Investigating the Longer Term Impact of Home Care Re-ablement Services

The Organisation and Content of Home Care Re-ablement Services

Interim Report

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Chapter 1   Introduction

1.1   Background - what is home care re-ablement?

English local authorities with responsibility for adult services are increasingly developing short-term, specialist home care re-ablement services. Re-ablement is often described as an 'approach' or a 'philosophy' within home care services – one which aims to help people 'do things for themselves', rather than 'having things done for them'. Home care re-ablement services provide personal care, help with activities of daily living and other practical tasks for a time-limited period, in such a way as to enable users to develop both the confidence and practical skills to carry out these activities themselves.

Home care re-ablement services can take different organisational forms. In some localities, home care re-ablement services are funded and operated jointly with NHS partners. In many local authorities, adult services departments have taken a lead themselves, often as part of the reconfiguration of the authority's home care services. Here, in-house home care staff receive training in re-ablement approaches and teams are often strengthened by the appointment of occupational therapists (OTs), OT aides and other specialist staff. In any case, easy access to equipment by re-ablement team members is considered important.

Home care re-ablement services fall into two broad groups. In 'discharge' services, re-ablement services work predominantly or exclusively with people who have been discharged from hospital. Discharge services are often selective, accepting only people certain to benefit from a re-ablement approach and, as with intermediate care, are likely to be free of charge. In other localities, home care re-ablement acts as an 'intake' service for a wide range of users who meet local Fair Access to Care (FACS) eligibility criteria and are referred for home care services. Often, only people thought unlikely to benefit, such as those with end-stage terminal illness or advanced dementia, will be screened out from an 'intake' service.

Home care re-ablement services are normally offered for up to six weeks, with some flexibility to continue for longer if the user would benefit from this or if appropriate longer term support services are not immediately available. Re-assessments and referrals for on-going home care and other services are made at the end of the period of re-ablement. Unlike intermediate care services, which were developed in the context of policy concerns about inappropriate hospital bed use by older people, re-ablement services are usually available to adults of all ages.

1.2   Policy background to the study

The need for greater investment in preventive and rehabilitation services was recognised a decade ago (Kings Fund, 1999). At that time there were relatively few alternatives to extended hospital stays or services that could avert admission to institutional care. The Audit Commission (1997) described this as a 'vicious circle' of spiralling costs, inefficient use of scarce resources and a failure to enable older people to live as they preferred – independently in the community.

The NHS Plan (Secretary of State for Health, 2000) announced significant investment in new intermediate care services. Intermediate care aimed to reduce the length of hospital stays by offering services to aid recovery outside acute settings; and/or provided a 'rapid response' in emergency situations to avert the need for admission to hospital or residential care. A wide variety of intermediate care services were established, based variously in acute, community and day hospitals; community-based teams working in people's own homes; and residential services in purpose-built units, sheltered housing or care homes. Some intermediate care services are entirely hospital-based; others are funded and delivered jointly by local NHS and social services organisations.

More recently, councils with adult social care responsibilities have begun to develop home care re-ablement services. A Care Services Efficiency Delivery questionnaire distributed to councils in England during autumn 2006 found that 24 per cent already had a home care re-ablement service; 16 per cent had a limited service that they were planning to expand; and 26 per cent were planning to establish home care re-ablement services (CSED, 2007). An updating survey published in 2008 found that 106 councils had a re-ablement service in place, were seeking to expand an existing service or were in the process of establishing a service. About a third of councils supplying the necessary information reported that they charged for re-ablement services while two-thirds did not nor intended to do so (CSED, 2008).

Local authority home care re-ablement services have quickly come to occupy an important place in policies aimed at enabling older people in particular to remain living independently in their own homes for as long as possible. They are a cornerstone of preventive service initiatives and as such have the potential to be cost-effective, if the costs of the service are outweighed by reductions in the use of more intensive services over time. The policy commitment to home care re-ablement services was restated in the recent Green Paper on future options for adult social care:

> **We think that people who are leaving hospital and need care and support for the first time should have the right to the re-ablement help they will benefit from at home, for example for six weeks.** This extra support will help people get back to their normal lives. (original emphasis)
> (Secretary of State for Health, 2009: 51)

1.3   Research background

The wide diversity of intermediate care services - their settings, the interventions they offer, the range of routes by which users access them and the 'destinations' to which users move on discharge - has made systematic evaluation very difficult (Barton *et al.*, 2005). High level performance indicators have shown few changes in the use of health and social care services, although they do suggest shifts in the 'routes' followed by users through a spectrum of health and social care services (Godfrey *et al.*, 2005). Nevertheless qualitative evidence from service users suggests that intermediate care can make a significant difference to their lives (Godfrey *et al.*, 2005).

Home care re-ablement services are likely to be characterised by less diversity than intermediate care. They are commonly based within local authority adult social care services, employing retrained, in-house home care staff, and offering up to six weeks intervention. The main difference within re-ablement services is likely to be whether they are restricted to people newly discharged from hospital (or intermediate care) or whether they accept everyone who has been accepted as eligible for local authority-funded home care services.

A key challenge in investigating the effectiveness and cost-effectiveness of home care re-ablement services to date has been the technical ability to link routine data on re-ablement service use with data on subsequent social care and other service use. Nevertheless, two preliminary studies have begun to develop an evidence base on the impact of home care re-ablement in England.

An early study investigated the impact of Leicestershire's pilot home care re-ablement service (Kent *et al.*, 2007). When the pilot started it was highly selective; it was later extended to become an 'intake' service for everyone assessed as needing home care. Users' subsequent use of home care services (as measured at the time of first review) was compared with that of a matched group of service users from another part of the county which at the time did not have a re-ablement service. Initially, people referred to the home care re-ablement service (both selective and 'intake' versions) had larger packages of care, as measured by weekly hours of home care, than those in the comparison group. However, when service use at the time of first review was compared, the re-ablement group was far more likely to have discontinued home care service use than the comparison group. The results were

particularly dramatic for users of the selective service. Among those re-ablement service users who did continue to use home care services, their level of services was more likely to have decreased and less likely to have increased at the time of the first review, than those who had not had re-ablement.

Although showing dramatic reductions in the use of home care services, the Leicestershire study was only able to demonstrate the impact of home care re-ablement at the time of first review, around three months after re-ablement. A further study examined the longer term impact of home care re-ablement (Newbronner *et al.*, 2007). This study used data from two local authority 'discharge support' re-ablement services and two further 'intake' re-ablement services and examined the use of social care services at 3, 6, 12, 18 and 24 months after discharge from re-ablement. In three of the four sites, between a third and a half of re-ablement service users used no other home care services, either before or up to 24 months after re-ablement. Among some of those who did use standard home care services following an episode of re-ablement, starting to use these services appeared to be delayed for a year or more; moreover in two of the four sites the percentages using less home care, compared with their discharge from re-ablement, actually increased over time.

This latter study was small and exploratory. It lacked robust baseline data on re-ablement service users and, crucially, it also lacked a comparison group of people who received only standard home care services. It was therefore not possible to conclude with certainty that any reduction in the use of home care services, in either the shorter or longer terms, was due to the impact of re-ablement; such reductions in service use might have occurred anyway as part of normal fluctuations in the health and support needs of older and disabled people.

A review of international evidence on the effectiveness of re-ablement approaches also suggests that positive impacts on users' functional status and subsequent use of services are likely (Ryburn *et al.*, 2009). The provision of aids, equipment and home adaptations appears particularly likely to improve functional status and result in longer term cost savings. However, the reviewers point to the limitations of the evidence base, as there have been relatively few evaluations of re-ablement services and those that have been undertaken have been limited by small sample sizes. Questions remain about the most effective types of programmes; about which groups are likely to benefit most; and about the most effective timing and duration of re-ablement interventions. Moreover, 'research looking at the longer term outcomes (i.e. post one year duration) from restorative programmes has been limited, so the longer term benefits have yet to be substantiated' (Ryburn *et al.*, 2009: 232). The overall re-ablement evaluation, of which this report is part, aims to fill that evidence gap.

1.4   Aims of the study

The study aims to:

1. Provide robust research evidence on the immediate and longer term benefits of home care re-ablement, including:
    a) User-level benefits (improved independence, quality of life, mental well-being)
    b) Service-level benefits (reduced demand for services, less use of expensive services).

2. Identify the factors that affect the level and duration of benefits for service users of a period of re-ablement (e.g. features of the service; user group characteristics; type and level of services used after re-ablement).

3. Identify any impact on and savings in the use of social care and other services that can be set against the costs of re-ablement services.

4. Describe the content and the costs of home care re-ablement services.

The overall design of the study, details of its implementation and changes that were made in the course of the data collection period are contained in the Appendix. This report addresses the fourth aim and provides a detailed account of the organisation and content of the five home care re-ablement services involved in the study.

A second interim report (Jones *et al.*, 2009) reports on the costs of home care re-ablement services and the immediate impact and outcomes for service users.

1.5   Structure of this report

Chapter 2 describes the data collection processes used in this part of the study. This is followed by a summary of the main features of the five re-ablement services in Chapter 3. Chapter 4 reports some of the key operating issues and Chapter 5 describes some of the main features of the re-ablement services. Chapter 6 reports the views of study participants on the factors enhancing and/or constraining the impact and duration of the benefits of re-ablement services in the shorter and longer terms. Chapter 7 concludes the report by bringing together some of the key points.

Chapter 2   Methods

2.1   Study design

The overall design of the study had a number of different elements (see Appendix). This report details the organisation and delivery of home care re-ablement in the five study sites.

The qualitative work for this report involved three strands of data collection, offering opportunities for cross checking, triangulation and exploring issues in depth between the different types of data. It started with interviews with the managers of the five re-ablement services. As well as collecting data on the organisation and delivery of the service, these interviews also identified issues to be explored in subsequent observations of home care re-ablement service visits to service users. Both these sets of data in turn informed the topics that were discussed in focus groups with front-line home care re-ablement staff in each of the five sites.

2.2   Interviews with service managers

A pilot interview to refine the topic guide was conducted with the manager of a re-ablement service in a local authority that was not participating in the study. This topic guide was then used to conduct semi-structured interviews with one (in some instances two) home care re-ablement service manager/s in each of the five re-ablement sites. In each site, the senior service manager was asked to identify a manager who could be interviewed about the establishment, operation and outcomes of the re-ablement service. In all five sites, the senior managers opted to take part in these interviews. In three of the sites they were joined by an operational manager.

A summary of the topics to be covered in the interview was sent in advance to interviewees. The interviews covered: the background to the establishment of the re-ablement service; how the service was established; the professional skills represented among front-line staff; the content of the re-ablement service; assessment, monitoring and discharge arrangements; and views on the factors promoting and hindering the impact of re-ablement. Managers were also asked for any relevant documentation relating to the re-ablement service.

Three interviews were conducted face to face and the remaining two interviews over the telephone. Interviews took between one-and-a-half to two hours. All interviews were tape recorded, with the participant's consent, and subsequently transcribed.

2.3   Observations of re-ablement activities

The interviews with managers were followed by observation of up to six re-ablement service visits to service users in each site. The aims of the observations were to:

- obtain a first-hand picture of the practice and processes of re-ablement, particularly the balance between providing a service <u>for</u> the client and encouraging clients to participate in and carry out tasks for themselves

- examine in more detail issues raised by the interviews with service managers

- obtain (further) insights into differences in the front-line operation of re-ablement services that might affect outcomes for service users

By including visits at different stages in the course of a re-ablement episode (ie some visits soon after referral to the service, others near to expected discharge from the service), there were also some opportunities to see whether the nature of the re-ablement intervention differed over the course of the episode.

Criteria for selecting the observation visits were refined following preliminary analysis of the interviews with the service managers about the factors reported to affect the conduct or outcomes of home care re-ablement services. Each site was asked to arrange for the researcher (PR) to observe visits to service users with the following range of characteristics:

- someone referred after hospital discharge and someone referred to the service from the community

- a male and female service user

- users with a range of ages and disabilities/illnesses

- users from majority and ethnic minority communities

- service users at different points in the re-ablement process

- users living alone and those living with a carer

- interventions with and without any involvement from an occupational therapist

- those completely new to adult social care services and those with previous histories of adult social care service use

- highly and poorly motivated service users.

Sites were also asked to include in the visits home care re-ablement staff with different levels of experience in the service.

