The reablement agenda: challenges and opportunities

Brief overview and analysis: February 2011

Key points:

This report makes the following key points:

- That care should be taken in interpreting and implementing reablement services without a clear and consistent definition of the range and function of these services in the local health and social care system.

- The latest prospective longitudinal study on homecare reablement published in December 2010 and covering a 12 month period following a reablement intervention worked with 10 Local Authorities (5 who provided reablement and 5 who did not) and included 241 cases in the former and 141 in the latter groups.

- That the study found significant improvements in the quality of life for people in the reablement group.

- That the social care costs including reablement across the twelve months of the study were 15% less for those receiving reablement and 60% less were you to exclude the reablement intervention.

- That health costs, captured on a self reporting basis, were not significantly different for either group, though there remain weaknesses in the methodology used to estimate these costs that might suggest costs here could also be less for people receiving reablement.

- Despite a range of methodological challenges in undertaking this study there remains a strong case for reablement, particularly when coupled with previous research about the longer term benefits of such an approach.

- That resources identified to support the development of reablement services need to be used in a way that manages risk and does not simply shift any system blockages to another point – greater integration of reablement into an intermediate tier should remain a clear objective.

- That overall the CSED report, and the current political interest in improving reablement services, makes a strong case for local developments that gather local evidence of effectiveness in an iterative way between local partners through implementation and ongoing monitoring.

- Despite differences in the definition and approaches to reablement services across the country there remains benefit in local commissioners learning from each other to minimise local wheel re-invention and to build a stronger case for reablement based on local evidence.
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1 The purpose of this report

This report briefly describes and analyses two recent developments of critical importance to commissioners of health and social care:

- The publication by CSED (Care Services Efficiency Delivery) of new research into the efficiency of homecare reablement as part of a ‘whole system’ of health and social care¹.
- The issuing of two tranches of non-recurring money by the Department of Health to PCTs in England relating to the commissioning of ‘reablement’ services.

It is intended to provide a quick digest of the main messages, and to identify some key potential implications for commissioners, including those for whom reablement may not be a familiar concept or an area of responsibility.

2 Definitions: proceed with caution!

The intermediate care sector, of which reablement forms a part, is a minefield of inconsistency in terms of the terminology used to describe services of different kinds, both between different localities and in some cases between different people and organisations working together in the same locality. The continuum of intermediate care, and the various services that may exist within it, is well illustrated in the Department of Health’s guidance Intermediate Care; Halfway Home (DH, July 2009), and shown below:

More recently, CSEDs reablement toolkit² includes a paper on definitions which uses the same basic concepts and draws a distinction between ‘homecare reablement’

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¹ The research was undertaken by SPRU at the University of York and the Personal Social Services Research Unit, at the University of Kent,
² Intermediate Care and Homecare Re-ablement: What’s in a Name? Available at http://tinyurl.com/6z8528p

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(seen as a social care centred activity, to the left of Brophy’s continuum) and other forms of intermediate care, but which may co-exist with them within a system.

In its own work WSP has developed a set of language that is consistent with this overall design and describes an intermediate tier that encompasses a range of services managed within a co-ordinated system of care in such a way as to ensure that there is early engagement, based on an assessment of need and coupled with the provision of appropriate short term care.

The overall purpose of the intermediate tier is therefore to help people to maintain or regain their health and independence through early engagement and assessment of need. For some this will mean avoiding an inappropriate hospital or care home admission, whilst for others it will ensure early discharge or transfer of care following acute illness, whilst promoting effective rehabilitation and other forms of support designed to maximise people’s independence within the community.

Within the Intermediate Tier there is therefore a legitimate distinction between:

• **Enabling homecare;** which provides the fundamental building block of a care system where optimised independence and choice is a primary goal. This is aimed at ensuring such skills are maintained by the individual and will be found across the whole care system including any homecare delivered as part of an intermediate tier;

• **Reablement;** for people with poor physical or mental health or disability where there is potential to improve independence and choice by learning or re-learning the skills necessary for daily living; and

• **Rehabilitation:** the process of restoration of skills by a person who has had an illness or injury so as to regain maximum self-sufficiency and function in a normal or as near normal manner as possible.

