

Care Services Efficiency Delivery Programme

Homecare Re-ablement Workstream

Retrospective Longitudinal Study November 2007

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Acknowledgements

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HEMOCARE RE-ABLEMENT RETROSPECTIVE LONGITUDINAL STUDY

Background

Care Services Efficiency Delivery (CSED) held a national workshop on 26th January 2007 to launch its Discussion Document ¹ and supporting evidence for Homecare Re-ablement. This was attended by 190+ people from 100 councils with social service responsibility (CSSR) and provided a forum both to share the 'body of evidence' collated and seek responses from attendees on the future direction of any work by CSED.

The CSED programme was formed to support English councils to achieve their Gershon efficiency targets within adult social care. 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.

During the workshop we sought to capture feedback from attendees through

- workshop evaluation and feedback forms
- wall chart tables
- themed discussion groups

The points picked up in the latter forum were prioritised by attendees themselves through the use of votes. In addition, other points were collated during our evidence gathering phase.

Because of this feedback, CSED was able to identify a number of areas where it can provide additional support to councils ². These areas were grouped into seven categories, one of which included the completion of a retrospective longitudinal study. This was to be approached in two phases: the first to provide evidence of the duration of benefit and inform the specification of a longer prospective study, and the second phase to address specific issues with control groups that would provide real value to CSSRs as they implement or extend a scheme.

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Introduction

¹ [CSED Homecare Re-ablement Workstream Discussion Document January 2007](#)

² [CSED Homecare Re-ablement Workstream Review and Proposed Direction March 2007](#)

In January 2007, CSED published a Discussion Document ³ that brought together a body of evidence about the benefits of homecare re-ablement schemes. Through a range of case studies and further information from schemes in operation, it became clear that significant benefits could be derived for users, in terms of improving their level of independence, and for councils with social service responsibility (CSSRs) through an appropriate reduction in the number of commissioned care hours required.

An evaluation study completed by the De Montfort University in Leicestershire ⁴ showed that, on average, a 28% reduction in commissioned hours had been achieved by those undergoing a phase of re-ablement when compared to a control group that had not.

Homecare Package at First Review		
Care package required post 1 st review	Matched service users (control group)	Re-ablement Roll-out (intake)
Discontinued	5%	58%
Decreased	13%	17%
Maintained	71%	17%
Increased	11%	8%
Total	100%	100%
Average reduction in ongoing care hours required		28%

As illustrated within the Homecare Re-ablement Discussion Document, subsequent performance in Leicestershire and other CSSRs has shown higher levels of independence being achieved. Having established that significant improvements could be achieved in the level of independence at the end of Homecare Re-ablement phase, it was recognised that there was no evidence of how long this benefit lasts.

This study builds on the body of evidence and seeks to

- determine the duration of benefit for those undergoing homecare re-ablement
- inform what a larger prospective study might usefully encompass to enable CSSRs to maximise the benefits of a service

³ [CSED Homecare Re-ablement Discussion Document](#) – request a link to this document and supporting information

⁴ [CSED Homecare Re-ablement Discussion Document Volume 2: Case Studies – Leicestershire: External Evaluation of the Home Care Re-ablement Pilot Project, De Montfort University](#)

The attached report, which was completed by the Social Policy Research Unit at the University of York and a specialist research organisation, Acton Shapiro, provides further details of the study, working with four CSSRs, and its outputs. However, the headlines are:

- 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 care package 2 yrs after re-ablement (4th = 87%)
 - (In 1 scheme 55 users that had previously required homecare before re-ablement continued to require no care package 2 yrs after re-ablement)
- 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 re-ablement (4th = 61%)
- Of those > 65 yrs that required a homecare package within 24 mths after re-ablement
 - In 3 of the 4 schemes the number that had reduced their package was higher after 24 mths than after 3 mths (4th = grew but then fell below 3mth level)
- Of those > 85yrs that required a homecare package within 24 mths after re-ablement
 - In 2 of the 4 schemes there was a marked growth in the number that reduced their package
- Excluding those transferred to LTC or died
 - In 3 of the 4 schemes no dramatic change in the mix of intensity over the 24 mths following homecare re-ablement

Whilst acknowledging that this study brings with it a number of caveats (e.g. only included four schemes, no control groups), the similarities in the outcomes are reasonably consistent. Therefore, we believe that this study adds significantly to the body of evidence, and provides further assurance that there is still a compelling case for CSSRs to consider the introduction of Homecare Re-ablement.

Research into the Longer Term Effects/Impacts of Re-ablement Services

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Executive summary

In 2006, the Care Services Efficiency Delivery (CSED) Programme (as part of its Homecare Re-ablement Workstream), carried out a major piece of work⁵ to bring together information about the development of homecare re-ablement services in England. The study showed that (by the end of 2006) 60 CASSRs had a homecare re-ablement service of some kind. It drew the distinction between 'intake' re-ablement services and 'discharge' or 'discharge support' re-ablement services. 'Intake' re-ablement services commonly accept referrals for all people assessed as needing or being eligible for homecare, and then screen out only those considered unlikely to benefit from re-ablement. In contrast, 'discharge support' re-ablement services primarily accept referrals for people leaving hospital and are usually highly selective, accepting only those people most likely to benefit from a re-ablement approach.

The evidence from the few services which have been evaluated suggests that there are significant reductions in use of homecare services following 'discharge' from a re-ablement service, compared with assessed levels of need on 'entry' to the service. However, there is no evidence on the longer term duration of such reductions, or on the factors that might lead to subsequent (increases in) service use. To begin to address this gap in the evidence, CSED decided to commission a very focused and rapid study of the longer term impact of re-ablement, which might both assist CASSRs considering developing a re-ablement service, and help inform and scope more robust evaluation of the long term impact and effectiveness of re-ablement services. The study had three main aims:

- Using routine service data from a number of CASSRs, to examine changes over time in the subsequent use of social care services following a period of homecare re-ablement.
- To identify factors that may affect subsequent use of social care services following a period of homecare re-ablement in the selected CASSRs.
- To consider what a larger evaluation of homecare re-ablement services might most usefully encompass, and identify issues that may need to be taken into account in designing such a study.

Methods

The study team selected four CASSRs with re-ablement services (two 'intake' services and two 'discharge support' services) which had been established for at

⁵ Care Services Efficiency Delivery Programme (2007) *Homecare Re-ablement Workstream Discussion Document*.

least four years. A brief profile of the four case study services is provided in Chapter 2.

In each site we:

- obtained routine quantitative data for clients who had an episode of homecare re-ablement in 2004-5, including the level of social care services they subsequently used over the following two years (i.e. 2005/06 and 2006/07);
- carried out interviews with the re-ablement service manager and at least one care management team manager.

A profile of the 'population' of re-ablement service users in each area, including a breakdown of age, gender and ethnicity, and an examination of the service users pattern of service use was prepared. Four main strands of analysis were then undertaken with the aim of gaining some insight into the overall impact of re-ablement, and the duration or sustainability of that impact. The results of these analyses are summarised below.

Key findings

Profile of re-ablement service users

Patterns of service usage for Leicestershire and Sutton are remarkably similar, despite the fact that Leicestershire is an 'intake' service, and the Sutton service which has a focus principally but not exclusively on 'discharge support'. Both the age profile of their service users (i.e. a higher proportion in the 85 years and over age group) and the proportion of service users who had homecare prior to re-ablement suggest that the level of understanding of re-ablement amongst referring practitioners may be significant.

Time from re-ablement to first episode of homecare

This analysis highlights the possibility that re-ablement service users fall into two broad groups: those who gain immediate but relatively short term (around three months) benefit from re-ablement; and, those for whom the impact is more sustained, possibly delaying their need for homecare by a year or more.

Change in homecare usage after re-ablement

The picture provided by the data on the change in homecare usage over the two years after re-ablement appears very positive. In Leicestershire and Sutton, the

percentages of service users needing less homecare than they did on leaving re-ablement actually increased over the two year period, including for the 85 years and over age group. In Salford the percentages of service users needing progressively more homecare did increase over the two years but only slightly.

Intensity of homecare usage after re-ablement

There do not appear to be any marked changes in the proportions of service users in each of the HH1 intensity of homecare usage categories, at the different snapshot points examined over the two year period (i.e. 3, 6, 12, 18 and 24 months after re-ablement). This, and the smaller proportion of service users in the 'over 10 hours' category in Leicestershire, suggest that intensity of homecare use over a prolonged period might be a valuable issue for CASSRs running re-ablement services to monitor, and an important effect to be examined in any future research in to the longer term impact of re-ablement.

In terms of the perceived impact of re-ablement services on the demand for social care services, the team managers across all four sites believed the re-ablement services had the result of reducing demand for social care. This was generally evidenced at an anecdotal level, based on their own observations, and positive feedback from social workers, service users and carers. An exception was Leicestershire, who had independently evaluated their pilot re-ablement service, and expanded it on the basis of the immediate benefits that were demonstrated.

Factors influencing the impact of re-ablement services

The interviews with re-ablement service managers and care management team managers highlighted a number of factors which they felt affected (positively and negatively) both the longer term impact of re-ablement, and the effectiveness of re-ablement services. Six key factors were highlighted in relation to the longer term impact of reablement:

- Independent providers – culture and contracting arrangements.
- The re-ablement package – duration and flexibility.
- Service users – understanding and attitudes.
- Carers – perceptions of risk and the need for on-going support.
- Signposting to other services and support.
- Culture of re-ablement across social care services.

The factors highlighted in relation to the effectiveness of re-ablement services included: quality of assessment; service flexibility; skill mix; staff attitudes and skills; service capacity and throughput; relationships with other teams and services; and carer involvement.

Clearly, without robust/detailed baseline data, and a control group for comparison, it is impossible to know whether the patterns of service usage seen in the data from the four case study sites are directly and predominantly the result of re-ablement, or whether the positive views of service and team managers can be substantiated. Nevertheless, a number of interesting possible effects have emerged which are worthy of consideration, and further examination, both if a more robust evaluation of the longer term effects of re-ablement was commissioned, and by CASSRs wishing to monitor the impact of their re-ablement service.

Chapter 1 Introduction

In 2006, the Care Services Efficiency Delivery (CSED) Programme (as part of its Homecare Re-ablement Workstream), carried out a major piece of work⁶ to bring together information about the development of homecare re-ablement services in England. CSED noted that across health and social care the terms 're-ablement', 'enablement', 'prevention', 'rehabilitation' and 'intermediate care' are used loosely, and the boundaries between the services they refer to are often blurred. For the purposes of this report, we have followed the definition of re-ablement used in the De Montfort University evaluation of Leicestershire's re-ablement service⁷ and subsequently adopted by the CSED study team:

'Services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living.'

