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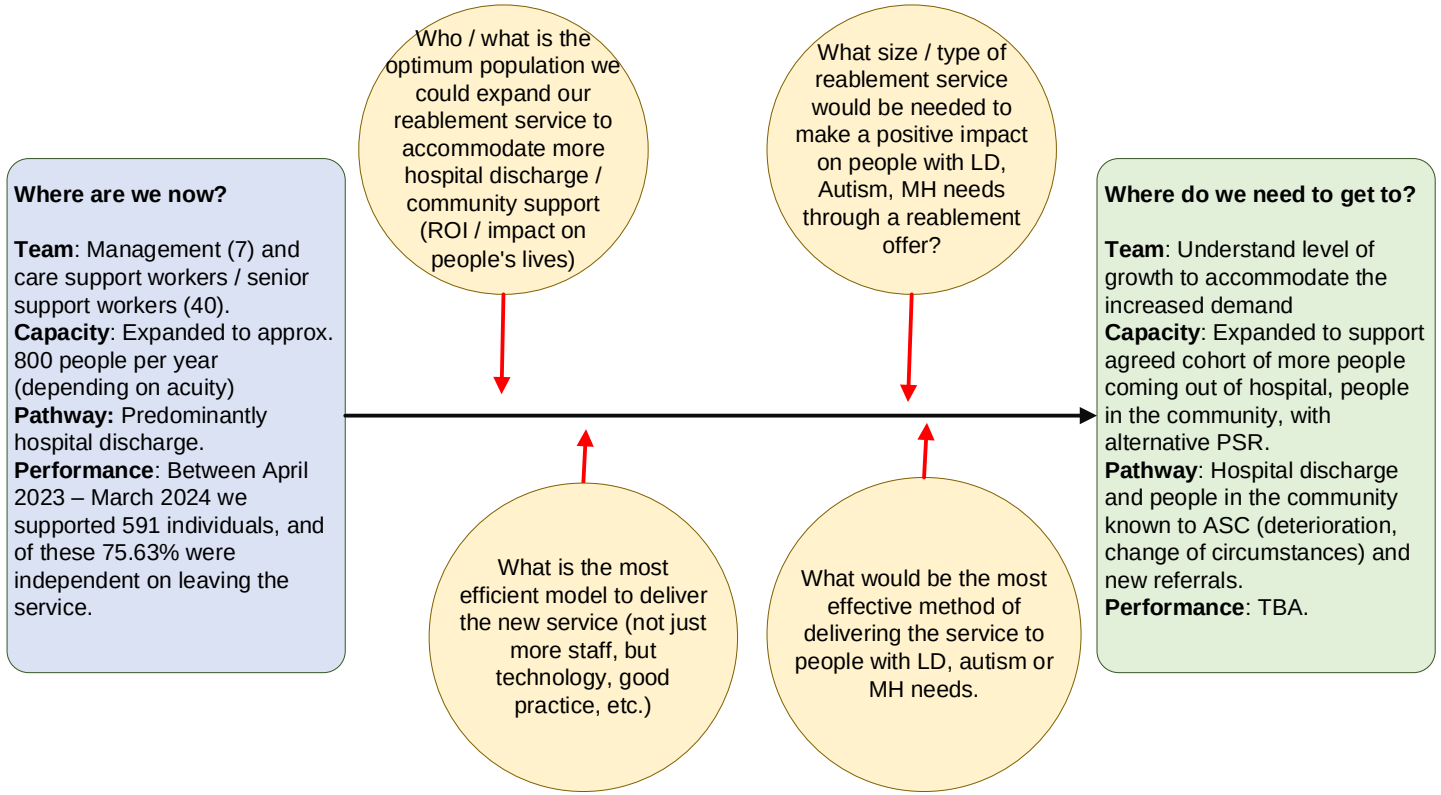
Reablement Review –Summary

January 2025

Stockton-on-Tees BOROUGH COUNCIL

Project Scope – Reablement / Enablement / Rehabilitation

- The vision is to ensure residents of Stockton-on-Tees live independently with tailored and timely support.
- Focus areas include reablement expansion, hospital discharge efficiency, enablement services, and performance tracking.