When referring to reablement in this context it is also helpful to distinguish between:

• **Intake reablement;** where all new referrals to adult social services (in particular home care) are considered for reablement; and

• **Targeted reablement;** where referrals to reablement are received from specific sources, normally hospital discharge or to prevent hospital admission.

These definitions are important in understanding the opportunities and challenges facing commissioners of health and social care in the current climate. For example, the focus for the non-recurrent funding discussed in part 2 of this paper refers to ‘reablement’ with an emphasis and expectation that this will impact particularly on the post-discharge element of an intermediate tier. The hospital discharge element of the intermediate tier has traditionally and appropriately had a rehabilitation focus, with reablement needing to dovetail and secure sustained improvements in independence and choice in a broader context of somebody’s wider and holistic ‘health’ needs.
Part 1: CSED Prospective Longitudinal Study on Homecare Reablement, November 2010

3 What does the study do?

The study compared the experience of people who had received a period of reablement (defined here and throughout Part 1 as a social care activity) with those who had not. It recruited 1,015 people for the study: 654 in the reablement group and 361 in a comparator group. The participants came from 5 Local Authorities providing reablement and 5 others where traditional home care was provided.

The aim was to compare the groups approximately 8 weeks after the start of reablement, and again after a further 10 months to identify what, if any, differences there were in the services used and the client experience. However there was a high drop-out rate of participants between the initial data collection and the follow-up interview (which the study recognises as a drawback) so that ‘before and after’ information was only available for 241 in the reablement group and 141 in the comparison group.

4 What data was collected?

Participants completed questionnaires at each stage of the research including the following outcome measures:

- Self-perceived health;
- Perceived quality of life;
- Health-related quality of life;
- Social care outcomes.

Councils were asked to provide information about the social care services (but not the health services) used by participants during the reablement period and by the time of follow-up.

Participants were asked to provide information on the health services they had used in the previous month and these were used to estimate the costs of health services for each person at the initial 8 week period and after a further 9-12 months (difficulties in recruiting respondents meant that the recruitment period had to be extended and consequently it was only possible to follow up the majority of service users for 9 or 10 months).

5 What were the results?

5.1 Quality of life

There were significant improvements for the reablement group in terms of

- Social care quality of life;
- Health related quality of life;
- Perceived quality of life;
- Perceived health (although over time this reduced again to a similar level to the comparison group).

http://tinyurl.com/36wgkga

"Homecare reablement 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." (report p 1)
5.2 Costs of care

5.2.1 Social care including reablement

The average cost of social care, ie reablement and/or conventional home care plus other forms of social care (day care, low level support etc) in the first 8 weeks for those receiving a reablement intervention was £1,640 while the social care services provided to the comparison group in the first 8 weeks cost an average of £570. However in the remainder of the year the reablement group received significantly lower levels of social care, £790 as opposed to £2,240 for the comparator group. The ‘break-even’ point for investment in an initial period of reablement would therefore be at about 30 weeks following the end of a reablement package.

Overall social care costs over the whole 1 year period (including both conventional care and reablement care) were therefore £2,430 for the reablement group and £2,810 for the comparison group – a 15% reduction (but not statistically significant, i.e. this difference could have been caused by natural variation between the two groups\(^5\)).

The costs of social care services used by people who had received reablement (excluding that reablement) over the twelve months of the study was actually 60% below that for the control group over the same twelve month period.

All the sites offered reablement for up to 6 weeks with the option of extending it in individual cases. The mean duration of reablement was 39 days (i.e. just over 5½ wks or very close to the notional maximum duration) and the longest was 23 weeks.\(^6\)

5.2.2 Health care

Costs were estimated based on the responses given by participants about the health services they had used recently, costed using national unit cost data (this methodology was a potential source of inaccuracy in the results and is discussed as such in section 5.4 below). At the initial 8 week stage the average cost of health as reported by clients was £1,600 for the reablement group and £1,095 for the comparison group. At follow up, the costs were estimated at £3,455 for the reablement group and £3,235 for the comparison. The differences were not statistically significant.

