Acknowledgements

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1. Introduction

1.1 Objectives of this document

This document aims to share knowledge and emerging findings from Councils with Social Service Responsibility (CSSRs) who have implemented, or have started to implement, a home care re-ablement scheme. We hope that by describing the steps taken, and the lessons learned from the CSSRs profiled here, that others will be enabled to broaden their understanding and progress their planning and implementation phases.

We hope too, in keeping with the Care Services Efficiency Delivery (CSED) programme’s remit, that it will help them achieve greater efficiency in implementing effective homecare re-ablement. We do not claim to have profiled all forms of homecare re-ablement but have tried to share a range of schemes based on the responses to a questionnaire that was distributed to all CSSRs with social care responsibility in England. Our aim is to promote information exchange and debate, within and across CSSRs, using this document as stimulus, to promote cross learning and, hence, a speedier route to the implementation of effective homecare re-ablement.

The present version contains studies of five CSSRs who have implemented various forms of homecare re-ablement, but also refers to elements of a further 13 schemes operated by CSSRs. It is entirely possible that other schemes will become known that add further to the knowledge base. If this is the case then we will continue to maintain a ‘living document’ that can be updated as progress is made, and our hope is that CSSRs and others will contribute in time. Hence, it will be made available through our website, which is www.csed.csip.org.uk.

The overall Discussion Document consists of three parts:

Executive Summary: this provides a top-level summary

Volume I of this document contains three main sections:

Section 1 Introduction: outlines the CSED programme background and the scope and broad approach taken to the Homecare Re-ablement workstream.

Section 2 Initial views on Homecare Re-ablement: sets out why CSSRs should consider homecare re-ablement, the financial and non-financial benefits that arise and an overview of the national picture.

Section 3 Implementing Homecare Re-ablement: sets out some of the key aspects to consider when implementing homecare re-ablement.
Volume II of this document contains three main sections:

Section 1 Detailed Case Studies: with supporting example documents, evaluations and monitoring reports where provided.

Section 2 Additional Information: from 13 other CSSRs that focus on particular aspects

Section 3 CSED Survey: the simple survey used and extracts from responses by CSSRs

1.2 Background to the CSED Programme

In July 2004, Sir Peter Gershon published *Releasing Resources to the Front Line*, an independent review of efficiency across the public sector. The Gershon Review focuses on making the best use of resources available for the provision of public services while ensuring that improvements are not delivered at the expense of service quality.

Government Departments and Local Government have agreed efficiency targets as a result of the Gershon Review which were included in the SR04 settlement. The Department of Health is committed to releasing around £6.5bn towards better care for patients and people using services. Consistent with the policy direction set out in *Our Health, Our Care, Our say: a new direction for community services*, the Department aims to reinvest efficiency gains to achieve changes in the planning, commissioning and delivery of care services that:

- are tailored to maximising the potential of each individual and providing real choice, with an emphasis on what individuals can do, rather than what they cannot do;
- Support improved health and well-being allowing people to live as independently as possible;
- remove barriers between social care, health and housing services.
- Increased choice and control for people who need support
- More focus on prevention and delivering care in or near to people’s homes

To support CSSRs in delivering Gershon efficiencies, The Department of Health, established the Care Services Efficiency Delivery Programme (CSED). Through collaborative working with CSSRs, CSED is exploring ways of delivering adult care services in England to maximise available resources and benefit users of those services. The CSED programme is sponsored by the DH Social Care Directorate. The programme team report to a Steering Board that includes representation from key stakeholders in this agenda, including DH, CLG, ADSS, CSCI, CSIP and the LGA.
The objectives of the CSED Programme are to support the delivery of efficiency improvements by CSSRs in Personal Care Services of £684m by end Financial Year 2007/08; and to achieve an improvement in the overall quality of services for people.

The Analysis and Options Appraisal Phase of the CSED Programme, conducted between September 2004 and February 2005, identified efficiency initiatives in collaboration with a number of local authorities visited during this period. Homecare Re-ablement is one of a number of workstreams currently being taken forward by the programme.

1.3 Homecare Re-ablement – scope, definition, objective and trends

1.3.1 Scope

Within the social care and health arena there is much use of the words prevention, rehabilitation, intermediate care, re-ablement and enablement, and in many cases the services they relate to merge and blur. In trying to define the work that CSED would undertake we took a simplistic view of the services seen in CSSRs and broadly categorised them into one of three forms along the lines adopted within the De Montfort report¹, namely:

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<th>PREVENTION</th>
<th>REHABILITATION</th>
<th>RE-ABLEMENT</th>
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<td>Services for people with poor physical or mental health to help them avoid unplanned or unnecessary admissions to hospital or residential care. Can include short-term emergency interventions as well as longer term low-level support.</td>
<td>Services for people with poor physical or mental health to help them get better</td>
<td>Services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living</td>
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Although specific services may be primarily focused on one of these three categories, in reality their benefits often crossover. Further, in some CSSRs all three categories are controlled through one senior line manager so that a co-ordinated package is available to the local community.

¹ Volume 2 Case Study: Leicestershire: External Evaluation of the Home Care Re-ablement Pilot Project, De Montfort University.
The CSED programme was established to support CSSRs to achieve their Gershon efficiency targets in adult social care and so, with a three year window, had to focus on tactical rather than strategic matters. Clearly, its work needs to be inline with policy and strategic direction but neither its remit nor time allows it to be anything other than tactical in its approach.

The relevance to this workstream was that any work needed to add value within a relatively short period.

- During our Analysis and Options Phase, we saw a number of intermediate care schemes that were in operation by CSSRs in association with their health colleagues. We were aware that DH had already commissioned some research into the range of intermediate care services and the benefits that could arise, and the reports were completed in early 2006. On review, it was felt that CSED could not add anything to this work within the Gershon timeframes.

- Rapid response teams in a variety of forms were seen in a number of CSSRs during our Analysis and Options Appraisal Phase and although it was felt that they provide an essential service and generated real benefits for recipients of care, there was no clear research based evidence of the benefits that arise. That is not to say that CSED did not believe that real benefits arise, merely that if evidence did not already exist in any tangible form then the programme did not have sufficient time to define and commission an appropriate evaluation study, publish the results and enable CSSRs to generate efficiencies within the Gershon timeframe.

- Similarly, a variety of re-ablement schemes, albeit less in number than intermediate care and rapid response, were also seen during the Analysis and Option Appraisal Phase and this led us to an independent evaluation that had been completed by an external academic unit for Leicestershire County Council. A simple questionnaire was distributed to all CSSRs in England with the purpose of trying to identify the existence of similar schemes and any evaluation evidence, the level of interest from those wishing to establish or extend schemes and evidence of any CSSRs that may have considered re-ablement but decided not to pursue it as a service. Although responses were not received from all CSSRs, a number of schemes were identified, there was a significant level of interest from those wishing to establish or extend schemes and no evidence of any CSSR deciding not to pursue. Therefore, it was felt that CSED could make a valuable contribution within the Gershon timeframe.

1.3.2 Definition

Different terms are used around the country and many use the words re-ablement or re-enablement. For the purposes of CSEDs work, we have used a relatively wide definition as used by the De Montfort University in their work for Leicestershire County Council, namely:
Services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living.

Many of the schemes give practical examples of what this means. For instance, in Newcastle their users leaflet\(^2\) includes:

- getting dressed and undressed
- personal hygiene
- laundry
- making a drink
- preparing a meal or snack
- managing prescribed medication
- supporting the user or their carer to look at how benefit or income can be collected, ways to pay bills, and obtaining shopping

It has been very interesting to see that CSSRs have adopted different approaches to how they achieve this but despite the variety schemes (including names, staff skill mix, structure of service) the principles and features are relatively consistent:

- Helping people ‘to do’ rather than ‘doing to or for people’
- Outcome focused with defined maximum duration
- Assessment for ongoing care packages cannot be defined by a one-off assessment but requires observation over a defined period

1.3.3 Objective

The objective of homecare re-ablement is, through the use of timely and focused intensive interventions:

- to maximise users long-term independence, choice and quality of life.
- to appropriately minimise ongoing support required,

and thereby minimise the whole-life cost of care.

\(^2\) Volume 2 Additional Information – Newcastle, Short Term Assessment and Rehabilitation Service Users Guide
This approach focuses on re-abling people so that they achieve their potential in terms of a stable level of independence with the lowest appropriate level of ongoing support or care.

In terms of policy fit, homecare re-ablement supports principles in the White paper\(^3\), namely

- delivery of care closer to home
- improved rehabilitation

### 1.3.4 Recent Trends and Projections in Home Care Services

As evidenced in a recent CSCI report\(^4\), there has been a steady growth in the number of homecare contact hours funded by CSSRs, growing from 2.9 million in 2001 to 3.6 million in 2005. Since 1992, the number has more than doubled, albeit that the number of people supported has reduced in a steady trend since 1992, reflecting a shift towards supporting those with more intense needs. This is also reflected within the Wanless Review which shows the same trends\(^5\)

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\(^3\) Our Health, our care, our say: a new direction for community services, DH 30\(^{th}\) Jan 2006
\(^4\) Time to Care? section 2.2, CSCI October 2006
\(^5\) Wanless Social Care Review, Securing Good Care for Older People: Chapter 3 section 3
Care Service Efficiency Delivery:
supporting sustainable transformation

In terms of future projections, these indicate that the demand for both homecare and care home support will increase.

- Population of those aged over 65 years is predicted to grow by approximately 11% between 2007 and 2012, and by 32% by 2022. Within this, the number aged over 85 years is predicted to grow 12% by 2012 and 45% by 2022.\(^6\)
- Improvements in life expectancy have not been matched by similar improvements in healthy life expectancy\(^7\)
- The best case ‘improved health’ projections indicate that those with a high dependency are predicted to grow by 10% in the 5 years to 2012 and 33% in the 15 years to 2022\(^8\)
- The main reasons for admission to care homes include physical and cognitive impairment.\(^9\) The incidence of these is closely related to age and there is no evidence at present to show that this situation will change.

The best case ‘improved health’ projections assume that two main requirements are met, namely\(^10\)

- ‘**moderate improvements in population health from reductions in levels of obesity and other negative health behaviours are forthcoming**, and
- ‘**that the emergence of new treatments or technologies are effective at reducing the disabling consequences of disease**’

### 1.4 Workstream Approach

The development approach for this workstream has included:

- CSED phase 1 research with 31 CSSRs – data gathering and identification of good practices
- Distribution of a simple questionnaire \(^11\) to all CSSRs to identify schemes and evidence of evaluations, gauge interest and understand potential reasons not to adopt homecare re-ablement
- Gauged support from audiences at a variety of events including regional ADSS branch meetings, CSED Steering Board and discussions with DASS
- Test checked the structure of case studies and the discussion document with a number of CSSRs that are likely to be recipients to ensure that it addresses their needs.

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\(^{6}\) [Wanless Social Care Review, Securing Good Care for Older People: table 11](#)

\(^{7}\) [Wanless Social Care Review, Securing Good Care for Older People: chapter 2, section 5](#)

\(^{8}\) [Wanless Social Care Review, Securing Good Care for Older People: table 13](#)

\(^{9}\) [Wanless Social Care Review, Securing Good Care for Older People: chapter 2 section 2](#)

\(^{10}\) [Wanless Social Care Review, Securing Good Care for Older People: chapter 2 section 7](#)

\(^{11}\) Volume 2 : Simple Questionnaire used by CSED
• In-depth case studies with 5 CSSRs that have implemented various forms of homecare re-ablement
• Further information from 13 CSSRs that have implemented or are in the process of implementing homecare re-ablement
• Discussions with other external parties

The programme has made a concerted effort to identify homecare re-ablement schemes around England and ensure that a representative example of different types of scheme are included in this document. We have also sought guidance and comment from the Older Peoples and Disability Committees of the ADSS to try to ensure that it will be of value to CSSRs.

1.5 Links with other Health and Social Care initiatives

Homecare Re-ablement is seen as being consistent with other initiatives across social care and health, and underpins key issues within the white paper.

Within this discussion document, we have sought to set out the linkages but we will not be issuing a prescriptive service model or detailing precise commissioning approaches, rather illustrating different models and commissioning approaches CSSRs have undertaken. The forthcoming Joint Commissioning Framework for Health and Well-being will outline how local commissioners, focusing on maximising outcomes for people, can work more closely to improve health and well-being.

Re-ablement can form part of a seamless joint commissioning strategy focused on maximising health and well-being for local populations. Re-ablement services can restore the capability for independent living as far as possible following a trauma or deterioration of an ongoing condition. Preventative services such as those being piloted through the Partnerships for Older People Projects and the Linkage Plus Pilots are primarily focused on preventing as far as possible, older people requiring an intensive re-ablement service, through a range of low-level services which maximise social inclusion.

Re-ablement also supports the implementation of policy on giving more choice and control to people who need support which is being taken forward through the Individual Budget Pilots, increasing the take-up of Direct Payments and the work of In Control on self-directed support as it seeks to re-able people, as far as possible, back to independent living.

1.6 Next steps

The case studies set out in this document will provide baseline information for any CSSR considering the implementation of homecare re-ablement. We have deliberately avoided drawing any one single set of conclusions or
recommendations, since local circumstances vary considerably, and each CSSR will need to shape its approach and responses accordingly. However, we hope that there is enough information to provide 'food for thought' and to help CSSRs determine which 'model' best suits their needs, circumstances and relationship with others including health colleagues. We have also included a range of additional information (see Volume 2) which, although not to the same depth as case studies, provides valuable information on other schemes.

For those CSSRs that express an interest in this area, we hope this will provide an opportunity to discuss issues, share thinking and identify solutions that will support them in their implementation plans and achievement of efficiencies.

If it is of value to CSSRs we will explore the establishment of learning sets to accelerate the uptake of homecare re-ablement. Therefore, we would like to receive feedback from CSSRs regarding how best CSED may support them to establish a scheme or enhance an existing scheme.

The learning set 'model' has been well received by CSSRs within another CSED workstream, Effective Monitoring and Modernisation of Homecare, and these have generally operated on a regional basis. Further details are available on the CSED website: www.csed.csip.org.uk
2. Initial Views on Homecare Re-ablement

2.1 Introduction

As a result of our investigations, and working with CSSRs, we have drawn together a number of points and would like to share some of the key areas with those CSSRs considering a homecare re-ablement service. The points presented are based on CSED team's work so far and so they may evolve as we find out more about other CSSRs. For instance, we have not had responses to our questionnaire from all CSSRs and so there may be other schemes in existence and the degree to which efficiencies may be replicated is unknown.

It is fair to say that our work has not unearthed one single model of homecare re-ablement that applies to all situations, and in fact that was not our intention. This document brings together a number of different types of scheme and those planning to establish or extend a scheme may wish to create a vision from one or more of those outlined.

This particularly applies to the measurement of financial benefits and their duration. We have not found any one site that has completed an evaluation, regularly monitors its service and has a clear evidence based view of the duration of benefit, and so, to that extent, readers will need to bring together elements from different schemes. Having said that, we believe that the balance of 'evidence' has moved in support of homecare re-ablement and that there is a compelling argument in favour of introducing a scheme.

2.2 Why should CSSRs consider homecare re-ablement

2.2.1 Increasing demand for homecare

As set out in previous sections, and well rehearsed elsewhere, the demand for homecare has increased in recent years and it is generally accepted that this has led CSSRs to focus on those with the greatest needs. In an effort to balance need with available budgets, CSSRs have steadily raised the entry hurdle through application of their local fair access to care services (FACS) criteria. As evidenced within a recent CSCI report, this has meant that CSSRs are now often only able to support those with the highest levels of need.

Whilst many CSSRs would say that this approach has been forced on them, it clearly cannot provide a long-term sustainable solution on its own because:

- most CSSRs are already towards the higher levels of need and so they are unable to lift the ‘bar’ much further
- many people who do not fulfil the current criteria and so are not entitled to CSSR funded care are likely to deteriorate and present with a higher level of need at a later stage. Intuitively this is unlikely to make economic sense within a prevention agenda.

12 Time to Care? October 2006
there is clear evidence that with changing demographics, the demand for support or care will continue to increase\textsuperscript{13}. Policy direction has added to the demand for homecare as CSSRs are required through targets (e.g. PAF AO/C28 supporting those with high dependency at home) to support minimum proportions of those with high levels of need within the community. This can only have added to the pressure that has resulted in a raising of the ‘bar’ on those supported.

2.2.2 Availability of Care Staff

Other factors also contribute to the need to find ways to appropriately minimise the demand for care and support. As demographics change, the proportion of people within the age bands that historically have provided care and support will reduce and so the ability to recruit, let alone retain or fund, the number of carers that would be needed would almost certainly be impossible to achieve.

As outlined in the Wanless Review\textsuperscript{14}, by 2046 the general population is predicted to grow by 10% whilst those aged over 85 years is predicted to grow by 86%.

2.2.3 Declining Care Home Use

There has been a view that the 5% annual reduction over recent years in the number of care home beds \textsuperscript{15} (both residential and nursing) will continue as care is taken closer to home and so this will release both staff and resources as the number of care beds, and therefore homes, reduces.

However, in work completed by the PSSRU as part of their input to the Wanless Review, they have modelled the incidence of the reasons that determine the need for admission to care homes.\textsuperscript{16} These are heavily influenced by conditions that lead to cognitive impairment and at present these are most closely related to age.

Therefore, it is their view that the although the proportion of those supported in care homes will reduce, the number of care home beds will need to increase in the coming years rather than remain static or even reduce.

2.2.4 Homecare Re-ablement: part of the solution

It is not a sustainable option for CSSRs to keep changing their eligibility criteria or merely trying to ‘dig faster’. They need to find new ways of managing the ever-increasing demand.

It would seem, therefore, that we need to find new ways of supporting people who have clearly stated that they wish to maximise their independence and remain in their home.

\textsuperscript{13} Wanless Social Care Review, Securing Good Care for Older People
\textsuperscript{14} Wanless Social Care Review, Securing Good Care for Older People
\textsuperscript{15} Wanless Social Care Review, Securing Good Care for Older People, chapter 1 section 4
\textsuperscript{16} Wanless Social Care Review, Securing Good Care for Older People: chapter 2 section 2
Intuitively homecare re-ablement meets these requirements, i.e. maximises independence thereby allowing care closer to home, and this is borne out by the case studies included within this document. It is fair to say that only one of the schemes visited, Leicestershire has undergone an evaluation by an external academic unit involving a control group but this clearly shows that significant benefits arise in terms of improving people’s independence and reducing the number of ongoing care hours required. This reduction in ongoing care hours is achieved by

- significantly increasing the proportion of people who, appropriately, no longer require an ongoing care package
- increasing the number whose care package is reduced
- reducing the number whose care package is increased
- reducing the number whose care package is maintained

when compared to a control group. Throughout the study period the FACS criteria were unchanged.

More recent data for Leicestershire, albeit based on a comparison with hours required at the start of re-ablement, shows a reduction in the average hours required even by those who continue to need an ongoing care package.

Other schemes listed have not, generally, undertaken an evaluation with a control group but their service monitoring reports show significant benefits.

### 2.3 The benefits of homecare re-ablement

#### 2.3.1 Customer Satisfaction

Most services undertake some form of customer satisfaction survey for their homecare re-ablement service and these generally show high degrees of satisfaction by users and their families. Many services expressed concern at the low response rate due to the relatively short duration of the service but others have combined this with a follow up telephone call to ensure that the user is progressing as planned, whether that be independent of care or with an ongoing care package.

#### 2.3.2 Financial

As outlined in greater detail in section 4.11 and in the individual case studies, significant reductions have been achieved in the number of people requiring support and care hours required when compared to a control group.

For instance, the Leicestershire evaluation study\(^\text{17}\) shows the following.

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\(^{17}\) Volume 2: Case Studies – Leicestershire: External Evaluation of the Home Care Re-ablement Pilot Project, De Montfort University
The pilot originally started on the basis that people were positively selected as being suitable for re-ablement and the results, when compared to the control group, were significant. The pilot then adopted an approach whereby everyone assessed as needing homecare would pass through the service and it was this approach that was rolled out across the county. The results remained impressive albeit they were, unsurprisingly, lower than from the originally selective approach.

