

Evaluation of the Southwark Reablement Service

Hannah Reidy

Social Care Workforce Research Unit, King's College London

Martin Webber

Centre for Mental Health Social Research, Department of Social Policy and Social Work,
University of York

Simon Rayner & Michelle Jones

London Borough of Southwark / South London & Maudsley NHS Foundation Trust



May 2013

Executive Summary

Background

The Southwark Reablement Service was set up in July 2012 to provide short, targeted social care interventions to clients with mental health problems. The service was set up as a pilot in order to evaluate the effectiveness of this way of working.

Aims

This evaluation aimed to:

- explore users' perceptions of the new reablement service and its impact on their lives
- evaluate short term outcomes for users of reablement
- explore the reablement team's perceptions of the service and its benefits to service users
- evaluate activity data for the reablement service in its first six months of operation
- establish a baseline cohort which could be followed-up in a later study

Method

This evaluation comprised analysis of routinely collected data which comprised socio-demographics, referral data and source data; Fair Access to Care Services criteria (FACS); Warwick Edinburgh Mental Health Wellbeing Scale (WEMWBS); Payment by Results Care Cluster (PbR); Health of the Nation Outcome Scales (HoNOS), and Resource Allocation System (RAS). Pre and post data were collected where possible. A worker focus group and 13 semi structured interviews with clients accessing the Reablement service provided qualitative data for thematic analysis.

Results

The data showed that clients' needs as measured by the FACS criteria were significantly lower after Reablement, and significant improvements were seen in six of the outcome domains. There were also significant reductions on the RAS for an Indicative Personal Budget. There were no significant changes in HoNOS, WEMWBS or PbR Clusters.

Conclusions

The data suggests that the Southwark Reablement Service is having a positive impact on the reduction of clients' needs and reducing the financial cost of their care immediately after Reablement. Additionally, clients are mostly very happy with the service. Further research needs to be completed at a later date to ascertain the longer-term success of the Reablement scheme.

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Background

Reablement Research:

Reablement originated in the field of physical health problems, where studies have found positive outcomes for reablement services across a variety of outcome measures including a reduction in future care. For example, an evaluation of the Edinburgh Council Home Care Reablement Service (McLeod & Mair, 2009) found that home care hours were reduced by 41% for individuals receiving reablement over a 6 week period of the intervention, and 60% of these individuals required fewer hours of care after the end of the reablement process. An evaluation of a Home Independence Program (HIP) in Perth, Australia, which provided a short-term restorative programme of care for older people without a diagnosis of dementia found improved outcomes of functional dependency, morale, confidence in performing everyday activities without falling and functional mobility in comparison with a control group (Lewin et al, 2010). A later randomised control trial of 750 people assigned either to the HIP group or to 'usual' homecare found that individuals from the HIP group were significantly less likely to need further care in the future (Lewin et al, 2013).

Systematic research into mental health Reablement is scarce due to it being a relatively recent initiative. However, an unpublished report from an NHS mental health Reablement provider has shown that Reablement resulted in a reduction of needs and a mean cost saving of £3253 per person per annum (Feldman, 2011). A service evaluation by Reablement provider Sirona CIC found that after 6-8 weeks of Reablement, 60% of cases were closed thanks to clients' needs being met. Additionally and importantly, this service was rated with high levels of satisfaction by the service users.

Southwark Reablement Service:

In July 2012 a new Reablement service to work with mental health service users was established by London Borough of Southwark Adult Social Care Services, South London and Maudsley NHS Foundation Trust (SLaM), and Together.

The Southwark Reablement service comprised a Team Leader (1.0 FTE), Reablement Clinician (1.0 FTE), and Reablement Practitioners seconded from Local Authority and third sector organisations (2.0 FTE). At the time of writing (April 2013), the two Reablement Practitioners comprised a 1.5 FTE position, and in addition there was a full time Student Social Worker (who also completed some assessments). The Team Leader also provided clinical consultancy and assessed more complex cases. The capacity for the service was 60 people at any one time, including approximately 20 accepted referrals and 20 discharges per month.

Individuals were referred to the reablement service from other community mental health teams (CMHTs), the Personalisation team and from GPs within the Borough. After an initial assessment using the Fair Access to Care Services (FACS) Criteria, the individuals were accepted into the service if they had substantial or moderate needs. Individuals' needs as highlighted by the assessment provided the domains for targeted reablement work.