5.2.3 Overall costs

Taking the 2 sectors together, the average cost of care per client studied is shown below. The differences were again not shown to be statistically significant.

<table>
<thead>
<tr>
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<th>Reablement group</th>
<th>Comparison group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial 8 week period</td>
<td>£2,650</td>
<td>£3,060</td>
</tr>
<tr>
<td>12 month total</td>
<td>£7,890</td>
<td>£7,560</td>
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</tbody>
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The overall conclusion was that there was no statistically significant difference in the costs of care over the first full year after referral for people who were referred to reablement compared to those who were referred to conventional homecare.

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\(^5\) Assessed by regression analysis and significance testing at p<0.001, 0.01 and 0.05.

\(^6\) Although some episodes lasted beyond the initial 8 week period, the average cost of reablement in the following 10 months is shown as £0 for the reablement group: it is not clear from the report how longer term reablement costs have been treated eg whether they were simply automatically allocated to the initial 8 week period.
5.3 Cost-effectiveness

This was measured by combining the data on costs with that on outcomes. The report concludes that reablement is cost-effective in terms of social care expenditure and its impact on health and (probably) social care quality of life. When health costs are included, the impact is less significant but it is still likely to offer some level of cost-effectiveness.

5.4 Methodological issues and their impact on results

5.4.1 Recruitment difficulties and drop-out rate

The research encountered a number of difficulties in recruiting sites and service users. There was a high drop-out rate of participants between the initial period and the follow-up: the report does not analyse the reason for drop-out although it identifies death, illness, (re)hospitalisation or refusal to participate in the follow-up interview as factors.

5.4.2 Duration of the study

The previous CSED report, summarised in Appendix 1, suggested that there is a strong likelihood that the benefits of reablement can be sustained over longer than 1 year with ongoing benefits and reduced service use for large percentages of reablement clients up to 2 years after reablement.

While this earlier report did not compare service use between reablement and other groups, or assess whole system costs for people receiving reablement, it does suggest strongly that further benefits might be deliverable across a longer period. All other things being equal it would seem therefore that this study cuts off the accumulation of financial benefit at a point just beyond the break-even, and that earlier reports suggests sustained financial benefit.

5.4.3 Referral routes into the services

There were some potentially significant differences in the referral sources, and therefore the nature and level of need likely to be incurred between the reablement group and the ‘control’ group. In particular, 75% of the reablement group were ‘step down’, ie had been referred for reablement following a hospital admission. Only 55% of the comparison group had been referred to services following an admission.

Similarly, 15% of the reablement group were first time referrals from the community as opposed to 29% of the comparison group. This potentially accounts for a significant part of the increased health service use in the reablement group, since more of them had recently been in hospital and were likely to require follow-up (or be at risk of a readmission).

While the referral route was taken into consideration in significance testing for differences in healthcare costs between the reablement group and the comparison group it does not appear to have been used in analysis of the social care costs for the two groups. If referral route does have an impact on social care costs (eg if people referred from hospital require higher levels of contact time) then this was not accounted for in the analysis and could have skewed results towards over-estimating the total cost of care for reablement clients in comparison to others referred through the same route.

5.4.4 Self-reporting of health service use

The fact that health use was self-reported and not collected from PCTs or health services could also have had an effect and certainly raises some questions about the reliability of the health care cost estimates in the report. It was acknowledged, for
example, that respondents referred from hospital might well have included the initial hospital admission in their answers although this was obviously not part of the health care they accessed during the period after referral and should not have been included in estimates of the cost of healthcare in the period under study.

Given that there were a higher proportion of people in the reablement group who had been referred from hospital than there was in the comparison group, any effect on total calculated healthcare costs due to mis-reporting of the initial admission by clients would be felt more strongly in the average cost of healthcare in the reablement group.

