joint improvement team
creativity, collaboration and continuous improvement

Home Care Re-ablement

Report on a Survey of Re-ablement Activity in Scotland & Performance Measurement

February 2013

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Case Study

Mrs Smith is 86 and lived alone. She fell at home and was admitted as an emergency to hospital. She had not broken anything but had strained her hands during the fall and could not hold or lift anything, was tearful and had lost her confidence. She was assessed as needing support with personal care, with dressing, showering and making meals and the package of care consisted of two visits per day for one hour in the morning and 30 minutes at night for seven days per week.

Home Care Re-ablement visited Mrs Smith to commence the service and the dedicated Occupational Therapist working with the Home Care Re-ablement service explained the short term nature of re-ablement and discussed with Mrs Smith what she wanted to achieve from the service. Mrs Smith wanted to get her confidence back and was embarrassed that staff were having to get her dressed, undressed and bathed. The Occupational Therapist supported Mrs Smith to set her goals to:

- dress and undress independently within 3 weeks;
- bath independently within 6 weeks;
- build her confidence within 6 weeks.

The Home Carers were undertaking most of the tasks for her over the first few days, while building a relationship and encouraging Mrs Smith that things would improve when the swelling and bruising on her hands reduced. The Occupational Therapist had ordered a helping hand and a long handled sponge that arrived within 24 hours and a Telecare package that was installed within 48 hours. The home carers helped Mrs Smith to practice using these.

The Home Care Re-ablement Team of Home Care Manager, 3 Home Carers and Occupational Therapist met after one week and spent 10 minutes discussing Mrs Smith's progress. By the end of one week she was using the helping hand but still had some difficulty with her confidence. She said she felt a bit safer with the Telecare support.

On the second week Mrs Smith was able to grip with her hands and was improving in using the helping hand. This success made her more confident about trying the long handled sponge and the Home Carers were able to stand back so she could shower herself. When the team met again with the evidence that Mrs Smith could do more for herself, they decided that the package of care could reduce to 30 minutes in the morning and 30 minutes at night with the home carers providing encouragement and evidence about Mrs Smith's progress.

Over the next weeks the staff were able to stand back more and evidence that Mrs Smith could undertake all the tasks herself. She said that she had regained her confidence and felt safer because of the Telecare package. She was pleased that she had her dignity back because she could dress and bathe herself. A review was undertaken and the decision was made to cease the service.

Foreword

The Joint Improvement Team with assistance from ADSW Home Care Committee has completed the survey of Re-ablement activity. The survey confirms that re-ablement activity has now become the norm in the majority of Scottish Local Authorities, following the series of workshops which the JIT led in 2011 across Scotland for partnerships.

The workshops as some of you will recall were very well received, and the JIT has offered further support to individual partnerships and organisations as progress on implementation has progressed.

The report indicates the range of approaches across the country, from whole system activity, including join up with health and independent sector partners in some areas, to discreet and focussed activity on discharge services. In some areas there has been development of step up and step down support utilising care homes and housing resources.

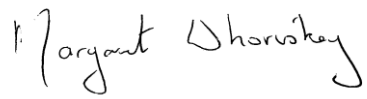
The report confirms that the re-ablement approach is shifting the focus of services from task and time approaches to a person centred outcome focus through dedicated and goal focussed assessment, which is well received by service users and carers.

Further work is required to understand the impact on costs and finance usage for care at home services, and on the relationships to health activity on discharge practice, rehabilitation and Intermediate Care which will be a continuing focus for the JIT throughout the Reshaping Care for Older People programme.

The JIT proposes to introduce further activity to support partnerships, on commissioning, on an approach to re-ablement and dementia services, and to continue to provide support to partnerships through the Reshaping Care for Older People programme.

Relationships to other key policy areas such as community equipment and adaptations, telehealthcare, the national Dementia Strategy, investing in – and up skilling – the homecare workforce, the integration agenda, and challenges to join up the Intermediate Care landscape of services will remain key challenges to local partnerships, while the introduction of the Self Directed Support Act will continue to focus the need for person centred and outcome based assessment and support, wellbeing and prevention.

Margaret Whoriskey



Dr Margaret Whoriskey
Director
Joint Improvement Team

SECTION 1: Report on a Survey of Re-ablement Activity in Scotland (July 2012)

1. Introduction

The introduction of re-ablement practice in Scotland was founded on an evidence base developed in England and followed from the early adoption of this practice in the City of Edinburgh in 2008. The major launch of Scotland's approach took place at the 'Into the Spotlight' Conference in Crieff in December 2008,[1] set within the direction of the current Reshaping Care for Older People strategy, and where elements of the re-ablement and integrated practice were explored through presentations and workshops.

The evidence base for re-ablement is now well documented with key findings from the Department of Health, Care Services Efficiency Delivery Programme and major research by the De Montfort University, University of York, University of Kent and the Edinburgh evaluation which the Joint Improvement Team (JIT) commissioned.[2]

Key themes which have emerged from research are:

- Re-ablement leads to improved health and wellbeing;
- Re-ablement improves outcomes and reduces expenditure on on-going support;
- No single leading delivery model exists. Many teams have developed from services such as in-house home care;
- Assessment and goal planning are integral to people achieving their individual aims;
- Valuing frontline home care workers;
- Occupational Therapists have a key role in the provision of re-ablement and can assist in on going re-ablement for people with complex conditions;
- Customer satisfaction can be high from a well-run re-ablement service.

The JIT has played a central role in facilitating and supporting the introduction of re-ablement practice in Scotland and in making links to other relevant strategies and policy; the Intermediate Care Framework; The National Dementia Strategy; Outcome based approaches and Talking Points; Delayed Discharge and anticipatory care activity; and to the emerging themes in Self Directed Support in Scotland. These strategies are all available on the JIT website.[3]

2. Background to Survey

The JIT conducted a series of two day regional workshops between April 2010 and November 2010 on the Step By Step Guide to Implementing Home Care Re-Ablement, attended by local social care and health professionals and other relevant

[1] www.jitscotland.org.uk;
[2] Ibid.
[3] Ibid.

stakeholders. These events took place in Aberdeen, Glasgow, Ayr and Stirling. A further workshop for the independent sector took place in January 2011. Materials were prepared and each partnership was invited to send delegates from home care sections, housing, health and the independent and voluntary sectors representing the 32 local authority partnerships. Each partnership was provided with a USB memory stick which contained all presentations, a number of development tools to provide calculations on staffing levels and finance in order to assist development and a range of research and evidence on re-ablement.

The workshops drew on the experience of the early implementers in Scotland, especially Edinburgh and Stirling, and facilitated time for local partnerships to develop their planning, thinking and consider activity around their own areas using development tools to model their re-ablement service using some of their local key data.

The feedback from the workshops was positive (See Chart 1 below) and many of the partnerships indicated that they were interested in developing re-ablement in their locality. Some of the benefits from the workshops are cited below:

'Learning from other experiences and how it fits into my own locality and what improvements are required to our own thinking and progress'.

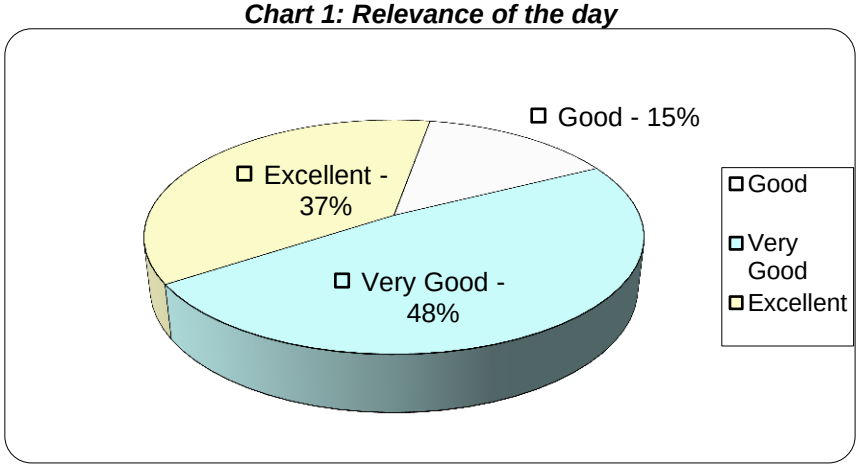
'Time out with colleagues to discuss development of local services around the re-ablement theme.'

'Useful ideas from other areas and found two events more useful than some enablement conferences I've been on, especially part one of this conference'

'Welcomed this opportunity for Network/ Shared experiences from evidently different approaches to the same problem, stimulated thought and understanding of challenges.'

'Very thorough input covering all aspect of the re-ablement model, strategic needs and implementation. Presentations and group discussion provided good material.'

Chart 1: Relevance of the day



The telephone survey, in relation to this report, was undertaken with authorities/ partnerships in early 2012, to review progress and developments in relation to re-ablement 12 to 18 months following the regional workshops.

3. Definitions

It is important to be clear about the terminology used in this report and in particular to consider the range of the variations in Home Care Re-ablement models. The Care Services Efficiency Delivery Programme points to the difficulties around definitions of Home Care Re-ablement within a range of services including Intermediate Care Services. In their 'What's in a Name?' publication[4] they say:

> *'any comparison of such disparate services is that similar services are often called different things, and different services are often called the same thing.'*
>
> *'It is important to be clear about the differences between intermediate care and homecare re-ablement because in some ways they appear to duplicate each other. The confusion is increased because there is no single model for either homecare re-ablement or intermediate care. In addition, as this document seeks to illustrate, the term 'intermediate care' is often used to refer to a function or to a service, and specific services can and do take a number of different purposes and forms.*
>
> *It remains our view that homecare re-ablement complements the work of intermediate care services (as defined by DH in its June 2009 publication, Intermediate Care - Halfway Home", Updated Guidance for the NHS and Local Authorities) rather than replaces it. Re-ablement seeks to support a different phase on the continuum of care, whether that is different groups of people or the same people at a different stage of their 'recovery'. In reality, the intermediate care and homecare re-ablement phases for specific individuals may overlap.'*

During the survey, there were strands that were common to all the models participants described:

- Re-ablement is a conceptual approach bringing together good practice rather than a service;
- It is outcomes focussed;
- It provides the means to providing a person centred assessment process to the individual rather than one size fits all;
- It provides a full assessment as to both the nature of further support necessary, and of anticipatory approaches which may help in the on-going self-management of issues;
- Home Care staff are trained and supported in the approach;

4 http://webarchive.nationalarchives.gov.uk/20120907090129/http://csed.dh.gov.uk/asset.cfm?aid=6647

- It is about supporting service users to do the activities of daily living they can do for themselves while still supporting them with the tasks they cannot do.