The CSED study showed that (by the end of 2006) 60 CASSRs had a homecare re-ablement service of some kind, and a further ten were in the process of establishing a service. It also showed that the characteristics of these services vary considerably; for example:

- Some are jointly funded, commissioned and/or managed by CSSR with PCT partners, some are funded, commissioned and managed by the CSSR alone.
- Some take people on discharge from hospital, others take most people referred to CSSR.
- Most are provided in-house but a few CASSRs have outsourced their homecare re-ablement service.
- Some re-ablement services are provided by retrained homecare staff; others have significant therapist inputs.
- Most are for older people only, but a few take adults of all ages.

Probably the most significant distinction is between:

'Intake' re-ablement services which commonly accept referrals for all people assessed as needing or being eligible for homecare, and then screen out only those considered unlikely to benefit from re-ablement (e.g. because they are not receptive to the approach, or in some cases require terminal care).

⁶ Care Services Efficiency Delivery Programme (2007) *Homecare Re-ablement Workstream Discussion Document*.

⁷ Centre for Group Care and Community Care Studies, De Montfort University and Leicestershire County Council (2000) *External Evaluation of the Homecare Re-ablement Pilot Project*.

‘Discharge’ or ‘discharge support’ re-ablement services which primarily accept referrals for people leaving hospital and which are usually highly selective, accepting only those people most likely to benefit from a re-ablement approach.

The few in-house and external evaluations focusing specifically on homecare re-ablement undertaken in the UK (e.g. the evaluation of the Leicestershire re-ablement service noted above) and an evaluation of an Australian homecare re-ablement service⁸ all suggest significant reductions in use of homecare services following ‘discharge’ from a re-ablement service, compared with assessed levels of need on ‘entry’ to the service. However, there is no evidence on the longer term duration of such reductions, or on the factors that might lead to subsequent (increases in) service use.

To begin to address this gap in the evidence, CSED decided to commission a very focused and rapid study of the longer term impact of re-ablement, which might both assist CASSRs considering developing a re-ablement service, and help inform and scope more robust evaluation of the long term impact and effectiveness of re-ablement services. The study had three main aims:

- Using routine service data from a number of CASSRs, to examine changes over time in the subsequent use of social care services following a period of homecare re-ablement.
- To identify factors that may affect subsequent use of social care services following a period of homecare re-ablement in the selected CASSRs (e.g. the use of other non-social care services following ‘discharge’ from homecare re-ablement or the impact of longer term maintenance homecare service use on the retention of self-care and other skills achieved during re-ablement).
- To consider what a larger evaluation of homecare re-ablement services might most usefully encompass (e.g. skill mix, impact on specific groups of service users), and identify issues that may need to be taken into account in the design of such a study (e.g. the need for a control group).

This report focuses primarily on the first two aims. The issues relating to the content and design of a larger evaluation of homecare re-ablement will be discussed in a separate briefing paper prepared for CSED.

⁸ Lewin, G., Vandermeulen, S. and Coster, C. (2006) Programs to promote independence at home. *Generations Review, Journal of the British Society of Gerontology*, 16, 3, 24-26.

1.1 Methods

The aims of the study were met by working with four CASSRs, in two ways. First, routine quantitative data were obtained for clients who had an episode of homecare re-ablement in 2004-5, including the level of social care services they subsequently used over the following two years (i.e. 2005/06 and 2006/07). Given the short timescale of the study, these data were used as a proxy for the impact of re-ablement. However, it was acknowledged from the outset that the longer the period following 'discharge' from homecare re-ablement services, the greater the likelihood of confounding factors (such as new health problems and/or other unrelated changes in circumstances) arising which could affect needs for and use of social care services, regardless of the impact of an earlier period of re-ablement. In the time available, it was not possible to investigate and separate out these effects in our analysis. However, in each site we collected qualitative data via interviews with re-ablement service managers and care management team managers about their perceptions of factors affecting the longer term impact of re-ablement services.

Approval for the study was obtained from the ADASS Research Committee and also IRISS (Institute for Research in Health and Social Sciences) Ethics Committee, a sub-committee of the University of York's Humanities and Social Sciences Research Ethics Committee established specifically to 'fast-track' applications.

1.1.1 Selection of CASSR sites

Before the study began, CSED had already emailed those CASSRs known to them to have a re-ablement service to ask about their willingness, in principle, to take part. Interested CASSRs were invited to supply a brief set of key information comprising: service type ('intake' or 'discharge support'); age range of users; length of time the service had been operating; volume of users in recent years, FACS eligibility threshold; how data on users were collected and stored; and what kinds of data on needs and service inputs were collected (and in what format).

Fourteen CASSRs expressed an interest by returning the information requested. Using this information, the research team used the following selection criteria:

- Two 'discharge support' re-ablement services and two 'intake' services (since this may have an impact on the characteristics of service users, and their subsequent use of homecare and other social care services).
- Sites in which the FACS threshold has remained unchanged over the past two years (since this would affect subsequent eligibility for, and use of, social care services).
- A spread of different types of local authority from different regions of England.

- Crucially, in the timescale available for the study, sites which: could accurately link records on use of homecare re-ablement services with records of subsequent social care service use (e.g. by using the same identifier); could extract the required information quickly and accurately for the researchers; had senior managers willing to support the work by facilitating access to records and staff.

The four sites were selected jointly by CSED and the research team and all agreed to take part. A meeting was then set up in each site, part of which was used to clarify the requirements of the study, the operation of the local service and the data held.

1.1.2 Quantitative data on use of social care services following re-ablement

Through the series of site meetings, the research team developed a core data set which the sites were asked to provide in an Excel spreadsheet. The core data set included information on: types of social care services offered by the authority; re-ablement clients during 2004-5; re-ablement services provided to these clients; and other social care services provided to these re-ablement clients (immediately before re-ablement, at the end of re-ablement and up to two years subsequently).

Liaison was then needed with the sites to 'clean' the data and understand the different terminology and service descriptions used. Not surprisingly, some problems were encountered in terms of data availability and limitations. In particular, some of the data provided could not be used in the analysis. These included:

- Records of services which fell outside the study period (i.e. ended before 1 January 2004 or started after 4 April 2007).
- Client records with no start and/or end date for re-ablement or other services.
- Clients with a re-ablement episode lasting 26 weeks or more (29 clients in total)

Clients with more than one episode of re-ablement were removed in order to simplify the analysis. To create the age groups used in the analysis, each client's age was set as at 4 April 2004, i.e. the beginning of the study group year.

1.1.3 Qualitative data on factors affecting use of social care services following homecare re-ablement

In all four sites, the research team carried out a minimum of two semi-structured interviews. In each case, the first interview was carried out face-to-face with the homecare re-ablement service manager (and colleagues) during the early site visit. The second interview(s) was with a manager responsible for a team of care managers. These interviews were carried out either face-to-face or via the

telephone. Owing to differences in local service structures, the number of team managers required to interview to obtain the information varied between sites, numbering six in total. All interviewees were sent the topic guide in advance and, where possible, team managers consulted their teams before the interview.

Together, the two sets of interviews explored:

- the operation of the homecare re-ablement service
- perceived factors contributing to the effectiveness of the service and limits on the impact and duration of its benefits
- factors affecting resumption or increase in social care service use after a period of homecare re-ablement
- knowledge about other services used on 'discharge' from the homecare re-ablement service
- knowledge of the factors contributing to multiple 're-entry' to homecare re-ablement services.

Factual data about the service were used to compile brief profiles of each site (which were sent to respondents for checking). Comments on service use and factors affecting the impact and effectiveness of re-ablement were analysed thematically across all four sites.

1.1.4 Joint research team/service managers meeting

In early October the research team met with the four reablement service managers and the project commissioner from CSED to discuss the findings from the study and to collectively consider the recommendations. The meeting also provided an opportunity to discuss the key issues to be examined in any larger evaluation of homecare reablement services.

1.2 Structure of the report

The report is organised into five chapters. Chapter 1 describes the background to the study and briefly sets out the methods used. Chapter 2 provides a short profile of each of the four case study services. Chapter 3 briefly describes how the data provided by the four sites were analysed and presents the key findings from this analysis. It goes on to examine both the quantitative and qualitative evidence relating to the longer term impact of re-ablement. Chapter 4 draws on the interviews with re-ablement service managers and care management team managers to explore the factors influencing both the longer term impact of re-ablement and the effectiveness of re-ablement services. Lastly, Chapter 5 presents the conclusions and key messages from the whole study.

Chapter 2 Description of the case study services

A brief overview of the re-ablement services in each of the four case study sites is provided in the tables below. The four services are:

- Wirral Enablement Discharge Service (WEDS), Wirral Metropolitan Borough Council (a 'discharge support' re-ablement service).
- Homecare Assessment and Re-ablement Team (HART), Leicestershire County Council (an 'intake' re-ablement service).
- Short Term Assessment and Re-ablement Team (START), London Borough of Sutton (primarily but not exclusively a 'discharge support' re-ablement service).
- Intermediate Home Support Service (IHS), Salford City Council (an 'intake' re-ablement service).