5.4.5 Potential impact of methodological issues

The combined impact of these issues on the findings of the report is difficult to quantify, but the balance would seem to have been to under-estimate the potential for reablement to deliver whole system savings.

5.5 Other findings and pointers for good practice

The study also included qualitative interviews with service managers and service users and highlighted some potentially helpful ‘good practice’ issues for reablement services concerning:

- Assessment arrangements;
- Discharge and onward referral arrangements;
- Key features of reablement services;
- Skill mix in the team;
- Staff commitment, attitude, knowledge and skills;
- Service user characteristics;
- Service user and carer views;
- Shared understanding and strong vision of the service.

The relevant section of the executive summary is included as Appendix 2 to this paper for ease of reference.

6 What does all this mean?

At first sight this report provides disappointing messages for advocates of reablement as offering not just improved quality for service users but also the prospect of significant sustainable cost savings. However the report does not provide a definitive answer on the ultimate benefits of reablement. Nor does it consider reablement in the context of other services (such as rapid response, health-focused intermediate care etc) which may work together in an ‘intermediate tier’ to prevent admissions and/or facilitate discharge.

The shortcomings of the methodology, particularly in the estimation of health costs and the potential differences in the benefits of reablement to ‘step up’ and ‘step down’ clients, suggest that it should perhaps be best used as an encouragement to further local work on costs and benefits to the whole system, which pick up on the earlier work to assess the benefits over a longer period than 1 year: meanwhile, it does confirm that, at a minimum, reablement “does no harm” to whole system costs viewed over a 1-year period.

What does seem clear on the basis of this and previous research is that reablement provides real and sustainable benefits for its users, and as such it is to be welcomed as a contribution to the ongoing debate about future service models and service transformation.

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**Part 2: October 2010/ January 2011 non-recurrent funding for reablement**

7 Announcement of new funding

There have been 2 recent announcements of ‘new funding’ to PCTs for reablement in addition to the announcement of investment in reablement in the Operating Framework, which stated that there would be £150m in 11/12 and £300m from 12/13) for these purposes:

- **Oct 10: £70m non-recurrent**
  “to facilitate seamless care for patients on discharge from hospital and to prevent avoidable hospital readmissions”. The letter announcing this funding is available at [http://tinyurl.com/5w2326m](http://tinyurl.com/5w2326m)

- **Jan 11: £162m non-recurrent**
  “to invest immediately in vital social care services which also benefit the NHS”. The letter announcing the funding is available at [http://tinyurl.com/6e9tdp8](http://tinyurl.com/6e9tdp8)

7.1 Oct 10: £70m non-recurrent

Detailed requirements underpinning this resource included the statement that:

“A proportion of this funding should be used to develop current re-ablement capacity in councils, community health services, the independent and voluntary sectors according to local needs. Resources can be transferred to local partners, including whether a pooled budget should be set up, wherever this make sense locally.

PCTs should use the plans developed for this year as a basis for co-ordinated activity on post-discharge support in 2011/12 and 2012/13 when changes to the tariffs will take effect. In 2011/12, non payment to Trusts for emergency readmissions will create savings for commissioners to reinvest in re-ablement and post-discharge support in year, whilst the intention is that from 2012/13 the tariffs are increased to cover the cost of post-discharge support, including re-ablement.”

For a local Commissioning Group this resource equates to c.£130k per 100,000 population. Our observations in regard to this resource are that:

- Although the £70m does carry with it an expectation that some will go to social care, there seems to be no actual requirement for this.
- It comes as an increase to baseline revenue.
- There are big risks for commissioners and providers in using this to develop any services with recurring costs (over and above those that might be planned with the recurring funding increases as below): for commissioners, there’s no guarantee that the fines for re-admission in 2011/12 will cover the costs of reablement services.
- For providers, from 2012/13 onwards, the direction of travel has been set by these funding mechanisms on developing hospitals as the default provider of post-discharge support (as opposed to community health if not managed by acute FTs, social care, 3rd sector etc). However, recent reviews have suggested that only 29% of community services will in future become part of Acute Foundation Trusts through vertical integration meaning that there will continue to be challenges of integration with the community at some point in the system.
7.2 Jan 11: £162m Additional Winter Pressures to Primary Care Trusts

Although the title suggests this may be of less interest to ‘whole systems’, it is in fact a non-recurring top-up to existing funding to be invested in social care by PCTs, effectively bringing forward the recurring funding increases already announced (£150m in 11/12 and £300m from 12/13 as per the operating framework).