Where a control group was not used, most schemes quantify efficiency by comparing the care package hours required as a person exits their time with the re-ablement team with those required in their first week with the team. In addition, schemes often monitor the point at which people are able to leave the scheme and their ‘destination’ e.g. self reliant at home, supported at home, extra-care, etc.

The approach to compare hours to the first week of re-ablement has also been adopted following the pilot control group study in Leicestershire. Clearly, a control group approach can only be used during a pilot phase, and once the service has been rolled out across a complete CSSR there are no users left to form a control group.

Some CSSRs have considered trying to compare the actual outcome package with a retrospective assessment of what might have applied if re-ablement had not been available, but this requires extensive time from a range of staff and tends to be possible for small sample numbers only. Therefore, although helpful in a pilot phase, it cannot usefully be applied as a routine approach to monitoring performance of the scheme.

Where a comparison is made between the ongoing care package hours following re-ablement and the hours required in the first week of re-ablement, this could be open to accusations of manipulation where the re-ablement staff
determine the extent of the opening package. This could, of course, be monitored to prevent general ‘inflation’ in the initial week by monitoring the average weekly input as illustrated within Newcastle’s evaluation report\textsuperscript{18}. However, any change in the proportion of people not requiring ongoing care packages and shifts in the proportions by destination cannot be manipulated and so these are seen to be both practical and appropriate measures of performance.

A useful tool may be to benchmark outcomes between different areas of the CSSR or possibly with other CSSRs, albeit that a number of variables may need to be considered. e.g. type of service (intake, hospital discharge, etc.) and level supported (moderate, substantial, etc.) We have neither sought nor been able to complete any comparison between services because of the inconsistency in data collection and limited number of examples of different forms of scheme.

A comparison should also be made between the cost of providing the re-ablement service and the benefits in terms of a reduction in the cost of the ongoing care packages. This is essential if one is to ensure that net financial efficiencies are generated.

This principle can be extended, as in one of the case studies\textsuperscript{19}, where we have sought to quantify the break-even point for each category of user: in this case defined by destination. Interestingly this shows that the cost of re-ablement for those who leave the service with no ongoing care package is soon recovered whilst the cost of those whose ongoing care package is ‘only’ reduced takes longer. By quantifying this, the financial case for re-ablement of at least the first group is clearly made. One needs to remember that where FACS criteria are applied at the point of entry into homecare re-ablement, only those qualifying for support enter the service. Therefore, without re-ablement these people are very likely to continue to be supported with ongoing care packages.

This analysis, although obvious, has a number of uses. For instance, one could consider the point at which further investment in re-ablement has no additional financial benefit. One CSSR\textsuperscript{20} included this within their evaluation by studying at what point any final care package, where required, was identified. This showed that 66% had reached their potential within 4 weeks, almost 80% within 6 weeks, 85% within 8 weeks and 93% within 10 weeks.

A longitudinal study would clearly be of value because it would give some guidance as to the duration of any benefits gained from re-ablement. If users lapse within a short period, without any other ‘event’, then it could assist services to determine how or if these relapses can be prevented, thereby extending the period of benefit.

\textsuperscript{18} Volume 2: Additional Information – Newcastle, Short Term Assessment and Rehabilitation Service Pilot, Evaluation Report
\textsuperscript{19} Volume 2: Case Studies - Leicestershire
\textsuperscript{20} Volume 2: Additional Information – South Gloucestershire
Anecdotally, CSSRs believe that they do not see users re-presenting for significant periods of time and one estimated that their service was cost efficient if users did not return within 18 weeks after completion of re-ablement\textsuperscript{21}. Another CSSR\textsuperscript{22} has completed a form of study and estimated that on average the benefits last for at least 2 years, whilst yet another CSSR\textsuperscript{23} completes telephone follow-up calls at regular intervals and this indicates that the users do not lapse, on average, for at least 12 months.

### 2.4 Homecare Re-ablement: the National Picture

As outlined above, the programme has made a concerted effort to identify homecare re-ablement schemes around the England. This entailed distributing a simple questionnaire\textsuperscript{24} to the 150 CSSRs with social care responsibility within England to try to gain an understanding of the number and nature of schemes in existence, whether they had been evaluated and the level of interest in establishing or extending an existing scheme. A summary of the responses is provided \textsuperscript{25} along with a map of the national coverage known to CSED.\textsuperscript{26}

By its nature, a survey provides a snapshot at a point in time and so it is likely that there have been some changes since this work was completed. However, it provides as clear a picture as is possible of the extent, nature and range of services.

Based on the responses to our simple survey

- 36 (24%) CSSRs have an established service
- 24 (16%) CSSRs have an established service but are currently planning changes to extend it to encompass either a larger user base or form of service
- 10 (7%) CSSRs are currently establishing a service: albeit that these are at various stages on the implementation timeline
- 28 (19%) CSSRs wish to establish a service

Of the remaining 52 (34%) CSSRs, it is understood from a variety of sources, including web searches and information from other CSSRs, that at least two have some form of service although no further details are known to us. The balance of 50 has not provided a response to our questionnaire.

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\textsuperscript{21} Volume 2: Case Studies - Wirral
\textsuperscript{22} Volume 2: Additional Information – Leicester City
\textsuperscript{23} Volume 2: Additional Information - Warrington
\textsuperscript{24} Volume 2: Simple Questionnaire used by CSED
\textsuperscript{25} Volume 2 : Extract from Simple Questionnaire responses
\textsuperscript{26} Appendix: Map of Coverage
2.5 Future of Homecare Re-ablement

There are clearly a number of schemes, of varying degrees, in existence within England but there are a larger number of CSSRs who wish to either establish a scheme or develop their existing scheme. Therefore, it would seem logical that much could be learnt by a sharing of experience, models and results because this should give rise to improved services and efficiencies.

It is likely that more of the schemes will develop as part of a package linked with other aspects of intermediate care and rapid response so that they encompass those within the community as well as those being discharged from hospital.

Various important steps are underway (e.g. longitudinal study, modelling the most appropriate mix of therapy and care staff) and these will contribute greatly if they are published and picked up by CSSRs.

Another potentially interesting development could arise from some work currently underway by a group of CSSRs within the West Midlands who are working with another CSED workstream on Referral, Assessment and Care Management. This group wish to consider whether, and in what circumstances, the distinction between assessment and homecare re-ablement should be blurred, to provide a greater understanding of a user's true long term needs after a suitable stabilisation period.

Re-ablement Colorado style
Our searches brought to light a ‘different’ approach to re-ablement adopted in Colorado, USA where a fee is paid if people can be removed from the care home sector and resettled in the community.

"Colorado has had success with its 3-year-old "bounty" program. The State pays Single Entry Point agencies to identify Nursing Facility (Residential and Nursing Homes) residents who want and have the functional potential to move into the community. The bounty fee is $200 per assessment, and $450-500 if the client moves into the community. In the program's first year (1997-08), the State saved $347,000 by moving 68 people from NFs into the community. Most of the 250 people served through this program have moved to Assisted Living Facilities (sheltered housing)."

We do not have any further details on this scheme and do not know how the dependency levels of those people in Colorado compare with those prevalent within England. However, the approach may bear some thinking about rather than being discarded out of hand.
3. Implementing Homecare Re-ablement

Virtually all of the schemes we visited or discussed have stressed that re-ablement requires a change of mindset for all parties concerned. The historical approach of doing things for people has to be replaced by one that seeks to enable people to do as much as they can for themselves. This change in mindset needs to occur within recipients and all those involved with recipients of homecare re-ablement, and that includes hospital based staff that refer or come into contact with potential users.

A number of the case study sites commented that it can be very difficult for someone who has been a carer, possibly for many years, to learn to hold back and allow users to do it themselves, with all the inherent frustrations and risks. This shift is not always possible, even for those who have been excellent carers, and so thought needs to be given as to what alternate role these members of staff can undertake.

One wonders whether this change in mindset could be applied to areas other than home care with similar benefits.

3.1 Pre-planning

The key to a successful implementation is to invest more time up-front before embarking on the journey. Questions to consider include:

- What is your overall vision for re-ablement services / intermediate care and how will homecare re-ablement fit within this?
- What type of service do you need? What is the main driver: is it to support hospital discharges to free up hospital beds and ensure a smooth transition back into the community rather than into care homes, or do you need to develop an intake service that will encompass all who are referred for homecare support.
- How joined up are you with Health colleagues? They will be stakeholders irrespective of the type of service that is being developed but a hospital discharge focused service will clearly require very close working and agreement. Pooled budgets are not a requirement but a common structure with jointly appointed management will almost certainly be required, and this needs trust on both sides.
- At which point should the FACS criteria and eligibility be applied? This may be shaped by the type of service and it will have an impact on a range of issues, including who can benefit, who pays, the ‘success’ rates achievable and how the service fits with other services both within social care and health.
- Do you intend to focus part of the in-house staff onto the re-ablement function or out-source it? If the former, then resources will need to be
freed up from current services to create the re-ablement function. Clear plans will need to be formed to manage this process. If the latter then a clear expression of outcomes will be required to engage the external market?

- Do you intend to focus in-house staff exclusively on re-ablement? If so, this will require extensive staff liaison and preparation with the external providers to ensure that they can accommodate their new role.

- If all internal staff are to be focused on a re-ablement function, what alternate opportunity do you need to provide for those members of staff who cannot adapt to this new approach?

- Have you considered a phased approach? Is it to be trialled / introduced in one location or across the whole CSSR.

- What changes will this require by the providers of ongoing care packages? Do they have the capability and capacity to support the change in role?

- Do you currently zone the home care service? If so, what impact will this have on the sustainability of providers if they receive less referrals?

- If you utilise block contracts, what changes will this require and how will they fit with timing on contract renewals?

- Do your external providers serve other CSSRs? If so, will your changes have any impact on the provider’s ability to operate across more than one CSSR?

- What other initiatives is your CSSR going to be focused on and what is the overall capacity for project management?

### 3.2 Objectives

Inevitably, a critical first step is to have clear agreement to the project objectives and a shared understanding, across the team and its stakeholders, of the expected benefits and potential barriers/concerns to address. This early clarity is likely to make implementation and benefits measurement easier and less problematic.

Reasons cited by CSSRs for implementing homecare re-ablement include:

- Support hospital discharges, reduce lengths of stay in acute hospitals and create a smooth transition back home

- Reduce the demand for ongoing care packages

- Focus relatively high cost in-house services on a role so that ongoing care packages outsourced are appropriately minimised

Whatever the primary objectives, it is crucial that a baseline be established. (see section 3.6.1)
3.3 Resourcing the project

Although resourcing needs are likely to differ with each CSSR, it is essential to have a dedicated project manager for all stages of the implementation. The introduction of a homecare re-ablement service has implications for a large number of people both within social care and health and is a complex project. Therefore, experience has shown that the involvement of a senior officer as chair of the project team, such as an Assistant Director, will help to smooth the implementation decision processes and increase the chances of delivery on time.

3.4 Communications and stakeholder management

It is important to identify your internal as well as external stakeholders from the outset so that appropriate engagement plans can be established. Internal stakeholders are likely to include:

- home care managers and supervisors – these groups will be critical in persuading care workers as to the merits of the system. However, they will first need to understand the objectives and benefits.
- care workers – need to ensure they understand the new approach and are willing and able to adopt it, and to earn their trust and support by addressing any concerns early on.
- CSSR intermediate care services – so that they understand how the services fit together
- social services finance – they will be involved in agreeing budgets and any subsequent reporting requirements they may have
- HR – they will be needed to help in managing discussions with staff and any subsequent changes to contracts of employment
- IT – there will be reporting requirements from the new service to monitor performance and these need to be in place early so that progress can be followed.
- social workers – to ensure they understand the role of the proposed service, selection / de-selection criteria, process to refer users.
- commissioners – they will need to be convinced of the benefits and then confident to trust the re-ablement team to define care package needs and changes throughout the service.

External stakeholders are likely to include:

- existing service users – these may need face-to-face contact explaining the changes. If any long term care users are to be transferred to another
provider this needs to be pro-actively managed in terms of communication, updated assessments and transfer.

- acute and PCT health colleagues – whether they are partners to the new service or not, they will need to understand how it will operate, how they are to link into it and what their role is
- ambulance trusts – if they are to be involved in diverting appropriate patients in accordance with protocols to be agreed
- home care providers – their role will change following the introduction of a re-ablement service in whatever form
- trade unions – discussions will need to be considered within the context of overall interaction with trade union representatives.

### 3.5 Anticipated timescales

Factors that may affect timescales:

- Pilot or whole service - CSSRs may wish to conduct a staged approach rather than implement across the whole CSSR straight away
- Changes to staff contracts – CSSRs may wish to resolve all changes to terms and conditions first or address these as successive phases implement
- Resources to implement - e.g. dedicated project manager to drive implementation
- Having a ‘champion’ / senior officer support
- External market – the capability and capacity of the external market to adapt to any changes required

### 3.6 Measuring the Benefits

#### 3.6.1 Need for a baseline

It is clearly essential that one is able to measure the benefits of any new service, if only to ensure that it has met the claims set out within the original business case. In the case of homecare re-ablement, the whole basis of adopting it is to deliver benefits both to the users and CSSR: in terms of maximising independence and appropriately reducing the level of ongoing care packages required.

To determine whether, and to what extent, the desired change has been achieved it is, therefore, essential that some form of baseline is established either by using a control group with which to compare the new service or by determining the critical data for the ‘as is’ service. In either approach, the critical data is likely to include:

27 Volume 2: Case Studies – Leicestershire and Additional Information - Newcastle
**Care Service Efficiency Delivery:**

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- Number of users analysed by referral direction after initial care assessment completed
  - those not eligible for service
  - those referred to home care
  - those referred to sheltered, extra care housing, etc.
  - those referred to care homes
  - those referred to hospital

- For those referred to homecare, it is suggested that ‘outcome’ data after the first 6 week review be collated for the following categories of user:
  - those whose package ceased
  - those whose package was reduced
  - those whose package remained the same
  - those whose package increased
  - those who did not complete the 6 week period for a variety of reasons including transfer to other specialist services, referred to a care home or hospital, declined service or died.

For each of these categories the suggested data is:
- number of users
- average weekly care package hours at the start of homecare, plus details of the range of hours
- average weekly care package hours following completion of the 6 week review, plus details of the range of hours

In the case of the last category (those who did not complete the first 6 weeks), additional information will be required about the average duration with homecare.

Based on discussions with numerous CSSRs, it would seem that subsequent reviews do not often result in reductions to ongoing care packages. However, if this is not the case then consideration will also need to be given to the rate of incidence as part of baselining the ‘as-is’ service.

It is unlikely that this data can be collated for all users over a previous 12 month period, and it is probably not necessary. Therefore, care needs to be taken to ensure that the time period(s) chosen are representative and can reasonably provide reliable ‘as-is’ base line data.

This will provide a reasonably robust understanding of the ‘as is’ service so that any changes that arise through re-ablement in terms of destinations or average size of ongoing care packages can be quantified.

Another aspect of the base line work could be to establish the level of satisfaction by users and their informal carers in the ‘as is’ service. User satisfaction is obviously an important aspect and so thought will need to be given to what extent any current survey data can be used. If this is not present already, it would require significant work to establish a survey and that will need consideration and balancing against the other pressures to implement as soon as possible.
3.6.2 Diagnostic Tool

As part of our work we have sought to create a diagnostic tool so that those considering such a scheme can estimate the likely range of capacity to benefit for their particular CSSR. To do this, we have tried to explore with CSSRs the proportion of people who do not qualify for their homecare re-ablement service so that the ‘starting point’ could be from the point where a person is identified as requiring homecare support. However, we have not been able to resolve this issue and so have a gap in the data:

- Where schemes select users (mainly hospital discharge support services) they often record the number of referrals and then the number who are suitable for service. However, they do not record the total number of discharges from which referrals are made.

- Where schemes operate as intake teams they record the number who pass through the service but often do not record the numbers who are deselected. In addition, at this point they are not necessarily aware of the number who never get to them because they do not meet the FACS criteria.

For these reasons we have not been able to create a comprehensive diagnostic tool that starts with the number of referrals.

However, based on available data, as summarised in the table below, we can draw general conclusions
## Care Service Efficiency Delivery: supporting sustainable transformation

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<td>FACS</td>
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<td>Moderate and above</td>
<td>Substantial and above</td>
</tr>
<tr>
<td>Type of Service</td>
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<td>Intake *1</td>
<td>Intake *2</td>
<td>Intake *1</td>
<td>Hospital Discharge (selective) *2</td>
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<td>% requiring no ongoing package</td>
<td>49.7%</td>
<td>21%</td>
<td>55%</td>
<td>44%</td>
<td>61.5%</td>
<td>80.5%</td>
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<tr>
<td>% requiring reduced package</td>
<td>18.3% to other specialised services but with average reduction of 16%</td>
<td>26%</td>
<td>11%</td>
<td>13% min. care package</td>
<td>31.1%</td>
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<td>% requiring maintained package</td>
<td>23%</td>
<td>7%</td>
<td>1% care package 4 – 7 hrs per wk</td>
<td>0.7%</td>
<td></td>
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<tr>
<td>% requiring increased package</td>
<td>28.5% ongoing but with average reduction of 30%</td>
<td></td>
<td>1% care package over 7hrs per wk</td>
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<tr>
<td>Admitted to other IC services</td>
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<td>6%</td>
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<tr>
<td>Admitted to Care Home</td>
<td>13%</td>
<td>3%</td>
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<tr>
<td>Other care</td>
<td>9%</td>
<td>28%</td>
<td>0.7%</td>
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<tr>
<td>Admitted to hospital</td>
<td>15%</td>
<td>13%</td>
<td>5.2%</td>
<td>9.5%</td>
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<td>Deceased after service commenced</td>
<td>3.7%</td>
<td>10%</td>
<td>2%</td>
<td>1%</td>
<td>0.7%</td>
<td>1.5%</td>
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<tr>
<td>Overall reduction in care hours</td>
<td>58%</td>
<td>42%</td>
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</table>

*1= FACS applied at entrance to homecare re-ablement
*2 = FACS applied at exit from homecare re-ablement
By drawing on a range of data, we have created two simple models, with a version of each for intake and hospital discharge support schemes. These seek to provide CSSRs with an indication of the capacity for benefit.

- The first is a simple ‘diagnostic’ tool that can be used by CSSRs that do not have a homecare re-ablement scheme: there are versions for intake and hospital discharge support schemes.
- The second is a simple ‘comparison’ model that can be used by CSSRs that already have a homecare re-ablement scheme.

In each case, a set of standard data is used that has been compiled from schemes that have been considered, and indicative levels of benefit are shown both in terms of a reduction in the number of hours of care to be commissioned and a financial value. Both models allow CSSRs to insert local rates where these are known. As further information becomes available we would intend to update and refine these two simple models.

The outputs of this simple tool will provide an indicative level of possible gross benefit and so CSSRs will wish to consider what service structure they wish to adopt since this will impact on the operating costs of the service they are considering. This consideration may also need to include to what extent, if any, parts of the service will be funded by health.

3.6.3 Benefits Measurement Tool

Based on discussions with the various case study sites, none of them felt that the current formal measures provide a useful or reliable quantification of the benefits generated by homecare re-ablement (see section 4.14). Therefore, it would seem likely that the only appropriate measurement tool must arise from a CSSR’s internal routine management reporting.

It is critical, therefore, that the management reporting requirements be considered early in the development and implementation phases so that they are in place in time and embedded into the service. An example, building on the template for base line data, is attached. This also seeks to apportion the cost of operating the homecare re-ablement service across each category based on the hours of re-ablement provided.