The sites were very helpful in setting up the visits. However, some planned visits were cancelled at short notice, because planned hospital discharges had been delayed or service users had unexpectedly been admitted to hospital. Because of

time constraints it was not possible to replace these. In total, 26 re-ablement visits were observed across the five sites.

The front-line staff were asked by their managers to take part in these visits. Verbal consent from the service users involved was obtained by the re-ablement workers prior to the visits. Written consent from the participants was obtained at the start of the visit by the researcher. The researcher wrote short notes during the visits and expanded these notes, elaborating on key points, later.

2.4   Focus group discussions with front-line staff

The original research proposal included two focus group discussions with front-line workers in each of the five re-ablement sites. We consulted the managers (in four of the re-ablement sites) about the practicalities of this. The unanimous view was that it would be preferable to conduct just one focus group that included members of different staff teams, to reduce the problems of providing additional cover while staff were busy in the focus group. This, together with the limited research staff availability, led to a decision to carry out one focus group discussion in each site.

In each of the five sites one focus group discussion was conducted with up to eight front-line staff. In total, 37 front-line staff took part in the focus group meetings. In three of the five sites, an OT participated in the focus group discussion. Two researchers conducted the focus group meetings. All focus group discussions were taped, with the participants' consent, and subsequently transcribed.

Participants had a mixture of occupational backgrounds, experiences and training; were drawn from different teams; and included one or two OTs where possible. The aim of the focus group discussions was to explore staff views on the factors perceived to promote or constrain the benefits of re-ablement, in the shorter and longer terms. The topic guide drawn up for the focus group discussions covered staff general views on the re-ablement approach, whether they thought re-ablement worked equally/differently for different groups of people and what factors would enhance/constrain the impact and/or duration of the benefits of re-ablement services in the shorter and longer terms. We also asked for staff views on how re-ablement services could be improved and, more specifically, what would help them to achieve more for service users. The topic guide also picked up and explored further issues covered in the interviews with managers and that had arisen from the observations of re-ablement visits.

2.5   Analysis

The data generated from the interviews, focus group discussions and observation visits were analysed using the framework approach and by a process of data reduction, data display, and conclusion drawing and verifying (Miles and Huberman, 1994). The data were summarised onto a series of charts according to analytical categories (both *a priori* and emergent themes) generated by the researchers based on their readings of the transcripts. The charts did not contain verbatim text but rather a synthesis accompanied by a reference to where it could be found in a transcript or the researcher's observation notes. Data were entered on the charts so that reading across a chart provided information about a particular site, while reading down a chart allowed comparisons to be made across the sample. The charts were used to identify overarching themes and draw conclusions. Conclusions were verified by checking with transcripts and through discussions within the research team.

Chapter 3 Description of re-ablement service profile

This section summarises some of the main features of the re-ablement services in each of the five study sites. It draws particularly on the accounts given by the service managers in the semi-structured interviews. In some instances, front-line staff were unaware of some of the details of the organisation of the service.

3.1 Site R1

	Re-ablement service profile	
1	Name of service	Community Response Service
2	Establishment of the service	2002/4: Pilot sites were established across all areas of the county, called First Response. This was an initiative within the in-house Home Care Service to provide a short-term rapid support service, predominately to older people being discharged from hospital, with the aim of promoting their independence, improving hospital discharge arrangements and reducing Delayed Transfers of Care. It was to form a foundation for change within the in-house home care service. 2004/07: Within a major transformation programme the whole of the in-house service gradually developed into a short-term assessment and re-ablement service, called Community Response focussing on crisis intervention and hospital discharge. 2008: The service moved to its new structure of four registered Area offices but is centrally managed to ensure strategic development, equity and consistency.
3	Operational structure of current service	There are four Area offices within the service. Each consists of : • A Registered Area Manager • Team Leaders in each area managing the day-to-day operational service; working within the care management process to undertake on-going assessments within the up-to-six week period of intervention; setting the goals and outcomes to be achieved; and undertaking the supervision and support of staff. • Community Response Assistants Level 2 (CRA2) are senior CRAs and support CRAs in complicated cases and also support the Team Leaders who work out-of-hours,

		particularly supporting discharges at weekends.
		• Community Response Assistants (CRA). Each team leader supervises CRAs in their district (each area being divided into three districts).
		There are no therapists within the re-ablement team.
4	Current service model	Currently, site R1 takes people for whom they think the service can make a difference. This includes identifying the right level of care to support service users who need on-going care packages; settling people at home after hospital discharges; trying to keep people out of long-term residential care; crisis intervention; and supporting people who are likely to have no further care needs after their intervention.

Typically the service is for six weeks (can be extended to eight weeks if necessary).

If the service user has on-going support needs, in most cases the team leader will commission a care package from an independent agency. However if the case is complex e.g. involving safeguarding then commissioning on-going support will be the responsibility of the care manager. |
| 5 | Eligibility criteria | The service is available to all adults requiring home care, aged 18 years and over. The service does not take people with learning difficulties as they are considered to need a long-term support package. The service supports predominantly older people with physical or dementia needs. It also offers support to younger people with newly diagnosed conditions such as MS, Parkinson's and motor neurone disease.

The local FACS threshold is 'critical and substantial' risk. |
6	Referral routes	The service takes referrals from hospital and community teams.
7	Skill mix and staff training	Team leaders have NVQ Level 4 in Care. All their staff have NVQ Level 2 in Care. Staff receive induction and training on re-ablement, on-going training on standard skills, dementia training and refresher courses (such as emergency aid, infection control, medication and falls). At the time of the interview, the team leaders had just started training on equipment. A number of CRAs have had training in how to do exercises with service users.
8	Current charging policy	People are charged for the service.

9	Joint funded/ managed with NHS partners	No

3.2   Site R2

Re-ablement service profile		
1	Name of service	Home Care Rapid Response Team
2	Establishment of the service	1997: The Home Care Rapid Response Team started as a project joint-funded for three years by health and social services and was based in the LA Home Care Service.
		2000: the team merged with the Social Services Integrated Care project.
		2002: The Rapid Response Team was merged with the Home Care Service and opened up to accept all referrals.
3	Operational structure of current service	The re-ablement service is comprised of two sections: Rapid Response (which does the assessments) and the provider side. There are 6 managers who do assessments. Within the providers, there are East and West teams. Each team consists of:
		• A line manager (responsible for planning care, managing staff, liaising with service users)
		• Leaders (supporting staff and setting up the packages of care)
		• Carers.
		There are no OTs and physios in the teams but they work closely with the therapy team and social workers.
4	Current service model	The aim of the service is to enable adults/older people to retain/regain their independence in order to facilitate early hospital discharge; prevent hospital admissions where medically safe to be treated at home; and reduce premature admission to long-term residential or nursing care. Re-ablement is offered within the home care service to service users identified as having the potential to become independent in at least one area of activity.
		The service provides support for six weeks (can be extended by two weeks, if necessary).

		The majority of referrals are of older people, an increasing number of whom may have dementia; a few people have mental health problems. If the service user needs on-going support, the care management teams are responsible for commissioning on-going support.
5	Eligibility criteria	The service is available to all adults requiring home care, aged 18 years and over. The local FACS threshold 'critical and substantial' risk.
6	Referral routes	The service accepts referrals from all routes. However, the majority of referrals to Rapid Response come from the hospital, GPs, Community Matrons, and only occasionally from the care management team.
7	Skill mix and staff training	All home carers are trained to provide re-ablement support.
8	Current charging policy	The service is free for the first two weeks. Clients are then charged according to their ability to pay.
9	Joint funded/ managed with NHS partners	No

3.3   Site R3

Re-ablement service profile		
1	Name of service	Homecare Assessment and Re-ablement Team (HART)
2	Service establishment	1999: Piloted for older people and adults with physical disabilities identified as having the potential for re-ablement, referred from the social care commissioning team. 2000: Pilot extended to include all people newly assessed (or re-assessed following a significant change in care needs) as needing home care support through an 'intake' team model.

3	Operational structure of current service	There are ten HART teams (five in each of the two geographically based areas – North and South). Each team includes: • Homecare Manager (overall responsibility for all cases, reviews and drawing up support plans for users needing on-going home care services on discharge from HART) • Senior Homecare Assistants (responsible for observing/monitoring Homecare Assistants, contributing to risk assessment work, supporting Homecare Assistants in more complex cases and assessing for minor adaptations) • Homecare Assistants • Clerical Support. The workload of homecare assistants is scheduled by a (F/T) Programme Arranger.
4	Current service model	HART has two main roles: assessment and re-ablement. All new referrals for homecare are referred to the HART team following a community care assessment by a care manager or from health via the Single Assessment Process. If there is no capacity within the team to support the service user, or if it is considered that they would not benefit from a short-term re-ablement intervention, they are referred straight to an independent sector home care provider. If the case is accepted by HART, the team provides support for up to six weeks (can be extended by one to two weeks if necessary). If the service user needs on-going care at the end of the period of re-ablement, the HART manager will commission home care from independent agencies.
5	Eligibility criteria	The HART service is available to all adults aged 18 and over assessed as needing home care support, including people with learning difficulties and older people with dementia. The only exception is when it is considered that a shor-term, re-ablement focused intervention would either be detrimental to the person or that the service user would not benefit from it in any way, e.g. somebody who is in the last stages of a terminal illness. The local FACS threshold is 'critical, substantial and moderate' risk. Currently about 80 per cent of their clients are older people.
6	Referral routes	Community referrals and hospital discharges

7	Skill mix and staff training	All Home Care Assistants have or are working towards NVQ Level 2 in Care and receive induction training on a set of core skills. They all receive on-going training such as client handling, personal safety, risk assessment, record keeping. In addition, HART had an initial re-ablement training programme over two days but this is no longer needed as new starters work alongside experienced staff to acquire the necessary skills. Staff also receive specific spot training as and when required. They also receive dementia training and attend Vista courses to support people with visual impairments. There are no OTs in the HART teams. Home care managers and senior home care assistants are trained to assess for minor aids and adaptations (such as trolleys, bath boards and perching stools) so that they can order such equipment as and when needed. Access to OTs for more complex cases is fast-tracked to the mainstream locality commissioning teams.
8	Current charging policy	The service is free for the first two days. Clients are then charged according to their ability to pay.
9	Joint funded/ managed with NHS partners	No

3.4   Site R4

Re-ablement service profile		
1	Name of service	START Service
2	Establishment of the service	2005: The START Service began as a pilot within the LA home care service delivering short-term re-ablement services, taking on all community referrals from one locality (out of four).
		2007: The START Service became Intermediate Care at Home Service, an NHS service delivering both enablement and clinical intervention (including OTs and physiotherapists).
		2008: The START Service opened up to accept all referrals.
		Currently the Rapid Response Service, which is a short-term Crisis Intervention Service delivering home care support for up to seven days with immediate effect, is part of the Intermediate Care at Home service.

3	Operational structure of current service	The Team Manager is responsible for the overall operational performance of the home care service, which includes START, long-term clients and extra care housing. There are seven teams, supporting Rapid Response and START clients; these include: - Managers (overseeing the whole service, supporting case management, risk management issues, line management of staff, supervision, performance observation of staff) - A scheduling team (allocating work to home care staff) - Senior care officers (overseeing cases, supervising staff, risk management) - Care officers (Rapid Responders) - Home care assistants
4	Current service model	The service is supporting individuals to regain their levels of independence and maximise their daily living skills. When there is no capacity to take on a referral, the referral will go back to the commissioning teams who will arrange care from independent providers. The START Service provides support for six weeks (extended by two weeks, if necessary). If the service user needs on-going support, the care management teams are responsible for commissioning the on-going support.
5	Eligibility criteria	The START Service is available to all people over 18 who are assessed as needing home care services (including people with mental health problems and dementia but excluding people with learning difficulties). The local FACS threshold is 'critical and substantial' risk.
6	Referral routes	Community referrals and hospital discharges
7	Skill mix and staff training	Currently, staff within the team are trained up to NVQ Level 3. All staff get all the basic homecare mandatory training (e.g. moving and handling training, hoist training, Mental Capacity Act, vulnerable adults and basic food hygiene), distance learning dementia training and a comprehensive two week induction programme to support enablement services. Staff receive limited mental health training. As part of the Intermediate Care at Home Service, the re-ablement service had direct access to a clinical team including OTs, physiotherapists and District Nurses. However, at the time

		of the interview the service was facing a real shortage in therapy services as the START Service had lost both its senior OTs and physiotherapists.
8	Charging policy	The service is provided free of charge.
9	Joint funded/ managed with NHS partners	Yes

3.5 Site R5

Re-ablement service profile		
1	Name of service	Homecare Assessment Re-ablement Team (HART)
2	Establishment of the service	2004: Enablement Discharge Service (WEDS) was established as a partnership between the in-house Homecare Service and the Hospital Trust.
		2006: WEDS ran a pilot for people over 65, discharged from elderly care hospital wards to include an assessment function based upon existing models.
		2007: Home Care Assessment and Re-ablement Teams (HART) were established with an assessment and re-ablement function and with a major expansion to include all referrals for people over 18 assessed as needing short-term homecare support.
3	Operational structure of current service	There are 30 HART teams (ten in each of three areas), including: • Registered managers (managing the organisers) • Organisers (line managing enablers, organising programmes/workloads, doing risk assessments and organising discharges) • Senior carers (taking on any complicated cases, doing quality assurance visits, supervising enablers) • Home care enablers • (P/T) community OTs, funded by social services and taking care of community referrals.

