

Putting People First
Transforming Adult Social Care

Homecare Re-ablement

Efficiency Delivery: supporting sustainable transformation

**Benefits of Homecare Re-ablement for
people at different levels of need**

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BENEFITS OF HOMECARE RE-ABLEMENT

Background

The Care Services Efficiency Delivery (CSED) programme was originally formed to support English councils to achieve their Gershon efficiency targets within adult social care and its role was extended to CSR07. As a tactical programme, with regard to Homecare Re-ablement, CSED is focused on helping councils to achieve either a step change in their implementation of a new service or refinement of an existing service.

As set out within a document¹ published in April 2008, we continue to work with CSSRs to extend the body of evidence and support them to either consider and then implement a local service, or extend an existing service. To achieve this we are focused on four main areas of work, namely

1. Continued support for CSSRs
2. Prospective Longitudinal Study
3. Homecare Re-ablement for those on 'maintenance' packages
4. Post initial phase homecare re-ablement

The first of these is composed of four sub-projects, of which one relates to gathering a wider body of evidence on the benefits of homecare re-ablement. Many CSSRs wish to understand the extent to which homecare re-ablement is beneficial for clients at differing levels of need. This document seeks to bring together further examples of the order of benefit experienced across a range of schemes.

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¹ [Outline of Proposed Direction for 2008/09](#)

Executive Summary

In this document, we have sought to add to the existing body of evidence by providing further examples of homecare re-ablement services. In direct response to comments received, 10 of the 14 services illustrated, across 13 Councils, operate to support those with substantial needs and above, or critical needs.

The additional evidence is limited by the number of councils that were able and willing to share data but even on this basis there is clear evidence that people at higher levels of need can and do benefit significantly from homecare re-ablement services.

In outline

No Homecare Package Required Post Re-ablement

- although the range of benefits for those operating at substantial and above is lower and more variable than for those at moderate and above, or even at critical, the more established services see similar levels of outcome benefit. Also, those at critical and above have relatively high results when compared with all other FACS groups.(see section 2.3.2)

Reduced Homecare Packages

- across all three levels of need, significant proportions of people benefit from greater independence even though they still require a subsequently reduced homecare package (see section 2.3.3)

Maintained and Increased Homecare Packages

- although most results are an improvement on what appears to be the situation without re-ablement, the group with the widest divergence is that where the start package was not altered by the re-ablement phase. (see section 2.3.4)

Duration of Homecare Re-ablement Phase

- the average duration for the vast majority of people is between 3.1 and 6.4 weeks. (see section 2.3.5)
- there is a significant consistency between services operating at substantial and above in that, with few exceptions, each maintained its relative position in shortest to longest durations for each of the user groups e.g. site with the shortest overall duration was shortest for every user group (no package required, package reduced, package maintained, package increased) (see section 2.3.5)

Thus, based on these additional examples, it would appear that Homecare Re-ablement does have significant benefits for people at substantial and even critical levels of need. What is also clear is that CSSRs need to continually monitor operational performance, identify fluctuations, investigate reasons and amend practice if they are to ensure that clients gain maximum benefit.

1. Introduction

1.1 Previous Work

This document seeks to build on previous work undertaken by CSED with a range of councils and improve the 'body of evidence' available.

1.1.1 Discussion Document

Early on in our work with Councils, we encountered an evaluation² that had been completed by the De Montfort University when they worked with the Homecare Assessment and Re-ablement Team (HART) pilot service in Leicestershire County Council. As part of their work, the evaluation included a comparison group.

The study considered the outcomes for people at the first 6 week review and found a significant improvement in independence when compared with those that had followed a 'conventional' homecare package.

Homecare Package at First Review *			
Care package req'd post 1st review (6 wks)	Matched service users (control group)	Re-ablement Pilot (selective)	Re-ablement Roll-out (intake)
Discontinued	5%	62%	58%
Decreased	13%	26%	17%
Maintained	71%	10%	17%
Increased	11%	2%	8%
Total	100%	100%	100%

* Leicestershire De Montfort study 2000

Initially the pilot adopted a selective approach but then moved to a de-selective approach which is more commonly used within intake and assessment services.

The evidence base was enlarged when we prepared 5 case studies by working with a number of councils and published these along with additional information from another 13 councils.³ Quite deliberately, the case studies portrayed a range of types of service, namely

- In-house and out-sourced services
- Enablement staff and mixed skilled teams
- Intake and assessment and hospital discharge support services

² [CSED Discussion Document , Case Study – Leicestershire: External Evaluation of the Home Care Re-ablement Pilot Project. De Montfort University](#)

³ [CSED Discussion Document – Volume 2, Section 2, Additional Information](#)

A summary of the outcomes at the end of a phase of homecare re-ablement for the services is as follows:

	Leicestershire 2005/06	Dudley 2005/06	Milton Keynes Sept 2005 Aug 2006	Poole Apr – Oct 2006	Salford Nov 2003 – May 2004	Wirral Nov 2003 – Mar 2004
FACS	Moderate and above	Moderate and above	Substantial and above	Moderate and above	Moderate and above	Substantial and above
Type of Service	Intake (de-select) *1	Intake *1	Intake *2	Intake *2	Intake *1	Hospital Discharge (selective) *2
% requiring no ongoing package	49.7%	21%	55%	44%	61.5%	80.5%
% requiring reduced package	18.3% to other specialised services but with average reduction of 16%	26%	11%	13% min.care package	31.1%	8.5%
% requiring maintained package		23%		1% care package 4 – 7 hrs per wk		
% requiring increased package		7%		1% care package over 7hrs per wk	0.7%	
Admitted to other IC services			6%			
Admitted to Care Home		13%	3%			
Other care			9%	28%	0.7%	
Admitted to hospital			15%	13%	5.2%	9.5%
Deceased after service commenced	3.7%	10%	2%	1%	0.7%	1.5%
Overall reduction in care hours	58%	42%				

Despite the range of outcomes, it was clear that significant benefits arose for the people that had undergone a phase of homecare re-ablement when compared to those that had been in receipt of ‘conventional’ homecare packages.

1.1.2 Retrospective Longitudinal Study

Building on the Discussion Document, CSED commissioned a study⁴ by the Social Policy Research Unit, University of York to work with four services. The purpose of

⁴ [CSED Retrospective Longitudinal Study](#)

the study was to determine the duration of benefit for those that had undergone a phase of homecare re-ablement and to identify the factors that should be addressed within a later prospective study.

The report is available from the CSED website but the main findings were

- In 3 of the 4 schemes: 53% to 68% left re-ablement requiring no immediate homecare package (4th = 94%) - 36% to 48% continued to require no homecare package 2 yrs after the end of their re-ablement phase (4th = 87%)
- Of those that required a homecare package within 2 yrs after re-ablement, 34% to 54% had maintained or reduced their homecare package 2 yrs after the end of their re-ablement phase

1.1.3 Homecare Re-ablement at higher levels of need

Some councils have, however, been concerned that although homecare re-ablement may be beneficial for those people with relatively low levels of need, there may be little benefit for those at substantial or even critical levels. Therefore, we have sought to collate further examples of schemes, and particularly those that operate at substantial or critical levels of need using the FACS definitions.

1.2 Collation of CSSR information

CSSRs were invited to share a summary of their scheme data with CSED so that it could be shared with others that either operate or are establishing homecare re-ablement services. This would allow them to access a wider 'body of evidence' and inform their business case and project planning process. Information for 14 services across 13 CSSRs is outlined within this document.

1.2.1 Range of Schemes

All but two of the 14 services illustrated operate an intake and assessment role, receiving users from a variety of sources including hospital discharges. Sutton changed its role from being primarily a hospital discharge support service from June 2008 (after the period covered by their data), whilst the data for Essex relates to a pilot hospital discharge support service. Wirral had operated as a Hospital Discharge Support service for a number of years, but in 2008 it deliberately evolved into an intake and assessment role.