3.6.4 Benefits Monitoring

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28 Appendix: Homecare Re-ablement Intake Diagnostic model
29 Appendix: Homecare Re-ablement Hospital Discharge Support Diagnostic model
30 Appendix: Benefits Monitoring Tool template
Having established a service and measured the benefits derived, there will be an ongoing need to monitor the performance in trend form, both in terms of user satisfaction and ‘activity’ data, to ensure these are at least maintained. This is best achieved through monthly monitoring of performance so that corrective action can be applied if necessary and effort focused on continuing to improve the service.

For instance, the number of people who decline the service after it has commenced may be an indicator that they are not being appropriately briefed on their role within the course of care that they have chosen to take. Homecare Re-ablement requires the user to understand and participate in the plan to regain independence. CSSRs have found that some users accept this course because it allows them to get home and then decline service almost as soon as they arrive at their front door.

Examples of monitoring reports are included within the various case studies and additional information sections.
4. Case studies

4.1 Overview

Based on the responses to the CSED simple questionnaire, web searches and information from early leads, we visited a selection of CSSRs that had established homecare re-ablement schemes in place. Originally it was intended that visits would only be made to those CSSRs that had completed some form of evaluation but this would not have provided coverage of the range of schemes. Therefore, we focused on those that had completed an evaluation and/or monitor performance on a regular basis.

In addition to those listed as case study sites, input has been received from a number of other CSSRs on particular aspects and so these have been included within the Additional Information section of Volume 2 so that CSSRs interested in establishing a service or extending an existing service can be aware of as wide a range of developments as possible.

4.2 Background to development of Homecare Re-ablement

The triggers for establishing a scheme are reasonably common across all those with whom we have been working and include:

- as the result of a best value review of existing in-house home care services
- as a result of movements in policy and development of the themes around intermediate care, care closer to home, etc.
- a coming together of like minds in social care and health that there must be a better way of supporting those with needs

4.3 Conducting a Pilot

Most CSSRs would seem to have run a pilot, whether it is by geographic area or type of user across the whole CSSR. In most, capacity was created by transferring existing users with the in-house homecare team to external providers, thereby releasing staff and managers.

A common feature of the pilot phase appears to have been a relatively slow take up of the service by those who refer users. Pilots seem to operate for approximately 6 months with relatively low numbers and in some schemes, the type of user, selection criteria and method by which they enter the scheme have been changed during the pilot phase to increase numbers.

The baselining of activity does not appear as a strong feature within the pilot phases of the schemes considered. Some appear to have used data from other CSSRs to support their proposal to establish a service but the absence
of any baseline data makes it very difficult to quantify the benefits of such a change in service or even to gauge whether the proposed service is delivering the benefits set out within the original business case. Two CSSRs, Leicestershire and Newcastle, used control groups with which to compare the results from their pilot studies whilst some others have compared the outcomes of the new service with more anecdotal evidence.

A common approach and view has been that prior to the introduction of homecare re-ablement, people referred for homecare would most often continue to receive the service for months, if not years, and that only a very small number of people would have the service terminated or reduced at either the first or subsequent reviews. This is supported by the Leicestershire study\(^{31}\) by the De Montfort University which shows that only 5% of users ceased to receive a care package as a result of the 6 week review prior to the implementation of homecare re-ablement. Based on this situation virtually any reduction in ongoing care packages represents an improvement and it is assumed in some cases that this represents an efficient use of resources.

### 4.4 Structure of Service

As can be seen from the case studies, there are a number of different structures in existence and these range from virtually a stand-alone service to those that form part of a package of services that operate under a jointly appointed manager by the CSSR and health partners who is responsible for rapid response, homecare re-ablement, intermediate care beds and community hospital teams.

For the purposes of this section we have sought to provide examples that illustrate three comparisons, namely:

- Intake versus Discharge support
- Care staff versus mixed teams of therapy and care staff
- In-house versus out-sourced

but as will be apparent there are cross-overs. For instance, some features arise because of the input by occupational therapists and commonly these operate more within hospital discharge services than intake teams. This situation is changing and we are aware of developments where therapists are employed in a hands-on re-ablement role.

- In the Wirral\(^{32}\) the current service is focused on hospital discharge support and so social care work very closely with health funded OTs to the point where they operate as one co-ordinated team. They are currently exploring how this service may be extended to encompass an intake function.

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\(^{31}\) Volume 2: Case Study – Leicestershire Appendix External Evaluation of The Home Care Re-ablement Pilot Project

\(^{32}\) Volume 2: Case Study – Wirral
In Coventry\textsuperscript{33} they have established a homecare re-ablement service that employs OTs directly. They are also currently conducting a study to determine the best mix of skills between professional therapy staff and carers / enablers. The results of this study will be of great interest and relevance to all schemes around the country.

In Rotherham\textsuperscript{34} the service started as a hospital discharge scheme but now includes an intake function utilising a mix of physiotherapists, occupational therapists and enablers.

Staffordshire’s East re-ablement team\textsuperscript{35} includes physiotherapists, occupational therapists and care staff

4.4.1 Intake versus Discharge support

4.4.1.1 Intake Approach

We have seen a number of examples of homecare re-ablement services that operate as intake teams, and therefore help to refine the need for ongoing care packages. Commonly all people assessed as needing and being eligible for homecare are passed to the intake team. They apply a ‘deselection’ criteria, in that all people undergo re-ablement unless they

- are not receptive to the approach: they want to be looked after
- have severe mental health or learning difficulty needs
- are not suitable because of their care needs: e.g terminal care
- are not old enough (commonly to be > 19yrs)

Thus, everyone is assumed to be able to benefit from re-ablement unless they are positively deselected or deselect themselves. People undergoing homecare re-ablement have commonly passed through the eligibility criteria as determined by the local FACS process and so the ‘success’ rate is likely to be affected by the CSSR’s declared support level e.g. moderate, substantial, etc.

Intuitively it is more likely that those with a moderate level of need will be fully re-abled than those with a substantial level of need, and this is likely to show in the relative ‘success’ rates. e.g. proportion of users re-abled to a point where they do not require any ongoing care package. Unfortunately we have been unable to support this logic from the data available from case study sites. This would require a comparison of a larger number of services and data to be collected on a consistent basis. However, it seems entirely logical that if an authority were to raise its ‘hurdle’ to be eligible for support, the ‘success’ rate will fall. Clearly there could also be a trade off because users

\textsuperscript{33} Volume 2: Additional Information - Coventry
\textsuperscript{34} Volume 2: Additional Information - Rotherham
\textsuperscript{35} Volume 2: Additional Information - Staffordshire
not eligible could present at a later stage with much higher needs and re-ablement may not be as effective in terms of reducing the ongoing care needs.

We are aware of two schemes\textsuperscript{36} where people with mental health and learning difficulties are not excluded from the homecare re-ablement service but we do not have consistency of data to be able to quantify the impact this inclusion may have on the re-ablement rates.\textsuperscript{2}

4.4.1.2 Discharge Support

Discharge support services tend to focus more on those who are judged to have the capacity to benefit from homecare re-ablement. Thus, people are positively selected onto the service, albeit that their criteria are commonly very similar to those outlined above.

Intuitively one would expect that the ‘success’ rate for a service that positively selects people on the basis that they have the capacity to benefit, rather than do not have the capacity to benefit, will be higher. This would appear to be evidenced within the evaluation report for Leicestershire because the first stage of their pilot worked on a selective basis. Although the proportions were not radically different (see section 2.3.2 and the detailed case study) the selective service achieved a 72% reduction in ongoing care hours as opposed to the intake service’s 28%.

Commonly these services are operated with health colleagues and are viewed as a form of intermediate care. Thus, participants are usually not ‘exposed’ to the FACS criteria until they exit the homecare re-ablement service and no charge is levied for the service on users.

4.4.2 Care staff versus mixed teams of therapy and care staff

4.4.2.1 Service delivered by care staff teams

Intake team models tend to be staffed by carers, more commonly known as enablers, who have access to therapy staff as required. Some services have expressed concerns that the absence of good levels of access to therapy staff can result in bottlenecks in the assessment and delivery of aids to daily living. These bottlenecks delay the transfer of users out of the re-ablement service and so prevent new users joining. However, some services have overcome this by training seniors and managers as trusted assessors so that routine items can be quickly arranged.

4.4.2.2 Service delivered by teams of mixed skills

Services focused on hospital discharge support tend to be staffed by teams that include therapy and care staff. The therapy staff are commonly a mix of OT and OT assistants but we understand that there are moves in some CSSRs to consider the role of an OT practitioner, someone between an OT

\textsuperscript{36} Volume 2: Additional Information – Halton and Staffordshire
and an OT assistant thereby trying to acknowledge the shortage of qualified OTs available.

As outlined above, commonly these services are joined with health, whether that be through formal budget arrangements or ‘simply’ very close working. During our visits it was virtually impossible to see any gaps between the two organisations that operate in the latter structure which relies on very good relationships and a high degree of trust.

4.4.3 In-house versus out-sourced

4.4.3.1 In-house

In most, but not all cases, the re-ablement service is delivered by in-house teams. These tend to have evolved from in-house homecare services as CSSRs have decided to out-source growing proportions of ongoing care packages. In some cases CSSRs have decided that all ongoing care packages should be out-sourced so that the in-house teams focus purely on a re-ablement agenda.

The decision to focus in-house teams on re-ablement would seem to have been commonly driven by economics. As can be seen from the data collated by the DH from the PSSEX returns, the unit costs for in-house services tend to be significantly higher than are available from the external provider market.

<table>
<thead>
<tr>
<th></th>
<th>2002/03</th>
<th>2003/04</th>
<th>2004/05</th>
<th>2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-house</td>
<td>15.97</td>
<td>17.15</td>
<td>17.84</td>
<td>21.02</td>
</tr>
<tr>
<td>Total</td>
<td>12.16</td>
<td>12.87</td>
<td>13.27</td>
<td>14.30</td>
</tr>
</tbody>
</table>

In 2002 research commissioned by the Greater London ADSS branch Procurement Benchmarking Group 37 starts to question the degree to which this comparison is valid because it is contended that hours commissioned from external providers often are not delivered because care staff cut short their visits so that they can travel between houses. Thus, a CSSR, and hence the recipient, is not getting what is commissioned and paid for. This is undoubtedly true in some cases and entirely likely where a CSSR has decided that it will not ‘pay’ for travel time. The clear truth is that a CSSR will pay for travel time, whether it is through specific agreed allowance, higher hourly

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37 ‘The Elusive Costs of Homecare’, by Starfish Consulting UK
rates or, in some cases, through visits being cut short. The existence of commissioned hours not being delivered can, of course, apply to in-house teams as well. Another CSED workstream, Effective Monitoring and Modernisation of Homecare, addresses this issue and enables a number of other efficiencies to be released. Further details can be obtained from the CSED website (www.dhcarenetworks.org.uk/csed) in the form of a discussion document with case studies and supporting example documents.

4.4.3.2 Out-sourced

A couple of the schemes listed have actually out-sourced their homecare re-ablement service as well, with at least one of these resulting from the transfer of all in-house staff to an external not-for-profit provider who also undertakes a significant proportion of the ongoing homecare packages.

4.4.4 Introducing an in-house service

As is exampled within some of the case studies, most schemes have evolved from previous in-house care teams. Commonly staff were selected for their willingness and aptitude to perform a re-ablement role.

It is fair to say that not all care staff are able or wish to adapt to this new role and some who have been excellent carers for many years find the transition very difficult if not impossible. They may well wish to remain in a carer role and some CSSRs have addressed this by offering to transfer them to other in-house services.

4.4.5 Introducing an out-sourced service

Also, as exampled in the case studies, we are aware of three CSSRs who have, or are in the process of, out-sourcing their re-ablement service.

- Westminster out-sourced the whole of their homecare service including the re-ablement function through a transfer to Housing 21, a third sector provider. Staff transferred and continue to operate from CSSR buildings. The transfer took two years to negotiate and complete.

- Poole out-sourced their service in 2000 to a third sector regional home care provider

- Croydon are currently planning to outsource their established homecare re-ablement service.

38 See Volume 2 Additional Information – Westminster: abridged case study
39 See Volume 2 Case Study – Poole: case study template (see page 61)
4.5 Stakeholder Management – Council Staff (Members, Officers and Staff)

4.5.1 Council Members

Most of the case studies indicated that the trigger to look at homecare re-ablement was a mix of best value reviews, government policy and local desire to find a different way of working. Council members commonly appear to have been convinced of the need to adopt a new way of working following best value reviews despite, in some cases, a history of wanting to be the provider of care services.

Some CSSRs have expressed the concern that continued adherence to this historic role, of having to provide homecare, continues to hinder progress despite apparent benefits for users in terms improved independence and for CSSRs in terms of reducing costs. It is hoped that this document will assist by providing details of various services and evaluated evidence.

4.5.2 Council Officers

It would generally seem that Officers are open to the need to consider changes to the way homecare is delivered. Some of the CSSRs have suggested that the involvement of a senior manager, Assistant Director level, helps to focus consideration and subsequent implementation of homecare re-ablement schemes because it shows clear senior management support and enables decisions to be made on a timely basis.

4.5.3 Staff

All of the CSSRs we have spoken with have described the need to get the message right for staff through a structured and planned communication plan. Time invested in this aspect is thought by many to be time ‘well spent’ and critical to the timely consideration and implementation of a service.

At least one CSSR held sessions with staff following completion of a pilot phase and left the room so that staff involved within the pilot could tell how it ‘really was’. This openness was well received and enabled them to gain momentum in their rollout of a mainstream service.

All CSSRs have stated that careful selection and training of staff is essential because this approach requires a different mindset and range of skills to those employed within an ongoing ‘caring’ role.
4.6 Stakeholder Management – Service Users
Communication with service users takes different forms throughout the establishment and subsequent running of the homecare re-ablement service.

Where CSSRs needed to either free-up current homecare staff to form the new service either by transferring internally or to external providers, they commonly engaged in a structured and controlled programme. This took the form of written communication and individual visits by social workers to explain the proposed change.

In some cases, CSSRs have taken this opportunity to re-assess those in receipt of ongoing care packages and this process in itself often resulted in reductions in the transferred package.

In one case, the CSSR established a dedicated team to manage the transfer of ongoing care packages to external providers. This enabled the CSSR to work with providers and ensure that they were ready to take up each individual case, thereby minimising the chances for anyone to fall through the gaps. This approach was felt by the CSSR and, it is understood by users, to be very effective.

In the same way that staff may have been involved with caring for the same user over many months and, in some cases, even years, this process can, understandably, be a source of major concern to users. Therefore careful management of the users smooths this transition for all concerned.

4.7 Stakeholder Management – External Providers
The introduction of homecare re-ablement in whatever form, or structure, will have an impact on external providers. The extent of the impact can vary and could be significant in some cases, so CSSRs have engaged with them earlier rather than later.

If the in-house home care service is to reduce its involvement in delivery of ongoing home care provision, then the external providers will need to be capable of absorbing the increased capacity demanded of them. Clearly the magnitude of this issue increases if all in-house home care provision is to be ceased.

As outlined earlier, the timing of such a move needs careful consideration where contracts exist, for instance, either in the form of block contracts and / or zoned arrangements. These changes could have an impact on the existing contracts and so consideration needs to be given as to how this is best managed.

Many of the CSSRs have stated that a change of role by the CSSR care teams to one of re-ablement has dramatically improved relationships with external providers because they become partners in the continuum of care for those who need it rather than competitors.
4.8 Implementation through an External Provider

Based on the responses to our simple questionnaire, we have identified only three CSSRs that are, or plan, to deliver homecare re-ablement through external providers.

- Westminster City Council transferred the whole of their in-house homecare service to a third sector provider, Housing 21. Homecare re-ablement has since evolved from other support services that were transferred.
- Borough of Poole Council have outsourced their homecare re-ablement service to a regional third sector operator, Southampton Care Association Community Care Services
- Croydon Council are currently outsourcing an existing service but have decided to retain the training function in-house so that this can be provided consistently to a range of potential providers.

There seems to be differing views about the relationship between outsourced ongoing homecare services and re-ablement services. In the case of Westminster Council, these are predominantly with the same provider whilst with others they have decided to seek different providers for each so that there is no conflict of interests.

4.9 Stakeholder Management – Commissioners

Clearly commissioners need to be convinced of the benefits before any new service is implemented. However, probably more crucially, CSSRs have stated that homecare re-ablement requires a deep seated trust between commissioners and the re-ablement service that they will deliver the right level of homecare if it is to work properly to the benefit of service users.

Re-ablement would seem to work best where the commissioner approves cases for provision of homecare and the re-ablement team then determine the size of the package. They then need to be able to reduce the package over the days and weeks as the person’s confidence and skills return and, finally, commence the ‘discharge’ process approximately a week ahead of the intended cessation date.

As can be seen from some of the case study data, the average hours per week reduce, most notably for those who will be discharged with no need for an ongoing package, at a relatively fast rate. These weekly reductions could not possibly be dependent on approval by the commissioning staff because of the speed of change and the fact that they will not have seen the user during the re-ablement process.

As part of the ‘discharge’ process the commissioner becomes involved again in the approval of any ongoing care package. In the case of hospital discharge support schemes, where the user does not pass through a FACS assessment
to gain access to homecare re-ablement, the commissioner’s involvement starts during the ‘discharge’ process.

4.10 Training
All CSSRs have stated very clearly that the role of enabler requires specific skills and most aim at NVQ L2 as their base qualification, with additional modules on topics such as drug administration.

Prior to this, all CSSRs provide their staff with an induction programme that enables them to understand the aims and basic skills of re-ablement. Some of these are examined in the case studies.

Two of the CSSRs40 have extensive in-house programmes that are linked to OT and / or NVQ skills and on completion the actual NVQ qualification is addressed.

One of the external providers, Housing 21 in Westminster41, is exploring the relevance of NVQ L3 for their senior enablers and are currently working with their second batch of staff to gain the qualification. Shropshire42 are also known to be working with NVQ L3

4.11 Benefits – financial
Each of those listed believe that their scheme has generated substantial financial benefits for the CSSR by

- increasing the number of people who do not require an ongoing care package
- reducing the average size of any subsequent ongoing care package
- enabling people to stay in their home, thereby reducing the number of placements supported in care homes

In addition, those that focus on hospital discharge support have reported that their service can reduce average acute lengths of stay by approximately 2 days43.

The order of improvement has been difficult to quantify in some cases because of the absence of formal baselining and some CSSRs do not compare the cost of delivering the homecare re-ablement service with the reduced ongoing costs.

However, the order of improvements in those that have quantified the results are substantial. Further details are set out within each of the respective case study summaries but the headlines are

40 Volume 2: Case Studies – Wirral and Milton Keynes
41 Volume 2: Additional Information - Westminster
42 Volume 2:Additional Information - Shropshire
43 Volume 2 Case Studies - Wirral
Leicestershire’s Home Assessment and Re-ablement Team
Based on evidence from an independent evaluation, ongoing care hours reduced by 28% when operating as an intake team (72% when operating on a selective basis)

Based on data for 2005/06 (1,836 users) for their intake service,
- 50% required no ongoing care package after an average re-ablement of 4.6 weeks
- 29% required an ongoing care package but these were reduced on average by 30% after an average re-ablement of 10.3 weeks
- 18% were referred to other services but still achieved an average reduction in their ongoing care package of 16% after an average re-ablement of 11 weeks
- these reductions equate to a saving of approximately £84k per week for all users compared with an average cost per week to run the scheme of £36k.

Wirral Enablement Discharge Service
Based on an internal pilot evaluation of their hospital discharge service
- 50% required no ongoing care package
- 31% required a reduced care package
- 9% had their care package maintained
- 3% had their care package increased

Based on data for the service in the 6 months to July 2006 (200 users)
- 80.5% required no ongoing care package
- 8.5% required an ongoing care package
- 9.5% were re-admitted to hospital after commencement of the service

It is estimated that the service also reduced average acute lengths of stay by approximately 2 days.

