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# **Home Care Re-ablement Services: Investigating the longer-term impacts (prospective longitudinal study)**

## **Executive Summary**

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## Executive summary

Re-ablement is a new, short-term intervention in English home care. It helps users to regain confidence and relearn self-care skills and aims to reduce needs for longer-term support. Home care re-ablement services are usually provided or commissioned by local authorities responsible for adult social care. Some services are selective, prioritising people discharged from hospital or recovering from illness and accidents; others are more inclusive, accepting almost all those referred for home care. In autumn 2010, £70 million was allocated to NHS Primary Care Trusts for further development of re-ablement services. Further funding to the NHS for re-ablement is being made available as a result of the government's spending review; £150 million in 2011/12, rising to £300 million per annum over the period 2012-15.

Research by the Social Policy Research Unit, University of York and the Personal Social Services Research Unit, University of Kent examined the immediate and longer-term impacts of home care re-ablement; the cost-effectiveness of the service; and the content and organisation of re-ablement services. People who received home care re-ablement were compared with a group receiving conventional home care services; both groups were followed for up to one year.

- According to data supplied by local authorities, the unit cost of a typical re-ablement episode is £2,088. The mean cost per hour is £20 and the mean cost per hour of service user contact time is £40.
- Re-ablement was associated with a significant decrease in subsequent social care service use. The costs of the social care services used by people in the re-ablement group during the 12 months of the study (excluding the costs of the re-ablement intervention itself) were 60 per cent less than the costs of the social care services used by people using conventional home care services.
- However, this reduction in social care costs was almost entirely offset by the initial cost of the re-ablement intervention. The total (including re-ablement) mean cost of the social care services used by the re-ablement group was £380 lower than the total mean cost of the social care services used by the comparison group.
- The re-ablement group had significantly higher healthcare costs than the comparison group during the first eight weeks of the study. However, more people in the re-ablement group had been referred to the service following discharge from hospital. These people had significantly higher healthcare costs (mainly arising from further hospital in-patient episodes) during the first eight weeks of the study than people who had been referred to re-ablement from the community. However, there was no significant difference between the re-ablement and comparison group in the costs of the health services used during the subsequent ten months of the study. When baseline differences were taken

into account, there were also no significant differences in the duration of inpatient stays or the total costs of healthcare service use when averaged across the two groups over the full 12 months of the study.

- Taking total healthcare, social care and re-ablement costs together, there was no statistically significant difference in the costs of all the services used by the re-ablement and comparison group over the 12 month study period.
- Re-ablement had positive impacts on users' health-related quality of life and social care-related quality of life up to ten months after re-ablement, again in comparison with users of conventional home care services.
- At a 'willingness to pay' threshold of £30,000 for each increase in health-related quality of life, there is a very high probability (99 per cent) that re-ablement is cost-effective if health and social care costs are taken into account, and just under 100 per cent probability if social care costs alone are included. At a more stringent threshold of £20,000 per health-related outcome gain, the probability of cost-effectiveness is still very high, at 98 per cent for health and social care costs and 99 per cent for social care costs only.
- For social care-related outcomes, at a 'willingness to pay' threshold of £30,000 per outcome gain, there is a 78 per cent probability that re-ablement is cost-effective if both health and social care costs are included and a 98 per cent probability that re-ablement is cost-effective if just social care costs are included. At the more stringent threshold of £20,000 per social care-related outcome gain, the probability of cost-effectiveness is 68 per cent for combined health and social care costs, but still 98 per cent for social care costs only.
- Effective re-ablement services require good initial staff training and on-going supervision; clear outcomes for users and flexibility to adapt these as needs change; and prompt supply of equipment. Prompt transfer to home care for those who need it at the end of re-ablement is essential to maintain capacity in re-ablement services.
- Users and carers were positive about the impact of re-ablement on their independence and confidence, although some would have liked more help to improve their mobility and undertake activities outside the home.

## **Background**

English adult social care departments are developing short-term, specialist home care re-ablement services. Re-ablement is a particular approach within home care; it supports users in developing confidence and relearning self-care skills, thereby increasing their independence. Providing equipment for use at home is an important part of re-ablement. Many re-ablement services started as selective schemes, primarily for people discharged home from hospital or recovering from an illness or accident. However, the approach is increasingly being extended to most people

eligible for adult social care and referred for home care support. Re-ablement is usually offered for up to six weeks; after this, some people may require no further support while others will be referred for conventional home care.

This study aimed to:

- Provide robust evidence on the immediate and longer-term benefits of home care re-ablement, by comparing outcomes for users of home care re-ablement with outcomes for people using conventional home care services.
- Identify factors affecting the level and duration of benefits for service users.
- Estimate the unit costs of home care re-ablement services
- Identify impacts on and savings in the use of social care and other services that could offset the costs of re-ablement.
- Describe the content of home care re-ablement services.

