AGENDA ITEM No.7

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

Meeting of East Renfrewshire Health and Social Care Partnership **Held on**	Integration Joint Board 30 January 2019
Agenda Item	7
Title	Care at Home Update

Summary

This report is to provide the Integration Joint Board with an update on Care at Home including the move to reablement, and action to address capacity issues.

Presented by	Candy Millard, Head of Adult Health and Social Care Localities

Action Required

Integration Joint Board members are asked to note and comment on the report.

Implications checklist – check box if applicable and include detail in report

☐ Financial	☐ Policy	☐ Legal	☐ Equalities
☐ Efficient Government	☒ Staffing	☐ Property	☐ IT

EAST RENFREWSHIRE INTEGRATION JOINT BOARD

30 January 2019

Report by Julie Murray, Chief Officer

CARE AT HOME UPDATE

PURPOSE OF REPORT

1. The purpose of this report is to provide the Integration Joint Board with an update on Care at Home.

RECOMMENDATIONS

2. Integration Joint Board members are asked to note and comment on the report.

BACKGROUND

3. The last report on Care at Home which was presented to the IJB in March 2017. That report described the programme of work to extend the in house Reablement Service to every individual identified as needing support to enable them to remain safely in their own home.

4. The reablement approach in homecare offers support and encouragement to individuals to help themselves and so increase their independence. It supports individuals 'to do' rather than 'doing to' or 'doing for'.

5. Goal setting and review of outcomes achieved are central to the reablement ethos. This means that we work with individuals and their carers to establish what tasks they want to gain confidence in doing or relearn particular skills. By engaging with individuals around 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 individual to have lost confidence around their ability to carry out certain tasks after spending time in hospital.

6. 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, often for length periods of time. While this is perfectly acceptable for a number of people who suffer from severe and complex conditions it has the potential to create a dependency for people who may have had the potential to relearn or regain skills. Reablement focuses on this potential and research suggest 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.

7. Many people have been able to manage without ongoing services following a period of reablement. The planned model was that following a period of reablement, if ongoing care and support was required it would be provided by either the remaining in-house homecare staff or externally commissioned services. For people for whom

offering reablement was not appropriate, for example, at end of life or people with advanced dementia, they would be offered a range of options depending on their individual circumstances.

8. The report also outlined the use of the CM2000, a fully hosted web-enabled homecare scheduling and monitoring solution providing accurate, real-time care visit data via the internet, 24 hours a day, 365 days a year. The CM200 system enables HSCP staff to log, analyse and report on external homecare delivery, and ensured that the HSCP only pays for the care that has actually been delivered.

9. The report set out plans to bring together the hospital discharge and reablement teams. This was intended to provide greater opportunities for reablement but in practice the increased volume of referrals from hospital coupled with the capacity of care at home, both the in house service and external providers, has reduced the time available for reablement. Locally and nationally there are ongoing issues with recruitment and retention of care at home staff that have impacted on this.

10. More recently the care at home service has experienced significant pressures due to higher than average levels of absence. A combination of external provider staff, agency staff and our own HSCP staff has been used to provide care at home services. This has impacted on our ability to guarantee continuity of care staff and timing of service delivery, which has caused some dissatisfaction about changes to services and times, however we have had to prioritise to minimise risk. The HSCP has however managed to maintain its performance on delayed discharge.

REPORT

11. Work East Ren is supporting employability initiatives, which will promote recruitment and retention within the care sector. A local employment fayre was held in December. Another potential initiative is to use the Modern Apprentice scheme in care services, targeting not only the 18 – 24 age groups, but additional initiatives for adult apprentices. This work will promote career pathways within health and social care, with links to the appropriate training and development opportunities. In addition the HSCP is working with East Renfrewshire Council to develop an internal bank of staff to assist at times of pressure.

12. To support the move away from a separate reablement team to a whole scale reablement service across East Renfrewshire, a further 141 of our care at home workers have been regraded to Grade 4. This will allow all staff across all our home care patches to undertake the duties and tasks to support a reablement approach to care. The move is being supported by a programme of workforce skills development.

13. We have increased the number of night time responders allowing us to provide a responder service in each locality rather than relying on a single cross area service. In order to support the increased number of staff working out of hours we are considering using the facilities and the skillset of senior staff within Bonnyton House.

14. Additional resources have been deployed to support our care at home organisers, this includes timely reviewing of clients, support for absence management and more effective use of the CM2000 system to schedule staff.

15. During 2019 we will align in house reablement home care with our Adult Localities teams and look to develop closer links with our rehabilitation teams making better use of both health and care staff skills. We recognise that not everyone can benefit

from rehabilitation and reablement. The Intensive Service Manger will work with the Senior Nurse to explore how care at home, Bonnyton House and community nursing services can work together to be responsive to people's changing health and end of life support requirements.

16. The HSCP will continue to work in partnership with the external market to ensure capacity to deliver care at home services and a market place which allows service users to exercise appropriate choices should they wish under their preferred option of SDS. In the longer term we will scope a new a model of contractual arrangement for care at home services that focus on outcomes.

FINANCE AND EFFICIENCY

17. The regrading of staff from grade 3 to grade 4 was profiled in the original care at home programme which included investment and savings. Given the changes in the provider market and demand on the service we continue to closely monitor this budget and associated redesign implications.

CONSULTATION AND PARTNERSHIP WORKING

18. In developing the proposals there was engagement with service users, staff and trade unions. This will continue over 2019.

IMPLICATIONS OF THE PROPOSALS

Staffing

19. Care at home staff have been regraded to 4.

Equalities

20. A full EQIA will be carried out as part of the next phase of the Care at Home at programme.

CONCLUSION

21. The HSCP retains its commitment to develop a reablement model of care at home. Learning from other areas we are moving from a limited service to a full scale reablement model embedded in our localities and aligned to rehabilitation services. The care at home programme includes work to redesign out of hours services and develop a more integrated and responsive approach to people's changing health and end of life support requirements. The HSCP continues to work in partnership with the external market to ensure capacity and choice.

RECOMMENDATIONS

22. Integration Joint Board members are asked to note and comment on the report.

REPORT AUTHOR

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January 2019

Chief Officer, IJB: Julie Murray

BACKGROUND PAPERS

IJB Paper: 29 March 2017: Care at Home Programme Update
http://www.eastrenfrewshire.gov.uk/CHttpHandler.ashx?id=19790&p=0