1.2.2 Council Profiles

Of the 13 (9%) CSSRs illustrated,

- Council types
 - 7 are County councils (England total is 35),
 - 2 are Metropolitan authorities (England total is 36),
 - 3 are Unitaries (England total is 46)
 - 1 is an outer London council (England total is 20)
 - none are inner London councils (England total is 13)
- they account for 14.5% of the total population of England
- they account for 16.0% of the total over 65 population, and 16.2% of the total over 75 population in England
- by population they range from the 1st to the 130th largest across England
- the mix by FACS eligibility criteria is

FACS LEVEL	Illustrated CSSRs		England	
	No	%	No	%
Low and above	0	0%	4	2.7%
Moderate and above	3	23.1%	38	25.3%
Substantial and above	8	61.5%	105	70.0%
Critical	2	15.4%	3	2.0%
TOTAL	13	100%	150	100%

Thus, although the illustrated CSSRs are not a representative sample of CSSRs across England, they provide examples based on a broad spread of councils and add to the 'body of evidence' contained within the CSED Discussion Document and Retrospective Longitudinal Study. Also, they were the only ones that were willing and able to respond to our request to share data.

Not all were able to readily complete every element of the standard template but it was not our intention to add to local pressures and so CSSRs were asked to complete as much as they could. Therefore, it is accepted that we do not have 'complete' data for each of those illustrated, but we still believe that the outputs are relevant and informative.

2. Benefits of Homecare Re-ablement

As a result of our further work with CSSRs, we have drawn together a number of points and would like to share these so that others may benefit in preparing business cases or reviewing the operational performance of their service.

2.1 Referrals to Homecare Re-ablement Services

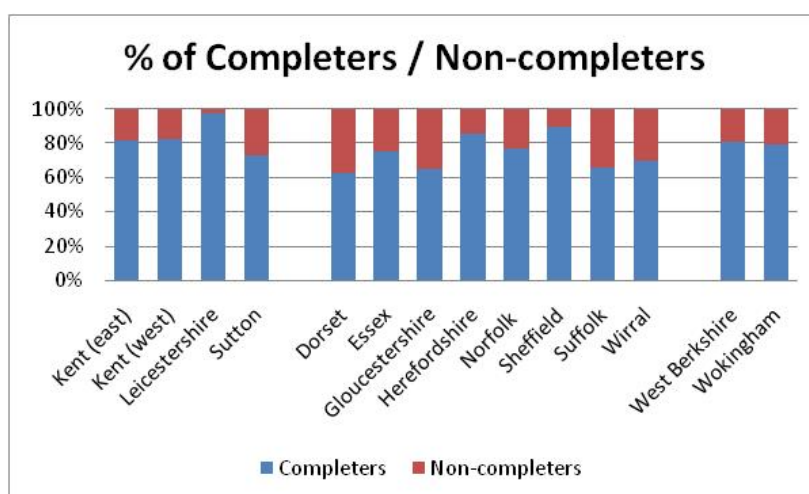
In our previous work we sought to identify the proportion of people that are referred to homecare re-ablement schemes but declined because the service was not appropriate to their needs. Anecdotally, services that apply a deselection approach have told us that these ‘de-selections’ represent less than 5% of all referrals.

However, through the collation of further data, another much larger ‘group’ of people have become visible: namely those who do not complete their phase of homecare re-ablement. One of the original case studies⁵ referred to this group because they felt that they were potentially the ‘symptom’ of inappropriate information before people joined the service. Thus, they monitored the number of people that started the service but then declined it shortly after commencement.

Within our earlier work,⁶ we emphasised the importance of establishing a baseline and then using this data to assist in monitoring performance as implementation occurs and in subsequent operational management⁷ of the service. At that time we suggested that a service needs to monitor, amongst other things, the ‘non-completers’ but this exercise has now provided further reasons why this may be appropriate.

2.2 Non-completers

With this new data, (see Appendix 1) it has become apparent that in some services, but not all, a significant number of people do not complete their phase of re-ablement. For those that have shared this data it appears to range from 10% to 35% of all referrals in established services, although some pilots have seen higher levels. The average across all illustrated services that have shared this data is 24% of all referrals.



⁵ [CSED Discussion Document, Case Study – Wirral section 15](#)

⁶ [CSED Discussion Document, section 3.6.1 Need for a baseline](#)

⁷ [CSED Discussion Document, sections 3.6.3 Benefits Measure Tool and 3.6.4 Benefits Monitoring](#)

A few of the illustrated services have provided some further analysis of this group and another, Sutton, has completed a detailed study albeit the time period differs from that included in this document.

It was always expected that some people's conditions or needs might change dramatically during their phase of re-ablement due to various factors, resulting in either admission to a care home or hospital. However, based on the limited information available, it would appear that in some services the largest cause of a break in the service is admission or re-admission to hospital.

As part of their six-month hospital discharge pilot study work, Essex encountered 192 people that did not complete their homecare re-ablement phase. These people represented 25% of all referrals to the service and of these, 20 went on to a care home, 158 returned to hospital and 14 died.

Sutton's data for 11 months relates to a period when the service's role was primarily that of a hospital discharge support service. It shows that 26.8% of referrals did not complete their homecare re-ablement phase. As a result of their ongoing monitoring work, they identified a 'spike' in hospital re-admissions in April and May 2008 and so completed an analysis of 'non-completers'. Although the time period studied differs from that for the data illustrated, the report identifies some relevant information.

Sutton routinely monitors the number and proportion of people

- Where care is taken over by a carer
- Client self supporting
- Ongoing care reduced
- Ongoing care maintained
- Ongoing care increased
- Admitted to a care home
- Re-admitted to hospital
- Care transferred to PCT
- Died

During the two month study period, 24 of 32 people who did not complete their homecare re-ablement phase were re-admitted to hospital and so case files were reviewed to identify possible lessons that might result in an improvement in the customer's journey by avoiding repeated changes in location and provider.

Based on this information, it would seem appropriate for services to establish and monitor the proportion of people that do not complete their phase of homecare re-ablement and, if significant, explore the underlying reasons.

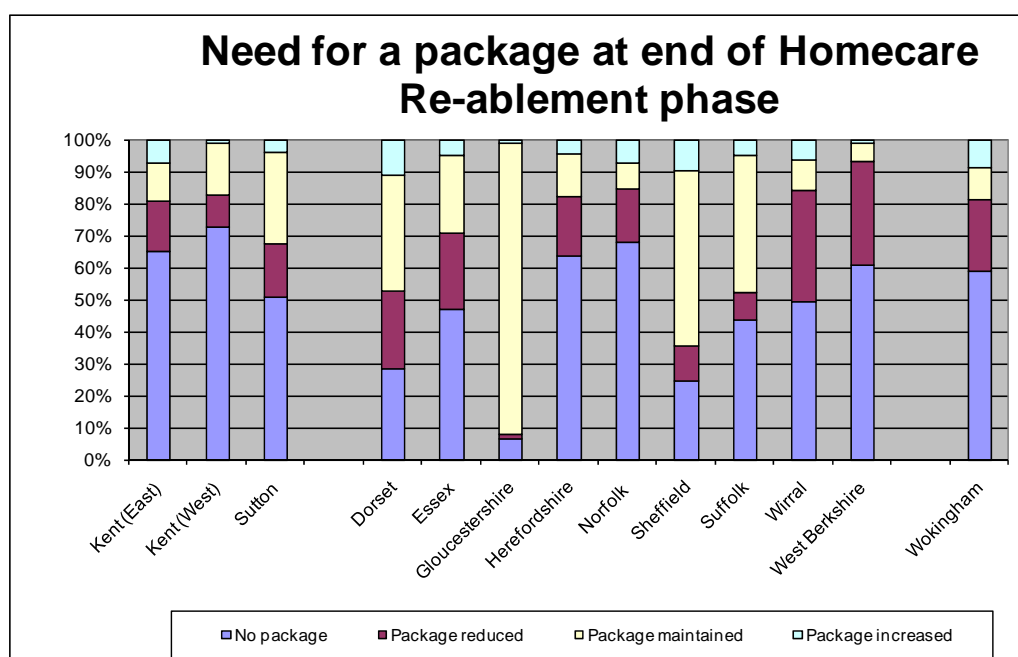
2.3 Completers

Given that the reasons for people not completing their phase of re-ablement seem to be primarily outside of the control of the service, our subsequent analysis has focused on those that have completed their appropriate period with the re-ablement team.

2.3.1 Need for a Homecare Package

The periods over which the data was collected varies for the illustrated CSSRs. However, in established (non pilot) services the actual number of completers range from 71 to 2,200, with an average of 557 per service, and so all but one are of a middle to large size. Further, when converted pro rata to annual activity levels, they range from 71 to 2,200 per annum with an average of 773 per service.

