsewhere

16. Performance improvement and diagnosis:
    - Benchmarking with the RRIC service (and performance elsewhere) has identified some issues in our performance. For example, we know that the time from referral to assessment is too long for BCC – typically 10 days compared to our target of 3 days (BHT RRIC typically achieves c. 4 days). Not only is this poor service for the client but during the waiting time, the client's condition can deteriorate leading to long term services. We need to radically improve upon this. We know that staff vacancies at the assessment stage will be a significant contributor but we also need to fully understand whether there are any factors which influence this.
    - Reablement outcomes – we use a person's ongoing care requirements at the end of reablement as a measure of how effective the reablement has been i.e. no care requirement or a reduction in their BCC-funded care (45.4% end of May 2019). This percentage varies from month to month and sometimes exceeds 50% and we know this can be improved upon. BHT is not able to provide comparative data for the RRIC service but we know that other Council reablement services are achieving better outcomes – typically 50-60%, with some achieving between 60-70%.

- There is also a statutory indicator which is the proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement/rehabilitation services (measured during the 3 month period of Oct to Dec each year). This is a joint measure between Health and Social Care. Performance has been diminishing year on year and is further evidence of why we need to place a concerted focus on improving this service. The Buckinghamshire score in 2017/18 is 66.3%, compared to the regional average of 82.2% and England average of 82.9% (see Appendix D for further information).
- Source of referral. Most of our referrals come via hospital discharge. In 2018-19, 73% of referrals (917 people) were via hospital discharge. We want to significantly increase the number of referrals of people before they have the crisis which triggers the hospital admission. We know that early intervention reablement will have the greatest and most sustainable impact but it will require a shift in mind set amongst social care practitioners, primary care and other referrers to think of BCC reablement as a preventative option.

17. We have a target to deliver savings in 2019/20 of at least £840,000 reduction in home care costs through effective reablement.

18. We will continue to work with BHT, aligning services where it makes sense to do and continue to work towards the ambition of a single service.

19. We will also be identifying what short term interventions can be developed to support people with learning disabilities or mental health issues to prevent them developing requirements for longer term services.

SINGLE POINT OF ACCESS

20. This intention is to create a Single Point of Access (SPA) to community services which will include triage workers, reablement and intermediate care assessors, mental health workers, physiotherapists, occupational therapists - both BHT and BCC social work assistants.

21. During the last 12 months, some preparatory work has taken place to map existing access points and the pros and cons, as well as co-design what a “to be” model could look like. A workshop on April 1st starting the co-design of the SPA, identifying some key design features and issues which would need to be addressed. The indicative SPA model includes the ambition of 24 hour turn round for referrals (same day if referred in the morning) so that people can be swiftly discharged form hospital; or hospital admissions avoided from swift short term interventions.

Single Point of Access – priorities for the next period

22. The ICS Integrated Care Board has established a Task and Finish group with the principal objective of developing a detailed design proposal and implantation plan for the SPA which can then be taken through the necessary governance of the respective organisations. It is anticipated that this could be completed by late 2019 although any quick wins could be implemented before then.

23. As the SPA will require whole system engagement (BCC, BHT, Frimley[2], Primary Care, SCAS[3], voluntary sector, OBMHT[4]) and the possible decommissioning of some existing access points, implementation may have to be phased.

INTEGRATED HOSPITAL DISCHARGE SERVICES

24. This will involve the integration of the BCC and BHT hospital discharge services to facilitate swift discharge, with a presumption of further assessment in the individual's home or community setting. Although there is close collaboration between the two services, we know that there is duplication of resources and significant opportunities for improving the service. In addition, BCC's discharge service also supports Wexham Park Hospital run by the Frimley Healthcare Trust.

25. Progress has already been made on the alignment of the discharge services (co-location at Stoke Mandeville, joint working, visits to other areas) and also agreement on the objectives and design principles for an integrated service. In addition, any opportunities for quick wins have been taken. For example:
    - The BCC Hospital Social Work Team has provided a Social Work Assistant to undertake reablement assessments as a trusted assessor, to support speedier discharge to the reablement service
    - The two teams are pooling resources to be able to provide more effective support to wards (including linking named staff to different wards) and reducing duplication between the two teams; and increasingly operating as a whole team

Integrated Hospital Discharge – priorities for the next period

26. A working group is taking forward this project - it is inextricably linked to the development and design of the SPA and will be taken forward in tandem with the SPA project and continue to explore what works well elsewhere.

