

St Monica Trust

Domiciliary Care Services

Report

June 2011

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Report

1 Introduction

This report has been prepared by The Institute of Public Care (IPC), at Oxford Brookes University for St Monica Trust. Its purpose is to:

- Identify the different forms of domiciliary service which can be provided on a continuum from home help at one end to intensive rehabilitative services and end of life care at the other.
- Describe key approaches, including business models which may sit behind them, and consideration of cost and business development implications.
- Identify examples of existing services.

The report is based on a short project involving an analysis of existing published materials, and follow up telephone conversations with a few existing services to explore the financial costing and employment issues.

2 Policy context

2.1 Demographic demand and economic pressures

The older population are a significant proportion of the UK population, and by 2025 it is projected that over a fifth of the population will be over 65 (in Bristol this will reflect about 12% of the total population and in North Somerset just under 25%). With increasing life expectancy it is the 85 year olds who are the fastest growing population group and by 2015 this group will increase by 27% (a smaller increase in Bristol and North Somerset: 7% and 15% respectively)¹.

Moreover it is estimated that the number of 65 years olds affected by stroke will increase by 40,000 over the next twenty years (an increase of 311 in Bristol and 543 in North Somerset). Furthermore, by 2025 nearly a million people, aged over 65 years old, will have dementia (5,267 in Bristol and 5,369 in North Somerset)¹.

These demographics coupled with the reduced working age population presents an unpalatable truth that demand for services far outweigh supply, at least in their current configuration.

Furthermore, the demand for home care has increased over recent years² and home care is a much valued service by older people³. However low level

¹ Projecting Older People Population Information System <http://www.poppi.org.uk/>

² Commission for Social Care Inspection (CSCI) (2009). The State Of Social Care 2007 – 2008.

interventions have, of recent years (especially with increases in eligibility criteria), been reduced with the trend being to provide more intensive services to fewer people. There is, thus, a mismatch between what people may want and desire compared to what they actually get.

In terms of unmet demand a recent study estimated that around 450,000 older people in need of care have some sort of shortfall in the formal care they receive, with 275,000 older people with less intensive needs getting no support from their local council⁴.

The current economic climate in which local authorities are having to make substantial cuts to services reflects a changing vision for the social care market. The reduction in state funding combined with greater pensioner wealth and greater numbers of older people suggests a greater number of self funders, and less dependence for providers on social care contracts.

2.2 The personalisation agenda

“In the future , all individuals eligible for publicly-funded adult social care will have a personal budget (other than in circumstances where people require emergency access provision); a clear, upfront allocation of funding to enable them to make informed choices about how best to meet their needs, including their broader health and well-being⁵”

By 2011 all councils are expected to ensure that person centred planning and self directed support has become the cornerstone of community care⁵. Councils are expected to re-engineer their assessment processes (introducing self assessment and a resource allocation system (RAS)) so individuals can have the option of commissioning and purchasing their own support and care arrangements.

Home care models of support will undoubtedly change due to the personalisation agenda as will other services:

“As people get used to this freedom, the demands and expectations of homecare services may well change. For example, there may be more emphasis on the need for help with domestic tasks, gardening and other assistance such as taking people out, the lack of these things at present being a main source of complaint⁶”.

In addition, other services, organisations, and sectors may deliver new services that replace the need for traditional home care. Individuals may be better supported by good housing such as well built homes for life, extra care housing (ECH) and helped to be independent by effective assistive technology⁷. Older

³ CSCI (2006). Time to Care an Overview of home care services for older people in England.

⁴ UKHCA (2011). An overview of the UK domiciliary care sector.

⁵ Department of Health LAC (2008)1. Transforming Adult Social Care.

⁶ Sawyer L (2008). The Personalisation agenda: threats and opportunities for domiciliary care providers. Journal of Care Services Management; 3(1): 41 – 63.

⁷ Communities of Local Government (2008). Lifetime Homes, Lifetime neighbourhoods: A National Strategy for Housing in an Ageing Society.

people may be supported by specialist health professionals that link into voluntary community initiatives such as dementia peer networks⁸.

Home Care will therefore need to support these other services and vice versa. For example Home care as a service may be more useful, if the right infra-structures are in place, if it is rehabilitative in nature such as providing a re-ablement service. It may be that home care can provide a crisis response service to enable early supported discharge or prevent admission to care homes and link in with be specialised to link in with high level/ acute case management cases.

For providers this agenda will see less emphasis on block social care contracts with the need to develop new ways of working with individuals who wish to commission and purchase their own care.

2.3 Prevention

Prevention is a theme that runs through all recent policy^{9 10 11}. Prevention as defined by the Partnerships for Older People is about "promoting independence":

"By 'promoting independence', we mean an approach which is focussed on ensuring that everything possible is done to ensure that peoples are able to remain in their own homes, with choice and control over how they live their lives".¹²

Services are to be configured to reduce care home and hospital admissions, promote independence, and support people through illnesses and life transitions. This involves selective and timely interventions to prevent premature reliance on more costly and intensive services^{13 14}.

Prevention is a whole systems approach that involves various interventions for the whole community and the individuals' life span. There are a wide range of initiatives and interventions that can fall within the prevention remit, such as:

- General health promotion.
- Initiatives around encouraging citizenship and inclusion.
- Ensuring people have the information they need about their options/choices so they are able to make informed decisions.
- Handy person services or befriending services.
- Early intervention services for individuals with physical and mental health difficulties, to prevent them from deteriorating.

⁸ Department of Health (2009). Living well with dementia: A National Dementia Strategy.

⁹ Department of Health (2007). Commissioning framework for health and well-being.

¹⁰ Department of Health LAC (2008)1. Transforming Social Care.

¹¹ Department of Health LAC (2009)1. Transforming Adult Social Care.

¹²

http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Olderpeople/PartnershipsforOlderPeopleProjects/DH_080122

¹³ Department of Health (2005). Independence, wellbeing and choice.

¹⁴ Department of Health (2006). Our health, our care, our say.

- The care finding and case finding of groups of people in the locality who may benefit from a targeted service to prevent them from deteriorating and hence needing higher end services prematurely.
- Early intervention could also take the form of dementia peer support networks¹⁵, memory clinics or more neighbourhood approaches such as improving pavements to prevent falls.

This continuum of prevention also includes ensuring independence as people's needs increase. Home care re-ablement initiatives, effective community support, institutional avoidance services, timely discharge initiatives from hospital, specialist disease management, and effective multi-disciplinary case management are essential focuses of the prevention agenda which, inevitably, home care has a large part to play.

Home care has to fit within the matrix of prevention. For example it needs to sit alongside sub-threshold services, community, voluntary services, housing, and health as these services support the individual to live at home *alongside* home care provision.

2.4 Choice and control

All the relevant policy drivers stress the importance of the individual:

"... ensure that people and their organisations are much more involved in the design, commissioning and evaluation of services and how their needs are met. This choice and control should extend to individuals in every setting and, at every stage; ranging from advocacy and advice services, prevention and self-management to complex situations where solutions are developed in partnership with professionals."¹⁶

Services should be tailored and be-spoke around individual desires, preferences and aspirations. Service users should have a range of providers to choose from and should have the final word as to how the service is delivered.

In the home care market this means, for example, that the times of home care visits should be as requested and that care should be delivered in a way that suits the individual's requirements and lifestyle¹⁷. Care and support should be around the needs of individuals and their families not the organisational needs.

Flexible attitudes from both the purchaser and provider in terms of values and ethos are crucial to person centred care as are quite simple practicalities such as ensuring regular carers go to visit individuals to build a relationship with the older service user¹⁷.

Another element of individual choice and control is ensuring that older service users and their families have the opportunities, as equal partners, to shape the commissioning and purchasing process. This can range from various

¹⁵ Department of Health (2009). Living well with dementia: A National Dementia Strategy.

¹⁶ Department of Health LAC (2009)1. Transforming Adult Social Care.

¹⁷ Patmore C and McNulty A (2005). Making home care for older people more flexible and person centred Factors which promote this.

engagement events which may involve organisations giving out new information, testing ideas, securing feedback to service users actually *shaping* ideas/ services. This could mean service users being involved in the process of drawing up specifications or editing public facing information. Home care organisations, especially within these changing times, could only benefit from relationship building and interaction with their customers.

2.5 Cost effectiveness

Policy makers hope that individual budgets, preventative services, assistive technologies, and re-ablement approaches will reduce the numbers of people requiring higher end and more expensive service provision, enabling people to be supported in their own homes and in their own communities. It is envisaged these services will be more be-spoke hence a lower unit cost and better quality outcomes ensuring value for money and efficiencies.

The recently published progress measures for the Putting People First transformation agenda include that by 2011:

“There is evidence that cashable savings have been released as a result of the preventative strategies and that overall social care has delivered a minimum of 3% cashable savings. There should also be evidence that joint planning has been able to apportion costs and benefits across the ‘whole system’.”¹⁸

Clearly the commissioning of effective and responsive home care services has the potential to prevent the need for more expensive service provision, particularly residential care home placements, as well as hospital admission.

2.6 Outcome based commissioning

Closely linked to individual choice and control is a policy commitment to outcome based services and contracting. Outcome based approaches require fundamental change in the way that services are delivered. Outcomes based approaches is about changing:

“the social care system away from the traditional service provision with its emphasis on inputs and processes towards a more flexible, efficient approach, which delivers the outcomes people want and need and promotes their independence, well-being and dignity”¹⁹.

Outcome based domiciliary care underpins a shift from specified care tasks and timed visits to a system where success and payment is based on achievement of agreed outcomes, encouraging the available time to be used constructively and imaginatively to ensure individuals outcomes are met. Business contracts between the Local Authority and the provider to deliver on outcome based care should specify outcomes to be achieved, these outcomes monitored and collated, feeding into an evidence base that informs strategic commissioning, purchasing and service design. The government is developing an information strategy to ensure a health and social care system in which people have the information they need to stay healthy, take control of their care and are able to make the

¹⁸ ADASS, DH, LGA (2009). Progress Measures for Delivering the Transformation of Adult Social Care Services.

¹⁹ Department of Health LAC (2008)1. Transforming Social Care.

right choices for them, their carers and their family, and hold the system to account. There are two elements to this²⁰:

- The Quality and Outcomes Data Set – a single, agreed set of data requirements which encompasses all routine social care information derived from council sources.
- A set of outcome focused measures that would allow councils and citizens to interpret the raw data and paint a picture of what social care is achieving locally.

Whilst it is possible to define existing processes such as the assessment, the care plan and the interventions around outcomes, the real shift in provision is only likely to take place and be sustained when providers are paid by the result that they deliver.

Outcome based working requires constructive relationship between the Local Authority with all key players the providers and the service users^{21 22}. As a recent study of emerging practice in this area has highlighted:

“A common feature underpinning the changes in each council has been a shift from traditional and often adversarial relationships towards collaborative and constructive partnership between commissioners and providers.”²³

The role of the commissioner as market facilitator is therefore increasingly important to the delivery of outcomes for the population and the individual.

2.7 Core councils

The trend to separation of commissioner and providers in the social care market, which commenced in England in the early 1990's has been given further impetus by this Government and many authorities are actively divesting themselves of remaining provider functions and moving to be a 'core commissioning council'. To achieve the above plethora of reforms requires commissioners to understand current provision, understanding what service users/ consumers need and want and facilitating the shifts required in the market to deliver on demands, expectations, and choice. Commissioner's roles will change from sole purchasers of care to facilitating markets so others can purchase care.

Councils will need to, not only, facilitate the development and commissioning of services that people will want to buy to support their care and support needs but also facilitate and develop services that support people to do this as consumers such advice, information, advocacy, and brokerage services.

Transformation will also require effective liaison and integrated working across sectors to ensure that consumers can access a whole nexus of support to their be-spoke requirements.

²⁰ Department of Health (2010). Transparency in Outcomes: a framework for adult social care.

²¹ Department of Health (2006). Our health, our care, our say.

²² Department of Health LAC (2009)1. Transforming Adult Social Care.

²³ Department of Health (2009). Contracting for personalised outcomes: Learning from emerging practice, DH/Putting People First Programme/Personalisation.

This means acquiring an understanding of not just current and future demand but understanding the supply side of local/ regional markets. In relation to home care, this will, in part, mean commissioners evaluating the potential threats and opportunities that personalisation may bring to the local domiciliary care market and trying to manage these as appropriate²⁴.

In addition, it will require developing an understanding of the impact of current procurement mechanisms on the market, and the flexibility these provide for the development of the personalisation agenda.

2.8 The self funder market

A '*Vision for Adult Social Care*²⁵' confirms the importance of councils recognising and working with all who receive social care support whether by funding their own care provision, being in receipt of direct payments or those on whose behalf the council purchases services. The Vision emphasises three key points about universal access to services:

"Whether they receive a direct payment or fund their own care and support, people should have access to a service that meets their needs".

"To have real autonomy and choice people need information and advice... people funding their own care have a particular need for information and guidance to help plan how their care needs are met."

"Our vision looks out to strong communities, not up to the state – to a big and open society... The increased use of personal budgets preferably as a direct payment, alongside people funding their own care, will be a catalyst for change".

Most commentators agree that in both the short and long term the number of self funders of care will grow²⁶. The numbers of people who self fund their care provision is primarily influenced by the relationship between state funding and individual wealth. Therefore, numbers may rise through: tighter eligibility criteria, increased charging, less state funding of community organisations, more people having direct payments and through people who are eligible, topping up their provision from their own, or their families', means. However, an increasing number of people who currently self fund their care home placements, may cross over to being council funded if the value of their investments diminish or through increased longevity and spending down capital assets. In the longer term occupational pensions and the value of housing equity held by many older people is likely to take large numbers out of state funding at the current thresholds.