To varying degrees the processes and structures within the models described in the survey differ, for example, in the processes there is/are:

- A specific period for re-ablement usually around 6 weeks;
- Specific dedicated and identifiable resources;
- Role of Occupational Therapists (OTs);
- Value placed on Home Carers;
- Assessment using formal written goal plans;
- Weekly progress meetings;
- Integration and links between Home Care Services and NHS Intermediate/ Rehabilitation Services;
- Referrals from community and/or hospital;
- Eligibility and access to the service;
- Reviews and Handover;
- Performance Management.

The structures are referred to throughout this report and include four main models below. There may be slight variations with the Stand Alone Home Care Re-ablement Service and the Integrated Home Care/ Intermediate Care Service, such as services starting off with hospital discharge only but with a view to move to community and hospital provision in the longer term.

Stand Alone Home Care Re-ablement Service

The Stand Alone service model builds the concept from the existing Home Care Service. Home carers and managers are deployed to a specific and dedicated Home Care Re-ablement Service and joined by occupational therapists to provide the service to all people referred for home care from hospital or the community. The model uses processes such as activity analysis, goal planning along with weekly team meetings for an intensive short term service of on average 6 weeks. After this, an initial review takes place and if further care at home is required there is a formal handover to the long term provider.

Integrated Home Care and Intermediate Care services

The Integrated Home Care/ Intermediate Care Service builds the concept on Intermediate Care Services (that will have operated the concept previously) and adding home carers from the in house Home Care Service to widen the availability to some or all home care referrals. Some of the staff groups are managed by different managers/agencies but work together in an integrated way and use the resources of home carers, nurses, occupational therapists, physiotherapists to provide a service to some or all of the referrals to Home Care from hospital and the community. They use processes such as activity analysis and goal planning along with weekly team meetings for a short term service of on average 6 weeks.

The two models above were how authorities/partnerships described their approach to reablement; however, there were sub categories of these which were evident.

Concept Approach
In this model there is no distinct service but a re-ablement conceptual and principled approach is embedded across all of Home Care that extends further to all services.

Continuity Re-ablement Model
Staff are deployed for a dedicated Home Care Re-ablement period of time to a service user and then continue to work with them if they require a long term care at home service. This model may be more common in rural or island authorities that have variable numbers of referrals and cannot afford to have a separate re-ablement team standing by but under deployed.

Care Workers
The term 'care workers' is used throughout to refer to the front line staff providing the lion's share of the re-ablement. Variously this may refer to home carers, rehabilitation assistant etc.

Authorities/ Partnerships
With the integration agenda there were various configurations of services between local authorities and health service. The term ***Authorities/ Partnerships*** is used throughout the report as a 'shortcut' to describe the various configurations of local authorities, local authorities and integrated health services along with other variations.

4. Methodology

A list of key contacts in each Local Authority with responsibility for Home Care was provided by the Association of Directors of Social Work (ADSW) Community Care Home Care Group. Each person was contacted by email or telephone and a date arranged to undertake a telephone survey. A list of questions were sent out to the participants in advance (see Appendix 1). The survey was undertaken by Gerry Graham and Alex Davidson (JIT) and responses logged on an Excel Spread sheet. This was then analysed using pivot tables.

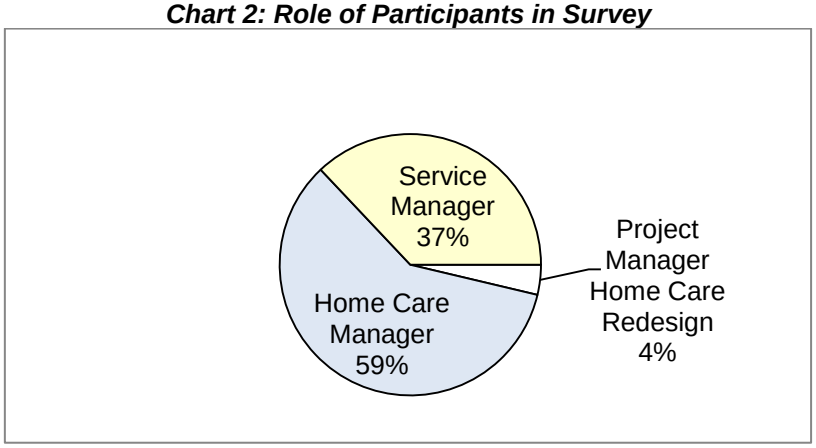
The nature of a telephone survey means that the information provided at the time is the best that the participant can provide; however, the figures require to be treated cautiously as detailed information may not have been available to the person or they may have used their best guess about figures. Some further information was provided by participants following the telephone survey but not in every case.

5. Response

There was a very good response to the survey with 31 out of the 32 authorities/ partnerships taking part. This equated to a 97% participation rate.

The roles of the people who participated in the survey (See Chart 2 below) were mostly Home Care Managers (59%) with a responsibility for the management of the service. The next most frequent role was Service Manager who had responsibility for Home Care along with other functions within the authority/ partnership.

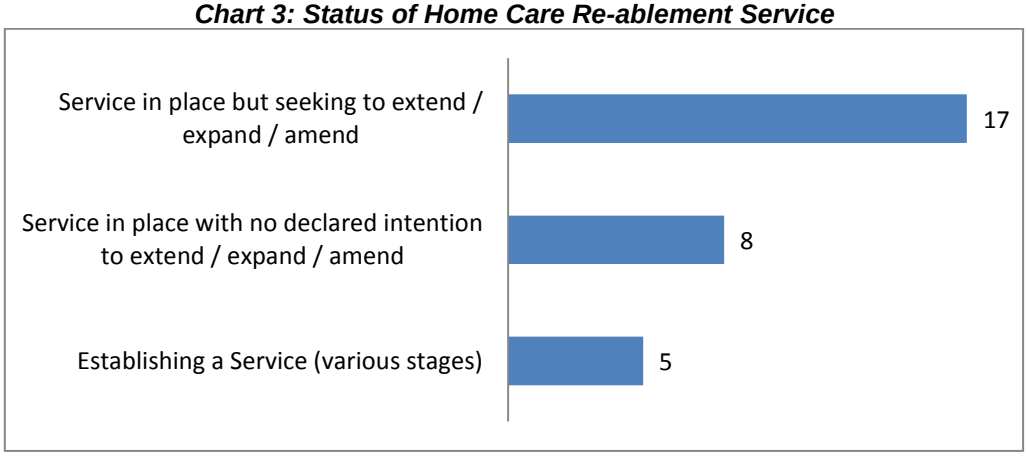
Chart 2: Role of Participants in Survey



6. Status and Type of Service

The status of Home Care Re-ablement is shown in chart 3 below with 30 authorities/ partnerships responding to this question. Most authorities/ partnerships (17) had a service in place but were seeking to expand. Ten of these authorities/ partnerships had 100% geographical coverage but wanted to further expand the approach to long term provision of home care or to other services such as day care. Some had started the service with only hospital discharge, while others had started re-ablement in a geographical area and wanted to spread this to all localities. Eight authorities/ partnerships had a service in place and were not thinking about expanding stating they had 100% geographical coverage. The authorities/ partnerships who were at various stages of establishing a service indicated that they would be starting within 3 months. Some of these services, at the point of writing, have now commenced and, for the purpose of this report, both existing and planned models have been described as if they were in existence. One other authority/ partnership planned to establish Home Care Re-ablement with a timescale longer than one year. This would indicate, for 30 of the authorities/ partnerships, that Home Care Re-ablement is considered as a relevant and worthwhile approach.

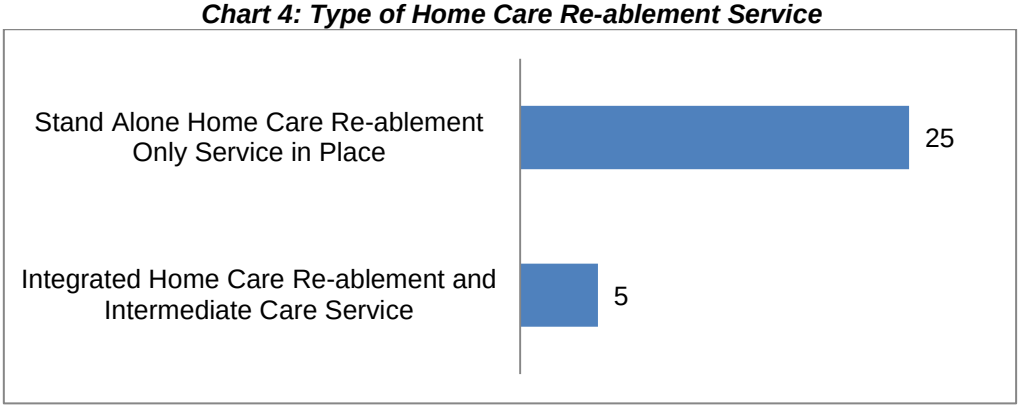
Chart 3: Status of Home Care Re-ablement Service



Participants described their current or planned re-ablement service model of provision, (see chart 4 below). These descriptions fell into two categories. Twenty Five authorities/ partnerships described their service as a stand-alone Home Care

Re-ablement Service built on their existing in house Home Care Service while five described their service as a Home Care Service integrated with NHS services such as Intermediate Care. On further examination, there were variations on this with some providing a conceptual model where the concept was applied to the Home Care and all services, while others applied a continuity model where all care workers were trained and could be deployed for home care re-ablement but would also work in long term home care (see the definitions section at start of report).

Chart 4: Type of Home Care Re-ablement Service

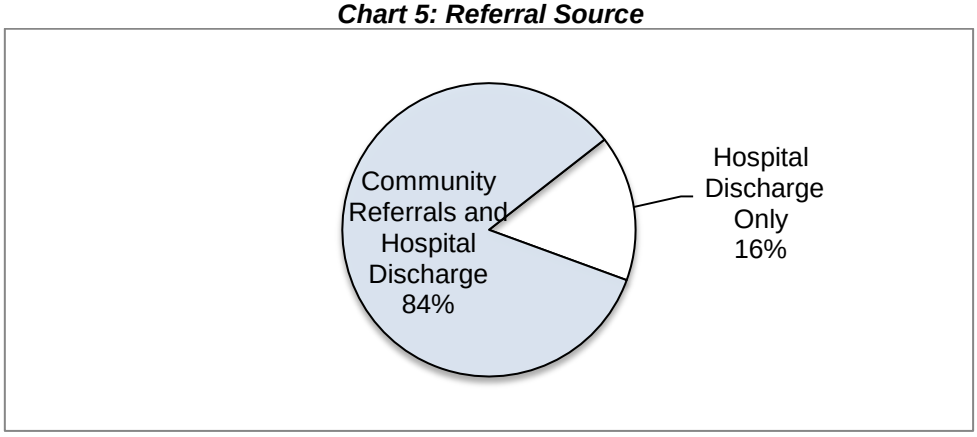


7. Scale of Service

17 of the authorities/ partnerships indicated that their Home Care Re-ablement Service was dealing with 100% of referrals for a home care service.