		Additional OTs are embedded in HART with different grades and funded by the Acute Hospital Trust, taking care of patients discharged from hospital.
4	Current service model	HART has two main roles: assessment and re-ablement. HART provides support for up to six weeks (can be extended for a week if necessary). If service users need on-going support, the HART manager will commission that from an independent agency.
5	Eligibility criteria	The HART service is available to all adults aged 18 and over who live in the local authority area. The only limiting factor is whether HART has the capacity to meet service users' needs, for example, people needing complex and/or continuing care packages. HART also excludes people in the last stages of a terminal illness who they consider would not benefit from short-term interventions. The local FACS threshold is 'critical and substantial' risk.
6	Referral routes	Community referrals and hospital discharges. The service takes referrals from care managers and occupational therapists
7	Skill mix and staff training	The majority of staff have an NVQ Level 2 qualification. All staff have had the standard training required for domiciliary care agencies. They all receive a half day induction and training on re-ablement. Nearly all staff have had medication training and they all undertake dementia training. Mental health training has not been part of re-ablement training. The staff also have condition -specific training. OTs are embedded in HART.
8	Charging policy	The service is provided free of charge for a period of six weeks, or longer if still providing re-ablement support. However, if the service users are just waiting for an independent provider to begin providing on-going care, they would be charged according to their ability to pay.
9	Joint funded/ managed with NHS partners	Yes

Chapter 4   Key operating issues - organising and running the service

4.1   Setting up the service

Interviews with the managers revealed a range of factors that were perceived to have driven the development of re-ablement services, reflecting a combination of local and national concerns. These included:

- Traditional in-house home care services being threatened by Best Value reviews because they were more costly than independent home care agencies
- national policies to develop Intermediate Care and hospital discharge schemes
- national health and social care collaborative work led by the Department of Health
- perceived benefits for service users.

All five re-ablement services have been developed from in-house home care services. They all started with relatively selective pilot projects, with referrals from intermediate care, discharge schemes or the community, and gradually broadened their criteria to become more inclusive, taking (almost) everyone referred for home care. All services can be characterised as having multiple functions with different emphases on individual functions in different sites. In additional to re-ablement, they have short- term intake and assessment functions and provide short-term home care support as well as delivering short-term, highly selective, targeted hospital discharge support (to complement NHS intermediate care). However, the approaches taken by the sites in developing their re-ablement services and their speed of roll-out differed for various reasons, including: the size of their in-house home care service; their existing resources; whether the service is provided jointly with NHS partners or within adult social care; what the service aimed to achieve for the service users; and the capacity of local independent sector providers. Four of the sites (all except R2) had to transfer some of their existing long-term home care service users from the in-house service to the independent sector in order to set up the new specialist re-ablement teams.

R3 and R5 followed a similar pattern in developing their re-ablement services. In both sites the service started operating across the whole of the local authority with a small re-ablement team in each locality. As the existing long-term home care work was transferred to the independent sector, workers' re-ablement caseloads expanded. The managers in both sites felt that the advantage of rolling out the service in such a way was that it enabled them to get people on board in each locality and allowed staff to build experience and knowledge about re-ablement. They also believed that this expansion strategy would help to create enthusiasm among the remaining home care workers, as the positive experiences of home care re-ablement

for users and staff were shared. However, the disadvantage of rolling out the service across the whole of the local authority was that, because of limited workforce capacity, they were only able to work with tight criteria for admission to re-ablement. In R3 the service was initially restricted to older people and adults with physical disabilities referred from the Intermediate Care Team, while R5 started with referrals from OTs of people over 65 who were cognitively able to participate and who were discharged from the Department of Medicine for the Elderly wards in the hospital. Having seen the benefits of the pilots, both sites broadened their entry criteria and made the service available to a wider range of service users and to referrals from all sources. The managers in R5 reported that the consequence of making the services more inclusive was that they were not able to achieve the same success (they reported that about 70 per cent of the service users in the pilot did not need any on-going support) and at the same cost, for their service users. This was because the earlier pilot only involved service users who were highly motivated to re-ablement whereas they were later working with virtually everybody.

In contrast, R1 and R4 took a phased approach and introduced the service locality by locality. In R1 the process of implementation started with the south west district and then extended to the north before it was rolled out across the whole county. R4 started with one locality/community team, increasing to two and then expanding to all four care management teams in all districts. In terms of client groups, R1 started with older people discharged from hospital and R4 started with people referred from the community. Both sites also extended their services to all referral routes.

The approach taken in R2 was different. Unlike the other four sites, where re-ablement was developed as a specialised service separate from the long-term home care service, in R2 re-ablement was incorporated into the in-house service and only offered to those identified as having the potential to improve their independent living skills. Thus, unlike the other sites, workers in R2 have mixed roles of traditional home care and re-ablement. They might have on their rota some people who are to be re-abled and others who are receiving long-term support, often without knowing which is which. Differences between home care and re-ablement dominated the focus group discussion with front-line staff in R2. When prompted to reflect on perceived differences between the two approaches, the overwhelming view was that there was no difference between them; encouraging service users to become more independent was claimed to have always been the focus of their home care practice and re-ablement was not any different; they took the same approach with everybody. This mixed approach has important implications for the organisational structure and the running of the service as well as potential outcomes for service users.

4.1.1 Re-training staff

None of the sites had received additional funding to recruit new staff but instead had retrained their existing home carers. The only site that had received some resources to recruit some new staff was R3 but that was only for their initial pilot. In the four sites where re-ablement was developed as a service separate from the long-term home care service (i.e. all except R2), the old in-house home care service was run down through voluntary redundancy, early retirement or by natural wastage, i.e. by not recruiting anybody into the service. In R3 and R5 the existing in-house home care staff were asked to volunteer to join the pilot. In R3 staff were given the choice of joining one of three new specialist services (Re-ablement, Dementia Care and Child Care services) or continuing with conventional in-house home care support. However, they were warned that if they chose the last option, work would eventually dry up and they would be out of work.

From the managers' point of view there were advantages and disadvantages in asking existing staff to volunteer to join a new re-ablement service and be retrained for it. The advantages were that they had a well trained and highly motivated workforce who liked new challenges and were keen to use the new approach. It also meant that training costs were minimised and workers could offer the service immediately, avoiding delays such as recruitment or Criminal Records Bureau (CRB) checks for new staff. The disadvantages were that some staff, particularly those who had not volunteered to join the new re-ablement service or who were nearing retirement, were resistant to changing the way they worked. The managers in the four sites where the in-house home care teams had been reduced reported that a number of staff had decided not to stay because they were not happy with the new approach. The biggest challenge for the staff, they said, was having to change their approach from being a care deliverer to being somebody who stood back, observed and encouraged. They thought many staff had become carers to look after people but felt that re-ablement did not allow them to care for people and form a relationship with them in just a few weeks. Although the focus group participants were not randomly selected/ representative, it was noticeable that the composition of participants in the focus group in R5 was quite different to the other sites. There was a prevalence of people with extensive experience in traditional home care, who had only recently moved to HART and not of their own choice. Their enthusiasm about the new service and their new job responsibilities was less pronounced and the nostalgia for the traditional role of carer and the difficulty of adjusting to their new role sometimes dominated the discussion.

There was some concern among managers about insufficient staff capacity in their re-ablement services. The manager in one site pointed out that when they set up the service, they had an enthusiastic group of staff who were willing to work with the new approach. However, as the service got bigger, it had become more challenging to train people. She said there was a group of ten to15 staff who would happily transfer

and another 20 who, she thought, may not fit in. Those staff, she thought, would struggle to work in re-ablement because they were not receptive to the new way of working and did not agree with it or did not understand the shift in the way of working. She gave the example of trying to put square pegs in round holes and felt that they had nearly reached that stage at the time of the interview. This suggests that, while having a few enthusiastic volunteers can help to secure interest and buy-in from other workers, the drawback of relying on volunteers is the risk of being left with some staff who are more resistant to change and compulsory retraining.

Managers in R1 and R4 reported that they were not, at the time of the interview, able to offer the service to everybody assessed as needing home care support. The manager in R4 mentioned that they were under a lot of pressure to get people out of hospital and even though there had been a significant growth within the service (from delivering 200 to 1,050 hours of care a week , there was still a significant shortfall of 45 per cent in their capacity to take everybody. She felt that this meant they were not offering an equitable service. There were individuals who she thought would benefit from a period of short-term re-ablement but they were only able to offer the service to half of them. There was no formal policy on how to prioritise the service users they offered the service to, but at the time of the interview she said they had to prioritise referrals from hospital and intermediate care because of the pressures from hospitals to expedite discharge.

4.2   Assessments and referral arrangements

Across all the sites the initial assessments were carried out to establish service users' eligibility for home care before they were referred to re-ablement services. On first referral to the re-ablement service, each site carried out further assessments to identify what the service user wanted to achieve and the areas of activity for the re-ablement team to focus on. The setting of these goals in all the sites was said to be a managerial decision involving one or two seniors (e.g. a team leader and/or a senior home care assistant), the service user and occasionally an OT. Informal family carers could also be involved.

The importance of the assessment role on first referral to re-ablement was highlighted in particular by the managers in R3 and R5. They both emphasised that having an assessment role within the team was not about questioning the assessments carried out by their commissioning colleagues but it was about adapting to the changing needs of the individual. However, taking on an assessment role, they thought, could appear threatening to care management staff and this needed careful explanation and negotiation. They explained that very often people's needs change as their circumstances change. For example, needs initially identified in hospital could be for assistance with food, drink and personal care, which are all crucial to enable someone to be discharged home from hospital. However, when

people are in their own environment the whole focus of assessment may shift. For example, people may be able to do some of the things they could not do in the hospital environment when they are in their own home, but may identify other areas where they need support to become more independent, such as help with shopping and/or social activities. Therefore the assessment role, they said, could be as much about reducing the level of support as increasing it.

One of the managers interviewed was concerned about the poor quality of initial assessments carried out prior to service users' discharge from hospital. She thought those assessments did not give the re-ablement team all the information they needed about the individual. Part of the difficulty was that hospital staff made no home visits and relied on what the service user told them. This created difficulties for the re-ablement team as they were under a considerable amount of pressure to get people out of hospital and were given short timescales to actually set up appropriate support arrangements for people. A number of front-line staff participating in the focus group in that site also expressed concerns about the inaccuracy of assessments prior to their first visit. They felt that hospital assessments often relied on self-reports from service users, who were eager to agree they could do things in order to be discharged. They gave many examples of visiting new service users for the first time and finding out that they could not do as much as had been claimed. The manager in another site expressed similar concerns. She said sometimes people come home but, unbeknown to the hospital, they cannot manage the steps to where they live; or the hospital had given the impression that only one carer would be needed but in actual fact they needed two carers, as a hoist was involved.

There were some concerns among the managers in two sites (R4 and R2) about the timing of some of the referrals made by hospital and intermediate care services. They felt referrals made on Fridays and late in the day did not give the care management team sufficient time to assess those service users before referral on to re-ablement. However, the situation was different in R1 as the Community Response Assistants - Level 2 (CRA2s) were able to carry out client assessments over the weekends. Several CRA2s from R1 who were present at the focus group discussion said that their assessments had resulted in a number of re-hospitalisations, for example when clients were not able to walk and had not been given any equipment on discharge.