27. Examples of further activity include:
    - More analysis of activity data, demand and forecasting to be able to model the service more effectively
    - Seeking feedback from the wards for their views on more effective discharge
    - Working with the wards to establish patient expectations about what will happen at discharge; in effect commencing the discharge conversation as someone is admitted to the ward. A "Welcome to the Ward" pack or leaflet is being developed which will include information about the approach to discharge to support that conversation starting with patients and their families at admittance.

[2] Frimley HealthTrust runs Wexham Park Hospital in Buckinghamshire

[3] SCAS is South Central Ambulance Service

[4] OBMHT is Oxfordshire & Buckinghamshire Mental Health Trust

PREPARING FOR ADULTHOOD

28. The long-term vision is the development of a whole life disability approach which will ensure that people are supported consistently throughout their whole lives through a multi-disciplinary approach that includes Adult Social Care, Children's Services, SEND and also has the scope to include Health, Mental Health and CAHMS as relevant. This will focus on early intervention and prevention to prevent and delay needs, promoting progression and personalisation to support people to develop the skills they need to live an independent live and promoting choice and control through a strengths-based approach.

29. The following objectives and indicative outcome measures have been agreed:

Objective	Measures
• Promoting service user and carer independence	• Number of children who have attended independent travel training and now use public or other transport • Number of people using the Local Offer to self-serve
• Developing person centred services	• Number of traditional day services vs increase in percentage using community options. • Family and service user feedback
• Maximising the use of community resources to provide a diverse range of opportunities to support independence and progression	• Number of traditional day services vs increase in percentage using community options
• Maximising opportunities for people to live at home and reducing the use of residential and nursing care, particularly out of county.	• Reduction in the use of independent and out of county placements (set targets) • Appropriate use of facilities – commissioning to need
• Removing artificial barriers and taking a whole life approach to facilitate a natural progression into Adult Services based on life events rather than age.	• Number of children that have transitions plans • Monitor plans for PfA – evidence that plans show support to promote independence and planning for future
• Utilising a strengths-based approach with a focus on support planning and achievement of outcomes rather than assessment.	• Every young person with an Education Healthcare Plan has personal outcomes recorded as part of their annual transition reviews.
• Co-production and co-design of service provision with young people and their families	• Service user feedback • Reduction in tribunal /legal challenge
• Continued engagement with young people and their families on what matters to them.	• Numbers of users accessing help, advice, and support from Special Educational Needs and Disability Independent Advice Service and other partners • Family and service user feedback

30. Due to the current improvement activity underway within Children's Services and Special Educational Needs, a phased approach has been agreed to ensure that the change is manageable and sustainable.

31. Phase 1 is co-location and closer working between the Children with Disabilities and Transitions services to create a 0-25 year service.

32. In addition, during 2018-19, a £500k savings in the Transitions budget was delivered (against a target of £300k), principally through a focus on CHC reviews and appropriate placements.

Preparing for Adulthood – priorities for the next period

33. Co-location to Amersham is underway with the expectation that the Children with Disabilities and Transitions service teams will be fully co-located by July 2019. (The Transitions team is already based in Amersham).

34. Phase 1 will be used to develop a detailed improvement plan which will include:
    - Developing a seamless pathway for young people, their families and professional stakeholders which removes key pitfalls and barriers to successful "transitioning" of our young people – including joint allocations and forum process, single set of paperwork/records
    - Evidencing impact and outcomes for people – creating a robust performance dashboard to track and measure against agreed KPIs which focus on impact and outcomes for people
    - Detailed forecasting and profiling of demand to enable effective financial and service/commissioning planning for young people

35. Phase 1 will also be used to co-design (with young people and their families, staff and other stakeholders) the model for the long term PfA and its governance which will be taken forwards in Phase 2 and a possible Phase 3. It is anticipated that the business case for Phase 2 will be developed by the end of 2019.

36. The development of the service will be overseen by a Joint Board between CHASC and Children's. Projects resources are also being secured to drive forward this new service and ensure that it maintains pace and traction.

Appendix A – Short term intervention pathways

A workshop in October 2018 agreed 3 pathways - admission avoidance, supported discharge, extended support which are now incorporated in the single service specification. The workshop notes are below.