84% of authorities/ partnerships stated that they received or were planning to receive referrals from hospital and the community, while only 16% of the authorities/ partnerships indicated that they received or planned to receive referrals only from hospital (see chart 5 below). A number of authorities/ partnerships stated that they were starting on an incremental basis and would be moving from hospital only referrals to include referrals from the community.

Chart 5: Referral Source

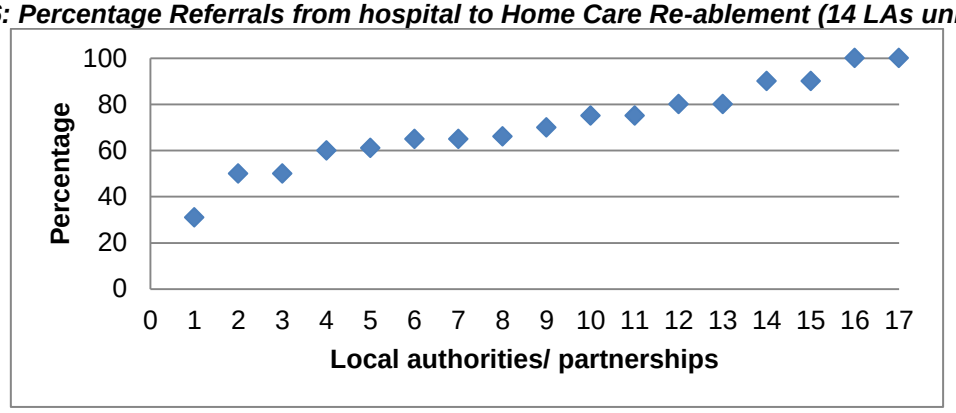


Geographical coverage was described as 100% by 19 authorities with variations from other authorities who were implementing on an incremental basis.

Chart 6 shows the percentage of referrals from hospital to Home Care Re-ablement. 17 authorities/ partnerships responded to this question and they are shown along the

bottom axis while the percentage is shown on the vertical axis. At one end, one authority was receiving 70% of its referrals from the community and 30% from hospital with the majority of authorities/ partnerships receiving between 60% and 80% referrals from hospital.

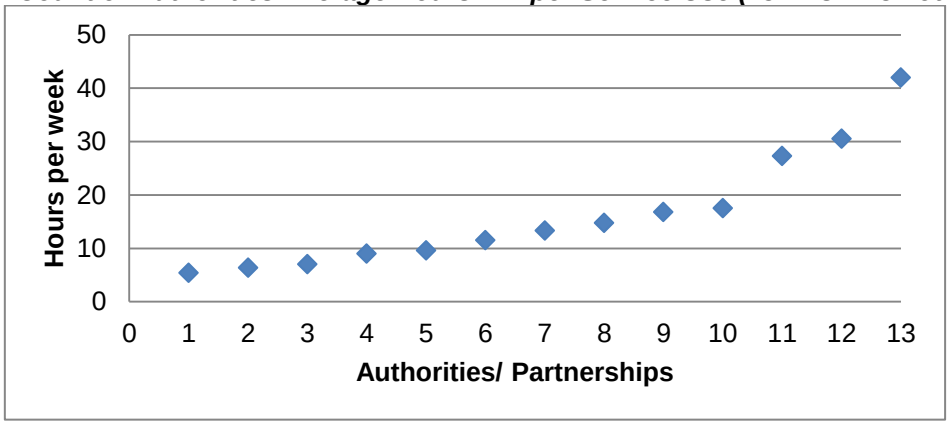
Chart 6: Percentage Referrals from hospital to Home Care Re-ablement (14 LAs unknown)



Only 13 authorities/ partnerships were able to identify the average number of service users receiving re-ablement at any one point in time. The majority of those responding had under 100 service users receiving re-ablement at any one point in time with 3 authorities/ partnerships between 100 and 200 service users. Two authorities/ partnerships said they had between 600 and 700 people receiving re-ablement at any one point in time. One of these was a large city authority and the other was a rural authority. The rural authority considered re-ablement to be a cultural concept and, where both all long term and new home care service users were receiving a re-ablement intervention. In contrast, the city authority had a distinct stand-alone home care re-ablement service providing a 6 weeks re-ablement period where there were intensive processes being undertaken. The city authority also believed that the conceptual approach of re-ablement extended to their long term home care service.

Participants were asked to identify the average hours per week that service users received during re-ablement and 13 authorities/ partnerships were able to respond. Five of the authorities/ partnerships had between 10 and 20 hours per week, five under 10 hours per week and two had between 20 and 30 hours per week. One authority had over 40 hours per week, (see chart 7 below). The mean average was 16 hours per week and the median is 13 hours per week.

Chart 7: Count of Authorities Average Hours PW per Service Use (13 LAs – 18 not known)

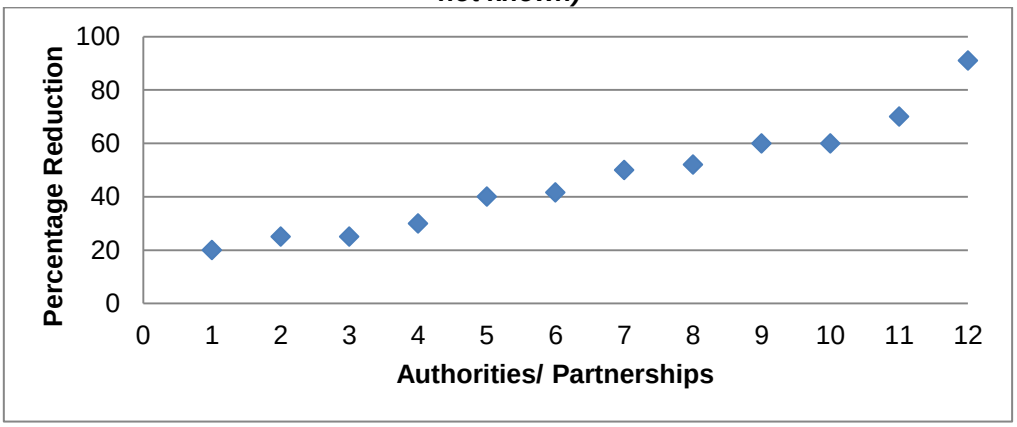


Only 12 authorities/ partnerships were able to respond to a question about the average percentage reduction in care hours by the end of re-ablement. Authorities/ partnerships who could not provide the information indicated that it was too early in the process to be able to report on this while other said that the information was not known. All those that answered (see chart 8) reported some reduction in care hours by the end but the amount of reduction varied widely from 20% to 91% reduction.

The mean reduction was 47% and the median was a 40% reduction in care hours by the end of re-ablement. There may be reasons for the different levels of reduction in care hours that merit further analysis, for example:

- Were the authorities/ partnerships with the highest reduction more selective in their eligibility for the service so that only those interventions assessed as successful would take part in re-ablement or were they undertaking processes that the authorities/ partnerships with lower reduction were not?
- There is also a question of whether care hours were inflated at the beginning of re-ablement and, therefore, show a higher level of reduction than would have been the case were the person merely assessed for provision of a conventional home care service.
- The processes that are in place around goal planning, team meetings and the role of Occupational Therapists.
- Service users, who do not complete re-ablement, if included in the reduction of care hours, will skew the results. For example, if service user x starts re-ablement receiving 21 care hours per week that reduces to 14 hours by week 3 and then dies in week 4, the reduction in care hours cannot be calculated as 21 hours per week. People, who do not complete the re-ablement period, usually 6 weeks, should be treated differently when calculating reduction in care hours.

Chart 8: Average Percentage Reduction of Care Hours by the End of Re-ablement (12 LAs – 19 not known)



8. Staffing

Some of the job titles mentioned during the survey were:

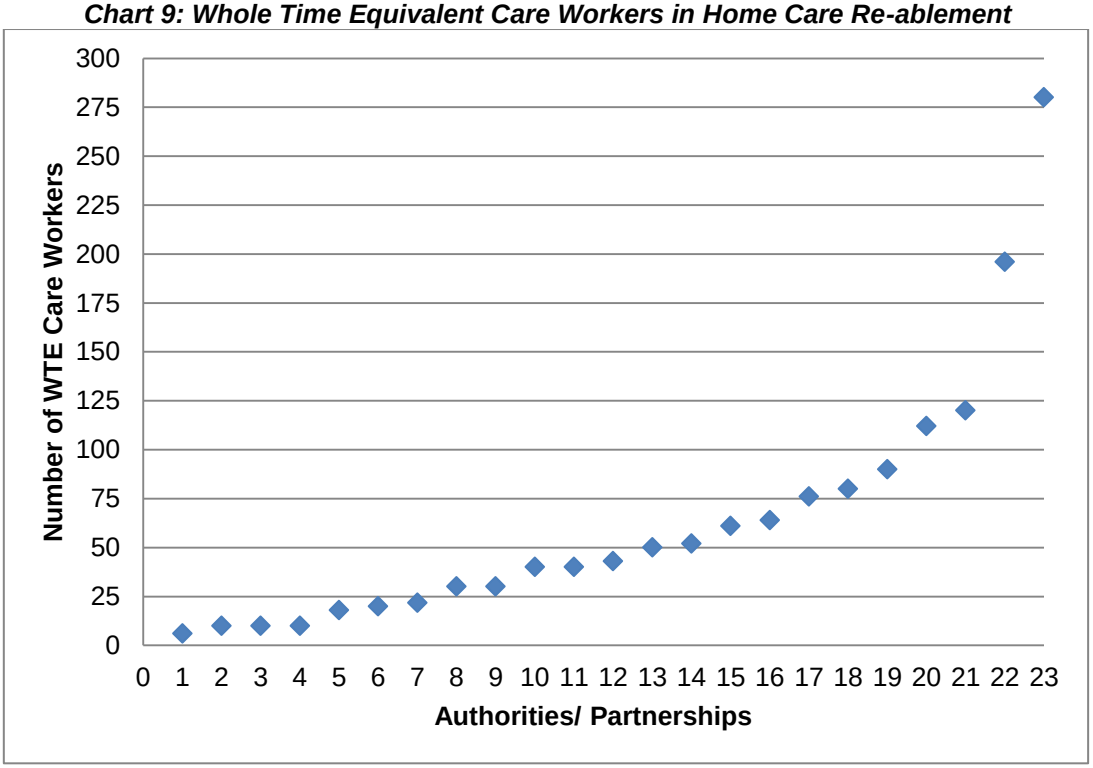
- Care at Home Workers Re-ablement;

- Care Support Workers;
- Enablement and Support Worker;
- Enablement Carers;
- Home Carer;
- Home Carer Re-ablement;
- Re-ablement Assistants;
- Rehab and Enablement Worker;
- Rehabilitation Carers;
- Social Care Workers/ Assistants;
- Support Workers.