Front-line staff were not involved in the initial assessment and setting of re-ablement goals for service users when they first come into the service in any of the sites. However, all the managers agreed that the care plan was to guide the front-line staff as to the essential work to be done. Moreover, the service relied on the regular feedback staff provided on day-to-day basis and on their continuous involvement in on-going informal reappraisal meetings that took place between a senior member of the team, the front-line staff involved, the service user and an OT, if available. In addition to these informal meetings, managers across the sites noted that more

formal reviews/appraisals take place at different points within the re-ablement period to further assess the service user's progress. In R1 and R2, there are two reviews within the six week re-ablement period. R3, R4 and R5 carry out one formal review. In R3, this was between week four and five; in R4 this was around week four and in R5 this happened at the end of the service.

4.3   Inclusion/exclusion criteria

As indicated in Chapter 3, all re-ablement services in the five sites were reported to be open to all adults over 18 years who were newly assessed as needing home care support, unless a short-term service was considered to be detrimental to the service user, for example someone who was at the last stages of their lives. However, one of the differences between sites was in the less formal judgments made about the individuals for whom short-term re-ablement interventions would be appropriate and the level of independence it was considered appropriate to aim for.

R3 took a strong social model approach on this, an approach which was later taken by R5 too. Rather than selecting people who were thought to be able to gain the most, the managers in both sites said that they offer the service to all people, including people with learning difficulties, even if re-ablement could only help them achieve small improvements and (re)learn small skills for themselves (like making a drink). As one of the managers in R3 put it, 'It is not about exercise in a chair; it's not about can you get out of that chair yourself but it is about finding out…is there any way that we can help you to still get what you want and work around that?'.

The interview with the managers in R1, however, suggested that they tended to take on people for whom they believed they could make bigger improvements. The examples they gave of their typical cases were helping people who would have, after intervention, no further care needs; helping people to settle back at home after hospital discharge; supporting people to avoid hospital admission; and crisis intervention. Currently, their client group is predominantly older people with physical support needs. They also offer the service to people with dementia as they have staff trained in dementia care. Unlike R3 and R5, the re-ablement services in R1 and R4 do not take on service users with learning difficulties because of their longer term needs for support. As mentioned earlier, in R2, re-ablement is provided as part of the in-house home care service and only offered to service users who are perceived to have the potential and motivation to be re-abled. There were not many accounts given by the front-line staff in R2 of any significant changes to users' independence during re-ablement periods. Only small improvements were mentioned, such as regaining the ability to hold a brush, make a cup of tea and wash one's face, which were empowering for the service users but may not make much difference to the volume of services required by them.

4.4   Day-to-day organisation of the service

4.4.1 Care plans

There was a consensus among all the managers interviewed and the front-line staff participating in the focus group discussions that re-ablement is a more dynamic process compared with traditional home care services. As described earlier, once service users were referred to re-ablement services, the managers carried out assessments to identify the service user's capabilities, goals and the areas of work for the team to concentrate on. A care plan/task plan was then prepared detailing all that information. Where OTs were involved, their assessments were also included in the service user's individual plan of needs. At the end of each visit workers were expected to record, in service users' folders, what happened during the visit; what progress was being made; and any concerns they might have had about the service user.

The manager in R2 believed that being based in the in-house home care service was an asset as it gave them more flexibility in responding quickly to changes in service users' care plans (for example, having to have two carers for a visit instead of one). None of the managers in the other sites expressed any concerns about their capacity to respond to changes in care plans as often as was necessary. However, a number of front-line staff across the sites pointed out that a shortage of staff sometimes limited the team's capacity to respond to service users' requests to have the visits at times that best suited them.

4.4.2 Flexibility over the duration of visits

Unlike traditional home care services, all managers reported having greater flexibility in the length of time for individual visits, which they thought was crucial to the effectiveness of re-ablement. If a particular client needed extra time, all the worker had to do was to call the office to rearrange their next call. A number of front-line staff mentioned that it was more important to have this flexibility at the start of re-ablement.

Staff in R1 felt that they were able to add value by offering a degree of flexibility within afternoon periods which are outside of core service times. Full time staff were able to undertake additional 'well-being' visits - perhaps returning to build confidence by walking the client to the shop or improving on daily living skills by practising making a drink or a sandwich for tea. These visits were particularly valued in settling people in the early stage after hospital discharge; a service user they had visited in the morning who they thought could benefit from some extra support could be visited

later in the day to check and improve their confidence, well-being and in some cases reinforce the re-ablement goals set earlier.

The focus group in R3 revealed some apparent inconsistencies in the degree of flexibility the HART teams were given. For instance, in one team 30 minutes was allowed with each client before staff had to call the office, in another team this was only 10 minutes. The situation in R2 was quite different. Almost all front-line staff were critical of the limited time allocated to individual service users, saying that care plans did not take into account the re-abling element of their work and allow any motivational work. For instance, one carer said it might take 15 minutes just to encourage a client to make their way to the bathroom, but this could be all the time that was allocated for having a bath. They all agreed that re-ablement took more time, yet there was no time difference between re-abling cases and conventional home care cases. It is important to bear in mind that as mentioned in section 2.3, the focus group participants were not randomly selected or representative. The apparent discrepancies between the views of managers and front-line staff could point to the fact that managers were not always fully aware of the operational issues and that in some circumstances there were not enough opportunities for staff to discuss their concerns with their seniors. There was a suggestion in one of the sites that those involved in putting together care plans should either shadow a worker or do the tasks themselves at some point to get a better understanding of how long certain tasks could take.

4.4.3 Staff rotas

All managers agreed that in an ideal world service users would benefit from having continuity in the carers allocated to them but, given that they often need several visits a day (and some need visits from two carers at a time), one-to-one care was not possible. Instead, sites organised work in teams so that any one service user was seen by a limited number of workers (apart from holiday/sick cover). It was particularly important to reduce the number of carers working with one person, not just because of quality issues but because of the need to communicate about changes in support needs, goals and abilities as users' abilities improved. There were variations in how different sites organised their staff rotas, but in all cases the number of carers visiting individual service users depended on the frequency and length of visits, the overall support package and how staff rotas were arranged in the site.

One of the difficulties some managers said they were facing in organising staff rotas was that most people wanted to work days and not evenings. The manager in R5 reported that this imbalance had meant that they had to turn work away. At the time of the interview, R5 was in the process of changing to a five week rota system, where their staff would do four weeks of days and one week of evening shifts. They felt that

the new structure would be fairer on the staff, give service users more continuity and avoid having to turn work away.

R4 had also recently introduced a new structure, whereby a group of eight staff supported a group of clients on a four week rota. This meant that the worker would stay with one person for a week and would see that person again three weeks later, if he/she was still using the service. The manager noted that the new staff rota enabled the staff to see the person throughout the day (rather than just mornings or evenings) and get a better idea of how their behaviour and abilities might change during the day.

Discussions with front-line staff revealed that it was not clear whether the same rota would work equally well for people with mental health problems. There were a couple of workers (from R2) who worked primarily with mental health clients as part of a pilot scheme. Each service user visited the same worker day after day. Both workers said they enjoyed the challenge of such specialisation and felt that this continuity was necessary for people with dementia, as it takes time for service users to develop trust and confidence in an individual worker; once this is done, it is possible to achieve significant results. However, they thought the down side of it was that having the same workers could create dependency on particular individual workers, which could result in the service user being reluctant to change care provider at the end of the re-ablement period.

4.4.4 Case recording

All managers agreed that from a re-ablement point of view it is absolutely essential to know what the workers do on each visit, why they do things differently from previous visits those service users may have had, and what the risk factors are. This information should give a clear indication to everybody involved in a particular case about how far the service users have progressed in achieving their objectives, what works (or not) for them and any concerns they may have.

Managers across the sites reported that there was a fear among staff that case recording would be quite an academic task and they were anxious about it. The manager in R3 had reassured staff that case recording was not necessarily about how much they wrote down but what they recorded and how the care plan had been carried out. Managers across all five sites mentioned that there were a lot of changes to the timing of the visits, caused by delays in hospital discharges, emergency admittance to hospital or staff covering for sickness and holidays. This made it more difficult for service users to see the same worker/s every day/week. This highlighted the importance of having a consistent and thorough recording system to ensure continuity of the support offered.

The flexibility in terms of who saw which clients was quite apparent in the observation visits. During these visits, many workers appeared to be seeing some service users for the first time, even though they had been receiving re-ablement services for a few weeks. A number of clients mentioned that they had no idea which worker they would be seeing the following day.

While all the carers in the focus group discussions said that they appreciated why it was important to write notes in service users' folders, the observation visits showed some irregularities in the way case recording was done in different sites. In most cases the notes were not written effectively. For example, workers tended to mention *what* had been done, but not how they were done. Examples of the typical notes made were: 'assisted to dress', 'assisted to shower', 'bed made', 'made a drink', 'made a sandwich' and 'bin emptied'. In some cases, the notes were not more than a couple of lines; in others they took a whole page, which could be difficult for someone new to the case to follow. Sometimes what was recorded did not include the right information to enable the next worker to build on the progress being made by the service users. The lack of continuity may impede development of a clear and systematic approach to encouraging service users to develop more self-reliance. This has important implications for staff training.

4.4.5 Communication within and between the teams

Interviews with managers in all the five sites revealed that there were opportunities between the workers and their seniors to discuss the progress of individual clients on a daily basis. In addition to these individual meetings, managers reported having regular team meetings where staff could share ideas and experiences within the team. These meetings were also said to be the platform for the managers/seniors to continue to challenge and embed a re-ablement approach in workers' day-to-day practice. The role of senior staff in these meetings was therefore important. The frequency of team meetings differed ranging from weekly (R5), every three weeks (R4), three meetings in a month (R3), once a month (R1) and every six weeks (R2).

All front-line staff participating in focus group discussions spoke very highly about the benefit of team meetings in supporting them, helping them to learn from each other and keeping them motivated. Most felt having an effective communication system was particularly important in the early stages of re-ablement, when they were more engaged in motivation work. A number of workers mentioned that they knew of others who did not adopt a re-ablement approach with clients and this impacted on the work of those who were committed to re-ablement. However, some staff pointed out that there could be practical difficulties with attending meetings, for example, the timing of the meetings clashing with their rotas and travelling time, as they did not live in the area. This did not seem to be an issue in R1 as front-line staff were encouraged to attend other teams' meetings if they were not able to attend their own.

4.5   Duration of intervention

Typically re-ablement services across all the sites offered support for six weeks, with some flexibility to extend it by one to two weeks if service users were considered to benefit from that. In general all participants felt this was adequate time for the intervention.

However, there was a consensus in managers' views that there should not be a strict number of weeks for the service. Whilst time-limited, the service should be flexible to meet individual needs. Some people may need a shorter time to gain back their lost confidence or reach their maximum potential. In some cases service users may decide to end the service themselves because they feel they do not need it. This often happened following hospital discharge, where the patients had agreed to having a care package in order to get discharged from hospital. We were told that in some cases the re-ablement service could be cancelled in the first two days after leaving hospital.

Most managers also agreed that making the duration of re-ablement intervention length would not necessarily make the service more effective. However, one manager reported concerns raised by a number of health colleagues that some service users might need a longer period of re-ablement. For example, a re-ablement service may not see huge improvements for someone who has had a stroke in six weeks but it might do in 12 weeks.

Not all managers commented on the importance of informing service users about the length of the service. However, the managers in two of the sites who did talk about it had different views. In R3, managers felt there was value in telling service users that they can have the service for up to six weeks so that they know it is a short-term service. On the other hand, the advice managers in R5 had for those setting up re-ablement service was not to give a time limit of six weeks but just say that it is a time-limited service, otherwise it would create expectations.

4.6   Charging policy

At the time of the interviews, there were no charges made for re-ablement services in R5 and R4. The policy in R3, R1 and R2 was that the first few days of the service were free. After that, people would be charged according to their ability to pay, like conventional home care packages. However, managers noted that in practice people rarely paid because they could only be expected to pay from the point at which they were financially assessed, but there were often delays in conducting these assessments.

In a couple of sites, managers were considering making some changes to their charging policy. In R3, for example, managers felt that for many people the prospect of paying for something was helpful in motivating them; on the other hand not knowing whether charges would be made for the service could cause unnecessary anxiety. To get round that, managers were thinking of telling new users the maximum amount of money they might have to pay at the start of the service, in case charges were in fact levied.

The manager in R4 explained that some service users had already spent six weeks in an intermediate care bed. That meant that by the end of re-ablement period, those individuals could have had 12 weeks of non-chargeable services. They were planning to start charging people who had already had six weeks of free services from intermediate care. They had made no final decision on this at the time of the interview.