Therefore, the data can be taken as being valid because it is drawn from relatively large numbers of all users that passed through a re-ablement phase.



2.3.2 No Homecare Package Required Post Re-ablement

The table at Appendix 2 provides a summary of the data where CSSRS were able to provide it. In summary they are

- Within 4 established services operating at moderate and above, between 50% and 73% of people did not require an ongoing homecare package after completing a phase of homecare re-ablement
- Within 6 councils operating an established service at substantial and above, between 7% and 68% of people did not require an ongoing homecare package after completing a phase of homecare re-ablement. The second lowest percentage was 24%, and three of the seven established services were at or above 50%. The two additional pilot services were 28% and 47%.

- Within the 2 councils operating an established service at critical they saw 61% and 59% of people not requiring an ongoing homecare package after completing a phase of homecare re-ablement.

As reflected in the table in section 1.1 above, the original case studies included in the CSED Discussion Document were

- 4 CSSRs operating at moderate and above. The proportion of people not requiring an ongoing homecare package ranged from 21% to 62%. The second lowest percentage was 44%.
- and 2 at substantial and above, where they experienced 55% and 80% (the latter being a selective hospital discharge support service)

Two of the original case study sites (Leicestershire and Wirral) are also included within the latest illustrated services.

Therefore, although the range of benefits for those operating at substantial and above is lower and more variable than for those at moderate and above, the more established services see similar levels of outcome benefit. Also, those at critical and above have relatively high results when compared with all other FACS groups.

2.3.3 Reduced Homecare Packages

Equally important, homecare re-ablement can improve the independence of people even though they still require an ongoing homecare package. The original case studies, and subsequent work, show that a significant number of people enjoy a reduced homecare package.

The table at Appendix 2 provides a summary of the data where CSSRS were able to provide it. In summary they are

- Recent data is available for 3 of the 4 operating an established service at moderate and above, and they saw between 10% and 17% benefit from a reduced homecare package. (The De Montfort study for Leicestershire showed 17%)
- Within 6 councils operating an established service at substantial and above, between 1% and 35% benefited from a reduced homecare package. The second lowest percentage was 9%. The two additional pilot services were 25% and 23%.
- Within the 2 councils operating an established service at critical they saw 22% and 32% benefit from a reduced package.

Therefore, despite the fact that some people still require a subsequent homecare package across all three levels of need, significant proportions of people benefit from greater independence.

2.3.4 Maintained and Increased Homecare Packages

As seen within Appendix 2, homecare re-ablement does not reduce or remove the need for a subsequent homecare package for all referrals. This was evident from the earlier work by CSED. However,

- There was a very wide range in the proportion of users who maintained the same size of package. Surprisingly, the proportion of those in services that support moderate and above, and only critical levels of need ranged between 5% and 29% whilst those in services that took substantial levels of need and above ranged from 8% to 91%. The second highest level was 55%. However, even with these widely different values, the overall average for people in the 13 services providing data was 28.8%. The average shown by the De Montfort study in 1.1.1 above was 17%.
- However, the range in proportions who actually required an increased subsequent homecare package was 1% to 11% across all three levels, with an average for people in all 13 services providing data of 5%. The average shown by the De Montfort study in 1.1.1 above was 8%.

The De Montfort study showed that without re-ablement, 71% of people had their original package maintained and 11% required an increased package at their first six-week review. Thus, although most of these results are an improvement on what appears to be the situation without re-ablement, the group with widest divergence is that where the start package was not altered by the re-ablement phase.

2.3.5 Duration of Homecare Re-ablement Phase

The table at Appendix 3 provides a summary of the data where CSSRs were able to provide it. In summary they are

- Within the 4 established services operating at moderate and above, the overall average duration ranged from 3.9 weeks to 7.2 weeks. Of these, 3 services ranged from 3.9 weeks and 4.9 weeks.
- Within 5 councils operating an established service at substantial and above, the overall average duration of the homecare re-ablement phase ranged from 3.1 weeks to 8.5 weeks. The second longest duration was 6.4 weeks. There was a significant consistency between the various services in that, with few exceptions, each maintained their order of shortest to longest duration for each user group. e.g. site with shortest overall duration was shortest for every user group. The two additional pilot services also retained virtually the same relative position with regard to the other six.
- The one council operating an established service at critical had an overall duration of 6.0 weeks, although this was the duration recorded for all groups.

Interestingly, three of the six services operating at substantial and above experienced a shorter average duration for those people who left their re-ablement phase with the same size of homecare package than the average for all their clients. Thus, it would

seem that they were relatively quick, when compared to other services, to identify those whose independence was already maximised.

2.3.6 Reduction in Commissioned Homecare Hours

As outlined within the CSED Discussion Document⁸, once a council has adopted a homecare re-ablement approach across the whole authority, it no longer has a comparison group so that it can compare the outcome benefits with those that do not undertake re-ablement. Thus, many compare the start and end package size as one measure to monitor performance.

Clearly, this could be open to accusations of manipulation because one could artificially inflate the size of the start package to create a greater apparent improvement. Intuitively, it is accepted that the start package within a re-ablement approach is often higher than would be the case within a maintenance service. However, based on the limited evidence available within the De Montfort study⁹, this does not indicate an excessive inflation. The average start hours within the comparative group was 5.6 hours per week whilst that within the intake and assessment pilot was 6.0 hours per week, or 7% higher.

Thus, whilst being cognisant of this possibility, the average net reduction in commissioned hours when compared to the start package, as shown within the table in Appendix 4, were

- For the 4 services operating at moderate and above, the average reductions ranged from 48% to 75% with 3 at or above 60%.
- For 7 of the services operating at substantial that have provided the data, the range was 21% to 74%, with 3 being at or over 60%. One service, Essex, have used as their start position the number of hours that would have been required had a domiciliary care package been put in place. Their data shows a reduction of 46%
- For the one service operating at critical that provided the data, the reduction was 67%

Therefore, despite the fact that homecare re-ablement does not reduce every client's homecare package, it is clear that there is a significant net reduction for all three FACS groups.

⁸ [CSED Discussion Document, Vol 1 section 2.3.2 Financial](#)

⁹ [CSED Discussion Document, Case Study – Leicestershire: External Evaluation of the Home Care Re-ablement Pilot Project. De Montfort University. Page 21](#)

3. Case Studies

Dorset County Council

1	Summary	
	Overall summary of the scheme	<p>Dorset County Council undertook a re-ablement pilot project in the Weymouth and Portland locality between September 2007 and March 2008. This involved the in-house domiciliary support service offering a six week re-ablement programme for all service users referred for home care. The service was only available to those whose needs already met the eligibility criteria (substantial or critical) and was a charged for service, although a flat rate charge, not the full home care cost.</p> <p>The project was evaluated and this demonstrated a significant level of success in reducing or right sizing packages of care. However, the county is now intending to pilot a service which is available prior to a FACS assessment and offered as part of an integrated, multi-agency intermediate care team.</p> <p>The service will be free for a maximum of six weeks. The project, which will begin in the East Dorset District Council area in March 2009, is viewed as part of the Transforming Social Care preventive agenda and, if successful, will be rolled out across the county.</p>
2	Council Profile	
	Brief description of the council	The County has a population of 390,980 (2001 census) with 91,446 (23.4%) ¹⁰ aged over 65 years and 12,219 (3.1%) ¹¹ aged over 85 years.
3	FACS Criteria	
		Substantial and above and applied at entry to the re-ablement service

¹⁰ [2001 census: national average aged over 65 = 15.9%](#)

¹¹ [2001 census: national average aged over 85 = 1.9%](#)

CSSR NAME	Dorset County Council	
FACS LEVEL	Substantial and above	Applied as people enter and leave re-ablement service
Period data covers	September 2007 to March 2008 (6 month pilot)	

