LEICESTERSHIRE COUNTY COUNCIL

EXTERNAL EVALUATION
OF THE HOME CARE REABLEMENT
PILOT PROJECT

CENTRE FOR GROUP CARE AND
COMMUNITY CARE STUDIES

DE MONTFORT UNIVERSITY
LEICESTERSHIRE COUNTY COUNCIL

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Julie Kent
Chris Payne
Marcia Stewart
Judith Unell

Centre for Group Care and Community Care Studies
De Montfort University
Scraptoft Campus
Leicester
LE7 9SU
Tel: 0116 257 7864
Fax: 0116 257 7806
Email: jkent@dmu.ac.uk
http://www.dmu.ac.uk
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Summary

1) The Centre for Group Care and Community Care Studies, De Montfort University, is undertaking an evaluation of three 'Promoting Independence' pilot projects. This report concerns the first of the three projects, the Home Care Reablement Team.

2) The aim of our research is to evaluate the extent to which the Home Care Reablement Team achieved its aims in terms of enabling people to achieve their maximum level of independence and thereby remain in their own homes within the community. To achieve this we have undertaken

   • A statistical analysis of the numbers of service users who have returned to live at home / remained living at home / been provided with a residential or nursing home placement and a comparison with a matched group of service users who have not participated in the project.

   • A qualitative analysis of the project that included audits of the pilot scheme's structure, inputs, processes and outputs.

   • A comparison of how the experience of the pilot project compares with projects elsewhere in the UK.

3) The early months of the three pilot projects have not been without their problems, in particular a very slow rate of referrals from commissioners and, in the spring of 2000, a period of industrial action by the Department's care staff in its residential and home care services. This has presented some difficulties for the research team in that we have not completed the research in the time span we had anticipated. We are still completing interviews with service users.

4) The Government has embarked upon a programme of rapid and radical change in the social policy arena. Ideas about best practice in community care are being re-drawn. A key part of the Government's agenda is enabling people to remain living in their own homes. We suggest that distinguishing between the aims of prevention, reablement and rehabilitation is helpful in learning from many exciting projects across the country.

5) Our work for local authorities across England confirms that the practical implications include a move towards less rigid commissioning / provider splits, more resources for low level preventative services, the re-introduction of holistic assessments and the clear evaluation of service outcomes.

6) The statistical analysis of service users who have been provided with a service from the Home Care Reablement Team and a comparison with a matched group of service users who have not participated in the project indicates the following

   • Overall very few services users of the Home Care Reablement Team or in the matched group were admitted to hospital, nursing or residential homes during the time span under examination.

   • Larger packages of Home Care were initially commissioned for service users of the Home Care Reablement Team than their counterparts in the matched group.
• Home Care packages for the Reablement Team's service users were far more likely to be discontinued at first review compared to the matched group of service users. (62% of packages compared to 5%).

• Home Care packages for the Reablement Team's service users were twice as likely to be decreased at first review compared to the matched group of service users. (28% of packages compared to 13%).

• Correspondingly Home Care packages for the Reablement Team's service users were far less likely to be increased at first review compared to the matched group of service users. (2% compared to 11%)

• Home Care packages for the Reablement Team's service users were far less likely to be maintained at their existing levels at first review compared to the matched group of service users. (10% compared to 71%)

7. When the reduction / discontinuation of home care services at 1st Review is taken as the measure, the Home Care Reablement Team has been very successful in enabling service users to achieve their maximum level of independence.

8. The qualitative analysis confirms that the pilot scheme is distinctively different from 'traditional' home care schemes both in terms of its underpinning principles and in the way these are put into practice. The feedback from commissioners on the quality of the Scheme has been very positive. This confirms our own observations.

9. We make some recommendations for how the Scheme might be developed and for future areas of research. In summary there are strong grounds for extending the Home Care Reablement Team's model of home care delivery to other areas in Leicestershire. In particular we recommend Home Care Reablement Team(s) act as 'intake' teams for all home care referrals. Essential to the replication of the Scheme are (a) the close involvement and support of multi disciplinary colleagues with occupational therapy and physiotherapy backgrounds (b) training and development opportunities for home care staff.
1. Introduction – Our Research Brief and Methods

1.1 The Centre for Group Care and Community Care Studies:

The Centre for Group Care and Community Care Studies, De Montfort University, is undertaking an evaluation of three ‘Promoting Independence’ pilot projects for Leicestershire County Council Social Services Department. The Centre is part of the Faculty of Health and Community Studies and is a joint venture between the University and the National Institute for Social Work. Professor Chris Payne and Julie Kent co-direct the Centre. Julie is undertaking the research with Marcia Stewart, Principle Lecturer in Social Work, and Judith Unell, an independent researcher commissioned by the University.

1.2 The Three ‘Promoting Independence’ Pilot Projects

1.2.1 The three ‘Promoting Independence’ pilot projects are (i) in the Home Care Reablement Team in Melton (ii) the Specialist Home Care Team in Coalville (iii) two Residential Rehabilitation projects in Hadrian House Older People’s Home in Thurmaston and Harvey House Older people’s Home in Barwell.

1.2.2 All three pilot projects have a common aim of maximising and promoting independence albeit in different ways according to the user group and individual needs. The intention of the pilot projects is to enable people to remain living in their own homes as long as possible by providing intensive packages of support and rehabilitation. All pilot projects aim to help people to look after themselves rather than ‘do’ for them. The projects are currently all provided in-house by Leicestershire Social Services Department. We recognise that the projects are not directly comparable, though taken as a whole they should illuminate the wider implementation of community care policies by the Department.

1.2.3 The Social Services commissioned us to undertake the research in the autumn of 1999. At this point in time the three pilot projects were at different stages in their development. The Specialist Home Care Team had begun work and by November 1999 had worked with seven service users. The Home Care Reablement Project was just about to start and we were asked to delay the research until the beginning of 2000 to allow the team to ‘get going’. Of the two residential rehabilitation projects, Hadrian House had started its project in the spring of 1999 and Harvey House in the following autumn.

1.2.4 The research team has met regularly with two representatives of Social Services Department - Jane Dabrowska, Promoting Independence Co-ordinator at the beginning of the research and currently Service Manager (Home Care Services) and Julia Eames, Rehabilitation Co-ordinator. Rachel Eastwood, current Promoting Independence Co-ordinator has recently joined what is in effect a small steering group.

1.2.5 The early months of the three pilot projects have not been without their problems, in particular a very slow rate of referrals from commissioners and, in the spring of 2000, a period of industrial action by the Department’s care staff in its residential and home care services.

1.2.6 This has made the research process difficult for us. We have been evaluating the three pilot schemes very early in their genesis. There has inevitably been a degree of ‘sorting out’ of aims and purpose in the projects, so we often have not been able to compare ‘like with like’. The three pilot schemes have worked with very few service users, making it hazardous to generalise from the research findings. Finally all three pilots schemes were naturally keen to receive feedback from us in order to shape their development. The research team has had to resist the temptation to conduct action research where there has, for the majority of the research period, been little action, despite the best efforts of the projects.
1.2.6 Nonetheless the research has, from the research team's point of view, thrown up some interesting results. It is an appropriate time to outline what these are and to offer some possible interpretations and recommendations.

1.2.7 This report concerns the first of the three projects, the Home Care Reablement Team. Our reports on the Specialist Home Care Team and the two Residential Rehabilitation projects will follow in the autumn of 2000.

1.3 The Home Care Reablement Team Research

1.3.1 The aim of our research is to evaluate the extent to which the Home Care Reablement Team achieved its aims in terms of enabling people to achieve their maximum level of independence and thereby remain in their own homes within the community.

1.3.2 In particular we agreed to provide

a) A statistical analysis of the numbers of service users who have returned to live at home / remained living at home / been provided with a residential or nursing home placement and a comparison with a matched group of service users who have not participated in the project.

b) A qualitative analysis of the project that included audits of the pilot scheme's structure, inputs, processes and outputs.

c) An up-to-date comparison of how the experience of the pilot project compares with projects elsewhere in the UK.