4.7   Discharge and onward referral arrangements

Towards the end of the re-ablement period, managers across all sites reported having a formal review process to decide whether service users needed on-going home care. This often involved a manager or a senior home care assistant, the service user and possibly family members. If no further care was needed, they agreed a closure date and the service user was discharged. Where it was decided that the service user needed on-going care and that there was nothing more the team could achieve for him/her (for example in the case of someone with severe dementia), the review indentified the correct level of support they needed before transferring them to independent providers. In fact, all the managers mentioned that their re-ablement service was not just about reducing the amount of support somebody needed but also about fine-tuning long-term home care packages. The case was then transferred to independent home care providers either by the service manager, if they had power to commission services (as was the case with R3 and R5); or referred back to care managers to commission on-going services (in the case of R4 and R2). In R1, in most cases the team leaders commissioned the care package directly from the independent agency, but where the cases were complex (e.g. involving safeguarding), the care management team took lead responsibility.

In order to maintain the level of turnover required by re-ablement services, all managers felt it was essential to be able to transfer users out of the service as quickly as possible. In practice, we were told that some service users stayed with the service for much longer than expected, not because they were considered to benefit from it but because the service could not manage to find an agency quickly enough for on-going care.

Two issues affected the discharge process. One of the key factors was said to be the ability of the re-ablement team to organise users' discharge themselves. Relying on referrals back to care managers, unless they were assigned to the re-ablement team, could lead to delays and the service becoming blocked.

The other issue was capacity within independent home care providers. Managers in R5, R3 and R4 reported a big capacity shortage within the independent sector which often blocked the re-ablement service. They all said it could take a few weeks and even months before they could identify agencies willing to go to some remote areas or able to accommodate the special needs that some service users may have. The managers in R5 reported that they had so far been able to cope with the capacity shortage within the independent sector without blocking the service because they still had some in-house home carers, but they were not going to have access to them for much longer.

To stimulate capacity within independent sector providers, the managers in R3 had carried out a new contracting exercise. They had identified a number of preferred, home care providers in geographical zones and had paid them upfront a number of a percentage of their potential income to give them some financial security so that they could start expanding. This zoning approach had also given providers some guaranteed provision in remote rural areas where the travel time might be as much as, or greater than, the call time.

Managers in R3 reported that they had been criticised for not taking on enough re-ablement cases, but their capacity was restricted because they could not transfer people if an agency was not found quickly. What they decided to do was to re-categorise those service users who were technically discharged from re-ablement as 'awaiting transfer' and continue their involvement until an agency was found. This not only signalled to senior managers within the department the shortage of independent sector home care services, but also prevented users who were ready for discharge from re-ablement from remaining 'hidden' within the service. At the time of the interview, the managers in R1 said it only took them a couple of days to find a provider in the independent sector.

A big issue raised by all managers and some front-line staff across all sites was that as soon as service users were handed over to independent providers, they were disabled because of the way those services were set up. This undermined their re-ablement efforts. A number of front-line staff felt extending the handover period by a couple of weeks would help ensure more continuity of approach. At the time of the interview, the handover period in all the sites was said to be in most cases one or two days but sometimes longer for complex cases, for example where someone was resistant about transferring to a new provider or where someone needed visits from more than one carer.

4.8   Summary

- All five re-ablement services had developed from in-house home care services. They started from relatively selective pilot projects, and gradually broadened their criteria to become more inclusive, taking (almost) everyone referred for home care.

- All services had multiple functions with different emphases on specific functions in different sites. These included: re-ablement, short-term intake and assessment, short-term home care support and short-term support for highly selective hospital discharges.

- The speed of roll-out differed between sites. This was mainly due to the size of the in-house home care service, their existing resources, and the capacity of local independent sector providers.

- All sites had to retrain their in-house home carers.

- Across all sites, initial assessments were carried out before service users were referred to the re-ablement service. Further assessments were carried out by managers/senior staff and service users to set re-ablement goals. This was followed by reviews, with different frequencies in different sites, to assess progress.

- There were concerns that hospital pre-discharge assessments gave insufficient information about service users and this delayed the re-ablement team's work.

- While the managers in some sites took the approach that there was something, no matter how small, that the re-ablement service could do for everybody, others expected the service to make bigger improvements.

- The time allocated for re-ablement visits varied from site to site. While there was more flexibility over the duration of visits than for the traditional home care services, some workers felt the time allocated was insufficient.

- Consistent and thorough recording of visits to ensure continuity of support was considered essential. However, in most observed cases the notes recorded what had been done but not what progress had been achieved or how.

- Front-line staff valued having team meetings to share ideas and experiences but staff in some sites struggled to attend the meetings.

- Typically all sites offered re-ablement services for six weeks with some flexibility. All participants felt this was adequate.

- In some sites the re-ablement service was offered free of charge. Others charged service users according to their ability to pay. In practice, delays in carrying out financial assessments meant few people paid.

- Towards the end of the re-ablement period, all sites carried out a formal review and assessment of longer term support needs and arranged transfer to an independent home care provider if the service user was considered to have on-going needs.

- Some sites experienced a big delay in transferring service users to independent home care providers. Two main issues affecting the discharge process were the ability of the re-ablement team to organise their own discharges (as against relying on care management teams) and capacity within independent home care providers.

Chapter 5   Key features of re-ablement services

5.1   Types of intervention

While the five sites had taken different routes to developing re-ablement services, all managers said they aimed to achieve similar objectives - to support service users in achieving their maximum potential for independence and to rebuild their confidence. Most managers said they aimed to do that by moving away from time- and task-specified services to flexible services with short-term interventions with the focus on helping clients to do more for themselves rather than doing tasks *for* them. In practice, most workers across all sites said they often adopted a more traditional social care role at the beginning of re-ablement but changed their approach and started to stand back more as service users started to progress. The importance of having the ability to motivate service users and build up their confidence was highlighted both in the managers' interviews and in the focus group discussions with front-line staff. However, as mentioned earlier, almost all front-line staff participating in the focus group in R2 felt the time allocated to each visit did not allow much motivational work.

The range of interventions offered was more or less the same across all the sites:

- Personal care – e.g. washing, dressing.

- Practical support – e.g. meal preparation.

- Prompting medication.

- Information and signposting – e.g. about library delivery service, Dial-a-Ride.

- Psychological, emotional and personal support – e.g. taking people out for a walk.

- Increasing social engagements/contacts – e.g. getting people back into the community, referrals to luncheon clubs, Age Concern, day centres.

- Advice on how to reduce the risk of falls.

Part of the re-ablement intervention in all the sites was said to be assessing risk and making sure that the environment was safe for people, e.g. checking people's kitchens and home layouts and the equipment they used. The observation visits clearly showed that access to equipment, such as grab rails, walkers and trolleys to carry food around played a vital, if not the most important role, in helping people become more independent.

We asked all managers if there were any types of interventions that were more or less common for any particular group of service users. The common view was that

older people who have had a fall or fracture mostly needed confidence building to help them get back to the routine they had before going into hospital. A significant proportion of the help provided to this group was with personal care needs, such as getting up, food preparation, making drinks, dressing and bathing. Younger people with physical impairments were thought to be motivated to achieve more independence. Therefore, for that group there was a heavier emphasis on developing social interaction and problem solving.

Managers in four of the sites noted that re-ablement staff would take people out for a walk or shopping if that was what they used to do before. This was particularly important for people who had a fall or fracture and had lost confidence to go out on their own. In one example, a woman who had fractured her hip wanted to be able to go out on her own again. Over the six week re-ablement period, she managed to move from having two carers going out with her to going on the bus on her own. The manager in R2 explained that when workers take people shopping they could only allow them to buy a bag of shopping that they could carry back themselves because eventually they would have to do it on their own. However, some front-line staff participating in focus group discussions did not know they were allowed to take service users out.

Managers in two of the sites (R3 and R5) explained that a lot of the work they carried out was creative problem solving (sometimes with the help of OTs), trying to devise different ways of doing things. Examples they gave included: using a stick to try and open curtains; a long handled sponge for people to wash their back (something which previously had been in their care package); or for people with poor mobility who needed to use two handrails when using stairs, a bag attached to a skipping rope, tied to the banister, to help them carry things up the stairs.

There was a common view among all interviewees that people with dementia and mental health problems required different patterns of engagement, where workers did a wider range of tasks themselves but encouraged clients to help with those tasks. With these clients, re-ablement work mainly focused on establishing a routine for users, while making sure that the care offered was safe and effective in meeting their needs. Some workers mentioned that they expected much smaller achievements for these groups, such as enabling them to dress themselves, but once clients got a sense of routine, their self-esteem would improve and eventually they would need less long-term support.

The front-line staff participating in the focus group in R1 referred to a pilot project in a local town, involving the re-ablement service. This involved six residential care home beds for people who had been discharged from hospital but who had such low self-care capacity that they needed to be admitted to residential care. During the six week re-ablement period they were looked after by the care home staff, but re-ablement staff visited to undertake the re-ablement programme - this could be in support of

daily living tasks, or confidence building/exercise programmes. The project gave the clients an opportunity to return home successfully. A number of workers thought that such temporary residential beds allowed quick success rates for re-ablement. Some service users were said to have been re-abled and returned home within the first two weeks of being discharged from hospital.

The observation visits revealed some common activities that the workers undertook across the five sites, including:

- assisting with personal care and hygiene
- dressing/undressing
- meal preparation
- household duties (making the bed, empting the bin, washing the dishes)
- prompting medication
- ensuring personal safety
- transferring to commode, chair, bed.

We had asked sites to try and include service users with a wide range of experiences in the observation visits (see Chapter 2). While we had a good variation in the sample across all the sites, the characteristics of the service users we visited in each site was not consistent and that made comparison between the sites difficult. For example, all the people involved in the study in site R1 were hospital discharges and had physical conditions. Other sites included community referrals and/or people with dementia as well.

However, overall the observation visits showed no noticeable differences between the sites in terms of what re-ablement workers did and how they involved service users. In general, it was surprising to see how much home care appeared to be done for people in all the sites. While it was not possible, given the one-off visits in each site, to identify any pattern to the nature of involvement over the course of the re-ablement episode within each site, evidence from the visits across the five sites revealed no marked differences in the way service users' involvement changed through the re-ablement 'journey'. Judging by what had been recorded on service users' files, in a number of cases where the service user was approaching discharge from re-ablement, the worker was still doing tasks which they or their colleagues had done since the service had started, like making a sandwich, doing the washing up, empting the bin or making the bed. There were plenty of examples where carers asked 'What can I do for you today?', 'Does your bed need making?', 'Do you need anything from the shop?', 'Do you want your hair washed?' and 'Are you sure there is nothing we can do for you?'

However, while the observations did not reveal marked differences between the sites, there were some apparent differences in the extent to which individual workers

involved service users in the tasks they were carrying out. The workers identified by the re-ablement services as being less experienced were those who had spent less time working within traditional home care services. In general, those workers (with some exceptions) appeared to involve service users a lot more than those identified as being more experienced. This involvement was both in terms of decision-making (e.g. asking people what they wanted to do today) and hands on, 'doing with' involvement in practical activities. For example, they would ask people to wash the parts of their body that they could manage; to join in to make sandwiches; to help make the bed together; or to help with washing up and drying the dishes. In a couple of cases workers helped service users to use the microwave and watched to make sure they were doing it right. The more experienced workers were more likely to look for ways of improving physical access, ensuring safety and making suggestions about other equipment that service users might find helpful, such as a ramp to remove a high step at kitchen door and a hydraulic seat in the bath. In all cases where complex items of equipment were needed, workers said they would report back to the office as further assessments would have to be done.

For a number of the observations conducted in R5 and R1, the re-ablement service aimed to provide short-term support to keep the family together. For example, in one case the care worker supported a wife who had Alzheimer's disease while the husband, who was her main informal carer, recovered from a broken leg. In another example, re-ablement was helping a man whose wife, who was his main informal carer, was taken into hospital. His daughter, who was present at the time of the observation visit, said that without the service her dad would have had to go into a nursing home. While these examples did not involve active re-ablement of service users, they enabled the families to stay together.