2.1 Wirral

Council profile		
1	Brief description of council	<p>Wirral is a Metropolitan Borough Council.</p> <p>It has a population of 312,000 (2001 census) with 57,000 (18.1%) aged over 65 years and 7000 (2.25%) aged over 85 years. Just under 3.5 per cent of the borough's population is from the black and minority ethnic community.</p> <p>The authority has an overall CPA rating of 2, with Adult Social Care services performing at 2 stars.</p>
2	FACS criteria	<p>FACS criteria are not applied to WEDS clients.</p> <p>The Department of Adult Social Service is currently working at the critical and substantial level.</p>
3	Brief description of homecare provision	<p>Currently there are four types of homecare in Wirral:</p> <ul style="list-style-type: none"> ○ WEDS (short term – see below) ○ In-House provision (longer term) ○ Independent sector provision (longer term) ○ Specialist independent provision <p>However, WMBC has taken the decision to adopt a 're-ablement approach' across all its adult and community services, and so in-house homecare services are currently being restructured. A 'new' service Wirral HART (Homecare Assessment and Re-ablement Team) is being established and WEDS will be absorbed into this service. HART will also accept referrals from Care Managers, and from hospital staff other than OTs.</p>

4	Background to development of re-ablement service	The idea for the service started with the OT Discharge Support Team, who found that when a package of homecare support was put in place for people leaving hospital, the care staff often did things for people rather than enabled them to do things themselves. Consequently, people did not improve or progress as expected. The training for the WEDS pilot was funded by the Changing Workforce Accelerated Development Programme. No new money was available for the pilot; the capacity was created by reorganisation of existing staff resources and use of the Access and Capacity Grant.
Re-ablement service profile		
5	Name of service	Wirral Enablement Discharge Service (WEDS)
6	Date service established and implementation stages	<p>The service was established in October 2003 as a pilot and service volume has built up steadily over the last three years:</p> <p>Oct 2003 – Sept 2004 = 124 service users Oct 2004 – Sept 2005 = 207 service users Oct 2005 – Sept 2006 = 314 service users</p> <p>With the changes in homecare services in WMBC, WEDS will become part of the new HART service in August 2007.</p>
7	Operational structure of current service	<p>The Homecare Manager is responsible for the service, with WEDS organisers undertaking risk assessments and organising care for individual clients.</p> <p>The service covers the whole of Wirral MBC area, with the WEDS staff and the OTs working with the service having a shared base in Beechwood.</p> <p>At present, when a client needs an on-going package of care, WEDS will refer them on to a Care Manager to undertake the assessment and set up the package of care. However, in 2004/5 WEDS did have dedicated Social Work support.</p>
8	Current service model	<p>The service only works with clients who have been discharged from hospital. Re-ablement is offered for six weeks, but with some flexibility according to need. The service offers personal care; mobility practice; practice with meal preparation and light domestic tasks.</p> <p>For those clients who do not need an on-going care package but would benefit from some support, the OT staff can signpost or link them into voluntary sector activities.</p>
9	Role in undertaking assessments/review	<p>The initial assessment is undertaken by the WEDS OT, and an enablement plan is then drawn up. In 2004/5, clients needing an on-going package of care were assessed by the Care Manager linked to the WEDS service. From the summer of 2005 to summer 2007 assessments for these clients have been conducted by the relevant Care Management Team. The new HART service will be able to assess clients for on-going packages of care, but reviews will be undertaken by the new Authority-wide review team.</p> <p>Risk assessments are undertaken by the WEDS organisers. The team do not undertake carer assessments.</p>

10	Screening & eligibility	The service accepts anyone over the age of 18 who has had an OT assessment and is being discharged from hospital.
11	Referral routes	Referrals are made by hospital based OTs directly to the WEDS OTs.
12	Staffing/skill mix and staff training	There are four groups of staff working in WEDS: <ul style="list-style-type: none"> ○ Home Care Organisers (2.4 WTEs) ○ Home Care Enablers (11.2 WTEs) ○ OT Team Leader (0.78 WTE) ○ Senior II OT (0.5 WTE NHS and 0.5 WTE Social Services) ○ OT Assistants (0.96 WTEs) The target qualification for Enablers is NVQ Level 2.
13	Charging policy	The service is classed as an intermediate care service and is free.
14	Management Information operating system(s)	WEDS maintains its own client database. The SSD main system is SWIFT. From August 2007 all Wirral HART service users will be recorded on SWIFT.

2.2 Leicestershire

Council profile		
1	Brief description of council	Leicestershire County Council has a population of 610,000 with 95,000 (15.7%) aged over 65 years and 11,000 (1.8%) aged over 85 years. It has a black and minority ethnic population of 7.3 per cent (2001 Census). It has an overall CPA rating of 4 stars, with Adult Social Care services performing at 3 stars.
2	FACS criteria	Currently moderate needs and above
3	Brief description of homecare provision	There are four types of Homecare service provision in Leicestershire: <ul style="list-style-type: none"> ○ Dementia team (longer term) ○ Child care team (longer term) ○ HART team (short term - see below) ○ Independent homecare services.
4	Background to development of re-ablement service	The development of a homecare re-ablement service was triggered by completion of a Best Value review in 1999, and funding was provided from the Promoting Independence project.
Re-ablement service profile		
5	Name of service	Homecare Assessment and Re-ablement Team (HART)

6	Date service established and implementation stages	<p>1999: pilot based in Melton area, focused on people selected as being appropriate for re-ablement</p> <p>2000: pilot extended to accept all people through an 'intake' team in the Vale of Belvoir</p> <p>2001: work began to restructure the in-house service into the four types of homecare provision outlined above across the whole county (the fourth team was maintenance services which have now ceased altogether).</p> <p>Service volume has changed since the county-wide roll out: 2004-05: 1,543 service users 2005-06: 1,917 service users 2006-07: 2,106 service users.</p>
7	Operational structure of current service	<p>A service manager, who reports to the Assistant Director, Older and Disabled People's Service, takes a lead role for the in-house homecare service.</p> <p>The teams have until recently been divided into six geographically based area groups, managed by five team managers. Each locality team is led by a team of Homecare Managers, plus an out-of-hours team. A recent re-structure has led to the HART service being managed from two main office bases, North and South.</p> <p>There is a 'fast-track' access to social care OTs and to OT services with Health through jointly funded posts. Homecare Managers and Senior Carers have been trained and can order aids to daily living.</p>
8	Current service model	<p>All new requests for (non-specialist) homecare are now referred to the HART team (though where there is no capacity a few people are referred straight to the independent sector). HART provides domiciliary support for up to six weeks. The level of provision is adjusted according to ongoing assessment and monitoring of changing needs. The aim is to work with service users to assist them to regain their independence, in essence by re-learning daily living skills or by gaining new ones. Following a period of re-ablement, homecare provision is contracted from the independent sector for those with ongoing support needs.</p>
9	Role in undertaking assessments/ review	<p>An initial care plan is received from the Commissioning Team and progress is monitored on a weekly basis through a review involving the Senior Carer and Care Workers. HART have the authority to amend the care package, based on their ongoing assessment. Homecare Managers and Senior Homecare Assistants undertake a risk assessment. The above will include the involvement of the Commissioning Worker where appropriate.</p> <p>At the end of the re-ablement phase, the HART Manager and Care Worker complete a review with the service user.</p> <p>A final written care package forms part of the handover to any ongoing care provider. If there is a need for longer term involvement, the case is usually transferred to a care management team – in these cases, interaction with HART is ongoing and more involved.</p>

		<p>The Single Assessment Process (SAP) is being rolled out across county, but is electronic in only one area (HART are involved in this).</p> <p>Carer assessments are undertaken by community teams.</p>
10	Screening and eligibility	<p>The HART service is available to all adults aged 18+. This includes people with mental health problems and learning disabilities, but excludes certain groups according to established criteria (e.g. complex mental health needs, last stage terminal care).</p> <p>FACS criteria is applied prior to service entry point.</p>
11	Referral routes	<p>The majority of referrals are received internally, following initial assessment – the only exception is where SAP is being rolled out and a small number of health staff make referrals. Approximately 57 per cent of referrals are from Hospital Discharge commissioning teams.</p>
12	Staffing/skill mix and staff training	<p>The area teams (all specialisms) consist of 16 Homecare Managers, 30 Senior Homecare Assistants, and 442 Homecare Assistants. Carer workers involved in the pilot scheme underwent five days of training which was then reduced down to two days every six months for new staff. Currently, new starters receive 'on the job' training from experienced HART workers. The target is for staff to achieve NVQ level 2, supplemented by additional training in manual handling, risk assessment, lone worker, dementia and medication.</p>
13	Charging policy	<p>The first two days are provided at no charge. Thereafter charges are made in accordance with the council's charging policies.</p>
14	Management Information operating system(s)	<p>Leicestershire use a tailor-made information system: Social Services Information System (SSIS) and integrated Electronic Social Care Records for each service user.</p>

2.3 Sutton

Council profile		
1	Brief description of council	<p>The London Borough of Sutton is located on the southern boundary of Greater London.</p> <p>It has a population of 179,768; with 22,443 (12.5%) aged 65+ and 3,695 (2%) aged 85+. It has a black and minority ethnic population of 10.93 per cent (2001 Census).</p> <p>Sutton has an overall CPA rating of 4 stars, with Adult Social Care services performing at 2 stars.</p>
2	FACS criteria	<p>Currently moderate (high) needs and above.</p>

3	Brief description of homecare provision	There are three types of homecare within Sutton: <ul style="list-style-type: none"> ○ Homecare Re-ablement (START - see below) ○ In-House provision (longer term) - includes high proportion of extra care ○ Independent sector provision (longer term).
4	Background to development of re-ablement service	A re-ablement service has been operating for over ten years, initially as a rapid response short term service to support discharge and prevent admission to hospital.
Re-ablement service profile		
5	Name of service	Short Term Assessment and Re-ablement Team (START).
6	Date service established and implementation stages	START has been operating in some form for over ten years. 2000: became Specialist Homecare Team 2003: shared capacity (but not fully integrated) with PCT nursing provider team (intermediate care) 2007: in April changed to START Team. Service volume has changed over time: 2004-05: average 45-50 users per week, averaging 16 new referrals/16 leaving service 2005-07: reduced capacity within team led to drop in average number of users to 35-40 per week, averaging 7-10 new referrals/7-10 leaving service.
7	Operational structure of current service	START is one strand of the overall in-house Home Care service which consists of one service manager, two team managers and seven assistant managers/seniors, in two geographically based areas (East/West). There is shared capacity with PCT nursing provider team (intermediate care), which provides direct access to nursing. There is also good access to in-house OT and equipment services. The service operates seven days per week.
8	Current service model	Homecare support is provided for approximately six weeks, but this is flexible according to need. The level of provision is adjusted according to ongoing assessment and monitoring of changing needs, with an emphasis on enabling people to do things for themselves. Staff consider needs holistically, not solely related to personal care issues, and signpost to a wide range of community support systems to enable independence.
9	Role in undertaking assessments/review	An initial care plan is received from the referrer. Senior Homecarers undertake assessments (including risk assessments) during the first visit along with regular progress reports throughout service provision. START has the authority to decrease/increase provision according to changing needs throughout the service. At close of the re-ablement service, recommendations are made for care planning where follow-on support is required, but the assessment/care planning will be carried out by the community teams. The teams are linked to the SAP roll out, but this is not yet fully established across the Borough. Carer assessments are carried out by community teams.