Referral pathways workshop 19/10/2018

The acceptance criteria previously agreed by the Core Team and Steering Group state that the team will accept referrals for:

- Professional referral only
- Adults from 18yrs onwards.
- Adults residing in Buckinghamshire and those registered with GPs in Buckinghamshire.
  N.B This will require agreements to be in place with neighbouring authority areas.

Three pathways have been agreed:

Admission avoidance: Up to one week of intensive support, following an unforeseen and rapid deterioration in function or change of circumstance in social or medical need that requires rapid response to prevent escalation (e.g. to avoid hospital admission, residential placement or , carer breakdown)

Supported discharge: Support to leave hospital for those who require an urgent response and need support to be able to go home. This is likely to be a cohort with high risk or complex needs.

Extended Support - Maximising independence (name to be confirmed): Up to 6 weeks support for those with medium and lower levels of need following either Hospital Discharge or Community referral. This pathway may be a continuation of either of the two pathways outlined above or be referred to directly.

N.B- One off intervention was discussed as a pathway, but it was agreed that this sits across all pathways and may require a rapid response to avoid admission or support discharge or a less urgent response. This may include one-off equipment, Community OT assessment or one-off visits.

Criteria	Admission avoidance	Supported discharge	Maximising independence
Cohort of patients	• Unforeseen deterioration in function or change of circumstance socially or medically • Referrals may be from Community or Hospital Front Door	• Patients that are medically optimised for discharge and safe to return home • Patients coming out of an acute/bedded service • Those with high needs/ those that would not be able to return home without immediate support in place	• Those with medium or low-level needs • Referrals from both Community and Hospital Discharge (must be able to return home without support in the first instance) • Non-urgent equipment provision
Response time/pathway timescale	• Triage to be within 2 hours • Response within 2 - 4	• Patient to be seen and supported on discharge • National guidance response	• 0-72 for initial triage and response to the referrer • High needs- would be

Criteria	Admission avoidance	Supported discharge	Maximising independence
	hours in line with waiting times in A&E of 4 hours **N.B- need to be clear on hours- will this be a 24/7 service?*	time of 72 hours • Contact the ward within 24 hours from receiving referral and discharge within 48 hours (reliant on ward following safe discharge process)	picked up through another pathway • Medium needs- 1-3 weeks to assessment • Low needs- 3-6 weeks to assessment
Referral Criteria	• Patients at risk of an admission, either social or hospital bedded environment • Unforeseen deterioration in function or change of circumstance socially or medically.	• Acute therapy • Clear goals have been set with the individual for short term intervention • Individual has the capacity and motivation to engage with the service • Individual has consented to, and understands, the service offer • Patient has the ability to be safe and complete transfers when home alone/overnight	• Clear goals have been set with the individual for short term intervention • Individual has the capacity and motivation to engage with the service • Individual has consented to, and understands, the service offer
Flow through	• Admission avoidance to be completed within a week. • Timely and seamless handoffs will be required to other services • May follow maximising independence pathway afterwards or be referred for ongoing services.	• Timely and seamless handoffs will be required to other services- this process needs to be improved for handoff to Adult Social Care services	• Patients can be referred to out-patients for ongoing therapy • Aiming for independence – no onward care by using Assistive technology, utilising community physio/CATS and HUBS etc. • Where long term care is required, timely and seamless handoffs are required- this process needs to be improved for handoff to Adult Social Care services

Appendix B – Single service specification and pathways (agreed August 2018)

Service Specification No.	**Version 10 – 18.07.18**
Service	**Regaining Independence Service**
Authority Lead	
Provider Lead	
Value of Contract/ Service	
Period	

1. Introduction

Buckinghamshire County Council and the CCGs both commission Intermediate Care and Reablement. NICE Guidance provides clarity on the varying forms of this. It cites four types of intermediate care:

1. Crisis response – services providing short-term care (up to 48 hours);
2. Home-based intermediate care – services provided to people in their own homes by a team with different specialities but mainly health professionals such as nurses and therapists;
3. Bed-based intermediate care – services delivered away from home, for example, in a community hospital; and
4. Reablement – services to help people live independently which are provided in the person's own home by a team of mainly care and support professionals.