5.2 Skill mix in the re-ablement teams

5.2.1 Roles and responsibilities

The basic structure of the current services is detailed in the service profile for each site. The majority of teams comprised a home care manager, an organiser/team leader and home care assistants/workers/re-ablers. In addition all the sites, except R2, had a senior position between the home care assistants and the team leaders/organisers responsibility for monitoring front-line staff and taking on any complicated cases. In R1 these were the CRA Level 2 workers who were responsible for supporting the team as well as undertaking risk assessments/ initial assessment of newly referred service users during the evening and weekends in conjunction with, and under the direction of, the Out of Hours Service which included Out of Hours CRT Team Leaders.

5.2.2 Staff training

Managers across the five sites reported that all the re-ablement staff had NVQ training and the standard core training skills required by Commission for Social Care Inspection (CSCI) for domiciliary care agencies. When joining the re-ablement team, they all receive training on how to work with a re-ablement approach. The initial re-ablement training was said to range from half a day (R5) to a comprehensive two week induction programme (R4). In addition every site offered on-going spot training. Some sites provided refresher courses for workers to update their training needs.

The importance of having access to specialist training was highlighted by all managers as it impacted on the level of support and type of care that workers could provide. In R3, the managers and senior home care assistants had been trained to assess for minor adaptations such as grab rails, and could order them through the Red Cross without an OT's involvement. Anything outside the Red Cross catalogue, the service users had to pay for. The team leaders in R1 had, at the time of the interview, just begun receiving this training. While all the sites required specialist OT assessment for more complex equipment, in a lot of instances the re-ablement workers were able to obtain small pieces of equipment such as back sponges and gadgets to help put stockings on. In R5 and R3, the workers also received additional training from the OTs on how to transfer the skills they already had.

All managers reported having some staff who had received specialist training on delivering short-term re-ablement services to people with dementia. None of the sites offered any mental health training. While some managers mentioned that the NVQ training covered some issues in helping people with visual impairments, managers in R3 reported that HART workers attended additional courses to learn about different aids available for this user group. A number of CRAs participating in the focus group in R1 mentioned that they had individual training in how to do exercises with clients. They could also go on courses about how to support people with specific health conditions such as MS and cancer.

Having formal training in special re-ablement skills was important to all workers. However, staff who had experience of shadowing more experienced workers found this particularly helpful in understanding how re-ablement was done in practice and how to cope with the biggest challenge they had, which was 'standing and watching'. Some more experienced staff in R1 said they still go to some calls together with another worker and find it helpful to see how other workers do things.

There seemed to be strict rules in all sites about what workers could and could not do; any medical care was something they could do. Some workers felt that they should be able to perform simple medically-related tasks such as putting eye drops in, changing or adjusting dressings or measuring glucose levels. A few staff said

they changed catheter bags and oftened suspect infection but had no tools to test for it. While all agreed that this would benefit the client, some were more concerned about the risks involved.

5.2.3 Access to specialist skills within the re-ablement team

The role of OTs within re-ablement teams was highlighted by the managers and front-line staff across all five sites. R5 and R4, the two sites that worked in partnership with the NHS, were the only two sites to have direct access to OTs. R5 had a number of OTs of different grades within their service who were funded either by the acute hospital trust or the department of adult social services. Managers in R5 noted that the involvement of OTs enabled them to gain quick access to equipment and adaptations for service users. However, a number of staff taking part in the focus group in R5 felt there were still not enough OTs in the team to cope with the number of service users coming into the service. Similarly, the manager in R4 emphasised the importance of having direct access to the clinical team (including OTs, physiotherapists and district nurses). However, she did say that at the time of the interview, they were experiencing a shortage of therapy services as they had lost both their senior OT and physiotherapist and this affected the timeliness of their responses. Sometimes an OT could not visit until four weeks into service which meant a huge amount of valuable time was lost. At the time of the interview, the manager in R3 reported that in two out of four areas they had jointly funded an OT to work in the intermediate care team to undertake community care assessments.

Among the sites where OTs were not part of the re-ablement team, managers in R3 reported that the re-ablement team worked closely with OTs within the commissioning teams and were able to fast-track referrals for equipment, which meant that the OTs would prioritise any referrals from the re-ablement team. Not only did this give the OTs a sense of involvement in the re-ablement service, it was also to their advantage to assist the HART process in order to create capacity for new referrals. The front-line staff in R3, however, expressed some concern over access to OTs, saying that they had only had fast access to OTs in emergency situations and that was not enough. R1 and R2 both reported facing a shortage of OTs they could access.

In two of the sites (R5 and R3), the managers reported initial problems that had to be overcome when working with some professionals. Some of the difficulties had involved questions about whether the re-ablement team had the necessary skills and knowledge to carry out assessments which had traditionally been carried out by qualified care management staff and health professionals. One of the barriers they had had to overcome was a shift from thinking that only people with professional qualifications can make decisions to one that gave credibility to vocationally qualified staff too. In one of the sites an OT participating in the focus group discussion was

critical of social services assessments, saying these were more about finding out if their staff would be able to cope with the patient and relied heavily on what the patients or their family thought they could or should be able to do. OT assessments were much more detailed and relied on factual information rather than on self-report from the clients. This had initially created a tension in the relationship between the re-ablement team and OTs. One of the OTs in R5 said there had been some anxiety among OTs about being sidelined within a service that OTs had pioneered. In both R5 and R2, the OTs participating in the focus group discussions wanted to be more involved in the training of re-ablement staff, as they considered re-ablement their specialism.

The shortage of OTs within the re-ablement teams, and difficulties some sites faced in having access to OTs outside the team, often meant a delay in getting equipment, holding the service user back and blocking the service. For those who needed equipment to get out of bed, the delay created a bed dependency.

5.3   Access to related skills outside the re-ablement team

All the managers interviewed agreed that having close involvement with professionals and skills outside the re-ablement team was important to the effectiveness of the service. Such involvement helped to provide better quality support; deal with any issues arising quickly; admit people onto the service; and sometimes discharge people from the service more effectively. They all reported that they worked closely with the care management teams, hospital social work teams and community health staff such as district nurses and specialists for visually impaired clients. In R1, managers noted that the team leaders had good assessment skills and were sometimes approached by the care management teams to be involved in initial assessments prior to referral to the Community Response Team.

Managers in all the sites felt there were some professionals outside the team that they would like to have closer contact with. Quicker access to physiotherapists was said to be the most crucial one as it would make a huge difference to the support they offer. Other professionals with whom better access was desired were continence advisors, Community Matrons and District Nurses.

5.4   Summary

- The range of interventions offered by the re-ablement services was more or less the same across all the sites. Interventions included personal care and practical support, prompting medication, information and signposting,

psychological/emotional/ personal support, increasing social engagement and advice on risk factors.

- Re-ablement for older people who had had a fall or fracture was felt to be more about meeting personal care needs and confidence building; for younger people, who were considered more motivated to become independent, it was more about social interaction and problem solving.

- Although there were no noticeable differences between the sites in terms of how the re-ablement workers involved the service users, there were some apparent differences in how individual workers involved service users; with some exceptions, workers with less traditional home care background seemed to involve people more than those with longer term experience.

- Re-ablement staff in all five sites receive standard basic training, training on the re-ablement approach, some specialist training and have access to on-going spot training.

- Most staff found the shadowing of more experienced workers particularly helpful in understanding the re-ablement approach. In some sites workers had more opportunities for shadowing than in others.

- In most sites the re-ablement team was able to obtain small pieces of equipment but needed an OT assessment for more complex equipment. In two sites, senior staff were trained/being trained in assessing for minor adaptations.

- Two of the sites that worked in partnership with the NHS had direct access to OTs; another site had fast-track referrals for equipment. However, in four out of five sites participants reported a shortage of accessible OTs, resulting in delays in getting equipment and thus service user progress.

- There were some tensions between the re-ablement teams and the care management teams and health professionals. This was mainly around the quality of assessments different people carried out.

- There were some professionals with whom re-ablement teams would like to have closer contact (e.g. physiotherapists).

Chapter 6   Factors perceived to affect the success of re-ablement services

We asked the managers and the front-line staff participating in focus group discussions in the five re-ablement sites about their views on the factors enhancing and/or constraining the impact and duration of the benefits of the re-ablement service in the shorter and longer terms. While the emphasis placed on different factors sometimes varied between the sites and between managers and front-line staff within a site, this chapter reports the key common themes raised by all those involved in the discussions.

6.1   Staff commitment, attitude, knowledge and skills

The commitment, enthusiasm, knowledge and skills of re-ablement front-line staff were highlighted by both managers and other staff as the most important factors in the success of home care re-ablement. They thought that the ideal re-ablement worker was someone with a good understanding of the concept and practice of re-ablement, with the skills to motivate and encourage service users to become as independent as possible rather than deliver care. These skills include observational skills and the ability to stand back and assess service users' potential to develop skills in various areas of their lives. They also include working closely with the service users to identify the appropriate support they needed to reach their potential. An important part of re-ablement was building up service users' confidence and convincing them that they could achieve more independence. For some service users this could involve helping people to appreciate the value of becoming more independent.

Most managers felt that staff with less experience of working in traditional home care services were easier to train and had proved to be the best re-ablement workers. The biggest challenge for many front-line staff with long histories of working as traditional home helps was having to 'watch' and not interfere when a service user was struggling to get something done. However, having seen the differences they had made to the quality of some people's lives, some former home help workers had realised how disabling their previous outlook and practice had been. Re-ablement workers across all five sites confirmed that they had found it hard at first to change their attitudes and practice, but almost all felt that the re-ablement approach had increased their job satisfaction, commitment and motivation. Workers who had recently joined a re-ablement team were more cautious about these outcomes, but they found it encouraging seeing other workers feeling so positive about the new approach. Most managers confirmed the increased job satisfaction experienced by

most staff who had started using a re-ablement approach. In one site managers reported that the sickness levels of their workers had decreased.

6.2   Service user characteristics

There was agreement among managers and front-line staff that the service users who were most likely to benefit from re-ablement were those who had had a fall or fractures, as often they mainly needed help to rebuild their confidence. Most workers said that it was easier for both service users and workers in such cases to work together on specific goals. Re-ablement increased the chance of recovery and regaining independence as, unlike traditional home care, it reduced the likelihood of people becoming used to having tasks done for them and thus helped avoid creating dependency. Conversely, front-line workers thought that re-ablement was unlikely to produce significant results for service users with dementia or mental health problems, as these people needed on-going support. However, this did not mean that no benefits could be achieved for those groups of service users; rather, that it was much harder to ensure a major improvement in a short period of time. Both managers and workers also felt that re-ablement was still useful for those groups of people as it could more accurately identify the nature of the long-term support they needed.

In addition, re-ablement was considered to be more successful if service users were motivated - 'people have got to want to do it'. The age of service users was not seen as a significant factor. However, some study participants felt that younger people were more likely to be motivated to maximise their independence.

Front-line staff across all sites agreed re-ablement worked better for new referrals to adult social care. The most difficult cases were service users who had a history of long periods of home care (either from social services or the private sector), because they were more likely to expect things to be done *for* them. Some workers said that people with a long history of using traditional care services had such strong expectations that they were unwilling even to consider a new approach. Some staff felt that service users' resistance to re-ablement could be linked to the charges users thought they had to pay for the service, reporting consumerist attitudes of 'I pay your wages, you do that for me'.

6.3   Shared understanding and strong vision of the service

All managers interviewed emphasised that the success of re-ablement services depended, to a large degree, on the extent to which all those involved in the service were signed up to the vision and clear about the aims and objectives of the service. Some managers felt that there was a danger for the service to be misused.

Pressures came from commissioning teams who did not have a clear understanding of what the re-ablement service could offer; who used the service as a 'holding' zone; and who made inappropriate referrals (e.g. people assessed as needing complex care packages) because no other services were available. Managers felt that in order to deliver a proper re-ablement service, it was important to retain clear eligibility and referral criteria, otherwise the service would clog up and they would not have the resources to work appropriately with service users who could benefit from re-ablement. The managers in R5 noted that at the end of the re-ablement period about ten per cent of people ended up going back into hospital. This could reflect the fact that some referrals were inappropriate for re-ablement.

Another barrier that some managers reported, particularly in the initial stages of service development, was the tension that existed between them and their professional colleagues within social care and health teams who questioned their ability to do assessments and found the service in some way threatening. Managers felt it was important for them to be trusted and empowered by their professional colleagues to do their job right.