10	Screening & eligibility	The START service is available to all adults aged 18+, who are perceived to benefit from re-ablement. This includes people with mental health problems and learning disabilities. The team also work with people with a terminal illness where their condition is stable and can benefit from re-ablement. FACS criteria applied at service entry point.
11	Referral routes	70 per cent of referrals are received from Hospital Care Managers. Referrals also received from: <ul style="list-style-type: none"> ○ Intermediate Care practitioners ○ SSD District Care Management teams ○ South West London Elective Orthopaedic Centre (referrals from here are growing).
12	Staffing/skill mix and staff training	21 home carers with capacity to provide 600 hours per week. 67 per cent qualified to NVQ level 2. One team member qualified to NVQ level 3 generic worker programme. 7 carers (seniors) have moving/handling qualification. 2 members of the team promote assistive technology.
13	Charging policy	Service became chargeable from day one from April 2007.
14	Management Information operating system(s)	SSD uses PARIS system. START team uses a tailor-made information system: 'Staff Plan' along with PARIS.

2.4 Salford

Council profile		
1	Brief description of council	Salford City Council is part of Greater Manchester, in the north west of England. In the 2001 Census, it had a population of 216,119, with 35,120 (16.3%) aged 65+ and 3,935 (1.8%) aged 85+. The Audit Commission's 2006 Corporate Assessment Report reports that 7.3 per cent of the local population are from the black and minority ethnic community. It has an overall CPA rating (April 2006) of 3 stars, with Adult Social Care services performing at 3 stars.
2	FACS criteria	Moderate and above.
3	Brief description of homecare provision	There are two types of homecare within Salford: <ul style="list-style-type: none"> ○ Intermediate Home Support (for up to six weeks - see below) ○ Independent sector provision (typically for longer term service).

4	Background to development of re-ablement service	The in-house homecare service traditionally provided long term care for people living in their own homes. Whilst having moved to a more person-centred approach, it was competing with an ever-increasing independent sector. To ensure a mixed economy of care and to meet the new agenda to promote independence, it was agreed that the in-house service would become much smaller and provide more specialist care aimed at helping people regain or maintain independent living at home.
Re-ablement service profile		
5	Name of service	Intermediate Home Support Service (IHS).
6	Date service established and implementation stages	<p>The service started in November 2003 via shifting staff from the existing homecare service, with longer term clients being passed to an external provider. The service has since grown and for about two years all incoming homecare referrals have been assessed by the team and either placed for IHS or for an initial period of in-house homecare.</p> <p>Although the latter is not formally a re-ablement service, it does have the ethos of promoting independence and, in time, it is expected that all new home support 'intake' will formally have a re-ablement approach.</p> <p>Volume of service users: 2004-05: approx 624 2005-06: approx 1,200 2006-07 approx 1,200.</p>
7	Operational structure of current service	One service manager, five Home Support Managers, three Assessment Officers and 11 Seniors. Eight admin staff. Support provided seven days per week between 7am - 10pm.
8	Current service model	Home support is provided for up to approximately six weeks and can be flexible in individual cases (e.g. where there are temporary difficulties putting longer term services in place and there is still potential for an improved outcome). With a focus on promoting independence, the service supports people with personal care, food preparation and eating, confidence-building and maintaining therapy routines, and household tasks. Service provision is reviewed weekly with the client. The final review after five weeks includes the social worker and any informal carers, at which time the need for any follow-up services (if any) is decided.
9	Role in undertaking assessments/ review	The service assesses all new home support referrals and re-assessments for existing clients whose circumstances have changed. Until recently assessments were carried out by the Home Support Managers, although resulting capacity problems mean that this role is now undertaken by dedicated Assessment Officers. If the referral involves hospital discharge, they will visit the hospital and be involved in discharge planning; otherwise they will visit the client's home. The assessment includes a risk assessment; where there is a hospital discharge this is completed by the Assessment Officer or Senior Home Support Assistant who visits the client once they are at home. Reviews are undertaken weekly (see section 8).

10	Screening & eligibility	The IHS service is available to all adults aged 18+, perceived to benefit from re-ablement or need some assessment to identify the most appropriate care and support to meet any long term needs. This includes people with mental health problems and learning disabilities, but not those with a terminal illness where there is a short life expectancy.
11	Referral routes	All referrals must be received from a SSD care manager or health staff in integrated teams. There are seven social work teams, including (so far) one integrated with health, plus referrals from hospitals outside Salford. These include Community Teams, the Hospital Team, Intermediate and Care.
12	Staffing/skill mix and staff training	138 Home Support Workers, some of whom are qualified at NVQ Level 2 in Care. A small number are qualified to NVQ Level 3 in Independent Living. Some Senior Home Support Assistants are qualified at NVQ Level 3 in Care, Promoting Independence and Supervisory Skills. Some Home Support Managers are qualified at NVQ Level 4 in Management and the Registered Manager is qualified at Level 5 in Management.
13	Charging policy	The service is provided free of charge.
14	Management Information operating system(s)	SSD uses the Care First system. The IHS service uses Care Time system, which is a module attached to Care First, to record some information and which is better able to process the frequent reviews.

Chapter 3 Exploring the longer term impact of re-ablement services

This chapter sets out the key findings from the analysis of the routine data provided by the case study sites. It also draws on the interviews with care management team managers to consider the perceived impact of re-ablement services.

3.1 Approach to the data analysis

Once the data had been 'cleaned' and checked, we prepared a profile of the 'population' of re-ablement service users in each area, including a breakdown of age, gender and ethnicity, and an examination of the service users' pattern of service use, both in terms of the number of repeat episodes of re-ablement, and the overall pattern of homecare and re-ablement use. Four main strands of analysis were then undertaken with the aim of gaining some insight into the overall impact of re-ablement, and the duration or sustainability of that impact. These were:

- An examination of the number of weeks from the end of re-ablement to the first episode of homecare (broken down by age group).
- Changes in the use of homecare after re-ablement (i.e. the proportion of service users who have continued with the same service, increased their use of homecare, or reduced their use of homecare), at the snapshot points of 3, 6, 12, 18 and 24 months after re-ablement.
- Intensity of homecare usage after re-ablement at the snapshot points of 3, 6, 12, 18 and 24 months, and based on the hours of homecare 'categories' used in the HH1 returns which all CASSRs are required to submit (i.e. two hours or less; two to five hours; six to ten hours; and more than ten hours).
- Take up of meals on wheels after re-ablement.

As the focus of this study is on the longer term impact of re-ablement, rather than the effectiveness of different models of re-ablement, no attempt has been made to examine the intensity, nature or duration of the re-ablement services provided.

It should also be noted that the number of service users in Wirral, and their pattern of service use, is somewhat different to the other three CASSRs. This is because the service in Wirral was very new in 2004/5 and at that time focused specifically on clients being discharged from hospital following an OT assessment. Nevertheless, their data provides a useful comparison.

3.2 Key findings

The key findings from this analysis are presented below.

3.2.1 Profile of the re-ablement service users

Table 3.1 below shows the number of service users supported by the four re-ablement services in 2004/5, broken down by age group and gender.

Table 3.1 Breakdown of the age and gender of service users

Case study site	Age group				Total
	Up to 64	65-74	75-84	85 and over	
Salford					
Female	28	58	147	73	306
Male	17	20	58	23	118
Total	45 (11.0%)	78 (18.3%)	205 (48.3%)	96 (22.6%)	424
Wirral					
Female	5	16	64	34	119
Male	4	5	13	5	27
Total	9 (6.1%)	21 (14.3%)	77 (52.2%)	39 (26.7%)	146
Leicestershire					
Female	74	116	453	372	1015
Male	61	81	208	136	486
Total	135 (8.9%)	197 (13.1%)	661 (44.0%)	508 (33.8%)	1501
Sutton					
Female	38	70	151	153	412
Male	20	31	82	51	184
Total	58 (9.7%)	101 (19.9%)	233 (39.0%)	204 (34.2%)	596

Although the percentage of service users in the four age groups is broadly similar for all four sites, it is interesting to note that in Salford and Wirral, the two more recently established services, a smaller proportion of service users fell into the 85 years and over age group. This may reflect differences in the attitudes/understanding of health and social care professionals around who can benefit from re-ablement (and therefore who they refer to re-ablement services), an issue discussed further in section 4.2.

In terms of the different client groups served by re-ablement services, in all four sites around 80 per cent of service users were categorised as 'physical disability', 'physical illness' or 'physical frailty'. Sutton has the highest proportion of service users in the mental health category (eight per cent). Sutton also had the highest proportion of service users from an Asian, black or mixed ethnic background at 6.6 per cent. In Leicestershire 1.9 per cent, and in Salford and Wirral less than one per

cent, fell into these groups. These percentages are all lower than the percentage of people from a black and ethnic minority background in the general populations in these localities.

We also examined the service users' 'profile' of service use, both in terms of the number of repeat episodes of re-ablement, and the overall pattern of homecare and re-ablement use. Table 3.2 below shows that a relatively small proportion of service users had more than one episode of re-ablement in the two years examined in the study. Leicestershire, perhaps not surprisingly as the largest and most well established service, had the highest proportion with just under seven per cent of service users having two or more episodes of re-ablement.

Table 3.2 Number of episodes of re-ablement

Case study site	<i>Number of episodes of re-ablement</i>		
	1 episode	2 episodes	3 or more episodes
Salford	405	19	0
Wirral	Data not available		
Leicestershire	1395	95	15
Sutton	538	26	2

Table 3.3 shows the overall pattern of homecare and re-ablement service use, with service users being divided into four broad groups as follows:

- Those who only had re-ablement and no homecare before or after.
- Those who had no homecare before re-ablement, then re-ablement, followed by homecare at some point in the following 24 months.
- Those who had homecare prior to re-ablement and then had homecare again at some point in the following 24 months.
- Those who had homecare prior to re-ablement but no homecare after re-ablement.

Table 3.3 Overall pattern of homecare and re-ablement service use

Case study site	Re-ablement only	Re-ablement followed by homecare	Homecare then re-ablement followed by homecare	Homecare then re-ablement only
Salford	184 (45%)	165 (41%)	45 (11%)	9 (2%)
Wirral	120 (87%)	15 (11%)	3 (2%)	0 (0%)
Leicestershire	491 (36%)	612 (45%)	205 (15%)	55 (4%)
Sutton	176 (33%)	236 (44%)	110 (20%)	16 (3%)

Note: These figures exclude those service users who had more than one episode of re-ablement, and those who were recorded as having a period of re-ablement of more than six months, but include service users who died or went into long term residential care.