The 13 week maximum duration for the service was longer than other mental health and social care reablement schemes, which are typically 6-8 weeks. A mid-point review at 6 to 7 weeks helped the team to decide whether a transfer to a CMHT for a Personal Budget at 13 weeks would be needed. Unlike other Reablement services, this length of time cannot be increased, but it could be decreased if the service is no longer required.

During the 13 weeks a Reablement Practitioner meets with a client at least once a week if possible. Between sessions, workers reflect and prepare information for the client, including setting tasks for them to complete by the next time that they meet.

The Southwark Reablement Service uses the Staying Well Plans (now known as Recovery and Support Plans) that were developed by Simon Rayner (the Head of Mental Health in the London Borough of Southwark), Amy Dunn, Stephen Bush and others in 2008. These plans aim to support the enhancement or learning of skills and/or coping strategies to enable people to gain more independence in managing their health and social care needs.

The support provided by the Reablement service can be summarised as follows:

1. Recovery and Support planning

This aims to enable people to develop an effective approach to overcoming distressing symptoms and unhelpful behaviour patterns. It is designed as an aid for learning about yourself, including what helps and doesn't help, and how to progressively take control of your life and your experiences. The recovery and support plan identifies individual personal goals which may include community and isolation, employment, volunteering or gaining qualifications. It may also include ways in which the individual can expand their personal and social connections by pursuing interests or connecting with local groups.

2. New Solutions

This aims to focus on solutions centred on the individual and offers the opportunity to identify obstacles which prevent people from living their life as richly as they would like to or achieving their goals. It may include challenging negative thoughts and perceptions, and gaining new techniques about how goals can be achieved.

3. Daily Living

This aims to assist people in activities of daily living which may include:

- Decision-Making;
- Personal Care;
- Meals and Nutrition;
- Home and Domestic Routines (including finances);
- Safety in and Outside of the Home.

Aims of the Reablement Service:

- Working with individuals to be as independent as possible
- Supporting people to make their own choices
- Helping people to develop their own skills in daily living
- Being flexible with people to meet their needs
- Offering a solution focused approach in order to achieve identified goals
- Developing strategies to overcome obstacles in people's lives
- Increasing self-esteem and confidence

Aims

This service evaluation aimed to:

- **Explore** users' perceptions of the new reablement service and its impact on their lives
- **Evaluate** short term outcomes for users of reablement
- **Explore** the reablement team's perceptions of the service and its benefits to service users
- **Evaluate** activity data for the reablement service in its first six months of operation
- **Establish** a baseline cohort which could be followed-up in a later study

Method

The evaluation used a mixed methods design. This included analysis of routinely collected data, qualitative interviews with users of the service and a focus group with Reablement team workers

The Reablement Practitioners used the Warwick-Edinburgh Mental Wellbeing Scale with their clients where possible and referred suitable clients to the researcher for qualitative interviewing. Routine data was obtained from ePJS and the service database by the Reablement Clinician and administrative support.

Routinely collected data:

Collected at Initial Assessment	Collected at Discharge
Gender	
Age	
Ethnicity	
Referral Source	
FACS domains and levels	FACS domains and levels
Payment by Results (PbR) Cluster	Payment by Results (PbR) Cluster
Health of the Nation Outcome Scale (HoNOS) Rating	Health of the Nation Outcome Scale (HoNOS) Rating
Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)	Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)
Resource Allocation System (RAS)	Resource Allocation System (RAS)

Semi Structured Interviews:

Purposive sampling was used to select 13 service users to take part in a semi-structured interview about the service. Eight participants had completed Reablement, and five were midway through their time in the service. The discussion guide asked open questions on how they had found the service and what they would like to see done differently, as well as asking these clients a six item measure adapted from the Patient Experience Data Information Centre (PEDIC).

Focus Group:

A focus group was conducted with 3 of the members of the Reablement team (the manager and one Reablement Practitioner were not present) to discuss benefits and challenges of working within the Reablement model, and to provide case studies of clients that they had worked with using the principles of Reablement.

