

## PERTH AND KINROSS COUNCIL

## Housing &amp; Health Committee – 19 May 2010

**RESHAPING OLDER PEOPLE'S CARE  
REABLEMENT WITHIN HOMECARE**

**Report by Executive Director (Housing & Community Care)**

**ABSTRACT**

*The purpose of this report is to seek approval for the development of a reablement service as part of Homecare Services.*

**1. RECOMMENDATION(S)**

Committee is asked to

- 1.1 Instruct the Executive Director (Housing & Community Care) to fully develop options for a reablement model within Perth & Kinross.
- 1.2 Instruct the Executive Director (Housing & Community Care) to review and report to Committee a proposed Homecare structure within the Council which has the ability to meet the increased demands given the projected demographics and the implementation of reablement.
- 1.3 Instruct the Executive Director (Housing & Community Care) to review and report to Committee the future commissioning strategy for Homecare.

**2. BACKGROUND**

- 2.1 Housing & Health Committee considered a report on Homecare (09/496(a)) and agreed that a further report on service development should be brought to Committee.
- 2.2 Any future service developments have to be guided on the principles in the Scottish Government's policy 'The Future Care of Older People in Scotland':-
  - Emphasis on health improvement and maximising independence and wellbeing in later life
  - Care should be provided at home or in a homely environment which meets individual needs as well as maximising independence and wellbeing
  - Any intervention should provide benefit, be kept to a minimum and take account of the individuals wishes
  - People should be in a level of care that is as low as possible to support independence.
  - Central to everything is the individual needs of the older person
  - Recognise that older people are citizens who play a valuable and important role in supporting peers, families and communities
  - Recognise the role of anticipatory care to reduce the numbers of unscheduled hospital admissions

2.3 Within Perth & Kinross we have had an ongoing programme of development and investment in Homecare Services which has allowed us to increase service provision, providing more intense packages of care which has allowed service users to remain at home rather than move into residential care. This is in line with the expressed aspirations of older people across Scotland with the majority wishing to remain and be cared for within their own home and communities.

2.4 The population is ageing across Scotland and the 65+ age group in Perth & Kinross is expected to increase by 74% by 2031, which is significantly higher than the national figure of 61% (Audit Commission 2008).

More than one fifth of the population within Perth & Kinross is of pensionable age and 9.1% of the population are aged 75 and over. These statistics are both higher than the Scottish average.

2.5 In order to provide services to older people to remain at home we have been working within Perth & Kinross to redesign services which will shift the balance of care and provide services for an increasing number of older people. This will include:-

- Reablement in terms of the skills necessary for daily living
- The effective use of staff and assistive technology such as telecare and community alarms
- Development of further partnership working with health colleagues to ensure the development of resources enabling the shifting of the balance of care from residential care to home.
- Development of Housing with Care and the review of Sheltered Housing

2.6 The attached strategy outlines the intention to provide reablement services within Perth & Kinross (Appendix 1).

### **3. REABLEMENT STRATEGY**

3.1 Reablement is defined as services for people with poor physical and/or mental health which will help them accommodate their frailty or illness by learning or re-learning the skills necessary for daily living.

3.2 The strategy outlines the proposed implementation of reablement within Perth & Kinross.

3.3 It outlines the purpose of the process and how it will be rolled out within the Council's area. It also describes a timescale for test and implementation, workforce planning and training as well as monitoring and measuring outcomes and success in terms of the reablement process and any ongoing support or maintenance.

- 3.4 Reablement uses the interpersonal skills of home carers along with other professionals such as Occupational Therapists to provide better outcomes for service users.

Forward planning is used to enable the service user to learn or re-learn daily living skills and thus maintaining independence.

- 3.5 Reablement changes the culture of home care from task and time to better outcomes and it shifts from 'doing to or for' the service user to undertaking tasks with them. In turn this maximises the services users long term independence and quality of life. This can result in appropriately minimising the support required and thereby reducing the whole life cost of care.

Initial results from Councils which have implemented reablement suggest that less care hours are required at the end of the reablement period. Those care hours which then become available can be used to meet the demand for home care from the increasing older population.