In Salford, Leicestershire and Sutton between a third and a half of service users had re-ablement only, with Wirral having by far the highest percentage of users who had re-ablement only. This may be because, in 2004-05 the WEDS service was very selective, only accepting service users who had been assessed by a hospital OT, and this may mean that the 'mix' of service users is significantly different to the other study sites. The percentage of service users (again with the exception of Wirral) who had re-ablement followed by homecare at some point in the following two years was remarkably consistent across the sites, at just over 40 per cent. Interestingly, the two most mature re-ablement services (Leicestershire and Sutton) had a greater proportion of service users who had had homecare before re-ablement, which again may reflect a greater understanding amongst referring practitioners of who may benefit from re-ablement.

3.2.2 Time from re-ablement to first episode of homecare

The data provided by the sites enabled us to examine when those service users who had homecare at some point after re-ablement had their first episode of homecare. Table 3.4 below shows that, with the exception of Wirral where the numbers are very small, the majority of service users who had homecare had their first episode within one week of leaving re-ablement.

Table 3.4 Users commencing homecare within seven days of re-ablement

Case study site	Users who had homecare after re-ablement	Users who commenced homecare within seven days of re-ablement
Salford	210	127 (60%)
Wirral	18	8 (44%)
Leicestershire	817	630 (77%)
Sutton	346	278 (80%)

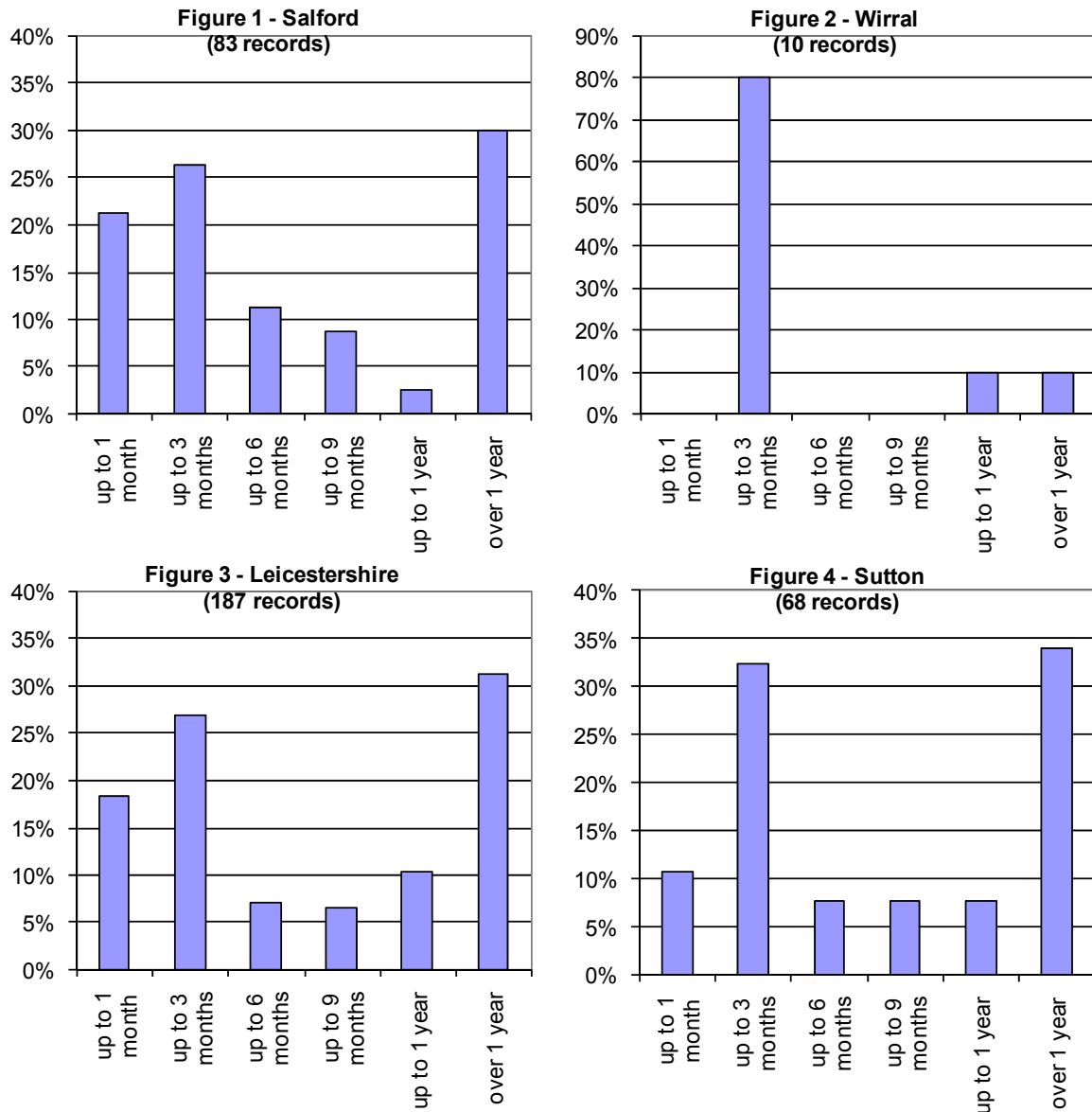
Note: The percentages given in brackets show the proportion of service users having homecare after re-ablement who had their first episode within seven days.

However, Figures 1 to 4 below show that, for those service users who begin homecare at a later point (i.e. more than seven days) after re-ablement, an interesting pattern emerges. In Salford, Leicestershire and Sutton there are two 'peaks' in the take up of homecare – at the 'up to three months' point and at the 'over one year' point. In terms of the longer term impact of re-ablement this may suggest that service users fall into two broad groups, those who gain immediate but relatively short term benefit from re-ablement, which avoids the need for homecare services for a period of a few months, and a second group for whom the impact is more sustained, and which delays their need for homecare by a year or more.

It is perhaps important to note that all the sites had experienced periodic difficulties in moving people on to homecare due to capacity issues amongst independent homecare providers. Whilst this may contribute to the peak at the 'up to one month' point and to a lesser extent the peak at 'up to three months', it is unlikely to account for the overall pattern.

In terms of the second group, it is possible that the peak at 'over one year' is in part influenced by those service users receiving another service provided or commissioned by social services (e.g. day care) being subject to the review process. However, again it seems unlikely that this would account for the trend, as many service users receiving 'minor' services such as meals on wheels, will not have a regular review.

Figures 1 to 4 Time to first episode of homecare



3.2.3 Change in homecare usage after re-ablement

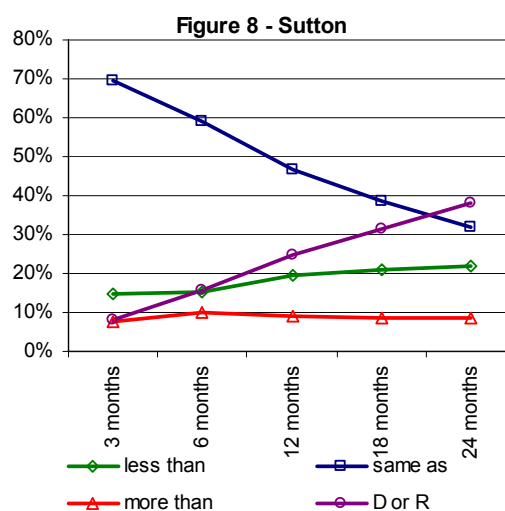
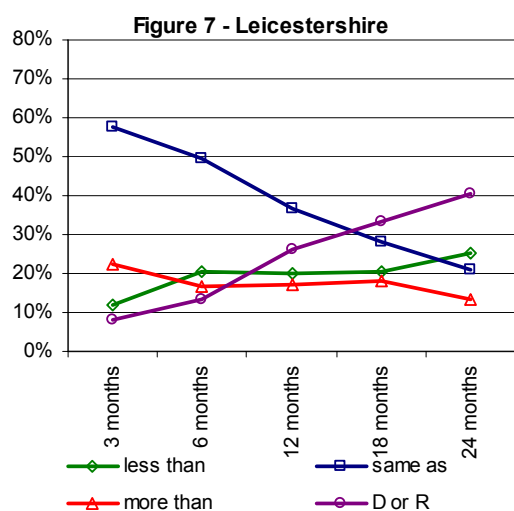
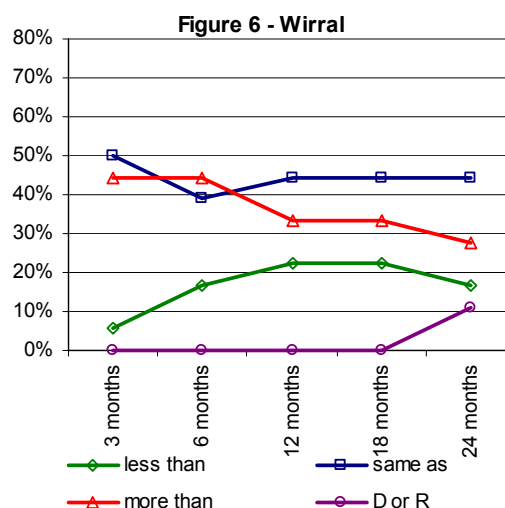
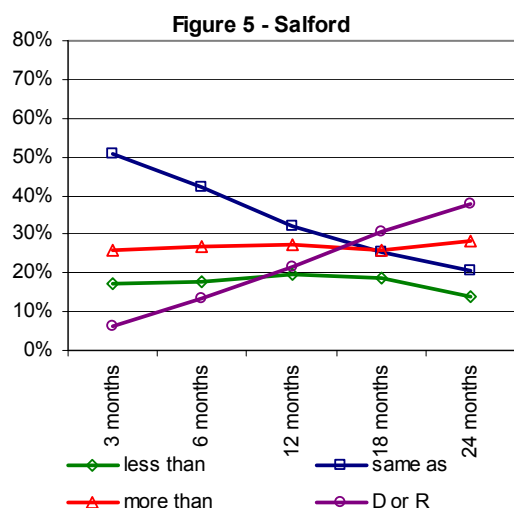
In this analysis, we have examined the change in homecare usage in the two years following re-ablement. In particular, we have looked at the proportion of service users who have: a) continued with the same level of homecare, b) increased their use of homecare, or c) reduced their use of homecare at the snapshot points of 3, 6, 12, 18 and 24 months after re-ablement.

Clearly a number of factors will influence each person's need for homecare services. Unfortunately, individual level analysis was not possible for this study, and so we have assumed that age, and previous use of homecare services (i.e. prior to re-ablement) may provide a crude proxy for level of need. For this reason we analysed the data in two ways - by age groups, and by those who did/did not have homecare

prior to re-ablement. However the pattern for those who did/did not have homecare prior to re-ablement was largely the same as that for all users and so has not been presented separately.