The English Longitudinal Survey of Ageing (ELSA) includes questions relating to help with care and where people get it from. Applying the proportion of people aged 65 who pay for care to the total older population in England indicates that

²⁴ Sawyer L (2008). The Personalisation agenda: threats and opportunities for domiciliary care providers. *Journal of Care Services Management*; 3(1): 41 – 63.

²⁵ Department of Health (2010). *A Vision for Adult Social Care: Capable Communities and Active Citizens*.

²⁶ IPC (2011). *People who pay for care: quantitative and qualitative analysis of self funders in the social care market. Putting People First*.

there are an estimated 168,701 older people paying for care²⁷. The number is projected to increase to 249,298 by 2030, if the proportion of the older population that pays stays the same. If support with instrumental activities of daily living²⁸ is included, then the estimated total number rises to 271,536 in 2010 increasing to 400,658 by 2030. The most recent data available from the UKHCA based on a sample week in September 2008 indicated that 21.4% of the total care hours were purchased by self-funders²⁹.

Whilst greater choice through a growth in the number of self funders and an increase in those with direct payments/personal budgets would appear to be good news for providers, there are a range of experiences²⁹:

- There are clearly challenges associated with managing a market that comprises a large number of individual purchasers as compared to large contracts with local councils.
- Providers vary in their understanding and engagement with the self-funder market; for some it is core business, while for others it remains marginal.
- Some providers distinguish between self-funders and those using Direct Payments/personal budgets, and may favour the 'pure' self-funder as a target market because of their greater purchasing power.
- Providers are disadvantaged by a lack of good intelligence on the self-funder population, compared to publicly funded clients. However, this picture is changing and improving with new quantitative data becoming available both about people privately purchasing services, and the workforce providing these.
- While recognising the importance of self-funders to their business, providers are also concerned that the journeys of self-funders are too often guided by happenstance rather than by clear information and advice.

In terms of the overall market, there are a number of possible trends²⁹:

- An increase in the market to provide domestic support – 'that bit of help' around the edges of care which enables people to continue to live independently in their own home.
- An increase in NHS continuing care as a result of older people having to wait till a crisis, due to tighter FACS eligibility criteria, resulting in hospital admissions and then NHS continuing care.
- Rising user expectations leading to greater demand for flexibility in how and when care is provided.
- Increasing numbers of people crossing the threshold from self-funding to local authority funded care due to increased longevity and rising care home fees.
- More effective marketing by providers which could increase self-funding overall, or only increase the provider's market share.

²⁷ Katz S et al (1970). Progress in the development of the index of ADL. *Gerontologist*, 10:20-30.

²⁸ Lawton MP & Brody EM (1969). Assessment of older people: Self-maintaining and instrumental activities of daily living. *Gerontologist*; 9(3): 179-186.

²⁹ IPC (2011). People who pay for care: quantitative and qualitative analysis of self funders in the social care market. Putting People First.

2.9 Clinical Commissioning Groups (formerly GP Consortia)

The White paper *Equity and Excellence: Liberating the NHS*³⁰ sets out the intention to devolve power from Whitehall and instead place it with patients, the wider public, and professionals. Emphasis will be on patient choice and better health outcomes. This will be achieved through GP commissioning via consortia arrangements in partnership with local authorities and the public via a new body, Local Health Watch. GP consortiums will be accountable to the NHS Commissioning Board and contracted provider services will be regulated by Monitor (economic regulator) and monitored by the Care Quality Commission. The government envisages that this will reduce NHS management costs by 45% over four years.

GP Consortia will be responsible for commissioning healthcare services across a range of clinical or service areas, including:

- Community health services (except where part of the public health service).
- Maternity services.
- Elective hospital care.
- Urgent and emergency care including A&E, ambulance and out-of-hours services.
- Older people's healthcare services.
- Healthcare services for children, including those with complex healthcare needs (except for those specialised services commissioned by the NHS CB).
- Rehabilitation services.
- Wheelchair services.
- Healthcare services for people with mental health conditions.
- Healthcare services for people with learning disabilities.
- Continuing healthcare.

Consortia may agree to commission some health improvement services jointly with local authorities. This could include, for example, obesity, smoking cessation and drug/alcohol services.

Duties of the GP consortia include: the planning of services; agreeing services; monitoring of services; improvement in quality of primary care; finances and governance; and specific duties of cooperation.

Whatever the configuration of GP consortia in forthcoming legislation the NHS is likely, in parts, to be looking for more cost effective service options, in partnership through Health and Wellbeing Boards with social care, to help people remain out of hospital and independent as possible living in the community. This will include commissioning of early intervention and preventative approaches such as re-ablement.

³⁰ Department of Health (2010). *Equity and Excellence: Liberating the NHS*.

2.10 Summary of policy context

These factors all suggest that overall demand for domiciliary based services for older people is likely to continue to grow, in response to population demand and to policy demands for effective alternatives to residential and hospital based care. They also suggest that the client-provider relationship is changing – local authorities and to some extent health services will be removed from the contracting transaction, resulting in more direct choice and control for service users.

3 Models of Domiciliary Care

Within an overall continuum of domiciliary care services, from traditional standard 'home help' at one end to the most intensive form of domiciliary support at the other, we have identified three example options and considered future demand, service risk and opportunities. These three options are:

- Standard domiciliary care – a standard model of domestic and personal care and consideration of how this could be developed and tasks widened beyond traditional home care with a need to be less task and time focused.
- Rehabilitation and re-ablement – a model for provision around re-ablement packages and consideration of add on services for those that need support beyond this.
- Specialist home care – models of care focusing in specialist areas, for example: complex and frail cases; dementia care; end of life care; and out of hours/night time service.

3.1 Standard domiciliary care

Most councils contract out the supply of domiciliary or homecare services to the independent sector, which provides over four fifths of publicly funded homecare³¹. Furthermore, increasing numbers of people need to or are choosing to fund their own care.

Domiciliary services provide personal care and practical help for adults in their own homes. This can be things like helping people get up in the morning and going to bed at night, help with taking a bath and going to the toilet, help with meal preparation and other basic domestic tasks. This is done to support and maintain people to be able to live at home for as long as possible. Care packages typically range from one to five visits a day, although some involve 24/7 living in care. Visits can involve one carer or use two carers if necessary.

The average price for a weekday, daytime hour of care privately purchased from the independent sector in 2009 was estimated as £12.98 in a market survey (though there can be vast geographical variations)³¹. The survey analysis also found that there was no evidence to support the suggestion that those individuals purchasing services privately pay significantly higher than those provided through the local authority. There was wide variation in the rate charged (£6-£15 per hour).

³¹ UKHCA (2011). An overview of the UK domiciliary care sector.

A survey reported by UKHCA³¹ indicated that over half of local authority funded visits lasted 30 minutes. 19% of visits were of 15 minutes, and a further interesting measurement was that 22% of a homecare workers time was spent travelling.

No research has identified the variety of models for how home care services can be organised³². However, there are areas for consideration when developing a domiciliary care service including³³ (further examples of considerations in the development of home care can be found in appendix one):

- The respective balance of power between care manager and provider manager to modify services for individual clients as necessary. Providers are often constrained by time and task orientated contracts detailing when and what is to be done for clients and the need to go back to the care manager to make any changes to the arrangements.
- Size of teams and in number of hours worked by staff members. Some teams comprise many workers each working only a few hours per week compared to other teams of few workers each working full time.
- Services approach to evening, weekend and public holiday provision must be deemed part of its model for service even if the service avoids covering these times itself.
- Systems for providing cover for staff who are unavailable through illness, holidays or job changes and how to manage sudden needs for extra help.
- System for managing times of peak demand (eg around getting clients up in the morning, meal times and bed times). This could reflect more part time staff to cover those hours or fewer staff but less flexibility over times offered and therefore staggering of time slots for clients.

Care provided is often time or task based. The tasks of home care are defined by its purpose, and within that, by a variety of influences, tradition, the skills and qualities of home care staff, the characteristics, home environments and attitudes of those receiving the service, the influence of their relatives, the willingness of other services to undertake certain tasks, the money available and so on³⁴. However, home care staff are available and via existing relationships are well placed to give prompt, flexible person-centred help to those older people who most need it³⁵. The range and variety of problems and issues is as large as can be imagined. At the same time the member of staff comes to fulfil a care plan within a limited time and subject to policies, rules and regulations³⁴. Flexible person-centred care for older people will depend on staff values and the ethos promoted within the organisation as well as particular assessment, review and service planning procedures³⁵. Characteristics of person-centred home care reflect³⁴:

³² Patmore C (2002). Towards flexible, person-centred home care services: A guide to some useful literature for planning, managing or evaluating services for older people. SPRU: York.

³³ Patmore C (2002). Towards flexible, person-centred home care services: A guide to some useful literature for planning, managing or evaluating services for older people. SPRU: York.

³⁴ Sinclair I et al (2000). The management and effectiveness of the home care service. Social work research and development unit: University of York.

³⁵ Patmore C and McNulty A (2007). Caring for the whole person: Home care for older people which promotes wellbeing and choice.

- Holistic care.
- A routine adapted to the clients.
- Flexibility.
- Time and thoroughness.
- Sensitivity.

3.1.1 A future model for standard domiciliary care

Lewis and Sawyer (2000 cited in Patmore 2002³⁶) suggest a model for organising home care services that is person centred, but highlights that conventional care management arrangements can act as a barrier to this kind of provision, calling for the development of alternative means for commissioning services (eg outcome based). The model described includes the following features:

"A manager has responsibility (and appropriate devolved budgets) for meeting a complete range of needs for a small (15 - 30 clients) case list - either through interventions by themselves, by a small home care team which they directly manage, or by other agencies which they purchase or broker, short-term or long-term, as client need indicates. A complete range of needs includes, in one of Lewis and Sawyer's examples: personal care; mobility and transfers; meals including special diets; laundry; banking and bill paying; shopping; transports to appointments and for social activities; helping to fit hearing aids and other means to communication; organising the gardening; monitoring medications; rehabilitation support; treatments such as eye drops; providing respite care at home; home maintenance; advocacy; emotional support and pet care. But the support is not limited to a specific list of activities or tasks. Such a service must respond swiftly and flexibly to whatever new needs emerge among its clients and the team's combined skills, versatility, knowledge of clients and staff freedom of action must match this challenge. The service must be able to respond at all times necessary - including evenings, weekends and public holidays. Another feature of the model is the use of small numbers of familiar staff to provide each client's services. For instance each client may have a key worker, who is both their routine home care worker and a person who communicates any emerging needs back to the team, backed by some other familiar staff who can give service when the key worker is not available. Importance is placed on adapting service to each client's preferred lifestyle and habits. Clearly it is a model which is well placed for responding to individuals' values and preferences".

Key issues coming out of the research described above and linking with the current government agenda is the need to develop domiciliary services which are outcome focused and contracting arrangements that offer providers the flexibility to provide such services. Outcome focused domiciliary care will move away from time and task based care and enable the provision of other care such as housing support and socialisation as well as more standard domestic and personal care.

The following example illustrates outcome based contracting which enables this change in provision.

³⁶ Patmore C (2002). Towards flexible, person-centred home care services: A guide to some useful literature for planning, managing or evaluating services for older people. SPRU: York.

Thurrock Council

In 2007 Thurrock Council tendered for an outcome based home care contract to be delivered by external agencies. Prior to the tender there was widespread consultation with all stakeholders, in particular with service users and providers, to ensure wholesale outcomes based working would be viable. The home care market in Thurrock is configured in a way that can operate an outcomes based contract across the board.

There is only one in house home care service and this is an intake and re-ablement team. Running alongside this is a PCT collaborative care team that assists with hospital discharges. At the end of these services all referrals are then passed to the external market.

There is a small intermediate care team attached to the Older People's Mental Health team, that assist specifically with preventing hospital admission and facilitating hospital discharge for those with dementia. Other than this, all dementia care is provided by the external agencies as part of the generic outcome based contract.

There are only four external providers that source the market. They are each allocated one geographical zone where work is guaranteed. Therefore there are four geographical zones.

There were concerns initially that this would narrow choice in the market however various service user engagement events prior to the outcomes contract tender, revealed that people preferred consistency of provision and flexible use of hours based on stated goals, aspirations and outcomes over 'choice' of providers.

Care managers assess what outcomes are to be achieved by the home care service, then based on this assessment a certain number of hours are allocated over four weeks. The detail of how, where and what will be provided to meet specified outcomes come out of a discussion between the provider and the service user. This is recorded on the individual service users support plan. The activities undertaken could be adapted on a day to day basis to meet the changing needs of the individual. The menu of possible activities included 'standard' home care support (personal care, domestic activities, practice and social support, monitoring visits) and non-standard (night sitting, day sitting, support for informal carers) as well as a 24 hour service. The hours delivered will then be invoiced to Thurrock Council where payment will be arranged.

There is very good feedback and high levels of satisfaction with the service. Also close ties between providers and commissioners.

3.2 Rehabilitation and re-ablement

Re-ablement has been defined as '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'³⁷. Re-ablement supports a service focus on independence and harnesses the joint input of health and social services. Re-

³⁷ SCIE (2011). Re-ablement: Emerging practice messages.

ablement is also central to the Government's vision for adult social care³⁸ which recognises the role of re-ablement in making savings to the NHS. The focus of re-ablement is on restoring independent functioning rather than resolving health care issues, and on helping people to do things for themselves rather than the traditional home care approach of doing things for people that they cannot do for themselves. Re-ablement is usually a six to 12 week intervention, focused on dressing, using the stairs, washing, and preparing meals. Re-ablement may include social re-integration and the provision of items of equipment. Although re-ablement overlaps with intermediate care, its focus on assisting people to regain their abilities is distinctive.