6.4   Flexibility and prompt intervention

The importance of working flexibly with service users, in terms of what the workers did, the duration of visits and the ability to adjust the service quickly to suit service users, was highlighted by all participants. Given that the re-ablement service is intended to be a short, focused programme of support, any delays during the intervention were thought to constrain the impact and duration of the benefits of re-ablement. High quality assessment before re-ablement started, quick access to specialist support and equipment, frequent reviews of re-ablement goals, leadership at all levels and staff knowing their role expectations were all factors thought to facilitate re-ablement teams' ability to operate more effectively and quickly.

In R2, where front-line staff had mixed roles (working with service users receiving long-term support and those for whom they used a re-ablement approach), those participating in the focus group discussion reported that re-abling took more time but little additional time was available in visits. Given the workers' inability to differentiate between their long-term home care and re-ablement cases, there was a danger that the workers could adopt a middle ground approach for everyone and act too quickly when making a decision about service users' potential to be re-abled.

6.5   Skill mix

There was a consensus among managers and front-line staff about the value of having OTs embedded in the re-ablement team. This facilitated quick access to equipment and prevented any unnecessary delays in service users' progress. At the same time, some managers were concerned about the role of OTs and felt that their involvement risked a 'medical approach' focusing on what service users can or can not physically do, whereas re-ablement was based on a social model approach. Where OTs were embedded in the re-ablement service, managers reported that their involvement in the team helped develop other workers' skills. Access to other specialist services outside the re-ablement service was said to be valuable in supporting particular groups (e.g. people with visual impairments).

6.6   Capacity within independent sector providers

The problem of capacity within independent sector home care providers and the need to ensure that service users requiring on-going support can be referred on quickly was highlighted by most managers and staff. In at least three of the sites, difficulties in finding an appropriate home care agency to provide on-going support had led to some service users remaining in the re-ablement service for weeks or months after completing a period of re-ablement, blocking the service. In one site, the zoning approach proved to be successful in ensuring that those living in remote areas who needed on-going support at the end of the re-ablement period did not face delays in receiving that support. Some managers reported that the ability to commission long-term home care support from within the re-ablement service significantly helped the service to minimise delays.

6.7   Resistance from family/informal carers

One of the barriers managers and workers said they had to overcome was the attitudes and perceptions of risk on the part of family members. They felt that for children, the idea of their elderly parent being independent was often a cause for concern. They wanted the reassurance of knowing that their parents were being looked after, despite the wishes of the older person to retain their independence. As was the case for service users, front-line re-ablement workers felt it was important to manage informal carers' expectations prior to their first visit by explaining to them the aims of the re-ablement service.

6.8   Summary

- Staff commitment, attitude, observation skills as well as skills to motivate and encourage service users were considered to be crucial to the success of re-ablement services.

- Some staff did not find it easy to adopt a re-ablement approach. However, most staff participating in the focus group meetings felt that using the approach in their practice increased their job satisfaction. Staff who had recently joined the re-ablement team found it reassuring to see others who had been on the scheme for longer being so positive about it.

- A common view among participants was that the service users most likely to benefit from re-ablement were those who had had a fall or broken bones. For service users with on-going support needs the benefits of re-ablement may be less dramatic.

- Staff considered re-ablement to be more successful for service users who are motivated and for new referrals to adult social care.

- For the re-ablement service to be successful it is crucial that all people involved are signed up to the vision and have a clear picture of its aims and objectives. The lack of understanding of what the service can offer could lead to inappropriate referrals and the service not being able to deliver effectively.

- Given that the re-ablement service is a short and focused programme of support, flexibility and prompt intervention are central to successful implementation. Any delays could impact on the duration of benefits or block the service, preventing access to potential new referrals.

- All managers and staff participating in this study, whether or not they had OTs embedded in their own service, felt that is beneficial to have OTs in the team. This facilitates quicker access to equipment and enhances the re-ablement team's ability to act more efficiently. Access to other specialist services was also considered valuable in supporting particular groups.

- The capacity within the independent home care service is a crucial factor in ensuring that service users needing on-going support can be referred on quickly. The capacity shortage in some sites meant that some service users remained in the service much longer than was necessary.

Chapter 7   Conclusion

This final chapter seeks to synthesise the key findings generated from the three strands of data collection conducted for this part of the overall study. The present study involved interviews with managers of five established re-ablement services; observations of front-line practice in the five study sites; and focus group discussions with front-line staff. This is the first in-depth investigation into the organisation and content of re-ablement services and the first detailed account of the activities of front-line re-ablement staff in working with service users. Given that re-ablement services are new, and are being widely encouraged, these insights are crucially important in taking forward their development. The findings in this report highlight the factors that contribute to good service design and delivery and help to identify which particular features might be responsible for any observed impacts of re-ablement on the service users' independence.

7.1   Main conclusions

7.1.1 Re-ablement as an intake service

A common feature among all five re-ablement services in this study was that they were involved in multiple functions, with different levels of emphasis on short-term intake and assessment functions; re-ablement; short-term home care support; and short-term intervention following hospital discharge. While all these functions are legitimate and reasonable, given the ways in which services have developed, some of them may have less visible/measurable impacts than the 're-ablement' one. For example, where the emphasis is on the assessment function, or the intervention is more in the form of short-term home care (either offered to the service user or their informal carers), it is more likely that some service users will leave the service with the same level of care needs as on entry to the service. This is because re-ablement has not been the aim/focus of service intervention for those individuals.

Furthermore, as services have developed a more inclusive 'intake' role for most or all new referrals for home care support, they have come to accept an increasing proportion of clients who have more limited potential to become independent. There was a consensus among all people participating in this study that the most dramatic benefits of re-ablement are seen among people who are recovering from falls or fractures. In comparison, people who are likely to need on-going support, such as those with dementia or mental health problems, are considered less likely to demonstrate significant improvements in their independence. Similarly, study participants believed there was less chance for re-ablement to show dramatic effects for people who are not motivated to become independent or who have long histories

of receiving traditional home care services, as their expectations of having tasks done for them can undermine the efforts of re-ablement workers. All these factors suggest that the outcomes of re-ablement services are likely to be considerably diluted for certain service users. Most participants agreed that small changes could nevertheless be achieved even for people with dementia or who need on-going care and those changes may mean a lot to them. In addition, re-ablement could have more far reaching impacts on those people's lives, by raising their confidence and giving them a sense of routine, which could eventually reduce their use of services.

7.1.2 Organisation of services

The importance of organising services so that they can be flexible in order to meet these multiple functions was highlighted by all participants. Organising work in teams, frequent team meetings, regular supervision to continually review clients' progress and increasing opportunities for on-going specialist training were among the steps taken, to different degrees, by all sites in organising re-ablement services. However, in practice there were certain restrictions within the existing features of various sites that made it difficult for those services to work more flexibly. One of the biggest challenges for sites was having access to specialist skills, in particular OTs. The interviews with managers revealed that there were significant differences between the sites that are jointly funded/managed with NHS partners and those that are funded and organised solely by the local authority. The way the services are organised and delivered in the sites that work in partnership with the NHS (namely R4 and R5) gave the re-ablement services better access to a range of professional expertise. In R3 the service had fast-track access to OTs but there was some concern among the front-line staff in that site that this was available only in emergency situations. Managers in R3 felt they would also benefit from having similar fast-track access to physiotherapists. In other sites the managers reported that capacity was not adequate to cope with demand.

Moreover, the way the rotas were organised and the time pressure on the front-line staff sometimes made it difficult for the workers to be more creative and motivating. This was particularly the case in R2 where workers had mixed roles (working with service users receiving long-term support and those for whom they had to use the re-ablement approach) and little additional time to re-able the latter group of service users. This has significant implications for delivering re-ablement services effectively and staff training. Having to use two different approaches, it is more likely that workers adopt a middle ground approach for everyone and act too quickly when making a decision about service users' potential to be reabled. One of the managers in R1 had this advice for somebody developing a re-ablement service:

> You need to focus on doing that …You can't do everything … you can't be a long-term service, and this and that. … Don't do too many things, don't be Jack of all Trades because you will be master of none.

7.1.3 Training and skills

The importance of re-ablement being an 'attitude' or an 'approach' came through very strongly in the managers' interviews. For re-ablement to operate effectively, staff need to have the skills to motivate and encourage service users to become as independent as possible. This highlights the significant role of re-ablement training/retraining and supervision and team/peer support to reinforce the re-ablement approach and ensure staff are kept well informed and motivated.

While it was obvious that some staff thought very highly of the re-ablement approach, the discussions in staff focus groups showed that there were some staff who had not received adequate training on certain aspects of their work, e.g. observational skills. Many workers referred to their job as 'standing and watching' and it was not clear whether they all appreciated that observation was part of the assessment process and an important job in itself. While standing and watching, staff were expected to try and identify service users' capabilities as well as motivating and encouraging service users to take more control of their lives where they could. It also appeared from staff focus group discussions that part of their job was explaining the service to the service users and managing their expectations during the course of re-ablement. Relying on carers who are not wholeheartedly committed to re-ablement or do not have a good understanding of the concept and practice of re-ablement to give information about the service could demotivate service users.

7.1.4 Factors external to the re-ablement service

Interviews with managers and the focus group discussions with front-line staff identified several key factors that have the potential to affect the success of re-ablement services. Some of these factors relate to the organisation, content and delivery of the service, for example, referral criteria and the consequent characteristics of service users to whom the service is offered; commitment to a re-ablement ethos among managers and front-line staff alike; effective communication within the team; good staff supervision; training opportunities; accessible and responsive managers; and appropriate skill mix and staff attitudes. Other factors are external to the re-ablement service, for example, access to specialists; rapid access to equipment; strong vision and leadership among all professionals; referral processes (particularly pressures from hospital discharge); ability to commission home care directly; and capacity within independent sector home care providers.

While all managers participating in this study demonstrated a lot of commitment and enthusiasm to take forward the development of the re-ablement services in their sites, the clear message from them was that they could not do this in isolation. Re-ablement services have significant potential to be life enhancing, impacting on the type and level of care services used. However, achieving that potential depends not only on the internal organisation and delivery of those services but also addressing external factors that presented real challenges to future development of re-ablement services.

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Appendix   Study aims, design and methods

A.1   Overall aims and objectives

The study aims to:

1. Provide robust research evidence on the immediate and longer term benefits of home care re-ablement, including:
   a) User-level benefits (improved independence, quality of life, mental well-being)
   b) Service-level benefits (reduced demand for services, less use of expensive services).

2. Identify the factors that affect the level and duration of benefits for service users of a period of re-ablement (e.g. features of the service; user group characteristics; type and level of services used after re-ablement).

3. Identify any impact on and savings in the use of social care and other services that can be set against the costs of re-ablement services.

4. Describe the content and the costs of home care re-ablement services.

Specific research questions are:
- What impact does a period of home care re-ablement have on:
  o User well-being, quality of life, independence.
  o Use of a range of statutory, voluntary and informal support services.
  o Wider outcomes (e.g. ability to continue living at home).
  o … in the shorter and longer terms?

- What characteristics of re-ablement service users and of re-ablement service interventions themselves appear to be associated with:
  o Improvements in user well-being, quality of life, independence.
  o Reductions in use of a range of statutory, voluntary and informal support services. Wider outcomes.
  o ... and with changes in these outcomes over time?

- What evidence is there that a period of re-ablement reduces the costs of subsequent service use (social care, NHS, voluntary sector, other) in both the shorter and longer terms; and to what extent do any savings outweigh the costs of the re-ablement intervention?

- What factors are associated with maximum savings in subsequent service use?