Dudley Community Re-ablement Service
Based on data for 2005/06 (1,412 users)
- 21% required no ongoing care package
- 26% required a reduced care package
- 23% required a care package that was maintained
- 7% required an increased care package
- 13% were admitted to a care home or hospital after commencement of the service

The first four categories, including those whose care package was increased, resulted in a 42% reduction in care hours when compared to packages before re-ablement. This equated to a reduction of 245k hours per annum.

Salford Intermediate Home Support Service
Based on pilot evaluation data for 7 months to May 2004 (163 referrals)
- 136 of the referrals were suitable for service and of these
Care Service Efficiency Delivery: supporting sustainable transformation

- 61% required no ongoing care package
- 31% required a reduced care package
- 1% required an increased care package
- 5% were admitted to hospital after commencement of the service

The first three categories generated an 80% reduction in ongoing care hours when compared to the assumed level from their first week of re-ablement.

Poole’s Woodland Community Team
Based on activity data for 7 months to October 2006, (89 users)
- 44% required no ongoing care package
- 13% required a minimal care package
- 1% required a care package of between 4 and 7 hrs per week
- 1% required a care package of over 7 hrs per week
- 28% were referred to other care
- 13% were re-admitted to hospital after commencement of the service

4.11.1 Duration of Benefits

Generally CSSRs have not completed any form of longitudinal study and so there is a scarcity of evidence to quantify the duration of benefit. Clearly, if users re-present within a short period of completing their time with a re-ablement team then any financial and quality benefits will be limited and possibly not cost effective.

Most CSSRs have stated, based on anecdotal evidence, that they believe that users do not re-present within many months of leaving the service unless other life events that are unrelated to their previous condition occur.

Clearly the completion of a longitudinal study would be of significant benefit to CSSRs by providing some further evidence of the benefit of re-ablement. However, in its absence:

- Leicester City believe that the benefits last for more than 2 years
- Leicestershire data indicates that the break-even point for those who require no ongoing care package is only 8 weeks
- Wirral believe, based on their knowledge, that 16 weeks was a ‘safe’ period within which users do not re-present and their data shows that over this period substantial efficiencies arise. Clearly this situation improves as the period extends.
- Warrington is understood to follow up progress with those who have been through their homecare re-ablement scheme by telephone.

We understand that a CSSR has recently commenced a longitudinal study but would like to hear of any others that have been completed.
4.12 Benefits – quality and satisfaction

Based on limited evidence from some of the case study sites it would seem that users appreciate the homecare re-ablement service and rate the service highly.

Most CSSRs operate a user satisfaction questionnaire and monitor the results to identify trends. It would seem that the response rates are relatively low and it is commonly felt that this arises because of the short duration of the service.

As with the quantification of financial benefits, we are not aware of any scheme that baselined the user satisfaction levels prior to the introduction of homecare re-ablement.

Some of the services that completed evaluations also included a review of customer satisfaction and these are included within the individual case studies where appropriate.

4.13 Monitoring the Service

CSSRs use a variety of reports and mechanisms to monitor the service and examples are included within the individual case studies where these have been shared with us.

4.14 Trace of improvements to PAF indicators

Most of the CSSRs we visited did not see any direct correlation between the improvements achieved by homecare re-ablement and the PAF indicators used to monitor and compare CSSRs performance. In fact some felt that they acted as a dis-incentive because measures such as unit cost would, logically, increase as re-ablement tends to move those with lesser needs to a point where they do not require an ongoing care package. One is then left with the heavier dependent users who, on average, benefit from a reduction in the care needs but will still be at the higher end.

One CSSR that works closely with health colleagues felt that the PAF indicators are of general use when communicating with health because it is a framework they understand and the indicators convey broad policy direction. Thus, they assist in understanding respective priorities.

4.15 Key points to introducing homecare re-ablement

Each of the case study CSSRs were asked to identify those factors that they considered essential to ensuring a smooth implementation. Many of these were common and so they have been summarised as follows:

- Project Team: the early establishment of a Project Group that can make decisions is critical to ensure a timely and responsive implementation. This is best achieved if led by an Assistant Director so that decisions can be considered and progressed on a timely basis.
Commissioning Team: a strong trusting relationship is required so that they can rely on the carers / enablers to make sure that the right end package is delivered

Re-ablement function: early and consistent messaging to users and all stakeholders that the scheme is about helping people to look after themselves rather than doing it for them, and that the service is time limited.

Entry and Exit: the re-ablement approach is dependent on an ability to progress users so that they achieve their maximum level of independence in a timely manner, thereby allowing the service to move onto further cases. Thus, it is essential that external support and providers are responsive to prevent delays and bottlenecks. This includes timely access to aids to daily living and progression to providers of ongoing care packages where required.

Staff: time on managing the staff is well spent so that they have confidence in the new way of working. It invariably takes longer than you might first think so do not under estimate the effort required.

Transfer of ongoing care packages: the establishment of a dedicated team to manage the transfer of ongoing cases to new providers is very beneficial and ensures a smooth transition of service users

Some carers are unable to adapt and are not suitable to the role of an enabler and so careful recruitment is essential. Have an alternate strategy for those who do not want to or cannot make the change.

Map processes and follow up with action plans to resolve issues

Important to establish a staged implementation rather than adopt a ‘big bang’ approach since this allows evolution and ‘safe’ testing and development of the service. Also be flexible and willing to adapt or change.

Clarity of roles is important, albeit that these will evolve, especially where different professionals are involved within a team: there needs to be clear accountability e.g. between health and social care. Also, need to establish a competency framework for all posts
Volume II

1. Detailed Case Studies

Case studies were completed with five CSSRs who kindly offered to share their experience, evaluations and example documents with us for inclusion within this Discussion Document.

In an effort to ensure that the outputs of the case studies would address the key issues for CSSRs, we tested a draft standard template with a range of those wishing to establish or extend a service. We also sought comments from those who had an established service.

It is fair to say, and not surprising, that CSSRs have approached the introduction of homecare re-ablement differently and so some of the sections of the standard template used do not apply to every scheme. However, the structure seeks to give some degree of consistency for the reader. Similarly we sought to capture example documents to aid the reader in their understanding of how a particular case study CSSR operates its service.

Without the support and co-operation of these case study sites, and those who provided information on elements of their scheme, this Discussion Document would have been impossible to produce and it would be devoid of some of the practical information we have sought to capture.

1.1 Detailed Case Studies

<table>
<thead>
<tr>
<th>Case Studies</th>
<th>Type of Scheme</th>
<th>Nature of Scheme</th>
<th>Ownership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leicestershire</td>
<td>Intake</td>
<td>In-house</td>
<td>Social Care</td>
</tr>
<tr>
<td>Milton Keynes</td>
<td>Hospital Discharge support</td>
<td>In-house</td>
<td>Jointly between Social Care and Health</td>
</tr>
<tr>
<td>Poole</td>
<td>Intake</td>
<td>Out-sourced</td>
<td>Jointly Social Care and Health</td>
</tr>
<tr>
<td>Salford</td>
<td>Intake</td>
<td>In-house</td>
<td>Social Care</td>
</tr>
<tr>
<td>Wirral</td>
<td>Hospital Discharge</td>
<td>In-house</td>
<td>Social Care and Health</td>
</tr>
</tbody>
</table>
Leicestershire

HOMECARE RE-ABLEMENT: CASE STUDY

Homecare Assessment and Re-ablement Team (HART)

<table>
<thead>
<tr>
<th>1</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall summary of the scheme</strong></td>
<td>The Homecare Assessment and Re-ablement Team started in November 1999 as a pilot in one area of the County. Following independent evaluation, it was rolled out and now covers the whole of the county. It is one of four services: HART, dementia team, child care team and ‘specialist’ maintenance. All standard ongoing homecare is delivered by out-house providers. The remit of each team is outlined in the Service User Guide. 44</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2</th>
<th>Council profile</th>
</tr>
</thead>
</table>
| **Brief description of council** | The County has a population of 610,000 (2001 census) with 95,000 (15.7%) 45 aged over 65 years and 11,000 (1.8%) 46 aged over 85 years. 

The authority’s latest CPA score is 4 stars.

The Social Services directorate have retained a 3 star rating for 5 consecutive years.

The authority commissions approximately 33,000 hours of care per week of which approximately 85% is placed with external providers. It currently serves those with moderate needs and above. |

<table>
<thead>
<tr>
<th>3</th>
<th>Background to development of homecare re-ablement service</th>
</tr>
</thead>
<tbody>
<tr>
<td>The development of a homecare re-ablement service was triggered by completion of a Best value Review in 1999 and funding was received under the Promoting Independence project.</td>
<td></td>
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</table>

This led the authority to focus on supporting people to be able to support themselves and they set a target of reducing the in-house provision to be 10% of the total delivered care. |

<table>
<thead>
<tr>
<th>4</th>
<th>Implementation stages and timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline of stages and timeline</td>
<td>November 1999: Pilot based in the area of Melton. This</td>
</tr>
</tbody>
</table>

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44 Appendix : Adult Social Care Services, Home Care Service, Service User Guide – Nature of Services Provided
45 2001 census: national average aged over 65 = 15.9%
46 2001 census: national average aged over 85 = 1.9%
### Care Service Efficiency Delivery: supporting sustainable transformation

<table>
<thead>
<tr>
<th>timeline to develop and implement service</th>
<th>focused on people who had been selected as being appropriate for homecare re-ablement.</th>
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<tbody>
<tr>
<td>May 2000 Pilot extended to accept all people through an intake team in the Vale of Belvoir</td>
<td></td>
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<tr>
<td>2001 Work begun to restructure the in-house service into the four ‘specialist’ team model across the County</td>
<td></td>
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</tbody>
</table>

#### 5 Conducting the pilot

<table>
<thead>
<tr>
<th>Outline of approach to pilot if run</th>
<th>An external evaluation of the pilot project was completed by the Centre for Group Care and Community Studies. This sets out background information, details of the phased development of the pilot project, statistical analysis, qualitative analysis and recommendations.</th>
</tr>
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<tbody>
<tr>
<td>In essence, a pilot was established which was then extended and, in its final phase, operated as an intake team for a given geographic area. A comparison of outcomes was made to a controlled group and tested against data for the previous year to ensure that the pilot was representative.</td>
<td></td>
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</table>

#### 6 Nature of current service

<table>
<thead>
<tr>
<th>Description of service</th>
<th>The scheme now operates across the whole of the County through intake teams and all adult users participate unless their care needs exclude them in accordance with established criteria. E.g. complex mental health needs, last stage terminal care.</th>
</tr>
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<tbody>
<tr>
<td>The HART service is one of four specialist teams within the County.</td>
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<tr>
<td>It provides a service for up to 6 weeks and approximately 57% of users are referred from hospital discharge teams. The first two days are provided at no charge, but thereafter charges are made in accordance with the councils charging policies.</td>
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<tr>
<td>The team no longer has any direct therapy input but retains direct links with the OT service within the</td>
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47 Appendix: [External Evaluation of The Home Care Re-ablement Pilot Project, De Montfort University](#)

48 Appendix: [Arranging Home Care Services – Procedural Guidance, sections 3 and 4](#)

49 Appendix: [Adult Social Care Services, Home Care Service, Service User Guide – Nature of Services Provided](#)

50 Appendix: [Arranging Home Care Services – Procedural Guidance, sections 10 and 11](#)
Commissioning Team. They also have fast track access to OT services with health through jointly funded posts.

Home Care Managers and Senior Carers have been trained and can order aids to daily living, thereby relieving demand on therapy staff and removing delays in the delivery of the re-ablement care package.

### 7 Structure of service

#### Description of operational structure

A Service Manager, who reports to the Assistant Director, Older and Disabled People’s Services, takes a lead role for the in-house home care service.51

The team are divided into 6 geographically based area groups, managed by 5 Team Managers. Each locality team is led by a team of Home Care Managers, plus an out of hours team. In total the area teams consist of 16 Home Care Managers, 30 Senior Home Care Assistants and 442 Home care Assistants.52

### 8 Monitoring the service

#### Description of how service monitored

An initial care plan is received from the Commissioning Team and progress is monitored on a weekly basis by a review involving the Care Manager, Senior Carer and Carers.

HART have the authority to amend the care package based on their ongoing assessment of the users needs.

At the end of the re-ablement phase, the HART manager and carer complete a review with the user in their home.

A final written care package forms part of the handover to any ongoing out-house care provider and it is understood that these are very rarely queried or changed.

### 9 Stakeholder Management – Council Staff (Members, Officers, Staff)

Elected officers and Managers were fully supportive of the need to develop the service as a result of the Best Value Review. The scheme was independently evaluated by the De Montfort University and this served to endorse the value of the service to Managers and

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51 Appendix : Leicestershire County Council – Adult Social Care Service, Older and Disabled People’s Services, Organisational Chart
52 Appendix : Leicestershire Adult Social Care Services – In House Home Care Service Structure
There were no TUPE implications because all staff were retained. Staff could elect which of the four ‘specialist’ teams they wished to transfer to when the service was restructured.

Staff involved with the pilot work provided feedback to other staff. Most saw this as an opportunity to extend their skills and return to the role they had previously held, prior to the split of purchaser / provider in 1991, which allowed carers to contribute towards the assessment and amendment of care plans to meet the needs of users.

### Stakeholder Management – Service Users

Many of the existing long-term users were nervous of the change and approximately 2/3rds were transferred to the independent sector. Others with complex needs were retained with in-house staff but transferred to one of the other specialist teams: e.g. long-term dementia care, maintenance.

### Stakeholder Management – External Providers

External providers were advised by the authority of this change and re-assured that the in-house would no longer be in direct competition. Contracts were renegotiated in 2005 and in April 2006 spot purchase contracts were augmented with block contracts based on geographic zoning. Detailed arrangements were made for the transfer of existing cases and those of a complex nature were managed with a period of approximately one week co-working to ensure a smooth transition.

### Implementation through External Providers

**Description of approach**

Homecare Re-ablement is undertaken by in-house teams only.

Given the need for increased capacity within the external provider market, it took between 3 and 4 years before most bottlenecks were removed in the transfer of cases at the completion of the 6 week re-ablement period across the County. The situation remains variable, some cases having to ‘wait’ a longer period before there is capacity in the market for transfer.

### Stakeholder Management - Commissioners

The relationship with the Commissioning Team was critical and benefited from a historical trust with the care teams.

The Commissioning Team sets initial care packages...
but HART have the authority to amend these to appropriately support the change in users needs through the re-ablement phase.

<table>
<thead>
<tr>
<th>14 Training</th>
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</table>
| **Description of training** | Carers involved in the pilot scheme underwent 5 days of training. 53 This is now 2 days every 6 months for new staff.  
The initial 2 days covers the philosophy and inherently different ways of working in HART, honing of care skills to provide confidence to carers, problem solving, skills to empower users to support themselves, minor aids and record keeping. 54  
Target is NVQ L2 (Care) supplemented by additional training in manual handling, risk assessment, lone worker, dementia and medication. All NVQ courses are run in-house.  
Managers believe it is essential that training is practical and directly relevant and so this function has now passed to line managers who deliver the induction phase. |

<table>
<thead>
<tr>
<th>15 Benefits - financial</th>
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</table>
| **Outline of the benefits** | The independent evaluation completed by the De Montfort University 55 provides a clear expression of the benefits of adopting a homecare re-ablement approach and quantified the order of benefit.  
- Based on evidence from the evaluation project, Leicestershire achieved a 28% reduction in homecare hours when the approach was applied to an intake team (72% when applied to a selective pilot scheme).  
Quarterly data from the in-house IT team provides basic information and it is intended to develop activity reports.  
A review of the cases for 2005/2006 56 confirms that in addition to continuing to enhance the independence of people referred to the service: |

53 Appendix : External Evaluation of The Home Care Re-ablement Pilot Project, De Montfort University, sections 5.8 & 5.9  
54 Appendix : Home Care Service, HART Core Skills Training Programme  
55 Appendix : External Evaluation of The Home Care Re-ablement Pilot Project, De Montfort University, particularly section 4  
Care Service Efficiency Delivery:  
supporting sustainable transformation

<p>| | |</p>
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|  | • 49.7% of those referred required no ongoing care package  
|  | • 28.5% of those referred managed to achieve an average reduction in their ongoing care package hours of approximately 30%  
|  | • and even those referred on to other specialist teams by HART managed to achieve an average reduction of 16% in their ongoing care package hours.  
|  | In all, these groups generated a gross weekly saving, when compared to the cost of their care package had HART not existed, of £84k. This equates to an average break-even point of approximately 23 weeks.  
| 16 Benefits – quality and satisfaction |  
| Outline of benefits. | The external evaluation included a review of quality and user satisfaction.  
|  | Surveys of user satisfaction are completed and monitored. A system is now being introduced to collate the information and produce trend reports. In addition, a feedback form is included within the Service Users Guide that is provided to all who pass through the HART service.  
|  | Close monitoring of complaints and compliments provide another useful gauge of satisfaction.  
|  | Consideration is currently underway to commission further evaluation work by the De Montfort University and this would include a longitudinal study.  
| 17 Trace of improvements to PAF Indicators |  
| Impact of Homecare Re-ablement on Performance Assessment Framework indicators | There are a few PAF indicators that HART intervention has an impact on. Unfortunately, due to the way in which the indicators are set up to measure success, the impact is not an improvement.  
|  | Two indicators measure the number of service users who receive an intensive package of home care (nationally defined as 10 hours and 6 visits per week); these are PAF C28 and PAF B11. As HART aims to reduce the need for home care, any packages that are initially above the defined level of an intensive package  

57 Appendix : [External Evaluation of The Home Care Re-ablement Pilot Project, De Montfort University, section 5](#)  
58 Appendix : [Adult Social Care Services, Home Care Service, Service User Guide – Appendix A](#)
that subsequently fall below this due to the intervention will not count positively within the indicator.

PAF C29 - C32 measure the number of service users supported to live at home (by client type). This involves a number of community based services including home care, regardless of the size of the package. As 50% of service users going through HART do not need any further home care, this reduction will have an impact on the PAF indicators as they may not be counted (if they are also in receipt of other services such as day care or mobile meals they will continue to be counted).

18 Next Steps

Proposed areas for development are

1. to finalise activity reporting in association with the IT team
2. to develop seamless working with Health colleagues to further improve the transfer of users between the two areas of care.
3. currently considering further evaluation work by De Montfort University
4. to transfer all existing maintenance packages to the independent sector and focus all in-house resources on the remaining three specialist areas

19 Tips for other Councils

Critical issues include:

1. a strong trusting relationship with the Commissioning Team so that they can rely on the carers to make sure that the right end package is delivered
2. time is well spent on managing the staff so that they have confidence in the new way of working
3. early and consistent messaging to users that the scheme is about helping people to look after themselves rather than doing it for them.
4. the HART approach is dependent on an ability to progress users so that they achieve their maximum level of independence in a timely manner, thereby allowing the service to move onto further cases. Thus, it is essential that external support and providers are responsive to prevent delays and bottle necks.
5. effective communication with all stakeholders (staff, external providers, Health colleagues, etc.) during the planning and implementation stages.
## Summary

| 1 | Milton Keynes operate a homecare re-ablement service as part of an integrated Intermediate Care Service jointly with Milton Keynes Primary Care Trust, and this provides a co-ordinated range of community rehabilitation and therapies for those aged over 18 years living within Milton Keynes and with a Milton Keynes GP.  

The services available are  
- Intermediate Care Team (ICT): homecare re-ablement service  
- Rapid Assessment and Intervention Team (RAIT)  
- Fraser Day Hospital: outpatient rehabilitation services  
- Bletchley Community Hospital: 28 bed intensive rehab and health care support  
- Orchard House (14 short-term self catering flats)  
- The Willows (4 intermediate care rooms for step-up care)  

Within these, there are three rapid response services  
- RAIT: responding within 30 minutes to urgent referrals and admission avoidance  
- Rapid Response Carer Service: over night service  
- Rapid Access Beds: to avoid admission to hospital  

All of these provide a co-ordinated service that can only be accessed through a single point of access upon referral by health or social care professionals. These services are available across the whole CSSR and operate on the basis that whoever assesses the individual first ensures that they are picked up by the

59 Appendix : Intermediate Care Services information leaflet  
60 Appendix : Intermediate Care Rapid Response Service
most appropriate service, thereby providing a safety net.

