

Special Report) +



Re-ablement.

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CareKnowledge Special Report

Home Care Re-ablement

1. Introduction

In this Special Report, Gerald Pilkington* sets out his views on the central importance of home care re-ablement to the future development of social care services, and points to some of the wider policy and other changes which, he believes, mean that the time to maximise its service benefits is limited.

The report provides a definition of home care re-ablement, and a detailed description of some of its service components. It argues for a continued focus on services for people whose needs are primarily for social care support, rather than those associated with health interventions. It also offers some illustrative examples of what home care re-ablement can look like on the ground, and of the kind of improved individual outcomes to which it has been shown to lead, including pointers to some of the available evidence.

The report also looks at next stage developments – particularly the challenges posed by increasing health-side responsibilities for post-discharge support arrangements – and at the need for future services that ensure effective outcomes for users through fully realising the benefits of home care re-ablement, as Gerald sees them.

In some ways, social care is a fast developing but under-researched field, often dominated by prevailing policy concerns rather than evidenced practice. This can mean that innovative approaches are not fully investigated or given the time required to fully substantiate outcomes.

Whilst the underlying evidence for the overall effectiveness of home care reablement may therefore not be complete, it certainly merits considered attention as one of the options that may deliver better outcomes for individuals – and may be increasingly overlooked as focus swings more and more to services for those with health needs, and which respond to NHS priorities – and away from services for individuals whose core need is for social care support.

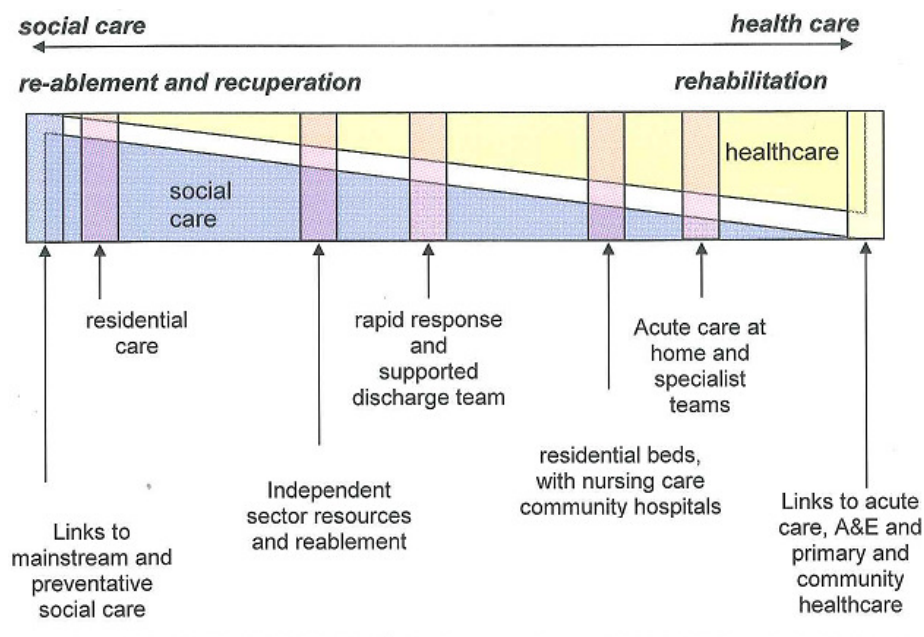
2. What is Home Care Re-ablement?

Many people will know about, or at least have heard of homecare re-ablement, albeit that, different titles may be used locally including enablement, re-enablement and even intermediate care. And, in recent years, government policy has increasingly incorporated

and adopted the principles of homecare re-ablement – although the latest focus is centred more on post hospital discharge support.¹

Homecare Re-ablement is a form of support provided in the home to help people to regain and maximise their independence. Although it falls within the broad scope of intermediate care, when considered as a function, it differs greatly from many of the intermediate care services we see around the country.

This is illustrated in a diagram used in the latest guidance issued by the Department of Health, England², to depict the scope of intermediate care as a function that links the two theoretical extremes, when a person has only health, or only social care needs.