1.4 The Statistical Analysis

1.4.1 To help us analyse information on service users referred to the Home Care Reablement Team, we gathered material from the team's own files on

- the age and gender of service users (ethnic origin was not recorded)
- the circumstances in the service users' lives which resulted in them being referred to the Home Care Reablement team as recorded by the commissioning worker
- which social work team made the referral to the Home Care Reablement team
- where the service user was living when the home care package was first reviewed
- the amount of home care time the service user received at the beginning of the involvement of the Home Care Reablement team
- the amount of home care time the service user received at the point of review when the Home Care Reablement team withdrew.

1.4.2 Identifying a matched group of service users proved difficult because the Home Care Reablement team changed its brief three times during the research period. We decided in light of our discussions with the Department that the best match possible for the purposes of the research was a group of service users who were

- referred for home care for the first time
- by commissioners in the social work teams in the north of the Department
- reviewed by the Department's Review Team around March 2000.

1.4.3 We outline in 4.2.4 below the similarities and differences in the two groups of service users and how this might inform interpretation of our findings.

1.4.4 Discussions with Linda Ruffle, Principal Officer, Management Information and Systems, and Anne Brown, Team Manager of the Review Team also helped us to clarify that the Department could not provide us with the statistical information in the form in which we
required it for the matched group of service users. We therefore extracted it ourselves from the service users' files held by the review team.

1.5 The Qualitative Analysis

1.5.1 We have completed part of the qualitative analysis by conducting the following activities:

- An analysis of the case files held by the Home Care Reablement team of 25 service users of the pilot project.
- Shadowing the home care team on visits to a representative sample of service users
- Attending a team meeting of the Home Care Reablement team
- Discussions with key people involved in the pilot including the Home Care Manager of the Reablement team, the Home Care Reablement team, two Commissioning Officers, and the Service Manager (Home Care).
- Interviewing a small sample of managers on the commissioning side of the Department.
- Issuing a questionnaire to commissioning teams in the Department and analysing the responses.

1.5.2 We are also in the process of interviewing a sample of service users of the Home Care Reablement team. We have piloted a questionnaire with three service users. We will be interviewing a representative sample of service users in August and early September 2000.
2. National Context – Community Care Transforming?

2.1 Rapid Changes in Social Policy

Since election in 1997 the Labour Government has embarked upon a programme of rapid and radical change in the social policy arena. Last year (1999) the National Institute for Social Work, for example, counted over 130 major policy initiatives that had implications for Social Services Departments. Many of the social policy initiatives have arisen as a result of perceived and recorded failings by those organisations in the education, health, housing and social care sectors charged with the responsibility for the commissioning and delivery of services.

2.2 Weaknesses in Community Care Services

The picture today is one of spiralling costs, a distorted care system and an avoidable loss of independence for many people. (Kings Fund 1999)

2.2.1 Reviews of community care services (see for example Department of Health 1998) have in general identified the following weaknesses:

- Assessment is focused on service users deficits rather than their strengths and capabilities
- Some areas of service users’ needs are routinely missed
- Assessments are service-led rather than needs led. In other words, service users are slotted into existing services, rather than services developed around identified needs.
- Service users’ views and carers’ views are ignored
- Services for ethnic minorities are poor
- There is poor monitoring of outcomes for service users – the quality of services may have been evaluated or inspected but not whether the services achieved the desired result for service users and carers. There is more emphasis on process than on outcomes.
- Recording is poor – for example the recording does not reflect service users ‘and carers’ views, or the reasons why decisions were made.
- Inability for sectors or organisations to work together for the benefit of service users
- Uneven development of links between care management and commissioning – lack of service development where there are gaps.
- Involvement of providers is unclear – providers can make valuable contributions to care management at a number of levels, for example feedback on the match between initial assessments by commissioners and the subsequent on-going assessments by providers.

2.2.2 The consequences from the Government’s point of view were, for example, that older people were kept in hospital for much longer than they needed to be. Appropriate services may have avoided admission in the first place. Contrary to the intention of the NHS and Community Care Act 1990, joint reviews by the Audit Commission and the King’s Fund found evidence in both health and social care services of deterioration in rehabilitation services, particularly those for older people. As a result there were fewer alternatives to longer stays in hospital, entry into residential care or nursing homes or complex packages of support at home. The result is what the Audit Commission described as a vicious circle – a distorted system of care, spiralling costs and inefficient use of scarce resources. (Audit Commission in Kings Fund 1999)
2.3 Prevention, Rehabilitation, Reablement and Promoting Independence

2.3.1 Prevention, rehabilitation, reablement and promoting independence are currently key words in community care and are often used interchangeably. However we think there is some merit in treating them as distinct concepts, if overlapping and to a degree contradictory, in order to help services define their aims and objectives. (Nocon and Baldwin 1998.)

<table>
<thead>
<tr>
<th>PREVENTION</th>
<th>REHABILITATION</th>
<th>REABLEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<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>
</tr>
</tbody>
</table>

Table One: Promoting Independence: Providing The Support Needed For People To Make The Most Of Their Own Capacity And Potential

2.3.2 Much of the rehabilitation literature focuses on issues relating to hospital discharge (Nocon and Baldwin 1998; Taraborelli et al 1998; Victoria Project 1998) and health service driven developments (NHS Executive 1998.) In these projects the importance of multi-disciplinary working and partnerships with social care is constantly emphasised. Yet at least until recently social services have not been regarded as innovators of such schemes, much of their work being implicit within their service delivery (Nocon and Baldwin 1998). Within social services there would seem to have been more emphasis placed on preventative aspects of community care and promoting independence as means of maintaining people, particularly those with dementia, in their own homes for as long as possible. (Bond 2000; Moriarty and Webb 2000).

2.3.3 The Government's national priorities and strategic objectives for local authorities, as expressed through the Performance Assessment Framework, clearly reflect combinations of rehabilitation, prevention and reablement. The Government is asking local authorities to take action that will, for example,

- improve arrangements for hospital discharge and community care
- increase the numbers of people being cared for in their own homes, rather than in residential care, by the provision of intensive home care
- prevent unplanned and avoidable admissions to hospital
- reduce inappropriate placements in residential and nursing homes

2.3.4 The key part of the Government's agenda is to enable people to remain living in their own homes. Similarly the intention is to move to a model of service assessment and delivery in which users are active and involved. As concepts, prevention, rehabilitation and reablement have some differences. Rehabilitation historically is an expert driven, medical model, often
with a focus on impairment and disability. The most desirable outcome is a return by the service user to good health. Promoting independence emphasises the service user as the expert and implicit in this is the social model of disability – services themselves may, if not carefully devised, disable service users.

Social services needs to move away from a culture of providing services which ‘do things for and to dependent people.’ Department of Health 1998

2.4 A New Approach to Community Care?

2.4.1 Promoting independence is part of a new approach to community care and it is a model many social care managers and practitioners welcome. We summarise below some elements of the ‘new’ and ‘old’ models of community care. New models of community care in our experience of helping local authorities to implement them require substantial shifts in policy, practice and value base.