USER GROUP	NO OF USERS (per annum)	START		END		AVERAGE DURATION (weeks)
		Average care package hours (per week)	Range of hours (per week)	Average care package hours (per week)	Range of hours (per week)	
1. No further homecare package required at end of re-ablement phase	15	6.2	2.5 to 10.5 hrs			4.2
2. Assessed homecare package at start reduced by end of re-ablement phase	13	7.7	3.5 to 14.0 hrs	4.9	2.25 to 10.0 hrs	6.2
3. Assessed homecare package at start maintained at end of re-ablement phase	19	8.7	2.5 to 42.0 hrs	8.7	2.5 to 42.0 hrs	6.8
4. Assessed homecare package at start increased at end of re-ablement phase	6	5.5	3.5 to 10.5 hrs	7.7	4.0 to 12.5 hrs	6.6
5. User did not complete re-ablement phase: e.g. referred to other services including LTC or health, declined service once started or died before end of re-ablement phase	32	6.5	3.5 to 10.5 hrs	6.2	3.5 to 10.5 hrs	1.8
TOTAL	85	7.1		6.8		4.4

Essex County Council

1	Summary	
	Overall summary of the scheme	<p>Essex's Domiciliary Re-ablement Service provides an assessment and intake service with a mixed team of therapists and enablement staff.</p> <p>Previously the service accepted adult service users aged from 18 to 65 years. However, as part of a re-organisation of Essex in-house services it now accepts referrals from Learning Disabilities, Older Persons and Adults with no upper age limit.</p> <p>The data shown is for the first six months of the service when admissions were only from hospital discharges. The service now accepts community referrals in addition to hospital discharges.</p> <p>(see Assessment Tools Doc ¹²)</p>
2	Council Profile	
	Brief description of the council	The County has a population of 1,310,835 (2001 census) with 218,839 (16.7 %) ¹³ aged over 65 years and 26,471 (2.0%) ¹⁴ aged over 85 years.
3	FACS Criteria	
		Substantial needs and above and is applied on entry to the service.

¹² [CSED Assessment Tools and Satisfaction Surveys](#)

¹³ [2001 census: national average aged over 65 = 15.9%](#)

¹⁴ [2001 census: national average aged over 85 = 1.9%](#)

CSSR NAME	Essex County Council	
FACS LEVEL		Applied as people enter and leave re-ablement service
Period data covers	April 2008 to September 2008 (6 month Hospital Discharge Pilot)	

USER GROUP	NO OF USERS (per annum)	START		END		AVERAGE DURATION (weeks)
		Average care package hours (per week) (see note 1)	Range of hours (per week)	Average care package hours (per week)	Range of hours (per week)	
1. No further homecare package required at end of re-ablement phase	272	7.0	1.0 to 24.5 hrs			4.1
2. Assessed homecare package at start reduced by end of re-ablement phase	135	10.0	1.75 to 28.0 hrs	6.7	1.0 to 23.5 hrs	6.6
3. Assessed homecare package at start maintained at end of re-ablement phase	141	9.0	1.75 to 31.5 hrs	9.0	1.75 to 31.5 hrs	5.6
4. Assessed homecare package at start increased at end of re-ablement phase	29	8.6	3.5 to 35.0 hrs	13.4	4.0 to 53.0 hrs	5.7
5. User did not complete re-ablement phase: e.g. referred to other services including LTC or health, declined service once started or died before end of re-ablement phase	192	8.9	1.75 to 31.5 hrs	8.9 (see note 2)		2.7
TOTAL	769	8.4		8.6		4.5

Notes:

1. The care package at the start is the domiciliary care package that would have been commissioned had the person not entered re-ablement
2. The care package at exit was generally zero but in this table it is shown as the same as the care package at start to ensure that only benefits from re-ablement illustrated

Gloucestershire County Council

1	Summary	
	Overall summary of the scheme	<p>From 1st April 2007, Gloucestershire County Council's in-house domiciliary care service moved to an Enablement model and was renamed 'Community STEPS (Short Term Enablement Programmes).</p> <p>The service is focused upon facilitating hospital discharges, prevention of unavoidable admission to hospital and long term residential care and has recently expanded to provide an intake function for all new referrals. The aim is to promote independence, enabling people to remain in their own homes.</p> <p>The service is subject to FACS on entry, is short-term - on average six weeks and chargeable. Following review, if ongoing care is required, this is provided by the independent sector.</p> <p>We have demonstrated that with timely and skilled support the level of care package can be significantly reduced, or even cease to be required with approximately 30% of service users either working their way out of the care system, or having a reduced care package.</p>
2	Council Profile	
	Brief description of the council	The County has a population of 564,559 (2001 census) with 98,017 (17.4%) ¹⁵ aged over 65 years and 12,579 (2.2%) ¹⁶ aged over 85 years.
3	FACS Criteria	
		Substantial and above and is applied on entry to the service

¹⁵ [2001 census: national average aged over 65 = 15.9%](#)

¹⁶ [2001 census: national average aged over 85 = 1.9%](#)

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CSSR NAME	Gloucestershire County Council	
FACS LEVEL	Substantial and above	Applied as people enter and leave re-ablement service
Period data covers	November 2007 to March 2008 (5 months)	

USER GROUP	NO OF USERS (per annum)	START		END		AVERAGE DURATION (weeks)
		Average care package hours (per week)	Range of hours (per week)	Average care package hours (per week)	Range of hours (per week)	
1. No further homecare package required at end of re-ablement phase	10	5.30	3.30 – 10.30 hrs			
2. Assessed homecare package at start reduced by end of re-ablement phase	2					
3. Assessed homecare package at start maintained at end of re-ablement phase	137	8.45	2.30 – 17.30 hrs			
4. Assessed homecare package at start increased at end of re-ablement phase	2					
5. User did not complete re-ablement phase: e.g. referred to other services including LTC or health, declined service once started or died before end of re-ablement phase	82	4.30	1.30 – 21.00 hrs			
TOTAL	233	18.45				

Herefordshire Council

(Unitary)

1	Summary	
	Overall summary of the scheme	<p>Herefordshire Council's Short Term Assessment Re-ablement and Review Service (STARRS) provides domiciliary support and re-ablement to people experiencing a short-term health crisis at home, who without support, may have been admitted to hospital, or people in hospital who require short-term support so that they can return home safely.</p> <p>The service is offered to adults who have met the Council's eligibility criteria under FACS, following a Social Work assessment</p> <p>The service operates a mixed team approach with therapists and support workers.</p> <p>(see Discussion Document ¹⁷) (see Assessment Tools Document ¹⁸)</p>
2	Council Profile	
	Brief description of the council	<p>The Council has a population of 174,871 (2001 census) with 33,583 (19.2 %) ¹⁹ aged over 65 years and 3,954 (2.3%) ²⁰ aged over 85 years.</p> <p>The authority's latest CPA score is 3 stars.</p> <p>The authority commissions approximately 7,000 hours of care per week of which approximately 87% is placed with external providers. It currently serves those with moderate needs and above.</p>
3	FACS Criteria	
		Substantial and above and applied on entry to the service

¹⁷ [CSED Homecare Re-ablement Discussion Document section 3.1.1](#)

¹⁸ [CSED Assessment Tools and Satisfaction Surveys](#)

¹⁹ [2001 census: national average aged over 65 = 15.9%](#)

²⁰ [2001 census: national average aged over 85 = 1.9%](#)

CSSR NAME	HEREFORDSHIRE COUNCIL, STARRS TEAM	
FACS LEVEL	Substantial and above	At entry stage occasionally take moderate and above For ongoing, needs to be substantial and above
Period data covers	April 2007 to March 2008 (12 months)	

USER GROUP	NO OF USERS (per annum)	START		END		AVERAGE DURATION (weeks)
		Average care package hours (per week)	Range of hours (per week)	Average care package hours (per week)	Range of hours (per week)	
1. No further homecare package required at end of re-ablement phase	201	8.84	1.75 to 28.0 hrs	0		3.25
2. Assessed homecare package at start reduced by end of re-ablement phase	58	10.56	5.25 to 21.0 hrs	5.88	1.75 to 12.25 hrs	4.58
3. Assessed homecare package at start maintained at end of re-ablement phase	42	7.25	3.5 to 14.0 hrs	7.25	3.5 to 14.0 hrs	2.82
4. Assessed homecare package at start increased at end of re-ablement phase	15	5.48	3.5 to 10.5 hrs	8.4	5.25 to 14.0 hrs	4.33
5. User did not complete re-ablement phase: e.g. referred to other services including LTC or health, declined service once started or died before end of re-ablement phase	52	8.78	3.5 to 31.5 hrs	8.51	3.5 to 17.5 hrs	1.76
TOTAL	368	8.24		7.27		3.24