In relation to rehabilitation there is often some confusion around what this involves, making it difficult at times to distinguish from other forms of care and support. An Audit Commission Review³⁹ reported emerging consensus that:

- The primary objective of rehabilitation involves restoration to the maximum degree possible, either of function (physical or mental) or role (within the family, social network or workforce).
- Rehabilitation usually requires a mixture of clinical, therapeutic and social interventions that also address issues relevant to a person's physical and social environment.
- Effective rehabilitation needs to be responsive to users' needs and wishes, to be purposeful, involve a number of agencies and disciplines and be available when required.

Its scope is wide and includes acute and chronic perspectives. For example, active treatment to reduce the severity of the underlying disease would be included (e.g. treatment of cardiac failure or pain relief in an arthritic knee), as would adapting the environment to the needs of a disabled person.

Rehabilitation embodies the concepts of⁴⁰:

- Impairment - the specific deficit.
- Activity limitation - the resultant limitation in functional capacity.
- Participation restriction - the impact of this limitation on quality of life experienced.

3.2.1 Re-ablement

No single leading model of re-ablement has yet been identified, with practice defined by local circumstances⁴¹. There is little evidence on: how they are best organised and delivered; what are the most effective interventions?; which groups of users benefit most?; and what is the optimum timing and duration of re-ablement interventions. Models of re-ablement are often closely linked to rehabilitation and a focus on physical health care. Some schemes accept all who

³⁸ Department of Health (2010). A vision for adult social care:

³⁹ Audit Commission (2000). The way to go home: Rehabilitation and remedial services for older people. London, Audit Commission.

⁴⁰ British Geriatrics Society (2009). Rehabilitation of older people. BGS Best Practice Guide 1.4.

⁴¹ SCIE (2011). Re-ablement: Emerging practice messages.

have been referred for homecare (eg an 'intake' re-ablement service) where as other schemes operate a more selective service for those who are judged most likely to benefit. Research findings are conflicting concerning who to focus the service on: those being discharged from hospital or people living in the community⁴¹.

Key features of re-ablement services described by CSED research⁴² include:

- It is important that the initial assessment review be completed in the client's house, particularly in transition from hospital. Once back in the home environment, it was possible that people may be able to do some things they could not do in hospital, but may identify other areas where they need support to live independently, such as help with shopping and/or social activities.
- Access to equipment, such as grab rails, walkers and trolleys to carry food around play a vital role in helping people become more independent.
- Workers identified by the re-ablement services as being less experienced were those who had spent less time working within traditional home care services. However, in general, these workers appear to involve people a lot more than those identified as being more experienced. This involvement was both in terms of decision making (e.g. asking people what they would want to do on the day) and hands on 'doing with' involvement in practical activities.
- More experienced workers were more likely to look for ways of improving physical access, ensuring safety and making suggestions about other equipment that service users might find helpful, such as a ramp to remove a high step at kitchen door and a hydraulic seat in the bath.
- The focus groups with front-line staff also confirmed managers' concerns that nostalgia for the traditional role of home carer and difficulties in adjusting to a new role were more pronounced among people with extensive experience in conventional home care services.
- Difficulties in finding an appropriate home care agency to provide ongoing support post the homecare re-ablement phase leads to some service users remaining in the re-ablement service for weeks or months, thereby blocking the service. A zoning approach can help to ensure that those living in remote areas who need ongoing support do not face delays.

The most important internal organisational factors contributing to the effectiveness of home care re-ablement have been described by research as⁴³:

- Commitment, enthusiasm, knowledge and skills of front-line staff. This requires thorough initial training and regular on-going supervision and peer support. Home care re-ablement services: Investigating the longer-term impacts. Training was particularly important for staff recruited from conventional home care services.
- High quality initial assessments by senior re-ablement staff; clear goals negotiated with users; regular reassessment throughout the re-ablement

⁴² CSED (2010). Homecare Re-ablement Prospective Longitudinal Study: Final report. Department of Health.

⁴³ CSED (2010). Homecare re-ablement prospective longitudinal study: Final report summary. Department of Health.

process; and flexibility to adapt the timing, duration and content of visits as users' needs and capabilities altered.

- Rapid assessment and delivery of equipment. Having quick access to occupational therapy skills and equipment may be more important than having occupational therapists employed as members of the re-ablement team.

Research suggests a number of other factors considered important to the success of the re-ablement service:

- Staff commitment, attitude and skills to encourage and motivate service users.
- A strong and shared vision of the service to ensure appropriate referrals and discharges.
- Flexibility, prompt intervention and quick access to specialist skills to prevent any delays.
- Adequate capacity within long-term home care services to maintain the level of turnover required by re-ablement services.

Research suggests⁴⁴ that following re-ablement people's need for social care services is reduced by 60% compared to if they had used conventional home care. Other studies⁴⁴ have shown that up to 63% of re-ablement users no longer need the service after six to 12 weeks, and that 26% had a reduced requirement for home care hours. Re-ablement also significantly improves people's wellbeing, particularly in terms of restoring their ability to perform usual activities and increasing their perceived quality of life⁴⁴.

Research indicates that a typical re-ablement episode cost £2,088, with a range of £1,609 to £3,575 (this reflects the total cost of the service including intervention and range of staff salary costs and overheads, per service user)⁴⁵. Re-ablement was also associated with a significant decrease in subsequent social care service use. Taking total healthcare, social care and re-ablement costs together, there was no statistically significant difference in the costs of all the services used by the re-ablement and comparison group over the 12 month study period. The findings from the study concluded that there is a high probability that re-ablement is cost-effective in relation to health-related quality of life outcomes and may also be cost-effective in relation to social care outcomes.

3.2.2 Rehabilitation

Community based rehabilitation requires a multi professional approach to care and can have a number of benefits. It can reduce the time spent in hospital, moves the patient either nearer home or indeed back home, has the potential for improved morale, increased visitors and reduced hazards from remaining in hospital⁴⁶. The impact and intensity of rehabilitation provided can vary

⁴⁴ SCIE (2011). Re-ablement: Emerging practice messages.

⁴⁵ CSED (2010). Homecare re-ablement prospective longitudinal study: Final report summary. Department of Health.

⁴⁶ British Geriatrics Society (2009). Rehabilitation of older people. BGS Best Practice Guide 1.4.

depending on the need for such services. For example, intensive rehabilitation is beneficial for those who have suffered a stroke, but may not be beneficial for those who have suffered a fractured femur⁴⁶. A randomised controlled trial compared a specialised interprofessional team approach to community based stroke rehabilitation with usual home care for stroke survivors using home care services. It concluded that a 12-month specialised, interprofessional team is a feasible and acceptable approach to community based stroke rehabilitation that produced greater improvements in quality of life compared to usual home care⁴⁷.

In Scotland a key theme within health and community care policy intended to bring about improvements in service delivery and health outcomes centres around shifting the balance of care⁴⁸. Shifting the focus of care is about shifting the emphasis away from acute services and towards preventative medicine, more care in the community and more continuous and integrate care for people with long term conditions. Interventions supported by strong evidence that could contribute to shifting the focus of care include rehabilitation in the community for a range of conditions. Shifting the balance of care reflects a shift in⁴⁸:

- Focus - shifting the emphasis towards preventative medicine and more care in the community, based on a fundamental change in the way we tackle the causes of ill health and by providing care which is quicker, more personal and closer to home. It also means shifting the focus away from services geared toward acute conditions to providing systematic support for people with long term conditions with a strong emphasis on continuous, integrated care rather than disconnected episodic care.
- Location - shifting the location of services and care in order to improve access to treatment and support. This involves the wider provision of diagnostic procedures and access to specialist services embedded into communities through Community Health Partnerships. This means less acute hospital-centred activity and more services and support provided in community hospitals, other local facilities and at home. Services and care should increasingly be provided in locations that are easily accessible for users with greater consideration given to transport requirements. This will enable care providers to get a better balance between planned and unplanned care.
- Responsibility - shifting the current view of patients/clients as passive recipients of care towards full partnership in the management of their conditions. This involves providing more support for people to look after themselves and remain as independent as possible using new technologies for telemedicine and telecare to help people to manage their conditions and stay longer in their own homes. Also in terms of professionals, shifting the emphasis away from the independence of individual practices and professionals towards a more extended primary and community care team approach. This means developing professional and staff roles, skills, expertise and responsibilities, with a greater focus on teams delivering integrated care pathways involving a wider range of partners, including patients and carers.

⁴⁷ Markle-Reid M et al (2011). Interprofessional stroke rehabilitation for stroke survivors using home care. *Can J Neurol Sci*; 38(2): 317-34.

⁴⁸ Johnston L et al (2008). Overview of evidence relating to shifting the balance of care: A contribution to the knowledge base. Scottish Government Social Research.

There are 4 main types of rehabilitation service⁴⁹:

- Acute: To treat acute illness and get patients medically stable.
- Intensive: Concentrated, focused, intensive rehabilitation with specialist medical and nursing support in the hospital setting.
- Intermediate: These meet a range of needs for the medically stable with a focus on 'confidence building'. Can be used post-discharge (step-down) or as a halfway house between home and hospital (step-up).
- Community based: Multidisciplinary teams working in patients' own homes and providing wider specialist support to intermediate settings.

Doctors, nurses, therapists and other health or social care workers all play a part in rehabilitation. The majority of community based rehabilitation services have input from physiotherapists and occupational therapists but fewer have access to nurses, speech and language or medical input. Staff shortages are a major problem, particularly among trained therapists. Some of the shortage can be rectified by training existing health and social care staff, like home-helps, to work differently. But there will need to be a significant increase in the number of fully trained workers available for rehabilitation for the level of support to increase nation-wide. It will also be important to train care and support workers to undertake more specialist work under supervision.

3.2.3 A future model of re-ablement

Research by Social Policy Research Unit⁵⁰ described functions of an 'intake' home care re-ablement service which include:

- Intensive short term intervention.
- Short term home care support.
- Extended assessment so appropriate levels of long term home care services are commissioned.

It further describes what re-ablement involves:

- Motivation – providing psychological and emotional support and encouragement.
- Providing equipment.
- Personal care and hygiene.
- Practical help (eg preparing meals).
- Prompting medication.
- Providing advice and information (eg about preventing falls and on local services).
- Helping (re)establish social contacts.
- Rebuilding confidence to get out (eg go shopping).

⁴⁹ Audit Commission (2000). The way to go home: rehabilitation and remedial services for older people. London, Audit Commission.

⁵⁰ Rabiee P and Glendining C (2010). The organisation and content of home care re-ablement services. SPRU.

CSED Homecare re-ablement toolkit suggests consider the following points and questions when designing the processes associated with a homecare re-ablement service⁵¹:

- **Think about the end-to-end process** and work from start to finish. Start with 'Where does my demand come from?' Go right through the process to beyond discharge from the service - incorporate your six month or yearly reviews in your process design.
- How do you keep the **intake process as simple as possible** so that a person is referred to the homecare re-ablement service as soon as possible?
- **Who will be involved in processing intake** and assessment cases?
- **How will these cases be logged** and how will you monitor intake numbers and sources, e.g. from hospitals, direct from contact centre, from area offices? This information will be important indicators of demand.
- **How will case notes and progress against desired outcomes be recorded** and maintained, and at the relevant level of detail, so that changes in a person's independence levels are noted as the homecare re-ablement phase progresses?
- Is the **'hand-over' of service users from one part of the process to another (across interfaces) clear** to the teams involved? How is the hand-over managed?
- How are results fed back and how is a **cycle of continuous improvement** achieved?
- How is **capacity monitored** and managed as demand changes, in order to eliminate bottlenecks? This is critical. If you can successfully identify and address these, you will be able to increase the efficiency and overall performance of your service.
- Is **discharge from the service effective and efficient?** Interim reviews of service users after 2 and 3 or 4 weeks can help improve performance by moving people through the system more quickly.
- Are your **policies and procedures appropriate, flexible and simple** to understand for the teams involved? Do they help your teams achieve the goals set out in your vision and business case?
- Do you have **robust reporting mechanisms** to measure performance of your service and provide solid evidence of achievement against the goals set in your vision and business case.

Key issues coming out of the research described above and linking with the current government agenda is the need to develop re-ablement services which have appropriate commitment and skills of front line staff supported by high quality assessment processes and access to additional support if required.

The following examples reflect approaches taken by a number of authorities.

West Sussex County Council (WSCC)

In 2005 WSCC moved from a generic in-house home care service of 60% share to a service of 10% share that focussed purely on re-ablement. It renamed itself the 'Regaining Independence Service'. This was accompanied by radical management restructuring with 16 middle manager posts reducing to 3. The

⁵¹ <http://www.csed.dh.gov.uk/homeCareReablement/Toolkit/>

service was changed to be OT led (6 OTs with 6 care quality coordinators supporting).

There are 150 Regaining Independence Assistants (RIAs) organised over 3 regions. In terms of related services, dementia and OPMH care were outsourced to specialist external providers.

The work is focussed around 6 week intense re-ablement packages. The new RIA was seen as very different from previous role to deliver this sort of intense service with new contracts and special training.

The change process required a very tight project management, staff TUPE arrangements, major HR involvement and that inclusion of trade unions. Unit costs for 2009/10 are £21.82 per hour excluding on costs and £26.21 including on costs. Savings in the first year were approximately £1m.

Gloucestershire County Council – STEPS service

On April 2007 Gloucestershire County Council in house home care reconfigured to provide an intake re-ablement service for all new referrals. The service is called Short Term Enablement Programmes (STEPS).

The STEPS service is for all adults over 18 years old, this includes people with physical disabilities, learning disabilities and older people; there is also a small case load of children's cases. STEPS provide six weeks re-ablement through detailed outcome and re-ablement based assessments and outcome based care planning. The service is reviewed weekly by a specific monitoring tool.

The aim of the service is to prevent admission to hospital and support timely discharges and prevent unavoidable admissions to care homes.