<table>
<thead>
<tr>
<th>‘New’ Approaches to Community Care</th>
<th>‘Old’ Approaches to Community Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holistic, needs-led assessment. Services developed to meet assessed needs.</td>
<td>Administrative model of assessment – does service user meet eligibility criteria and if so what services are available.</td>
</tr>
<tr>
<td>A focus on services user’s strengths and abilities</td>
<td>A focus on service user’s weaknesses and deficits</td>
</tr>
<tr>
<td>Service user an active participant in assessment process – expert.</td>
<td>Service user may be consulted.</td>
</tr>
<tr>
<td>Care packages state required outcomes for service user and how the services commissioned will meet these. The outcomes can be measured.</td>
<td>Care packages state their general aims and the services to be commissioned.</td>
</tr>
</tbody>
</table>

Table Two: New and Old Approaches to Community Care

2.4.2 We are therefore in a period of rapid and constant change, where expectations of Social Services are acute and often contradictory. Rehabilitation and Reablement are two not wholly interchangeable concepts, as we will see in the remainder of this report.
3. **Prevention, Rehabilitation and Reablement Projects: Four Case Studies**

### 3.1 The Four Schemes

As part of our literature review projects in the UK, we identified projects that illustrate the three 'Promoting Independence' strands of reablement, rehabilitation and prevention. It is unfortunate that the Worcestershire scheme has 'reablement' in its title – we have firmly placed it in the rehabilitation category!

<table>
<thead>
<tr>
<th>The Home Care Reablement Team, Leicestershire</th>
<th>The Community Reablement Team, Worcestershire</th>
<th>Elderly Persons Integrated Care Scheme, Derby</th>
<th>SHARP, Sedgefield</th>
</tr>
</thead>
<tbody>
<tr>
<td>Predominantly Social Care Staff</td>
<td>A mix of Social Care, Occupational Therapy and Physiotherapy Staff</td>
<td>A one-stop care shop with a range of services and advice under one roof – home care, district nurse, community psychiatric nurse, social worker. Monthly surgeries by a pharmacist and weekly hearing aid service.</td>
<td>Led by a district nurse and by mobile wardens. Commissions home care, physiotherapy and occupational therapy.</td>
</tr>
<tr>
<td>Single agency</td>
<td>Single agency</td>
<td>Single Agency</td>
<td>Multi Agency</td>
</tr>
<tr>
<td>Time Limited – 6 weeks approximately. Referral on to other community care services where appropriate.</td>
<td>Time Limited – 12 weeks approximately. Referral on to other community care services where appropriate.</td>
<td>No time limit.</td>
<td>Time Limited – 7 days</td>
</tr>
<tr>
<td>Relies on referrals from commissioners – referrals originally were of service users about to be discharged from hospital and now also those living in the community for whom commissioners assess the Scheme to be appropriate. Experimenting with taking all referrals for home care in a specified geographical area.</td>
<td>Strict referral criteria – excludes service users where there is no possibility of rehabilitation or where services users have only short term, predictable needs. All other referrals for home care services come to the team.</td>
<td>All referrals made to a multi disciplinary care group that meets weekly.</td>
<td>Takes all emergencies. Refers on to the Social Services Department if services are required after 7 days.</td>
</tr>
<tr>
<td>Focus on Reablement</td>
<td>Focus on Rehabilitation</td>
<td>Focus on Prevention</td>
<td>Focus on Prevention</td>
</tr>
</tbody>
</table>

Table Three: Four Case Studies of Community Care Schemes with Rehabilitation, Reablement and Prevention Themes
3.2 The Home Care Reablement Team, Leicestershire

3.2.1 The Home Care Reablement Team, Leicestershire Social Services Department, the focus of this research, started in November 1999. The team currently consists of 6 home carers, 1 programmer, 1 senior home care assistant and a half time Home Care manager. The pilot also had a Commissioning Officer specifically identified to work with the team. This role is currently undertaken by the Rehabilitation Co-ordinator, a qualified Occupational Therapist. She plays a crucial role in commissioning services from the team, setting aims and objectives for care plans and reviewing progress.

3.2.2 The Home Care Reablement Team offers intensive packages of domiciliary care for between 4 - 6 weeks to service users in the Melton area. The aim is to work with service users to assist them re-gain their independence, in essence by re-learning daily living skills or by gaining new ones. Packages of home care are tightly focused and short term, service users moving to other forms / providers of care if further support is still required. This may be in-house or in the independent sector.

3.2.3 During the time of our research, we have calculated that the team has worked with 47 service users. Just over half (57%) of these were service users referred to the pilot on discharge from hospital and the remainder were identified as eligible for Home Care services whilst living in the community. The team originally focused specifically on those service users identified by commissioners as appropriate for the pilot project and either ready for discharge from hospital or living in the community. It is experimenting with a ‘Home Care Intake’ model, working with all referrals for Home Care in a specific geographical area.

3.3 The Community Reablement Team, Worcestershire

3.3.1 The Community Reablement Team offers a period of rehabilitation designed to help people recover their skills and confidence for living independently and to look at health need. The Scheme states in a leaflet for service users that “a short period of reablement can make all the difference and can help you remain at home.”

3.3.2 The Scheme is a short-term service and is intended to last for less than twelve weeks. The team consists of a team manager who also acts as the social worker for the team, an occupational therapist, two half time physiotherapists, a therapy assistant and six reablement assistants.

3.3.3 Initially the team took all referrals for South Worcestershire, but (as in Leicestershire) these were very slow. After a year, an analysis of referrals showed that there were three broad categories of referrals for the service

- referrals that were for short term help where an end date could be defined right at the beginning of the service;
- referrals for palliative care where service users had severe deteriorating neurological conditions or dementia and where care was likely to be long term;
- all the rest.

3.3.4 The Social services Department has now developed a set of procedures that in effect does not allow commissioners a choice of where to refer. The Reablement team works with all service users in the third category, “all the rest.”

3.3.5 Packages of care are written very tightly so that they cannot continue indefinitely. Reviewing officers visit to check the package is safe to withdraw. Reviewing officers are fully independent and are attached to the Reablement team. The Reviewing Officers in effect do an independent assessment of the service user’s needs. They are not given the information from previous assessments.
3.4 Arthur Neil House - Elderly Persons Integrated Care Scheme, Derby City

3.4.1 There are four Units in the Elderly Persons Integrated Care Scheme – three are already open and a forth, specifically for Derby’s black Asian community is about to open.

3.4.2 Arthur Neil House, the first Unit in the Scheme to open, aims to give regular access to a range of services to older people and their carers. The Scheme is open 24 hours a day, seven days a week. It brings together under one roof a range of social care and medical professionals previously scattered, for example home carers, district nurses, community psychiatric nurses, social workers, GPs, physiotherapists, occupational therapists, dentists, opticians, pharmacists, and dentists. Arthur Neil House also offers a welfare rights service database, a bathing service, a hearing aid service and a hairdressing salon. There are also some of the features of a traditional Older People's Home - a drop in centre, three short-term respite beds, two enhanced nursing care beds and twenty permanent residential beds. Service users can however access the Centre at a range of levels – for example drop in to have a cup of coffee or activate a night sitting service.

3.4.4 The scheme is located in the Social Services Department. Social Workers, GPs, district nurses, home carers and families make referrals. Service users have also referred themselves. All referrals go to a multi disciplinary core group – the manager of the Centre, home carers, district nurse, community psychiatric nurse and a service manager from Social Services - that meets once a week.

3.5 Sedgefield Home Assessment and Rapid Response Team

3.5.1 SHARP is a partnership between Social Services, the NHS Healthcare Trust, a Borough Council and a Primary Care Group. Home care is provided by six private sector care agencies on a rota basis. The SHARP service became operational in June 1999.

3.5.2 Sharp offers short term emergency services to older people in their own homes at times of crisis that requires previously unplanned care. Care managers, emergency duty teams, nurses and paramedics make referrals to a dedicated hotline number in a community care link service, a control room where wardens respond to anyone who has pressed their community alarm. During working hours the project co-ordinator, a district nurse, responds within an hour of receiving the referral. Out-of-hours a mobile warden visits to make an assessment and take appropriate action.