Kent County Council

1	Summary	<p>Kent Home Care Service [in-house provider of Kent County Council] has been developing re-ablement services over the past 3 years.</p> <p>In the West Kent area of our county we are working with Health in the delivery of a Recuperative Care Scheme, which also involves the input of therapists. This scheme is currently being evaluated.</p> <p>Throughout the county we run Active Care services which do not have therapy input. These schemes are regarded as intermediate care and can last for up to six weeks. They take hospital discharge, hospital avoidance at A&E and new referrals from the community. The aim of the Active Care service is to enable the recipient to become as independent as possible by regaining their confidence in their every day skills of self-caring. Approximately 60% of the service users do not require any on-going care package at the end of the intervention. For the people who does need an on-going care package in most cases this has reduced by a significant amount of time per week.</p> <p>We have statistics over the past three years showing the inputs and outcomes for the people who have been on the scheme.</p>
2	Council Profile	<p>Brief description of the council</p> <p>The County has a population of 1,329,718 (2001 census) with 228,060 (17.2%)²¹ aged over 65 years and 29,161 (2.2%)²² aged over 85 years.</p>
3	FACS Criteria	<p>Moderate and above – East: when people leave the service, and West: when people enter the service</p>

²¹ [2001 census: national average aged over 65 = 15.9%](#)

²² [2001 census: national average aged over 85 = 1.9%](#)

CSSR NAME	Kent (East only)	
FACS LEVEL	Moderate and above	Applied as people leave re-ablement service
Period data covers	January 2008 to March 2008 (3 months)	

USER GROUP	NO OF USERS	START		END		AVERAGE DURATION (weeks)
		Average care package hours (per week)	Range of hours (per week)	Average care package hours (per week)	Range of hours (per week)	
1. No further homecare package required at end of re-ablement phase	71	5.6	1.5 to 21.0 hrs			3.6
2. Assessed homecare package at start reduced by end of re-ablement phase	17	7.0	0.5 to 13.0 hrs	2.8	0.25 to 10.25 hrs	4.0
3. Assessed homecare package at start maintained at end of re-ablement phase	13	9.0	1.5 to 21.0 hrs	9.0	1.5 to 21.0 hrs	4.7
4. Assessed homecare package at start increased at end of re-ablement phase	8	5.2	0.5 to 10.5 hrs	6.6	1.0 to 17.5 hrs	4.7
5. User did not complete re-ablement phase: e.g. referred to other services including LTC or health, declined service once started or died before end of re-ablement phase	24	7.0	2.5 to 14.0 hrs			
TOTAL	133	6.3				

CSSR NAME	Kent (West only)	
FACS LEVEL	Moderate and above	Applied as people enter and leave re-ablement service
Period data covers	April 2007 to March 2008 (12 months)	

USER GROUP	NO OF USERS (per annum)	START		END		AVERAGE DURATION (weeks)
		Average care package hours (per week)	Range of hours (per week)	Average care package hours (per week)	Range of hours (per week)	
1. No further homecare package required at end of re-ablement phase	780	5.2	1 to 14 hrs			4.5
2. Assessed homecare package at start reduced by end of re-ablement phase	105	8.6	3 to 24.5 hrs	4.3	1 to 10.5 hrs	6.8
3. Assessed homecare package at start maintained at end of re-ablement phase	178	5.3	1.5 to 21 hrs	5.3	1.5 to 21 hrs	5.6
4. Assessed homecare package at start increased at end of re-ablement phase	12	4.2	1 to 7 hrs	8.2	3.5 to 14 hrs	4.1
5. User did not complete re-ablement phase: e.g. referred to other services including LTC or health, declined service once started or died before end of re-ablement phase	229					
TOTAL	1,314					

Leicestershire County Council

1	Summary	
	Overall summary of the scheme	<p>The Homecare Assessment and Re-ablement Team (HART) operates as an intake and assessment function across the whole of the county.</p> <p>It is one of four specialist services: HART, dementia team, child care team and 'specialist' maintenance. All standard ongoing homecare is delivered by out-house providers.</p> <p>(see Discussion Document ²³) (see Assessment Tools Document ²⁴) (see Retrospective Longitudinal Survey ²⁵)</p>
2	Council Profile	
	Brief description of the council	<p>The County has a population of 609,578 (2001 census) with 95,448 (15.7%) ²⁶ aged over 65 years and 10,913 (1.8%) ²⁷ aged over 85 years.</p> <p>The authority's latest CPA score is 4 stars.</p> <p>The Social Services directorate have retained a 3 star rating from the start of the star rating system.</p> <p>The authority commissions approximately 33,000 hours of care per week of which approximately 85% is placed with external providers. It currently serves those with moderate needs and above.</p>
3	FACS Criteria	
		Moderate and above and applied on entry to the service

²³ [CSED Homecare Re-ablement Discussion Document: case studies and section 3.1.1](#)

²⁴ [CSED Assessment Tools and Satisfaction Surveys](#)

²⁵ [CSED Retrospective Longitudinal Survey Document](#)

²⁶ [2001 census: national average aged over 65 = 15.9%](#)

²⁷ [2001 census: national average aged over 85 = 1.9%](#)

CSSR NAME	Leicestershire County Council	
FACS LEVEL	Moderate and above	Applied as people enter and leave the re-ablement service
Period data covers	April 2007 – March 2008 (12 months)	

USER GROUP	NO OF USERS (per annum)	START		END		AVERAGE DURATION (weeks)
		Average care package hours (per week)	Range of hours (per week)	Average care package hours (per week)	Range of hours (per week)	
1. No further homecare package required at end of re-ablement phase	1,231	4.8				4.8
2. Assessed homecare package at start reduced by end of re-ablement phase	941	6.1		4.6		10.3
3. Assessed homecare package at start maintained at end of re-ablement phase						
4. Assessed homecare package at start increased at end of re-ablement phase						
5. User did not complete re-ablement phase: e.g. referred to other services including LTC or health, declined service once started or died before end of re-ablement phase	45	5.6				4.0
TOTAL	2,217	5.4				7.1

Norfolk County Council

1	Summary	<p>Norfolk County Council Adult Social Services remodelled its home care services and commenced our re-ablement service in February 2008.</p> <p>To date 23% of service users have not required an ongoing service. We still have our home care service for people who need continuing home care but this is being transferred out to the independent sector over the next 3 -5 years</p> <p>Norfolk First is currently receiving referrals from the acute hospitals, community hospitals and transitional beds. The decision to commence with hospitals was to release the pressure on hospital discharges and the consequential delays and "bed blocking" .Where possible we also take service users from the community and we are working alongside our Independent sector colleagues to increase capacity and introduce new block contracts. Once additional capacity is available, the service will be provided for all service users who meet the criteria for the Norfolk First support service.</p> <p>Norfolk First support service is a six weeks service of intensive input to optimise service user's independence. The service is chargeable and all service users are subject to FACS assessment at entry to service.</p> <p>Norfolk first support has trained 250 staff who work in the service in assessment and re-ablement skills. The service works very closely with our Occupational therapy teams</p>
2	Council Profile	<p>Brief description of the council</p> <p>The County has a population of 796,728 (2001 census) with 159,611 (20.0%)²⁸ aged over 65 years and 19,979 (2.5%)²⁹ aged over 85 years.</p>
3	FACS Criteria	<p>Substantial and above and applied on entry to the service</p>

²⁸ [2001 census: national average aged over 65 = 15.9%](#)

²⁹ [2001 census: national average aged over 85 = 1.9%](#)

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CSSR NAME	Norfolk County Council	
FACS LEVEL	Substantial and above	Applied as people enter and leave re-ablement service
Period data covers	February 2008 to September 2008 (8 months)	

USER GROUP	NO OF USERS (per annum)	START		END		AVERAGE DURATION (weeks)
		Average care package hours (per week)	Range of hours (per week)	Average care package hours (per week)	Range of hours (per week)	
1. No further homecare package required at end of re-ablement phase	207	8.0	3.5 to 15.75 hrs			5.0
2. Assessed homecare package at start reduced by end of re-ablement phase	51	9.0	5.5 to 17.75 hrs	3.0	3 to 11 hrs	6.0
3. Assessed homecare package at start maintained at end of re-ablement phase	25	12.5	3 to 18.75 hrs	12.5	2 to 18.75 hrs	6.0
4. Assessed homecare package at start increased at end of re-ablement phase	23	7.0	3.5 to 11.75 hrs	9.0	3.5 to 15 hrs	8.0
5. User did not complete re-ablement phase: e.g. referred to other services including LTC or health, declined service once started or died before end of re-ablement phase	91	11.0	1.5 to 12.25 hrs	5.0	1.5 to 12.25 hrs	3.0
TOTAL	397	9.0		5.9		4.9