- 3.6 Studies from other authorities which have implemented this practice have indicated that not all service users can benefit from reablement. A number of conditions such as advanced dementia and end of life care would not benefit from reablement. In these and other cases ongoing support on a maintenance basis will be required. Future planning will be required to address how this maintenance support will be delivered.

#### **4. CONSULTATION**

Since the last Committee, discussions have taken place with a variety of staff and providers. This has contributed to the design of our strategy. We have also visited a number of other authorities both in Scotland and in England to examine their progress in implementing a reablement service.

However, as part of the implementation process there will be a communication strategy to consult and inform all stakeholders.

The Head of Democratic Services was consulted during the compilation of this report.

#### **5. RESOURCE IMPLICATIONS**

There are no direct resource implications as a result of the recommendations in this report. However the future reablement proposals which will be brought back to Committee will significantly change how homecare services are delivered within Perth & Kinross. Detail financial and workforce planning is underway.

A test area for reablement will be identified and take place later this year. This will further inform our workforce plans and financial planning. During this test we will also work with our colleagues within the independent sector to develop an appropriate commissioning strategy which compliments the Council's reablement strategy. This will be contained within the existing budgets.

## 6. COUNCIL CORPORATE PLAN OBJECTIVES 2009-2012

The Council's Corporate Plan 2009-2012 lays out five Objectives which provide clear strategic direction, inform decisions at a corporate and service level and shape resources allocation. They are as follows:-

- (i) A Safe, Secure and Welcoming Environment
- (ii) Healthy, Caring Communities
- (iii) A Prosperous, Sustainable and Inclusive Economy
- (iv) Educated, Responsible and Informed Citizens
- (v) Confident, Active and Inclusive Communities

*This should identify to which of these objectives the report relates.*

## 7. EQUALITIES IMPACT ASSESSMENT (EqIA)

The function, policy, procedure or strategy presented in this report was considered under the Corporate Equalities Impact Assessment process (EqIA) with the following outcome:

- Assessed as **relevant**.

Monitoring will also take place during the test phase of the development to make plans to reduce and or remove any unintentional negative impact on our service users.

## 8. STRATEGIC ENVIRONMENTAL ASSESSMENT

The matters presented in this report were considered under the Environmental Assessment (Scotland) Act 2005 and no further action is required as it does not qualify as a PPS as defined by the Act and is therefore exempt.

## 9. CONCLUSION

The implementation of a reablement model of Homecare will appropriately focus discrete resources on service users who have the ability to regain daily living skills. This will maximise independence and reduce the requirement for ongoing and sustained service input. In conjunction with a reablement model a robust commissioning strategy with the independent sector will compliment this approach in targeting resources at appropriate levels of need.

A test area will be identified and following the conclusion of this exercise a further report will be submitted to Committee which will recommend in more detail the time scales for implementing a reablement model across the Council area.

**David Burke**  
Executive Director

**Note:** No background papers, as defined by Section 50D of the Local Government (Scotland) Act 1973 (other than any containing confidential or exempt information) were relied on to any material extent in preparing the above report.

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**Reablement – transforming homecare  
across Perth and Kinross**

**2010/11**



## Reablement in Homecare

### Draft Strategy

#### **Abstract**

The following outlines the concept of reablement. It examines the positive benefits to service users. It examines the potential cost efficiencies within a demographic climate whereby there is an anticipated significant increase in the older people population over the next 20 years and restrictions on budgets. Reablement focuses on positive outcomes and moves us away from the historical approach of doing things for people and is replaced by a service which seeks to enable people to do as much as they can for themselves.

There is now compelling evidence to support the effectiveness of reablement both from the perspective of improved individual outcomes and organisational efficiency. The increasing number of people requiring support and limited resources requires local authorities to be innovative in how they deliver support. The research suggests that a reablement approach can result in a reduced use of home care services.

#### **Introduction**

##### **What is reablement?**

Older people have in the course of their lives, episodes which affect their daily living and which reduce their ability to function as they would wish. These could be due to a fall, a hospital admission, the death of a loved one or some other such incident or indeed even a short illness which may be treated at home by the doctor. Because of these incidents they may lose confidence in their ability to undertake tasks that they would normally do or require some extra support till they feel more able. Past approaches have been to intervene and offer care to undertake these tasks for the older person and this would normally be ongoing from then on.