3.5.3 The service provides domiciliary care, physiotherapy and occupational therapy for a maximum seven days. SHARP is geared towards service users who do not need more than eight hours service a day but exceptionally 24-hour care can be give. If the situation is not resolved at the end of seven days or additional services are needed, a referral is made to Social Services. SHARP staff members have access to Social Services database. Everyone in the SHARP service follows agreed procedures and methodology, so care managers receive valuable information from different disciplines that can be used to devise strategies to enable people to remain living in the community. So while SHARP is providing the temporary care, assessment and planning is taking place to remove the risks that led to the crisis. In its first six months the SHARP worked with 57 clients.

3.5.6 SHARP states it is able to provide the right support at the right time and keep in the person in their own home.
3.6 Points of Similarity and Difference

3.6.1 The Home Care Reablement Team is unique in some ways. It emphasises the part social care can play in ‘Promoting Independence’, with home carers having crucial roles in their own right, rather than as assistants to other professional colleagues. The contribution of the Rehabilitation Co-ordinator, in her capacity as occupational therapist, should not be underestimated. Nonetheless, social care staff lead and deliver the Scheme.

3.6.2 The Home Care Reablement Team has established that the majority of service users have some capacity for reablement. As a result the Team sees itself as having a wide brief, rather than the more targeted approach of the Worcestershire project.

3.6.3 At this point in time, the Scheme cannot respond to emergency referrals made out-of-hours, although we understand this is under consideration.

3.6.4 The Home Care Reablement Team does not see itself as continuing to have a role for those service users whose capacity for reablement has been fully realised or for the small number of services user whom it identifies will continue to require a maintenance package for the foreseeable future.

3.6.5 It is logical therefore that the team sees its most useful contribution as the equivalent of a home care ‘intake’ team. Such a team would receive all referrals for home care and work with service users for a short, intensive period of time to help them learn or re-learn the skills for daily living.
4. A Statistical Analysis of the Home Care Reablement Project

4.1 The aim of the Statistical Analysis

We aimed to compare service users who have been provided with a service from the Home Care Reablement Team with a control group, in other words a matched group of service users who had not participated in the project. We wanted to identify whether receiving a service from the Home Care Reablement Team resulted in different outputs and outcomes for service users and if so, what these were.

4.2 Identifying the Control Group

4.2.1 Identifying a control group was more complex than we anticipated. The referral sources of the Home Care Reablement Team have changed twice in the relatively short period since the project began. As stated earlier, the team began by delivering packages commissioned by hospital social work teams. As a result of a slow rate of referrals in the early months, the team decided to accept packages of Home Care commissioned by locality-based social work teams. In the last few weeks the team has in addition taken all commissions of home care from one particular geographical area in the Vale of Belvoir.

4.2.2 In addition, we discovered in the course of our interviews with key people in the Department and in particular with Linda Ruffle, Principal Officer, Management Information and Systems, that the Local Authority did not collect data that was readily adaptable for our purposes.

4.2.3 After helpful discussions with Anne Brown, Team Manager of the Review Team, we chose as the control group:
- service users in the north of the County
- receiving home care services for the first time
- whose first review was held around the month of March 2000
- and whose home care package was reviewed by the Home Care Review Team.

4.2.4 This would enable us good access to reliable data through written information held in the Review Team’s case files. It would also yield similar numbers of service users albeit over different time spans.

<table>
<thead>
<tr>
<th>Service Users in Home Care Reablement Scheme</th>
<th>Service Users in the Matched Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Majority of Service Users new to Home Care Services</td>
<td>Majority of Service Users new to Home Care Services</td>
</tr>
<tr>
<td>Some cases open to the Access team or Adult Commissioning team - these likely to have been assessed as more complex.</td>
<td>All cases closed to the Access team or Adult Commissioning team – assessed as not complex.</td>
</tr>
<tr>
<td>Reviews carried out by the Commissioning worker, the Rehabilitation Co-ordinator.</td>
<td>Reviews carried out by the Review team.</td>
</tr>
<tr>
<td>All home care packages in-house</td>
<td>Home care packages delivered in-house and by independent sector organisations</td>
</tr>
<tr>
<td>Majority of service users identified by commissioners as appropriate for the Reablement Scheme.</td>
<td>Majority of service users not in the catchment area for the Reablement Team</td>
</tr>
</tbody>
</table>

Table Four: Comparison of Service Users in the Reablement Scheme and in the Matched Group
4.3 Composition of Service User Groups

At the time we were compiling the data there were forty-two services users who had gone through the Home Care Reablement Team. We compared these with 38 service users in the matched group. The table below gives basic information about numbers of service users in each group, the gender composition and average age of each service user group.

<table>
<thead>
<tr>
<th>Categories</th>
<th>Service Users in North Leicestershire Excluding the Reablement Team</th>
<th>Service Users of the Reablement Team</th>
<th>Service Users of the Reablement Team Roll-Out (ii)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Numbers of Service Users</td>
<td>38 (i)</td>
<td>42</td>
<td>12</td>
</tr>
<tr>
<td>Gender</td>
<td>63% Women 37% Men</td>
<td>69% Women 31% Men</td>
<td>50% Women 50% Men</td>
</tr>
<tr>
<td>Average Age of Service Users</td>
<td>82 yrs (Youngest 52 yrs Oldest 9 yrs)</td>
<td>78 yrs (oldest 95 yrs youngest 17 yrs)</td>
<td>76 yrs (oldest 90 yrs, youngest 58 yrs)</td>
</tr>
</tbody>
</table>

Table Five Composition of Service User Groups by Age and Gender

(i) The figures for the number of service users in North Leicestershire include four couples. We have counted these as eight people.

(ii) The roll-out is a further division of the Reablement Service Users and represents a group of service users where there was no pre-selection by commissioners.

4.4 Source of and Reasons for Referrals

4.4.1 We identified which social work teams commissioned packages of home care for the two cohorts of service users and the reasons given for service users' eligibility for services.

4.4.2 Referral patterns for the Reablement Team and the Roll-Out were broadly similar. It is not possible to draw any other direct comparisons from these figures.

<table>
<thead>
<tr>
<th>Categories</th>
<th>Service Users in North Leicestershire Excluding the Reablement Team</th>
<th>Service Users of the Reablement Team</th>
<th>Service Users of the Reablement Team Roll-Out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source of Referral</td>
<td>83% Access Teams 17% Hospital Social Work Teams</td>
<td>44% Access Team 32% Hospital Social Work Teams 22% Adult Commissioning Teams 2% Transition Team</td>
<td>50% Access Team 25% Hospital Social Work Teams 25% Adult Commissioning Teams</td>
</tr>
</tbody>
</table>

Table Six: Source of Referrals to the Two Groups of Service Users
4.4.3 Commissions of home care for people recently discharged from hospital were as likely to come from Access Teams and Adult Commissioning Teams as they were from Hospital Social Work Teams. We identified several pragmatic reasons for this, for example one small local hospital did not have a social work team, whilst another large hospital in a neighbouring city did not have mechanisms for making referrals to the Melton teams. Some referrals came from district nurses after service users had been discharged from hospital and were struggling to cope.

4.4.4 Eligibility for services was on the whole recorded in terms of ‘deficits’ rather than capacity for reablement. When looking at eligibility for services and commissioning of home care packages, we therefore identified whether the referrer recorded social care needs as a result of poor physical health, of poor mental health, or for carer support. In some case records, services users were assessed as having combinations of all three. The aim of the Home Care package was in the majority of cases expressed rather generally, for example “to enable the service user to continue living in the community”.

4.4.4 Commissioners appear less likely to commission the Home Care Reablement Team where service users have social care needs arising from poor mental health. This is worth further investigation. We suggest it is a pertinent illustration of our earlier debates about rehabilitation, prevention, and reablement. Commissioners may perceive service users with dementia, for example, as requiring long-term preventative services rather than short-term reablement.