Reablement services have been shown to offer considerable benefits for many people who have been supported to regain skills rather than be 'cared for' in a traditional sense. An intensive period of coordinated 'enabling' support focusing on outcomes and drawing on the expertise of a number of professionals can achieve positive results, both for the person, and for organisations. (*Ambrey Associates and Helen Sanderson Associates, A New Reablement Journey, April 2011)*

'Intermediate Care including Reablement' should be seen as a pathway or a concept rather than as a service, where people should be able to access short-term, sometimes intensive, support to promote their independence and wellbeing. This support is aimed at reducing or removing the need for continued support and may be delivered in the context of achieving certain short-term outcomes that promote recovery or independence for people who already have longer-term support needs in other areas of their life.

Reablement and Intermediate Care is for all adults irrespective of whether they have eligible needs for ongoing care and support. Additionally, these services are to be provided free of charge by both the Local Authority and the CCG for up to 6 weeks of the specified period based on need or, if the specified period is less than 6 weeks, for that period.

Moving forward, our aim is to shift our approach to one that enables people to live well and fulfilling lives at home and draws on their strengths as individuals and the community that they live in rather than becoming dependent on the long–term support of Health and Social Care. Focussing on individual wellbeing from a perspective of preventing dependence on public services will enable people to draw on their strengths and the assets that they have available to them from either their personal or community networks, or indeed both.

The role of the Voluntary Community Sector is also another vital strand to the reshape to ensure

people are linked into local networks of support which helps prevent isolation and grows natural networks of support and the use of volunteers. We want to ensure that in the future people of Buckinghamshire are supported to live as independently as possible by providing information, guidance and support at the right time; ensuring that services for those in greatest need represent value for money and are sustainable into the future.

2. Service Scope

A joint service will be provided between Health and Social Care to support adults in Buckinghamshire to avoid crisis, regain their independence, reduce reliance on long term care and support.

2.1 Service outline/ model

The key functions of the service are:

- To provide rapid admission avoidance and intervention at home to appropriate patients to prevent patients being unnecessarily admitted to hospital
- To support hospital discharges to enable appropriate patients to return to their normal place of residence as soon as medically fit to commence rehabilitation and maximising their level independence in their own environment
- To deliver community-based interventions to patients with increasing complexity and acuity
- To support patients in having greater ability to manage their own health, promoting independence, choice, well-being and resilience
- Ensuring people receive the right support, at the right time to help them live at home for as long as possible
- Enabling people to get back the skills and confidence they may have lost through poor health, a disability or going into hospital or through other care they have received
- Enabling people to learn and in some cases re-learn and practice personal care tasks and other activities of daily living so that they can live independently at home for much longer.
- Supporting people to maintain links with their friends and community which promote natural networks of support and avoiding isolation and loneliness
- Promotion of the use of assistive technology solutions to enhance the effectiveness of an enablement approach and maintaining as independence

The Integrated Team will facilitate rapid crisis response, prevention of admissions, timely hospital discharge and preventative/ recovery focused support, rehabilitation and reablement through:-

- Working alongside families/carers, community services and ward staff to coordinate the safe discharge of people from hospital back into their communities in a timely fashion, using a recovery and maintenance approach, whilst assessment and further planning is undertaken, utilising a “discharge to assess” approach.
- A swift, therapy led Initial Assessment of a person’s needs which includes person-centred goal setting and support planning, in consultation and agreement with the individual, their carer(s), therapists and other professionals as required.
- Effective planning and delivery and continual review of short term (up to 6 weeks based on clinical need) person-centred, goal-oriented rehabilitation that enables, empowers and encourages people to ‘do things for themselves’, rather than ‘having things done for them’.
- A dynamic process for monitoring and reviewing the person’s progress towards and achievement of their rehabilitation goals (with ongoing clinical reviews of goals and progress)
- Actively involve people and their families and carers in decision-making during assessment and goal setting in their rehabilitation as per NICE guidance
- Holistic assessment, linked to the final review towards the end of the intervention, where a

need for ongoing social care has been identified
- Effective communication with all related services at all times
- To work in collaboration with all relevant partner agencies
- To have risk assessments for all patients that also address the safeguarding agenda
- Commitment to an outcomes focused approach of improving people's quality of life
- Ensure clear planning for transfer between services, or when the service ends and this can be before 6 weeks if potential for improvement has been reached

Changing culture and how we think about Intermediate Care and Reablement will be a fundamental part of the overall transformation programmes across the ICS and will involve moving the support towards a more therapeutic, goal setting, enabling model.