Reablement is based on the premise that early and positive intervention which focuses on enhancing an individual's potential to maximise their daily living skills promotes independence, increases confidence and reduces the requirement for on going and often intrusive support. It examines why individuals may have lost the ability to carry out everyday living skills and introduces strategies to allow that individual to regain all or some of these skills. It changes the way we assess people for care services by focussing on what people can and want to do. Academic research and evaluation of the reablement process underway in other Local Authorities illustrates that the following benefits are eminently achievable.

- It reduces the level of admissions to care homes by supporting people to remain in their own homes.

- It allows a move away from isolating people in a ‘care system’ towards helping older people live the ordinary lives that they want.
- By redesigning home care services away from doing things to people we can move towards supporting them to undertake many of these tasks themselves.
- It reduces the numbers of avoidable hospital admissions by developing good alternative community supports.

Reablement is a goal orientated service. This means that we work with the older person and their carers to establish what tasks they want to gain confidence in doing or relearning particular skills. By engaging with older people around an agenda of what they can do and what they would like to do we can develop short term interventions which support them to achieve these goals. These are often around basic daily living skills such as dressing, meal preparation, and mobility. It is not uncommon for an older person on discharge from hospital to have a crisis of confidence around their ability to carry out certain tasks. Our traditional home care approach has been to assess people around what they no longer can do and provide a service to meet these deficiencies. As a result services are embedded into people’s lives and are of long duration. While this is perfectly acceptable for a number of people who will suffer severe and complex conditions it has the potential to create a dependency for people who may have had the opportunity to regain many personal functions. Reablement focuses on this potential and research suggests that many people who would have received a traditional service leading to risks of dependency can eventually become more confident and lead fulfilling lives when they regain lost skills.

The table below contrasts the differences in approach between the traditional model of service delivery and a reablement model.

<b>‘New’ Approaches to Community Care</b>	<b>‘Old’ Approaches to Community Care</b>
Holistic, needs-led assessment. Services developed to meet assessed needs.	Administrative model of assessment – does service user meet eligibility criteria and if so what services are available
A focus on service user’s strengths and abilities	A focus on service user’s weaknesses and deficits
Service user an active participant in assessment process – expert	Service user may be consulted
Care packages state required outcomes for service user and how the services commissioned will meet these. The outcomes can be measured	Care packages state their general aims and the services to be commissioned

Table 1  
Source: De Montford external evaluation of Leicestershire County Council

Home care reablement uses the interpersonal skills of home carers along with other professionals such as Occupational Therapists to provide better

outcomes for service users. Goal planning is used to re-able the service user to learn or relearn daily living skills and maximise their independence. There are a number of key elements to Home Care Reablement, some of which are noted below:

- Assessing for improved outcomes with individual service users over a time limited period
- Formulating the package of care around goal plans that have been set with the service user and their family or carers
- Providing home care reablement for up to 6 weeks
- Including unpaid carers (family or friends) in the process
- Providing public information about home care reablement
- Using home carers interpersonal skills
- Providing additional training for home carers on home care reablement
- Adjusting packages of care on a daily/weekly basis to take account of progress being made or where extra support may be required in a particular area
- Determination on levels of maintenance care (if any) that may be required after reablement.
- Introducing telecare as a key component of care services

### **What would reablement look like in Perth & Kinross?**

When a person is referred for a service they would be assessed and discussion would take place around such issues such as:

- Feeding
- Toileting
- Getting to bed
- Walking
- Dressing
- Bathing
- The ability to use stairs

Having undertaken the assessment the worker would, with the service user and their family formulate a package of care around the goal plans identified. This would also include support received from the family or friends so that they would be continuing to deliver the reablement that the homecare staff are undertaking. There will also be access to advice and further assessment from an occupational therapist who will advise the assessing worker and the reablement staff.

Homecare staff will receive a training programme to develop the skills they already possess and this will normally last for two days. It would include concepts such as empowerment of service users, communication skills, the use of equipment and the skills required in reablement. This training programme will be developed for Perth & Kinross but will be built upon the courses which have been used by other local authorities.