Sheffield Council

1	Summary Overall summary of the scheme	<p>Sheffield developed its re-ablement service in December 1997 and has continued to increase resources into this service from that time.</p> <p>We are now clear about the size of the service we will provide, which is 3 times larger than it is currently. This acknowledges the success of this type of provision.</p> <p>Also we are very clear that in order for us to make the changes and achieve sustainability, we do have to take a whole systems approach in Sheffield working alongside our commissioning and contracts section for a whole market approach to achieving the rebalance of home support in the city.</p> <p>If the package is intermediate care then the person is not charged. The remainder of service users are assessed for a charge, so we do apply our policy on fairer charging to all STIT users except those who are receiving intermediate care interventions. There is an Assessment and Care Management protocol that sits behind this to ensure the relevant actions are taken and the service user is charged, where appropriate.</p> <p>The strategy for the in-house service is to reconfigure resources, currently in ongoing home care, into the re-ablement service. It is Sheffield's intention that all new service users and those existing service users who would benefit from this type of service will receive support from the re-ablement service initially.</p> <p>This is part of wider strategy on our integrated services, which also includes resource centres for Short Term Intervention Services</p>
2	Council Profile Brief description of the council	<p>The Council has a population of 513,234 (2001 census) with 84,056 (16.4%)³⁰ aged over 65 years and 10,639 (2.1%)³¹ aged over 85 years.</p>
3	FACS Criteria	<p>Substantial and above and applied on entry to the service</p>

³⁰ [2001 census: national average aged over 65 = 15.9%](#)

³¹ [2001 census: national average aged over 85 = 1.9%](#)

**Care Service Efficiency Delivery:
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CSSR NAME	Sheffield Council	
FACS LEVEL		Applied as people enter and leave re-ablement service
Period data covers	April 2008 to June 2008 (3 months)	

USER GROUP	NO OF USERS	START		END		AVERAGE DURATION (weeks)
		Average care package hours (per week)	Range of hours (per week)	Average care package hours (per week)	Range of hours (per week)	
1. No further homecare package required at end of re-ablement phase	139	6.0				8.1
2. Assessed homecare package at start reduced by end of re-ablement phase	63	10.5		6.1		11.3
3. Assessed homecare package at start maintained at end of re-ablement phase	313	7.2		7.2		8
4. Assessed homecare package at start increased at end of re-ablement phase	55	8.0		12.5		9.2
5. User did not complete re-ablement phase: e.g. referred to other services including LTC or health, declined service once started or died before end of re-ablement phase	65			7.7		
TOTAL	635					

Suffolk County Council

1	Summary	
	Overall summary of the scheme	<p>The in-house Home First scheme first started in Sept 2006, initially offering a chargeable 12 weeks re-ablement service. The service changed in October 2008 and now provides a free re-ablement and assessment service for up to 6 weeks for people being discharged from hospital or at a point of crisis. Any remaining need the customer has for long-term home care is commissioned from private sector providers.</p> <p>Scheme has been successful in terms of helping people to reach and maximise their potential, support the assessment process and reduce hospital delays in transfers of care</p>
2	Council Profile	
	Brief description of the council	The County has a population of 668,553 (2001 census) with 122,671 (18.3%) ³² aged over 65 years and 15,667 (2.4%) ³³ aged over 85 years.
3	FACS Criteria	
		Substantial and above and applied on entry to the service

³² [2001 census: national average aged over 65 = 15.9%](#)

³³ [2001 census: national average aged over 85 = 1.9%](#)

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CSSR NAME	Suffolk County Council	
FACS LEVEL	Substantial and above	Applied as people enter and leave re-ablement service
Period data covers	October 2007 to September 2008 (Oct '07 to Mar '08 service was for 12 weeks. Apl '08 to Oct '08 service was for up to 6 weeks) (12 months)	

USER GROUP	NO OF USERS (per annum)	START		END		AVERAGE DURATION (weeks)
		Average care package hours (per week)	Range of hours (per week)	Average care package hours (per week)	Range of hours (per week)	
1. No further homecare package required at end of re-ablement phase	456	6.03	3.5 to 8.75 hrs			5.5
2. Assessed homecare package at start reduced by end of re-ablement phase	93	8.12	5.25 to 17.5 hrs	3.73	1 to 12.75 hrs	6.75
3. Assessed homecare package at start maintained at end of re-ablement phase	450	6.78	4.0 to 15.75 hrs	7.72	4 to 15.75 hrs	7
4. Assessed homecare package at start increased at end of re-ablement phase	50	8.05	3.5 to 28.0 hrs	12.65	5.25 to 31.5 hrs	7.75
5. User did not complete re-ablement phase: e.g. referred to other services including LTC or health, declined service once started or died before end of re-ablement phase	552	9.30	2.5 to 28 hrs	12.47	1.5 to 31.5 hrs	7
TOTAL	1,601	7.66		7.31		6.8

Sutton Council (London Borough of)

1	Summary	
	<p>Overall summary of the scheme</p>	<p>Historically the scheme principally supported hospital discharges. However, in line with the Council's plans to modernise Community Based Services in September 2007 the Council's Executive Committee approved plans to transform the in-house Home Care service into a Re-ablement 'intake' team by September 2008.</p> <p>We changed to being a chargeable service from 01.04.07 (following a financial assessment). We were previously a free service and we were worried that the change would impact on the number of people coming through but it actually made no difference. We do not charge for all our specific care/planning, risks assessments / progress reports or OT equipment collection, just for the direct hours provided to work with people towards the agreed objectives and outcomes</p> <p>The existing START service, which formed part of the in-house team, was greatly expanded so that all new users of homecare services in Sutton have the opportunity to receive a period of intensive assessment and rehabilitation in the home, in order to assist people to be as independent as possible.</p> <p>Existing service users will also have the opportunity to be referred to the service if it has been identified they would benefit from a short-term period of assessment to meet changing needs.</p> <p>The expansion of the START service means the in-house Home Care team will no longer be able to provide long-term care packages. Our intention is to provide a service which:</p> <ul style="list-style-type: none"> • Is a universal re-ablement service open to all, regardless of diagnosis or clinical rehabilitation potential. • Works closely with service users and carers to maximise independence • Assists service users to link in with other support services and social activities in order to promote choice and well-being.

		<ul style="list-style-type: none"> • Takes referrals from both health and social services, including GPs, nurses, intermediate care practitioners and care managers. • Refers directly to specialist health care practitioners where required. • Is a flexible service, which can respond quickly according to need and can accept referrals out of traditional hours. • Where ongoing care needs are identified, reviews and hand-over individualised outcome focussed care plans, which will be maintained by mainstream providers. <p>And which focuses on the following types of situation:</p> <ul style="list-style-type: none"> • Intake of all new homecare referrals to promote independence from first contact with services. • Support of timely hospital discharges • Prevention of admission to hospital • Prevention of admission to residential or nursing care. • Prevention of care breakdown /provision of crisis support to informal carers • Detailed assessment of complex cases - for instance where there is uncertainty about risk management <p>(see Retrospective Longitudinal Study ³⁴)</p>
2	Council Profile	
	Brief description of the council	The Council has a population of 179,768 (2001 census) with 26,138 (14.5%) ³⁵ aged over 65 years and 3,695 (2.1%) ³⁶ aged over 85 years.
3	FACS Criteria	
		Moderate high and above and applied on entry to the service

³⁴ [CSED Retrospective Longitudinal Study Document](#)

³⁵ [2001 census: national average aged over 65 = 15.9%](#)

³⁶ [2001 census: national average aged over 85 = 1.9%](#)

CSSR NAME	Sutton Council (London Borough of)	
FACS LEVEL	Moderate high and above	Applied as people enter and leave re-ablement service
Period data covers	September 2007 to July 2008 (11 months)	