<table>
<thead>
<tr>
<th>Categories</th>
<th>Service Users in North Leicestershire Excluding the Reablement Team</th>
<th>Service Users of the Reablement Team</th>
<th>Service Users of the Reablement Team Roll-Out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for Eligibility: Social Care Needs.</td>
<td>Social Care Needs as a Result of Poor Physical Health – 64% of reasons given.</td>
<td>Social Care Needs as a Result of Poor Physical Health - 67% of reasons given</td>
<td>Social Care Needs as a Result of Poor Physical Health - 58% of reasons given</td>
</tr>
<tr>
<td></td>
<td>Social Care Needs as a Result of Poor Mental Health – 27% of reasons given.</td>
<td>Social Care Needs as a Result of Poor Mental Health - 13% of reasons given</td>
<td>Social Care Needs as a Result of Poor Mental Health - 21% of reasons given</td>
</tr>
<tr>
<td></td>
<td>Carer Support – 9% of reasons given</td>
<td>Carer Support – 16% of reasons given</td>
<td>Carer Support – 21% of reasons given</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social Care Needs in relation to Non-direct care - 4% of reasons given</td>
<td></td>
</tr>
</tbody>
</table>

Table Seven: Service User Groups – Source of Referral and Social Care Needs
4.5 Numbers Of Service Users Who Were Living At Home at the Time of the First Review

<table>
<thead>
<tr>
<th></th>
<th>Service Users in North Leicestershire Excluding the Reablement Team</th>
<th>Service Users of the Reablement Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numbers of Service Users</td>
<td>38</td>
<td>42</td>
</tr>
<tr>
<td>Living at Home by Time of 1st Review</td>
<td>36 (95%)</td>
<td>36 (86%)</td>
</tr>
<tr>
<td>In Hospital</td>
<td>1 (2%)</td>
<td></td>
</tr>
<tr>
<td>In Residential / Nursing Home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respite care</td>
<td>1 (3%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Service User Moved</td>
<td>1 (3%)</td>
<td></td>
</tr>
<tr>
<td>Service User Died</td>
<td>4 (10%)</td>
<td></td>
</tr>
</tbody>
</table>

Table Eight: Where Service Users Were Living At the Time Of The 1st Review

4.5.1 Very few service users in either cohort had entered hospital, nursing homes or residential care homes by the time of the 1st Review.

4.5.2 Four service users referred to the Home Care Reablement Team died. Three of the service users were too ill for reablement – one died shortly before the Home Care Reablement Team started its involvement and two were quickly re-admitted to hospital and died shortly afterwards. All three service users had been assessed by commissioners as requiring substantial home care packages.

4.6 Home Care Packages when Commissioned

4.6.1 We gathered data on the nature of Home Care packages commissioned for service users and whether these changed at the point of first review. Our aim was to identify to what degree the Home Care Reablement Team had succeeded in 're-ableing' service users, the logical outcome of which would be a reduction in the Home Care Services the service user required. This would of course also indicate the success of commissioners in identifying service users who had the capacity to recover or re-learn skills needed to live independently in their own homes. The outcome measure selected was home care hours rather than service user's goals, since these had not by and large been set for the matched group. Further research however could be undertaken specifically for the service users of the Reablement Team.

4.6.2 The figures in the table below indicate that larger packages of Home Care were commissioned for service users of the Home Care Reablement Team than their counterparts in the control group.

<table>
<thead>
<tr>
<th>Categories</th>
<th>Service Users in North Leicestershire Excluding the Reablement Team</th>
<th>Service Users of the Reablement Team</th>
<th>Service Users of the Reablement Team Roll-Out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Care Package at Start</td>
<td>5.6 hrs per week per person (Highest 15.75 hrs per week, lowest 1 hr per week.)</td>
<td>8 hrs (Highest 18.5 hrs per week, lowest 0.75 hrs per week)</td>
<td>6 hrs (Highest 17.5 hrs per week, lowest 0.75 hrs per week)</td>
</tr>
</tbody>
</table>

Table Nine: Home care packages at the beginning of engagement with service users
4.7 Home Care Packages at First Review

4.7.1 Home Care packages for the Reablement Team's service users were far more likely to be discontinued at first review compared to the matched group of service users.

<table>
<thead>
<tr>
<th>Categories</th>
<th>Service Users in North Leicestershire Excluding the Reablement Team</th>
<th>Service Users of the Reablement Team</th>
<th>Service Users of the Reablement Team Roll-Out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Service Users whose Care Packages was Discontinued at 1&lt;sup&gt;st&lt;/sup&gt; Review</td>
<td>5%</td>
<td>62%</td>
<td>58%</td>
</tr>
</tbody>
</table>

Table Ten: Care packages discontinued at 1<sup>st</sup> Review

4.7.2 Home Care packages for the Reablement Team's service users were more likely to be decreased at first review compared to the matched group of service users.

<table>
<thead>
<tr>
<th>Categories</th>
<th>Service Users in North Leicestershire Excluding the Reablement Team</th>
<th>Service Users of the Reablement Team</th>
<th>Service Users of the Reablement Team Roll-Out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Service Users whose Care Packages was Decreased at 1&lt;sup&gt;st&lt;/sup&gt; Review</td>
<td>13%</td>
<td>26%</td>
<td>17%</td>
</tr>
</tbody>
</table>

Table Eleven: Care packages decreased at 1<sup>st</sup> Review

4.7.3 Home Care packages for the Reablement Team's service users were less likely to be increased at first review compared to the matched group of service users.

<table>
<thead>
<tr>
<th>Categories</th>
<th>Service Users in North Leicestershire Excluding the Reablement Team</th>
<th>Service Users of the Reablement Team</th>
<th>Service Users of the Reablement Team Roll-Out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Service Users whose Care Packages was Increased at 1&lt;sup&gt;st&lt;/sup&gt; Review</td>
<td>11%</td>
<td>2 %</td>
<td>8 %</td>
</tr>
</tbody>
</table>

Table Twelve: Care packages increased at 1<sup>st</sup> Review

4.7.4 Home Care packages for the Reablement Team's service users were far less likely to maintained at the same level at first review compared to the matched group of service users.

<table>
<thead>
<tr>
<th>Categories</th>
<th>Service Users in North Leicestershire Excluding the Reablement Team</th>
<th>Service Users of the Reablement Team</th>
<th>Service Users of the Reablement Team Roll-Out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Service Users whose Care Packages was Maintained at 1&lt;sup&gt;st&lt;/sup&gt; Review</td>
<td>71%</td>
<td>10%</td>
<td>17%</td>
</tr>
</tbody>
</table>

Table Thirteen: Care Packages maintained at 1<sup>st</sup> Review
4.7.5 The data indicates that the Home Care Reablement Team has been very successful in 're-ableing' service users, the logical outcome of which has been significant reductions in and discontinuation of the home care services the service users have required.

Whilst the total home care hours for service users in the North Leicestershire cohort remained roughly the same at first review, the home care hours for service users of the Reablement Team dropped by three quarters and those for the roll-out by a quarter.

The figures for the Vale of Belvoir 'roll out', although small, are especially impressive given that the Home Care Reablement Team worked with all-comers rather than those selected by commissioners. As we noted earlier, a quarter of these cases were open to the Adult Commissioning Team and hence likely to be more complex.