“This could include current services such as telecare, community directed prevention (including falls prevention), community equipment and adaptations, and crisis response services. ... further investment in reablement and rehabilitation services, to help people regain their independence and reduce the need for ongoing care. “

Fines from 2011/12 on hospitals for ‘avoidable’ re-admissions (and so dependent on hospital performance), plus (from 2012/13) tariffs revised to include post-discharge support will be retained by the PCT over and above the recurring funding.

For a local Commissioning Group this resource equates to c.£310k per 100,000 population.

7.3 Observations

The £70m and the £162m are not 2 slices of the same cake and there are more risks for commissioners in using the £70m for service development as this does not have a recurrent funding stream behind it – and is only targeted at post-hospital reablement, not more general models including intake.

Post-discharge support may be part of a system of intermediate care which also includes social care reablement, but it is not necessarily the same thing as reablement (and certainly, if delivered by an acute hospital provider, may work to a very different service model than a reablement service delivered in the community by a social care provider). The use of ‘reablement’ to describe hospital-provided post-discharge support may therefore be unhelpful resulting in the risk of over-medicalising intermediate care, and particularly the reablement function.

This said, there is no reason, given a sufficiently robust and partnership based approach to commissioning, together with effective performance management, why this could not be done as part of an effectively managed whole system of intermediate care. However, there remains a danger that community-based step-down intermediate care, which might currently include social care reablement, is replaced by new ‘decant wards’ providing holding facilities for large numbers of patients who may have been discharged from an acute tariff but who remain within a medicalised model of care with reduced opportunities for rehabilitation, reablement and maintaining independence.

The CSED research report suggests that social care reablement produces positive benefits in terms of quality of life: while ‘post discharge support’ may not be the same thing as social care reablement, it exists (or at least can exist) within the same intermediate tier and as such the lessons of the research in terms of user experience may be very pertinent.

As a final comment, although the role of pathfinder GP commissioning consortia is made explicit in the October 2010 announcement regarding post-discharge support, consortia will clearly have a wider role in commissioning intermediate care with their partners in local authorities. This is not mentioned in the January 2011 announcement, but given that this brings forward recurrent funding that will be a key part of the resources at the disposal of consortia in future, PCTs would be well advised to ensure that GPs are engaged now in the process of planning for the deployment of this non-recurring funding.
Appendix 1: overview of findings of CSED Homecare Re-ablement Retrospective Longitudinal Study (2007)

In November 2007 CSED published the results of a retrospective longitudinal study that was completed by the Social Policy Research Unit (SPRU), at the University of York and a specialist research organisation, Acton Shapiro. This study built on the existing body of evidence and sought to:

- determine the duration of benefit for those undergoing homecare re-ablement
- inform what a larger prospective study might usefully encompass to enable CSSRs to maximise the benefits of a service

The headlines of that report were:

- In 3 of the 4 schemes
  - 53% to 68% left re-ablement requiring no immediate homecare package (4th = 94%)
  - 36% to 48% continued to require no care package 2 yrs after re-ablement (4th = 87%)
  - (In 1 scheme 55 users that had previously required homecare before re-ablement continued to require no care package 2 yrs after re-ablement)

- Of those that required a homecare package within 2 yrs after re-ablement
  - 34% to 54% had maintained or reduced their homecare package 2 yrs after re-ablement (4th = 61%)