The service has proved to be successful with 30% of service users care plan significantly reducing or ceasing altogether.

The service wants to develop ways of identifying with service users wider outcomes that may be met alongside home care provision, such as leisure, transport, housing etc. The service is training their home support officers to do this.

Improving client pathways is a priority for the service and two areas of work have been identified:

- Roll out re-ablement training to the external market so the quality of care and ethos of re-ablement is continued for the service user as long as they require formal input.
- Currently the intermediate care service and the START (Short Term Assessment and Re-ablement Team) service work in silos and again the service is committed to try and bridge these gaps and work towards a more integrated approach.

London Borough of Sutton – START Service

START, which was part of Sutton's in house home care provision, was a small service that was designed to support hospital discharges service. The service

proved to be very popular and effective and given this it was decided that the START service was to be greatly expanded in size to form an intake and re-ablement service available to all new service users. This has meant the in house home care divesting itself of longer term care packages and becoming solely an Intake and re-ablement team. The service went live in September 2008.

The service is for all adults over 18 years old and provides a flexible short-term period of assessment and rehabilitation, in order to assist people to maximise their level of ability and independence within their own homes. Existing service users can also have the opportunity to be referred to the service if it has been identified they would benefit from a short term period of assessment to meet changing needs.

The service aims to prevent admission to hospital and support timely discharge arrangements, promote independence, and prevent unnecessary admissions to care homes and breakdown in care arrangements in the community.

Service users have outcome based support plans. The home care assessors work with the service user to meet these stated outcomes via the care/ support package. Service users can be sign-posted to other services and sectors by carers who have been trained to be able to do this as appropriate. The choices that people are making are being fed back to commissioning bodies as are outcomes achieved by the service. Monitoring tools are in place that review re-ablement progress at the start of the service and then weekly to the end of the intervention.

Flexible contracts with care staff over the hours of 07:00 and 23:00 covering 365 days a year means that the service can provide a seven day flow of carers who are available. Each service user is therefore given a flexible period of time for individual outcomes to be met in accordance with their support plan.

The team has close working links with their health partners and START carers have the role as 'trusted assessors' which means that they can do low level occupational therapy assessments such as kitchen skills, moving and handling assessments; as a result of these assessments the service has direct access to the relevant equipment. Moreover community occupational therapists and physiotherapists provide training and set programmes and goals for carers to follow with service users.

When the service has come to an end the service user, if required, is then transferred to the external mainstream providers. The service however keeps 20% capacity for complex and unstable cases and people with palliative care.

The Local Authority offers the same mandatory training for external agencies as it does for the START service and also offers the wider home care sector re-ablement training.

From Sept 2007 – July 2008, 182 service users no longer required care after a period of re-ablement from START and 60 service users care reduced.

New Zealand - Community FIRST

Community FIRST (Flexible Integrated Restorative Support Team), established in Hamilton (New Zealand) in 2002⁵². Community FIRST aimed to support older people with high and complex needs. A multi-disciplinary team provided an in-depth support plan, which was delivered by well-trained support workers/therapy aids closely supervised by the multi-disciplinary team. Some 113 people participated from the Hamilton region, of whom 56 received Community FIRST and the remainder received usual care. The results showed mortality risk and the risk of admission to residential care were reduced for the Community FIRST group compared with individuals in receipt of usual care. Moreover, a trend for improvement in activities of daily living was observed in older people in the Community FIRST service compared to the usual care group.

3.2.4 A future model of rehabilitation

A review by the Audit Commission found four key themes in relation to rehabilitation services reflecting the need for access, assessment, organisation and continuity:

- Access to rehabilitation needs to be available when required – through appropriate arrangements for assessment and to appropriate services in a range of settings.
- There is strong evidence that comprehensive assessment, followed by the implementation of individual care plans, reduces the risk of older people being re-admitted to hospitals or placed in long-stay care. It also improves survival rates and physical and cognitive functioning.
- The appropriate organisation of services is also critical to their effectiveness. Services should 'be organised to achieve co-ordination of different interventions and different phases of the rehabilitation process'. Furthermore, the 'more one can achieve co-ordination of diverse inputs through a systematic approach, protocol or team delivery, the more effective the rehabilitation may be'. The evidence here is particularly strong for stroke care, where there is co-ordinated multidisciplinary care, education, training and the specialisation of staff.
- Continuity of care is essential. Where people receiving rehabilitation are transferred between different services, it is essential that their care plan is transferred with them. Services 'should be organised to achieve co-ordination of different interventions and different phases of the rehabilitative process'. However, managing and delivering this complexity in practice is difficult. It requires a multiplicity of agencies, professions and services to work together, even though they are all funded, managed and held accountable through different means.

Those who need rehabilitation can be divided into three groups⁵³:

- Those who will recover quickly and who do not need more than a limited amount of help with rehabilitation.
- Those who will take much more time and who need a lot more help.

⁵² CSED (2010). Homecare re-ablement prospective longitudinal study: Final report summary. Department of Health.

⁵³ Audit Commission (2000). The way to go home: rehabilitation and remedial services for older people. London, Audit Commission.

- Those whose recovery will be limited, and who will need palliative or continuing care.

There is evidence that rehabilitation works best where it is well organised. As rehabilitation can be provided by a variety of different professionals, from the NHS, social services and other organisations, it is important that all those involved in a person's care are working cooperatively and that they understand how their efforts fit together. It is also important that the person receiving care is involved in decisions about what support they receive. Rehabilitation is about giving older people a better chance in life, so responding to their personal views about the kind of support they want are crucial to its success. If the user has a carer at home, for example a spouse or son or daughter, the carer should also be seen as a member of the team, with an important contribution to make.

Rotherham – Community Assessment Rehabilitation and Treatment Scheme (CARATS)

Between 1990/91 and 1994/95 Rotherham Acute Trust experienced a 32 per cent growth in emergencies and an 85 per cent increase in admissions through A&E. A review of inpatient and other facilities in general medicine and medicine for the elderly showed that an additional beds were required. Predicted demographic change suggested that the Trust would need another 29 beds (ie, another ward) by the year 2000 unless alternatives to hospital care were developed locally.

The response was to develop a Community Assessment, Rehabilitation and Treatment Scheme (CARATS) in 1997, using money from the Continuing Care Challenge Fund. CARATS was developed by local NHS and social services organisations to:

- Prevent avoidable admissions to hospital.
- Reduce lengths of stay in acute hospital care.
- Prevent inappropriate admissions to residential/nursing home care.
- Devolve care assessment and management of these patients to the primary care team.
- Help to identify local community care needs.

Initially, the scheme was made up of two major elements:

- A 'fast response service'.
- Residential and day rehabilitation schemes.

The University of York Health Economics Consortium has evaluated both. The rapid response team received 644 referrals in its first 15 months of operation, with 406 being accepted. Approximately twice as many accepted referrals were to prevent admission than to facilitate discharge, and increasing numbers of assessments were undertaken in the community. Terminally ill patients accounted for about 40 per cent of accepted referrals. Only 8 per cent of patients had to be admitted to hospital while in receipt of CARATS. Considerable numbers of bed days have been saved (1,684–2,880 depending on assumptions about length of stay), at a lower cost per bed day.

In addition to the two major elements of CARATS, other schemes have been developed. These have included:

- The provision of therapy (physio- and occupational therapy) to a social services day centre to complement the social rehabilitation scheme.
- The use of nursing home beds for recovery. These were for patients who no longer required hospital-based medical care but who needed a maximum two-week period of nurse-supported care and recovery before returning home. They were also used to prevent hospital admission for people whose carer had fallen ill.

In addition, other developments are being planned as there is still considerable potential to improve the schemes further and to extend the range of care provided in patients' homes.

3.3 Specialist home care

The number of people with complex and severe needs is growing as a result of advances in medical science and an ageing population. The multiple needs of individuals can include learning difficulties, physical disabilities and mental health disorders. This poses significant challenges to adult social care commissioners and providers. A personalised and specialised support package that addresses a breadth of different, but inter-related, needs is expensive. It also requires coordination across a wide range of services, professionals and other workers, particularly across health and social care.

3.3.1 Complex and frail cases

It is important to recognise that care and support workers are more than ever helping people with various disabilities and complex health and personal care needs to live in their own home instead of in residential or nursing homes or long stay hospitals. The provision of this type of personal domiciliary care services is evolving rapidly and reflects changes at the interface between health and social care. Complex cases are therefore characterised by people with a range of disabilities or combinations of long term health conditions requiring specialized management or treatment or support. This would include people who are particularly frail where a variety of physical and mental health issues often interact requiring input from both health and social care. Complex cases are not rigidly defined and could include palliative or end of life care with the sort of issues evident in the examples discussed below relating to other specialist home care.

Initiatives to support frailer, or chronically ill older people should be underpinned by a number of principles⁵⁴:

- Increasing choice and control, by enabling older people to play a more active role in managing their own health and care and by building partnerships between older people and professionals.
- Proactively promoting health, by focusing on 'upstream' interventions that aim to enhance well-being and avert crises.

⁵⁴ Audit Commission (2004). Supporting frail older people: Independence and Wellbeing.

- Adopting a whole-person approach, by exploring the whole range of issues that have an impact on older people's well-being, based on broad assessment processes.
- Building a whole-system response, by ensuring that not just the NHS, but also social services, housing, the pensions service and a range of other agencies are appropriately involved.

Whatever model is chosen to fit local circumstances, it needs to be implemented carefully if it is to deliver greater independence and well-being to frail older people, giving them greater choice and control. This requires a number of key steps⁵⁵:

- Building a case for change.
- Making sure that everyone understands what is involved.
- Identifying people who can benefit.
- Carrying out thorough assessments.
- Helping people to retain control and choice.
- Shifting control and decision making from the hands of professionals, to partnership with older people.
- Involving older people in decision making about services that meet their needs.
- Developing professional support.
- Managing the whole process into being.
- Anchoring new developments in commissioning plans.

EverCare

EverCare, a subsidiary of United Health Group (UHG), provides enhanced medical care and co-ordinates services to frail, chronically ill and disabled older people. In the US, the program focuses on people in nursing homes, using a Primary Care Team model, where physicians, nurse practitioners and care staff work together to improve outcomes. The core principles of the approach are to:

- Apply an individualised, whole-person approach to care, with all interventions focused on promoting maximal function, independence, comfort and quality of life.
- Use primary care as the central, organising force for healthcare.
- Provide care in the least invasive manner, in the least intensive setting.
- Avoid adverse effects of medication and polypharmacy.
- Use data to strengthen decision-making.

49 Older people identified for the scheme are allocated a nurse practitioner, who sees them regularly, providing more than the usual episodic care. They monitor the older person, but also liaise regularly with family members and primary care doctors. By delivering medical management in a timely fashion, EverCare has successfully improved outcomes for people and, at the same time, reduced hospital stays dramatically. Evaluations have shown:

⁵⁵ Audit Commission (2004). Supporting frail older people: Independence and Wellbeing.

- A 50 per cent reduction in the hospitalisation rate of those enrolled in the scheme, without any apparent increase in mortality, as compared to a control group.
- A reduction in the number of prescription drugs taken while maintaining health. This reduces the side effects associated with taking a large number of medications and achieves cost savings.
- A 97 per cent satisfaction rating among families, as well as an extremely high physician satisfaction rating.

In the UK, the NHS Modernisation Agency is overseeing a project involving ten PCTs that are working with, and learning from, UHG's experience. Nine of these PCTs are implementing the EverCare model.

Pursuing Perfection

Pursuing Perfection is an international programme developed by the Institute for Healthcare Improvement (IHI), based in Boston, Massachusetts. The initiative aims to improve individual outcomes by striving to:

- Provide high-quality care to people at the right time, in the right place and by the right person.
- Identify the most effective clinical and managerial processes for individual service users through the detailed examination and redesign of health systems.
- Reduce risk and adverse incidents, thereby providing a safe environment for people, their carers and healthcare staff.
- Respect the unique needs and preferences of individuals.

Four UK pilot sites are testing the approach with the support of the NHS Modernisation Agency. The model places a strong emphasis on working in partnership with service users and, in the UK, is based on cross-organisational working within whole health and social care communities. While Pursuing Perfection does not focus on older people alone, some areas have chosen to prioritise developments for older people. Improvements are measured against six dimensions of quality. These are:

- Safety: provide a safe environment.
- Effectiveness: the care system should reliably match care to science, avoiding overuse of ineffective care and underuse of effective care.
- Patient-centredness: healthcare should reliably respect the individual in terms of informed choice, culture, social context and specific needs.
- Timeliness: care should continually reduce waiting and delays for both service users and those who give care.
- Efficiency: the reduction of waste and, thereby, the reduction of the total cost of care should be unceasing.
- Equity: the system should seek to close ethnic and socio-economic gaps in health status.

Lambeth and Southwark are one of the pilot sites where a number of organisations are working in partnership to deliver the programme. These include the PCT, acute trusts and the local authorities. One of the areas that the

team have initially chosen to focus on is testing ways to improve the management and assessment of frail older people.

The initial phase of this part of the programme will focus on improving care and support in two GP practices, whose lists form the target population. Currently, over 450 people aged over 75 years attend the local acute trust each month. The project aims to shift service provision and access to care and support away from reactive, emergency care to proactive, planned care. By doing this, they hope to reduce A&E admissions for the two local practices by 25 per cent. To achieve this, local services are working together to identify vulnerable older people and meet and manage their needs by providing a number of new services. These include improved care co-ordination, one-to-one appointments with older people's specialists and multidisciplinary reviews. Data analysis is used to help staff to have a better understanding of how services are currently used and to provide a clear indication of the impact of the changes. Central to the approach of the Pursuing Perfection programme is the introduction of new ways of working on a small scale, testing them out and then spreading the learning across the whole system once the impact of the changes is fully understood. The overall ambition is to ensure that the whole population of frailer older people within Lambeth and Southwark receive ideal care.

