



Step by Step Guide to Home Care Re-ablement

1 November 2010

What is Home Care Re-ablement?

Home Care Re-ablement uses the interpersonal skills of home carers along with other professionals such as Occupational Therapists and their managers, to provide better outcomes for service users. Goal setting is used to support the service user to learn or relearn daily living skills and thus maximise their independence. The key elements of Home Care Re-ablement are:

- Providing public information about Home Care Re-ablement
- Assessing for improved outcomes with individual service users
- Formulating the package of care around goals set with the service user
- Including unpaid carers as partners in the process
- Providing Home Care Re-ablement for up to 6 weeks
- Utilising home carers' interpersonal skills
- Providing additional training for home carers on Home Care Re-ablement
- Home Carers recording daily progress
- Home Carers linking to Occupational Therapists for expert advice
- Using team meetings to consider the progress on goals each service user has made
- Adjusting the package of care on a daily/ weekly basis
- Providing monitoring information for the Care Manager undertaking review
- Deciding on long term package of care
- Ensuring high standard for handover to long term provision of care at home

The key messages of Home Care Re-ablement are:

- The approach changes the culture of home care from 'task and time' to 'better outcomes'
- 'Doing with' service users rather than 'doing to' or 'doing for' service users
- Maximises service users long-term independence and quality of life
- Appropriately minimises ongoing support required and, thereby, minimise the whole life-cost of care

- Service users making the most of their lives

Why do it?

- Prioritising the personalisation agenda requires consideration of the service users' needs with a greater focus on preventative approaches to promote independence and wellbeing .
- The number of older people continues to grow and this, combined with pressure on limited local authority budgets, requires a reshaping of care to do more with the same resources.
- Shifting the balance of care requires approaches that can maximise independence and enable people to develop the skills to remain safely in their own home.
- Home Care Re-ablement provision in England and Scotland has accumulated compelling evidence indicating that the approach improves confidence, motivation, empowerment, choice and maximises independence for service users. In addition, because service users need less care hours at the end of re-ablement than they would have received from a traditional home care service, the care hours available can be used to meet the demand for home care from an increasing number of older people.
- This approach indicates an effective and efficient use of limited local authority/ partnership resources.
- Home Care Re-ablement represents added value where this is provided by local authority in house service.
- Key research about Home Care Re-ablement is available from :
 - [Care Services Efficiency Delivery Programme](#)
 - [Joint Improvement Team and RP&M Associates](#)
 - [University of York - Social Policy and Research Unit](#)

What is the Step by Step Process to Introduce Home Care Re-ablement?

A process of preparation, stakeholder involvement, data analysis, policy evaluation and visioning along with option appraisal and decision making will be required prior to commissioning a Home Care Re-ablement Service. The following steps assume that a policy decision has been made to redesign services to provide a Home Care Re-ablement Service. This covers the planning of the redesign, engagement and

communication, implementing change, providing the service, preparing handover arrangements and tracking progress made. Some of this may have taken place during the preparation to decision making stages but will require confirmation and further development.

There is no single right approach to implementing Home Care Re-ablement and redesign will be subject to optimising existing strengths and partnership agreements within localities. The steps below provide an example of one approach that has been used to develop Home Care Re-ablement:

Preparation - Visioning and Policy Decision

- Establish a Scrutiny Group made up of service user representative stakeholder groups e.g. including representatives from the older peoples' forum
- Undertake an Equalities Impact Assessment
- Develop Home Care Re-ablement as part of the vision for modernising home care
- Agree Home Care Re-ablement as a policy decision for the Council/ Partnership

Preparation - Planning the Implementation of Service Redesign

- Identify project leadership and resources to make the transition from existing service to remodelled service
- Communicate the vision to service users, their carers, staff, managers and other stakeholders including Trades Unions
- Benchmark with other authorities

Data collection and analysis

- Identify the numbers of service users referred from hospital and community to receive a home care service
- Identify demographic changes and how this impacts on capacity

- Develop a staff plan to ensure that the capacity of the Home Care Re-ablement Teams is sufficient including consideration of rural requirements
- Consider the use, role and capacity of Occupational Therapists as part of the team
- Develop a financial framework to identify costs and project the benefits from re-ablement
- Undertake a risk analysis including financial element
- Set up tracking arrangements to report on the impact of Home Care Re-ablement
- Review processes from referral to Home Care Re-ablement and then, where required, long term provision
- Set up processes and paperwork for referrals, assessment, goal setting, monitoring progress, team meetings, adjusting number of care hours, reviews, decision making and handover
- Develop public information leaflet

Implementing Change

- Communicate with existing service users about potential change of their current home carers
- Develop a quality checklist to reduce the impact of change for existing service users
- Seek expressions of interest from existing staff group to be part of the Home Care Re-ablement Teams
- Interview and select staff
- Re-provision existing home care service for service users where staff are moving to Home Care Re-ablement Service
- Link to Providers to prepare for re-provisioning
- Ensure all stakeholders are aware of the processes from referral to review decision
- Provide training for home carers

Providing the Service

- Provide public information leaflet
- Receive and process referrals quickly
- Initial visit to confirm goals with the service user and their carer/ family
- Record progress on daily progress sheet with service user and carer
- Team meeting on weekly basis including Home Carers, Managers and Occupational Therapist to consider progress service user has made and adjusting package of care accordingly
- Input changes to client management IT system to be available for care management