There were 27 authorities/ partnerships who trained their workers in re-ablement with a programme lasting two days. Also, 7 stated that they trained in rehabilitation techniques. 20 authorities/ partnerships stated that care workers were 100% dedicated to working in re-ablement and 8 stated they worked in both re-ablement and long term home. Care workers attended weekly re-ablement team meeting In 20 authorities/ partnerships.

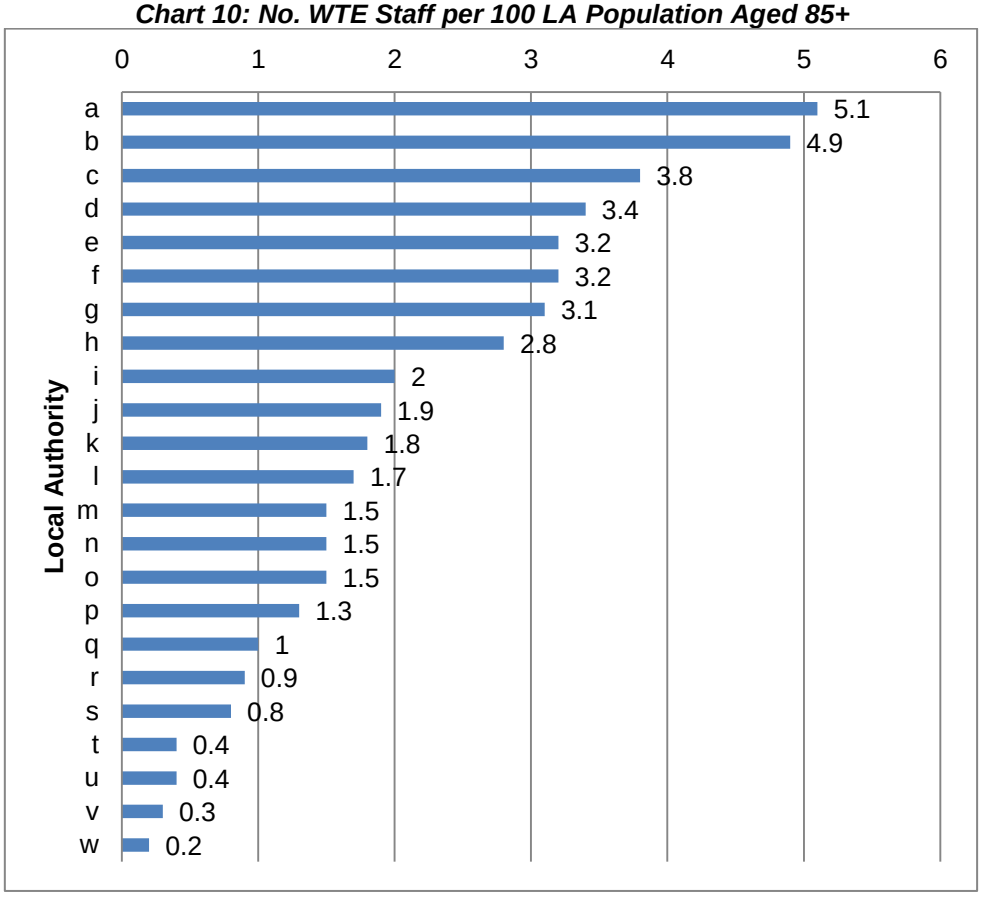
In terms of the numbers of staff involved, there were some authorities/ partnerships who stated that they took a service wide systemic response to the question and said that all their home care staff in long term provision were operating in a re-ablement mode. Others, (23), described a specific re-ablement service and counted the care workers in that service. Chart 9 shows the range of Whole Time Equivalent (WTE) care workers across the 23 authorities/ partnerships that had a specific re-ablement service with staff deployed to this service. The lowest number was 6 WTE staff and highest was 280 WTE staff. The total WTE staff working across all 23 authorities/ partnerships dedicated to re-ablement was 1,500 WTE.

Chart 9: Whole Time Equivalent Care Workers in Home Care Re-ablement



When these numbers were compared to the population aged 85 or over, the rate ranged from 0.2 WTE Care Workers per 100 of the 85+ population in authority/ partnership 'w' to 5.1 in authority/ partnership 'a'. The mean average was 2WTE and the median was 1.7 WTE, (see chart 10).

Chart 10: No. WTE Staff per 100 LA Population Aged 85+



Occupational Therapists (OTs) have been considered to be a useful inclusion into Home Care to achieve a skill mix with care workers and their managers to provide a Home Care Re-ablement Service. They bring a number of skills including activity analysis, goal setting, work with equipment, clinical reasoning, assessment and review that complement the skills of frontline care workers and their managers in building relationships, building confidence, empathy, use of self, coping in a crisis, providing monitoring information and personal care.

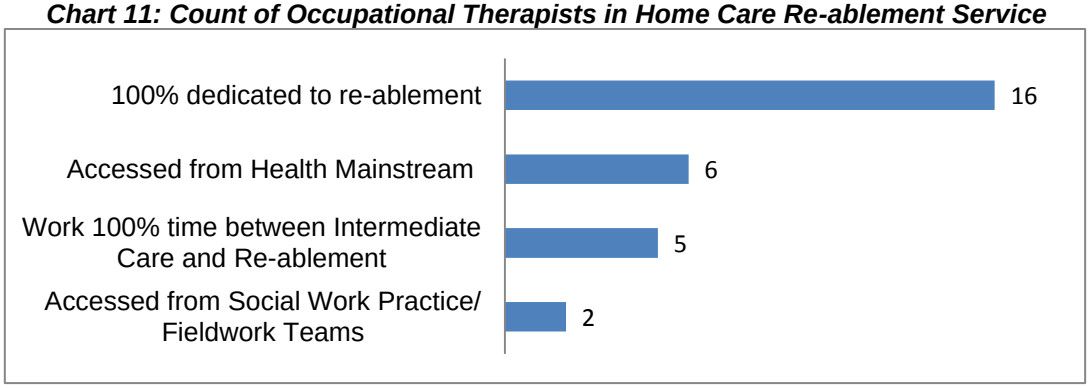
Chart 11 indicates the nature of how OTs have been deployed or accessed in Home Care Re-ablement.

- 29 authorities/ partnerships were able to respond to the question. 21 of the 29 had 100% dedicated OTs, while 8 authorities/ partnerships accessed the OTs from Health or Social Work;
- 16 authorities/ partnerships (15 with stand-alone Home Care Re-ablement and 1 Integrated Home Care and Intermediate Care) had OTs who were 100% dedicated to the re-ablement service;

- a further 6 authorities/ partnerships (4 with stand-alone Home Care Re-ablement and 2 Integrated Home Care and Intermediate Care) accessed the OTs from the Health mainstream service;
- 5 authorities/ partnerships (4 with stand-alone Home Care Re-ablement and 1 Integrated Home Care and Intermediate Care) had OTs 100% dedicated to working between re-ablement and Intermediate Care; and
- 2 authorities/ partnerships both with stand-alone Home Care Re-Ablement Services accessed the OTs from Social Work Fieldwork.

One authority commented that: 'More dedicated OTs based in re-ablement would be better than accessing OT input from a generic OT pool.'

Chart 11: Count of Occupational Therapists in Home Care Re-ablement Service



89% of authorities/ partnerships (25) that were able to respond to a question about lead manager for the service, stated that they had a Social Work Home Care Manager as the lead manager for Home Care Re-ablement; 7% (2) stated that they had a Health Nurse Manager; and 4% (1) that they had a Social Work Therapist Manager.

9. Service Characteristics

Participants were asked about the characteristics of their re-ablement service and the most common specific elements were:

- Use of a Talking Points Approach (25 out of 28 who responded) **;**
- Use of a formal written goal plan for each service user (25 out of 28 who responded);
- Arranged Weekly Team Meetings to discuss the progress of 100% of service users (20 out of 24 who responded);
- Service on an average of 6 weeks (20 of 24 who responded);
- Use of a Single Point of Access via Social Work (6 of 28 who responded);
- Use of a single point of Access via Health (4 of 26 who responded);
- Use of a Joint single Point of Access for Social Work and Health (19 of 23 who responded);
- Inclusion of people with dementia in re-ablement (18 of 23 who responded);
- Use of anticipatory care planning in conjunction with re-ablement (14 of 19 who responded);
- Re-ablement facilitated quicker discharge from hospital (15 of 20 who responded).

More general characteristics or factors mentioned by one or more participants to describe their Home Care Re-ablement Service and which may be of use to authorities in benchmarking their service included:

Referrals

- Assess and review within home care, exempt end of life and advanced dementia;
- Constantly reviewing in order to expand to community referrals;
- Single point of access and close working with the Discharge Coordinator;
- An increased volume of referrals.

Outcomes

- Re-ablement helped identification of service users with complex care needs;
- Embedded Talking Points approach and support from the Joint Improvement Team have been helpful in making the connection between re-ablement and outcomes.

Rurality

- As an island authority, there is a single in house market, all staff trained in re-ablement and no separate re-ablement team. This is due to the rural nature of the islands and the small number of referrals. Home Carers work with service users requiring long term support following a period of re-ablement and continue provision of long term care in the same mode as re-ablement;
- Rural areas, less populated, compared to bigger towns, are making more use of re-ablement than expected;
- Rural areas operate in the same way as urban areas.

The role of re-ablement in expanding the approach to other sectors

- Expanding re-ablement approach into Day Care and Learning Disability;
- OTs x 2 are being provided to the independent sector.

Integrated Working

- Re-ablement has reduced delayed discharge which previously was quite high;
- Re-ablement has been a good example of joint working by demonstrating a different way of working. This has resulted in getting people signed up, including GPs who are key partners in re-ablement;
- Working in an integrated way using paperwork for goal planning that follows the person from hospital to home care re-ablement;
- Strong links to Day Hospitals that work in partnership to monitor improvements for individuals;
- Plan to move to fully integrated continuum of Hospital - Intermediate Care - Re-ablement;
- Fully integrated Community Health Care Partnership, (CHCP), built around three localities that mirrors rehabilitation teams and GP surgeries / health centres;
- A small dedicated team working closely with Intermediate Care team where the rehabilitation care workers from Intermediate Care work predominately on early supported discharge;

- An integrated model is in place and this has led to services not working in silos;
- Separate teams, Health and Social Work, but working very closely together. Pathways were already in place before the implementation of Home Care Re-ablement and it is almost like one team;
- Social Care is moving ahead faster in developing re-ablement than the NHS, leading to a stand-alone Home Care Re-ablement. Given the size of the authority, if there is one person in an organisation that is resistant to a change, then this can block developments;
- There is integration with Telecare to provide opportunities to test equipment during re-ablement.