3.3.2 Dementia care

In the development of domiciliary care services for people with dementia, there has been debate concerning whether these should be delivered on a specialist basis or as part of more generic home care services for vulnerable older people. Few organisations provide solely specialist domiciliary care for people with dementia, although this may be offered as a discrete service within a larger organisation⁵⁶.

Research⁵⁶ has found that there were few differences in 10 quality standards between specialist and generic care. The quality standards assessed were: systematic assessment; flexibility; individuality; culturally appropriate care; management practices; integration; care worker good practice; carer involvement; staff training; and briefing documents. Whether sourced from a generic or specialist provider, it is important that there is a sufficient quantity and intensity of care available to provide for the multiple and changing needs of people with dementia. There were benefits of linkages between domiciliary care providers, specialist case managers and community mental health teams for older people.

Provision of support for both generic and specialist domiciliary care services was seen to reduce the risk of admission to a care home, particularly for older people with severe dementia⁵⁶. Specialist domiciliary care could be effective if targeted on those with more severe needs, such as people in the later stages of dementia.

Differences in costs found between specialist domiciliary care and generic services may also reflect the cost associated with variations in the commissioning and contracting processes of different local authorities. What mattered more that cost was whether the service conformed to good practice or quality

⁵⁶ PSSRU (2010). Expert Briefing paper 2: Community support services for people with dementia. The relative costs and benefits of specialist and generic domiciliary care services.

standards for dementia care and the evidence suggests that both generic and specialist providers may offer this.

Key attributes of a domiciliary care service for people with dementia include:

- Individuality or user centred practice.
- Dementia specific training for staff.
- Continuity of care.
- Flexibility of response.
- Intensity of provision of support.
- Service mix (specialist such as focus on behaviour and generic focusing on activities of daily living).
- Service linkages eg between community mental health teams for older people.
- Cost effectiveness.

South Gloucestershire Dementia Service

The purpose of the dementia team is to provide a specialist service for people with a medical diagnosis of dementia and who meet the eligibility criteria of the Older Peoples Mental Health Team.

It aims to provide a holistic and person centred care approach to older people whose primary needs are associated dementia rather than physical needs. Another element of the service is to provide care for people at home who without this specialist input would be unable to remain at home. This later objective includes service users that are difficult to engage or are resistant to main stream services.

It is hoped that such a service will enable people to remain in their homes and prevent unnecessary admissions to hospital or other more intensive interventions. It is hoped that this service will not only be good value for money but also provide care of the highest quality in line with good practice principles.

The Dementia Team is split in to two teams that cover North and South of South Gloucestershire. The team is staffed by a part time manager, 2 coordinators, a part-time administrator, and a team of carers.

An evaluation of the service found⁵⁷:

- The dementia service is a very small but good quality service which aims to engage with often challenging service users through a flexible approach to service provision and having a focus on outcomes.
- The service appears to be an expensive service.
- It has a relatively low contact time suggesting improvements could be made to its efficiency.
- There is limited availability to take on new referrals.
- The ability to increase care packages in response to changing need can be affected by lack of availability.

⁵⁷ IPC (2009). South Gloucestershire Evaluation of Homecare Service.

- There is a high level of service user and carer satisfaction with the service.

3.3.3 End of life care

End of life care can be described as the care, treatment and support that is provided to enable a person with an advanced, progressive, incurable illness to live as well as possible before management of pain and other symptoms, the provision of psychological, social, spiritual and practical support, and support for the family⁵⁸. According to the Department of Health's *End of life care strategy*⁵⁹, high quality end of life care "should be available wherever the person may be: at home, in a care home, in hospital, a hospice or elsewhere".

Core principles for delivery of end of life care include⁵⁸:

- Care is client centred and integrated.
- Treat individuals with dignity and respect.
- Identify and respect people's preferences.
- Provide care after death.

There is a need to work with other professionals in health and social care and assist staff to⁵⁸:

- Identify when someone is approaching the end of life phase.
- Assess needs and develop a care plan.
- Review care planning.
- Help to review practice.
- Support communication and team working.
- Understand that staff may be affected by the death of a client and identify some measures to support them and provide information.

Quality markers have been described along the end of life pathway:

Step 1 – Discussions as the end of life approaches.

- Have an action plan/policy in place which will support workers caring for those approaching the end of life.
- Have a mechanism in place which identifies and records which people may be approaching the end of life.

Step 2 – Assessment, care planning and review

- Ensure an holistic assessment has been carried out and those who need to be are aware of the resulting care plan.
- If wishes and preferences about future care have been expressed they should be communicated, with permission, to the appropriate people.

⁵⁸ National end of life care programme (2011). The route to success in end of life care – achieving quality in domiciliary care.

⁵⁹ Department of Health (2008). End of Life Care Strategy: Promoting high quality care for all adults at the end of life.

Step 3 – Co-ordination of care

- Consider the needs of the carer.
- A mechanism should be in place to co-ordinate care across organisational boundaries 24/7.
- Have essential services available and accessible 24/7 as end of life approaches.

Step 4 – delivery of high quality care in domiciliary care

- Be aware of end of life care training opportunities and enable relevant workers to access or attend appropriate programmes dependent on their needs.

Step 5 – care in the last days of life

- Adopt a standardised approach (Liverpool care pathway or equivalent) to care for people in the last days of life.

The Liverpool Care Pathway⁶⁰ (LCP) is an integrated care pathway that is used at the bedside to drive up sustained quality of the dying in the last hours and days of life. It is a means to transfer the best quality for care of the dying from the hospice movement into other clinical areas, so that wherever the person is dying there can be an equitable model of care. The LCP has been implemented into hospitals, care homes, in the individuals own home / community and into the hospice. It is recommended as a best practice model, most recently, by the Department of Health in the UK.

Step 6 – care after death

- Ensure systems are in place to monitor and evaluate the provision of end of life care.

End of Life Care for People with Dementia⁶¹

A study into the care of people with advanced dementia in one London borough suggests that small changes to local health and social care services could significantly improve their end of life care as well as providing greater value for money.

End of Life Care for People with Dementia, produced by the Marie Curie Palliative Care Research Unit with a number of partners, including ForDementia and the National Council for Palliative Care, says that dementia patients are often hospitalised in times of medical or social crisis. But, the report suggests, most of these people would be better cared for if they remained in the community.

It recommends, among other things, a holistic dementia care pathway in the borough, better coordination among the different community agencies and more training for those acute hospital staff expected to care for people with dementia.

⁶⁰ <http://www.liv.ac.uk/mcpcil/liverpool-care-pathway/> (accessed 08/06/2011).

⁶¹ <http://www.endoflifecareforadults.nhs.uk/> (accessed 08/06/2011).

The objectives of the project, which began in 2008 were to: identify key issues of importance and concern to patients, carers and services; identify any barriers to good quality end of life care; scope existing dementia services in the borough, and make cost-effective recommendations to improve care pathways and outcomes at the end of life.

The study was based on focus group meetings with a range of professionals, in-depth conversations with seven carers who had recently been bereaved and a detailed examination of the case notes and care pathways experienced by nine patients with dementia who died in a home or institutional environment between May 2008 and March 2009.

Most of the people studied spent an average of 12 days on each admission in an acute hospital setting, ranging from two to 40 days. All the admissions reviewed were unplanned and in most cases involved ambulatory care sensitive conditions – that is, conditions that with adequate support could have been treated within the community, ranging from falls, urinary tract infections and dehydration, the need to give the carer respite or where a care package was breaking down.

The study calculated that the average cost of purchased care for someone with dementia in their last six months of life was around £25,000 with acute hospital episodes responsible for almost 20% of those costs. The costs of looking after someone at home (just under £20,000) were significantly less than for residential or nursing care (£37,000).

The authors recommend greater use and discussion about advance care planning from early on in the disease trajectory. There should be more help for carers, including greater respite support. They also support the introduction of a register for people with dementia similar to the GPs' palliative care register.

Partners involved with the project have already committed to using the findings to improve local services. In addition the borough is setting up several care pathways to address some of the issues identified.

A report of the study's findings and recommendations, including a full technical and economic analysis report, is now available on the Marie Curie Cancer Care website. In addition the team has produced a toolkit on the internet to enable other UK service providers to carry out similar work in their localities

Respite palliative homecare teams⁶²

Respite palliative homecare teams in Salford and Trafford are enabling terminally ill patients to be cared for and die at home – regardless of diagnosis.

The homecare teams were originally set up after local studies in the two areas showed that as few as 21% of all cancer patients were dying at home.

But a year after their introduction a survey revealed that 80% of all patients visited died at home while three quarters of the remaining 20% died in the place of their choice.

⁶² <http://www.endoflifecareforadults.nhs.uk/> (accessed 08/06/2011).

Evaluation studies also showed the care provided was excellent and that all carers, professional and lay, benefited from the increased support provided.

Recently it was decided to extend the service from the last few weeks to the final year of life – and to provide support not only to patients but also their carers.

Within Trafford it was also decided to provide care overnight where necessary.

The two teams, which are funded by their primary care trusts in collaboration with St Ann's Hospice, offer a combination of psychological and practical support, nursing care and advice that is supplementary and complementary to the existing community services.

They facilitate the discharge of palliative care patients from hospital or hospice, especially those whose preferred place of care is home, and provide support if either the patient or carer are facing a crisis

Each team consists of a full-time coordinator and team leader together with registered nurses and health care assistants.

Both are underpinned by an extensive bank of nurses who have experience in delivering palliative care at home.

The main challenge when setting up these services was the poor response from the district nursing teams.

This has been overcome by raising awareness and involving the DNs in decisions about service delivery and change.

The teams are now planning to expand their remit to a greater number of non-cancer patients.

Although care is provided to anyone with a life limiting illness only around 17% of all patients visited have a non-cancer diagnosis.

The professionals working in these clinical areas will be told about the service in the hope that raised awareness will lead to an increase in referrals.

Education and training will also be provided to all team members to ensure they are adequately equipped to offer appropriate support.

3.3.4 Out of hours/night time service

The delivery of specialist home care will require the provision of care for individuals outside of normal working hours. Furthermore, in order to provide a flexible domiciliary service which offers individuals choice and flexibility will require a service that can operate when required, and not just provide care between set hours. Almost half of providers of home care services offer night sitting, day sitting and respite for carers, though some local authorities retain

this element of domiciliary care for in-house services⁶³. A review by CSCI⁶⁴ found a need for better out of hours services as currently they are inadequate.

The provision of domiciliary care services out of hours still requires providers to respond appropriately to calls from service users and ensure that an efficient and effective domiciliary care service is provided in accordance with individual care plans. It also provides an element of an emergency response service and reassurance for service users and their families.

3.4 Costs of domiciliary care

Independent sector providers of home care have traditionally charged for their services at rates which are low relative to the costs of such services provided directly by local authorities⁶⁵. Despite changes in employment law and other pressures on workforce costs which have, to some extent, been recognised by price increases rates have still not reached the necessary level to cover the real costs of providing the service and to give a reasonable margin to allow for risk or to enable a realistic return on the capital involved in providing the service. In-house teams in many areas have experienced changes designed to make them more competitive in the market. For some this has meant reductions in guaranteed hours, changes in terms and conditions, restructuring of services.

One of the main reasons for the cost differences between in-house and externally provided services has been the extent to which in-house staff have been paid for non-contact time, i.e. time which is not spent in direct service provision⁶⁵. Increasingly non-contact time now also has to be paid in the independent sector. This is likely to be primarily for:

- Time spent travelling between service users.
- Time spent training.
- Time for supervision.
- Guaranteed time.

Standard domiciliary care

The average price for a weekday, daytime hour of care privately purchased from the independent sector in 2009 was estimated as £12.98 in a market survey (though there can be vast geographical variations)⁶⁶. The survey analysis also found that there was no evidence to support the suggestion that those individuals purchasing services privately pay significantly higher than those provided through the local authority.

A report by PSSRU investigating domiciliary care providers found that across charities and voluntary organisations as a whole there is a wide range in rate charged (£6-£15 per hour) but among those organisations which are both registered charities and limited companies there is less variability (£6-£13.60 per

⁶³ Matosevic T et al (2001). Domiciliary care providers in the independent sector. PSSRU.

⁶⁴ CSCI (2006). Time to care: an overview of home care services for older people in England.

⁶⁵ UKHCA (2003). Calculating the real cost of homecare: A costing model provided by the UKHCA.

⁶⁶ UKHCA (2011). An overview of the UK domiciliary care sector.

hour)⁶⁷. There was also a significantly greater difference between weekday and weekend daytime prices than between weekday and weeknight prices and greater variation in prices in London and the South than there was in the North. Travel costs were included in hourly charges for the majority of providers, although for privately-funded clients there was more likelihood that travel costs would be added according to the client situation. Some 70% of organisations had their travel costs included in the price of service for the publicly-funded clients whereas for private payers, 55% of providers included travel costs in their prices.

Re-ablement

Research suggests⁶⁸ that following re-ablement people's need for social care services is reduced by 60% compared to if they had used conventional home care. Other studies⁶⁸ have shown that up to 63% of re-ablement users no longer need the service after six to 12 weeks, and that 26% had a reduced requirement for home care hours. Re-ablement also significantly improves people's wellbeing, particularly in terms of restoring their ability to perform usual activities and increasing their perceived quality of life⁶⁸.

Research indicates that a typical re-ablement episode cost £2,088, with a range of £1,609 to £3,575 (this reflects the total cost of the service including intervention and range of staff salary costs and overheads, per service user)⁶⁹. Re-ablement was also associated with a significant decrease in subsequent social care service use. Taking total healthcare, social care and re-ablement costs together, there was no statistically significant difference in the costs of all the services used by the re-ablement and comparison group over the 12 month study period. The findings from the study concluded that there is a high probability that re-ablement is cost-effective in relation to health-related quality of life outcomes and may also be cost-effective in relation to social care outcomes.