Results

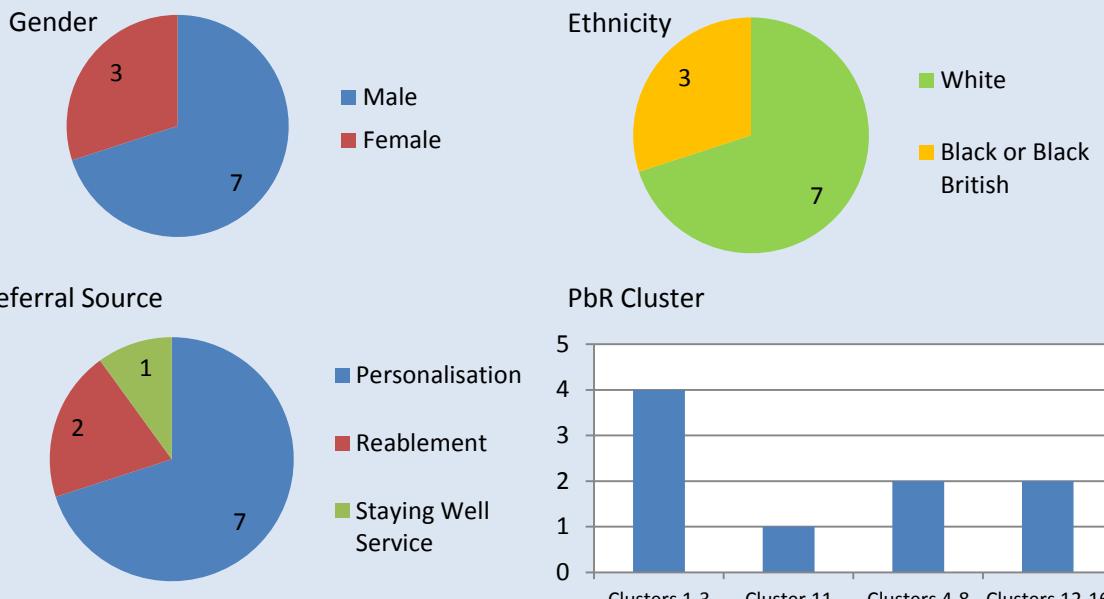
Sample:



Key findings:

- The evaluation showed a significant overall decrease in FACS levels of need
 - Significant improvement on 6 outcome domains
 - Most improvement on Community and Isolation and Safety Indoors
 - Worst performance on Personal Care – Dress and Bathing (not significant worsening)
 - HoNOS score was a significant negative predictor of change in FACS (the higher the HoNOS score, the less likely that FACS levels would decrease)
- The majority of individuals remained in the same PbR cluster before and after Reablement
- FACS and PbR were not significantly associated with one another
- There was a significant reduction in RAS for Indicative Personal Budget after Reablement
 - Total RAS for the group decreased by £42,380.56 from £104,378.25 to £61,997.67
 - The number of clients with a RAS fell from 44 to 15 (13 within Reablement)
- There was no significant change in HoNOS or WEMWBS scores before and after Reablement
- The Health outcome domains on FACS and HoNOS scores were not significantly associated

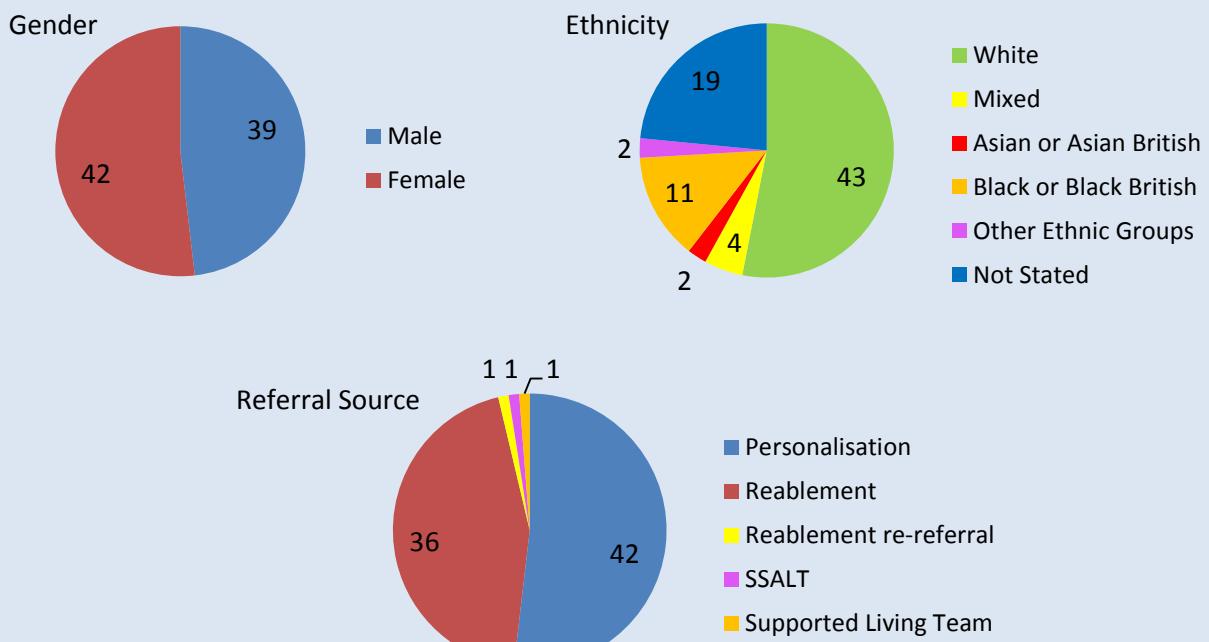
Profile of the 10 individuals who did not engage in Reablement (data on PbR Cluster was not available for one person):