Working with Long Term Independent Home Care Providers

- If the independent sector ask for increase in care hours, then re-ablement staff will visit to work alongside care workers in the private sector assisting with practice issues, e.g. consistency of practice, communication where there are changes of staff, being aware not to do tasks for service users that they have relearned to do for themselves during re-ablement period;
- Framework providers' arrangements have provided some blockage.

Team work

- Administration workers are dedicated within the team for re-ablement.

Management

- There is an increased management ratio within Home Care Re-ablement of 1:20.

Team Meetings

- Weekly progress meetings are well established;
- Handover period between staff takes place each day rather than weekly meetings;
- Some meet more often than weekly meetings;
- Progress meetings take place 3 weekly rather than weekly.

Rotas

- Throughput a constant issue and the introduction of new shift patterns for the Long Term Home Care Service assisted throughput from Re-ablement;
- Scheduling of work initiated major changes for home care.

Processes

- Paperwork for the re-ablement period has been improved.

Technology

- Technological solutions to improve operations included a new scheduling system that provided reports on outcomes. Also, this provided work schedules for workers. Smart phones funded through Change Fund were provided to workers resulting in less paper;
- Blackberry messaging/ data is being used to improve communication for re-ablement.

Training

- All staff will be trained in re-ablement in complex care service as well as re-ablement service;
- The impact of re-ablement has been positive on home care staff with high morale and commitment leading to the professionalism of home care, maximising use of staff, developing group identity and increasing confidence and knowledge base.

10. Impact of Re-ablement

Shift in Spend

When participants were asked whether re-ablement was making a difference in shifting spending, 19 authorities/ partnerships said yes with an emphasis mostly on investment that had been made to implement the re-ablement service. Some statements made by the participants were as follows:

- 300 people had received a Home Care Re-ablement Service with 40% requiring no further support;
- There had been an increased investment in Home Care with an additional 50 WTE Home Carers recruited at a cost of £1m;
- There had been investment in recruiting 6 OTs;
- £60k had been invested in new Home Carers, training and techno gyms;
- Money was invested to 'backfill' for reprovisioning for service users whose care worker had moved to the re-ablement team. Expectation was that this will be recovered once re-ablement fully develops;
- End of life services had improved;
- Increase in rapid response function with an extra team integrated into re-ablement;
- There had been an investment in a part time Community Care Assistant and Occupational Therapist for the independent sector.

Finally, authorities/ partnerships stated that the Change Fund used to resource Home Care Re-ablement ranging from £25k to £2m per authority.

Commissioning and Procurement

The impact noted by participants on the commissioning and procurement of long term packages of care at home from the independent sector was that the introduction of re-ablement:

- Had resulted in more service in house;
- Was building capacity in the independent sector, including through provision of training;
- Resulted in the independent sector working on re-ablement themes;
- Changed the contract to include continuity of a re-ablement approach;
- Resulted in the contract containing a section on re-ablement expectations;
- Resulted in contracts reflecting the whole system approach including the rehabilitation and re-ablement agenda;
- Led to meetings with providers regarding the expectations from them following re-ablement;

- Led to providers receiving re-ablement training support through Change Fund;
- Led to reduced demand and more throughput of service users;
- Led to service specification providing enablement;
- Led to significant numbers moving out of service;
- Has speeded up the configuration of the mixed economy with a target of 70% purchase and 30% in house.

Integrated working with NHS Rehabilitation Services

The impact noted by participants in relation to the how re-ablement was integrated with NHS Rehabilitation services was very positive with a few negative points, clear links to hospital discharge, new processes and joint planning. The points made by them included that:

Positive Points

- There was already a strong link. Home carers are doing what rehabilitation assistants used to do;
- It continued an existing integrated approach;
- There is better joint understanding, less duplication and setting outcomes for service users;
- There is close working with Intermediate Care;
- That it will help with the current review of Intermediate Care;
- Community Psychiatric Nurses can now be involved;
- Joining up rehabilitation and re-ablement has resulted in skill sharing, task sharing with use of 22 step down units and 60 rehabilitation beds;
- There are more links to Rapid Response;
- Integration has been positive;
- The service is joined up with health and we are attempting an holistic approach.

Negative Points

- There are many challenges to resolve;
- Fairly integrated before but the use of OT and physiotherapist could improve.

Hospital

- Hospital OTs completing assessments and passing these to re-ablement;
- There are integrated teams in the community. Integrated Discharge Facilitator post means that assessments can be undertaken quicker;
- There has been a small reduction in hospital delayed discharge.

Processes

- There are regular weekly meetings between OTs and Rehabilitation service;
- We are working closely with Rehabilitation services and there are plans for service users to pass from rehabilitation to re-ablement.

Planning Arrangements

- Health are involved in planning through CHCP;
- There is a plan to join the services;
- There is a plan to move to a fully integrated model including Re-ablement, Intermediate Care and Hospital continuum;

- There is provision of workshops and briefings for NHS staff about re-ablement.

Telecare, Telehealth and Equipment

The impact of the introduction of re-ablement on Telecare, Telehealth and equipment was positively reported by the majority of participants, citing increases in referrals, increased use and quicker access to equipment, improved joint working and involvement of Telecare in training for Care Workers. The points included:

Referrals

- Potentially referrals will go up;
- There have been increased referrals from re-ablement for Telecare but not the same for Telehealth;
- There was earlier introduction of Telecare and greater assessment in the home.

Increased use of equipment and Telecare

- Increased use and quicker access as well as small pieces of equipment;
- There has been a large increase to Telecare, community equipment and to smaller items;
- Equipment was received quicker through re-ablement;
- Increased referrals and additional staff in Telecare. Quicker access to smaller pieces of equipment;
- There is a target to increase the number of people with dementia using Telecare and a general increase in the use of Telecare for over 65s;
- An increase in medication management systems.

Joint Working

- Joint working between re-ablement and Telecare/ Telehealth lead to support for people with long term conditions being addressed;
- There were good links with sheltered housing;
- Care and repair services could be instigated.

Performance

- Telecare in our authority is the fourth highest in Scotland, second for 65+ and first for 85+.

Training

- Telecare in training for speedy access;
- Training is provided in the introduction to re-ablement for care workers by a Telecare lead.

Negative

- The local view is that Telehealth and Telecare were underdeveloped.

Anticipatory Care Plans

The relationship between re-ablement and Anticipatory Care Plans was at an early stage for most authorities/ partnerships who indicated a positive view of working jointly and using these plans during re-ablement. The points made were:

- This is something for future action;
- We are at the first stages of considering use of these in partnership with health colleagues;
- It is in our plans to look at this once restructuring in hospital settles down;
- We would like to introduce these in re-ablement;
- We are looking at GP practices focusing on Anticipatory Care Plans;
- We are looking at this in the future;
- For people with Long Term Conditions, we are considering using this and we will in the future;
- A pilot will be tested;
- We are working with crisis plans;
- This is a positive approach but will be introduced slowly;
- We will use during re-ablement and afterwards;
- It could be adopted for long term care required at the end of re-ablement;
- We are not quite sure how it will develop. We are looking at a single document set rather than range of documents;
- Yes, we will use this for people at end of life or with degenerative illnesses.

11. Performance and Outcomes

There were variations in how well authorities/ partnerships were able to report how re-ablement was performing or to provide basic information. While some had performance reports that identified how well they were dong on a month to month basis, some authorities/ partnerships could not provide information or basic data with regards to re-ablement. Some of the reasons given for this were:

- Authorities/ partnerships were still testing operational information and had difficulty accessing information from their systems including:
    - Staffing numbers;
    - Number of service users;
    - Care hours of service users per week;
    - Before and after care hours;
    - Unit Cost;
    - Reduced hours and reduced delayed discharge.

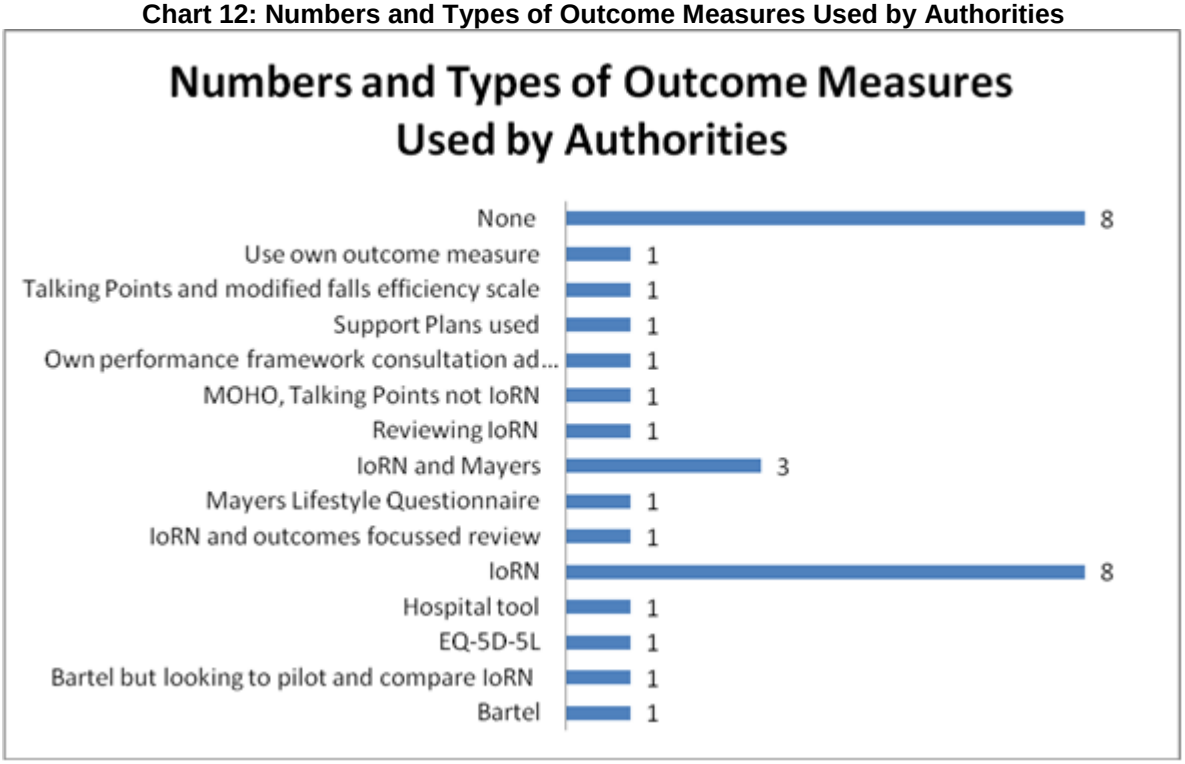
Some authorities/ partnerships had project groups overseeing the development of re-ablement, for example, one authority had two focus groups (strategic and operational) monitoring and developing re-ablement.