The diagram recognises that, at any point in time, many people have a mix of health and social care needs and that many of the intermediate care services we see are actually serving people whose primary need is one of a medical / clinical nature, whilst re-ablement seeks to assist people whose need is primarily of a social support nature.

Commonly, people who qualify for intermediate care must have a medical / clinical need and not 'merely' a social care need, and the services are led by a clinician and adopt a clinical model of care. Thus, many people eligible for social care support would not qualify or be eligible for intermediate care services.

¹ NHS SUPPORT FOR SOCIAL CARE 2010/11 – 2012/13, letter 13 Jan 2011

² Intermediate Care – Halfway Home, Chap 5 page 10, Dept of Health, England, June 2009

It is true, however, to say that the two services complement each other by supporting

- different people and / or
- the same people but at different stages in their 'recovery'

Recognition of this difference is important and will become even more so as services seek to work with health partners under the current government policy on post-hospital discharge support.

3. Re-ablement and Post-hospital Discharge Support

Extensive funding has been made available in two broad tranches to create further capacity for re-ablement and to encourage both social care and health to work together. Further, it is currently intended that health, in the form of acute trusts, will take financial responsibility from April 2012 for ensuring that post-discharge support, including re-ablement and social care³, is provided during the first 30 days for many people. However, in this context re-ablement actually means:

- post-hospital discharge support for some but not all;
- re-ablement but not ongoing social care support;

and for those councils that are assuming or even relying on health to deliver re-ablement, they need to remember that

- approximately 50% of referrals to established homecare re-ablement services come from the community and not the NHS, and so these referrals will not fall within the responsibility of the NHS;
- the NHS has little if any experience of homecare re-ablement and so is likely to adopt an intermediate care model unless guided by councils through the local Health & Wellbeing Boards;
- the acute health sector's responsibility is to ensure that post discharge support is provided for up to 30 days and so councils may wish to ensure that appropriate decisions and support are given in those early days because they will impact on the nature and costs of longer term support that will fall to them;.
- most homecare re-ablement services support people for up to 6 or even 8 weeks, and so health's responsibility will only cover a portion of this phase.

³ NHS SUPPORT FOR SOCIAL CARE 2010/11 – 2012/13, letter 13 Jan 2011

4. Homecare Re-ablement in action

So, homecare re-ablement is appropriate when the primary need is one of social care / support rather than medical care and the service focuses on helping people to do as much as they can themselves, rather than relying on others. Evidence shows that timely bursts of social care re-ablement, focusing on skills for daily living, can enable people to live more independently and, in most cases, reduce their need for ongoing homecare support.

Historically, social care has sought to take over activities that a person is no longer able to undertake, thereby creating a dependency on others. Homecare re-ablement is about helping people 'to do' rather than 'doing to or for' them. Typically this service phase lasts for up to 6 weeks. A number of goals are agreed with the person (e.g. I want to be able to bathe myself, get to the shops, etc.) and these are broken down into stages which are then focused on, during the home care re-ablement phase.

Homecare re-ablement is more than just another service – it requires a shift in mindset and approach to a position where the default position should be to work with people in a time-limited and outcome-focused way to maximise their independence, minimise their need for ongoing care and explore how best to support any underlying needs.

The service starts by identifying personal outcomes with service users. These may be things that they used to be able to do or they may be completely new, but they focus on what is important to the service user. For instance, this may be to be able to cook a meal, regain mobility around the home or community or get themselves up, washed, fed and dressed. The identification process is undertaken through dialogue with the service user as well as observing them in their own home.

These targets are then broken down into stages which often include activities of daily living or instrumental activities of daily living, and these are further broken down into critical building blocks. The daily focus with the service user is on these basic building blocks that will often support more than one stage or target.

It is often the case that items of community equipment or telecare can assist the service user during their re-ablement phase and afterwards, and so it is important that these are considered at an early stage and throughout the intervention. In fact many services have trained their seniors / supervisors to be trusted assessors in line with the training approved by the College of Occupational Therapists, so that they can appropriately and speedily deal with aids to daily living.