- Of those > 65 yrs that required a homecare package within 24 mths after re-ablement
  - In 3 of the 4 schemes the number that had reduced their package was higher after 24 mths than after 3 mths (4th = grew but then fell below 3mth level)

- Of those > 85yrs that required a homecare package within 24 mths after re-ablement
  - In 2 of the 4 schemes there was a marked growth in the number that reduced their package

- Excluding those transferred to LTC or died
  - In 3 of the 4 schemes no dramatic change in the mix of intensity over the 24 mths following homecare re-ablement
Appendix 2: headlines from CSED Prospective Longitudinal Study (Dec 2010): service design and good practice

Assessment arrangements

The findings within the re-ablement sites highlighted a number of issues, including:

- It is important that the initial review be completed in the client’s house, particularly in transition from hospital. Once back in the home environment, it was possible that people may be able to do some things they could not do in hospital, but may identify other areas where they need support to live independently, such as help with shopping and/or social activities.
- All sites felt that the initial setting of goals with clients was a managerial role involving one or two senior carers, the service users and occasionally an OT. Feedback from front line staff was important throughout the phase but formal reviews were necessary at different stages to further assess progress and define any appropriate ongoing package requirements.

Discharge and onward referral arrangements

- Where discharges are reliant on referral back to care managers, who are not within the team, this can cause delays and result in blockages. Some services allow the re-ablement team to commission services.
- Difficulties in finding an appropriate home care agency to provide ongoing support post the homecare re-ablement phase leads to some service users remaining in the re-ablement service for weeks or months, thereby blocking the service. A zoning approach can help to ensure that those living in remote areas who need ongoing support do not face delays.
- Managers and some front line staff feel that the re-ablement approach is likely to be undermined when people with ongoing needs are transferred to ongoing providers.

Key features of re-ablement services

- Access to equipment, such as grab rails, walkers and trolleys to carry food around play a vital role in helping people become more independent.
- Workers identified by the re-ablement services as being less experienced were those who had spent less time working within traditional home care services. However, in general, these workers appear to involve people 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 would want to do on the day) and hands on ‘doing with’ involvement in practical activities.
- 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.
the focus groups with front-line staff also confirmed managers’ concerns that nostalgia for the traditional role of home carer and difficulties in adjusting to a new role were more pronounced among people with extensive experience in conventional home care services

Skill mix in the team

- difficulties in accessing OTs, whether they are within the team or outside, often mean a delay in getting equipment, thereby 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. Many councils have established trusted assessors within the service to appropriately deal with low level items.
- difficulties in accessing OTs for therapy input resulted in delays in some cases of up to four weeks after re-ablement had started. This affected the timeliness of service responses.
- while there was some evidence to suggest that services organised in partnership with the NHS gave re-ablement services better access to a range of professional skills, in practice what was considered to be more important was having adequate and rapid access to OTs and other specialists rather than having those professionals necessarily embedded in the re-ablement team.

Staff commitment, attitude, knowledge and skills

- managers felt that increased job satisfaction was 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.
- 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.

Service user characteristics

- it is felt that the most difficult cases tend to be service users who have a history of long periods of home care (either from social services or the private sector), because they are more likely to expect things to be done for them.
- there was a common view among teams that people with dementia and mental health problems required different patterns of engagement, where workers undertake a wider range of tasks themselves but encourage clients to help with those tasks. However, re-ablement could more accurately identify the scale and nature of long-term support.
- there was a consensus among all managers that re-ablement for older people who had had a fall or fracture focused more on personal care and confidence building; for younger people, who were considered more motivated to become independent, it was more about social interaction.
Service user and carer views

This section highlights the extent to which services are meeting the goals and priorities of service users

- involvement in setting their own goals appeared to be highly motivational in encouraging people to attempt to do more for themselves
- in a small number of cases service users and carers felt that the re-ablement goals they had identified had been thwarted by restrictions on the service
- service users were often disappointed about the changes to their eating habits. Help with food preparation was provided but this was usually limited to making toast and tea or a sandwich
- for many service users living alone, the primary benefits were feelings of safety and the company of other people. Services need to consider that the focus of service user needs varies depending on their personal situation.
- many service users expressed a desire for support to improve mobility around and outside their home and linked the inability to achieve this to the absence of physiotherapy input. However, through discussion with intervention sites it became clear that many of their service are focused on activities of daily living (ADLs) within the home and not on instrumental activities (IADLs) outside the home. Thus, this 'shortfall' in meeting user's goals may be more to do with the scope of the service than the availability of any particular skill.