USER GROUP	NO OF USERS	START		END		AVERAGE DURATION (weeks)
		Average care package hours (per week)	Range of hours (per week)	Average care package hours (per week)	Range of hours (per week)	
1. No further homecare package required at end of re-ablement phase	182	7.1	0.75 to 27.25 hrs			3.0
2. Assessed homecare package at start reduced by end of re-ablement phase	60	10.6	1.5 to 33.6 hrs	6.0	0.5 to 28 hrs	5.25
3. Assessed homecare package at start maintained at end of re-ablement phase	104	10.5	1 to 45.5 hrs	10.5	1 to 45.5 hrs	4.66
4. Assessed homecare package at start increased at end of re-ablement phase	14	9.9	1.75 to 24.5 hrs	13.6	3.5 to 29.0 hrs	4.61
5. User did not complete re-ablement phase: e.g. referred to other services including LTC or health, declined service once started or died before end of re-ablement phase	132	12.0	2.5 to 35 hrs			2.0
TOTAL	492	9.7				3.4

West Berkshire Council

(Unitary)

1	Summary	
	Overall summary of the scheme	<p>The service has been running alongside intermediate care for just over two years. The team of 8 staff provide a re-ablement service primarily for referrals from the community, although a few of those discharged from hospital also undertake a re-ablement phase. The team also provide a home from hospital service and crisis response service.</p> <p>The data included in this document relates only to those from the community.</p>
2	Council Profile	
	Brief description of the council	<p>The Council has a population of 144,483 (2001 census) with 19,158 (13.2%)³⁷ aged over 65 years and 2,301 (1.6%)³⁸ aged over 85 years.</p>
3	FACS Criteria	
		<p>Critical and above and applied on entry to and exit from the service if further package required.</p>

³⁷ [2001 census: national average aged over 65 = 15.9%](#)

³⁸ [2001 census: national average aged over 85 = 1.9%](#)

CSSR NAME	West Berkshire	
FACS LEVEL	Critical and above	Applied as people enter and leave re-ablement service
Period data covers	August and September 2007 (2 months Pilot)	

USER GROUP	NO OF USERS	START		END		AVERAGE DURATION (weeks)
		Average care package hours (per week)	Range of hours (per week)	Average care package hours (per week)	Range of hours (per week)	
1. No further homecare package required at end of re-ablement phase	43	7.0	1 to 14 hrs			6.0
2. Assessed homecare package at start reduced by end of re-ablement phase	23	7.61	1 to 14 hrs	5.6	3.5 to 10 hrs	6.0
3. Assessed homecare package at start maintained at end of re-ablement phase	4	7.43	3.5 to 14 hrs	7.4	3.5 to 14 hrs	6.0
4. Assessed homecare package at start increased at end of re-ablement phase	1	12.3	14.5 to 15.75 hrs	15.8	15.8 hrs	6.0
5. User did not complete re-ablement phase: e.g. referred to other services including LTC or health, declined service once started or died before end of re-ablement phase	17					
TOTAL	88					

Data only relates to community referrals undergoing a phase of homecare re-ablement

Wirral (Metropolitan Borough of)

1	Summary	
	Overall summary of the scheme	<p>After a number of years of operating a hospital discharge support service, Wirral decided to expand the service to become an intake and assessment service. In August 2007 we changed the name from Wirral Enablement Discharge Service to Wirral Home Assessment and Re-ablement Teams (Wirral HART)</p> <p>We have now increased the size of the service to cope with most of the hospital discharges and have been able to take some of the work from the newly established access team and also undertaken assessments in relation to provision of direct payments.</p> <p>A clear strategic lead has been given by movement of the Wirral HART service from the care services division into the Access and Assessment division. The role of the team as assessors has been clearly established and will be strengthened in the planned growth of the service. Agreed that in principle most people will not receive permanent or increased care without assessment via HART service</p> <p>Wirral HART Organiser staff have been trained as assessors for assistive technology, referrers for medicines management and have been trained in the pathway for provision of Direct payments. The role of the team as sign posters to low level services is being strengthened by training</p> <p>Discussions have been taking place with the PCT as to the strategic fit of the service both within intermediate care and also integrated service pathways. Discussions are taking place on how HART can now have a role as a step up preventative service.</p> <p>(see Discussion Document ³⁹) (see Retrospective Longitudinal Study⁴⁰)</p>
2	Council Profile	
	Brief description of the council	The Council has a population of 312,293 (2001 census) with 56,574 (18.1%) ⁴¹ aged over 65 years and 6,996 (2.2%) ⁴² aged over 85 years.
3	FACS Criteria	
	Substantial and above and applied on exit from the service if further package required.	

³⁹ [CSED Discussion Document: case study](#)

⁴⁰ [CSED Retrospective Longitudinal Study Document](#)

⁴¹ [2001 census: national average aged over 65 = 15.9%](#)

⁴² [2001 census: national average aged over 85 = 1.9%](#)

CSSR NAME	Wirral (Metropolitan Borough of)	
FACS LEVEL	Substantial and above	Applied as people enter and leave re-ablement service
Period data covers	August 2007 to March 2008 (8 months)	

USER GROUP	NO OF USERS	START		END		AVERAGE DURATION (weeks)
		Average care package hours (per week)	Range of hours (per week)	Average care package hours (per week)	Range of hours (per week)	
1. No further homecare package required at end of re-ablement phase	144	10	2 to 28 hrs			2.5
2. Assessed homecare package at start reduced by end of re-ablement phase	101	14	5 to 56 hrs	7	0.25 to 20 hrs	3.8
3. Assessed homecare package at start maintained at end of re-ablement phase	27	10	2 to 21 hrs	10	2 to 21 hrs	2.8
4. Assessed homecare package at start increased at end of re-ablement phase	19	7	1 to 17.5 hrs	11	2 to 28 hrs	3.9
5. User did not complete re-ablement phase: e.g. referred to other services including LTC or health, declined service once started or died before end of re-ablement phase	124					
TOTAL	415					

Wokingham Council

(Unitary)

1	Summary	
	Overall summary of the scheme	<p>Intake and assessment scheme in operation with approx. 215 clients pa. The team has a dedicated OT and offers armchair exercises to service users and a Footcare Service.</p> <p>A&E can refer direct OOH.</p> <p>The service is free for up to 6 weeks and offers a Hand-over to Long Term provider if required.</p>
2	Council Profile	
	Brief description of the council	The Council has a population of 150,229 (2001 census) with 17,917 (11.9%) ⁴³ aged over 65 years and 2,062 (1.4%) ⁴⁴ aged over 85 years.
3	FACS Criteria	
		Critical and applied on entry to the service.

⁴³ [2001 census: national average aged over 65 = 15.9%](#)

⁴⁴ [2001 census: national average aged over 85 = 1.9%](#)

CSSR NAME	Wokingham Council	
FACS LEVEL	Critical	Applied as people leave re-ablement service
Period data covers	April 2007 to March 2008 (12 months)	

USER GROUP	NO OF USERS (per annum)	START		END		AVERAGE DURATION (weeks)
		Average care package hours (per week)	Range of hours (per week)	Average care package hours (per week)	Range of hours (per week)	
1. No further homecare package required at end of re-ablement phase	98					
2. Assessed homecare package at start reduced by end of re-ablement phase	37					
3. Assessed homecare package at start maintained at end of re-ablement phase	16					
4. Assessed homecare package at start increased at end of re-ablement phase	15					
5. User did not complete re-ablement phase: e.g. referred to other services including LTC or health, declined service once started or died before end of re-ablement phase	44					
TOTAL	210					

4. Further Updates

This document has brought together data from a number different homecare re-ablement services. These were offered in response to a general request that was sent to all CSSRs that had an established service, and particularly those working at Substantial and above or Critical levels of need.

If any other CSSRs are willing to share their data CSED will provide updates to this document and make them available via our website.

www.csed.csip.org.uk.