Peopletoo Review Activity

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Visits and shadowing teams	Case Reviews with Stockton professionals	Conversations with senior leaders and regional leaders	Analysing and benchmarking data
Over 50 touchpoints, including on-site shadowing, visits with workers and meetings at all levels from frontline practitioners to the DAS. • Reablement Managers & team • STEPs Team • Community Support Workers • Early Intervention & Prevention • Rosedale Centre • LD & MH Service Manager • Head of Community Services • ISPA Team • Therapies Manager • Scrutiny Manager	64 cases reviews were completed of a sample identified of 90 cases over x3 workshops prior to Stockton's CQC inspection visit. 32 attendees of disciplines across all teams in Adults social care. Teams who attended include reablement, intermediate care, early intervention & prevention, Learning Disabilities, Mental health, Opps& sensory, adult social care, project delivery, Occupational Therapy, Dementia, Rosedale Centre	• Director of Adult Social Care • Assistant Director Adult Social Care • Performance Lead • Finance Lead • Transformation Manager • Assessment and Planning • CIAT – front door • One-call Manager • Specialised Service Manager- NHS • Therapies Manager • STEPs Manager • Early Intervention and Prevention Manager • LD/ MH service Manager	• Open package data • Service Demand data • POPPIPANSI • ASCOF Data • Reablement activity data • Rosedale activity • Discharge data • Phase 1 financial modelling • STEPs activity data • Community Support Worker caseloads and activity • D2A Tracker • One-call activity **Ad hoc data requests to support analysis

Note: The Directorate had a CQC inspection taking place during this work. The project team worked around service capacity.

Overview of key findings from Reablement

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1 Improved Independence Outcomes	• The percentage of clients leaving the service independent increased from 71% in 2023 to 75% in 2024 • Stockton leads in the region, with 70% of individuals requiring no further services post- reablement, compared to 54% regionally and 45% among CIPFA group averages
2 Increasing Referrals	• Referrals have grown significantly, with an 85% increase in October 2024 compared to October 2023, aligned to bringing D2A service into Reablement. • The majority of referrals come from hospital discharge (66%) • Population aging and health inequalities are driving higher demand for adult social care services. • Capacity in the service can lead to waiting lists and some missed opportunities for early intervention.
3 Challenges with Declined Referrals	• Of the referrals declined, 73% were declined primarily due to capacity constraints and lack of availability for double- handed care of evening calls. • Bottlenecks in care transitions, delaying timely support beyond six weeks. • Miscommunication about reablement purpose in and duration by referrers leads can lead to mismatched client expectations.
4 Staff and Workforce Development	• Staff retention is strong, but there are capacity challenges due to sickness, health leave and retirements • Training gaps exist, particularly for working with clients with learning disabilities, mental health issues or autism
5 Digital and Technological Integration	• While power BI tools are in use, daily operations still rely on excel spreadsheets indicating a need for further digital transformation • There is potential for increased use of assistive technology to improve outcomes
6 Benchmarking and Performance	• Stockton demonstrates strong performance in promoting independence and reducing transitions to long- term care compared to its peers
7 Cost and Resource Efficiency	• Average cost per episode of reablement is estimated at £1600, with an average of 22/23 hours of care per episode • There is the potential to increase community referrals by targeting identified profiles with potential for independence. • There is a potential cost avoidance savings by improving referral pathways and expanding service capacity.

Overview of key findings from Hospital Discharge

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1	Reablement uptake	• A high proportion of patients are directed to Pathway 2 (Rosedale overnight beds), limiting independence-promoting pathways.
2	Delays in Hospital Discharge	• Delays are consistent in the process, though are concentrated around ISPA triage and their interface with SBC services, with 812 days delayed reported within a 5-month period (June-November). • Paper-based and inconsistent SBARD forms exacerbate delays due to miscommunication and inefficiencies.
3	Over-prescription and Risk Aversion	• Decisions by health services often prioritise quick discharge and can subsequently lean towards: overprescription, inappropriate referrals, and pathways that do not optimise independence. • Limited in-person assessments at home contribute to poor risk management and suboptimal pathway allocation
4	Strain on Rosedale Centre	• Rosedale beds experience high demand due to inefficiencies in other pathways. • Current capacity is constrained by operational inefficiencies (e.g., time-intensive MAR form completion).
5	ISPA and multi- disciplinary Gaps	• ISPA lacks integration with OTs and CIAT, reducing its ability to make accurate pathway decisions. • Goal-setting and therapy-based interventions are often missed due to these gaps.