Figures 5 to 8 below show the change in homecare usage for all service users in the four areas. The pattern for Leicestershire and Sutton is broadly similar, with the percentage of service users needing less homecare than they did on leaving re-ablement actually increasing over the two years. In Salford, the percentage of service users needing less homecare than they did on leaving re-ablement does fall after 18 months but the percentage of service users needing progressively more homecare is only slightly higher at the end of the two year period. The picture for Wirral is very different, but here again there appears to be a significant change at the 18 month point.

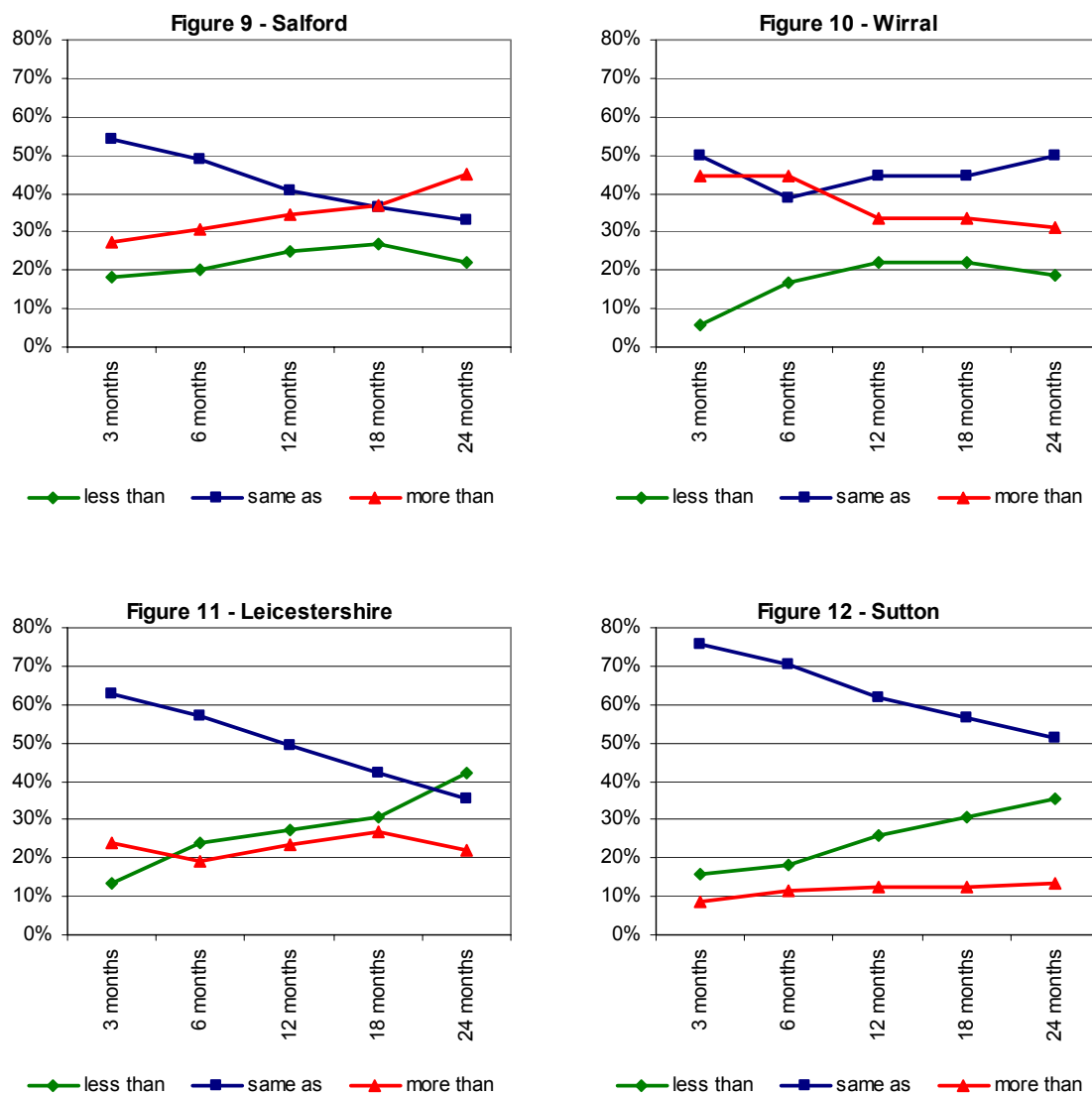
Figures 5 to 8 Change in homecare usage after re-ablement for all service users



Note: D = died; R = Entered permanent residential care

If the figures at each snapshot point are adjusted to exclude those who have died or entered permanent residential care, the change in the pattern of homecare use for the remaining cohort of service users appears to be even more marked, as Figures 9 to 12 below show.

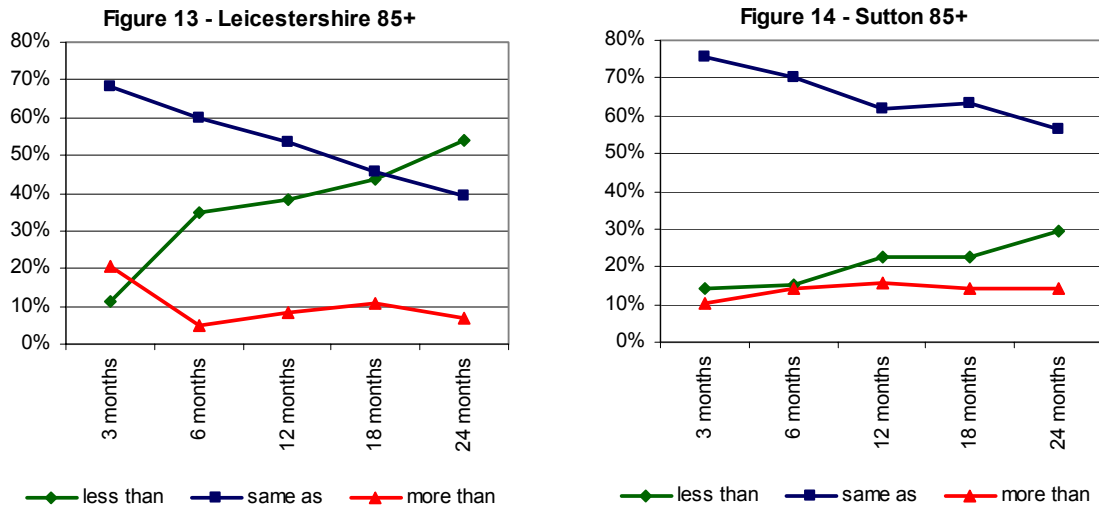
Figures 9 to 12 Change in homecare usage after re-ablement adjusted for death or entry to long term care



When we examined the data by age group, the pattern of change for the 85 years and over age group in Leicestershire and Sutton appeared contrary to what might be expected for this older age group (see Figures 13 and 14 below). In both sites, the percentage of service users requiring less homecare than when they left re-ablement actually rose significantly over the two year period, starting at just over ten per cent in both sites, and ending on over 50 per cent for Leicestershire and around 30 per cent for Sutton. This cannot be accounted for by people dying or going into residential care, as the figures at each snapshot point exclude these people. However, clearly there could be an element of 'the survival of the fittest' which,

linking back to the analysis of time from re-ablement to the first episode of homecare (see section 3.2.2), might suggest that for some service users, including very elderly users, the skills and attitudes gained through re-ablement help to sustain them for a relatively long period.

Figures 13 and 14 Change in homecare usage after re-ablement in the over 85 age group



3.2.4 Intensity of homecare usage after re-ablement

The analysis presented here examines the intensity of homecare usage (in a week) at the snapshot points of 3, 6, 12, 18 and 24 months after re-ablement (for all service users who had one episode of re-ablement). We have used the hours of homecare 'categories' used in the HH1 returns⁹ which all CASSRs are required to submit to group the data provided by the sites. The categories are:

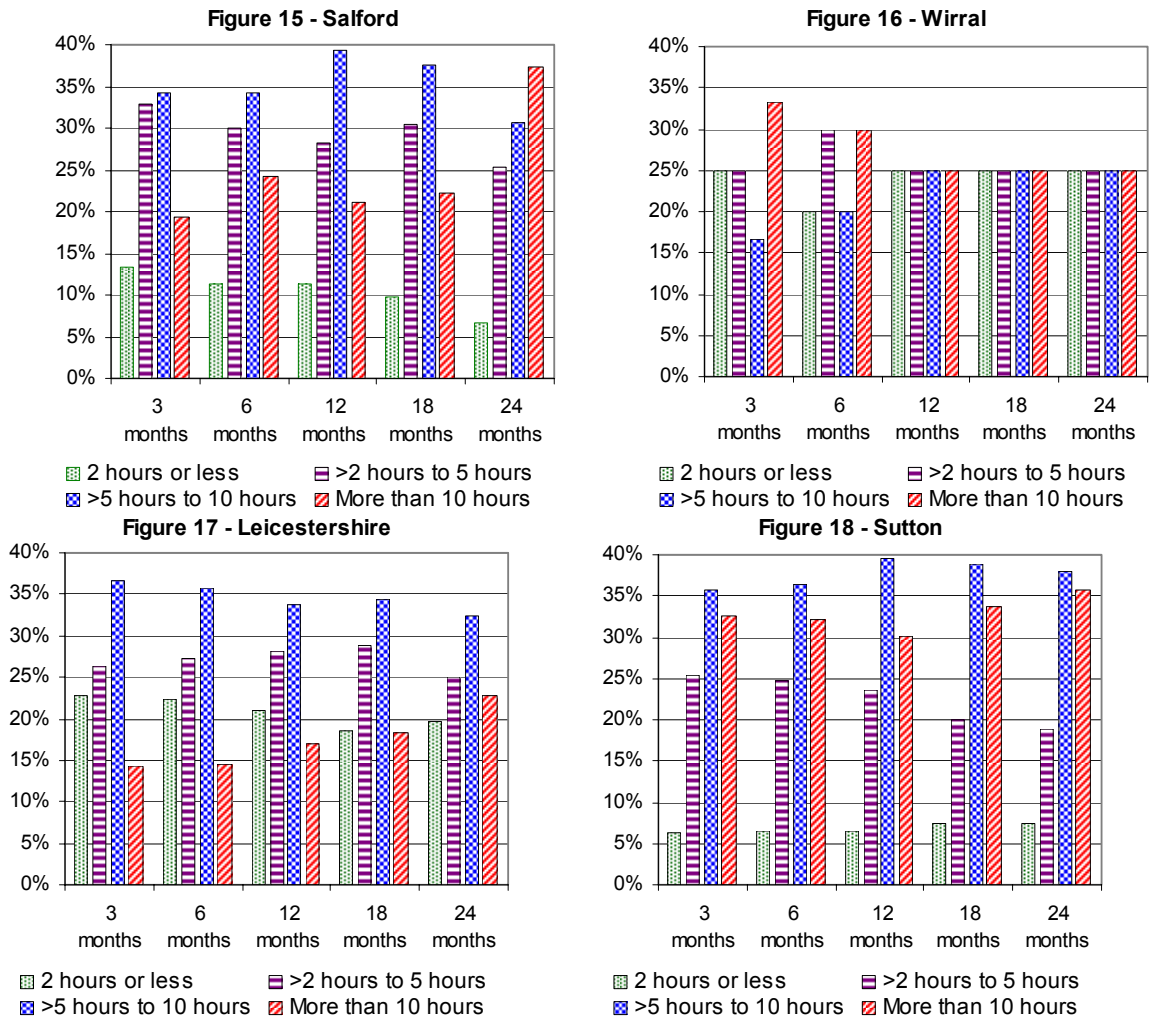
- two hours or less
- more than two hours, up to and including five hours
- more than five hours, up to and including ten hours
- more than ten hours.