APPENDICES

Appendix 1 – Total Referrals to Homecare Re-ablement Services

Appendix 2 – People Completing a Phase of Homecare Re-ablement

Appendix 3 – Average Duration of Homecare Re-ablement Phase

Appendix 4 – Average % Reduction in Commissioned Care Packages

Appendix 1 – Total Referrals to Homecare Re-ablement Services

CSSR HOMECARE RE-ABLEMENT SCHEMES - COMPARATIVE TABLE

TOTAL REFERRALS TO HOMECARE RE-ABLEMENT SERVICE

CSSR NAME	Kent (East Kent Only)	Kent (West Kent Only)	Leicestershire	Sutton	Dorset	Essex	Gloucestershire	Herefordshire	Norfolk	Sheffield	Suffolk	Wirral	West Berkshire	Wokingham
FACS LEVEL	Moderate and above	Moderate and above	Moderate and above	Moderate high and above	Substantial and above	Substantial and above	Substantial and above	Substantial and above	Substantial and above	Substantial and above	Substantial and above	Substantial and above	Critical	Critical
Period data covers:	January 2008 to March 2008	April 2007 to March 2008	April 2007 to March 2008	Sept 2007 to July 2008	Sept 2007 to March 2008 (six month pilot)	Apl to Sept 2008 (Hospital Discharge Pilot)	November 2007 to March 2008	April 2007 to March 2008	February to September 2008	April to June 2008	Oct 2007 to Sept 2008 (see notes)	August 2007 to March 2008	Sept 2007 to Aug 2008	April 2007 to March 2008
USER GROUP	% OF USERS	% OF USERS	% OF USERS	% OF USERS	% OF USERS	% OF USERS	% OF USERS	% OF USERS	% OF USERS	% OF USERS	% OF USERS	% OF USERS	% OF USERS	% OF USERS
Completed a phase of homecare re-ablement	82.0%	82.6%	98.0%	73.2%	62.4%	75.0%	64.8%	85.9%	77.1%	89.8%	65.5%	70.1%	80.7%	79.0%
Non Completers	18.0%	17.4%	2.0%	26.8%	37.6%	25.0%	35.2%	14.1%	22.9%	10.2%	34.5%	29.9%	19.3%	21.0%
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Appendix 2 – People Completing a Phase of Homecare Re-ablement

CSSR HOMECARE RE-ABLEMENT SCHEMES - COMPARATIVE TABLE

PEOPLE COMPLETING A PHASE OF HOMECARE RE-ABLEMENT

CSSR NAME	Kent (East Kent Only)	Kent (West Kent Only)	Leicestershire	Sutton	Dorset	Essex	Gloucestershire	Herefordshire	Norfolk	Sheffield	Suffolk	Wirral	West Berkshire	Wokingham
FACS LEVEL	Moderate and above	Moderate and above	Moderate and above	Moderate high and above	Substantial and above	Substantial and above	Substantial and above	Substantial and above	Substantial and above	Substantial and above	Substantial and above	Substantial and above	Critical	Critical
Period data covers:	January 2008 to March 2008	April 2007 to March 2008	April 2007 to March 2008	Sept 2007 to July 2008	Sept 2007 to March 2008 (six month pilot)	Apl to Sept 2008 (Hospital Discharge Pilot)	November 2007 to March 2008	April 2007 to March 2008	February to September 2008	April to June 2008	Oct 2007 to Sept 2008 (see notes)	August 2007 to March 2008	Sept 2007 to Aug 2008	April 2007 to March 2008

USER GROUP	% OF USERS	% OF USERS	% OF USERS	% OF USERS	% OF USERS	% OF USERS	% OF USERS	% OF USERS	% OF USERS	% OF USERS	% OF USERS	% OF USERS	% OF USERS	% OF USERS
1. No further homecare package required at end of re-ablement phase	65.1%	72.8%	56.7%	50.6%	28.3%	47.1%	6.6%	63.6%	67.6%	24.4%	43.5%	49.5%	60.6%	59.0%
2. Assessed homecare package at start reduced by end of re-ablement phase	15.6%	9.7%	43.3%	16.7%	24.5%	23.4%	1.3%	18.4%	16.7%	11.1%	8.9%	34.7%	32.4%	22.3%
3. Assesses homecare package at start maintained at end of re-ablement phase	11.9%	16.4%		28.9%	35.8%	24.4%	90.7%	13.3%	8.2%	54.9%	42.9%	9.3%	5.6%	9.6%
4. Assessed homecare package at start increased at end of re-ablement phase	7.3%	1.1%	3.9%	11.3%	5.0%	1.3%	4.7%	7.5%	9.6%	4.8%	6.5%	1.4%	9.0%	
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Appendix 3 – Average Duration of Homecare Re-ablement Phase

CSSR HOMECARE RE-ABLEMENT SCHEMES - COMPARATIVE TABLE

AVERAGE DURATION OF HOMECARE RE-ABLEMENT PHASE

CSSR NAME	Kent (East Kent Only)	Kent (West Kent Only)	Leicestershire	Sutton	Dorset	Essex	Herefordshire	Norfolk	Sheffield	Suffolk	Wirral	West Berkshire
FACS LEVEL	Moderate and above	Moderate and above	Moderate and above	Moderate high and above	Substantial and above	Substantial and above	Substantial and above	Substantial and above	Substantial and above	Substantial and above	Substantial and above	Critical
Period data covers:	January 2008 to March 2008	April 2007 to March 2008	April 2007 to March 2008	Sept 2007 to July 2008	Sept 2007 to March 2008 (six month pilot)	Apr to Sept 2008 (Hospital Discharge Pilot)	April 2007 to March 2008	February to September 2008	April to June 2008	Oct 2007 to Sept 2008 (see notes)	August 2007 to March 2008	Sept 2007 to Aug 2008

USER GROUP	AVERAGE DURATION (weeks)	AVERAGE DURATION (weeks)	AVERAGE DURATION (weeks)	AVERAGE DURATION (weeks)	AVERAGE DURATION (weeks)	AVERAGE DURATION (weeks)	AVERAGE DURATION (weeks)	AVERAGE DURATION (weeks)	AVERAGE DURATION (weeks)	AVERAGE DURATION (weeks)	AVERAGE DURATION (weeks)	AVERAGE DURATION (weeks)
1. No further homecare package required at end of re-ablement phase	3.57	4.45	4.78	3.00	4.20	4.10	3.25	5.00	8.10	5.50	2.50	6.00
2. Assessed homecare package at start reduced by end of re-ablement phase	4.00	6.82	10.28	5.25	6.20	6.60	4.58	6.00	11.31	6.75	3.80	6.00
3. Assesses homecare package at start maintained at end of re-ablement phase	4.70	5.57		4.66	6.80	5.60	2.82	6.00	7.97	7.00	2.80	6.00
4. Assessed homecare package at start increased at end of re-ablement phase	4.70	4.14		4.61	6.60	5.70	4.33	8.00	9.21	7.75	3.90	6.00
TOTAL	3.85	4.86	7.16	3.92	5.89	5.13	3.49	5.47	8.49	6.36	3.07	6.00

Appendix 4 – Average % Reduction in Commissioned Care Packages

CSSR HOMECARE RE-ABLEMENT SCHEMES - COMPARATIVE TABLE

% REDUCTION IN HOURS

CSSR NAME	Kent (East Kent Only)	Kent (West Kent Only)	Leicestershire	Sutton	Dorset	Essex	Herefordshire	Norfolk	Sheffield	Suffolk	Wirral	West Berkshire
FACS LEVEL	Moderate and above	Moderate and above	Moderate and above	Moderate high and above	Substantial and above	Substantial and above	Substantial and above	Substantial and above	Substantial and above	Substantial and above	Substantial and above	Critical
Period data covers:	January 2008 to March 2008	April 2007 to March 2008	April 2007 to March 2008	Sept 2007 to July 2008	Sept 2007 to March 2008 (six month pilot)	Apl to Sept 2008 (Hospital Discharge Pilot)	April 2007 to March 2008	February to September 2008	April to June 2008	Oct 2007 to Sept 2008 (see notes)	August 2007 to March 2008	Sept 2007 to Aug 2008
USER GROUP												
1. No further homecare package required at end of re-ablement phase	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2. Assessed homecare package at start reduced by end of re-ablement phase	60%	50%	24%	43%	36%	33%	44%	67%	42%	54%	50%	27%
3. Assessed homecare package at start maintained at end of re-ablement phase	0%	0%		0%	0%	0%	0%	0%	0%	-14%	0%	0%
4. Assessed homecare package at start increased at end of re-ablement phase	-27%	-95%		-37%	-40%	-56%	-53%	-29%	-57%	-57%	-57%	-29%
TOTAL	68%	75%	63%	48%	30%	46%	70%	74%	21%	36%	64%	67%

Essex calculated the reduction by comparing the end package with that which would have been put in place had a conventional homecare approach been adopted