Referrals are also made by the local ambulance control against agreed protocols, and IC staff respond to appropriate calls sometimes accompanied by an Emergency Care Practitioner.

2 Council profile

Brief description of council

The authority has a population of 221,600 (latest 2006 estimate) and is the fastest growing Council in Britain with an estimated 23,000 (10.4 %) aged over 65 years and estimated 2,820 2,400 (1.3 %) aged over 85 years. Milton Keynes is Britain’s largest and newest new town, but includes older urban towns of Wolverton and Bletchley, large 70’s Council estates of poor quality, and a significant rural area of North Bucks (rural population 35,000).

The authority’s latest CPA score is ‘Good’ – 3 star

The Social Services directorate are currently rated as a 1 star service, but adult services are rated as serving most people well, promising prospects (2 stars) and have been since 2003.

The authority commissions approximately 10,632 hours (HH1 2005) of home care per week of which 42% is placed with external providers. The Intermediate Care Team assess and accept an average of 110 new service users each week and provide approximately 240 hours per week (care provided for 6 weeks maximum).

The authority currently serves those with substantial needs and above.

3 Background to development of homecare re-ablement service

The service was first proposed as a result of an Older People’s Services Best Value Review. This was built upon in a Locality Structure paper and an Intermediate Care Strategy paper.

4 Implementation stages and timeline

Outline of stages and timeline to develop and

- Early 2002 - set up the Intake and Rehab Teams (IRT)
| implement service | • Nov 2002 - expanded service to include users who required homecare  
• Jan 2003 - added the care team who support rehab flats  
• 2004 - appointed a joint Intermediate Care Manager with health and brought together the Intake Rehab Team (IRT) and Community Health Access Team (CHAT)  
• Mar 2005 - developed out of hours rapid response service and introduced Community Matrons.  
• Nov 2005 - co-located managers and support staff  
• Mar 2006 - reconfigured 11 rapid access beds |

5 Conducting the pilot

| Outline of approach to pilot if run | The current Intermediate Care Team structure and service evolved over a number of months as part of an integrated service. (see section 4 above) |

6 Nature of current service

| Description of service | The ICT service operates through five teams, each with 5 homecare staff. As can be seen from the data\(^{64}\), most referrals come from hospital wards and are more often received on the day of discharge. The team leader visits, makes an assessment and prepares a care plan. Assuming that the individual’s needs can be best met by the ICT, they are added to the programme from the next day. Hence the service is highly responsive to demand.  

The Team Leader acts as the focal point. Carers collect details of their morning’s list along with any changes that may have occurred overnight, and generally complete their visits between 7 and 11.30am. Feedback is provided to the Team Leader who allocates the afternoon lists and, again, feedback is provided by the afternoon team members. Care plans and notes are left with the user in their home and these are spot checked by the Team Leader from time to time. By its nature, different members of the team work with individual users unless there are complex needs and / or particular specialist pieces of equipment are required.  

A second assessment is completed by the Team |

\(^{64}\) Appendix : Intermediate Care Operational Reports – Summary of Referral and Destination Data Sept 2005 to August 2006
Leader after a couple of weeks and then, towards the end of the individuals time with the ICT, the Team Leader discusses the next stage including any ongoing care package, direct payments if applicable, etc. with the user and gains their agreement. Any final report proposing an ongoing care package is referred to the Priorities Panel who meet weekly and approve packages, allocation to in-house or external providers and establish arrangements. All contracts with external providers are placed through one point in the Council’s contracts department.

The duration of ICT support varies with an average time of approximately 14 days. The published maximum duration is 6 weeks although this can be extended where benefits would be derived. Some users, particularly where it involves the re-instatement of a previous service, may only be with the team for 2 days. The service also supports a small number of palliative care cases from time to time to ensure continuity and because they are able to be highly responsive to changing needs.

No charge is made for the intermediate care services and the local FACS criteria are applied at the conclusion of a person’s time with the team if they require an ongoing care package.

<table>
<thead>
<tr>
<th>7</th>
<th>Structure of service</th>
</tr>
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</table>
| **Description of operational structure** | All of the Intermediate Care Services operate under one jointly appointed manager (Intermediate Care Services Manager)\(^{65}\) who reports to both the Head of Adult Social Care (Milton Keynes Council) and the Director of Primary Care (Milton Keynes PCT).

Within the team there are clear agreements regarding role and responsibilities as well as managerial control and professional supervision for all health and social care staff.\(^{66}\) |

<table>
<thead>
<tr>
<th>8</th>
<th>Monitoring the service</th>
</tr>
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</table>
| **Description of how service monitored** | Monitoring of the service takes different forms within each of the partners to the joint service.

Social care staff monitor indicators \(^{67}\) including |

\(^{65}\) Appendix : [Consultation Paper on the Proposed Integration of Intermediate Care Services - page 19](#)

\(^{66}\) Appendix : [Consultation Paper on the Proposed Integration of Intermediate Care Services – pages 20 to 24](#)

\(^{67}\) Appendix : [Medium Term Team Plan 2006-7, section 2, page 3](#)
### Stakeholder Management – Council Staff (Members, Officers, Staff)

A consultation process took place between October and November 2004 regarding proposals to bring together a number of intermediate care services under one managerial structure. This was to integrate health and social care teams and to extend capacity, skills and experience.

### Stakeholder Management – Service Users

### Stakeholder Management – External Providers

### Implementation through External Providers

Description of approach

### Stakeholder Management - Commissioners

### Training

Description of training

All home care staff within the ICT undergo an Accelerated Development Programme during their first year. This provides them with the skills and training to undertake the role, and provides evidence to support their progression through NVQ L3 which is the target qualification.

Additional training is provided through the Council’s On Track scheme. This covers basic skills such as moving and handling, communication skills, risk

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68 Appendix: Intermediate Care Operational Reports – Summary of Referral and Destination Data Sept 2005 to August 2006

69 Appendix: Consultation Paper on the Proposed Integration of Intermediate Care Services

70 Appendix: Intermediate Care Rehabilitation Assistant Training Programme
<table>
<thead>
<tr>
<th>15 Benefits - financial</th>
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<tbody>
<tr>
<td>Outline of the benefits</td>
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<tr>
<th>16 Benefits – quality and satisfaction</th>
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<tbody>
<tr>
<td>Outline of benefits</td>
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<tr>
<th>17 Trace of improvements to PAF Indicators</th>
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<tbody>
<tr>
<td>Impact of Homecare Re-ablement on Performance Assessment Framework indicators</td>
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<table>
<thead>
<tr>
<th>18 PAF Indicators</th>
</tr>
</thead>
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71 Appendix: Example Intermediate Care Operational Report August 2006
72 Appendix: Cost Benefit Analysis of Intermediate Care
## Next Steps

The Intermediate Care Service continues to evolve and the current plans include:

- To develop the admission avoidance activity including increasing the number of admission avoidance beds
- To reconfigure the OOH Rapid Response Service to also provide a nighttime ‘intake’ team: this will reduce the number who cannot remain in their own homes because of their requirement for nighttime care visits.
- To roll out an IT based Single Assessment Process: the current paper based version is 10 pages long.

## Tips for other Councils

Establish a single point of access into services

**Risk**
- establish risk management
- ensure you establish the right skill, experience and competency levels
- establish competency framework for all posts

**Health & Safety**
- if a joint service use the skills and experience of all partners for risk assessments, actions plans, etc.

Map processes and follow up with action plans to resolve issues

Establish good care planning
- involve the client at outset and agree plan
- create a ‘formal’ contract with the client regarding plan
- ensure that activities are relevant and stimulating

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73 Appendix: Medium Term Team Plan 2006-7, sections 5 (pages 5 & 6) and 6 (pages 7 to 16)
74 Appendix: Example ‘Community Matron / Case management Competences Index and Domain Descriptions’
**Care Service Efficiency Delivery:**
supporting sustainable transformation

Poole

**HOMECARE RE-ABLEMENT: CASE STUDY**

Woodlands Community Team

<table>
<thead>
<tr>
<th>1</th>
<th><strong>Summary</strong></th>
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<tbody>
<tr>
<td>Overall summary of the scheme, stage of development and outline timeline to complete implementation</td>
<td>The Woodlands Community Team provides intermediate care and complex rehabilitation to adults. It is multi-disciplinary and includes, and works with, dedicated consultant time, therapists, rehabilitation assistants, social care staff, nursing teams and a pharmacist and pharmacy technicians.(^{75}) The Rehabilitation Home Care Service is provided by Southampton Care Association Community Care Services which is a large regional third sector provider appointed following a tendering exercise. This service is the focus of the intermediate care provided by the Woodlands Community Team... It is strictly time limited to 6 weeks. The service is usually delivered in the user's home but, if appropriate, can be provided on an outpatient basis within Alderney Community Hospital, which is where the team are based. The service operates 7 days a week between the hours of 7 am and 10 pm.(^{76}) 365 days a year and is one element of a co-ordinated range of services.</td>
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<tr>
<th>2</th>
<th><strong>Council profile</strong></th>
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<tbody>
<tr>
<td>Brief description of council</td>
<td>The authority has a population of 138,300 (2001 census) with 28,054 (20.0 %)(^{77}) aged over 65 years and 3,940 (2.9 %)(^{78}) aged over 85 years. The authority's latest CPA score is 3 star The Social Services directorate are currently rated as a 3 star service. The authority commissions approximately 1,500 whole hours of care per week and 4,700 half hours of care per week of which 75% is placed with external providers. The Rehabilitation Home Care Service is a block contract of</td>
</tr>
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\(^{75}\) Appendix : Woodlands Community Team (Users Guide)  
\(^{76}\) Appendix : Woodlands Community Team, Rehabilitation Homecare Service – 6 monthly analyses
### 3 Background to development of homecare re-ablement service

| The trigger to commence a re-ablement service was the general agenda of intermediate care following the NSF for Older People in 2000. The drive to outsource the service was as a result of Best Value Reviews and the Council’s vision at that time for the delivery of provider services. The decision was made that there was a need to increase the throughput of the Community Hospitals and so capacity was created in the community. A decision was also made to close the day hospital and provide service’s in a person’s own home. This originally started with a very small team of three: a care manager, physiotherapist and a nurse. |

### 4 Implementation stages and timeline

<table>
<thead>
<tr>
<th>Outline of stages and timeline to develop and implement service</th>
</tr>
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<tbody>
<tr>
<td>The Rehabilitation Home Care Service started in 2001. There was a lead in period to enable the provider to recruit staff and build up to the 200 hours block contract per week. Formal discussions and the tendering process were started in 2000 in response to the NSF Older People Intermediate Care.</td>
</tr>
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### 5 Conducting the pilot

<table>
<thead>
<tr>
<th>Outline of approach to pilot if run</th>
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<tbody>
<tr>
<td>Not applicable</td>
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</table>

### 6 Nature of current service

<table>
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<tr>
<th>Description of service</th>
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<tr>
<td>The Woodlands Community Team operates across the whole of the borough. Referrals are received from a number of health and social care professionals with approximately 20% arising from acute health trusts and the balance from within the community. These tend to be categorised into three priority groups: same day, within 5 days and within 10 days. The latter two groups tend to be those whose need will arise when they are discharged from hospital. The Rehabilitation Home Care Service is accessed mainly by the Woodlands Community Team staff based on a completed multi-disciplinary assessment and rehabilitation care plan and programme with clear person centred goals. A multi-disciplinary review is completed within the first 2 weeks and a further review is completed in advance of the completion of the 6th week of service. There is a specialist</td>
</tr>
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77 2001 census: national average aged over 65 = 15.9%  
78 2001 census: national average aged over 85 = 1.9%
worker in the Acute Trust who can also refer directly to the Service.

Tolerance levels are required within the Rehabilitation Home Care Service to ensure that adequate capacity exists to respond to referrals. Close co-ordination with other social care and health feeder and post re-ablement services is maintained because changes in their capacity and workload impinge on the re-ablement service as well as each other.

Initially a member of the therapy staff who visits the users within their home completes an assessment. Goals are set and agreed with the user and re-ablement is then provided by staff from the external provider. Reviews are completed weekly by the Manager with the Rehabilitation Assistant at which time input can be received from therapists and nursing staff. As progress against goals is achieved, the re-ablement package is stepped down.

No charge is made for the service which is provided for up to 6 weeks. Discharge from the service is approved by a member of the therapy staff and the need for any ongoing care package is gauged by any unmet goals. People referred from hospital have their assessment completed by hospital based therapy staff and so they are fast tracked.

Ongoing care packages are arranged through a central brokerage service utilising a mix of block and spot contracts.

As part of the re-ablement service, the Woodlands pharmacist and pharmacy technicians work very closely with the Community Team. They provide medication management input with a view to simplifying the user’s medication in terms of their understanding of how to take it, the ‘packaging’ and form it is taken in, the number of doses required, etc. This service is a major contributor to the services’ ability to keep users within their home as evidenced within a study validated by the Department of Healthcare Statistics and Epidemiology at Bournemouth University. This study showed, amongst other things, that for every six people reviewed and managed, one admission to hospital was saved. The attached paper79 will

79 Appendix : Report of the Poole Primary Care Trust Medicines Management Service
be presented at a BMJ arranged international forum in April 2007.

Where appropriate, linkages are made with Lifeline’s call centres to support those with mild dementia at home.

<table>
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<tr>
<th>7 Structure of service</th>
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</table>
| Description of operational structure | The operational structure of the service is depicted in an organisation chart.  
80 Appendix: Woodlands Intermediate Care Unit Organisational Chart |

<table>
<thead>
<tr>
<th>8 Monitoring the service</th>
</tr>
</thead>
</table>
| Description of how service monitored | Monthly reports are submitted by the external provider which list all those discharged from the service along with basic information.  
81 Appendix: Intermediate Care Service Activity Monitoring Form |

As set out above, progress is reviewed weekly with input as required from therapy and nursing staff within the co-ordinated team.

The external provider reports monthly on the source and destination of all those ‘discharged’ from the service.  
82 Appendix: Intermediate Care Services Activity Monitoring Form - example  
83 Appendix: Monthly Discharge Data trends - example |

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<tr>
<th>9 Stakeholder Management – Council Staff (Members, Officers, Staff)</th>
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<th>10 Stakeholder Management – Service Users</th>
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<tr>
<th>11 Stakeholder Management – External Providers</th>
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<tr>
<th>12 Implementation through External Providers</th>
</tr>
</thead>
</table>
| Description of approach | The Rehabilitation Home Care function was outsourced to a large regional third sector provider of home care services.  
84 Appendix: Intensive Rehabilitation Homecare Service Specification |

The contract specification documentation sets out a range of terms, including the values, principles, and service standards that will apply.

<table>
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<tr>
<th>13 Stakeholder Management - Commissioners</th>
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<tr>
<th>14 Training</th>
</tr>
</thead>
</table>
| Description of training | The training requirements are set out within the service specification and includes  
85 Appendix: Intensive Rehabilitation Homecare Service Specification |

80 Appendix: Woodlands Intermediate Care Unit Organisational Chart  
81 Appendix: Intermediate Care Service Activity Monitoring Form  
82 Appendix: Intermediate Care Services Activity Monitoring Form - example  
83 Appendix: Monthly Discharge Data trends - example  
84 Appendix: Intensive Rehabilitation Homecare Service Specification  
85 Appendix: Intensive Rehabilitation Homecare Service Specification
### Care Service Efficiency Delivery: supporting sustainable transformation

- formal detailed induction
- 2 weeks shadowing for those new to the care industry
- attainment of NVQ L2 provided by therapists and other staff from within the Woodlands Community Team
- arrangements for ongoing training

### 15 Benefits - financial

**Outline of the benefits**

Based on data for the 7 months to October 2006, 43.5% of users were re-abled to a level of full independence within an average period of 5.3 weeks. Across all outcome categories the average duration with the service was 4.9 weeks and 91% of users had left the service within 7 weeks.

### 16 Benefits – quality and satisfaction

**Outline of benefits**

Within the contract specification, the provider is required to manage and make available the results of a variety of measures, including:

- complaints management and reporting
- quality assurance: users satisfaction questionnaires
- mismatches between service requests and provision

### 17 Trace of improvements to PAF indicators

**Impact of Homecare Re-ablement on Performance Assessment Framework indicators**

Generally it is felt that the performance and benefits of homecare re-ablement do not appear within the current PAF structure. Clearly the greater the success, the lower the number admitted to residential care (AO/C26 and AO/C27) but homecare re-ablement is merely one contributor to movements in this indicator.

### 19 Next Steps

1. Future development plans depend very much on the recommendations of the Strategic Review of Services for older people in Poole. We are also undergoing restructuring after the merger of Bournemouth and Poole PCTs on 1 October 2006. The new Bournemouth and Poole PCT will be making a bid for capital money from ‘Our health, our care, our community’. This will be centred on the vision of a centre of excellence for rehabilitation and

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86 Appendix: Woodlands Intermediate Care Unit Activity Data, April to October 2006
87 Appendix: Intensive Rehabilitation Homecare Service Specification: sections 12 and 14
more diagnostics and treatments available outside an acute setting.

A joint report is currently being undertaken by Poole Social Services, Poole Primary Care Trust, Dorset Healthcare NHS Trust, Poole Hospital NHS Trust and voluntary services which seeks to complete a strategic review of services to older people in Poole. This brings together all services, presents a gap analysis and makes recommendations on how the various services might work together. The outcome of this review will have an impact on the direction and inter-relationship of the Woodlands Community Team service.

<table>
<thead>
<tr>
<th>20 Tips for other Councils</th>
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</thead>
<tbody>
<tr>
<td>1. Be very clear on outcomes you want to achieve and how to measure them</td>
</tr>
<tr>
<td>2. Decide how the service will fit into current care pathways within the community and acute settings: apply FACS criteria as people leave the service not as they join it</td>
</tr>
<tr>
<td>3. Consider which skill mix is best: therapists v carers</td>
</tr>
<tr>
<td>4. Consider how you will sell / explain what re-ablement is about: need to agree definitions</td>
</tr>
<tr>
<td>5. Medication management is critical to a successful homecare re-ablement service: unless a user’s medication is consistently under control they will not be able to benefit from input by therapy, nursing or homecare staff.</td>
</tr>
</tbody>
</table>
Salford

HOMECARE RE-ABLEMENT: CASE STUDY

Intermediate Home Support Service

1 Summary

| Overall summary of the scheme, stage of development and outline timeline to complete implementation | The Intermediate Home Support Service helps Salford residents who need support with every day living to enable them to have a better quality of life and to continue to live independently in their own homes. The emphasis of their work is to enable people to maximise and maintain their independence.

The service supports people with:

- personal care such as washing, dressing, continence promotion, getting in and out of bed
- cooking, preparing meals and helping to eat
- building confidence and continuing supportive programmes
- identifying what longer term care and support is needed
- shopping, pension collection, laundry and other household tasks

The service also provides a short term assessment role to identify any on-going needs and how they can best be met. |

2 Council profile

| Brief description of council | The authority has a population of 216,103 (2001 census) with 35,120 (16.3%) aged over 65 years and 3,936 (1.8%) aged over 85 years.

The authority's latest CPA score is 3 star

The Social Services directorate are currently rated as a 3 star service.

The authority commissions approximately 14,740 hours of care per week with external providers and, |

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88 Appendix A: Intermediate Home Support Service, Statement of Purpose
89 2001 census: national average aged over 65 = 15.9%
90 2001 census: national average aged over 85 = 1.9%
addition, the IHS team are commissioned to provide approximately 4,000 hours per week. The authority currently serves those with moderate needs and above.