Figures 15 to 18 below present the results for all service users, across the four sites. Interestingly, there do not appear to be any marked changes in the proportions of service users in each of the intensity of homecare usage categories, at the different snapshot points. Given that the data from each site relates to a cohort of users' progress over two years, it is perhaps surprising that the proportion of service users

⁹ Note: The HH1 Statistical Report presents information provided by CASSRs relating to homecare services purchased or provided during a sample week (details are collected on the number of homecare contact hours provided by each sector and the number of households receiving services; homecare is defined as services that assist the client to function as independently as possible and/or continue to live in their own home; direct payments are excluded from the HH1 return).

in the higher intensity categories does not increase more markedly. When the patterns for the different sites are compared, Leicestershire stands out as having the smallest proportion of service users in the ‘over ten hours’ category.

Figures 15 to 18 Intensity of homecare usage



3.2.5 Take-up of meals on wheels after re-ablement

We also examined the number of service users who had meals on wheels at some point in the two years after re-ablement. For Leicestershire and Sutton around a quarter of service users had meals on wheels but for Salford and Wirral the figure was much lower at just under ten per cent.

3.3 Perceived impact of re-ablement services on the demand for social care services

In their interviews, the team managers across all four sites believed the re-ablement services had the result of reducing demand for social care. This was generally evidenced at an anecdotal level, based on their own observations, and positive feedback from social workers, service users and carers. Many found it was difficult to quantify the impact on demand or any financial benefits because: there were so many variable factors; information had not been gathered systematically for this purpose; and/or they were unable to provide evidenced comparisons with service users who had not experienced re-ablement. An exception was Leicestershire, who had independently evaluated their pilot re-ablement service, and expanded it on the basis of the immediate benefits that were demonstrated.

All team managers were of the view that the re-ablement service generally reduced packages of care (compared to the package which might have been expected without re-ablement), and some stated that this was 'significant'. They were also of the view that, even where there was a small reduction, this was still important – they felt that all service users should be able to benefit from re-ablement, and it should not just be targeted at those who were perceived to benefit the most, or to provide the biggest savings. The team managers provided a number of general and specific examples where they believed the re-ablement services had reduced the level or intensity of social care support required:

- **Avoiding residential care admissions:** An example was provided where a woman was being discharged from hospital. It was the view of health care staff that she could not manage independently and would require residential care. At her insistence, the woman was discharged home with the support of the re-ablement service. Initially she deteriorated due to the adjustment, but over a short time period regained her independence. Prior to hospitalisation, the woman had privately purchased support from an independent sector homecare provider; she and her family commented that there was 'no comparison' in terms of the level and quality of the support and the impact the re-ablement service had in increasing her independence/avoiding a residential placement.
- **Promoting a sense of well-being:** Team managers all commented on the wider benefits of the service in promoting a sense of well-being and confidence, which could have an impact in all realms of the individual's life, and also have a preventive function in reducing risks. One team manager pointed out what she felt were the longer term benefits for the individual which could in turn have an impact on service demand. For example, where the skills gained during re-ablement could be drawn on as a 'bank' of knowledge if another episode of ill

health was experienced. She felt this was not just on a practical level but also on a psychological level. As she put it – *'I've done it before, so I can do it again'*.

Team managers felt that the regular re-assessment/review element of the re-ablement service had a direct impact on the demand for social care services (especially where people were discharged from hospital and were not yet in a stable state), because the care package could be adjusted down. This was compared with service users who did not experience re-ablement, and where a package was commissioned from the independent sector at the initial perceived level of need. Managers commented that under present contracting arrangements there was no incentive for independent providers to promote independence/adjust packages down because it was not in their financial interests.

However, instances were cited where social workers felt the re-ablement service had provided or recommended a package of care that was too large (or larger than they could have routinely commissioned). The social workers were concerned that this could risk 'disabling' service users or lead to unrealistically high expectations of what could be provided on an ongoing basis. In areas where this was an issue, the team managers thought that this was a matter of culture and awareness – sometimes a bigger package is initially needed because more time is required to do things 'with' rather than 'for' people.

Chapter 4 Factors influencing the impact of re-ablement services

The interviews with re-ablement service managers and care management team managers highlighted a number of factors which they felt affected (positively and negatively) both the longer term impact of re-ablement, and the effectiveness of re-ablement services. This chapter describes how these factors influenced the impact of re-ablement services and where appropriate suggests how services may need to change to address them.

4.1 Factors affecting the longer term impact of re-ablement

We asked contributors to comment on the issues which they felt affected both the overall impact of re-ablement on clients, and the duration or sustainability of that impact. Whilst the emphasis placed on different factors sometimes varied between the four sites, the themes were common and clear.

4.1.1 Independent providers – culture and contracting arrangements

Managers from all four sites reported that often when a service user moves from re-ablement to an on-going package of care provided by an independent care provider, they revert to having tasks done for them rather than being supported to undertake tasks themselves. As a result the level of independence they have achieved may not be maintained. A number of factors were seen as contributing to this:

- The culture or ethos of most independent providers does not encourage re-ablement and so the way packages of care are delivered does not promote/maintain independence.
- Most staff working for independent care providers have not had specific training in re-ablement and many may not have reached NVQ Level 2, which does have a promoting independence element.
- Often the package of care commissioned does not allow time for staff to take a re-ablement approach, and so they simply have to 'go in and get the task done'. This situation can be made worse where staff are not paid for travel time.
- Contracting systems do not allow for a flexible approach. In particular, there is little scope to vary hours to reflect fluctuations in service users' needs.
- Sometimes packages of care are set for long periods, and are not adjusted or reviewed frequently enough to take account of significant improvements or reductions in service users' functioning.

There was recognition that if independent providers are to be encouraged to adopt a re-ablement ethos, authorities need to move to a contracting approach that is less task orientated and more outcomes focused. There was also a view that there

should be less pressure to commission minimum packages of care, and more emphasis on reviewing packages more frequently if necessary. A number of managers described the steps their authorities had been taking to address these issues. One had introduced a new contract for service users with fluctuating health needs which allowed 'spare hours' to be used flexibly without a client needing to be reassessed; another had changed the service specification used with independent providers and had introduced a handover period with independent homecare providers to ensure that they had a clear picture of what was expected of them. Another was training its staff in outcomes based commissioning and one authority had also made its in-house training available free of charge to staff from independent sector providers.

4.1.2 The re-ablement package – duration and flexibility

All four re-ablement services in the study said the duration of their service was normally six weeks, but with some flexibility to meet individual needs or to cope with delays in moving people on to on-going packages of care. Several contributors felt that the flexibility that homecare re-ablement services have to respond to people's needs was important in ensuring that people left re-ablement with a good chance of maintaining their level of independence. This flexibility or '*personalised approach*' as one contributor described it, included speedy access to equipment (including complex equipment) and adaptations so that people could progress quickly but also the capacity to remove equipment or reduce the level of service, so that people did not become dependent. However, some contributors also raised concerns about the pressure to limit re-ablement to six weeks. They felt that some service users need a longer period of re-ablement in order to regain their skills and confidence, and to ensure that the effects of re-ablement are sustainable.

4.1.3 Service users – understanding and attitudes

The outlook and attitude of the service users themselves was seen as very important in maximising and then maintaining the impact of re-ablement. Many contributors emphasised the importance of service users, from the outset, understanding what the re-ablement service did and what would be expected of them. This is discussed in more depth in 4.2 below. In particular, the service users' desire to regain and/or maintain skills was crucial. However, a number of contributors noted that service users' attitudes can be significantly affected by the attitudes of their carer/family, especially in relation to risk, and this is discussed further below. The approach of the re-ablement staff is also crucial in building confidence and creating a 'can do' attitude in users. A number of the care management team managers interviewed commented on the motivational skills of re-ablement staff and their strong commitment to helping people regain as much of their independence as possible, which they felt differed from that of most staff in both in-house and independent homecare services. Not surprisingly, service users' social circumstances also affect their attitude to services, with contributors noting that users who are isolated or lonely may be able to undertake a task themselves but want a regular homecare service because the visits provide social contact. The availability of suitable housing was also an issue in two of the case study areas. For example, even when service users recognised that they needed to move to a different type of housing (e.g. supported housing, or an accessible bungalow) a limited supply of such housing may make it difficult for them to move - or at least move quickly.

4.1.4 Carers - perceptions of risk and the need for on-going support

Carers clearly play a crucial role in both the re-ablement process and the longer term impact of re-ablement. There was a strong view that if carers can be engaged and supported both during re-ablement and as part of any on-going package of care there was a much greater chance of the effects of re-ablement being maintained in the longer term. Clearly practical support for carers is very important, but several contributors noted the value of working with carers, especially non-resident carers, to agree acceptable levels of risk and to accept that telecare systems can provide an appropriate alternative to pop-in/monitoring visits. There were mixed views about whether re-ablement staff should undertake or be involved in carers' assessments. Either way, there was a consensus that re-ablement services have a key role in ensuring that on-going support for carers is put in place at the end of the service user's package of re-ablement, and that this support can be a significant factor in ensuring that the effects of re-ablement are sustainable.