A.2   Summary of the overall research design

The research design aimed to generate data to facilitate a robust comparison of the impact and outcomes of the use of home care re-ablement services with conventional home care service use. A randomised design to assess the impact of the re-ablement intervention was not feasible given that, in any given local authority, only home care re-ablement services or only standard home care services were likely to be available. A comparative design was therefore adopted. Study participants were recruited from five councils that offered home care re-ablement services and five comparison group sites where standard home care services were available. The study was designed to examine the length of the impact of service use. To that end, the same questionnaire, containing a number of standard outcome measures, was administered when a service user first entered the study at Time 1 (T1), and some 12 months later at Time 2 (T2). For re-ablement service users, the same questionnaire and outcome measures were also administered when the service user was 'discharged' or exited from the re-ablement service (T1+R). T1 and T1+R data collection took place between November 2008 and September 2009; T2 interviews began 12 months later, in November 2009 (see below).
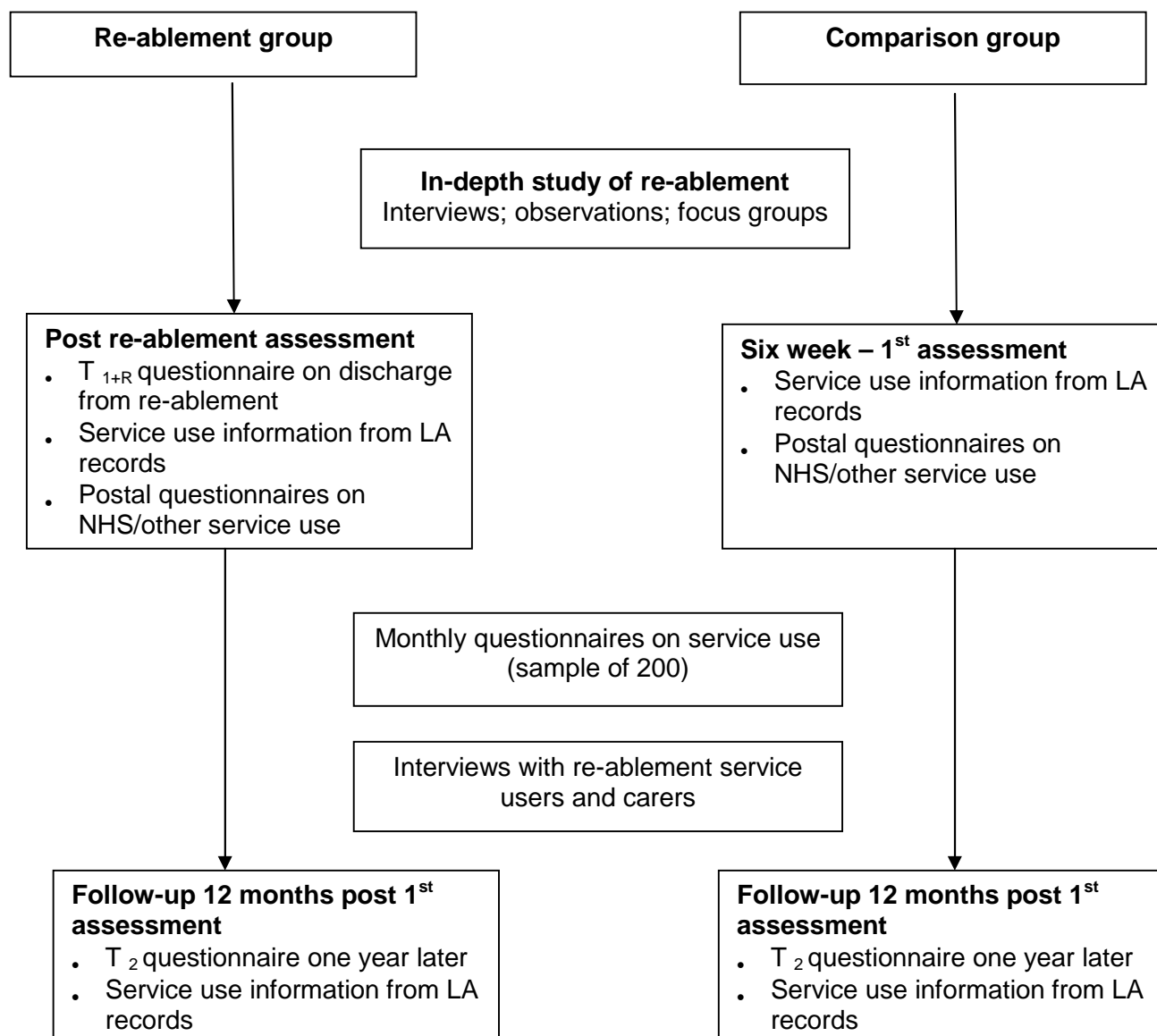
A significant component of the study was to collect information on the content and costs attributed to the re-ablement service. For each re-ablement site participating in the study, we have endeavoured to provide a bottom-up costing. This is an approach that identifies the different resources tied up in the delivery of the service and assigns a value for each of these resources. The sum of these values is the total cost. Unit costs are then calculated by linking these costs to different units of activity.

It is important to know how far the benefits of re-ablement extend to reduced use of NHS services and social care services. After eight weeks from the date of consent, a postal questionnaire was sent to each participant asking for information about health and social care service receipt. The data collection was supplemented by sending monthly questionnaires to a sub-sample of service users to ascertain service use in the twelve months after the date of consent. For further information about research methods for the quantitative component of the study see (Jones *et al.,* 2009*)*

In addition, a range of qualitative methods was used to investigate the structure, operation and content of the home care re-ablement services in the respective study sites. Semi-structured interviews were conducted with each of the re-ablement service managers; observations of a sample of home visits to service users were carried out (with the consent of the workers and service users involved); and focus group discussions with samples of front-line staff in each of the re-ablement local authorities were conducted to explore their perspectives on the themes and issues arising from the interviews and observations.

The structure of the study design is summarised in Figure A.1 below.

Figure A.1   Overall design of study

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┌─────────────────────────────┐         ┌─────────────────────────────┐
│     Re-ablement group       │         │     Comparison group        │
└─────────────────────────────┘         └─────────────────────────────┘
              │                                          │
              │        ┌────────────────────────────┐    │
              │        │  In-depth study of re-ablement │ │
              │        │ Interviews; observations; focus groups │
              │        └────────────────────────────┘    │
              ▼                                          ▼
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Post re-ablement assessment
- T_{1+R} questionnaire on discharge from re-ablement
- Service use information from LA records
- Postal questionnaires on NHS/other service use

Six week – 1st assessment
- Service use information from LA records
- Postal questionnaires on NHS/other service use

Monthly questionnaires on service use (sample of 200)

Interviews with re-ablement service users and carers

Follow-up 12 months post 1st assessment
- T_2 questionnaire one year later
- Service use information from LA records

Follow-up 12 months post 1st assessment
- T_2 questionnaire one year later
- Service use information from LA records

A.3   Selecting study sites

A 'screening' questionnaire was developed and e-mailed by DH Care Services Efficiency Delivery (CSED) programme in April 2008 to all English local authorities with responsibilities for adult social care services. The purpose of the questionnaire was to establish whether or not councils met the following essential criteria for selection as a study site:

- ability to access management information (MI) data on service users electronically

- ability to link easily records of individuals' current service with records of their past and subsequent service use

- willingness to work with the research team and to share outputs with other councils on a named basis

- availability of local resources (e.g. staffing) to undertake data collection

- in addition, data was collected on the Fair Access to Care Services (FACS) eligibility criteria currently operating in each local authority, and on the average monthly numbers of referrals to the council's re-ablement service/home care service.

Positive responses were received from 29 councils. Two individuals (a member of the research team and a CSED representative) assessed responses against the specified criteria. Some councils were eliminated at this point. Councils were also excluded if they had only very low numbers of referrals to their home care services, as it was anticipated this would make it difficult for them to achieve the appropriate level of recruitment to the study. Choices of comparison group sites were also restricted because many adult social care departments reported that they were currently planning or rolling out home care re-ablement services across the authority. Sites that were selected included councils operating different levels of FACS eligibility thresholds, so that the study could assess the longer term impact of re-ablement on clients with greater and less severe levels of disability.

These sites were sent a detailed list of activities they would be involved in if selected; at least one of the 29 sites expressing an interest in the study then withdrew. The final selection at this initial stage of the study comprised five councils offering home care re-ablement services (two of which had teams that included occupational therapy staff as well as re-ablement workers); and four councils offering conventional home care services.

A series of 'site visits' was made to the nine councils by a CSED representative and two research team members. The visits explained in detail the respective roles and responsibilities of both the sites and the research team in terms of taking part in the study, recruiting service users and collecting data. Sites were offered financial reimbursement to cover administrative and other costs incurred through taking part in the study. One of the comparison group sites withdrew shortly after this initial site meeting. Although a replacement site was recruited, there were inevitable delays before the new site was in a position to start recruiting.

During September and October 2008, training workshops were held in all sites to ensure a consistent approach by front-line staff to recruitment, obtaining informed consent from service users and collecting data (see below). The research team

prepared a comprehensive guide for staff involved with the study: (a) to help them establish a service user's eligibility to take part in the study; (b) to provide them with step-by-step procedures when recruiting and administering questionnaires.

At the end of March 2009, one of the comparison group sites confirmed that it was no longer in a position to recruit any more participants to the study. The roll-out of that site's own re-ablement service meant that it was no longer appropriate for front-line staff who had now been trained in re-ablement practices to continue providing standard home care services.

Rates of recruitment were particularly low in the comparison group sites (see below) and efforts were made to recruit additional sites. One further council entered the study in May 2009 as a comparison group site for the final two months of the extended period of recruitment (June and July 2009). The final study therefore involved five re-ablement sites and five comparison group sites.

A.4   Recruitment of service users

The original study proposal focused only on older users of re-ablement and standard home care services. Given their frailty, this group of service users risked high attrition rates over time, between the T1 and T2 interviews. Consequently, the study aimed to recruit 1600 service users (800 in each group) at T1, in the hope of achieving a final sample at T2 of 1000 study participants (500 in each group).

Responses to the initial screening questionnaire that had been sent to all English councils had alerted the study team to the fact that some home care re-ablement services screened out some potential referrals as unsuitable for re-ablement, or lacked the capacity to offer a re-ablement approach to all new referrals. We therefore anticipated that the home care re-ablement sites would not be able to achieve as high levels of recruitment to the study as local authorities providing standard home care services. The five re-ablement sites were therefore asked to recruit 160 service users each; the (original) four comparison group site were asked to recruit 200 service users each. The initial intention was for all sites to recruit service users to the study over a six month period, from October 2008 to March 2009 inclusive. In reality, however, sites were not in a position to start recruiting until November 2008.

On the whole, local authority social services staff who had taken part in the training workshops were responsible for recruiting service users to the study and administering the T1 (and T1+R in the re-ablement sites) questionnaires. However, one or two sites developed different procedures; for example in one site the council sub-contracted the local Age Concern organisation to administer the questionnaire.

Individuals were eligible to be invited to take part in the study if they met the following criteria:

● were newly referred to adult social care services (or, for existing service users, if they had been referred for a review following a major change in circumstances and needs)

● had been accepted as eligible for social care support under local FACS criteria

● were aged 65 years or older

● had the mental capacity to understand the research and consent to take part; this meant that service users with moderate or severe dementia or other cognitive impairments were not recruited to the study.

As noted above, all research sites were in a position to start actively recruiting study participants by early November 2008. A specially designed database was used to manage and monitor recruitment and record receipt of completed consent forms, T1 and T1+R questionnaires and the monthly service use questionnaires.

Initially, recruitment rates were quite low and soon it became clear that sites faced a number of difficulties recruiting service users to the study. In February and March 2009, following discussion with all the study sites, steps were taken to address these problems and boost recruitment rates:

● the age limit was lowered and recruitment extended to all adult service users (ie aged 18 and above) able to give informed consent

● the recruitment period was extended by a further month to the end of April 2009

● incentives for staff were introduced, whereby a sum of money proportionate to the total number of study participants recruited by the site would be donated to a charity chosen by staff

● incentives for study participants were introduced, whereby £5 would be donated to a charity for each person recruited to the study. The total accumulated through these incentives was to be shared equally between three charities: Help the Aged; National Society for the Prevention of Cruelty to Children; Hearing Dogs for Deaf People. One of the sites chose not to take part in the incentive scheme for participants, as it was confident that it would achieve its target figure without this.

In addition, CSED emailed directors of adult services in the study sites to ask for their support in meeting target recruitment numbers.

Recruitment continued to be slow, however, particularly in the comparison group sites. In April 2009, again after discussion with the study sites, it was decided to take the following further measures:

- People who consented to take part from mid-April onwards were each offered a £10 grocery voucher on receipt of a completed T1 questionnaire. This replaced the £5 charity donation per study participant

- Sites were offered the opportunity to conduct telephone interviews instead of face-to-face interviews

- The period of recruitment was extended for a further three months to the end of July 2009

- One additional comparison group site was recruited (see above).

A.5   Ethics and advisory group

NHS ethical approval for the study was obtained, as well as approval from the ADASS (Association of Directors of Adult Social Services) Research Group. Research governance approval was obtained from individual local authorities taking part in the study.

The project is supported by a Reference Group comprising academics, re-ablement service managers, representatives from Care Services Efficiency Delivery (CSED) programme, ADASS and an older people's voluntary organisation.