West Sussex Regaining Independence Service has some example costs:

- Weekly contact hours = 2,405.
- Annual contact hours = 125,060.
- Support worker contact rate = 65%.
- Direct cost per hour = £22.82.
- Total cost per hour = £23.96.

Rehabilitation costs are more initially because it requires extra services – both facilities and staff. But it may be cost effective where the person who has been rehabilitated then needs less long-term care, or where the move from acute care to rehabilitation facilities releases acute beds. Detailed information on cost for rehabilitation is limited however, a report by the Audit Commission suggest unit costs for social rehabilitation schemes are around half those of community

⁶⁷ Matosevic T et al (2001). Domiciliary care providers in the independent sector. PSSRU.

⁶⁸ SCIE (2011). Re-ablement: Emerging practice messages.

⁶⁹ CSED (2010). Homecare re-ablement prospective longitudinal study: Final report summary. Department of Health.

hospitals (£66.50 gross per day compared to £123 per day), but therapy input can be higher⁷⁰.

Specialist services

Specialised support packages that address a breadth of different, but inter-related, needs are expensive. They also require coordination across a wide range of services, professionals and other workers, particularly across health and social care.

Dementia – Whilst specialist provision has been argued to be more suitable for people with dementia, there is little evidence as to its differential benefits over more generic provision. The evidence for differences in costs between specialist and generic forms of domiciliary care for those with dementia is limited⁷¹. In terms of unit cost, whilst on average specialist domiciliary care was slightly more expensive, given the overlap in costs, this was not always the case. Although the costs of specialist domiciliary care appeared higher than generic, an average of £16 per hour compared to £13 per hour, there was considerable degree of overlap in the costs of different types of home care between different local authorities. Hence a cost of £16 per hour could represent either a generic or a specialist domiciliary service in some local authorities. Differences in costs found between specialist domiciliary care and generic services may also reflect the cost associated with variations in the commissioning and contracting processes of different local authorities. What mattered more than cost was whether the service conformed to good practice or quality standards for dementia care and the evidence suggests that both generic and specialist providers may offer this.

An example end of life care for people with dementia study found that the average cost of care for someone with dementia in their last 6 months of life was around £25,000 with acute hospital episodes responsible for almost 20% of those costs. The costs of looking after someone at home (just under £20,000) were significantly less than they might have been for residential or nursing care (£37,000).

These are of course only indicative charges and costs. More work would be needed to identify local comparative rates. In addition it needs to be noted that regulation is imposing new costs on the industry, for example, training and supervision, registration fees and QA systems. Perhaps the crucial comparator however, particularly for intensive support services, is with the costs of residential, nursing home and hospital care.

4 Service design

In any service development we suggest that the following 3 approaches will need to be very carefully considered, being potentially very attractive to service purchasers:

⁷⁰ Audit Commission (2000). The way to go home: Rehabilitation and remedial services for older people. London, Audit Commission.

⁷¹ PSSRU (2010). Expert Briefing paper 2: Community support services for people with dementia. The relative costs and benefits of specialist and generic domiciliary care services.

- Outcome focused approaches – focusing on the impact of the service on an individual's quality of life, in contrast to services whose content and/or forms of delivery are standardised or are determined solely by those who deliver them. Consideration will be given in terms of what this means in relation to service users, service delivery and contracting.
- Targeted and early intervention/prevention approaches – for example those which provide a 'rapid response' and those that use a 'turnaround' approach in that the attempt is both to turn people around from their health and well being deteriorating and that the interdisciplinary, inter-conditions approach represents a turnaround in terms of thinking about service provision.
- Integrated health and social care approaches – those which cut across professional disciplines providing seamless care for individuals.

4.1 Outcome focused approaches

Outcome based approaches require fundamental change in the way that services are delivered. Outcomes based approaches is about changing:

“the social care system away from the traditional service provision with its emphasis on inputs and processes towards a more flexible, efficient approach, which delivers the outcomes people want and need and promotes their independence, well-being and dignity”⁷²

4.1.1 Outcome based commissioning and contracting

Traditionally home care has been commissioned by Local Authorities with registered providers via block or spot contracts. Specifications have tended to be prescriptive in terms of tasks to be performed and with care defined by time limited slots. Additionally care management assessments have focused on need and what the person cannot do as opposed to what they would like to achieve or aspire to. This has resulted in care delivery that, firstly, concentrates on person's deficiencies and, secondly, does things for people within specified amounts of time. With demand for home care increasing this means that care can be rushed because the carer needs to get on to their next call. This has led to unimaginative, long standing and at times static and expensive care arrangements and contracts. Such a situation can be regarded more of a 'system centred'⁷³ approach as opposed to the desired person centred approach.

Outcome based contracting moves from specified care tasks and timed visits to a system where an individual is assessed and allocated a number of hours; the use of this time can then be arranged constructively and imaginatively to ensure outcomes and aspirations are met. For example if a person wants to use their time to go for a walk to improve their mood and see friends, then this is what will be supported. The individual outcome for this scenario may be 'I would like to socialise and get out of the house more' the strategic outcome may be 'to reduce the numbers of people feeling socially isolated'. The details of the care delivery and what outcomes want to be achieved is worked out between the older person and the provider agency.

⁷² Department of Health LAC (DH) (2008) 1Transforming Social Care

⁷³ Patmore C and McNulty A, Making home care for older people more flexible and person centred Factors which promote this (2005)

An outcome focused approach to funding requires commissioners to ask:

- What are we buying in outcome terms?
- What are the chances we will get it?
- Are we paying the best price for the best results and highest quality?

Outcome based purchasing means putting in place a set of arrangements whereby a service is defined by, and paid for, on the basis of a set of agreed outcomes rather than the volume or way in which it is delivered. It also means having a system for measuring and monitoring outcomes and using that information to drive the strategic direction and the commissioning decisions. Currently there is no common framework to capture outcome based data, although a number of approaches are being used and there are some emerging examples that illustrate what a good strategic approach might entail⁷⁴.

4.1.2 Outcome based service delivery

Working in an outcome focused way will mean a different role for providers reflecting the need to:

- Design services and support that will achieve outcomes.
- Effectively monitor the achievement of outcomes.
- Be able to provide evidence to commissioners that service is meeting outcomes.
- Regularly evaluate and assess individuals outcomes.

The focus on outcomes will enable providers to work more creatively and flexibly with service users to ensure they meet their needs.

There are a number of tools which can be used by providers to evaluate and monitor outcomes. These include:

- ASCOT – Adult Social Care Outcomes Toolkit which is used to measure improvement in outcomes for individuals and can measure: changes over time; current and expected situation in the absences of a service; expected gain from service use; and capacity of the individuals to benefit from a service.
- Talking Points (Scotland) – is an approach which is seen to provide an opportunity to ‘get back to basics’ in working with individuals and families to identify the goals they want to achieve. Talking points provides a framework for people to use in order to get people talking about the outcomes they want to achieve during assessment and support planning processes.
- Outcomes Star – a scoring system measuring wellbeing on a number of areas which are relevant to the individual.

⁷⁴ Putting People First (2009). Working together for change: using person centred information for commissioning.

Guidelines for promoting flexible, person centred home care which is outcome focused reflect ⁷⁵:

- Belief in 'caring for the whole person'. Belief in the value of flexible, person centred home care.
- Customers are served by regular provider staff enabling them to get to know individuals priorities and aspirations and to enable staff to become motivated to help fulfil them.
- The provider can deploy some staff time flexibility for ad hoc purposes.
- Clear, agreed policies concerning flexibility, use of spare time and assisting customers to find private extra help.
- Purchasers directly commission interventions to address customers quality of life.
- A pragmatic approach by provider management to decisions on flexible, person centred help.
- Staff rewards which can attract and retain high quality care workers.
- Provider management must be sufficient to ensure basic standards.
- Having enough time is always important.

4.1.3 Service user experience of outcome focused services

An outcome focused approach could provide a change in service provision and experience for service users. An outcome focused approach can provide:

- Greater choice and control.
- Care management assessments that are focused on what they would like to achieve or aspire to as opposed to need and what the person cannot do.
- Flexibility and creativity in how care is provided. Time can then be arranged constructively and imaginatively to ensure outcomes and aspirations are met. For example if a person wants to use their time to go for a walk to improve their mood and see friends, then this is what will be supported. The individual outcome for this scenario may be 'I would like to socialise and get out of the house more' the strategic outcome may be 'to reduce the numbers of people feeling socially isolated'.

Hartlepool Borough Council

The Joseph Rowntree Housing Trust (JRHT) Hartfields Extra Care and Support scheme has been operational since the summer of 2008 providing a mixture of approximately 240 tenure options and support arrangements currently providing services to approximately 50 clients funded by Hartlepool Borough Council Child and Adult Services (HBCCAS). The care and support to the HBCCAS funded clients has been designed and delivered according to an outcome based specification and a care and support planning template developed in 2008.

There were three outcomes specified in the contract:

- "Contribute to the initial reduction of the levels of care and/or support previously received by the Service User before entering the scheme.

⁷⁵ Patmore C and McNulty (2002). Caring for the whole person: Home care for older people which promotes wellbeing and choice.

- Support the on-going care and support needs of its Service Users and reduce the likelihood of admission to long term care.
- Contribute to the prevention of hospital admission, re-admission and enable early discharge.

In addition to the three outcomes specified above, the Provider was also required to:

- Deliver health promotion outcomes to both Service Users and Residents of the Wider Community. Examples of individual outcomes that the Service will need to deliver for include:
 - Contribute to supporting people to live independently, stay healthier and recover quicker from illness or accident.
 - Contribute to improving the independence and quality of life of people with long term conditions.
 - Assist people in enabling and maintaining a positive, active and productive approach to their lives.

The HBCCAS's Care and Support Plan was used to identify the intensity of an individual's care and support needs and be placed in one of three bands (excluding "Basic Support"):

Basic Support - For Service Users who will need assistance to develop or maintain their independence within the community through housing related support.

Level 1 - For Service Users who will need brief daily monitoring visits and assistance in the week to maintain or improve their outcomes.

Level 2 - For Service Users who need frequent assistance or supervision through the day and/or night to monitor their health, safety and well-being, (13 hours per week including 1 overnight).

Level 3 - For Service Users who need intensive assistance or supervision through the day and/or night to monitor their health, safety and well-being, (20 hours per week including 3 overnight).

The provider Hartfields then used the information in the Care and Support Plan to develop an individual Care and Support Programme with the resident to identify how the service will be delivered. HBCCA funded a certain number of people at level 1, 2 and 3 which was agreed before hand with Hartfields to reflect what was anticipated. The intention was to encourage the provider to maintain residents more independently needing lower levels of care which then enabled the provider flexibility to offer enhanced care for short periods of time to all residents as required. This kind of flexibility was seen as an important benefit of this kind of contracting process. Furthermore, the focus on outcomes and basic support offering housing related support provided residents more choice and better opportunity of addressing their needs that a traditional time and task based contract would not have allowed.

An evaluation of the outcome based contract suggested work that still needed to be undertaken by the provider in order to provide evidence for the local authority for contract monitoring purposes. Essentially, this reflected the need: to link the tasks undertaken by carers to the outcomes identified by the individual; for outcome focused reviews; and better, more appropriate recording of information.

4.2 Targeted and early intervention/prevention approaches

Many recent government policy documents make reference to the need for preventative and early interventions across health and social care. Much of the current focus is on providing care and support to enable people to remain in their own homes for as long as possible or to prevent admission to hospital or long term care⁷⁶. Table 1 below categorises the types of preventative intervention that a strategic approach would need to cover.

Table 1 Populations and provision for health and social care prevention			
Universal populations	Vulnerable populations	Targeted populations	Deferred populations
<p><i>Broad based provision that has an impact on health and social care but is available to an entire community.</i></p> <p><i>It may also represent the health and social care impact of particular policies and interventions by public bodies, eg, local government, police.</i></p>	<p><i>Low intensity services that have a solely health and social care focus.</i></p> <p><i>Many of these services are provided by voluntary organisations or private companies.</i></p>	<p><i>Health and social care services targeted on specific problems or issues which if unaddressed would have a considerable likelihood of leading to high intensity health and social care provision.</i></p>	<p><i>Services that defer from or often more likely, delay further high intensity provision.</i></p> <p><i>These populations may already have had 'a taste' of high end provision, perhaps through respite or intermediate care.</i></p> <p><i>This group may also include those who receive high intensity provision from family carers.</i></p>

Often services that are provided reflect the need to respond quickly and effectively, but also the need to provide interventions that are perhaps more low level.

Rapid Access Intervention Team (Milton Keynes)

The Rapid Access Intervention Team (RAIT), is a team of NHS nurses and therapists (nurses, physios, SALT, OTs and rehab assistants) funded by the PCT. It provides urgent intensive therapy in the community and an in-reach service within the hospital. It has access to a 20 bedded unit ICU for more intense work (health led) and a sheltered unit of 14 beds (social care led) for less intense work with patients.

There is a night time rapid response which has two care staff and an emphasis on admission avoidance. There are also other out-of- hours services such as twilight nursing.

⁷⁶ HM Government (2007). Putting People First: A shared vision and commitment to the transformation of adult social care.

Rapid Response Adaptations Programme (Wales)

The RRAP provides a small rapid response adaptations/repair service for older and disabled people which ensures that they can continue to live in a safe home environment as comfortable as possible. This service is complementary to the adaptation work funded by local authorities through the Disabled Facilities Grant and Home Repair Assistance. The service focuses on hospital discharge and reducing hospital admissions.