<table>
<thead>
<tr>
<th>3</th>
<th>Background to development of homecare re-ablement service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The decision to reshape the service arose from a coming together of like minds from within the Council and local Health Trust, and was at a time when both the Council and government thinking was following the Promoting Independence theme.91</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4</th>
<th>Implementation stages and timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline of stages and timeline to develop and implement service</td>
<td>Salford adopted a staged approach to the establishment of the Intermediate Home Support service. 92</td>
</tr>
</tbody>
</table>

Stage 1
2000 – service users receiving domestic care services from in-house teams were transferred to an out-house provider (Manchester Care), thereby freeing up resources through early and voluntary retirement packages. No new referrals for domestic care were accepted by the in-house team.

Stage 2

Nov 2003 – IHS established and so all service users with a mixed package (in-house and external providers) of long-term home care transferred to external providers. No new referrals for long-term home care packages were accepted by the in-house team.

June 2004 – Evaluation of new service completed

Stage 3
Oct 2005 – transfer of all remaining 160 service users with the in-house long-term care teams to external providers completed

<table>
<thead>
<tr>
<th>5</th>
<th>Conducting the pilot</th>
</tr>
</thead>
</table>
| Outline of approach to pilot if run | At an early stage a Project Group was formed to ensure that all interested parties were involved in the

---

91 Appendix B : Development in the In-house Home Support Service, Briefing Note – May 2005, Background section
92 Appendix B : Development in the In-house Home Support Service, Briefing Note – May 2005
Care Service Efficiency Delivery:  
supporting sustainable transformation

creation of the new service. This was chaired by an Assistant Director and so decisions could be made on a timely basis rather than being referred, resulting in delays. This was particularly important because as the service evolved it needed to be able to adapt at short notice.

The IHS started with a limited service but across the whole City. Initially referrals were only taken from the intermediate care service and hospital discharges against specific criteria. The team were separated from the in-house home care service and consisted of 2 managers, 3 seniors and two teams of home support workers.

This approach enabled the authority to use the process as a learning experience and refine arrangements and protocols.

<table>
<thead>
<tr>
<th>6</th>
<th>Nature of current service</th>
</tr>
</thead>
</table>
| **Description of service** | The current service operates 7 days a week, 7am to 10pm and referrals are made upon completion of the authority's FACS criteria. It is intended that it operate as an intake service for all aged over 18 yrs unless it is clear needs have been assessed as not appropriate for either the enablement or the assessment part of the service. Examples of where this service is not appropriate are:

1. it is assessed that continuity of care by the same agency is the best way of meeting needs.
2. an appropriate care plan is already in existence but was 'disrupted' by a short admission to hospital, etc. and there has been no change in needs or how those needs can best be met.
3. the service user is terminally illness and continuity of care is required over what is expected to be a short period.

In addition, current capacity problems within the IHS team mean that some service users who meet the re-enablement criteria are diverted to external providers and so the assessment only function has been applied for these service users.

The service is not subject to a charge93, following which the service user is either re-abled to a point  

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93 Appendix A: Intermediate Home Support Service, Statement of Purpose
where they do not require an ongoing care package or their care is transferred to an approved external care provider.

A separate rapid response team operate under the Intermediate Care service and respond to urgent needs. Service users’ needs are stabilised and often passed over to the IHS team within 24 hours.

### Structure of service

#### Description of operational structure

The IHS team operate as part of Integrated Services (Older People) service.  

### Monitoring the service

#### Description of how service monitored

Following receipt of a referral from the social work team, an assessment is completed by a Home Support Manager who determines what care will be provided and discussed with the potential service user who is required to agree any proposed plan of care. At that time a guide is passed to the service user. It is stressed that the service is for up to 6 weeks, and so some service users will leave the service before then.

A Senior Home Support Worker completes a first visit and then once a week to review the care planned and adapt if required the care for the next week.

The Manager and Seniors meet weekly to discuss and review progress.

During week 5, or earlier if appropriate, the Senior and social worker meet and discuss with the service user and any family the proposed discharge and any required ongoing care package.

### Stakeholder Management – Council Staff (Members, Officers, Staff)

Significant efforts were made to engage staff prior to and throughout the transition of the in-house service.

Negotiations were held with staff to create a flexible workforce that could support the change in role and enable the service to match the peaks and troughs in times when service is required. Some staff who did not feel comfortable with the role of becoming an enabler rather than a carer were offered options of

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94 Appendix D : [Intermediate Home Support Organisational Chart](#)
95 Appendix E : [Evaluation of the Intermediate Home Support Service, Appendix 1: Referral, Assessment and Implementation Process](#) – see Appendix 1
96 Appendix F : [Intermediate Home Support Service, Service User Guide](#)
97 Appendix G : [Intermediate Home Support, Guidance for Social Workers](#)
redeployment within the organisation.

Joint training sessions were held with social workers based in the local health trusts to gain early understanding and co-operation and this has been supported by guidance for social workers.97

10 Stakeholder Management – Service Users

The authority spent a considerable amount of time managing the service users through the transfer of domestic and long-term care packages and the transition to a re-ablement service.

All existing users were contacted and this was followed up by a re-assessment of their care plans by a social worker. This in itself gave rise to reductions in care plans that were to be passed to the external providers and the process was well received by service users. Many compliments and very few complaints were received about the change in role.

A Care Finders Team was formed to manage and place care contracts for the first phase when in-house domestic services were outsourced. A dedicated team was then formed to manage the placing of home care contracts.

11 Stakeholder Management – External Providers

Work was undertaken with external providers to ensure that adequate capacity was available. Arrangements were made through the Care Finder Teams for service users to be supported by in-house teams until external providers were able to take over individual cases, thereby encouraging co-operation and ensuring that service users achieved a smooth transfer.

Providers were zoned to ease coverage and became Neighbourhood Providers.

12 Implementation through External Providers

Description of approach

The re-ablement service is provided solely by an in-house team.

13 Stakeholder Management - Commissioners

The service has a strong relationship with the commissioners and this was assisted by their membership of the original Project Group.

They are authorised to provide service by the commissioners and it is for the team to determine the size of the initial re-ablement package and to reduce or increase it as their work progresses and the user
<table>
<thead>
<tr>
<th>14</th>
<th>Training</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description of training e.g.</strong></td>
<td>All new members of the team undergo basic training to enable them to acquire the skills to perform the role. This includes induction, health and safety, first aid, food hygiene, medication monitoring, customer care and safeguarding adults.</td>
</tr>
<tr>
<td>nature and form of training</td>
<td>The target qualification is NVQ L2 with additional elements to cover topics including health and safety and promoting independence. A significant proportion of the team have acquired this qualification and some of the seniors either have achieved, or are working towards, NVQ L3.</td>
</tr>
<tr>
<td>who (including numbers) and by whom</td>
<td>Some of the managers are qualified to NVQ L4 whilst the Team manager is qualified to NVQ L5.</td>
</tr>
<tr>
<td>timeline to training</td>
<td>The Council leads on a Training Partnership with external providers and courses are open to staff from both in-house and external providers.</td>
</tr>
<tr>
<td>cost of training</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>15</th>
<th>Benefits - financial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline of the benefits</td>
<td>Prior to roll out of the third phase, the Council undertook an evaluation of the service. This related to 163 referrals received during the period November 2003 to May 2004.</td>
</tr>
<tr>
<td></td>
<td>The evaluation considered the source of 159 referrals, tracked how many from each were delivered with a re-ablement service (136) and the reasons why 23 did not receive a service. It also showed that the IHS service enabled:</td>
</tr>
<tr>
<td></td>
<td>• 61% to require no ongoing care package, and</td>
</tr>
<tr>
<td></td>
<td>• 31% to require a reduced care package</td>
</tr>
<tr>
<td></td>
<td>The study assumes that without a re-ablement approach service users would have continued to be provided with a care package equivalent to that of their first week. This indicates that the overall reduction in care packages equated to a reduction of 1,038 hours (80%) across 129 service users.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>16</th>
<th>Benefits – quality and satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline of benefits</td>
<td>Questionnaires are used to capture comments of</td>
</tr>
</tbody>
</table>

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98 Appendix A : [Statement of Purpose: Staff Qualifications section](#)
100 Appendix H : [Summary of Reduction in Care Packages and Hours.](#)
service users and these are summarised for internal distribution twice a year.

Return rates for the latest reported period were 24% and most responses show a ‘very good’ or very well’ rating.\(^{101}\)

### 19 Next Steps

The service is still evolving and work is planned to:

1. develop the reporting systems
2. consider completion of a further evaluation study
3. review staffing structures and refine them to better match demand
4. consider the adoption of electronic monitoring as part of a wider initiative so that data can be more easily and accurately captured.

### 20 Tips for other Councils

Based on their experience, a number of items require early consideration:

1. the early establishment of a Project Group that can make decisions is critical to ensure a timely and responsive implementation
2. ensure that key managers within teams are ‘on-board’ with the proposals because you will need their enthusiasm and commitment
3. ensure that SW commissioners are ‘on-board’ with both the change in role and the need for the service to be able to set the care plan
4. be prepared to be flexible and willing to adapt or change if original plans do not work
5. consultations with staff are critical but often take longer than one first allows in the implementation plan and so should not be underestimated
6. the establishment of a dedicated Care Finders Team was very beneficial and ensured a smooth transition of service users by a team that created a very good understanding of providers and their capabilities.
7. a change in the role of the in-house team to one of re-ablement will bring with it significant changes for admin staff so plan ahead
8. the service requires a greater degree of flexibility of staff: some may prefer to complete all negotiations and arrangements before embarking on the change but this is likely to

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\(^{101}\) Appendix I: Intermediate Home Support Questionnaire Results May 2006.
| | create significant delays to implementation, the release of capacity and the generation of benefits for service users and the Council. |
Wirral

HOMECARE RE-ABLEMENT: CASE STUDY

Wirral Enablement Discharge Service (WEDS)

<table>
<thead>
<tr>
<th>1 Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall summary of the scheme, stage of development and outline timeline to complete implementation</td>
</tr>
<tr>
<td>The Wirral Enablement Discharge Service (WEDS) represents a partnership between the Metropolitan Borough of Wirral and Wirral Hospital Trust to provide an enablement service to local residents who have been in receipt of in-patient health care. The service was established in 2003 and a pilot study was run between 1st November 2003 and 31st March 2004</td>
</tr>
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<table>
<thead>
<tr>
<th>2 Council profile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief description of council</td>
</tr>
<tr>
<td>The authority has a population of 312,000 (2001 census) with 57,000 (18.1%) 102 aged over 65 years and 7,000 (2.2%) 103 aged over 85 years.</td>
</tr>
<tr>
<td>The authority’s latest CPA score is 2 star</td>
</tr>
<tr>
<td>The LA is a 2 star Authority under the new CPA Harder Test</td>
</tr>
<tr>
<td>Last year, CSCI rated the old combined Social Services Department as 1 star but the judgement they gave Adult Services was “meeting most people’s needs and with promising prospects” That judgement would give Adult Social Services a separate rating of 2 stars.</td>
</tr>
<tr>
<td>The authority commissions approximately 21,600 hours of care per week of which 80% is placed with external providers. Thus, the In House team provides approximately 4,000 hours per week which includes the hours provided by the WEDS team. The WEDS team are able to deliver up to 400 hours per week of enabler time (including travel and training hours) but where these hours cannot be used for re-ablement they are redistributed to the patch teams to avoid the use of additional hours or overtime. In 2005 – 2006 there were 7,158 enabler contact hours delivered to 239 service users</td>
</tr>
</tbody>
</table>

102 2001 census: national average aged over 65 = 15.9%
103 2001 census: national average aged over 85 = 1.9%
<table>
<thead>
<tr>
<th></th>
<th>WEDS FULL YEAR DATA</th>
</tr>
</thead>
<tbody>
<tr>
<td>No of referrals accepted</td>
<td>185</td>
</tr>
<tr>
<td>Ave hrs per SU</td>
<td>36.5</td>
</tr>
<tr>
<td>Ave length of intervention</td>
<td>3.8 wks</td>
</tr>
<tr>
<td>The authority currently serves those with substantial needs and above.</td>
<td></td>
</tr>
</tbody>
</table>

3 **Background to development of homecare re-ablement service**

The service evolved from the local Occupational Therapy Supported Discharge Service and was formed through joint working between the Council’s homecare team and the local OT service.

It became clear that many of the users were common to both services and, to an extent, their approaches were counter productive with home care ‘supporting’ users whilst the therapy service was seeking to ‘enable’ users.

4 **Implementation stages and timeline**

<table>
<thead>
<tr>
<th>Outline of stages and timeline to develop and implement service</th>
<th>June 2003 - Started formal discussions with Wirral Hospital Trust OT</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>End of July 2003 - Commenced preparation for service including discussions with HR and Trade Union (Unison)</td>
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<tr>
<td></td>
<td>September 2003- Recruited staff by ring fencing posts to carers already within the Service. Negotiation with Care Management colleagues with regard to dedicated social work support to service.</td>
</tr>
<tr>
<td></td>
<td>October 2003 - Staff training and protocols developed along with documentation to support service provision. Hospital OT’s briefed in relation to criteria for referral and aims of the service</td>
</tr>
<tr>
<td></td>
<td>Nov 2003 to March 2004 - ran pilot phase</td>
</tr>
<tr>
<td></td>
<td>July 2004 - Committee Paper asked Social and Health Select Committee to support the continuation of the service and established WEDS as a ‘core’ service</td>
</tr>
</tbody>
</table>

5 **Conducting the pilot**

<table>
<thead>
<tr>
<th>Outline of approach to pilot</th>
<th>During the pilot phase, the service only received</th>
</tr>
</thead>
</table>
patients from the Department of Medicine for the Elderly, with referrals being made by the ward based OTs. Care packages were prepared by the ward OTs and so allowed for a continuation of the patient’s rehabilitation within their own home.

Patients were selected for referral to the WEDS service to ensure maximum benefit was achieved from the service.

WEDS were part of the first wave of the Accelerated Development Programme in partnership with the PCT and hospital trusts and sponsored by the Changing Workforce Programme, which was part of the Modernisation Agency. This helped the service to develop the roles and ways of working for social care staff, to move from being ‘carers’ to become ‘enablers’.

Staff were recruited to WEDS from the existing homecare teams via an interview and selection process. Two days of training, linked to NVQ standards, were facilitated by the OTs to provide the staff with the skills and confidence to deliver an enabling service.

Dedicated Social Work support was an integral part of the team and this ensured speedy access to assessments so that a clear exit route from the service was established and maintained. In summer of 2005 dedicated Social Work support was withdrawn due to reorganisation of services. This has had an impact on the time taken to discharge service users from WEDS and the service is now exploring the use of the single assessment process to allow the OT’s to be able to assess for and commission any ongoing packages of care which may be required.

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104 Appendix : Wirral Enablement Discharge Service Selection Criteria and Guidelines
Outcome measures were used to evaluate the project 105 and these show clear benefits for the patients and the Council in terms of reducing the ongoing level of care package required. The average duration of a service user’s enablement programme was 3.5 weeks with an average of 45 hours of enabler time. The average number of enabler hours has subsequently reduced (see section 2 above).

### 6 Nature of current service

#### Description of service

The service operates across the whole of the authority and only works with patients discharged from hospital. The approximate capacity of WEDS is 250 referrals per annum.

The enablement service is provided for up to 6 weeks at no charge. If a patient is referred from one of the residential intermediate care centres then their period of admission is taken to be part of the 6 week service for the purposes of charging.

Since the pilot phase:
- the service now accepts appropriate referrals aged >19 years (previously >65 years).
- the dedicated social worker input to WEDS was removed as part of a reorganisation within Council and the service now need to access SW for assessments.
- OT input has increased and there were some changes to the number of enablers.

### 7 Structure of service

#### Description of operational structure

Referrals are submitted 106 by the ward based OTs to the WEDS OTs. The WEDS Organisers check availability / capacity within the team, following which the ward OT completes the discharge arrangements 107. On arrival home, the user is assessed by a WEDS OT and an enablement plan is created 108.

Typical activities include:
- Personal care practice including bathing and showering
- Mobility practice around the home including stairs

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105 Appendix : WEDS Results of Pilot  
106 Appendix : WEDS Telephone Pre-referral form  
107 Appendix : Wirral Enablement Discharge Service Referral form  
108 Appendix : Wirral Enablement Discharge Service Patient Aims and Plan
<table>
<thead>
<tr>
<th><strong>8 Monitoring the service</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description of how service monitored</strong></td>
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<td></td>
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<table>
<thead>
<tr>
<th><strong>9 Stakeholder Management – Council Staff (Members, Officers, Staff)</strong></th>
</tr>
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<tbody>
<tr>
<td>Initially Trade Union representatives were involved in relation to recruitment and training issues. There were no TUPE issues as the Home Carers remained employed by the LA and the OT’s by the Acute Trust.</td>
</tr>
<tr>
<td>In the summer of 2005 the WEDS occupational therapists moved from their hospital base to join the Home Care Team in their central locality office. Initially there were some professional concerns from OT staff about moving from their hospital base but generally the move was embraced with much enthusiasm on both sides. There was an initial and unexpected problem of poorer communication between team members as a result of the move. This was identified as partly being due to the team falling into less formal communication patterns and an encouragement to return to more formal team meetings and contacts helped to improve the situation.</td>
</tr>
<tr>
<td>Integration of IT systems so that OT staff could pick up their email from health was achieved after minimal problems. The redrawing of professional boundaries is a source of constant debate and will as the nature of the work that the team is undertaking presents new challenges. An example is the agreement that, where appropriate, the OT’s could undertake responsibility for implementing risk assessment paperwork on behalf of the Home Care</td>
</tr>
</tbody>
</table>

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109 Appendix: WEDS Service Accountability and Responsibility
110 Appendix: WEDS OT ASSISTANT TASK LIST
service at the start of a care package. This has meant that both the Organiser and the OT do not have to visit prior to start of service as either can carry out the risk assessments as required by the Home Care registration standards.

Management was established via a Steering Group which includes users of the service and the Joint Commissioning Manager for the Older People and Physical Disabilities Division. The service has also been under the direction of the Intermediate Care Strategy Group which includes senior managers from health.

A Partnership SLA between The LA Home Care Service and Wirral Hospital Trust OT Department has been used to agree staffing levels of partner agencies and areas of responsibility and accountability within the service.

<table>
<thead>
<tr>
<th></th>
<th>Stakeholder Management – Service Users</th>
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<tbody>
<tr>
<td></td>
<td>The Steering Group includes previous users of the service.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Stakeholder Management – External Providers</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Implementation through External Providers</th>
</tr>
</thead>
</table>

| Description of approach | The enablement service is provided by a partnership team between the Metropolitan Borough of Wirral and Wirral Hospital Trust and so external providers are only commissioned to provide ongoing care packages. |

<table>
<thead>
<tr>
<th></th>
<th>Stakeholder Management – Commissioners</th>
</tr>
</thead>
</table>

|   | The Joint Commissioning Manager has been involved in the management of the service and during the production of the Service Level Agreements |

<table>
<thead>
<tr>
<th></th>
<th>Training</th>
</tr>
</thead>
</table>

| Description of training | New enablers undergo an initial one day of training which covers background to WEDS and the different approach for ‘enablers’, use of equipment, report writing, use of aids, etc. A certificate is awarded upon completion of the one day and a written record of competency, linked to relevant NVQ’s, and based on that for OTAs, is maintained. The target qualification is NVQ L2 with additional competency modules in manual handling, health and |

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111 Appendix: WEDS Enabler Certificate
112 Appendix: WEDS Record of Competency for Enablers
### 15 Benefits - financial

**Outline of the benefits**

The service undertook a formal evaluation based on 49 referrals during its pilot phase and this showed significant benefits in terms of the re-ablement of users and a reduction in the level and number of ongoing care plans. For instance, based on 46 of the cases, it was estimated that the saving to Social Care, if one assumes that any care plan would have lasted for at least sixteen weeks, was £60k and after including the OT costs to health partners, this was still £58k. (No longitudinal study has been conducted to establish the true duration of benefit but local knowledge suggested that sixteen weeks was a conservative estimate: the true benefits could be higher than estimated) In addition, the decision to allow direct referral to the service by the ward OTs was estimated to have saved the local hospital trust 64 bed days.