Unit costs were so varied as to be unusable. Participants stated that their unit costs ranged from £8.60 per hour to £28 per hour with 21 participants indicating that, while they knew the unit costs for home care, they did not know what the unit costs were for re-ablement. The research carried out by the University of York indicated a unit cost of on average of £42 per hour of contact for Home Care Re-ablement, while The Policy and Social Service Research Unit at University of Kent indicated, in their Unit Costs for Social Care 2011, a unit cost of £32 per hour for a local authority mainstream home care service.

Twenty four authorities/ partnerships had more positive outcomes using some kind of outcome measure. Chart 12 indicates:

- There were at least 10 different outcome measure models;
- High uptake of the Indicator of Relative Need with 16 authorities/ partnerships either using it on its own or with another tool. Some authorities reported that they used the IoRN before and after re-ablement.

Chart 12: Numbers and Types of Outcome Measures Used by Authorities



SECTION 2: Performance Measurement – Report on WebEx Seminars

1. Background

The Joint Improvement Team hosted a series of three WebEx seminars to consider the key questions of:

a) What do we know about the components of an effective Home Care Re-ablement service?
b) How can we demonstrate the effectiveness and outcomes that Home Care Re-ablement delivers?

It is anticipated that local performance reporting will reflect the range of operational arrangements across Scotland (including structure, systems and processes) and the financing of the service, and that some will reflect outputs and outcomes measurement. The WebEx aimed to test the range of options and approaches currently in place.

The WebEx sought to ensure that the JIT heard from stakeholders about Home Care Re-ablement services and the most supportive way to develop and agree a small number of measures that are most likely to demonstrate the efficacy of such services.

2. What We Know Already

Alison Petch, from the Institute for Research and Innovation in Social Services (IRISS), was engaged to summarise research findings and she highlighted the substantial body of evidence that demonstrates proof of the concept of Home Care Re-ablement.

Alison highlighted that studies show improvements over the short term in respect of perceived health, quality of life and social care outcomes – e.g. Edinburgh: 92% greater confidence; care at home hours decreased by 41%.

Outcomes

Studies on longer-term outcomes show improvements in users' health-related quality of life and social-care quality of life and users and carers were positive about the impact of re-ablement on their independence and confidence; some would have liked more help with mobility and activities outside the home. Evidence shows a 60% reduction in the need for social care following re-ablement.

Cost effectiveness

Findings related to costs vary; in general initial costs of re-ablement are higher but the reduction in service use longer term implies cost reduction. The SPRU/PSSRU[5]

[5] Care Services Efficiency Delivery: Homecare Re-ablement: Prospective Longitudinal Study. Final Report Summary, November 2010

study found no net cost savings to health and social care in the first year of re-ablement but considered re-ablement was cost effective on the basis of the improved outcomes for individuals.

Key factors

Evidence suggests that there are a number of factors that impact on the effectiveness of service including:

- Type of scheme i.e. selective (e.g. hospital discharge) versus inclusive (e.g. intake);
- Eligibility criteria e.g. age;
- Professional mix – important role of OT skills in service delivery;
- Flexibility of re-ablement period and package, signposting to other services;
- Culture of independent providers;
- Training for home care support workers;
- Specific service or culture across the organisation.

Performance

In the context of the subject of the WebEx, it is interesting to note that the Department of Health longitudinal study highlighted the importance of:

- Creating sound operational performance management[6] systems and reporting to ensure that decisions can be made in a timely manner and that services maximise benefits;
- Monitoring non-financial benefits in terms of improvements to quality of life for people using the service and their carers.

The DoH report went on to highlight a range of factors perceived to enhance the success of re-ablement services and some of this was also summarised in Insight 3 from IRISS:[7]

- Re-ablement has been shown to work best when staff are fully trained; receive on going management support; have sufficient flexibility over the duration and content of visits; and are working in multi-disciplinary teams;
- Studies suggest that any transfer of provision for individuals from local authority re-ablement services to independent providers should be carefully handled in order to minimise disruption to service users.

Differences in Approach

The WebEx also included a summary of the findings presented in the first section of this report, which demonstrate a very wide variation of indicators that are the result of the distinctly local way that services have developed. The variations included:

- The count of average hours of Home Care shows a range of between 5 and 42 hours per week indicating a differential approach across areas;
- An average percentage reduction of care hours by the end of Re-ablement, from 20% to 90% (where known - 39% authorities);

[6] Ibid.
[7] Effectiveness of Reablement Services. Insight 3, The Institute for Research and Innovation in Social Services (IRISS) (2010)

- Unit costs suggests a range of hourly costs between £8.60 and £28.00 (where known - 26% authorities);
- At least eight different performance methods being tested including Bartel, EQ-5D-5L, Mayers Lifestyle Questionnaire, MOHO, Talking Points, IoRN, modified falls efficiency scale, bespoke local outcome measures with some others complementing one system with another.

3. WebEx Participant Comments and Discussion

There is a widespread interest and range of activity contributing to measuring aspects of Re-ablement Care at Home Services. Starting from the range of data that is currently collected, many are looking to add to this with information about levels of service (such as at the start and end of a period of Re-ablement), costs and the outcomes achieved. There is some (apparently limited) work on going around IT systems.

There is a variable approach to the structure of service with some focused on hospital discharge and others offering the service to other service users if or when resources allow. There is no body of knowledge developed that readily supports and gives effect to the service choices that are made:

- How does re-ablement work most effectively across Community based services and hospital based services?
- Where and how does it fit most effectively with rehabilitation and intermediate services?
- What is the most effective role of assessors? And do they adopt an outcomes focused approach?
- Is the role of providers maximised? Why are most services only delivered by in-house teams?
- Should there be handover standards to guide services at the end of a period of Re-ablement?
- How does partnership with Carers / Service Users impact on effectiveness?

There was no sign that authorities are currently collaborating on the development of performance measures such as:

- Why should service costs appear to vary so widely? (In following the public pound);
- What are the components of unit costs of service?
- Is / how is effectiveness measured beyond six weeks?

There is evidence of some detailed work being done in some areas, but no evidence of collaboration or that suggests this would result in comparable data. One area has recently invested some Change Fund monies in external evaluation.

There is limited evidence to suggest that performance measures are being developed in partnership with service providers or that many service providers are supported to develop a re-ablement ethos.

A number of participants suggested the need for information about good practice on the components that make for effective services and also on relevant performance measures.

Most authorities wish to hear more about what is being measured by others and most people who spoke said they were willing to share information. One example was given of an authority willing to share a study of baseline performance analysis prior to re-ablement commencing. It was agreed to share participant contact details to offer the opportunity of informal sharing at this stage.

4. Discussion

The findings of the WebEx development work has highlighted a range of issues that arise as the result of a very localised approach to the development of Home Care Re-ablement. Prime among these is an absence of clear answers to the initial questions:

- What are the components of an effective service?
- How is the effectiveness of Home Care Re-ablement being measured?

There is no doubt that colleagues who participated would wish to see a systematic approach to information sharing about the effective development and meaningful measurement of the performance of Home Care Re-ablement Services.

Additionally, in the context of Reshaping Care for Older People and Integration of Health & Social Care, the research review for this WebEx has also raised the profile of an emerging set of questions about the relatively limited nature of a re-ablement approach within Home Care Services. These are highlighted in a recent Demos Report[8] that speaks of the need for a 're-ablement ethos'. Among other questions, it asks:

- Is there a common view about re-ablement in social care and also in health care?
- Is a re-ablement ethos only relevant within a six week period of Home Care?
- What is the longer term impact of the six-week 'cliff edge' of re-ablement services?
- Is there a need for service providers to be more involved e.g. housing support providers?

The WebEx has confirmed that there is a wish for shared experiences and learning about the measurement of the difference Home Care Re-ablement Services make. However further work would be required if this was to extend further than sharing and the implications of this is considered next.

Implications of Differences in Approach

The differences of approach have been picked up in the Demos publication which found that *"re-ablement remains something of a nebulous concept, interpreted and applied differently across the country" and goes on to say "while re-ablement moderately reduces care costs over the longer term, it does not always reduce*

[8] The Home Cure. Claudia Wood and Jo Salter, Demos (2012)

health costs... [this]...*may be due to a range of limitations with the current re-ablement offer that we have identified through the course of this research, including:*

- *a narrow application of re-ablement to focus just on 'within the home' tasks, rather than enabling older people to re-engage with their community networks;*
- *a cliff-edge of support ceasing after the six-week period without adequate steps taken to ensure that a 're-ablement ethos' follows to maintain the good work achieved during the intervention;*
- *delays in access to equipment and adaptations; and*
- *a lack of flexibility and personalisation with the re-ablement support on offer."*

The challenges generated by these observations are important in the current context and also signal that:

- There is some confusion around what exactly re-ablement means, with health and social care professionals sometimes using different terminology**;**
- A 're-ablement ethos', focusing on helping people stay independent and active, is vital to help maintain the positive impact of re-ablement once the six-week intervention period had ended.

5. Conclusion and Key Findings

The findings on the status and scale of Home Care Re-ablement indicate there has been a positive transformational development in reshaping of care for older people since the regional workshops in 2010. The process of re-ablement gives direction to a number of themes emerging from the Self Directed Support Strategy for Scotland. It provides, at its heart, a person centred approach to assessment which makes the service user the focus of the process, uses multi-agency and multi-disciplinary approaches, emphasises and, in many cases, uses the Talking Points framework as well as the Indicator of Relative Need (IoRN) to provide a sharp focus on outcomes. It also provides a framework to build an anticipatory care planning approach with citizens.