The aim of the proposed new service is to develop an Integrated, multidisciplinary model of Rapid Response, Rehabilitation and Reablement which aligns and co-locates the Buckinghamshire County Council Reablement team with Buckinghamshire Health Trust RRIC team.

The expectation is that the combined new service will be managed as a single entity with staff roles and functions defined by the needs of the service as whole rather than individual professional groups or functions. The workforce will be required to be agile and adaptable to meet a range of shared outcomes.

The service will have:

- Single shared management structure for the whole service. With identified Responsible Individual and Registered Manager
- Single shared business support structure for the whole service.
- A core group of qualified nurses, social workers, occupational therapists and physiotherapists who will undertake complex assessment and activity and will offer clinical/practitioner oversight for the team as well as highly competent support workers to undertake hands on support.
- Rehab, healthcare and Reablement Assistants who will undertake the majority of rehabilitation and coordination tasks.
- A trusted assessor approach.
- "Cross-skilling" and upskilling through joint training to eliminate duplication and to encourage positive skills flow through the system.

2.2 Days/hours of operation, response times and prioritisation

The service will be required to accept referrals and respond between 7am – 10pm, 7 days a week with therapeutic staff available 8am-8pm each day.

Assessments for a new urgent/rapid response initial assessment will be undertaken within 2 or 4 hours depending on urgency.
Assessments for routine community visits will be assessed using agreed criteria and a response agreed with the patient/ referrer within the following timescales:

- 24 hours for non-urgent priority visit
- 72 hours for a planned routine visit

Rapid Response - 2 to 4 hour response

Assessment and intervention for patients with an urgent need to prevent hospital admission or

social care support, to undertake this all agencies will need to facilitate the rapid response which includes the front door assessment and intervention.

Intermediate Care Pathway - 6 to 24 hour response

Physiotherapy and/or occupational therapy assessment and healthcare assistant support to facilitate an early discharge from hospital or avoid a hospital admission.

Maximising Independence Pathway - response time dependent on need. People that are likely to meet this pathway are those requiring community therapy interventions only (i.e. not intermediate care). People are prioritised into high, medium and low:

High – 2 hours to 48 hours

Medium high – 2 days to 10 days

Medium - 10 days to 21 days

Low – 21 days onwards

2.3 Referral criteria

Referral to the Service will all be received via a Single Point of Access and referrals will be accepted from:

- Buckinghamshire County Council Community Response Team
- Community Health Professionals
- Acute Health settings
- Social &Community Services Locality Teams - Social Workers Occupational Therapists & Care Co-ordinators
- Urgent Response and Telecare Service

The service will operate inclusive acceptance criteria that is not linked to diagnosis, to ensure all adults that will benefit, can access the service.

The team will work closely with professionals across the system to promote an ethos of reablement and rehabilitation as the default position and to learn from experiences where referrals were inappropriate.

The ethos of rehabilitation and reablement will be to improve and promote independence and to reduce the reliance on more formal care. To deliver a person-centred approach, there needs to be potential to improve from current baseline and agreement by the person to cooperate with the interventions and ethos of rehabilitation and reablement in order to reduce the amount of care needed or care packages being removed because the person or their carer has reached a level of independence appropriate for them and can undertake tasks themselves.

Rapid Response, Rehabilitation and Reablement should be considered for all people accessing health and social care services, the referral should be linked to need rather than medical diagnosis. Referrals will need to evidence:

- Reablement potential- a clear benefit to the individual from a period of reablement
- Understanding of the service- the individual understands the aims and remit of the service and the need to engage/ work towards goals.
- Mental Capacity- the individual has the capacity to engage with the service.
- Willingness to participate- the individual is motivated to engage with the service and work towards their reablement goals.

2.3.1 Referral Response

All urgent referrals for prevention of admission will be responded to within 2 to 4 hours as appropriate from health and social care professionals depending on the nature of the crisis. Response will usually be a face to face assessment at the individual's usual place of residence

Examples of rapid response referral –2 to 4 hour response

Sudden deterioration in health condition where a person is at risk of hospitalisation e.g. fall/ UTI and requiring assistance to remain at home whilst recovering, supported discharge as appropriate

Examples of Non urgent care – Planned response

No risk of serious deterioration– need can be met through use of routine services.