<table>
<thead>
<tr>
<th>Categories</th>
<th>Service Users in North Leicestershire Excluding the Reablement Team</th>
<th>Service Users of the Reablement Team</th>
<th>Service Users of the Reablement Team Roll-Out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Care Package at Start</td>
<td>5.6 hrs per week per person</td>
<td>8 hrs</td>
<td>6 hrs</td>
</tr>
<tr>
<td></td>
<td>(Highest 15.75 hrs per week, lowest 1 hr per week.)</td>
<td>(Highest 18.5 hrs per week, lowest 0.75 hrs per week)</td>
<td>(Highest 17.5 hrs per week, lowest 0.75 hrs per week)</td>
</tr>
<tr>
<td>Average care package after 1st Review for Service Users Still Receiving a Service.</td>
<td>5.9 hrs per week per person.</td>
<td>5.53 hrs per person.</td>
<td>9.6 hrs per person per week.</td>
</tr>
<tr>
<td></td>
<td>95% of service users were still receiving a service</td>
<td>38% of service users still receiving a service</td>
<td>42% of service users still receiving a service</td>
</tr>
<tr>
<td></td>
<td>(Highest 14.75 hrs per week, lowest 1 hr per week.)</td>
<td>(Highest 15.75 hrs per week, lowest 1 hr per week.)</td>
<td>(Highest 15.75 hrs per week, lowest 3.5 hrs per week)</td>
</tr>
<tr>
<td>Total Increase or Decrease in Home Care for Service User Groups as a Whole.</td>
<td>Increased by 1%</td>
<td>Reduced by 72%</td>
<td>Reduced by 28%</td>
</tr>
</tbody>
</table>

Table 14: Average Care Packages and Overall Increase or Decrease

4.8 Testing the Data

4.8.1 The success of the Reablement Team compared to the matched group - using hours of home care as the measure - has been so spectacular that it caused the research team some worries. We decided therefore to test how typical a month March 2000 was by comparing it with March 1999 and April 1998 – March 1999.

4.8.2 The figures obtained from the Review team show the number of care packages that were maintained, increased or decreased for all home care packages in Leicestershire. There is sufficient consistency for us to be confident that March 2000 was a fairly average month.
<table>
<thead>
<tr>
<th>Timespan</th>
<th>Total Number of Cases Reviewed</th>
<th>Percentages of Cases Where Care Package Maintained</th>
<th>Percentages of Cases Where Care Package Increased</th>
<th>Percentage of Cases Where Care Package Decreased</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 1999</td>
<td>254</td>
<td>80.7%</td>
<td>4.3%</td>
<td>15%</td>
</tr>
<tr>
<td>April 1998 to March 1999</td>
<td>2639</td>
<td>74.3%</td>
<td>3.5%</td>
<td>24.1%</td>
</tr>
<tr>
<td>March 2000 (Research Team’s Statistics)</td>
<td>38</td>
<td>71%</td>
<td>11%</td>
<td>18%</td>
</tr>
</tbody>
</table>


4.9 The Statistical Analysis Reviewed

As stated earlier, the statistical analysis alarmed the research team, as the outcomes of the Home Care Reablement Team were radically different to those of other home care teams. In some ways the analysis raised more questions for us than it answered.

There is no doubt however that the Home Care Reablement Team has been very successful. We have confirmed this by ‘having a good look’ at the work undertaken by the team. We outline our qualitative analysis in the next section.
5. A Qualitative Analysis of the Project

5.1 Quality Versus Quantity

5.1.1 In the previous section we have shown how the successful the Home Care Reablement Team has been in 're-ableing' service users to the degree that many of them no longer needed home care support. We will now try to identify what makes the Home Care Reablement Team so successful compared to other Home Care teams. We will also give a flavour of the 'ups and downs' the project has experienced in its first year and how the project has worked to resolve these.

5.1.2 We came to conclusions about the quality of the service the Home Care Reablement Team offers by

- Analysing 25 case files held by the Home Care Reablement team
- Shadowing the home care team on visits to a representative sample of service users
- Attending a team meeting of the Home Care Reablement team
- Discussing the project with key people involved in the pilot and some commissioners
- Issuing a questionnaire to commissioning teams in the Department and analysing the responses.

5.2 Distinctive Qualities of the Home Care Reablement Team

The Home Care Reablement team has a philosophy and a way of working that serves to distinguish it from other home care schemes. In essence the project aims to help service users to do things for themselves. This is very different to the kinds of help home care schemes have traditionally delivered.

<table>
<thead>
<tr>
<th>Distinctive Features of the Home Care Reablement Team</th>
<th>Some Characteristics of Traditional Home Care Schemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short term involvement with service user – clear message given to service users.</td>
<td>Open-ended involvement with service users, although subject to regular review.</td>
</tr>
<tr>
<td>Clear goal setting and monitoring. Includes the service user.</td>
<td>Aims of care package tend to be general, for example to help the service user remain living in the community.</td>
</tr>
<tr>
<td>High standards of case recording.</td>
<td>Case recording is not a high priority</td>
</tr>
<tr>
<td>Dedicated Commissioning Officer who also reviews the case.</td>
<td>Commissioned by a range of workers.</td>
</tr>
<tr>
<td>Ability to react quickly, for example to withdraw a service no longer required.</td>
<td>Reviewed on a regular timetable, although it can be brought forward if necessary. Reviewing officer is independent of the team.</td>
</tr>
<tr>
<td>Regular team meetings to review service users’ progress and to adjust goals.</td>
<td>Opportunity to meet as a team relatively rare. No goals for the service users.</td>
</tr>
<tr>
<td>Service users have a small number of Home Carers (2) to ensure consistency.</td>
<td>Service users have a recommended maximum of carers, often six.</td>
</tr>
<tr>
<td>Quick response to referrals from commissioners.</td>
<td>Very little access to training, other than what is legally required, for example lifting and moving.</td>
</tr>
<tr>
<td>Specific training for example on report writing.</td>
<td></td>
</tr>
<tr>
<td>Goal Setting and Rehabilitation Techniques</td>
<td>No Capacity for Investment of Time at the Beginning of the Contact with Service Users</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Potential to invest more time at the beginning of the work with service users.</td>
<td>Time is very tight and just sufficient to achieve the task.</td>
</tr>
<tr>
<td>Emphasis on social care model rather than medical model of Reablement. For example, goals can include enabling service user to build up social networks.</td>
<td>Engagement is task-orientated and focused on physical tasks. Little capacity or time to help service users do things for themselves.</td>
</tr>
<tr>
<td>Consistency of care delivery – all members of the team aim to help service users to do things for themselves.</td>
<td>Consistency more difficult to achieve given the number of carers.</td>
</tr>
<tr>
<td>Team’s ability to motivate and encourage service users to help themselves as much as possible – withdrawal of services framed for service users as due to their achievements rather than as a loss.</td>
<td>Service users often see home care as a service they are entitled to and come to rely on it to meet a range of needs not specifically part of the contract.</td>
</tr>
</tbody>
</table>

Table Sixteen: Distinctive Features of the Home Care Reablement Team

5.3 Referral Processes

5.3.1 The majority of referrals to the project were appropriate. This reflects the skills of commissioners in identifying service users for whom the scheme had something to offer. In addition the pilot project’s philosophy is that very few people have no capacity for reablement.

5.3.2 A small number of referrals to the Project were inappropriate. At the extreme end, as stated earlier, three service users were too ill for Reablement – one died shortly before the Home Care Reablement Team started its involvement and two were quickly re-admitted to hospital and died shortly afterwards. All three service users had been assessed by commissioners as requiring substantial home care packages.

5.3.3 Overall the Home Care Reablement Team received far fewer referrals from commissioning teams in the Department than had been anticipated when the team was first established. In order to explore this we sent a brief questionnaire to social work teams who commission Home Care in the Department. We received 36 questionnaires back (out of a total of 70 sent out) from commissioning workers in seven teams.

5.3.4 We had anticipated that the slow rate of referrals were due in part to commissioning workers not knowing about the pilot scheme. However we were surprised that the majority (75%) of commissioning workers who returned the questionnaire had heard about the project, most frequently from written information, team meetings and team managers. Roughly two thirds (63%) of commissioning workers who had heard about the Scheme had made referrals to it.

5.3.5 In a typical week, commissioning workers stated that, on the basis of their current caseloads, around 55 service users a week would benefit from referral to a scheme like the Home Care Reablement Team. Estimates varied widely from 1 service user to 15 service users. One commissioning worker suggested 80% of her workload. This bodes well if the pilot scheme is extended to other parts Leicestershire as replies were received from teams outside the catchment area of the Melton team.