Over the days and weeks the focus with the service user will change as these building blocks are put in place and as stages are completed. This results in the length of visit and potentially number of visits per day being reduced as the service user regains, or

gains, greater confidence and levels of competence. Some services have likened this to teaching a child to ride a bike. In the early days we hold the saddle and help them but as confidence and skill grows we hold on less tightly, followed by ever-growing periods when we observe and encourage.

Most services work with people referred for a homecare package both from the community and those discharged from hospital, with the proportions from both being more or less evenly split. However, a small number of services have decided to focus solely, or primarily, on people discharged from hospital because of the pressures to assist with discharges.

Whilst this may be important, it ignores the needs and potential of an equal number of people who pass straight to a conventional or maintenance package of homecare. For many councils, homecare re-ablement has become the default route unless there are clear indications that such a phase is not appropriate. Thus, a de-selective rather than a selective approach is adopted.

Most services operate for a period up to between 6 or 8 weeks and although there is little evidence to indicate that 6 or 8 weeks are the 'right' maximum durations, it is clear that

- an 'up to' approach is important because not everyone needs the full 6 or 8 weeks. In fact. A significant number will have completed their phase in 4 to 5 weeks. It also reaffirms the mindset that this is a short-term focused phase and towards the end an assessment will be completed of any ongoing underlying needs.
- some people may require slightly longer but this should be on an exceptions basis with clear expectation that additional progress is about to be achieved.

The ability to identify when people are nearing the end of their phase is very important and services need to develop their ability to manage service users out of the service rather than only focusing on getting them into service.

5. Why do it?

It is widely accepted that most people want to retain their independence for as long as possible and for any support required to be personalised to their needs. Homecare re-ablement meets both of these desires. However, we are also facing major issues in terms of both demographic change and financial pressures.

In recent years, demand for homecare has risen, partly as a result of demographic change and partly because of the policy to place care and support as close to home and

in the community as possible. Demographic trends also show that the number and proportion of people aged over 65, 75 and 85 will grow dramatically over coming years. Even if we had sufficient public funding we are unlikely to have sufficient care and support staff to fulfil the roles.

The number of people aged 65 years and over in England in 2010 was estimated at 8.6m or 16.5% of the total population, and the projected growth from that point is as follows ⁴:

	2015	2020	2025	2030
Over 65 Population (8.6m)	13%	23%	35%	51%
Over 75 population (4.2m)	10%	25%	50%	66%
Over 85 population (1.2m)	15%	36%	66%	101%

So, with the increasing demand for independence combined with trends in policy and demographics we have to find new ways of working.

Home care re-ablement offers the people, for whom it is appropriate, the prospect of intensive support over shorter periods of time, leading to a potentially much reduced need for dependence on services at other times. This is an important element as councils develop services that mirror the real needs and aspirations of service users and will enable them to maximise the range of choices increasingly open to them through the more extended use of personalised approaches.

6. Does it ‘work‘?

Evidence shows that with ‘conventional’ homecare, approximately 95% of people provided with a package will continue with it after the first six weeks ⁵, and, anecdotally, are likely to continue with it for the rest of their lives.

However, after a phase of homecare re-ablement, approximately 60% of people will not need a homecare package, and two years later, approximately 40% will still not have

⁴ Projecting Older People Information, Oxford Brookes University

⁵ Evaluation of the HART Service, Leicestershire County Council, DeMontfort University, 2000

required a homecare package ⁶. Of those that do need a homecare package, a larger proportion do not need an increase in their support over the two years when compared with conventional homecare. Studies also show that most people benefit in terms of their quality of life ⁷.

Homecare re-ablement does not 'work' for everyone, but the numbers and proportions that do not benefit are lower than is the case with conventional homecare. Of course, it is not, on its own, the whole answer but it is a critical element in any strategy designed to look after those who require support.

Evidence shows that homecare re-ablement, when operated correctly, can generate material financial benefits for the council and achieve a break-even point within 30 weeks ⁸.

7. Delivery of Homecare Re-ablement

Most homecare re-ablement services are operated by council social service teams although there are a growing number of services that are partially or wholly outsourced. In England, 149 councils have reported that they operate a service, whilst many across Wales and Scotland are also operating or implementing a service.