## **The impact of re-ablement on quality of life and social care outcomes**

Home care re-ablement appears to have positive impacts on individuals' health-related quality of life and social care outcomes. Overall, re-ablement was associated with significantly greater improvements in health-related quality of life, compared with people using conventional home care services. People who had used re-ablement also had greater improvements in social care outcomes compared to users of conventional home care services, although the effect was not as strong. These results took account of any differences in the characteristics of the re-ablement and comparison groups.

## **The costs of re-ablement services**

Established methodologies were used to estimate the typical unit costs of home care re-ablement. A typical re-ablement episode in the five study sites cost £2,088, with a range of £1,609 to £3,575. The mean cost per hour is £20 and the mean cost per hour of service user contact time is £40. These costs are higher than for typical conventional home care services of the same duration. Although based on limited evidence, re-ablement services that employ occupational therapists as members of the team appear no more expensive than those employing only social care staff.

## **The impact of re-ablement on the use and costs of social care and health services**

The mean cost of the re-ablement (and any other social care) services used by study participants during the first few weeks of the study was £1,640. This was significantly higher than the mean cost of the conventional home care and other social care services used by the comparison group during the same period, at £570. However, people who had had home care re-ablement used less social care services in the ten months following the re-ablement episode than the comparison group that had used conventional home care services. The mean cost of the social care services used by the re-ablement group over the following ten months was only £790, compared to £2,240 in the comparison group. These lower social care services costs following the completion of re-ablement cancelled out the higher cost of the initial re-ablement intervention. Over the course of a year, the mean total (re-ablement plus other social care services) cost of the social care services used by the re-ablement group was only £380 lower than mean total cost of the social care services used by the comparison group during the same period. This difference was not statistically significant. After accounting for differences in baseline characteristics, the costs of the social care services (excluding re-ablement) used by people in the re-ablement group were 60 per cent lower than the costs of the social care services used by the comparison group over the year (mean £1,130 compared with £2,850).

People in the re-ablement group had significantly higher mean health services costs during the first eight weeks than those who had been referred to conventional home care. This was particularly the case for people who had been referred to re-ablement following discharge from hospital; the mean cost of the health services used during the first eight weeks by those who had been discharged from hospital was £1,850, compared to a mean cost of £1,020 for those referred from the community. These higher health service costs were largely caused by greater use of expensive hospital inpatient services. However, there were no significant differences in the mean costs of the health services used by the re-ablement and comparison groups, whether referred from hospital or the community, over the subsequent ten months, and therefore over the duration of the study as a whole.

## **The cost-effectiveness of home care re-ablement**

Cost-effectiveness is measured by comparing improvements in health-related quality of life and/or social care outcomes against the costs of those improvements. When assessing the cost-effectiveness of treatments, the National Institute for Health and Clinical Excellence (NICE) generally assumes that £20,000 to £30,000 (at the top of its threshold) is an acceptable cost for each increase in health-related quality of life outcome.

On the basis of this study, home care re-ablement is cost-effective in relation to health-related quality of life outcomes and may also be cost-effective in relation to social care outcomes. Assuming a willingness to fund an intervention if it costs no more than £30,000 for each increase in health-related quality of life outcome, the study found a 99 per cent probability of re-ablement being cost-effective if both health and social care costs were included and just under 100 per cent if social care costs only were included. At a more stringent willingness-to-fund threshold of £20,000 per unit improvement in health-related quality of life, the probability of cost-effectiveness was 98 per cent if health and social care costs were taken into account but was still over 99 per cent if just social care costs were considered. These minor differences in probability arose because, as noted above, some of the re-ablement service users had higher health care costs than people who used conventional home care.

Similarly, the study found re-ablement was cost-effective in relation to social care outcomes. Assuming a willingness-to-fund threshold of £30,000 for each unit gain in social care outcomes, there was 78 per cent probability of re-ablement being cost-effective when total health and social care costs were taken into account.

When just social care costs were included, the probability of cost-effectiveness rose to 98 per cent, again because of greater health service use by some of the re-ablement group. At a threshold of £20,000 per unit improvement in social care outcomes, the probability of cost-effectiveness was 68 per cent for health and social care costs and 98 per cent for social care costs only.

These findings have important caveats. Fewer participants than expected remained in the study for follow-up interviews nine to 12 months after referral to re-ablement (or conventional home care); this may be a source of bias. Data on use of health services during the study relied on participants' recall and may be inaccurate. Data supplied by local authorities on social care service use excluded services and/or equipment purchased privately or supplied by voluntary organisations, thus potentially underestimating the use and costs of such services. Finally, as with any statistical analyses, 'statistically significant' results mean that a very high probability can be assumed, but not absolute certainty.

## **The organisation and content of home care re-ablement services**

According to service managers and front-line staff, factors contributing to the effectiveness of home care re-ablement fell into two clusters: internal organisation and management; and the wider service environment. The most important internal organisational factors were:

- Commitment, enthusiasm, knowledge and skills of front-line staff. This requires thorough initial training and regular on-going supervision and peer support.