The ten clients who did not engage in Reablement had a mean age of 54 years. There was a higher proportion of males and Black/Black British ethnicities in those that did not engage than in the sample as a whole. All ten were assessed to have substantial needs on the FACS criteria and all had a Resource Allocation Score for an Indicative Personal Budget. The mean for this was £4,901.86, and their mean HoNOS score was 10.3, comparable to the group that did engage.

Demographics of main group:

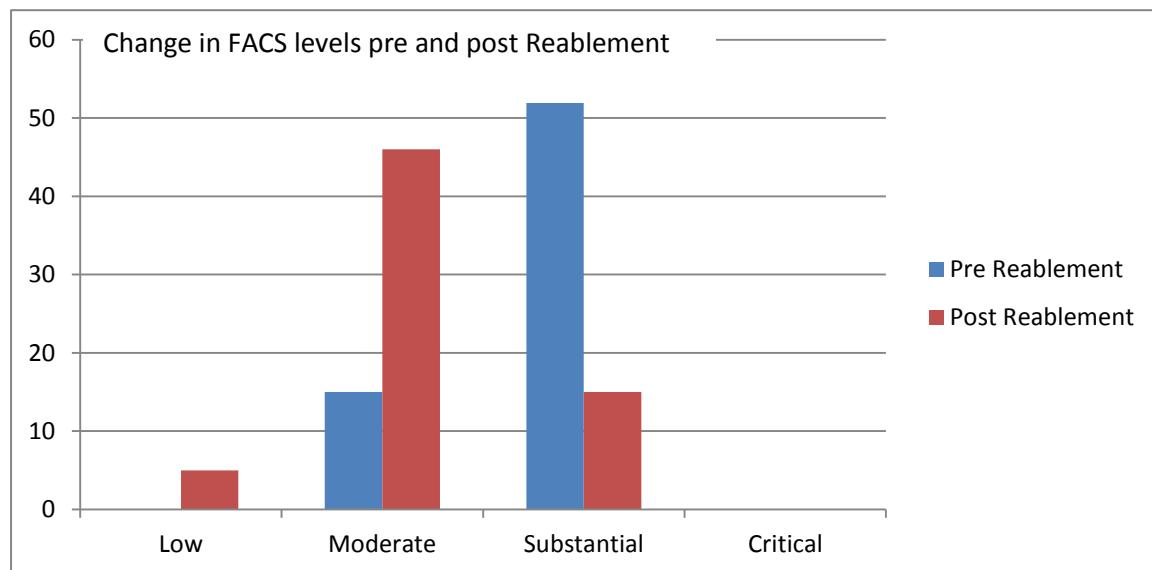
The following shows the profile of the 81 clients who engaged with the Reablement service.



The mean age of the sample was 50 years. The youngest referral was aged 19 years and the oldest was 72. Of this group, 14 clients had not completed Reablement by the end of the research, so these were also excluded from the sample to leave 67 clients with data from both the start and end of their Reablement.

FACS levels:

There was a significant overall decrease in FACS criteria over the course of Reablement, with 33 clients moving from a substantial level of need to a moderate level during Reablement, as shown in the chart below.