However, based on work with a number of councils it is evident that many have yet to mainstream the service and gain the full potential benefits both for the people using their services as well as for the council. It has been estimated that services across England are probably reaching about 50% of the potential number of annual referrals.

Further, whilst good progress has been made, many services are not achieving the level of performance that has been evidenced elsewhere. Established services should be seeing approximately 55% of people leaving their service not requiring an ongoing homecare package and that benefit lasting for up to two years for 40% of their completers. In addition, others should still achieve an improvement which means that their homecare package will be smaller than otherwise would have been the case.

These issues will be important to bear in mind, as councils move from their role as principally coordinators and providers of service, to their more strategic role in ensuring the availability of appropriate resources for the increasing number of individuals who may be planning their own care.

⁶ Retrospective Longitudinal Study, CSED, Dept of Health, 2007

⁷ Prospective Longitudinal Study, CSED, Dept of Health, 2010

⁸ Prospective Longitudinal Study, CSED, Dept of Health, 2010

8. Outsourcing

.An increasing number of councils are considering the establishment of local authority trading companies, social enterprises or outsourcing of the homecare re-ablement service.

This may well be the right option but careful thought needs to be given as to how the service is commissioned and monitored.

Simply outsourcing a service will not, in itself, ensure that it operates efficiently and cost effectively. The consequences of not performance managing, an outsourced service– is that the users of service will not achieve their potential level of independence and the council will incur excessive expenditure for many months or possibly years.

9. Funding for homecare re-ablement

Additional funding has and continues to be available to stimulate both further capacity to deliver post discharge support services and services in social care that will benefit both them and health.⁹

Purpose	2010/11 (£m)	2011/12 (£m)	2012/13 (£m indicative)	How the funding should be used
Development of post-discharge support and re-ablement services	70	150	300	<ul style="list-style-type: none">•Work with LAs to develop local re-ablement capacity.•Funding may be transferred to local partners or pooled budgets
To support social care services	162	648	622	<ul style="list-style-type: none">•Funding must be transferred to LAs to spend on social care which also benefits health

In addition to these two funding streams that have been distributed via PCTs, the guidance also indicates that savings arising within PCTs from the non-payment for certain acute hospital re-admissions should also be added to the development funding.

From the table above it is clear that significant amounts of funding (£648m in 2011/12) **must** be transferred to local authorities, whilst the £150m **may** be shared with them based on priorities agreed between the PCT, local authority and other health partners.

⁹ NHS SUPPORT FOR SOCIAL CARE 2010/11 – 2012/13, letter 13 Jan 2011

10. Next Stages

Some councils are exploring the extension of the homecare re-ablement philosophy, which has historically been used with older adults, to other client groups and other forms of care. Whilst this is to be encouraged, they need to ensure that this will not divert their attention from realising the benefits for the essential core service first.

There is a limited period during which councils have an opportunity to maximise the benefits of the foundation service if they are to realise its potential, as financial pressures increase; and to evidence and support discussions with health partners on the future range of services that need to be made available in their locality as part of the post-discharge support arrangements. If services are to be ready by April 2012, when acute hospitals will become responsible for post discharge support that work needs to start now.

*Gerald Pilkington has over 26 years of experience working in health and social care across the independent sector (acute, long-term care and rehabilitation) and the NHS.

Gerald was previously Chief Executive of a not-for-profit group that owned care homes and acute hospitals across England and Wales, and managed others under contract. He has also served as a Trustee and non-executive Director of a not-for-profit hospital.

More recently Gerald was the national lead for homecare re-ablement within the Care Services Efficiency Delivery programme at the Department of Health, supporting 152 English local authorities to achieve their efficiency targets within adult social care.

He is the founder of Gerald Pilkington Associates.



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Summer 2011 Publications England: Adults.

CareKnowledge Special Report 55, October 2011

This Special Report reviews all the key items we've highlighted since the end of June, through to the early part of September, and provides an easy-access reminder to the selected publications that we think are most important or interesting.