Reviewing the Service

- Feedback progress to the person with the care management responsibility for the service user
- The care manager will decide on long term home care provision based on feedback from Home Care Re-ablement Service
- Where long term home care provision is required, this will be arranged by the care manager
- Undertake satisfaction survey for all service users

Handover Arrangements

- Proper handover arrangements should be included in contracts with Providers
- Arrange joint meeting with service user, information on progress made, shadowing, paperwork and continuation of functioning reached by service user

Track and Review Progress with Implementation

- Track referrals, status following referral, numbers of service users, hours at start and end, hours that increased, stayed the same, reduced or where nil service was decided

- Track Satisfaction Surveys and correspondence from service users and their family
- Track quarterly sustained impact of re-ablement
- Post implementation audit and review of implementation at 6 month point
- Standardise any divergence across the authority/ partnership

What options are there to develop Home Care Re-ablement?

- Home Care Re-ablement will require decisions on the direction that suits each local authority and their partners. This may include:
 - Having Home Care Re-ablement as a selective service with strict access criteria or open to all people who need a home care service
 - Building the service on either the in house Home Care Service, the Intermediate Care Service or Independent Providers
 - Deciding whether dedicated Occupational Therapists should be part of the team
 - Starting with the Talking Points outcomes approach within care management before, at same time, or after, Home Care Re-Ablement
 - Recruiting new staff or deploying existing staff

Training Home Carers for Home Care Re-ablement

- Occupational Therapists contribute to the training
- Managers should attend but in sufficiently small numbers as not to detract from the focus being for Home Carers
- The learning outcomes of Home Care Re-ablement training are to gain a knowledge and understanding of:
 - The reasons for modernisation of the Home Care service
 - The role of Home Care Re-ablement
 - Where to find information about Home Care Re-ablement
 - The Service User's perspective
 - Empowerment for Home Care Re-ablement
 - The range of skills required for Home Care Re-ablement
 - How goal setting works

- How activity analysis works and problem solving in Home Care Re-ablement
 - Techniques for assisting service users to participate in an activity
 - The importance of recording in Home Care Re-ablement
 - Communication skills for Home Care Re-ablement including special needs issues
 - How equipment and adaptations support the work of Home Care Re-ablement including Telecare
- A programme for Home Care Re-ablement requires two days training and includes within the content :
 - Arrival and Welcome
 - The Service User's Perspective - How would it feel to receive a home care service?
 - What is Empowerment?
 - Introduction to Home Care Re-ablement
 - Comparison Between Home Care Skills and Home Care Re-ablement Skills
 - Equipment and Adaptations and their role in Home Care Re-ablement
 - Communication Skills including Special Needs
 - Experiences of Service Users using video or case studies
 - Teamwork
 - Why Record? - Using Home Care Re-ablement Goal Planning Paperwork
 - Sticking to the Facts – Practical Exercise Using Home Care Re-ablement Goal Planning Paperwork
 - What might a service user need to enable them to participate in an activity?
 - Goal Setting
 - Activity Analysis - Problem Solving
 - Case Studies – Real Life Scenarios and Solutions
 - Telecare as an aid to Re-ablement
 - Key Messages of Home Care Re-ablement
 - Question and Answer Session involving Service Users and Managers
 - Course Evaluation

Where is Home Care Re-ablement Happening?

- Around 100 local authorities in England have developed Home Care Re-ablement. Information can be accessed from the Care Services Efficiency Delivery Programme (CSED)
- The City of Edinburgh Council has developed a Home Care Re-ablement Service with over 225 staff, including 8 occupational therapists, in 6 localities, providing a service to around 600 people every 6 weeks

- Stirling Council is in the first year of implementing a Home Care Re-ablement Service
- Midlothian Council is in the early stages of implementing their Home Care Re-ablement Service

Where can I find out more about Home Care Re-ablement?

- Additional information about Home Care Re-ablement is available from:
 - [Joint Improvement Team](#)
 - [Care Services Efficiency Delivery Programme](#)

What will the Joint Improvement Team do?

Within the learning network for care at home, the Joint Improvement Team will:

- Provide links between local authorities at various stages in their development of Home Care Re-ablement
- Undertake review, research and publication of progress by local authorities in implementing Home Care Re-ablement Services
- Make connections with other elements of the care at home workstream, for example, Talking Points outcomes approach, Telecare and integrated working with community nursing
- Collate tools that local authorities have found useful in the development of Home Care Re-ablement
- Publish case studies of Home Care Re-ablement
- In order to provide practical support to partnerships who are considering or who have started to redesign home care services, the Joint Improvement Team is arranging a series of regionally based 2 day workshops. The first workshops were held in Aberdeen (during April/ May 2010), these will be continuing in other regions over 2010
- Following the workshops, the Joint Improvement Team will be able to provide up to 2 days “on site” practical support to local “redesign” teams if required and further inputs may be available by negotiation. The Joint Improvement Team will also be setting up a web based Q+A forum.

- This programme will be led by Gerry Graham and Alex Davidson on behalf of the Joint Improvement Team and supported by Karl Zaczek (JIT Core Team).
- For any further information relating to this programme please contact Karl Zaczek either by email: karl.zaczek@scotland.gsi.gov.uk or telephone on 0131-244-3652

Gerry Graham

07788 951182

g.b.graham@btconnect.com