5.3.6 Commissioning workers suggested that clearer guidelines on the Scheme’s remit would be helpful for them in deciding whether to make a referral.
"More information would be useful."

"Health staff seemed very unaware of the projects or unclear of their purpose, which in my view, ought to be (re?) addressed."

"I was not able to get through gatekeeping. Suggest criteria stated rather than discretion of individual staff i.e. who is the service aimed at."

"Needs clearer guidelines re eligibility."

5.3.7 Some commissioning workers had inaccurate information.

"At Melton criteria based on hospital discharge but other existing service users may benefit."

"The Reablement Project (Melton) is very beneficial but only to a minority of service users i.e. those who have sustained an injury which has potential to be healed hence service user likely to return to previous ability. May be better placed in hospital teams looking at discharges."

5.3.8 We recommend therefore that the Home Care Reablement Team states its remit very clearly and continues to distribute information to commissioning workers in the Department.

5.3.9. The Reablement Team does respond quickly to referrals it receives. We have confirmed this by reading the service users' files, by observation of the team and by feedback from commissioners.

"A rapid response has always been available."

"Are able to respond quickly and have been able to respond to all requests."

Received a quick response to the initial referral and the service was provided within two weeks."

5.4 Initial Assessment Processes

5.4.3 We noted consistently that initial assessments by commissioners seldom had much detail or depth. The assessments served to establish service users' eligibility for services and prescribed what the service should be. Outcomes – what it was intended the service should achieve for the service user – were often vague and general.

"The overall aim is to help you to be as independent as possible. In particular, we aim to rehabilitate you to your home."

5.4.4 Some assessments were in contrast much more specific.

"Help you light a boiler – work out ways of making the task easier. Help you to prepare your breakfast – look at ways of safe activity in the kitchen. Help you feed the cats – look at ways to make this task easier."

5.4.5 A small number of assessments by commissioners were inaccurate – for example one recorded that the service user could walk unassisted with the aid of a stick. The Home Care Reablement Team noted that the service user needed two carers to assist her to walk.

"Tripod urgently needed as x is very unstable with walking stick..."
"X struggled to walk to the bedroom – very unsteady. Assistance from Y was necessary."

"X not weight-bearing and not able to walk."

5.4.6 In practice the Home Care Reablement Team tested assessments it received, and inevitably this involved some degree of re-assessment. We welcome this as we believe assessment is a continuous process as much as a discrete task with an end and a beginning. There are of course implications for how those purchaser / provider splits in services are organised, especially where they are unnecessarily rigid. Assessment is not the sole preserve of commissioners.

5.4.7 We do recommend however that the Social Services Department re-consider how it undertakes initial assessments. The Modernising Agenda requires local authorities to measure and evaluate the effectiveness of their community care strategies. Commissioners, particularly in Access Teams, will need to have the time and skills to undertake holistic assessments and to set clear aims, objectives and timescales.

'Suggestions for improving the service – a standard format for the referrer to use to detail the aims and objectives.'

Community Care Worker in an Adult Commissioning Team.

5.5 Care Planning, Implementation and Review

It's not rocket science...it's the little things that make a difference...

Home Care manager.

5.5.1 A great strength of the work of the Home Care Reablement Team is the care planning and review process; in particular the setting and monitoring of goals in agreement with service users. We outline below some examples extracted from the recording of the beginning, middle and end of one case to illustrate this. The service user had a very high package of care at the beginning of the engagement – 22 hours. She continued to receive 10.5 hours of home care when the Reablement Team withdrew.

**Beginning**

Mrs x is 85 yrs old and is recovering in hospital from a stroke. She remains in need of help with daily living activities and has not regained her former independence. Mrs x has medium care needs due to her poor eyesight and balance. She does not appreciate the difficulties and at times puts herself at risk by undertaking activities that are unsafe for her. She has a strong wish to return home. Nursing and therapy staff say this is full of risk. A return home with a reablement package is appropriate whilst acknowledging the high risks that will be involved when she is alone. (Commissioning Worker)

Rang JE (Rehabilitation Co-ordinator) to ask her to visit Mrs x today to assess some clear goals for home care assistants to work towards in order to re-enforce safety issues and to give the home care assistants guidance re next stage of Mrs X's Reablement. (Home Care Manager)
Mrs X to help with small domestic and kitchen tasks, e.g. preparing vegetables, spreading bread, dusting, hand washing. To practice whilst carers present. Leave tasks to do between visits. (Rehabilitation Co-ordinator)

Discussed JE’s guidance notes with all home care assistants at team meeting. (Home Care Manager)

**Middle – Progress and Re-Assessment**

Asked JE to visit to assess if Mrs X safe with kettle. If safe, home care assistants to be instructed to watch Mrs X make hot drink while they are there. (Home Care Manager)

Mrs X made a hot drink using an electric kettle. With a couple of attempts she was able to put plug into socket and managed to pour without any spillages. She used worktops to support self during the process and used trolley to take drink into living room. Was able to plan task without any assistance. (Rehabilitation Co-ordinator)

Rang Mrs Y (daughter) to inform her that home care assistants are now encouraging Mrs X to make drinks while they are there. (Home Care Manager)

Mrs X washed and dressed herself with very little help. She mastered the stairlift well. She also got her own breakfast. (Home Care Assistant)

Mrs X made a ham and mustard sandwich for herself. She will eat it later. She is going to try using the tin opener tomorrow to open her rice pudding. (Home Care Assistant)

Mrs X would like to put self to bed when ready – to confirm how she manages with home care staff, appears safe using lift and has alarm. (Rehabilitation Co-ordinator)

**End**

Appears to be achieving goals but noticed she has had two recent falls. Discussed achievements and current level of home care input. Agreed future care requirements and new care plan. (Rehabilitation Co-ordinator)

When Mrs X was discharged from hospital it was anticipated she may need to go into residential care. However she wished to return home and with the support of the Reablement team she has made significant improvements. The on-going care package should remain stable. (Letter from Rehabilitation Co-ordinator to Private Home Care Agency)

5.5.2 The role of the Rehabilitation Co-ordinator, an occupational therapist, is invaluable in helping the team to set realistic achievable goals to work on with service users. She also regularly reviewed care plans, discussing them in the Reablement Team’s meetings and visiting service users in their own homes. This ensured that care plans were adjusted to meet service users’ needs. Below we reproduce part of an initial assessment by the commissioning worker and the goal sheet produced by the Home Care Reablement Team.

Mrs B wishes to return home and maintain independence. Mrs B needs encouragement and someone to work alongside her for personal care tasks until her confidence has increased. Also worker will encourage Mrs B to prepare own dinner over the next few weeks if Mrs B so wishes. (Commissioning Worker)
<table>
<thead>
<tr>
<th>Date</th>
<th>Goal</th>
<th>Plan</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>22.2.00</td>
<td>To be independent with washing and dressing.</td>
<td>Supervise only. Please note any difficulties.</td>
<td>28.2.00</td>
</tr>
<tr>
<td></td>
<td>To prepare own breakfast.</td>
<td>Supervise only and give encouragement and support only as required.</td>
<td>28.2.00</td>
</tr>
<tr>
<td></td>
<td>To prepare own tea.</td>
<td>Supervise only and give encouragement and support only as required.</td>
<td>28.2.00</td>
</tr>
<tr>
<td></td>
<td>To increase confidence in carrying out kitchen tasks.</td>
<td>Please note any difficulties. Encourage achievements.</td>
<td></td>
</tr>
<tr>
<td>28.2.00</td>
<td>To make bed independently</td>
<td>To allow Mrs B to do this for herself.</td>
<td></td>
</tr>
</tbody>
</table>

5.5.3 Commissioning workers have also commented about the care planning and review process.

I would like to be involved in the end of package review and may be yet. (Worker in Adult Commissioning Team)

The service provided was well organised – there was good liaison with the co-ordinator and within the Reablement team. The service user received continuity by having the same worker throughout. The service was flexible in terms of duration depending on the service user’s needs. (One area of need can take longer to develop than others). (Worker in Adult Commissioning Team)

Team is committed to working towards maximising independence. Have time available to work on specific goals to achieve this. (Access Worker)

Good feedback of service users’ progress that highlights concerns and needs, which may require an increased care package. Or alternatively a decrease in services. (Access Worker)

5.5.4 Reviews are a crucial part of the Reablement Team’s work. The team has developed its own distinctive review process. The Commissioning Officer works closely with the Reablement team from the point of referral to the team, through goal setting and monitoring and to review. The Review can be at any point during the service user’s contact with the team. The Commissioning officer therefore knows in some detail both the quality and quantity of Home Care delivered to the service user.