In addition, planned care telephone contacts will be made within 48 hours.

2.4 Eligibility for Rapid Response and Intermediate Care

The service is for those who :

- All residents of Buckinghamshire
- Are 18+ with eligible health and adult social care needs
- Have had a recent event/ decline impacting on their level of ongoing need for support
- Have medical needs that are stable and can be met in the community

Referrals will be accepted for adults for the following:

- An urgent assessment in response to a sudden and unforeseen change in health or need
- Assessment and/or intervention to avoid an admission
- A change in health status following an episode of illness now requiring care/reablement/nursing intervention
- Intermediate care following an inpatient stay

Referrals will be made to the Community Care Coordination Team (integrated single point of access between BHT and BCC) by telephone or e-referral. The Community Care Coordination Team is manned 8am to 5pm 7 days a week and outside of these hours referrals will be picked up the following day. Referrals will be accepted by default and referrers informed the referral has been received. If the referral is not appropriate for the integrated RRIC and reablement service, the Community Care Coordination Team will inform the referrer and signpost to the appropriate service.

2.6 Reviews of care and support and exit plans

2.6.1 Reviews

There will be ongoing reviews towards the person's goals as well as resetting these as required

Ongoing review is an integral element to the remodelled support of rehabilitation and reablement. Where it is apparent early in the pathway that an individual will require ongoing/ longer term support a referral should be made at that point.

Intermediate Care and Reablement support will be available for up to 6 weeks based on clincial, rehabilaition or reablement needs. Where it is considered that someone would benefit from slighly longer than the 6 week maximum period then the appropriate level of discretion should be applied.

2.6.2 Exit Plans

An exit plan, taking into account waiting times, will be required from the Integrated Team for people who need ongoing care and/or swift transfer to Adult Social Care, to ensure capacity within the service is not blocked and that support can be offered from the most suitable service.

2.8 Carers of Individual Service Users

Where a person is supported by their family / an informal carer, the Integrated team will identify the needs of the carer(s) and take account of their ability to provide or continue to provide care (both during the reablement period and afterwards) when deciding what intermediate care and reablement services / inputs to provide.
In order for this to happen this should:

- Be undertaken alongside the holistic Initial Assessment of service user needs, rehabilitation, reablement goals and potential
- Take account of whether the carer wishes to work, learn or have leisure activities
- Refer the carer(s) to Carers Bucks where they will get information, advice, guidance to navigate around health and social care services and who will also provide access to a Learning and Development Programme for carers called 'Caring for You'. This help carers make a positive difference to their life and that of the person they care for and includes sessions on Money Matters, Managing Stress, Getting the Help that you Need, Caring Day to Day and Looking after Yourself
- Refer the carer(s) for a Carer's Assessment
- Take account of carers' needs in the delivery of rehabilitation and reablement support and assessment of ongoing care needs

2.9 Equality and Diversity – age, culture, religion, disability, gender, sexuality

- People are individuals and have the right to dignity, privacy and independence
- All those involved in providing the service must acknowledge and respect individual's gender, sexual orientation, age, race, religion, culture, lifestyle and values or social circumstance
- Individuals should be encouraged and enabled to exercise control over the service they receive
- The service should be supportive of individuals and their carers
- The service should respond sensitively and flexibly to the individual's changing needs
- Communication regarding the service must be in appropriate formats and made easily available for children, young people and their families in order that informed choices can be

made

- Information leaflets are available in different languages and formats for service users and their families and those who might access the service in future

3. Outputs – Key Performance Indicators

On a monthly basis the provider is expected to report on the following:

High Level Outputs	Further Output definition
Number of referrals and source	Demographical Information of service users and categorisation of referrer • Hospital discharge • Community health or social care team
Number of inappropriate referrals and source Target <10%	Demographical Information of service users and categorisation of referrer
Number of contacts/ hours delivered	N/A
Average time from referral to assessment (days)	
Percentage (and numbers) of people with no ongoing package required at the end of intervention Target >50% of service users with 5% year on year improvement for the next 3 years	Demographical information
Percentage (and numbers) of people who required a package at the end of the intermediate care and reablement phase Target <50%	• Those whose outcomes identified at the start were achieved by the end of the reablement phase • Those whose outcomes identified at the start were partially achieved by the end of the reablement phase • Those whose outcomes identified at the start were not achieved by the end of the reablement phase
Percentage of people who complete without requiring further support at:	• 2 weeks • 4 weeks • 5 weeks • 6 weeks
Percentage of people who did not complete reablement programme	Reason and destination: • Went into long term residential care • Was offered a short-term home care package • Was offered a long-term home care package • Hospitalised • Died • Respite • Relocated • Health deteriorated • Patient on caseload for EOLC
Average length of time in service Target 4 weeks	N/A
Number and type of safeguarding	Demographical Information of service users and

alerts	categorisation of safeguarding concern
Patient experience >90% rate as good or excellent	Patient experience questionnaires

4. Outcomes and Impact for people

Intermediate Care and Reablement will need to show how the support offered has made a difference to individuals; below are some of the things you will need to demonstrate and evidence on a quarterly basis.

The Integrated Team will work with the individual to determine the outcomes they wish to achieve in a person-centred goal orientated plan. This will be monitored on an ongoing basis in a dynamic way which links to the offer of further rehabilitation and reablement to the maximum of 6 weeks, identifying other longer term care options or the removal of care because the person has achieved a safe level of independence. The outcomes will link to the following areas:

Individuals will say that:

- They feel safe, happy and more stable in their home
- They feel empowered to continue with their rehabilitation independently
- They have learned/ re-learned ways to manage problems they were having
- They understand the support available to remain as independent as possible
- They feel as though they have choice and control in the decisions that affect their lives
- Their carers have been made aware about the support that is available to them
- They have opportunities to continue to develop informal networks of support
- They understand how technology can be used to help them remain independence
- Their voice was heard not only in saying what was best for them but also in how the service could be improved for others
- If new issues arose that they were worried about

Outcomes are used as proxy measures to the following high level performance indicators:

- Preventing admission or re-admission
- People being at home 91 days post discharge from hospital following reablement support
- Customer satisfaction and feedback about the service
- Return to baseline level prior to episode requiring intermediate care or reablement

Impact of the service will also be collated by the provider via the submission of case studies and service user/ carer feedback.

5. Monitoring requirement and informing future commissioning

- Maintain accurate data set to regularly review service to identify areas of improvement
- Ensure that management information is readily accessible and accurate which will facilitate timely monthly reporting to commissioners as agreed
- Recording data, assessment and plans

Appendix C – Short Term Intervention performance dashboard

The May 2019 version of the dashboard is attached. This is still a work in progress and development is ongoing.

- Where there are gaps, it is because the data is not collected at present, or not available in a comparable format
- More development is required on independence outcomes – at present we use changes in Home Care provision as a proxy for independence outcomes which does not fully capture the outcome for people who self-fund their care. Likewise, a measure on user experience needs to be introduced.
- We are in the process of developing measures for the Community Occupational Therapy service onto the dashboard.

Measure - BCC	2019 Apr	2019 May	2019 Jun	2019 Jul	2019 Aug	2019 Sep	2019 Oct	2019 Nov	2019 Dec	2020 Jan	2020 Feb	2020 Mar	Current Outturn	Target	Good to be	Description
Number of referrals	140	158											158		High	Number of appropriate referrals to Reablement during the month (includes Non-Starters)
% of referrals where criteria was met	64.9%	68.2%											68.2%		High	% of referrals to Reablement during the month which were accepted (appropriate)
% of inappropriate referrals	24.3%	20.2%											20.2%	10.0%	Low	% of referrals to Reablement during the month which were not accepted (inappropriate)
Number of inappropriate referrals	45	40											40		Low	Number of inappropriate referrals to Reablement during the month
Average time from referral to assessment	7.8	8.2											8.2	3.0	Low	The average number of days (calendar) between date of referral during the month and subsequent date of first contact/planned contact (not including Non-Starters)
Number of reablement starts	120	135											135		High	Number of clients starting a Reablement care package during the month
Number of people receiving reablement	110	81											81		High	Number of clients receiving an assessment or service from Reablement at month end
Number of visits (contacts)	5153	5036											5036		Monitor	Total number of assessor and care worker visits to clients during the month
Number of hours delivered	100.03	96.51											96.51		Monitor	Actual (not planned) number of hours assessors and care workers spent with clients at visits during the month (not including wasted calls)
% of people with no ongoing package at the end of reablement	38.9%	38.7%											38.7%	54.0%	High	%of clients achieving an outcome of Independent (including Equipment Only and Information/Advice Given) during the month
Number of people with no ongoing package at the end of reablement	49	58											58		High	Number of clients achieving an outcome of Independent (including Equipment Only and Information/Advice Given) during the month
% of people with a reduction in package at the end of reablement	10.3%	6.7%											6.7%		High	% of clients achieving an outcome of Reduced during the month
Number of people with a reduction in package at the end of reablement	13	10											10		High	Number of clients achieving an outcome of Reduced during the month