4.1.5 Signposting to other services and support

An interesting facet of all four re-ablement services was the scope they felt they had to link service users into community and non-social services department services, which could help improve their quality of life and so maintain their independence. However, the emphasis placed on this varied between the sites. One site in particular saw re-ablement as an 'holistic activity' which linked people into community activities rather than focusing more narrowly on personal care in the home. The services that people were put in touch with ranged from semi-formal referrals to activities and services run by voluntary organisations or other government agencies (e.g. Skills Centre for younger adults), to providing information about a local mobile hairdresser or promoting the use of the internet. Several contributors noted that this was something encouraged in their re-ablement service, and staff regularly exchanged information about useful services/activities.

4.1.6 Culture of re-ablement across social care services

Several contributors spoke about the importance of establishing a 're-ablement culture' across all social care (and related) services, so that once someone leaves re-ablement there is a continued emphasis on the service user's ability to maintain or even improve their skills and confidence. As well as mainstream homecare services, day services and transport were highlighted. In particular, it was suggested that day services should not be seen as necessarily a long term service but an opportunity to enable people to move on to mainstream community activities, if possible.

4.2 The effectiveness of re-ablement services

The interviews with re-ablement service managers and care management team managers highlighted a number of factors which potentially can influence the effectiveness of re-ablement services. Whilst these may not directly affect the longer term impact of re-ablement, it is perhaps valuable to note them in this report, as clearly an effective service provides the foundation for achieving longer term impact.

- **Quality of assessment:** Although the referral routes for the four re-ablement services in the study varied, some contributors said that poor quality or incomplete/inaccurate assessments prior to re-ablement wasted time and hindered the re-ablement team's ability to put together an appropriate package of re-ablement quickly. One site expressed concern about multiple assessments and the implications this had for staff time and service users. However, other contributors noted that whatever assessment the service user had had prior to re-ablement, they would carry out their own assessment to ensure that the right re-ablement package was put in place. One 'intake' service mentioned the difficulties that can arise in terms of responding quickly to referrals, where re-ablement managers are both managing staff and undertaking assessments, and/or where re-ablement assessors are not available at the weekend (e.g. following a Friday discharge from hospital).
- **Flexibility:** All four sites highlighted the importance of being able to work very flexibly with clients, not only in terms of what they did, but also the frequency of reviews and (within limits) the duration of the service offered. They felt this led to their services being more personalised and more effective.
- **Skill mix:** There were differing views about the most effective skill mix for a re-ablement service, and in particular the value of having occupational therapists (OTs) within the team. Some contributors felt that OT involvement might lead to a more 'medical model' approach, and were concerned that health professionals in general were more 'risk averse', which might lead to an over-cautious approach to some service users. By contrast, the one site in which OTs were integral to the service felt extremely positive about their involvement. They felt it enabled them to gain very quick access to equipment and adaptations for service users, and working alongside OTs had helped re-ablement staff to develop valuable OT assistant-type skills.
- **Staff attitudes and skills:** Many contributors highlighted the commitment, attitude and skill of re-ablement staff. One site highlighted the benefit of recruiting staff specifically for the re-ablement service, rather than transferring staff from existing homecare services, as they felt this helped to ensure staff really wanted to work to a 're-ablement approach'. However, others had focused on retraining

existing homecare staff and emphasised how important this training was in changing attitudes and culture. In terms of staff training, several contributors said that their aim was for all staff to have achieved, or be working towards, NVQ Level 2. However, many contributors again noted that attitude was key, speaking very positively about the enthusiasm and commitment to improving people's independence that re-ablement staff had.

- **Capacity and throughput:** Several contributors highlighted the problem of capacity within the re-ablement service. This related to both entry into the re-ablement service, and the need to ensure that service users who need an on-going package can be referred on and assessed quickly, so that the re-ablement service does not become 'silted up'. In three of the four sites, difficulties and delays when clients were referred on had led to some service users remaining in re-ablement for much longer than required, or even having a gap between re-ablement and their on-going package of care being put in place.
- **Relationships with other teams and services:** Not surprisingly, the working relationship between the re-ablement service and other social care/health teams and services was seen as an important factor in ensuring that re-ablement services can operate effectively. Contributors stressed the importance of those referring to the re-ablement service understanding what the re-ablement service could offer and so making appropriate referrals. In part, this related to avoiding inappropriate referrals (e.g. people who ideally needed a period of convalescence before they could fully benefit from re-ablement), but there was also a strong view that some people (e.g. people with dementia) who potentially could benefit from re-ablement were not being referred. There was also concern that sometimes practitioners encouraged people to accept the service because it was 'free for six weeks', without explaining what would be expected of the service user, and so people did not start the service with the 'right attitude' to benefit from re-ablement.
- **Carer involvement:** As was noted in section 4.1.4, the relationship between the re-ablement staff and the carer and/or family of the service user was seen as crucial to ensuring the effective delivery of re-ablement services. In particular, contributors noted that staff needed time to work flexibly with both the service user and the carer. This time was needed to build up understanding so that issues such as perceptions of risk could be dealt with appropriately, and on-going monitoring or 'pop-in' visits reduced or ceased.

Chapter 5 Conclusions and key findings

Clearly, without robust/detailed baseline data, and a control group for comparison, it is impossible to know whether the patterns of service usage seen in the data from the four case study sites are directly and predominantly the result of re-ablement. However, a number of interesting possible effects have emerged which are worthy of consideration, and further examination, should a more robust evaluation of the longer term effects of re-ablement be commissioned. Certainly the patterns of service usage for Leicestershire and Sutton, the two longest established re-ablement services, are remarkably similar, despite the fact that Leicestershire is an 'intake' service, and the Sutton service has a focus on 'discharge support'. Both the age profile of their service users (i.e. a higher proportion in the 85 years and over age group) and the proportion of service users who had homecare prior to re-ablement suggest that the level of understanding of re-ablement amongst referring practitioners may be significant.

The analysis of time from re-ablement to first homecare episode highlights the possibility that re-ablement service users fall in to two broad groups, those who gain immediate but relatively short term (around three months) benefit from re-ablement, and those for whom the impact is more sustained, possibly delaying their need for homecare by a year or more. This is clearly an important issue which would benefit from further examination. If it is a genuine effect of re-ablement it would be valuable to identify whether the service users in each group share any common characteristics, and whether they benefit from different approaches to, and durations of, re-ablement.

The picture provided by the data of change in homecare usage over the two years after re-ablement appears very positive. In Leicestershire and Sutton, the percentages of service users needing less homecare than they did on leaving re-ablement actually increased over the two years, including for the 85 years and over age group. In Salford the percentages of service users needing progressively more homecare did increase over the two year period but only slightly.

In terms of the intensity of use of homecare, there do not appear to be any marked changes in the proportions of service users in each of the HH1 intensity of homecare usage categories, at the different snapshot points over the two years. This, and the smaller proportion of service users in the 'over 10 hours' category in Leicestershire, suggest that intensity of homecare use over a prolonged period might be a valuable issue for CASSRs running re-ablement services to monitor, and an important effect to be examined in any future research into the longer term impact of re-ablement.

The staff interviewed across all four sites were of the view that their re-ablement service had the effect of reducing demand for on-going social care support. This was

not just related to improving people's physical functioning and ability to manage practical tasks in the home; staff also stressed the importance of building people's confidence and a sense of well-being, which could have a far-reaching impact on many aspects of their lives.

Staff also identified several environmental and circumstantial factors which had an impact on whether the benefits of the re-ablement service would be sustained. For example:

- Access to appropriate housing
- Access to equipment, assistive technology and telecare
- Access to, and information about, wider social and community support
- Charging and people's ability/willingness to pay for ongoing support.

In addition, carer involvement, carers' attitudes to re-ablement, and their access to ongoing support was considered a key factor.

Where people required ongoing homecare support following re-ablement, this was often provided by the independent sector. Staff were concerned that current arrangements could undermine the benefits of re-ablement, including:

- Inflexible contracts which made it difficult to provide flexible hours as required.
- Funding arrangements which did not provide any incentive for providers to identify the need for reduced hours, where an individual's level of independence continued to improve.
- A culture (reinforced by contractual arrangements) concerned with inputs rather than outcomes.
- Staff not necessarily trained with a re-ablement ethos.

5.1 Key lessons for CASSRs establishing re-ablement services

The four sites differed in their history and operation, and the results of the data analysis give no indication of a 'blueprint' for a successful re-ablement homecare service. However, some of the key 'lessons learned' shared by sites were:

- **Training:** Staff training in the re-ablement philosophy is key. This is particularly important where staff cannot be recruited and are transferring from existing homecare services.
- **Communicating the re-ablement ethos:** The service should communicate its re-ablement ethos clearly to staff, other agencies, service users and carers. This enables effective referral and ensures people understand the short-term, goal-oriented nature of the service.

- **Capacity:** Capacity needs to be carefully considered, to ensure access to re-ablement, *and* the ability to refer on for ongoing homecare support, so that the re-ablement service does not get blocked.
- **Flexibility:** A strict number of weeks of re-ablement should not be adhered to; the service, whilst time limited, should be flexible according to individual need.
- **Access:** Access should be as wide as possible. Several re-ablement service managers and team managers commented on the value of assisting people with small changes and the need to avoid focussing on those who will most obviously benefit. Indeed, those sites interviewed who operated on a selective basis were all aiming to move towards a more open 'intake' approach.
- **Relationship to other professionals:** The sites varied in their relationship to, and location with, other professionals (such as occupational therapists), and had different views about what was desirable. However, effective relationships and the ability to make swift referrals were of obvious importance.
- **Relationship with carers:** Re-ablement staff need time to work with carers in order to build up understanding so that issues such as perceptions of risk can be dealt with appropriately.
- **Role in assessment/review:** The sites varied in terms of staff's role and relationship to assessment and review, and some experienced tensions around this. Discussions with the sites highlighted the need for clarity of role, and the importance of the re-ablement service in undertaking regular reviews.
- **A 'whole systems' approach:** Whilst none of the sites said they had achieved a whole systems 're-ablement' culture, they all in some way regarded this as an important area of development so that this approach could be sustained on a multi-professional and cross-agency basis. In particular, they stressed the importance of independent homecare providers being able to at least sustain the gains achieved for individuals by re-ablement. They felt that this would need to be addressed through commissioning/contracting arrangements, including working with independent sector providers to increase the flexibility and skills of homecare staff, and in some areas to improve capacity of the sector as a whole.