The service continues to monitor its performance on a monthly basis and these show that approximately 80% do not need an ongoing care package.114

One of the statistics of interest to the team is the number of users that cancel or withdraw from WEDS. Although not high in number, they often indicate that the selection criteria have not been applied correctly or that the user has not truly agreed with the concept of enablement. These cases are ‘expensive’ in terms of resource because of the upfront investment in the referral, scheduling and WEDS OT assessment stages.

### 16 Benefits – quality and satisfaction

**Outline of benefits**

During the pilot phase a survey was conducted to ascertain the views of the users 115.

The service continues to collect the views of users through a follow up telephone call and the use of a simple questionnaire that is completed 6 weeks after the user has left the service. 116 The latest results for the period Jan to July 2006 show significant levels of satisfaction based on A response rate of 72%

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113 Appendix : WEDS Results of Pilot
114 Appendix : WEDS Patient Outcomes January to July 2006
<table>
<thead>
<tr>
<th>17</th>
<th>Trace of improvements to PAF Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Impact of Homecare Re-enablement on Performance Assessment Framework indicators</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>18</th>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Consideration is underway for WEDS to take other appropriate hospital discharges. Since the pilot phase, the service has already extended beyond those &gt;65 yrs being discharged from hospital. In addition, the service is planning a pilot to extend the service so that it will also take ‘referrals’ from within the community</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>19</th>
<th>Tips for other Councils</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6. Important to establish a staged implementation rather than adopt a ‘big bang’ approach since this allows evolution and ‘safe’ testing of development of the service</td>
</tr>
<tr>
<td></td>
<td>7. Some carers are unable to adapt and are not suitable to the role of an enabler and so careful recruitment is essential</td>
</tr>
<tr>
<td></td>
<td>8. The service requires very clear documented criteria and an exit strategy for users to prevent a bottle neck</td>
</tr>
<tr>
<td></td>
<td>9. Clear communication of the philosophy of enablement to patients and their carers\textsuperscript{117}, staff and all those connected to the service\textsuperscript{118}</td>
</tr>
<tr>
<td></td>
<td>10. Within the criteria, the service needs to be flexible so that it can trial changes and evolve. e.g. accepting younger adults onto WEDS</td>
</tr>
<tr>
<td></td>
<td>11. Clarity of roles is important, albeit that these will evolve, especially where different professionals are involved within a team so that there is clear accountability e.g. between health and social care</td>
</tr>
</tbody>
</table>

\textsuperscript{115} Appendix : WEDS Presentation  
\textsuperscript{116} Appendix : WEDS User Questionnaire  
\textsuperscript{117} Appendix : WEDS Information for Patients and Carers leaflet  
\textsuperscript{118} Appendix : WEDS – Your Questions Answered – A guide for OTs
2 Additional Information

In addition to the case studies contained within the previous section, valuable information has been received from a variety of other schemes. These have not been the subject of a specific visit and the documents are not, generally, as comprehensive as a case study. However, they provide a wider example base and, in some cases, focus on particular aspects. To access these documents – refer to [http://www.csed.csip.org.uk/our-work/workstreams/homecare-reablement/discussion-document/documents/references.html](http://www.csed.csip.org.uk/our-work/workstreams/homecare-reablement/discussion-document/documents/references.html).

<table>
<thead>
<tr>
<th>Additional Sites</th>
<th>Type of Scheme</th>
<th>Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birmingham City Council</td>
<td>Intake</td>
<td>• Evaluation of the Independence at Home Service – Executive Summary</td>
</tr>
<tr>
<td>Bradford Council</td>
<td></td>
<td>• Report on the future role and configuration of Home Care Provider Services</td>
</tr>
<tr>
<td>Dorset County Council</td>
<td>Hospital admission avoidance pilot</td>
<td>• Emergency Admission Pilot report</td>
</tr>
<tr>
<td>Dudley Metropolitan Council</td>
<td>Intake</td>
<td>• Summary of Activity 2005-2006</td>
</tr>
<tr>
<td>South Gloucestershire</td>
<td></td>
<td>• Home Care Service Development Project Report (version 3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• START Information leaflet</td>
</tr>
<tr>
<td>Halton Borough Council</td>
<td>Domiciliary Care Services within overall service</td>
<td>• Intermediate Care Services Evaluation report 2004-2005</td>
</tr>
<tr>
<td>Leicester City Council</td>
<td>Intake</td>
<td>• Overview of the Intake Service</td>
</tr>
<tr>
<td>NE Lincolnshire Council</td>
<td>Intake</td>
<td>• The START Service – 6 months on.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• January 2006.</td>
</tr>
<tr>
<td>Newcastle City Council</td>
<td>Community service</td>
<td>• Short Term Assessment and Rehabilitation Service Pilot May 2006 – October 2006</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Project Organisation Structure</td>
</tr>
<tr>
<td></td>
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<td>• Referral Process</td>
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<tr>
<td></td>
<td></td>
<td>• Users Leaflet</td>
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<tr>
<td></td>
<td></td>
<td>• STAR Training Programme</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Service User Consultation questionnaire</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Illustration of Projected Costs and Savings</td>
</tr>
<tr>
<td>Staffordshire</td>
<td></td>
<td>• East Staffs Re-ablement Team</td>
</tr>
<tr>
<td>County Council</td>
<td>Presentation</td>
<td></td>
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<tr>
<td>--------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Sunderland City Council</td>
<td>● Performance and Management Information Summary; Qtr 3 2003/04</td>
<td></td>
</tr>
<tr>
<td>Westminster City Council</td>
<td>● Abridged Case Study</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Monthly monitoring report of External Provider</td>
<td></td>
</tr>
</tbody>
</table>
3. **CSED Survey and CSSR responses**

A simple questionnaire\(^{119}\) was sent to all councils to help us establish
- the number of homecare re-ablement schemes in existence
- whether they had been evaluated
- the level of interest in the proposed work by CSED
- details of any councils that had considered homecare re-ablement but decided not to adopt it, and their reasons why.

Responses have been received from 98 councils and a number were kind enough to share further information.

### 3.1 Responses

The following table is based on extracts from the council responses received, categorised as follows:

- Those who have a service in place and have not stated that they are currently seeking to change or extend
- Those who have a service and have stated that they are currently planning to change it in some way
- Those who are currently establishing a service albeit that this represents those at various stages in this process
- Those who would like to introduce a service but have yet to start

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\(^{119}\) Appendix: [CSED Homecare Re-ablement Questionnaire](#)
### 3.1.1 Service in place

<table>
<thead>
<tr>
<th>CSSR</th>
<th>Current Service</th>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cheshire</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. The scheme of Home Care Re-ablement in East Cheshire is jointly funded by the County Council &amp; Eastern Cheshire PCT. Staff are employed &amp; managed within the Home Care service, but are a separate team, working specifically with Intermediate Care clients.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Workers support older people in their own homes or in a residential setting, by assisting with personal care tasks and by rehabilitation practice. There is guidance and support from professional staff, so that people can improve confidence and relearn skills such as getting dressed and meal preparation.</td>
<td></td>
<td></td>
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<tr>
<td><strong>Doncaster</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Doncaster’s re-ablement team is an integrated health and social care team and does include care/intervention traditionally provided by home carers. The team also meet much of the definition being used by the Care Services Efficiency Delivery.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Currently considering ways of expanding our re-ablement service to incorporate more home care staff within the re-ablement model and would be keen to network/meet with other colleagues</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dudley</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>See Volume 2: Additional Information Section</td>
<td>1. Service in place.</td>
<td></td>
</tr>
</tbody>
</table>
### Ealing (London Borough of)
1. The In-house Homecare Service provides re-ablement care to service users who have been referred by care management teams. This service provides care for a period of 6 weeks, and then a review of the care package is carried out by care management to determine future care needs.
2. The Service is predominately targeted towards providing re-ablement care to service users from referrals from Active Rehabilitation and Intermediate Care Services (ARISE) and Community Mental Health Team (CMHT). Due to the complexity of needs of ARISE and CMHT clients it is common for the majority of packages of care to extend beyond 6 weeks.
3. The service has been in operation since January 2005.

### Greenwich (London Borough of)
1. Re-organising our in house Homecare service based on our re-ablement model
2. The Greenwich Intermediate Care at Home team has been operational for over 2 years and has achieved significant reductions in levels of care for those Service Users who have benefited from the service.
3. The team was developed using staff from the in-house Homecare service, through the NHS modernisation, workforce development and role redesign initiative, training care workers in therapy and healthcare tasks.

### Hackney (London Borough of)
1. The team has been running for about 10 years. Originally, its remit was to support people
leaving hospital with potential to make substantial improvements within 6 weeks with the support of Rehabilitation Care Workers.

2. Three years ago the team added an Occupational Therapist and an OT Assistant to the establishment to increase the rehab focus – develop more detailed rehab plans and support the manual handling challenges of complex care needs in the community.

3. Currently working to benchmark our data against a similar service.

<table>
<thead>
<tr>
<th>Halton</th>
</tr>
</thead>
<tbody>
<tr>
<td>See Volume 2: Additional Information Section</td>
</tr>
<tr>
<td>1. Evaluated internally</td>
</tr>
<tr>
<td>2. Have the following re-ablement services attached to an MDT within intermediate care services, providing intensive re-ablement</td>
</tr>
<tr>
<td>• in-house home care service incorporating crisis intervention</td>
</tr>
<tr>
<td>• extra care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Herefordshire</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. STARRS has been operational since September 2004. Prior to this, Herefordshire Council ran a Re-ablement Service which consisted of a Residential Unit called Homeward Bound and attached to this was a small domiciliary outreach service. This ran from March 1999 until October 2003 when it transferred in Partnership with the PCT to the Hillside Intermediate Care and Outreach service.</td>
</tr>
<tr>
<td>2. Hold a database for all service users of STARRS, which details service provision at the beginning of the service and at the end of our involvement, stating either the ongoing care required or whether the service user is</td>
</tr>
</tbody>
</table>
### Care Service Efficiency Delivery: 
supporting sustainable transformation

<table>
<thead>
<tr>
<th><strong>Hounslow</strong> (London Borough of)</th>
<th><strong>Islington</strong> (London Borough of)</th>
</tr>
</thead>
</table>
| 1. Expanding our in-house “Assessment and Re-ablement” Service so that during 2007 all new cases (including younger disabled people) receive the optimum type and level of service.  
2. Limited evaluation to date has been encouraging, indicating modest purchasing budget savings and increased independence. | 1. Evaluation of outcomes for small sample group of people who had an enabling home care service |

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5. The STARRS team consist of five teams covering the whole of the County. Each team consists of two Senior Support Assistants and four Support Assistants most of whom were Homecare Assistants prior to their appointment. We also have one full time Occupational Therapist working with the team and are looking for resources to add a Physio Therapist to the team.

6. STARRS is the only in-house domiciliary service remaining in Herefordshire Council.
<table>
<thead>
<tr>
<th>Royal Borough of Kensington &amp; Chelsea</th>
<th>1. Scheme currently undergoing evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Kent</strong></td>
<td>1. Kent Home Care Service [in-house provider of Kent County Council] has been developing re-ablement services over the past 3 years.</td>
</tr>
<tr>
<td></td>
<td>2. In the West Kent area of our county we are working with Health in the delivery of a Recuperative Care Scheme which also involves the input of therapists. This scheme is currently being evaluated.</td>
</tr>
<tr>
<td></td>
<td>3. Throughout the county we run Active Care services which do not have therapy input. These schemes are regarded as intermediate care and can last for up to six weeks. They take hospital discharge, hospital avoidance at A&amp;E and new referrals from the community.</td>
</tr>
<tr>
<td></td>
<td>4. The aim of the Active Care service is to enable the recipient to become as independent as possible by regaining their confidence in their every day skills of self-caring. Approximately 60% of the service users do not require any on-going care package at the end of the intervention. For the people who does need an on-going care package in most cases this has reduced by a significant amount of time per week.</td>
</tr>
<tr>
<td></td>
<td>5. We have statistics over the past three years showing the inputs and outcomes for the people who have been on the scheme, which we are willing to share with you.</td>
</tr>
<tr>
<td><strong>Kirklees Metropolitan Council</strong></td>
<td>1. Scheme operated for approx. 4 years but not formally evaluated</td>
</tr>
<tr>
<td>Region</td>
<td>Details</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Leicestershire County Council</td>
<td>1. Scheme operated since early 2000. Evaluated by De Montfort University</td>
</tr>
<tr>
<td>Luton</td>
<td>1. Scheme operating</td>
</tr>
<tr>
<td>Middlesbrough</td>
<td>1. Scheme operating</td>
</tr>
</tbody>
</table>
| Northamptonshire            | 1. Currently reconfiguring our service to ensure that all new service users are put through a re-enablement programme prior to commencement of any ongoing services.
2. It is vital to prevent the culture of dependency on services and it links well with the long-term conditions NSF and the community matrons. The health link with emphasis on the promotion of independence is key. |
| North Yorkshire             | 1. In house provision of personal care at home (County Care Services)                                                                         |
| Oxfordshire                 | 1. Scheme in operation                                                                                                                                 |
| Peterborough                | 1. Service is quite diverse. We do offer enablement to all our service users, and staff are trained to do this enabling work however small.
2. Also provide service to people who are the most difficult to care for and include in their care enabling tactics, so as not to disable any of our services users where possible. |
| Poole (Borough of)          | 1. Winner of Queen Mother Award for Intermediate                                                                                           |
### Care Service Efficiency Delivery: supporting sustainable transformation

<table>
<thead>
<tr>
<th>Location</th>
<th>Case Study Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poole Primary Care Trust</td>
<td>Jointly commissioned service with Poole Primary Care Trust – rehabilitation home care service specialist block contract with independent provider.</td>
</tr>
</tbody>
</table>
| Rotherham | 1. The homecare re-ablement service in Rotherham is called Community Rehabilitation Team (CRT). It comprises of a team of Occupational and Physio Therapists and homecare enablers.  
2. Currently in the process of evaluating the service as part of our 3 year intermediate care strategy |
| Salford | 1. Intermediate Home Support team established |
| Sefton | 1. Re-enablement Service has recently undergone a service review and is under consideration for transfer to a Social Enterprise Company. |
| Shropshire | 1. START service in operation. |
| Southampton | 1. Scheme in operation |
| Southend | 1. The Collaborative Care Team provide intensive rehabilitation at home to promote optimum independence, with the outcome to enable people to remain in their own homes and prevent long term admission to residential care.  
2. Team supported by an occupational therapist and a physiotherapist with nursing input from a community matron and assessment nurse. The nursing input is in the process of being increased due to the complexities of some of the patient groups.  
3. Working closely with the intermediate care teams and the Cumberlege Intermediate Care |
<table>
<thead>
<tr>
<th>Location</th>
<th>Description</th>
<th>1. Wish to undertake an evaluation</th>
</tr>
</thead>
</table>
| South Gloucestershire     | 1. Scheme in operation called Short Term Assurance & Recuperation Team (START)  
2. Evaluated internally |                                                                                                                                                |                                    |
| Suffolk County Council    | 1. HOMEFIRST scheme has been running for about a year now. The focus is on re-ablement with the first 12 weeks of the re-ablement service being delivered by the in-house domiciliary care service. After then the care is provided by independent providers.  
2. Scheme has been successful in terms of helping people to reach and maximise their potential.  
3. Philosophy meets the County Council’s aim of assessing the long-term needs of customers. |                                    |
| North Staffordshire:      | 1. Have a range of re-ablement services both in the home and in other settings to enable holistic multi disciplinary assessments to take place and we find the outcomes are excellent. Some of our schemes have been in use for six years with others developing on an incremental basis.  
2. As well as the re-ablement at home schemes and residential re-ablement unit we have a scheme which looks at the needs of people with dementia type illnesses who are usually excluded from any type of re-abling type services. Assistive technology is used significantly with re-ablement service users therefore reducing dependency even further on traditional type services. We would welcome |

Centre (residential), the team have enabled a reduction in home care packages that would have been provided by the independent sector.
any opportunity to share best practice and evidence based outcomes.

South East Staffordshire
3. Worked hard to develop an inclusive, flexible and responsive team that does not discriminate on age or condition. If it is appropriate and we can make a difference and we are the most appropriate service we will respond.
4. Service picks up many people who have fallen through the net due to having multiple issues/pathology and therefore may have entered one service at the expense of gaining access to another. Been able to catch them or minimize this happening because the service is generic and diverse.
5. As a Re-ablement team, covering across the two localities of Lichfield and Tamworth, currently provide a generic service to all adult age groups and specialisms including mental health, as appropriate to their needs.
6. Have achieved strong integrated working partnerships with Health; already have joint funding and pooled budgets.
7. Generic services include:
   • Active, intensive therapy led Re-ablement intervention
   • Equipment and minor adaptations, (which has included re-site tracking hoists where appropriate)
   • Integrated pathways for smooth transition between Re-ablement therapists and
community/hospital outpatients therapy services

- Hospital discharge, - local integrated discharge pathway, ward attached OT and SW, designated team member on weekly MDM for both Lichfield and Tamworth hospitals, we also respond to county and out of county hospitals
- Therapy support to the step down nursing beds
- Therapy managed Re-ablement/intermediate care beds jointly worked with hospital team
- Intensive integrated intervention to give a whole system approach to people with multi pathology, which is the majority of older people with complex needs, for example OT, SW, Physio, mental health nurse, team attached home care manager and Re-ablement assistants
- Complex Assessment
- Carers Assessment
- EMI stay home scheme and support for people with MH - we have developed integrated working with CPN teams and the local psychiatric hospital and will have direct access to the CPNs and Consultant Psychiatrist.
- Integrated service working with Rapid Response providing a priority 1 response with OT and SW attached with immediate access to Re-ablement intervention or a mainstream enablement care package, and equipment as appropriate.
- Integrated Night Support Service Re-ablement and Rapid Response which has been jointly developed to cover social care, therapy and low level nursing support and can be accessed by any social services or health professional -
Care Service Efficiency Delivery: supporting sustainable transformation

(through this service we have developed a generic worker role, have an agreed job description and validated joint training programme, ADP)

- Long-term Conditions - Partnerships with specialist nurses in particular to support people with chronic neurological conditions.
- Joint Review system with the above to prevent further loss of independence, slow down or manage deterioration
- Work closely with the independent and particularly the voluntary sector to find innovative ways to support peoples (day care) needs (Brokerage in its infancy?)
- Assistive Technology smart house and training/awareness sessions, (currently developing partnership working with health, district housing, voluntary agencies and the fire service to promote wellbeing equipment)
- Fast, direct response to Home care managers for OT and Physio input to avert a crisis and the necessity for a referral to the area team

<table>
<thead>
<tr>
<th>Stoke on Trent</th>
<th>Telford</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Rehabilitation service currently being evaluated</td>
<td>1. 4 years ago we considered whether to retain an in-house Home Care service, given that all residential and day care provision for older people had been externalised.</td>
</tr>
<tr>
<td>2. Benchmarking other authorities at present around good practice</td>
<td></td>
</tr>
</tbody>
</table>
2. Concluded that we would retain the service, but reduce it in size and differentiate it to provide short-term interventions only on a rapid response basis in an emergency; as a rehabilitation and enablement support service to our multi-disciplinary joint intermediate care service and as a contributing part of the social care assessment of needs - enabling service users to reach their full potential with daily living tasks.

3. Transferred the remaining long-term clients to independent providers and commenced re-skilling the workforce. This was achieved on target and our registered home care provider now focuses on rapid response and support to Intermediate Care. The Co-ordinators of the Home Care service are an integral part of the multi-disciplinary Intermediate Care Team, run in partnership with T&W PCT.

4. The development of this service has certainly been one of the factors that have helped us improve significantly, our performance around admissions to residential/nursing home care, helping people to live at home and delayed discharges.