Shared understanding and strong vision of the service

- a lack of common understanding can result in the service being misused. For instance, commissioning teams sometimes use the service as a 'holding' zone and / or make inappropriate referrals (e.g. people assessed as needing complex care)
Appendix 3: A reablement ‘Gold Standard’ & toolkit

1 Introduction

The following ‘standards’ have been developed as part of a toolkit for reablement designed to enable participants in a learning network to:

1. Compare practice across a number of authorities and share notable practice.
2. Undertake a self assessment diagnosis against these standards and therefore to build a local development plan for reablement services.
3. Use a capacity planning tool designed to simulate future capacity and resource use in line with the emerging CSED evidence base and local experience.

2 Referral

<table>
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<tr>
<th>Standard</th>
<th>What would the Gold Standard look like?</th>
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</thead>
</table>
| Comprehensive information for the service user and carer | o Information on the service is clear and easily accessible  
   o There is specific information for professionals that makes referral procedures clear  
   o There is information that is specifically targeted at carer’s that explains their what reablement for the one they care for might mean and their own right to a carer’s assessment  
   o Information is provided in a variety of formats including those suitable for people from different language or ethnic groups and those with disabilities |
| Clearly Defined Eligibility Criteria – as inclusive as possible | o Eligibility should be described used inclusive language rather than identifying groups who might be excluded – potential to benefit from the service should be paramount  
   o Certain groups of people should be expected, by default, to be referred to the service, for example, all people at the point of admission to care home, unless there is a clear reason not to |
| Single point of access | o There should be a single point of access for people referred to or wishing to access the service  
   o The single point of access should be itself accessible through a number of different media, for example by phone, e-mail or internet |
| Links with other services are clear and transparent and understood by all | o The extent of integration or links with intermediate care are made explicit  
   o Pathways and sign-posting between reablement and the voluntary and third sector are clear with good quality information for the service user and carer to ensure they can make full use of alternatives to traditional home care or related service  
   o Links between reablement and services such as day care are explicit both in terms of referral and shared use of resource |
| The role of the Reablement service in relation to hospital discharge is clear | o There is a clear and consistent set of referral pathways and documentation to facilitate hospital discharge  
   o Mechanisms are in place to enable early assessment and contributions from reablement staff to discharge planning  
   o People are provided with clear information about how their hospital discharge is being planned including the role and contribution that reablement will make |
| Referrals into the service include existing service users who are being reassessed / reviewed | o The service is provided to people at the point of reassessment / review if they have not previously been through the reablement service; or when there is a change in circumstance |

7 Developed in partnership between WSP and the Social Services Improvement Agency during 2009/10 through the development of an action learning set involving 9 of the 22 Welsh Local Authorities.
### 3 Screening & Assessment

<table>
<thead>
<tr>
<th>Standard</th>
<th>What would the Gold Standard look like?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility for Re-ablement</td>
<td>o As above</td>
</tr>
<tr>
<td></td>
<td>o Clear definition of service focus</td>
</tr>
<tr>
<td></td>
<td>o Clear reasons why people may be screened out</td>
</tr>
<tr>
<td></td>
<td>o The triggers for reablement are clear and transparent</td>
</tr>
<tr>
<td>Clear definition of service focus</td>
<td>o The reablement service has developed and consistently applies good documentation that identifies care plans and agreed outcomes with the service user and their carer</td>
</tr>
<tr>
<td>Assessment for reablement fits within the UA process</td>
<td>o All people referred have an initial period of assessment by the reablement service before they are screened out</td>
</tr>
<tr>
<td></td>
<td>o Assessment is ongoing during the period of Reablement</td>
</tr>
<tr>
<td></td>
<td>o Standard dependency tool is used as part of the assessment to assess ‘progress’</td>
</tr>
<tr>
<td></td>
<td>o There is a named care coordinator</td>
</tr>
<tr>
<td></td>
<td>o The role of all staff within the team is clearly understood</td>
</tr>
<tr>
<td></td>
<td>o A multi disciplinary approach is taken</td>
</tr>
</tbody>
</table>