The aim of the programme is to ensure that older and disabled people who are to be discharged from hospital have a safe home to which to return. It also has a significant role in preventing hospital admissions by addressing problems of homes that are no longer safe or appropriate for older and disabled people. The intention of the programme, and which sets it apart from other repair services, is to enable Care and Repair agencies to provide a quick response service to problems identified by local authority or health staff. The Care and Repair agency receives the referrals and instructs a suitably qualified contractor or handyperson to carry out the required work. There is a 15-day maximum target date for completing the works from referral.

Referrals come from a range of statutory and health sector organisations and channelled through Care and Repair agencies. The service group eligible for the service are older and physically disabled people who are owner-occupiers or private tenants and:

- Are in hospital or who have recently been discharged from hospital where the circumstances require urgent intervention.
- Who wish to continue to live at home as independently and safely as possible, and whose homes require small works to enable them to do so.

The type of eligible work may include:

- Small ramps and home access.
- Door entry.
- External/internal rails.
- Hand grips.
- Cover way to w/c.
- Toilet and outhouse upgrading.
- Levelling paths.
- Partial rewiring.
- Upgrading heating to essential rooms.
- Access to toilet facilities.
- Community safety alarms.
- Safety in the home eg additional lighting, electrical safety, hot water safety, floor/stair/wall safety.

Care and Repair Cymru describe how investing in the RRAP will equate to a £7.50 saving for every £1 invested through RRAP⁷⁷.

4.3 Integrated health and social care approaches

While all users of health and social care should be able to access and experience seamless or integrated care, for older people this integration is especially important as they tend to suffer from a combination of health problems and may at the same time experience increasing isolation, lack of social support and increased personal vulnerability. Integrated care reflects elements of the previous two approaches in terms of focusing on outcomes and targeting and prevention strategies.

Good integrated health and social care can be described in terms of structures, processes and the outcomes achieved⁷⁸. In terms of structures and processes, this involves bringing together staff and resources, and focuses on the way activities are integrated. This will involve joint working approaches across organisations which could reflect multi-disciplinary teams. Modern technology can be used to help joint working and even create virtual organisations if required. Key features of integration include the provision of a single point of entry for older people and the means for full and rapid exchange of information between organisations. In terms of outcomes, seamless and person-centred care are the key outcomes to be achieved by integrated working.

Intensive case management is an example of integrated working and is a proactive, community-based approach that combines the contributions of health, social care and other agencies reflecting the range of needs of these older people may have. The approach identifies and targets people who already receive a large amount of support from health and social care services. Various different service models of intensive case management have started to emerge across the country. These include individual case managers, jointly co-located teams and 'virtual teams'. These are generally located in the community, in PCTs, social services departments or, in some cases, across the two settings. While these models vary, the specific skills and knowledge that case managers must possess, have been identified. These include⁷⁹:

- The ability to listen and work with the older person, rather than making plans on their behalf.
- Interpersonal skills to ensure effective negotiations with others.
- Good team and collaborative working skills.
- Excellent communication skills.
- The ability not to be confined by their own professional role.
- Close working knowledge of needs of client group and local service and community resources.

⁷⁷ Heywood F and Turner L (2007). Better Outcomes, lower costs: Implications for health and social care budgets of investment in housing adaptations, improvements and equipment: a review of evidence.

⁷⁸ Centre for Health Services Studies (2003). Integrated health and social care for older persons: theoretical and conceptual issues.

⁷⁹ Audit Commission (2004). Supporting frail older people: Independence and Wellbeing.

- Technical skills in assessment and knowing when more specialist input is needed.
- Experience of working across a range of agencies and understanding each of their roles.

Turnaround approach

To date the approach has been entitled 'Turnaround' in that the attempt is both to turn people around from their health and well being deteriorating and that the interdisciplinary, inter-conditions approach represents a turnaround in terms of thinking about service provision. It is suggested that the 'Turnaround' approach should embody the following features:

- **An approach not a service.** Turnaround should be about demonstrating whether and how targeting populations has an impact on people's potentiality to have repeat hospital admissions or a care home admission. If it works, or elements of the approach work, they should change the preventative interventions that social care and the PCT adopt rather than drive the creation of another service or initiative.
- **The approach needs to be interdisciplinary.** Whatever is provided needs to cut across professional disciplines and be capable of successfully intervening with a range of conditions?
- **The volume and type of input needs to be determined by the outcomes to be achieved.** This means it is not necessarily determined by the staff available, by the skills of employees or by time boundaries. Where new or additional skills are needed the duty would be on the provider to assess in advance and ensure that they are available as and when required. Payment for the approach needs to be based all or in part on the successful achievement of outcomes. Staff should be encouraged to adopt a 'doing what it takes' approach.
- **Delivery needs to be flexible.** The service developed needs to be flexible and available when needed in order to achieve the agreed outcomes. This is not the same as office hours but neither is it on demand from the service user.
- **The approach adopted needs to be based on identifiable, agreed and proven methodologies.** This applies in two ways. First, in identifying the targeted population and secondly in defining appropriate methodologies of intervention that have the best chance of success. In the case of the former then the literature reviews have already identified a number of failings where poor outcomes may be predicted. Where the results from other schemes may not be definitive then in the absence of clear research evidence there should be a lesser test of non-harm and 'more likely than not', eg, giving Vitamin B and D to older people at risk of falls may not have been conclusively demonstrated but on the evidence available there is a greater potential benefit than any risk of harm. How will Turnaround work?

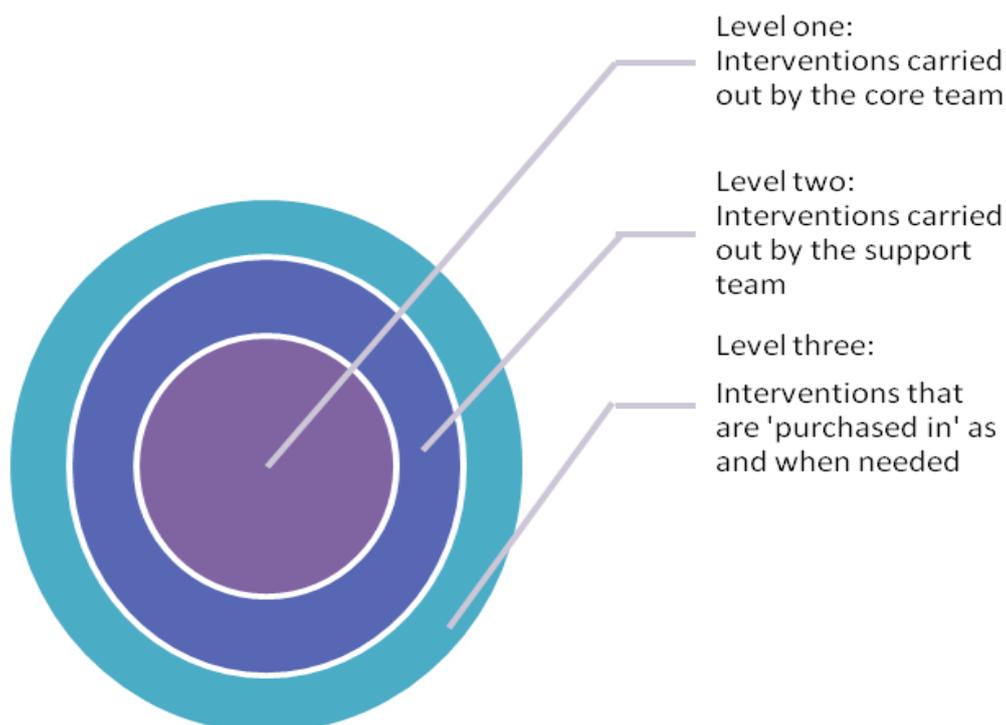
The need is to construct a service based on bringing together a range of personnel based on their capacity to deliver the outcomes required rather than constructing provision based around existing health care conditions (eg, stroke, fractures etc), service boundaries (eg, home care, intermediate care) or professional disciplines (eg, physiotherapist, occupational therapists, social workers).

The focus of the approach would be on developing provision that does not necessarily just maintain a person in the community or slow deterioration, but lessens the likelihood of admission to hospital or care, or lessens demand for high intensity community provision. This should be achieved through a focus on the range of issues or conditions somebody may possess, and through the development of a holistic approach which focuses on improvement, recovery and rehabilitation based on methodologies that can be shown to deliver. Clearly such an approach does not need to work for everybody, only those where there is the greatest likelihood of success and where the reduction in demand delivers the highest potential cost benefit.

Therefore, Turnaround may comprise a mixture of any or all of the following:

- A combined community care capacity bringing together home care, assistive technology, care and repair and some nursing skills.
- Some enhanced health care based capability, (knowledge of medical risk, medication, capacity to fast track health care when needed).
- A focus on improving mobility (physiotherapy, occupational therapy, personal trainer skills).
- A focus on improving diet and nutrition (help and support to change and improve diet) may also involve receiving dental care if dental decay or poor fitting dentures are a barrier to healthy eating.
- Delivering social contact (ensuring social contact with others is increased and sustained).
- Welfare benefits and income maximisation where alleviable poverty is a driver towards poor health and care.

Figure 2 Turnaround model of delivery



- Level one has at its heart small groups of enhanced home care workers. These groups may comprise six staff working with around 30 people. All workers in the team will be known to those taking the approach which will help to deliver a more flexible service.
- Level two will offer workers at level one access to a range of specialist support, for example, physiotherapists, occupational therapists, etc. These people will use their specialist skills to help apply methodologies and approaches.
- Level three then offers additional skills that may be brought or bought in such as dentistry, community alarm, care and repair.

5 Market opportunities and risks

This section of the report will consider future marketing and business strategies, especially in relation to:

- Local authority and GP consortia.
- Personal budget and individual budget holders.
- Self funders.

5.1 Implications and risks

In terms of developing different market opportunities, the 3 key purchasers in the market are given in the table below with the risks and opportunities for each of the 3 service options considered against them:

TABLE 2: Implications and risks of change for providers

	Standard domiciliary care	Re-ablement	Specialist home care
Local authority & Clinical Commissioning Groups	LA's will continue to fund primarily in independent sector but tighter budgets and with higher eligibility criteria. As in other areas commissioners will reframe contracts around outcomes. Risks: pressure on providers, lower margins, greater competition for longer term case contracts and higher risk of business failure of those who are slow to innovate, inflexible or cannot meet challenges of outcome based contracting.	In house re-ablement services will continue but greater externalisation of re-ablement to independent sector. Both LAs and GPs will focus on re-ablement to save longer term home care and residential costs and reduce pressure on hospitals. Providers needing to make significant investment in staff, ways of working and structures to deliver. Risks: organisational uncertainty and lack of strategic approach in LAs and NHS working against local joint and innovative commissioning in short term. Short sightedness by some commissioners around higher initial costs.	Similar to re-ablement; drivers to reduce pressure on hospitals and residential/nursing plus demographics giving greater scope for providers to meet more specialist individual needs at home. Risks: organisational; investment in staff and structures alongside health to ensure seamless service; commissioners must be willing to fund in longer term.
Personal budget and individual budget	Task centred approaches will continue to be in	Limited - traditional 6-12 week approaches still	For longer term conditions both health

	Standard domiciliary care	Re-ablement	Specialist home care
holders	<p>demand but service users wanting greater flexibility and control.</p> <p>Risks: to a degree this market is still emerging and the extent who exactly will be in control; potential for reductions of individual allocation funding by statutory sector.</p>	<p>likely to be funded by central statutory budgets but may well be market for 'top ups' to standard packages being offered plus more around social integration with follow up work over longer term.</p> <p>Risks: demand may not emerge given traditional short term approach.</p>	<p>and social care may well fund using these budgets in far greater numbers especially as NHS grasps PBs approach – proviso being ability of service users or others to take control and manage process.</p> <p>Risks: Disruption of both joint and single agency commissioning due to organisational change in NHS.</p>
Self funders	<p>Demographic, economic social factors plus tighter LA eligibility continue to see growth in demand by those who can pay. Important market for 3rd sector providers looking to cross subsidize other areas of work.</p> <p>Risks: complacency - not grasping the quality and innovation agenda and just simply providing more of the same.</p>	<p>Limited - traditional 6-12 week approaches still likely to be funded by central statutory budgets but may well be market for 'top ups' to standard packages being offered plus more around social integration with follow up work over longer term.</p> <p>Risks: demand may not emerge given traditional short term approach.</p>	<p>For longer term conditions both health and social care may well fund using these budgets in far greater numbers. However some self funders may well opt for greater quality and quantity of service than is being offered by statutory sector</p> <p>Risks: uncertainty how much demand for specialist home care by self funders – it may well vary greatly by specialism in local markets e.g. night care.</p>

In summary:

Standard domiciliary care

- LA's will continue to fund primarily in the independent sector but with tighter budgets and higher eligibility criteria. As in other areas commissioners will reframe contracts around outcomes. The risks are pressure on providers, lower margins, greater competition for longer term case contracts and higher risk of business failure of those who are slow to innovate, are inflexible or cannot meet challenges of outcome based contracting.
- Task centred approaches will continue to be in demand but service users will want greater flexibility and control. The risks are this market is still emerging and the extent who exactly will be in control with potential for reductions of individual allocation funding by the statutory sector.
- Demographic, economic social factors plus tighter LA eligibility will continue to see growth in demand by those who can pay. This will be an important market for 3rd sector providers looking to cross subsidize other areas of work. The risks are complacency - not grasping the quality and innovation agenda and just simply providing 'more of the same'.

Re-ablement

- In house re-ablement services will continue with some LAs but there will be greater externalisation of re-ablement to the independent sector in attempts to reduce internal overheads and higher unit costs. Both LAs and GP

Consortia will focus on re-ablement to save longer term home care and residential costs and reduce pressure on hospitals. Providers will need to make significant investment in staff, ways of working and structures to deliver. Risks are organisational uncertainty and lack of strategic approach in LAs and NHS working against local joint and innovative commissioning in the short term. There may well be short sightedness by some commissioners around higher initial costs of re-ablement compared to existing home care services.