5.6 Involvement of Service Users in Review Processes

The Reablement Team has made arrangements to seek the views of service users. Some of the case files include questionnaires completed by service users. We include brief extracts below.

Do you feel the Reablement Service has helped to make you more confident and more able to cope?

“Yes – to just know that help was available if and when needed was very comforting.” (Service User)

“Yes – they continued to assist like the nurses in hospital i.e. where I could not they helped and where I could they made sure I did.” (Carer)
"Definitely – now completely independent and able to fulfill all previous tasks.”

The information we have gathered from service users’ files and from the days when we shadowed the Team confirm our observations are that service users are very positive about the Home Care Reablement Project. We will be interviewing a representative sample of service users during the summer of 2000 to test this.

5.7 Involvement of Other Disciplines

5.7.1 This is an area that needs more exploration. The Home Care Manager’s view is that there has been little need for involvement of Occupational Therapists or Physiotherapists over and above the contribution of the Rehabilitation Co-ordinator. In her view a large percentage of reablement work is appropriate for social care and well within the competence of home care assistants. The Rehabilitation Co-ordinator suggests reablement is only in the competency of home care assistants if properly delegated – assessed, taught and supervised. These views are not so disparate as might first appear. As the role of the Rehabilitation Co-ordinator has been crucial to the team and integral to its success, so too is the role of occupational therapists and physiotherapists to any expansion of the Reablement Scheme.

5.7.2 Reablement is very familiar to Occupational Therapists and is indeed a core part of their training. As researchers who also teach on a Diploma in Social Work Programme, we know that reablement principles have yet to make their mark on our students. Reablement is still very new to the majority of staff in Social Services Departments, whether on the commissioning or provider side. Implementing reablement principles will require a cultural shift in both staff and service users. Some service users will inevitably firmly believe they are entitled to a service and want to be 'looked after'.

5.8 Staff Selection, Training and Development

5.8.1 The pilot project has required particular qualities and skills of home care staff. The home care assistants work in accordance with philosophies of care very different from other home care teams. Observation of the home care assistants working directly with service users and in a team meeting suggest that the qualities and skills needed to do the job well include:

- **Stillness.** The ability to do nothing, to observe and assess, rather than just to act.
- **Patience.** It is easier and quicker for the home care assistant to take over than to watch service users slowly and sometimes painfully complete a task.
- **Communication skills.** Verbal and non-verbal confirmation for the service user that the home care assistant will assist only when required and in a way that re-inforces service user successes and progress, rather than their difficulties and failures.
- **Ability to articulate observations made of service users.**
- **Good writing skills so the essential detail of reablement can be captured.**
- **Reflection.** The capacity to think through situations and to find creative solutions with service users.
- **Values.** Seeing the service user as a person rather than through the mask of age or disability.
- **Control of own dependency needs so home carer assistants do not to need service users to need them.**
- **Ability to accommodate the ambivalence of service users who may in practical ways depend on home care assistants for most aspects of their daily living.**
- **Knowledge base including reablement principles.**
5.8.2 We have noted that the project has had access to some staff training and development. Including welfare rights. The Reablement Team, for example, has arranged training on rehabilitation principles, welfare rights and recording. There are regular team meetings in Melton for home care staff and associated multidisciplinary colleagues. As we consider home care assistants to be a much-neglected group in the social care workforce, we applaud these developments. Training and development opportunities are vital if home care staff are to embrace new ways of working with service users.

5.9 NVQ Awards

We have looked at the range of NVQ Awards and suggest that the most appropriate qualification is Promoting Independence Level Three. Candidates need to achieve the five Mandatory Units plus a minimum of three from Option A. We list below those Units we think are the most appropriate and from which candidates and their line managers might choose.

Promoting Independence Level 3 (NVQ)

<table>
<thead>
<tr>
<th>Mandatory Units - 5</th>
<th>02, CL1, CU1, SC8, Z1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option A - 9</td>
<td>CL2, CU5, SC1, SC3, SC14, X2, Y2, Y4, Y5,</td>
</tr>
<tr>
<td>Option B - 6</td>
<td>CL5, CU7, W8, X15, Z6, Z12</td>
</tr>
</tbody>
</table>

5.10 Feedback from Commissioners

<table>
<thead>
<tr>
<th>Positive Comments / Strengths</th>
<th>Areas to Develop</th>
</tr>
</thead>
<tbody>
<tr>
<td>My views are very positive.</td>
<td>There need to be more staff so more hours can be covered i.e. later in the evenings.</td>
</tr>
<tr>
<td>Excellent team!</td>
<td>The Scheme can set standards of care which independent care agencies don’t always meet.</td>
</tr>
<tr>
<td>Good service.</td>
<td>Can set up unrealistic expectations re level of care available after the 6 weeks is up. Need to ‘wean’ service users and relatives carefully.</td>
</tr>
<tr>
<td>The team is committed to working towards maximising independence. Have time available to work on specific goals to achieve this.</td>
<td>All home carers should be working in the same way that carers from reablement team work, maximising independence should be a main objective.</td>
</tr>
<tr>
<td>Reassuring to know the service exists if and when needed.</td>
<td>Training on learning disabilities for the care workers.</td>
</tr>
<tr>
<td></td>
<td>The time scale for using the project should be more flexible – a strict six weeks is not always appropriate.</td>
</tr>
</tbody>
</table>

Table Seventeen: Feedback from Commissioners

5.10.1 We record below feedback from commissioners given to us through the questionnaire. The areas to develop are especially useful.
5.11 Qualitative Analysis: Conclusions

Our qualitative analysis has established that the Home Care Reablement Team has set high standards of practice. In particular the Team undertakes core social care tasks and processes extremely well – for example setting targets, helping service users to do things for themselves rather than ‘do’ for them and recording.

Service users’ perspectives are crucial and we look forward to reporting these in the Autumn.
6. RECOMMENDATIONS

6.1 There are strong grounds for extending the Home Care Reablement Team's model of home care delivery to other areas in Leicestershire. In particular we recommend the Department consider establishing Home Care Reablement Teams to act as 'intake' teams for all home care referrals. This will ensure that all service users have access to reablement opportunities. It will also help to establish clarity amongst commissioners about the purpose of the Scheme and how to refer to it.

6.2 Essential to the replication of the Scheme elsewhere are (a) the close involvement and support of multi disciplinary colleagues with occupational therapy and physiotherapy backgrounds (b) training and development opportunities for home care staff. The quality of the staff are key to the success of the team.

6.3 We recommend that the Social Services Department re-consider how it undertakes initial assessments. The Modernising Agenda requires local authorities to measure and evaluate the effectiveness of their community care strategies. Commissioners, particularly in Access Teams, will need to have the time and skills to undertake holistic assessments and to set clear aims, objectives and timescales.

6.4 There are some key areas for further longitudinal research including
   • Service users' views on the Home Care Reablement Team (research on-going)
   • At what point, if any, services will need to re-introduced where they have been discontinued.
   • The degree to which service users sustain their independence when their home care packages are transferred to other home care teams and agencies.

6.5 There are clear benefits in establishing a research steering group to include representatives from all three pilot schemes.
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