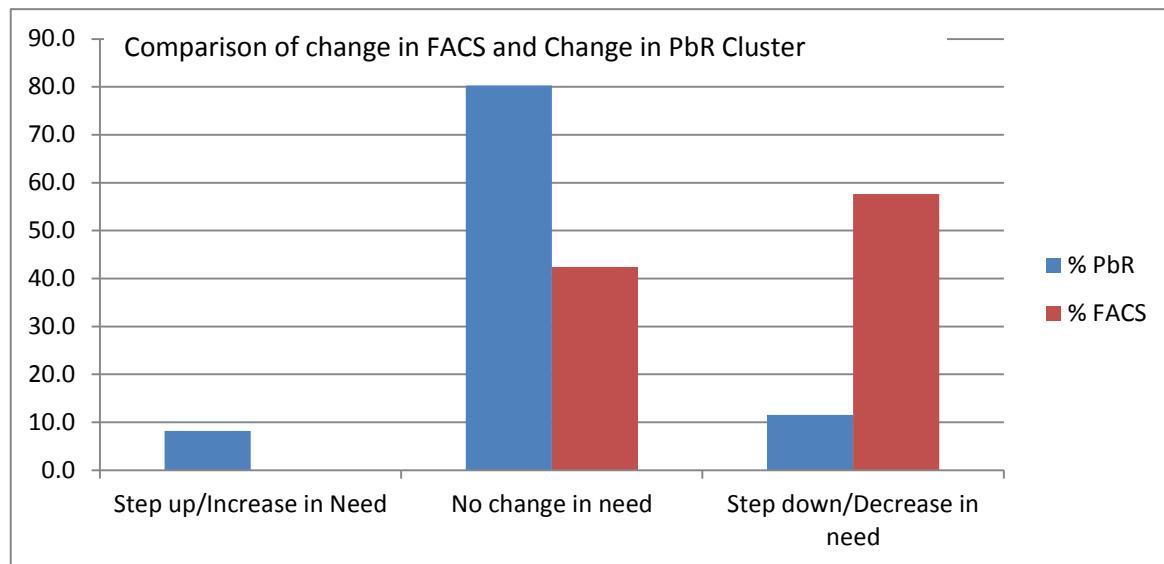
Within the 12 FACS domains that make up the overall score, 6 showed a statistically significant improvement. These are (listed with the most improved first):

- Community and isolation
- Safety indoors
- Decision making
- Personal care – hygiene
- Work and learning
- Home – domestic routines

The other 6 domains did not show a statistically significant improvement, and the domain of Personal Care – dress and bathing became marginally worse. Importantly though, no measures showed a statistically significant worsening in the levels of need during Reablement. Higher HoNOS scores were associated with lower levels of improvement on the FACS criteria.

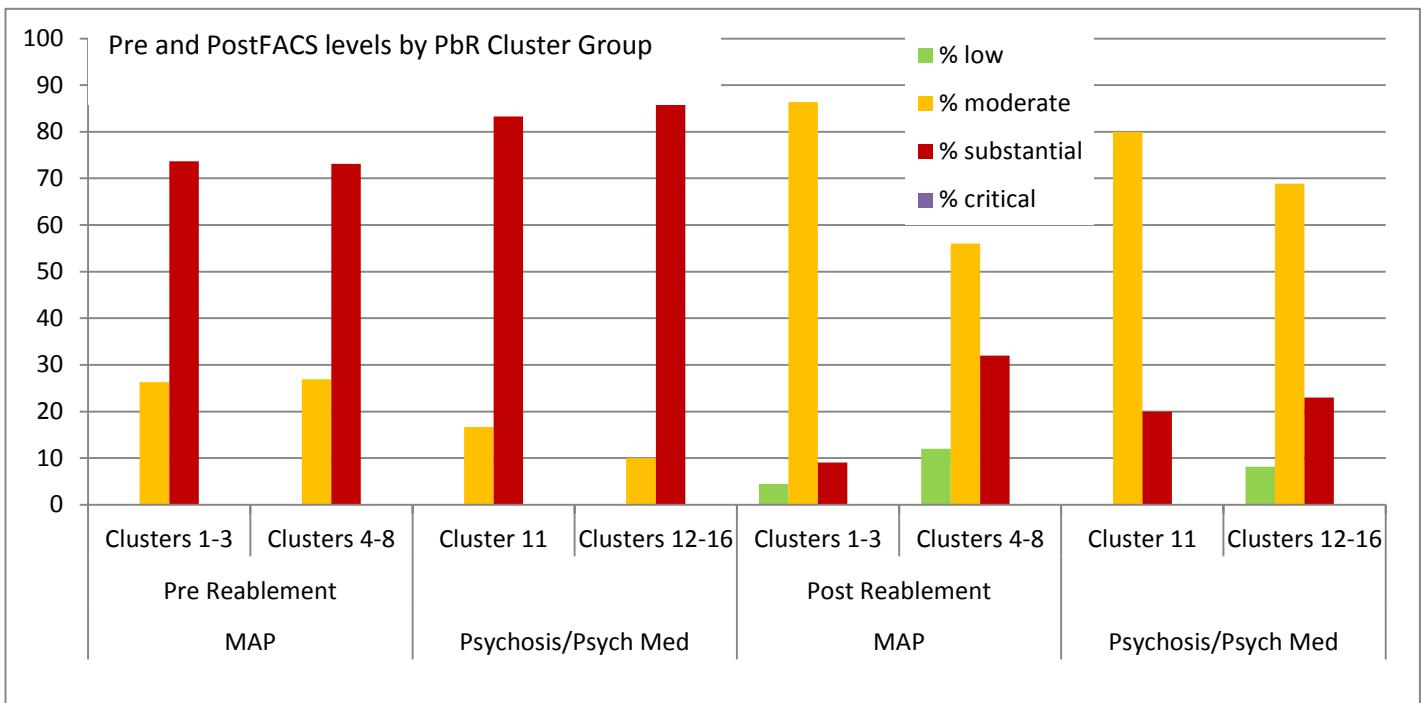
Payment by Results Clusters:

The majority of clients (80.3% of the 61 (n=49) that we had information for) remained in the same Payment by Results (PbR) cluster pre and post Reablement. Of the remaining that we had information for, 8.2% (n=5) stepped up and 11.5% (n=7) stepped down to different clusters. This was not associated with a change in FACS level, where many more people moved to a lower level of need. The two can be seen compared on the chart below.



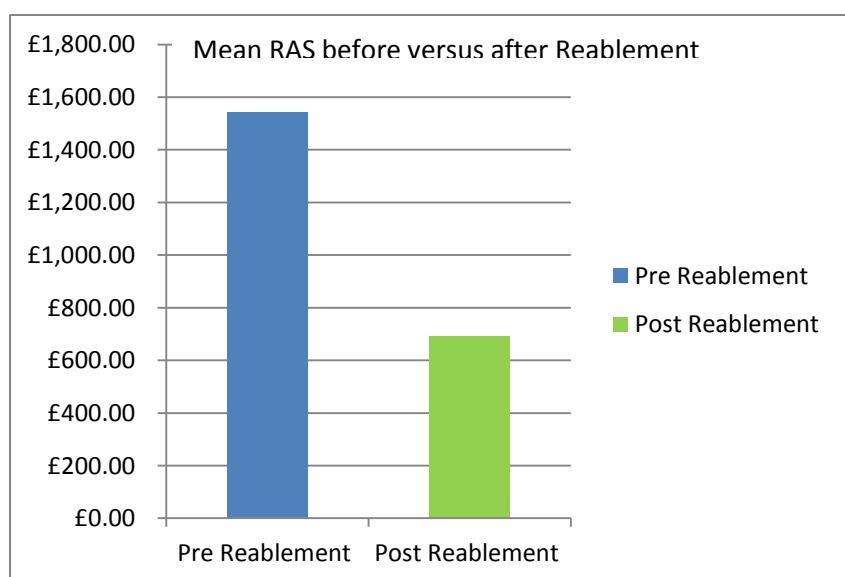
The Relationship between FACS and PbR:

Clusters 1-3 and 11 represent Primary Care, and Clusters 4-8 and 12-16 represent secondary care. We would therefore expect to see a higher proportion of 'moderate' and a lower proportion of 'substantial/critical' in the primary care clusters than in secondary care clusters. There was no real difference in the proportions of clients within different FACS criteria by Cluster pre Reablement. At entrance to Reablement, 26.3% (n=5) of clients in Clusters 1-3 showed moderate need and 73.7% (n=14) showed substantial need on the FACS. This was very similar to the proportions showed by Clusters 4-8 where 26.9% (n=7) and 73.1% (n=19) of clients showed moderate and substantial needs on the FACS respectively. After Reablement the groups were more distinct as 4.5% in Clusters 1-3 (n=1) showed low needs, 86.4% (n=19) moderate needs, and 9.1% (n=2) substantial needs; whereas in Clusters 4-8, 12.0% (n=3) showed low needs, 56.0% (n=14) moderate needs and 32.0% (n=8) substantial needs. A higher proportion of people remained at the 'substantial needs' level within the Clusters associated with secondary care. This pattern was similar for Clusters 11 and 12-16. The change between start and end of Reablement for each group of Clusters can be seen on the graph below.



RAS:

At the start of Reablement, 44 clients had a RAS Indicative Personal Budget. After Reablement only 15 clients still had a RAS Indicative Personal Budget. Only 13 of these Personal Budgets were funded within mental health, and 2 were elsewhere. At the start of Reablement, the total RAS for the sample was £104,378.25, and the after Reablement the total was £61,997.67, which showed a decreased total RAS for the group of £42,380.56. This meant that there was also a large mean decrease in RAS over the course of Reablement from £1,557.88 per person to £925.34 per person. When one client incurring more than a 600% increase in their RAS from pre to post was excluded, as their data was anomalous, the difference was significant and can be seen on the figure below with a change from a mean of £1,541.43 to £691.09 after Reablement.