- Traditional 6-12 week re-ablement packages are still likely to be funded by central statutory budgets but there may well be a market for 'top ups' to these standard packages being offered, plus more demand around social integration approaches (as opposed to just functional) with follow up work over a longer period of time. Risks are demand may not emerge given traditional short term packages of re-ablement.

Specialist home care

- There are similar issues here as for re-ablement where there are drivers to reduce pressure on hospitals and residential/nursing against demographic change (dementia for example) giving greater scope for providers to meet more specialist individual needs at home. Risks are primarily economic/organisational; there must be significant investment in staff and structures alongside health to ensure a coordinated service; commissioners must be willing to fund this investment for the longer term.
- For people with long term conditions/complex needs both health and social care may well fund using PBs in far greater numbers especially as the NHS grasps a PBs approach – the proviso being the ability of service users, families, carers or others to take control and manage the process. Risks are around the disruption of both joint and single agency commissioning due to organisational change in the NHS.
- Some self funders may well opt for greater quality and quantity of these services than is being offered by statutory sector. Risks are around the uncertainty of how much demand for specialist home care by self funders will there really be – it may well vary greatly by specialism in local markets e.g. for night care and out of hours care.

5.2 Service Development Opportunities

In short, the key opportunities in the market appear to be around expanding the range of re-ablement approaches alongside a continuum of specialisms while possibly maintaining a up to date high quality 'traditional home care' base.

Both social care and Clinical Commissioning Groups will look to see savings and community benefits associated with re-ablement prevention work. In addition self funders will continue to demand a whole range of home care services and therefore will be significant for a 3rd sector organisation looking to cross subsidize its other services.

While these market opportunities have been identified in this 3 fold categorization, the style and approach to developing these opportunities will be crucial eg providers will need to invest in their staff, focus more on outcome based contracts with commissioners, engage with the flexibility of personal

budgets and redesign their services even further than in the past, so that they can cross what were the traditional boundaries between health and social care - an integrated approach.

What follows below is a brief exploration of some of the operational considerations arising from developing the market opportunities described above.

5.3 Operational Considerations

Based on examples from a variety of studies and schemes across the country there are clear messages about the operational running of re-ablement and specialist team approaches. Most of the examples below are however taken from LA re-ablement teams, given there is much less research available about specialist developments; a lot of the issues and pointers though are applicable to both.

Staffing Issues

1. Terms, conditions and sustainability of the workforce

In West Sussex the change to a re-ablement service meant not only retraining and regrading the new 'Regaining Independence Support Staff' (see below) but also altering their role and job descriptions to reflect their greater responsibilities and skill levels (see Appendix 2), for example, their overall purpose is:

To contribute to a team approach in delivering programmes of re-ablement with customers in their own homes to enable them to retain or regain daily living skills. The role will support the work of the Occupational Therapist by assisting the customer to complete a graded programme of daily activity to support them in maximising/restoring their ability to complete activities of daily living independently

In the evaluation of Torfaen's Virtual Residential Care project (VRC) staff commented positively not only on increased pay but also on job security and motivation levels of an integrated specialist service.

"VRC is not much more financially lucrative than doing a full domiciliary care shift. However, many people like the security of working for VRC. They will get paid for their shift even if someone goes into hospital. In this case, we will ask them to do other work during this time. We haven't lost many people from VRC. They tend to go only where there are issues (for non-drivers) around getting to the start of their shift. Generally, people are more likely to stay working for VRC than mainstream domiciliary care. It is more interesting, and they like working as a team. Some pairs are mother and daughter or father and son / husband and wife teams"

There is evidence from the case file analysis, individual interviews with managers and focus group meetings with VRC staff that this model is providing an attractive work package and environment for home care staff. The service has been able to attract both experienced workers, and those who are new to providing care in the community, including male staff, younger workers and family pairs. Staff retention figures already appear to be very favourable. And

efforts have been made in recent months to strengthen formal support arrangements, including by regular staff meetings.

The service had followed 'best practice' as a home care employer identified in a recent UKHCA report as follows:

- Above average level of hourly pay (with no enhancements for weekends).
- Guaranteed hours.
- Mileage for travel.
- Team working within a locality with one supervisor for 12 – 20 workers, resulting in continuity of care, and an ability to build up relationships that are satisfying and rewarding to staff.
- Management offering close support in case of difficulties.
- Spare time in the rota, in case of sickness (for example, allowing half an hour 'slack time' in the workers' rota) .

2. Training and Qualifications

West Sussex and other LAs all speak about undertaking training or retraining for those staff that have a re-ablement focus – this covers skills, attitudes and cross disciplinary working with other professionals in health and social care particularly OTs.

In Emerging Practice (SCIE 2010) there is a discussion whether OT skills need to be in the re-ablement team or just accessible to it:

The existing skills of home care staff are the key resource,⁵ but some teams include OTs (or train home care staff in OT skills). It is unclear whether OT skills are essential to successful outcomes¹¹ but 30 per cent of users in one study saw an OT⁵ and interaction with an OT was especially valued by care workers in another study.⁹

Occupational therapy skills are viewed as essential in the teams we visited. However, occupational therapists do not necessarily have to be members of the teams. OT input may be secured through collaboration and co-location or referral. OT input may help to keep the re-ablement focus on tasks and to train carers.

Furthermore the need for a worker to 'facilitate and stand back' is emphasized, as is the point about the need for frequent re-assessment:

While re-ablement includes actively assisting people to regain their ability, some aspects require staff to learn to 'watch' and not interfere when a service user [is] struggling to get something. Users need to change their expectations: 're-ablement was considered to be more successful if service users were motivated - 'people have got to want to do it'.⁵ Our local teams drew attention to the need for active re-assessment – almost at every session – in order to maintain progress.

In terms of qualifications backed up by training for the new role of re-ablement:

Re-ablement staff all had basic home care training up to NVQ level 2 or 3, as well as specialist induction and training in re-ablement. In some localities, new staff were trained by accompanying experienced re-ablement workers on visits. Some

localities were able to offer additional training on dementia, visual impairments or mental health problems, thus extending the capacity of the service to work with a wider range of users. Retraining established home help staff could be a challenge as it involved learning to observe, encourage users and help them solve problems rather than carry out tasks for users. Observations of re-ablement visits confirmed that newly recruited workers were more likely than retrained staff actively to involve users in both decisions and home care activities. However, a re-ablement approach led to greater worker job satisfaction and commitment⁸⁰.

3. Pay levels and deployment

From the examples studied staff pay for those who moved into re-ablement services did go up. For example in Dorset and West Sussex there was a rise of between 6-9 percent, or from LA Grade 3 to Grade 4 (Grade 4 equals £17161 pa in 2009/10). Torfaen also mentioned an increase in pay but this was relatively minor compared to the other perceived benefits.

In terms of deployment of staff both the independent sector and in house services use 'zoning' of teams to particular geographical areas. With external providers this can be linked to a Framework Agreement where a particular provider takes a certain area after a contract has been awarded.

West Sussex organised its teams such that OTs took a management lead with a county wide 6 member OT team covering 3 regions – see full structure chart in Appendix 2.

Day to Day Organisation and Team Structures

As indicated, an example team structure for West Sussex is provided in Appendix 3. Also included in Appendix 4 are the roles of the key management and other staff – Re-ablement Service Manager, OT Manager, OT Team, Resource Managers, Care Coordinators and the Support Workers themselves. The 'access criteria' for service is included in Appendix 5.

From the recent research literature on re-ablement the general findings on day to day organisation and team structures are as follows:

1. Day to day organisation of services

After referral, clients were reassessed by a senior re-ablement worker and care plans devised with the re-ablement goals and areas of activity. These reassessments were important because hospital discharge information did not always cover what clients could do at home and often people's needs changed once they were in their own environment. It was important that care managers understood the reasons for re-ablement reassessments and did not feel their expertise was undermined.

Because users often required very high levels of support (sometimes involving two carers), one-to-one care was rarely possible. However, careful staff rostering ensured that each user was seen by a limited number of workers.

⁸⁰ Rabiee P and Glendining C (2010). The organisation and content of home care re-ablement services. SPRU.

Some services were able to offer greater continuity to users with dementia or mental health problems. This involved having only two or three workers with specialist training providing their re-ablement services.

Flexibility over the length of visits was crucial, particularly at the start of a re-ablement episode. If a visit took longer than anticipated, workers could ring the office to rearrange subsequent visits.

Good records of each visit were important in ensuring continuity, particularly as users' needs and abilities could change rapidly. Re-ablement workers discussed users' progress with their supervisors on a daily basis and with each other in team meetings. Team meetings were valued by workers and also provided regular opportunities for supervisors to reinforce training and embed the re-ablement 'approach'. However, the frequency of team meetings varied and staff in some localities reported practical difficulties in attending all team meetings. In one locality, if care rotas prevented attendance, workers were encouraged to attend other teams' meetings. Workers also valued regular opportunities to 'shadow', or go on joint visits with, more experienced staff.

Re-ablement was provided for an average six weeks, but with wide variations. It could be extended beyond 6 weeks if further independence gains were likely; other people newly discharged from hospital only needed the service for a few days. Charging policies varied – some services were free but elsewhere income related charges were made after the first few days.

2. Access to Occupational Therapy skills and equipment

Rapid provision of equipment such as grab rails or walking frames was a major part of re-ablement services. Front line staff could usually order small, basic items themselves. For larger, more complex items, occupational therapists (OTs) were involved. Where services operated in partnership with the NHS, OTs were part of the re-ablement team; in one locality the re-ablement service was able to 'fast-track' referrals to OTs based elsewhere in the local authority.

3. Discharge and onward referral

Formal reviews were conducted towards the end of a re-ablement period to assess whether on-going home care or other services were needed. People needing on-going home care could be referred back to care management teams for this to be commissioned. Alternatively, where the re-ablement service managers had authority to commission, they could do so directly and more quickly (unless safeguarding issues were involved).

Shortages within the independent home care sector often delayed discharge from re-ablement. Users would continue to be supported by the re-ablement service until a provider could be found. This reduced the re-ablement service capacity to accept new referrals. Hand-overs to independent home care providers usually lasted only a couple of days; some front-line workers felt this was not long enough to ensure continuity of the re-ablement approach. Consequently, the achievements of re-ablement could quickly be undermined⁸¹.

⁸¹ Rabiee P and Glendining C (2010). The organisation and content of home care re-ablement services. SPRU.

Client Expectations

Feedback from users about how re-ablement services have been received is important intelligence for further development of services and what follows are some of the messages from the operational research carried out recently:

- It is felt that the most difficult cases tend to be service users who have a history of long periods of home care (either from social services or the private sector), because they are more likely to expect things to be done for them.
- There was a common view among teams that people with dementia and mental health problems required different patterns of engagement, where workers undertake a wider range of tasks themselves but encourage clients to help with those tasks. However, re-ablement could more accurately identify the scale and nature of long-term support. There was a consensus among all managers that re-ablement for older people who had had a fall or fracture focused more on personal care and confidence building: for younger people, who were considered more motivated to become independent, it was more about social interaction.
- Involvement in setting their own goals appeared to be highly motivational in encouraging people to attempt to do more for themselves. In a small number of cases service users and carers felt that the re-ablement goals they had identified had been thwarted by restrictions on the service.
- Service users were often disappointed about the changes to their eating habits. Help with food preparation was provided but this was usually limited to making toast and tea or a sandwich.
- For many service users living alone, the primary benefits were feelings of safety and the company of other people. Services need to consider that the focus of service user needs varies depending on their personal situation.

Many service users expressed a desire for support to improve mobility around and outside their home and linked the inability to achieve this to the absence of physiotherapy input. However, through discussion with intervention sites it became clear that many of their service are focused on activities of daily living (ADLs) within the home and not on instrumental activities (IADLs) outside the home. Thus, this shortfall in meeting users goals may be more to do with the scope of the service than the availability of any particular skill⁸².

⁸² CSED (2010). Homecare Re-ablement Prospective Longitudinal Study: Final report. Department of Health.

APPENDIX ONE

Developing home care: examples of local priorities⁸³

- Making home care more accessible, by improving information and signposting services.
- Finding ways of giving people more choice, and putting them more in control of the services they receive.
- Reducing waiting times, especially to guarantee a fast response for those experiencing a crisis and for those leaving hospital.
- Securing the supply of home care by investing in recruitment and retention initiatives, including those that target school leavers.
- Raising the quality of services, both by tackling workforce shortages, addressing disadvantageous terms and conditions for care workers, and by investing in training and development.
- Ensuring more consistent coverage – for example, for people in rural areas – and better out-of-hours services.
- Addressing gaps in specialist provision, including more culturally sensitive services for people from BME communities and better services for older people with dementia.
- Increasing the numbers of people receiving support, perhaps as part of an overall early intervention strategy.
- Assessing the potential of other council services (such as transport, leisure and adult education) to contribute more to the well-being of older people as part of an overall strategy.
- Offering 're-ablement' services to ensure that people have every opportunity to regain their independence after an episode of ill-health.
- Developing new models of service that integrate health and social care, perhaps creating different roles such as community healthcare assistants and rehabilitation officers.
- Exploring the potential for efficiency gains, such as cutting down the paperwork associated with the contracting process and/or using electronic monitoring techniques.
- Making better use of new technology, including 'telecare' and 'telemedicine' to support people at home.
- Laying down the conditions for long-term development – for example, by investing in the relationship with local providers and exploring the potential for more active collaboration.

October 2009

⁸³ Patmore C (2002). Towards flexible, person-centred home care services: A guide to some useful literature for planning, managing or evaluating services for older people. SPRU: York.