Measure - BCC	2019 Apr	2019 May	2019 Jun	2019 Jul	2019 Aug	2019 Sep	2019 Oct	2019 Nov	2019 Dec	2020 Jan	2020 Feb	2020 Mar	Current Outturn	Target	Good to be	Description
% of people who required an ongoing package at the end of reablement	26.2%	25.3%											25.3%	50.0%	Low	% of clients ending Reablement with an outcome of Maintained, Reduced or Increased during the month
Number of people who required an ongoing package at the end of reablement	33	38											38		Low	Number of clients ending Reablement with an outcome of Maintained, Reduced or Increased during the month
% of people who did not complete reablement programme	15.1%	22.7%											22.7%		Low	Number of clients ending Reablement due to a Residential or Hospital admission (not including Declined Service and Service did not start) during the month
Average length of time in service	22.8	22.8											22.8	28.0	Low	Of clients ending Reablement during the month, average time between first contact and closure date
% of people satisfied at the end of their reablement	87.4%	93.0%											93.0%	90.0%	High	Of clients ending Reablement who have scored their reablement 4 or higher
Number of safeguarding alerts	6	1											1		Low	Number of safeguarding alerts relating to Reablement clients during the month
Costs Avoided															High	
Number of non-payers															Low	i.e. Self Funders & Full Cost Payers
Percentage of non-payers															Low	

x = No data available/not yet reported

Measure – BCC and BHT Combined 2019/20	2019 Apr	2019 May	2019 Jun	2019 Jul	2019 Aug	2019 Sep	2019 Oct	2019 Nov	2019 Dec	2020 Jan	2020 Feb	2020 Mar	Current Outturn	Target	Good to be	Description
Number of referrals	718	770											770		High	
% of referrals where criteria was met															High	
% of inappropriate referrals														10.0%	Low	
Number of inappropriate referrals	110	73											73		Low	
Average time from referral to assessment														3.0	Low	
Median time from referral to assessment (days)																
Number of reablement starts	588	634											634		High	
Number of people receiving reablement	869	868											868		High	
Number of contacts	10190	10355											10355		Monitor	
Number of hours delivered	3,314	3,408											3,408		Monitor	
% of people with no ongoing package at the end of reablement														54.0%	High	
Number of people with no ongoing package at the end of reablement	49	58											58		High	
% of people with a reduction in package at the end of reablement															High	
Number of people with a reduction in package at the end of reablement	13	10											10		High	
% of people required an ongoing package at the end of reablement														50.0%	Low	
Number of people required an ongoing package at the end of reablement	33	38											38		Low	
% of people who did not complete reablement programme															Low	
Average length of time in service														28.00	Low	
% of people satisfied at the end of their reablement														0.9	High	
Number of safeguarding alerts	6	1											1		Low	
Costs Avoided															High	
Number of non-payers															Low	
Percentage of non-payers															Low	

Appendix D - Adult Social Care Outcomes Framework (ASCOF) Indicator 2B1

This indicator is the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services. It is a combined indicator for Health and Social Care.

It 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. The measurement is based upon people being discharged from hospital into reablement between Oct and Dec each year. It captures the joint work of social services, health staff and services commissioned by joint teams, as well as adult social care reablement.

Year	Buckinghamshire score	Region score	England score
2017-18	66.3	Average 82.2 (BCC lowest @ 66.3%, highest 90.8%)	Average 82.9 (lowest 50%, highest 100%)
2016-17	75.2	80.1	82.5
2015-16	66.3	81.1	82.7
2014-14	71.1	79.4	82.1