HoNOS:

There was no significant change over time in HoNOS scores (pre mean = 10.18 and post mean = 11.85). An important point to note is that although those with substantial and critical levels of need in the Health domain of the FACS criteria scored higher on the HoNOS (mean score = 11.58) than those with lower needs (mean score = 9.37), this difference was not significant. This may suggest that the two scales were either measuring slightly different constructs or are being used differently..

WEMWBS:

Only 9 clients completed both pre and post WEMWBS making it difficult to make a meaningful statistical comparison. There was a small improvement in WEMWBS score from pre (mean = 36.22) to post (mean = 39.89) Reablement, but this was not statistically significant due to the small sample size.

Themes from the Interviews and Focus Group:

A major theme emerging from the interviews was a lack of knowledge and clarity as to what reablement was before an individual started the service. Many people did not know that it existed. This was in part due to the service being new and other people using mental health services being unaware of it, preventing the usual ‘word of mouth’ sharing of information about it.

“I didn’t know what to expect at first, but after a few weeks it was quite clear that the help that I had been offered was a good thing”.

– client, Reablement service

There was also some confusion about reablement being a social care rather than a health care service, spanning from the clients themselves to other organisations.

“(I was) rejected by the clinic, because they thought that I was getting secondary mental health services via (Reablement). (Reablement worker) then had to explain to them that he was not providing any health care whatsoever, that he is providing social care”

– client, Reablement service

The length of the service polarised opinions. Some users felt 13 weeks was too short, whereas some workers felt that the short time allowed for focused goals to be tackled. Both workers and clients felt that it took some time for a rapport to be built up, which ate into the short timescale. This contrast is highlighted in the comment below, where a worker describes the challenge of balancing the two aims of maintaining focus whilst instilling hope and the desire to try new things in a client.

“It’s such a short focussed 13 weeks then you want to keep it to the specific thing that they have come to you for, that they are eligible for support for, but then again you say ‘Reablement is whatever you want it to be’ so we’ve got 13 weeks, however you want these 13 weeks to go’ ”

– worker, Reablement service

Major strengths of the service were having one worker making regular weekly visits. The wider team's support was also widely complimented by clients, aided by the hands-on management style of the team leader.

"It was good having it every week...I could focus on something and pursue it...if it was like once a month or something, I would probably see (Reablement worker) today, and have like a brilliant idea, and then go away and then over the two or three weeks before I see him again, it would be...ahhhh....put to the back of my mind.

– client, Reablement service

Clients were keen to speak about the flexibility of the service and how personalised it felt. Topics they spoke about included setting goals, a worker giving responsibility to a client, and helping people to move on.

"(It's) Someone guiding you and helping you along, you find that it's much more rewarding, and basically...instead of relying on someone to do everything for you like my brother – he relies on his key worker to do things like that...you can't do no more for a person, you put them on the right track and basically, hopefully they won't derail"

– client, Reablement service

The worker provided practical support (for example introducing a client to new services, and attending these with them) and worked flexibly. Additionally, they gave emotional support and hope to clients.

"Basically he read my books, and (laughs) he was impressed...he said something to me at that last meeting – he said that I should write proper books, he thinks I – I should – I have enough knowledge and experience to express it and share it with others, and maybe write – professionally".

– client, Reablement service

The client needed to be in 'the right place at the right time' for Reablement to be effective, with some stating that it felt too soon for them. Illness and attitudes were often seen as barriers, and having strong personal networks an asset.

"And if you did want to get in work, and they could put you in touch with people, and organisations for that...then that is going to work for you. But if I – I mean, if someone was at the point where they were still suicidal, I cannot say – I can say it probably won't work for you, as it stands at the moment. But that's nothing to do with the service..."

– client, Reablement service

When asked what they took from the service, respondents talked about changing their attitudes. Most hoped that they would continue to implement the new ideas after the end of the service. Overwhelmingly, clients stated that they would recommend the service to another person.