Overview of Overall Opportunities

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Short Term	Medium Term	Long Term
Pilot Enablement Pathways: - Collate learnings from the enablement support provided at existing Learning Disability Respite and Day Services - Develop a pilot to provide intensive goal-focused enablement to clients currently living at home to support continued independence and progression towards goals - Develop clear KPIs and tracking to monitor and report on progress of Pilot	**Enhance Reablement Based Services:** - Grow home-based reablement solutions, including home adaptations and technology-enabled care (incl. expansion of One-Call) - Collaborate with local organisations to enhance community support networks - Look at how the capacity for evening and double handed care slots and develop	**Embed Reablement as Core Practice:** - Transition to a model where all eligible service users undergo a reablement assessment as a standard procedure - Use reablement outcomes as key performance indicators for service evaluation
Enhance Frontline Training: - Equip care practitioners with tools and skills to integrate reablement principles in daily activities - Conduct workshops and refresher courses to embed a culture of enablement and enablement across teams	**Optimise Resource Utilisation:** - Focus on clients with high potential to benefit such as individuals transitioning from hospital care or those with complex needs	**Sustain Financial Savings:** - Invest cost savings from reduced long-term care reliance into innovative enablement programs and workforce development - Monitor expenditure trends to ensure sustainability
Streamline Data Collection: - Improve data accuracy and timeliness to support decision-making - Standardise data collection and reporting processes across workstreams	**Improve Interdepartmental Coordination:** - Integrate PMO insights with operational planning to ensure alignment between strategic goals and frontline execution	**Evaluate and Scale Successful Models:** - Continuously assess pilot programs to identify best practices - Scale proven enablement models across all relevant service areas

How this could be implemented

Reablement

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Step 1: Develop Clear Criteria and Educate on Reablement Offer

- Optional: Complete a questionnaire to assess practitioner confidence in reablement aims, opportunity and eligibility
- Develop a training session on the benefits of reablement and outline profiles of clients that would be eligible and are likely to benefit
- Deliver the training session to Assessment and Support Planning and Brokerage teams to identify clients with reablement potential
- Update Adult Social Care Practitioner Onboarding to include the reablement training essentials
- Review inappropriate referrals and develop criteria to utilise capacity currently spent with inappropriate referrals

Step 2: Generate Reablement Capacity

- Review declined referrals for capacity and consider problem solving trends (creating capacity for evening slots)
- Review downtime opportunities and create a capacity report shared weekly amongst leadership teams
- Develop shadowing or deliver training to reablement coordinators on working with clients with different needs (LD, Autism, MH)
- Review opportunities to reduce time spent on paperwork by exploiting technology that allows this work to be completed on visits

Step 3: Community Referral Process

- Create a waitlist of clients that have been identified to benefit for reablement at the point of Assessment/Review (non-urgent referrals)
- Utilise available capacity and new capacity generated from previously accepted inappropriate referrals to deliver reablement support during quieter periods

Step 4: Outcome Monitoring and Reporting

- Set up measures that track outcomes and associated benefits from changes over time to identify trends and continue high performance
- Assess and adapt based progress and capacity

How this could be implemented

Hospital Discharge

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Step 1: Delay Root Cause Analysis and Solution Generation

- Understand current system approach and uncover opportunities to strengthen partnership working and improve outcomes
- Organise and deliver a series of workshops to identify causes driving delays begin solution generation
- Agree solutions to be taken forward and communicate with teams
- Create implementation plan

Step 2: Pathway Decision Making Workshop

- Deliver a workshop to identify criteria for pathway decision making with a multi-disciplinary team
- Define criteria for each pathway to assist decision making
- Agree solutions to be taken forward to optimise practice and process and communicate with teams
- Create implementation plan

Step 3: Positive Risk Enablement Training & Strength-Based Practice

- Develop a training session and toolkit for hospital workforce and Assessment and Support Planning teams
- Implement a re-occurring case audit to challenge positive risk enablement
- Review forms and processes to optimise positive risk-taking enablement

Step 4: Data Collection, Visibility and Reporting

- Agree data points to be collected to support outcome and performance monitoring
- Develop reporting mechanisms to enable tracking of progress against targets

High Level Steps - Subject to existing workstreams and feedback on final report