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**Wakefield**

1. Started React 3 years ago to facilitate hospital discharge (in line with re-imbursement). Initially we just supported the hospital but soon developed into an Intake Team for all requests for domiciliary care. Take referrals from all service areas.
2. We are a six week assessment team working alongside Care Management to stabilise packages of care and to encourage services users to their optimum level of ability. Once we have achieved this we then have a reduced package of care which will be passed onto a long-term provider, a discharge from the service entirely or the service user goes onto a long-term provider with a tailor made package of care to suit their needs even if it is still a large package.

3. The service is staffed by Wakefield employees and an Occupational Therapist attached to the Team and managed and funded by social care, with supervision by Health’s OT manager for professional development.

4. 2 teams based East and West of the district; the West is co-located with Health and a social work Team, so there is a lot of joint working.

5. The OT has only been with the service since May 2006 but training has started on enabling skills. When the service first started it had an OT and Physio to train staff but the service has grown and more staff have joined who need further training.

<table>
<thead>
<tr>
<th>Westminster City Council</th>
<th>1. This service was originally an in-house specialist team. The whole in house home care service was transferred to Housing 21 in 2001.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. The specialist teams work closely with care management and with the rehab teams.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Wokingham</th>
<th>1. Scheme in operation</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Worcestershire</th>
<th>1. Scheme in operation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. No formal evaluation has been completed.</td>
</tr>
</tbody>
</table>
### Care Service Efficiency Delivery: supporting sustainable transformation

| 3. Use results from the standardised outcome measure that demonstrate that service users have an increased level of functional performance as well as satisfaction levels |

### 3.1.2 Service in place but seeking to extend / expand / amend

| Birmingham  | 1. In view of Birmingham’s size, it has recently been working in four geographical areas. This has meant that some work has been undertaken around home care re-ablement but it is not universal.  
2. The OT service ran a successful pilot scheme for some years called Independence @Home which was not a multi-disciplinary venture as such but provided low-level support to help reduce the final package of care. This has been evaluated by the University of Birmingham and has useful user profiles in it.  
3. The use of home care re-ablement sits within the framework of Re-ablement which is the business transformation model that Birmingham is using to change its service |
| Blackburn with Darwen | 1. Blackburn with Darwen Social Services Department does provide some input around re-ablement. Primarily this is in relation to hospital discharge and intermediate care. |

| 1. Have looked particularly at the model Shropshire use and are modelling our process around their structure. Work under way to have this live by February 2007 and includes the use of OTs in setting up the rehab package. |

| 1. Interested in re-patterning the larger mainstream in-house homecare service around the principles of time-limited re-ablement.  
2. Early work is looking at the potential models for delivery and the |
### Blackpool

1. This forms a very small part of in-house home care and is part of our wider intermediate care service that includes two resource centres [ARC and Hoyle] and Vitaline which is our assistive technology service. The service is also offered for 10 days to prevent delayed discharges from hospital, this is classed as interim care.
2. Have full multi disciplinary team meetings twice a week to go through referrals and ensure that the individual is directed to the correct service i.e. home care, a six week assessment in the resource centre and always linked with what technology could support the person at home.
3. A number of the staff have been trained as generic workers with health and can also provide some low level nursing care such as skin care, simple dressings and blood sugar monitoring. It is further hoped to expand this training.

### Bolton

1. Scheme partly in operation
2. Short-term assessment and support team currently undergoing a review.
3. All referrals/requests for domiciliary support for Older Adults are supported by this team who evaluate how needs can be best met – then commissioned from Ind. Agency.
4. Currently in house service with no PCT input.

1. Hope to expand the service to provide shorter six week assessments.
| Bournemouth Borough Council | 1. Community and Rehabilitation Team (CART) jointly funded with PCT.  
2. Operates as a multi-disciplinary team of rehabilitation assistants, OTs and Physiotherapists who provide up to 6 weeks rehabilitation in people’s own homes.  
3. Team currently attached to surgeries in the east of the Borough, but we are working hard with our PCT partners to expand the service across the north and west of the Borough in the coming year. | 1. Also looking to expand service further and to develop slow stream rehabilitation on an outreach basis. This will deliver rehabilitation for periods that may be longer than 6 weeks and will also build in programs to re-visit service users as ongoing maintenance / prevention.  
2. This is building on rehabilitation work that is conducted on a daily basis in the day centre that specialises in people with physical / mobility issues and will enable this work to also be conducted in a person’s own home. |
| Bradford | 1. Scheme currently operates through two ‘home care enablement teams’ with limited capacity within 2 of our 4 current PCT areas | 1. Considering establishment of an intake / re-ablement function. |
| City of York | 1. Small service which meets approximately 30% of our referrals provided by the independent sector.  
2. Customers access the service for a maximum 6 weeks for re-ablement etc before moving onto other long-term services if appropriate. The basis will be the same with all new referrals accessing the service for a period of up to 6 weeks. | 1. Establishing a re-ablement service for all new referrals and provided by the in-house service. |
| Coventry | 1. Scheme running but looking to extend and establish concept across the council |  |
| Croydon | 1. Formerly used in-house service to provide a Re-ablement service that was not only very successful but also commissioned follow up | 1. About to market test to purchase the service in the Independent Sector. The in-house service has now been closed |
| **Enfield** (London Borough of) | 1. Pilot Home Care Re-Enablement Service (which we called a First Response Team) within the In-House Home Care Service ran from December 2005 for approximately 6 months.  
2. Pilot operated in half of the Borough and involved all new potentially long term Home Care referrals, whether from hospital or the community, going to the First Response Team for an initial 4-6 week period prior to being transferred to the independent sector or for long term care by the In-House service.  
3. Pilot evaluation showed there was no difference, i.e. savings could not be demonstrated by the Rapid Response Team and therefore it was disbanded. | 1. Consideration is being given to setting up another Re-ablement team, but this time to include an Occupational Therapist. It is also being considered whether the team would be better provided as part of our Intermediate Care Service rather than the In-House Home Care Service.  
2. The Intermediate Care Team (social services element) provides a short-term rehabilitative service for individuals leaving hospital who have been assessed as having rehabilitation potential. (The service is about to extend to also take referrals from the community) |
| --- | --- | --- |
| **Leicester City** | 1. Two services – a full model Intermediate care home care service (ICIS) and a home care ‘Intake Service’.  
2. The former provides a 6 week in-home period of | Currently exploring how to enhance the Intake service, e.g. with broader multi-disciplinary input, to further increase its re-ablement function and efficiency. |

|  | 1. research to test the outcome a year later.  
2. Trained all our staff including managers and that training document is still valid.  
3. At its peak, 70% of service users received no service after 6 weeks or very much reduced from the level at the start of the care period.  
4. Re-ablement does work but have serious doubts about it working with In House Services unless there is flexibility in a rolling shift system such as that in Greenwich and Enfield | because of its inefficiency. |
rehab, with therapy. The latter is purely social care and deals with new packages of care, providing a focus on rehab and promotion of independence to reduce packages over a 6 week period prior to longer term commissioning of services for an individual.

**Milton Keynes**
See volume 2: Case Study

1. Rehabilitation home care service in operation
2. All service users receive this service for the first six weeks. Service starts same day as referral.
3. Service is all in house but integrated into intermediate care service with PCT.
4. After 6 weeks those who need long term home care get in-house or external. If external, care is arranged with independent providers though one point in contracts.
5. We strongly believe in rehabilitation/ re-ablement and having a longer assessment process than just a one off social work visit. We believe that our service has both helped people to become more independent at home quicker and controlled out long-term home care expenditure. The service has also impacted on hospital admission avoidance where we have a very low rate of GP referral to hospital and where attendance at A & E are growing at only 1% a year (less than the population growth). So the service fits with the White Paper aim of services closer to home and can save money in the health economy as well as in local authority.

**North East Lincolnshire**
See Volume 2: Additional Information Section

1. Internal home care team initiated a pilot short term & re-ablement team approx 8 months ago.
2. Team made up of Home Care Assistants

1. Intention to expand the team by including the Intermediate Care Team based in a residential setting
supervised by a Senior Care Officer. There has been no real therapy input or involvement from Health.

3. The results from the pilot have been encouraging in terms of reducing dependency amongst older people using this service.

| Nottinghamshire | 1. The role of part of the in-house home care service has been changing over the past three to four years to focus on the first 6/8 weeks of service, with a key aspect of the ‘Initial Response Service’ being the re-ablement of service users who have experienced a recent deterioration in their ability to care for themselves.  
2. It has been found that with some intensive, skilled support, the level of care package needed could reduce significantly or even cease to be required at all. | 1. The in-house service sole role will be the provision of service for the first 6/8 weeks, focusing on the continuation of the initial assessment and re-enablement. |

| Richmond (London Borough of) | 1. Service is integrated with the PCT as part of a multidisciplinary Intermediate Care Service, including access to 10 beds in total.  
2. Service takes both hospital discharge and community referrals, with eligibility criteria based on prospects for rehabilitation and need for a multidisciplinary service. |  |

<p>| Sheffield | 1. Sheffield developed its re-ablement service in December 1997 and has continued to increase resources into this service from that time. | 1. The strategy for the in-house service is to reconfigure resources, currently in ongoing home care, into the re-ablement service. It is Sheffield’s intention that all new service users and those existing service users who... |</p>
<table>
<thead>
<tr>
<th>Council</th>
<th>Details</th>
<th>Notes</th>
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<tbody>
<tr>
<td><strong>Solihull</strong></td>
<td>1. Currently this is a very small service which operates within our Intermediate Care service – it has not been evaluated</td>
<td>1. We are very keen to move to a more “mainstream” approach – making a re-ablement service available to all our customers unless there is a reason not to.  2. We are keen to link up with other authorities who may have introduced such a service or are at the same stage as ourselves.</td>
</tr>
<tr>
<td><strong>Surrey County Council</strong></td>
<td>1. Currently have a range of services across different areas of the County. These include both stand alone and joint services with health</td>
<td>1. Currently reviewing range of schemes with a view to adopting consistent approach</td>
</tr>
<tr>
<td><strong>Sutton</strong></td>
<td>1. Scheme supports hospital discharges</td>
<td>1. Interested in expanding the specialist service to deliver efficiencies across the whole system; not just supporting hospital discharge.</td>
</tr>
<tr>
<td><strong>Walsall</strong></td>
<td>1. Scheme in operation.  2. Small scale evaluation completed</td>
<td></td>
</tr>
<tr>
<td><strong>Warrington</strong></td>
<td>See Volume 2: Additional Information Section 1. Currently scheme focuses on supporting hospital discharges</td>
<td>1. Seeking to extend scheme to encompass community intake</td>
</tr>
<tr>
<td><strong>Warwickshire</strong></td>
<td>1. Small pilot scheme in operation  2. Offers 6 weeks at direction of SW / OT</td>
<td>1. Homecare re-ablement not evaluated yet</td>
</tr>
<tr>
<td>Wigan</td>
<td>Wirral</td>
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| 3. Have hospital discharge scheme covering ¼ county taking referrals from acute hospital and ICT  
4. Fast response team aimed at preventing admissions to residential care or hospital | 1. Piloted an “in-take” service in one particular location. |
| 1. Seeking to refine and extend the scheme – particularly to all hospital discharges. | |
| **See Volume 2: Case Study** | 1. Established a re-enablement team in 2002 as a partnership service between Wirral Acute Hospital Trust and the in-house home care service.  
2. Home Care worker roles within the service were developed as part of the Accelerated Development Programme run by the DoH.  
3. The cost benefits of the service have been able to be demonstrated using a comparative model the cost of the care package that would have been put in place at the point of hospital discharge if the service had not been available.  
4. Efficacy of the project has been reported in a variety of formats  
5. Service been able to demonstrate significant reductions in care package costs and also good user outcomes and high levels of service user satisfaction. | 1. Currently the service is small and is only able to deal with approximately 250 referrals per year from hospital.  
2. Proposals for expansion to take all suitable hospital discharges are currently being considered. |
### 3.1.3 Establishing a Service (various stages)

<table>
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<th>Borough</th>
<th>Details</th>
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| **Barnet**       | 1. We do not currently have a home care enablement service but we are in the process of setting one up.  
                      2. Expect to have tenders shortly and pilot a scheme for 6 months starting October 2006.                                                                 |
| **Barnsley**     | 1. Service established June 2006 and operated by in-house service  
                      2. Anticipate service will evolve up to 1,000 care hours per week and link to intermediate care and OT teams in health through PCT  
                      3. Main focus will be through older people including those with dementia and mental health needs.                                    |
| **Hampshire**    | 1. We are in the process of moving the home care service into a short term re-ablement service.  
                      2. Specific re-ablement training programmes are commencing in November ’06 and all team leaders have been trained in assessment and reviewing skills. |
| **Harrow**       | 1. Scheme in pilot form  
                      2. To date more 30 people have been through the pilot, which started early last summer (2006) with some good results (nearly 50% no longer needed care after a short period)  
                      3. Currently it is linked closely to Intermediate care and Hospital Discharge                                                                 |
<p>| <strong>Hertfordshire</strong>| 1. We are currently rolling out an enablement scheme with 4 early adopter Home Care                                                                                                      |</p>
<table>
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<tr>
<th>Agency</th>
<th>Details</th>
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<tbody>
<tr>
<td>Hull</td>
<td>1. Hull CC is in the process of merging the in-house homecare service (that is currently around 20%) with the intermediate health care team which is currently purely health.</td>
</tr>
<tr>
<td>Lancashire</td>
<td>1. In the process of establishing an in-house homecare re-ablement scheme that will operate as an intake function for all Older People’s service requests</td>
</tr>
<tr>
<td>Newcastle</td>
<td>1. Scheme currently in pilot phase in a specific area of the city. 2. The pilot is to last until October when it will be thoroughly evaluated to assess if we will roll out to the rest of the city.</td>
</tr>
<tr>
<td>Sunderland</td>
<td>1. Scheme is currently in pilot stage. 2. Evaluation will be completed in April 2007</td>
</tr>
<tr>
<td>Wandsworth</td>
<td>1. Pilot commenced Apr 2006 for 12 months 2. Currently being evaluated</td>
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1. Anticipate further expansion will be focused on service users being discharged from acute hospital.
### 3.1.4 No scheme in place but wish to develop

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<thead>
<tr>
<th>Location</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Barking and Dagenham (London Borough of)</td>
<td>1. No scheme</td>
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<tr>
<td>Bracknell-Forest Borough Council</td>
<td>1. No scheme</td>
</tr>
<tr>
<td>Bury Metropolitan Council</td>
<td>1. Concentrated on rapid response &amp; step down intermediate care to date.</td>
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<tr>
<td>City of London</td>
<td>1. No scheme</td>
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<tr>
<td>Cornwall</td>
<td>1. No scheme</td>
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<tr>
<td>Darlington</td>
<td>1. No scheme</td>
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</table>
| Dorset                                | 1. Dorset County Council has recently produced a strategy for domiciliary care in which it set out a number of options for future delivery. These options were appraised by the Institute for Public Care (IPC) at the request of Dorset County Council. The recommendations confirmed that Dorset County Council would move to developing a re-ablement domiciliary care service amongst other changes.  
2. Subject to Cabinet Decision  
3. Subject to Cabinet Decision                                                                 |
| Gateshead                             | 1. Currently in the process of devising Promoting Independence Teams, the focus of which is re-ablement and                             |
promoting independence in the service users home. This has been part of a wider move to involve independent providers through a tendering process for hours to be given to them on a regular basis so that we can restructure our current service.

2. The structure we are moving to will provide short-term intervention and a filtering of all cases initially. We will have our promoting independence teams to cover the whole of Gateshead as well as long-term teams who will be looking to take long-term cases, which will specialise in the types of cases taken.

3. Typically, cases will be complex in nature – dementia cases, moving and handling issues as well as others. We are aiming to provide a service that will be flexible and provide a swift response where needed i.e. hospital discharges.

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<thead>
<tr>
<th></th>
<th>1. No scheme</th>
<th>1. Although we do not have a re-enablement team for Home Care, we have been running an Outreach Team for Older People with Mental Health Problems for a number for</th>
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<tbody>
<tr>
<td>Gloucestershire</td>
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<tr>
<td>Havering (London Borough of)</td>
<td>1. No scheme</td>
<td></td>
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<tr>
<td>Isle Of Wight</td>
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<tr>
<td>Kingston (Royal Borough of)</td>
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1. Currently modernising in-house home care services, and are considering the use of them as primarily a short term service, and years. This team provides flexible, responsive and concentrated needs led service, which is short term, usually up to 3 months to individuals who have failed to engage or maintain a relationship with mainstream services.

2. The aim of the service is to develop a clear understanding of the person, their potential for improvement, their existing support network, the risks they are subject to, their wishes and those of their carers. The team provide concentrated support to the service user, short term to enable mainstream services to be established. They work within clearly defined and agreed objectives and review at agreed regular intervals with the care manager on the progress.

3. In the new year we will be developing our existing Hospital Discharge Team as an intake team taking on all new service users for a fixed short term period before transferring to long term services if required.

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### Leeds

1. In the process to run some action learning schemes to identify what the benefits of a re-ablement service are and what capacity is required to run such service for in-house & independent sector providers and how it should interface with other services like rapid response, intermediate care and long term maintenance home care.

2. New contracts with independent providers already take into account these developments.

### Lewisham

1. Currently looking at modernising the in-house home care service and re-ablement could be a part of the modernisation process

### Lincolnshire

1. Currently implementing a plan to modernise our In-House Service. Part of that service will be Re-ablement Service as defined in the preamble to this document.

### Manchester

1. No scheme

### Medway

1. No scheme

### Newham (London Borough of)

1. No scheme. However there is a joint PCT and Council funded service, wholly managed by PCT. Previously there were 2 separate services.

2. At present, we are concentrating on:
<table>
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<tr>
<th>Norfolk County Council</th>
<th>North Tyneside</th>
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<tr>
<td><strong>1.</strong> Norfolk County Council Adult Social Services department is currently remodelling the homecare service. The model of care outlines two services, one a short term assessment and re-ablement service and the other a continuing support service for those people assessed as having longer term care needs.</td>
<td><strong>1.</strong> North Tyneside is undertaking a modernisation</td>
</tr>
<tr>
<td><strong>2.</strong> Re-ablement is the key element in the short term service and NCC service proposal fits well within the CSED definition.</td>
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- implementation of: Safer Care Safer Working (“SCSW”) – electronically recording domiciliary care sessions and alerting if critical visits are missed. This includes checking the integrity of Care First and Care Time data. We will be implementing project in stages and there is expectation to create a Rapid Response Team to manage critical alerts.

- recruitment of new Home Support Care Workers

- recruitment of Trainee Home Support Care Workers; joint scheme with Newham Hospital Trust PCT

- recruitment of new Home Support Assistants with revised Job Descriptions.

- Taking over medication Level 1 and 2 from District Nursing Teams

- Redefining In House Home Support Service in light of national developments; internal restructuring with PCT and working partnerships
programme of Adult Services. The internal home care service is part of this programme and we are currently working with independent providers to offer a mixed economy of care within the Borough.

2. For some time now we have used our Intermediate Care at Home Team to offer a multi-disciplinary assessment of need prior to a home care package being offered. We have been successful with this approach and we will be developing a re-ablement team as we modernise the home care service.

3. Timely intervention provided in the person’s own home has proven that the individual is more likely to improve their functional ability with the support of a generic support worker and to regain independence and motivation.

4. We have used this team to facilitate discharge from hospital and to prevent unnecessary admission to hospital and long term care.

| Portsmouth | 1. Decided to modernise in-house home care using this as a major part of model |
| Reading    | 1. No scheme |
| Sandwell   | 1. Embarking on a modernisation programme for homecare which includes increasing our modest fast responses service and introducing a 6 week service which will focus on re-ablement. |
| Solihull   | 1. Wishing to establish a service |
| North Somerset | 1. Currently actively considering introducing such a service and would be very grateful for any evidence available re the effectiveness of such services around the country. |
| Swindon        | 1. No scheme |
| Waltham Forest | 1. No scheme |