The core questions that informed the initial WebEx have been answered and there is an appetite to share experiences and learning in performance information, and secondly, if service users are benefitting from the positive effects of a re-ablement ethos in Home Care Re-ablement then should such an ethos be extended further? The Demos report points to solutions that would work for Home Care Re-ablement but goes further by including the following in its recommendations:

- There needs to be further evaluation of re-ablement practice to identify best practice and 'what works' in achieving the best outcomes, and greatest cost efficiencies, over the longer term;
- There needs to be a more coherent and consensual understanding of what re-ablement entails;
- As part of this standardisation, there needs to be a wider, more holistic approach to re-ablement embedded as best practice. Such an approach strives to achieve independence in one's community, not just in one's home;
- Finally, and perhaps most importantly, clinical commissioning groups must think more creatively about how re-ablement is delivered and who delivers it. There is considerable potential for re-ablement to become more cost-effective

and achieve improved outcomes, looking to a wider range of re-ablement providers, and providers who work in partnership with other stakeholders to achieve more person centred support, is an important step towards identifying 'what works' in re-ablement.

WebEx Recommendations:

1. Good practice information should be developed to support the development of Home Care Re-ablement service components.

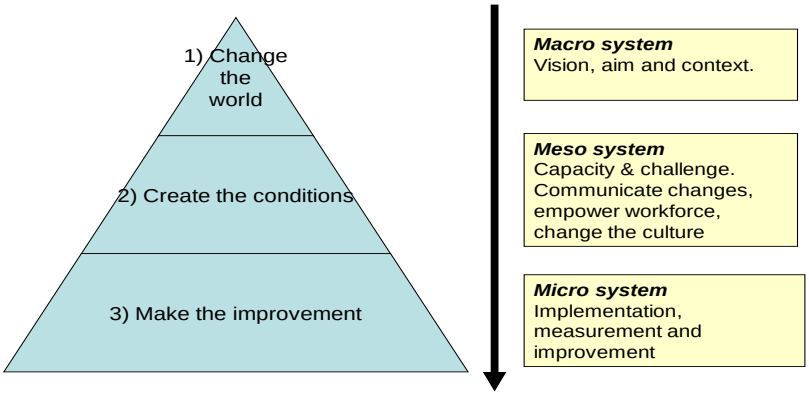
2. The development of performance measures on Home Care Re-ablement service should be supported in a way that creates the circumstances for sharing and learning about the impact on outcomes for service users – perhaps with a view to benchmarking.

3. Consideration should be given to clarifying what a 're-ablement ethos' is, and to using this broader definition to create a broader debate and understanding that the benefits of re-ablement have potential beyond a six week Home Care package.

SECTION 3: Conclusion

The JIT activity falls clearly within the 3 Step Improvement Framework for Scotland's Public Services, by providing some vision but more importantly providing the focus for partnerships on creating the conditions for change, and supporting the improvement. The current survey and the recent WebEx confirms that while a start has been made, there continues to be a need to assist the process through contact and development, best integrated practice and a focus on how best to maximise the impact of health and social care input.

The 3-step Improvement Framework for Scotland's public services



From the survey, 25 authorities/ partnerships have a Home Care Re-ablement Service and 5 authorities/ partnerships indicate they were in the development stage (months away). One authority/ partnership was looking to introduce re-ablement in 12 months. All re-ablement models were in house rather than purchased from the independent sector. Local authorities have added value to their in house service by providing re-ablement as a specialism compared to the conventional purchased care at home services. It may be that this will require being market tested at some point in the future.

There has been a change in culture for home care services in moving to an outcomes approach rather than the perceived wisdom of 'task and time' as the most efficient way to provide a home care service of doing tasks for people.

The most common model described was a Stand Alone Home Care Re-ablement Service (25 authorities/ partnerships,) with the Integrated Home Care and Intermediate Care services in 5 authorities/ partnerships. It would be worth undertaking further evaluation comparing and contrasting these different models in more detail to examine the merits of both. The ways that authorities/ partnerships have adapted the approach to suit their unique circumstances has seen sub categories of models for rural/ island settings, i.e. the continuity model. While there is no right or wrong configuration approach, the authorities/ partnerships that were able to identify a specific period of time attached to the provision of re-ablement, appeared better able to know how well they were progressing with re-ablement processes.

It is clear that one of the main routes into home care and re-ablement is through health services, and particularly on discharge from hospital. A high number of authorities/ partnerships (84%) were receiving referrals for Home Care Re-ablement from both hospital and community. Those who were receiving referrals only from hospital were planning to receive them from the community at some point in the future. A number of areas are now developing step up and step down models using residential care settings, some housing settings to provide a re-ablement service on discharge, or to prevent admissions. The process of re-ablement also allows the process of commissioning for home care to be more roundly addressed, given that a better understanding of the landscape for care at home is developing along with the need for support for people with complex care needs.

There were common characteristics described within this report that could help with providing a national standard for Home Care Re-ablement, reduce variation, and assist regularity bodies when evaluating services.

Home Care Re-ablement has yet to demonstrate an impact on spend and in responding to the increased demography of older people in Scotland. Performance information and basic information for some authorities/ partnerships was a challenge and a number of participants indicated that operational and outcomes measures by authorities/ partnerships would be an area of work that was worth exploring. While the nature of a telephone survey has certain limitation, it is the view of the interviewers that some authorities/ partnerships simply do not have information or systems in place to capture the information they need, and to assist in the commissioning activity central to Reshaping Care for Older People. In June 2012, the WebEx's summarised in Section 2 confirmed the appetite for standardising and benchmarking around performance measures for re-ablement.

There is still scope for further development of Telecare and Telehealth linkages, but there is good evidence of improved provision of community equipment from the earlier intervention of Occupational Therapists.

Further work is required in understanding the impact of turnover in re-ablement, and the effects of eligibility on the numbers entering the system, particularly in relation to different type of models

Finally, some quotes from participants about their overall view of their re-ablement service were:

> ***'We have had a number of significant successes with service users'.***
>
> ***'No older person remains in hospital now. People receive an assessment in their own home. There is no delayed discharge over 6 weeks and we are now moving to a 4 week target. There are no direct placements from hospital to a care home.'***
>
> ***'Re-ablement is the best thing we have ever done in redesigning home care'***

> ***'I would not underestimate the cultural shift and practice shift re-ablement has caused. We still need to engage publicly about the service users' experience of receiving the re-ablement service'***

The JIT continues to develop mechanisms of support in its work with authorities/ partnerships on re-ablement in combination with themes on whole system approaches to reshaping care for older people.

Next Steps

The Survey has been helpful in placing the national development into context, and the challenges facing partnerships in implementing such a major change from 'task and time' models to person-centred assessment and provision of services. The immediate pressures of Delayed Discharge are major drivers as is the demographic pressure impacting on care at home services, and in particular the nature of assessment processes being sharpened to involve users and family carers in self-directed models of support.

To date however, the commissioning (and procurement) agenda in care at home has largely been about investment in services (which may be necessary in its own right), and mainly through the opportunity provided by the Change Fund, but opportunities for greater partnership practice with NHS services, and the independent sector are clear.

Good practice information should be developed to support the development of Home Care Re-ablement service components. The development of performance measures on Home Care Re-ablement service should be supported in a way that creates the circumstances for sharing and learning about the impact on outcomes for service users – perhaps with a view to benchmarking.

Consideration should be given to clarifying what a 're-ablement ethos' is, and to using this broader definition to create a broader debate and understanding that the benefits of re-ablement have potential beyond a six week Home Care package, with relationships to 'Intermediate Care' and rehabilitation services. This should become a component of the Commissioning agenda, and could undertake work on the cost effectiveness of re-ablement, and compare to traditional AHP led rehabilitation services.

The challenge is now to understand more fully the impact and contribution to Reshaping Care for Older People, anticipatory and preventative outcomes, and supported hospital assessment and discharge practice.

The JIT has been working with ADSW on a range of related areas, particularly on support in medication practice, and with Alzheimer's Scotland on a 're-ablement' approach to supporting dementia practice in care at home services, and will continue to promote the following themes:

- Promoting best practice and efficient and effective models;
- Commissioning and contracting practice in care at home services;
- Understanding financial and practice changes arising from re-ablement and its relationship and contribution to the Reshaping Care for Older People

Programme and integrated practice with health services, the independent and voluntary sectors;
- Developments in medication, and on practice to support the National Dementia Strategy in care at home services;
- Developing outcome based activity and approaches to support Self Directed Support;
- Supporting individual partnerships.

Gerry Graham, **Sam McLean** and **Alex Davidson.**
Joint Improvement Team, February 2013

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Name of Authority/ Partnership	**City of Edinburgh Council Health and Social Care**
Contact	Andy Shanks, Home Care Re-ablement Manager
Description of Service	The Home Care Re-ablement Service in Edinburgh started in October 2008 and within six months was operating across the whole of the city of Edinburgh. The Home Care Re-ablement teams are separate from the mainstream home care service. The service evolved from the existing in house Home Care Service and the Home Care Re-ablement staff moved to this service following indications of interest from frontline staff. All staff were Social Care Workers and some had previously been involved in the hospital discharge service. A formal evaluation of the re-ablement service was funded by the Scottish Government and published in November 2009.
The scale of the service	The service now has 280 whole time equivalent home care workers along with 11 occupational therapists and 18 co-ordinators who are 100% dedicated to providing home care re-ablement. There are around 600 service users at any given point of time.
Access to the service	Clients are referred from hospital and the community with approximately 46% being referred from hospital. There is a policy of providing all people referred to home care with a re-ablement service and currently this is being achieved for 77.5% of clients. Goals are set with all new clients and this involves either the Occupational Therapist or the Home Care Manager. Paperwork outlines each goal and this is updated at weekly meetings to check on progress with the goal. Home Care workers attend weekly meetings to discuss progress. Use of an IoRN is proposed to ensure an outcomes approach.
Service Characteristics	The length of time service users remain in Home Care Re-ablement is on average 7.7 weeks. The average hours per week are around 7.4 hours. Staff are trained using a nine day training programme developed and tailored for front line home care workers.
Performance	The use of an IoRN before and at the end of 6 weeks is proposed and this will be developed by the service. The reduction in care hours at the end of re-ablement averages around 39.5%. Approximately one third of service users do not need a service following re-ablement. If someone still needs a service after re-ablement, there is a handover process to long term care at home providers or in house long term home care. A quarterly survey is carried out to check the satisfaction of service users following re-ablement, and the results demonstrate that since October 2012 over 85% of people using the Re-ablement service have been satisfied with it.
Next steps in the evolution of re-ablement	The next steps for Re-ablement in Edinburgh involve further developing links and pathways with other services, including the Intermediate Care Service and a range of community initiatives funded through the Change Fund. The Re-ablement service needs also to work within the frameworks of the emerging systems and processes for personalisation, integration and managing service users with complex needs.