Funding Care (July 2011)

CareKnowledge Special Report 54, July 2011

This Special Report looks at the conclusions of the Commission on Funding of Care and Support, and at the wider financial and resource issues facing adult social care. It includes particular reference to the recent Audit Commission report on productivity in the sector and to the latest Office for Budget Responsibility comments on next-stage financial pressures.

Munro and Social Work: Realities and Aspirations

CareKnowledge Special Report 53, July 2011

This report attempts to clarify the guiding principles on which Munro's recommendations depend, sets out some of the systems elements and change processes that need to be addressed in the implementation process if it is to result in changed behaviours – and practice – on the ground.

Children's Policy: Stock take: Part Two

CareKnowledge Special Report 52, June 2011

This is the second part of a two-part report that sets out to provide an overview of children's policy developments ahead of what may turn out to be a programme of further major reform, as the coalition gets to grips with its policy agenda.

England, the North/South Divide: the diversity of place.

CareKnowledge Special Report 51, June 2011

This report, by Mike Lauerman, goes beyond the coalition government to look at the growing economic and social gap between the North and South of England.

Assistive Technologies: part of the mainstream.

CareKnowledge Special Report 50, May 2011

This report looks at Assistive Technologies, an issue that has been a feature of social care life for several decades, and which will certainly be a part of next-stage developments. The report also provides a brief description of current and developing technology types.

Children's Policy: Stock take March 2011

CareKnowledge Special Report 49, April 2011

In this first section of a two part report, Mike Lauerman considers what we know about the broad policy intentions of the coalition, as far as they affect children's services.

Munro on ICT: challenge and opportunity

CareKnowledge Special Report 48, April 2011

This report takes a detailed look at some of the interim conclusions of the Munro Review of Child Protection in England, which has devoted specific attention to the contribution – good or bad – made

by information technologies, to the practice of social work.

The Big Society: new wine in old bottles?

CareKnowledge Special Report 47, April 2011

In this first report of the new series, Mike looks at some of the – as yet rather uncertain – implications of the Big Society initiative.

Case Recording – the Essential Task

CareKnowledge Special Report 46, March 2011

This is the first in a series of Special Reports we intend to run between now and the summer which will look, in some detail, at the essential role case recording plays in social work.

Your Views on CareKnowledge

CareKnowledge Special Report 45, February 2011

We ran our third annual survey in September / October 2010, again offering CareKnowledge users the chance to tell us what they think of the service. This is a summary of the key findings.

The Munro Review of Child Protection Interim Report: The Child's Journey

CareKnowledge Special Report 44, February 2011

This short special report provides summary and key point briefing drawn together immediately after the report's publication. It offers an introduction to some of the main elements in the report, particularly for CareKnowledge readers who may not yet have had time to access the report in full.

Why Supervision Matters

CareKnowledge Special Report 43, January 2011

This Special Report is part of a short series written for CareKnowledge by Mike Lauerma in which he provides a personal perspective on a number of key professional concerns that will need to be addressed as the new government takes forward its social care policy agenda.



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Recent documents

- Keeping Children Safe From Harm: Committed, Accountable, Responsive. Home Office circular setting out new arrangements for the Border and Immigration Agency. [26-Jun-2007]
- Section 58 of Children Act 2004 Review (Consultation). Consultation from the Department for Education and Skills on a review of the law pertaining to physical punishment of children by their parents. [15-Jun-2007]
- Working across children's and adults services: creating seamless services in the most FCH words. Speech by Beverley Hughes to an LGA conference in which she highlight the need for good joint working between services for children and adults. She looks at disabled children's transitions, young carers, safeguarding children, and whole family approaches. [14-Jun-2007]
- CareKnowledge Commentary: 3rd Quinquennial Report to the UN Committee on the Rights of the Child - United Kingdom. This CareKnowledge Commentary provides an overview of the lengthy submission to the UN Committee on the Rights of the Child, which provides an exhaustive coverage of developments over the past five years. [01-Jun-2007]
- Care Careers: the Work and Family Lives of Workers Caring for Vulnerable Children. Summary of research carried by the Thomas Coram Research Unit on behalf of the Department for Education and Skills. [31-May-2007]

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