### 4 Support Plan and Intervention

<table>
<thead>
<tr>
<th>Standard</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Clear documentation that is fit for purpose</td>
<td>o There are clear distinctions between the function of care plans (with identified outcomes for the service user), the support plan (with ????) and service delivery plans (with clarity about who will provide what and when)</td>
</tr>
<tr>
<td>Outcome based and user focused</td>
<td>o Outcomes should always be identified and should be measurable in relation to either the chosen dependency or evaluation scale and/or expressed in terms of activities of daily living/engagement in the local community</td>
</tr>
<tr>
<td>Carers are actively involved in agreeing throughout</td>
<td>o Carers are involved in agreeing the outcomes</td>
</tr>
<tr>
<td></td>
<td>o Time is spent with Carers to explain the reablement approach</td>
</tr>
<tr>
<td>The role of all staff within the team is clearly understood</td>
<td>o There should be clear role definitions for the contributions made by each member of the team including the team leader, care manager, reablement assistant and any specialist input</td>
</tr>
<tr>
<td></td>
<td>o Role in the team should be distinct from professional background</td>
</tr>
<tr>
<td>Equipment and telecare should be readily available</td>
<td>o Telecare is an integral part of the reablement service</td>
</tr>
<tr>
<td></td>
<td>o Rapid access to community equipment</td>
</tr>
<tr>
<td></td>
<td>o Reablement staff are able to assess for minor equipment (Trusted Assessor)</td>
</tr>
</tbody>
</table>
## 5 Dynamic Reviewing

<table>
<thead>
<tr>
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</table>
| Reviews are a regular and ongoing feature of the service | o Multidisciplinary Reviews are held weekly as routine  
  o The service can respond within 48 hours if this is required  
  o Where there is clear evidence that a client is either not likely to achieve the desired outcomes or where this is risk of deterioration due to a change in circumstances pathways should be in place to end the reablement episode at the optimal point without risking deterioration or in a way that responds to changes in need |
| The emphasis is on outcomes achieved | o Progress toward jointly agreed outcomes should be the basis for the ongoing review process  
  o Challenging and revising agreed outcomes should be part of the review process where an individual’s confidence is improved as a result of the reablement input |
| Users/carers are fully involved in the review | o Clients should be given regular opportunities to comment on and gauge their own progress toward stated outcomes  
  o Carers should equally have regular opportunities to review their own contribution and the impact of the reablement package on their own lives and have this reflected in the ongoing care planning |
| Follow up review | o There should be a follow up review after 12 weeks to assess if outcomes are being achieved / maintained |

## 6 Handover Closure

<table>
<thead>
<tr>
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</table>
| Community inclusion where no ongoing social work support is required | o Service users should be sign posted to appropriate community support  
  o The availability of services and support from the voluntary sector, third sector and other statutory services (for example, culture and leisure) should be documented and kept up to date  
  o The monitoring of uptake from non-social care services following reablement should be monitored and fed into any market development programmes and commissioning activity undertaken by the Council |
| Work with other providers where handover takes place? | o Handover for ongoing care should clearly outline the outcomes to be achieved in promoting independence  
  o Handover processes and documentation should be clear for all involved, in particular for the client and their carer and should include clear directions and contact information |
| Evaluation | o All completed reablement packages should contribute a summary set of information to inform ongoing evaluation of the service. This should include, for example, re-entry to work or voluntary activity, engagement in other community or neighbourhood support networks etc |