Training was particularly important for staff recruited from conventional home care services.

- High quality initial assessments by senior re-ablement staff; clear goals negotiated with users; regular reassessment throughout the re-ablement process; and flexibility to adapt the timing, duration and content of visits as users' needs and capabilities altered.
- Rapid assessment and delivery of equipment. Having quick access to occupational therapy skills and equipment may be more important than having occupational therapists employed as members of the re-ablement team.

Wider environmental factors were:

- Clarity among all relevant staff (including hospital discharge planning staff and adult social care managers) about the aims, potential and limitations of home care re-ablement.
- Access to specialist training and skills, especially if re-ablement services are less selective and accept users with a wide range of health problems and impairments. Access to occupational and physiotherapists was particularly important; other relevant professionals to whom easy access was important included continence advisors, community matrons and specialist workers for visually impaired people. Training and advice on working with people with dementia or other mental health problems could also extend the effectiveness of home care re-ablement.
- Prompt transfer to long-term home care services at the end of re-ablement for those needing continuing help. Without adequate capacity in long-term home care, re-ablement services risked becoming 'blocked' by clients awaiting transfer and their efficiency correspondingly reduced.

User attitudes and motivation were also considered important success factors.

## **User and carer perspectives on re-ablement services**

Service users and carers initially knew very little about the nature and aims of home care re-ablement. Nevertheless, they reported improved independence, greater confidence and increased motivation to make further gains in self-care skills. The most commonly reported achievements related to personal care and preparing simple meals/snacks. Knowing they were being regularly and frequently monitored, and the routines created by regular re-ablement visits, boosted users' confidence, especially after illness or hospitalisation. The quality of relationships with front-line re-ablement workers was an important source of motivation to achieve agreed goals.

Users with non-progressive health conditions reported greater improvements. Some users would have liked more help with improving their mobility and social activities outside the home. Carers reported improved confidence in supporting users, but would have welcomed more advice on how to maximise users' independence.

## **Recommendations for policy and practice**

On the basis of this study, current policies to promote home care re-ablement appear well-founded and show good value for money, especially in achieving health-related outcomes.

The following areas of practice could be developed:

- Greater attention to explaining the aims of the service – probably on several occasions following initial assessment – may help users' understanding and enhance their responsiveness.
- Closer relationships between home care re-ablement and physiotherapy services may be appropriate, especially as NHS Trusts begin to invest in re-ablement.
- How carers can contribute to, and benefit from, re-ablement warrants further consideration.
- Further consideration is needed as to whether re-ablement should be a targeted service or accept most referrals for home care. There was widespread agreement among participants in this study that re-ablement had greater benefits for people recovering from acute illnesses, falls or fractures than those with chronic, complex or progressive health problems. Given increasing pressures on all health and social care services, a more targeted approach may be appropriate.

## **Study design and methods**

- A comparative design was adopted. Service users from home care re-ablement services in five English local authorities were recruited, as were users of conventional home care from five different local authorities. Both groups were recruited on referral to re-ablement/conventional home care services; baseline interviews were conducted at this time.
- The re-ablement group was interviewed a second time, on completion of re-ablement.
- Both re-ablement and comparison groups had a follow-up interview nine to 12 months later.
- Initially 1,015 people were recruited to the study, 654 to the re-ablement group and 361 to the comparison group. Between recruitment and follow up nine to 12

months later, a total of 633 participants were lost to the study because of death, illness, (re)hospitalisation or refusal to participate in the follow-up interview.

- Allocation of service users to the re-ablement group and comparison group was not random, although equivalent selection criteria were used for each group. The potential for selection bias was mitigated by adjusting for a comprehensive range of baseline characteristics in the data analysis and by the follow-up study design. This design allowed us to measure any differences between the groups in how their experiences differed over the nine to 12 month follow-up. The size of the *difference* in any outcome over time is less sensitive to baseline characteristics than the (absolute) scale of the outcome at any given time.
- The recruitment rates to the study were lower than expected and the follow-up drop-out rates higher than expected, leading to smaller sample sizes than anticipated. The potential for statistical error is higher in smaller samples.
- At each interview, standardised, validated outcome measures were used to assess:
  - Self-perceived health
  - Perceived quality of life
  - Health-related quality of life (EQ-5D)
  - Social care-related quality of life (ASCOT).
- Local authorities supplied data on the volume and costs of services used by study participants. Study participants provided details of the health and voluntary organisation services and equipment they received.
- Sites provided detailed information on the unit costs of their home care re-ablement services.
- The organisation, management and delivery of re-ablement services were investigated through:
  - Interviews with senior and operational managers
  - Focus groups with front-line staff
  - Observations of re-ablement visits.
- In-depth, semi-structured interviews were conducted with small samples of re-ablement users and carers.