Once the care package begins the homecare staff would work alongside the service user to help them gain confidence and relearn the tasks that have been identified in the care planning. This is monitored on a daily and weekly basis and the team regularly consider the progress on the goals each service user has made, adjusting the package of care to reflect the progress and to ensure that appropriate supports are in place. The period of reablement is a concentrated and intense period of support which allows time for the homecare staff to work with the service user, encouraging, supporting and examining problems or barriers that may arise. The homecare staff will have access to Occupational Therapy staff for advice and support. However the skills of the homecare staff and the relationship they will develop with the service user will provide the encouragement and increase confidence the service user will require.

While assessing the persons needs and the goals they wish to achieve the worker may also provide, where appropriate, other services and supports that would assist in the process such as equipment or adaptations which would aid daily living, community alarm and telecare or a meals service as well as linking with other local supports such as volunteer programmes or local groups.

The objectives derived from the above would be:

- An approach which changes the culture of home care from task and time to a culture of better outcomes. Allowing the older person to be more in control of their care and achieving outcomes that they have set for themselves.
- 'Doing with' service users rather than 'doing to' or 'doing for' service users.
- To maximise service users long term independence, choice and quality of life.
- To appropriately minimise the ongoing support required thereby minimising the whole-life cost of care.

In general a reablement process will take up to 6 weeks within which time an individual will have achieved their full potential in terms of a stable level of independence with the lowest appropriate level of ongoing support or care. This period can be shorter but also can be extended to ensure the maximum independence and reablement has been achieved. On going care and support arrangements would be on a maintenance basis and it is unlikely that there would be much change to the duration and frequency of this.

### **What is maintenance?**

During the reablement process many people regain the confidence they have lost or are able to relearn task of daily living which allow them to be as independent as possible and provide for their own living needs. However there will be some people who, following reablement, still require some form of ongoing support. Towards the end of the period of reablement it will be identified what ongoing support, if any, will be required. This will normally be of a less intense level of support and will be to maintain the service user in the

level of self care that they had obtained or re-learned during the reablement period.

Such support will be commissioned on an individual basis but will also be reviewed on a regular basis to ensure the correct levels of support are being provided.

There will be some people who will continue to require fairly significant care and support packages within their homes, such as those requiring end of life care and those with multiple disabilities or severe dementia. This service will be maintained and commissioned as at present.

### **Why introduce a reablement model.**

At present in Scotland the current national expenditure across health and social care is £4.5 billion per annum. If we continue to provide services as we do at present on then this budget will require to increase to £5.6 billion per annum, an overall increase of 22% whilst at the same time seeing a reduction in total public expenditure of between 10% - 14%. Therefore, Councils need to look closely at how they will promote independence as part of a new approach to community care and a move away from a culture of providing services which 'do things' for and to dependant people to a 'doing with' culture.

Information from the Scottish Government Joint Improvement Team (JIT) indicates that if we do not shift the current balance of care and given the current demographic and financial pressures that Scotland faces over the next 20 years, it has been identified that in order to meet demands:

- A new 600 bed hospital would have to be built every 3 years for the next 20 years.
- A new 50 bed care home would be required every 2 weeks for 20 years
- A further £2.8 billion investment in sheltered housing would be required and
- Most of our school leavers would need to choose the care sector as a career path to sustain the required staffing levels.

Given the above projections the status quo is clearly not an option. While there will be various options for reducing or redistributing resources the option of reablement is attractive in that research has shown that it is highly valued by service users. In an evaluation of the Edinburgh model most of the reablement service users interviewed were very positive about the new service and were all satisfied with any reductions in hours of service that resulted at the end of the reablement period. In particular, the setting of goals and being encouraged 'to do' rather than having things 'done for them' had meant that they were able to manage with less support at the end of the reablement period. The new service was also positively viewed by front-line and advisory staff, with recognition that reablement allowed much more to be achieved with service users than would otherwise be the case in the non-reablement/traditional home care service.

There are a number of additional reasons as to why an increasing number of Councils are introducing a reablement model of home care.