"You know, without being blindly optimistic I would like to think that in 6 months' time I will be in a much (better) situation than I was 6 months ago"

– client, Reablement service

Summary

This evaluation provides an insight into the Reablement service during its first 6 months of operation. Its key findings are:

- **Reduction in need:** The data shows a significant decrease in overall FACS levels from substantial to moderate. This corresponds with the reports of most of the interviewees that their reablement worker had promoted their independence. People with higher health needs, as measured by the HoNOS, showed a lower success rate in the reduction of their overall social care needs (the FACS criteria), however the HoNOS and the FACS “Health” domain were not correlated which suggests that these scales may not be measuring the same thing.
- **RAS:** There was a significant decrease in the RAS of clients from before to after Reablement, suggesting a reduction in cost to mental health services as a result of the Reablement service.
- **The attitude of the client:** This appeared to play a key role in the success of the reablement service as a willingness to take responsibility, a desire to make positive changes and to try new activities was necessary for the client to move forward. Mental health problems were seen as a barrier in several instances.

Limitations

We were unable to evaluate change in well-being over time due to having only a few pre and post WEMWBS scales. The evaluation only captured two time points – the start and immediate finish of Reablement. As Reablement is intended to have high initial costs with the intention of reducing long-term need and its associated costs, the longer term outcomes are important to capture as well. People with reduced need at the point of exit from the service may only display this because of the immediate effect of Reablement, and this may not necessarily continue. Re-referrals to this or to other services after the 13-week period may be common, but were not captured by this evaluation. There was also no control group, meaning that it is possible that any change observed could have occurred even if clients had received an alternative or no service.

Recommendations

Further research

- Collect full data from all participants including WEMWBS
- Obtain necessary data from ePJS and complete CSRI questionnaires to complete baseline data collection
- Follow-up cohort one year from finishing reablement and record all measures again to establish longer term impact of Reablement on outcomes:
 - Include analysis of whether clients are receiving a personal budget or not, and if so how much it is worth
 - If possible conduct follow-up qualitative interviews with the 13 clients interviewed during this evaluation to learn about progress
- Establish a control group who have not undergone Reablement to better evaluate its efficacy
- Use the new version of the spreadsheet provided by the research team to allow more comprehensive capturing of data and ease of future analysis

- Record each question on the HoNOS scores separately to allow full analysis of this scale
- Record each question of the CSRI separately to allow full analysis of this scale
- Examine the relationship between a client's (qualitatively recorded) desire to change and change in outcomes such as HoNOS, WEMWBS and other social outcomes.

Reablement Service

Duration of reablement: Most interviewees stated that they did not feel that the service was long enough as it often took several weeks to 'settle in' to the service and 'build the relationship'.

However, the premise of Reablement as being an intensive, short term intervention contradicts this and the challenge for the service is to find a way to bridge this gap. Clients may feel that they still need support at the end of Reablement, so it is important that towards the end of the service Reablement Practitioners:

- Review the Staying Well plans with the client to ensure familiarity
- Give a clear list of alternative support networks for after Reablement is completed

Attitudes: People who did not feel ready to embark on reablement did not appear to gain as much from it as those who were. Many appeared regretful and upset that they had not used the time effectively, which could be detrimental for their mental health. It may be beneficial to:

- Develop a brief measure to assess readiness for participation in reablement, such as an adaptation of the Readiness to Change Questionnaire (Heather & Rollnick, 1993)
- Make the purpose and structure of Reablement very clear to new referrals
- Emphasise progress through the service at regular intervals to keep the client focused on achieving their goals.
- Train staff in Motivational Interviewing techniques

Clarity about the service: Reablement is a new service in Southwark and it is not surprising that many people were unsure about what to expect when they entered it. Some clients reported not knowing what it was even after a few sessions:

- Additional publicity about the service is required within the service itself and mental health services more generally.

Cohesiveness: The team appeared to work well together and the ability of the clients to contact other members of the team if necessary was valued.

- Continue with the flexible nature of the staffing of the service

Conclusions

Clients and workers both appeared to appreciate the ethos of reablement. The team appeared engaged and enthusiastic about the service which contributes to positive outcomes for service users. This evaluation found tentative signs of positive outcomes for users of the Southwark Reablement service, but small samples and a lack of a control group means this needs to be treated with caution.

Acknowledgements

The researchers would like to acknowledge the following individuals and organisations for their expertise, cooperation and collaboration in this evaluation:

Simon Rayner – Head of Mental Health

Michelle Jones – Reablement Team Manager

The staff of Southwark Reablement Service

The individuals accessing the Southwark Reablement Service, in particular those who gave their time and opinions by completing an interview

The Commissioner and those that commissioned this research: the London Boroughs of Southwark, Croydon and Lewisham

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