Name of Authority/ Partnership	**Orkney Health and Care**
Contact	Rachel Ware, operational Manager
Description of Service	The Home Care Re-ablement service is provided by the Home Care mainstream service. The home care service receives the person referred and home carers from this service re-able them. The same workers will then continue to work with the person on a long term basis if this is required. The reason for this is that the numbers of referrals are variable in rural settings and there was a strategic decision for all home carers to have the potential to undertake re-ablement. A few extra teams were recruited to facilitate this and create time for staff to complete re-ablement with new clients.
The scale of the service	The numbers receiving a re-ablement service at any point in time is around 12, and approximately 12 home carers are working with these clients. The service is offered across the islands other than the remote islands. There are 8 Home Care managers who have all received the same training as the home care staff and a temporary Occupational Therapist was recruited using Change Fund finances.
Access to the service	A localised version of the Canadian Occupational Performance Measure (COPM) measure outcomes and a Talking Point approach is used in Health and Care. Goals are set with all service users.
Service Characteristics	Home Carers receive a two day training programme that is led by the home care managers and involves the service's Occupational Therapist.
Performance	The performance of the service has been reported for the first 6 months and indicates that a high number of service users did not require a service following re-ablement. The reduction in care hours for those who completed re-ablement was 51%. There is no mixed economy of care on the Islands and this means that all clients who require a service receive this from the in house service. There are some who receive Direct Payments.
Next steps in the evolution of re-ablement	The in house service is currently under review and the positive findings from the performance information in re-ablement are being used to inform this review.

Name of Authority/ Partnership	**Stirling Council**
Contact	Julie Gallacher, Care at Home Manager
Description of Service	The Home Care Re-ablement Service was developed incrementally in 2010 and 2011. It started small with just a few postcode areas prior to developing in the urban areas and finally in the rural parts of Stirling Council. The development of the service was implemented with cooperation from the Reach Intermediate Care Service and a process was set up for shortcutting referrals from one service to the other.
The scale of the service	The Service now covers the whole area, has 1 Manager and 2 Care Co-ordinators and 4 Occupational Therapists. There are also some Social Care Officers who help with goal setting. There are 65 Home Care workers and they deal with up to 75 clients at any given point in time.
Access to the service	Referrals come from both hospital and the community and the percentage split between hospital and community is 80% and 20%. Goals are set by the Occupational Therapist using straightforward paperwork. An IoRN is used to measure outcomes. A Talking Point outcomes approach is used.
Service Characteristics	The average length of time for a service user is 6 weeks and staffs meet weekly and review the service users progress and any amendments to care needs are implemented. Around week 4 if it is identified that the service users will require on-going support, a care plan is then forwarded to one of the Framework Providers. Staff are trained using a two day training programme.
Performance	There is a great deal of information gathered for home care re-ablement that tracks and reports on the care hours for each person. The average reduction in care hours per week is 25%. Following re-ablement, some service users do not require a home care service while others receive a service from one of the Frame Work Providers. A business Unit arranges the handover between the re-ablement team and the providers. The re-ablement team carers attend the handover. A survey of the service user and their unpaid care is undertaken following re-ablement. A 6 week post re-ablement review takes place.
Next steps in the evolution of re-ablement	There has been a reduction of 22% in care home beds since the inception of re-ablement approach and this has been included in a step up step down service. Contracts with the independent sector now have a section on re-ablement expectations.

Name of Authority/ Partnership	**Perth and Kinross Council**
Contact	Colin Johnson, Service Manager, Community Care
Description of Service	The service is provided by dedicated teams in the Access/Re-ablement team and has been in operation since October 2010 for Perth City and expanded into Rural Areas in May 2011
The scale of the service	There are 102 re-ablement workers providing a service to 115 clients at any one point in time. This involves 5 managers and an Occupational Therapist.
Access to the service	Approximately 31% of service users are referred from a hospital setting. Both the IoRN and Mayer's lifestyle questionnaire are used to measure outcomes for service users. The Talking Points approach is used within the authority. There has been an initial assessment tool developed to allow direct access to the service from Hospital based professionals. Also to allow easier access to re-ablement services a single point of contact (dedicated telephone line) has been introduced for health professionals. There has been an increase in the re-ablement team by 12 re-ablement assistants named as the Immediate Discharge Service, who work with people being discharged from Hospital for a maximum of seven days. They are then reviewed and either discharged from the service (currently 30% leave the IDS service with no service) or go onto mainstream re-ablement or mainstream care at home. This movement through the services allows us to provide a service to patients who are ready for discharge quickly and supports the reduction of delays in discharge from hospital
Service Characteristics	Staff receive a 2 day training programme in re-ablement which is also provided to the independent sector staff in order to maximise the long term benefits of re-ablement. We are now at the stage with staff where refresher course are being provided 6 monthly. Weekly meetings take place where frontline staff have direct access to a manager or Occupational Therapist and this is viewed positively by staff. There are weekly monitoring reviews carried out by Community Care Assistants with, a final review to look at any future outcomes the service user may have.
Performance	Home Care re-ablement regularly achieves around 40% reduction in care hours. This translates into a benefit of £1.2m per annum to the council that would otherwise have been spent if re-ablement had not been in place. Around 70% of clients who need a service go on to receive a service from the independent sector while 30% receive a service from the long term in house home care service.
Next steps in the evolution of re-ablement	Re-ablement is expanding into providing a service to clients in day care, Drug and Alcohol services, Mental Health Services and learning disability services. Our future joint partnership plans are to provide an in reach service to our NHS Community Hospitals and to clients who are in Step up or Step down facilities to commence the re-ablement service in a timely fashion and to prevent any possibility of institutionalisation or dependency.

Name of Authority/ Partnership	**North Ayrshire**
Contact	Mark Halpin, Team Manager – Care At Home
Description of Service	Home Care re-ablement is integrated with Health through the Intermediate Care and Enablement Service (ICES). There has been history of cooperation between social care and health in North Ayrshire. The ICES service and re-ablement service work together to support service users reach their full potential following discharge from hospital or community based referral. This is for new service users OR existing service users who require an increase in their service following a significant event. Both use North Ayrshire Care at Home staff to provide the daily support to service users, following the guidance of the allied health professionals within the teams. The ICES team have Physiotherapy, OT, Pharmacy, Technical Instructors and Rehab Nurses and focus on the high end rehabilitation needs. The re-ablement team has dedicated Occupational Therapists working as part of the care at home service. Weekly meetings with Care at Home Managers, ICES, assessment team and frontline care at home staff discuss progress towards goals and agree on focus for the next week service. Service users' journeys can continue from intense rehabilitation with ICES team through to re-ablement team for on-going outcome focussed services, with the aim of service users achieving their optimum level of independence. A member of staff from the assessment team has been seconded onto ICES to support the assessment process, and allowing the AHP's to focus on their therapeutic intervention.
The scale of the service	The service is being provided across the whole authority (including Arran) and is available to all service users referred from community (new case or increase) or being discharged from hospital. There are dedicated team across each of the locality areas who are focussed on supporting service users to achieve their maximum potential. All service users will be screened for their suitability for either re-ablement or ICES, however there is now a focus to supporting all service users with a re-ablement approach. Supporting service users to achieve increased independence or to support them to maintain the skills and ability that they have.
Performance	An evaluation of the re-ablement service is currently being commissioned and should be completed by the end of March 2013
Service User Experience	Mr S was admitted to hospital for a surgical procedure to create a stoma due to bowel and rectal cancer. On discharge Mr S received input from North Ayrshire Council's Re-ablement Team. Home care was provided twice daily, morning and lunch for personal care and meals and Mr S was visited by a social work assistant and an occupational therapist. Equipment was provided in Mr S's bathroom to enable him to shower independently and a stool was provided in kitchen to preserve Mr S's energy whilst cooking. With equipment in situ and encouragement from staff Mr S's care was reduced gradually over a period of seven weeks. Mr S has now returned to full independence and does not require on-going input from social services. Mr S stated "I was quite active before the operation, but struggled to get up by myself when I returned home - but I've always been self-sufficient and I'm gradually getting more of my strength back so I am able to do more each day."

APPENDIX 1: Telephone Survey of Status and Scale of Home Care Re-ablement in Scottish Local Authorities/ Partnerships Spring 2012

Thank you for taking part in this telephone survey which is intended to gather information on the status and scale of Home Care Re-ablement in Scotland and to identify the range of models being developed. The results will inform the Care at Home workstream within the Joint Improvement Team but will also inform wider pieces of work for the JIT including Reshaping Care for Older People. The questions covered in the telephone survey are listed on the following page. You will be contacted by email to identify the best time to telephone you. The interview should take no more than 30 minutes. We will also take a note of:

- Name of Authority/ Partnership;
- Name of contact;
- Job Title of Participant;
- Contact Telephone Number;
- Contact email.

1. What is the status of Home Care Re-ablement in your authority/partnership?
2. If you are establishing a Service, what stage are you at?
3. What approvals do you have in place from Committees or Health Boards?
4. What are the organisational features of your service?
5. What is the scale of your Home Care Re-ablement Service?
6. What is the percentage spread across local authority areas?
7. How many whole -time equivalent Home Carers are dedicated to Re-ablement Service?
8. What type of staffing do you have in post?
9. How are Occupational Therapists involved in your Home Care Re-ablement Service?
    a. Are there other Allied Health Professionals involved in Home Care Re-ablement?
    b. Are other professionals involved in assessment, and do they lead the process?
10. Who is the Lead Manager for your Home Care Re-ablement Service?
11. What are the main features of your service?
12. What is the capacity at any one point in time (number of service users/ patients)- Average number of hours per week per service user –
13. What is the number of care hours reduced per month - Validated Percentage reduction in care hours-
14. What is the Unit Cost Per Hour for the Re-ablement Service?
15. Has there been a shift in spend on home care in line with the national reduction in continuing hours? What is it?

16. Has the introduction of re-ablement services had an impact on commissioning, procurement and contracting with the independent and private Care at Home Sector? How?
17. Has the introduction of re-ablement services had an impact on integrated practice with NHS rehabilitation (intermediate care) services, and or in Long Term Conditions activity? How?
18. Has the introduction of re-ablement had an impact on the use of Telehealth care, community equipment and adaptations, and on housing involvement? How?
19. What methods or tools, if any, are you using to assess outcomes of re-ablement (IoRN, Mayer, etc.), for service users and for family carers?
20. Have you used the opportunity to develop anticipatory care plans, during or following the period of re-ablement?
21. Additional description of your Home Care Re-ablement service, e.g. are there any other features that have not been covered above that best describes your Home Care Re-ablement Service?
22. Any other comments?
23. Additional areas of interest to JIT:
    a. Has Change Fund financial support been provided for Home Care Re-ablement?
    b. Is it making a difference?
    c. Do you have an agreed Administration of Medicines Policy or Procedure?
24. Are there areas of practice, performance or policy development that the JIT could facilitate through national or local development?

Thank you.