- The number of older people continues to grow and this, combined with pressure on limited local authority budgets, requires effective methods of intervention.
- Shifting the balance of care requires approaches that can maximise independence and enable people to develop the skills to remain safely in their own home.
- Home care reablement in Scotland and England has accumulated compelling evidence indicating that the approach improves confidence, motivation, empowerment, choice and maximises independence for service users. In addition, because service users need less care hours at the end of reablement than they would have received from a traditional home care service, the care hours available can be used to meet the demand for home care for an increasing number of older people.
- This approach indicates an effective and efficient use of local authority resources.
- Home care reablement represents added value where this is provided by local authority in house service.

Over the past few years a number of Councils across Britain have been developing reablement as the main focus of their homecare services. Below are some examples of the impact of home care reablement within local authorities who have implemented this model of service delivery:

#### **Leicestershire's Home Assessment and Reablement Team**

Based on independent evaluation for 2006/06 there were 1,836 service users referred through their intake service.

- 50% required no ongoing care package following reablement
- 26% required an ongoing care package but these were reduced on average by 30% after a period of reablement
- 18% were referred to other services but still achieved an average reduction in their on going care package of 16%.

#### **Dudley Community Reablement Service**

Based on data for 2005/06 (1,412 users)

- 21% required no ongoing care package
- 26% required a reduced care package
- 23% required a care package that was maintained
- 7% required an increased care package

This resulted in a 42% reduction in care hours when compared to packages before reablement.

## **City of Edinburgh**

Based on an independent report for the Scottish Government

Analysis of data showed that over the six week re-ablement period, the service had a considerable impact in reducing the number of hours of care required by clients. The total hours of care required were reduced by 41% over the six week period.

- 60% of the 90 clients reduced their care hour requirements over the period of the reablement service.
- Almost two thirds of these required no further home care service at the end of the reablement period.

This has to be balanced by the increased costs of care and support during the reablement period where intensive packages of support are provided.

### **The development of a reablement service in Perth & Kinross**

If a policy decision is made to redesign services to provide a Home Care Reablement Service the following steps will require consideration. This is based on the assumption that we would wish to optimise existing strengths within the authority and consider the best service on which to build Home Care Reablement.

- Agree home care reablement as a policy decision for the council.
- Develop home care reablement as part of the vision for modernising home care.
- Develop a communications strategy to promote the vision to service users, their carers, staff, managers and other stakeholders.
- Identify the numbers of service users referred from hospital and the community to receive a home care service.
- Identify demographic changes and how this impacts on capacity. There may be workforce variations for urban and rural communities.
- Identify a workforce plan to ensure that the capacity of home care reablement is sufficient to meet demand.
- Consider the use and capacity of Occupational Therapists as part of the team.
- Introduce telecare as a key service in any ongoing support for service users on the principle that it is less intrusive and is a responding service rather than a consistent staff presence.
- Develop a financial framework to identify costs and project the benefits from reablement.
- Review processes from referral to home care reablement and then, where required, long term provision.
- Seek expressions of interest from existing staff groups to be part of the home care reablement teams.

- Re-provision existing home care services for service users where staff are moving to a home care reablement service.
- Provide training for home carers.
- Decide on the provision of long term maintenance home care and arrange for appropriate handover arrangements which should be included in any contracts with providers.
- Develop an appropriate commissioning strategy which meets the requirements of a redesigned home care service.

### **Suggested roll out for Perth & Kinross**

Prior to receiving permission for a roll out of reablement, the Service will consult widely with service users, carers, providers and health colleagues. We will design and describe the processes for referral for assessment and for decision making to fit, as closely as possible, existing processes to minimise confusion for service users and carers.

We will fully consider the training needs of staff and will bring before Committee a training plan which will support the test site implementation and thereafter, if approved, a full roll out across Perth & Kinross.

It would be our intention to carry out consultation and process redesign to accommodate the test site commencement on 1<sup>st</sup> October 2010. The report to Committee will detail the location of the test site, the results of the consultation process, the training programme and a list of deliverables and benefits to be achieved.

Full roll out of the reablement process will depend upon the lessons learned from the test site, but it would be our intention to bring a detailed timeline for implementation to Committee.

