

# Care Services Efficiency Delivery

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HOMECARE RE-ABLEMENT – The UK Experience

**Active Service Model Seminar**

**Melbourne – 25<sup>th</sup> February 2008**

# HEMECARE RE-ABLEMENT: Objectives of this Presentation

- Social Care in England
- Examples and evidence of models in operation
- Experience and learnings from a retrospective study
- Key success factors
- Focus of future studies and work

# HEMECARE RE-ABLEMENT: Social Care in England (1)



- Department of Health has policy responsibility and determine funding allocations
- Delivery is responsibility of councils with social service responsibility (CSSRs)
- Councils report to Communities and Local Government department NOT Dept of Health – locally responsible to elected councillors
- Gross spend on adult social care 2006/07 - £16.5 bn (excluding children, families and asylum seekers)

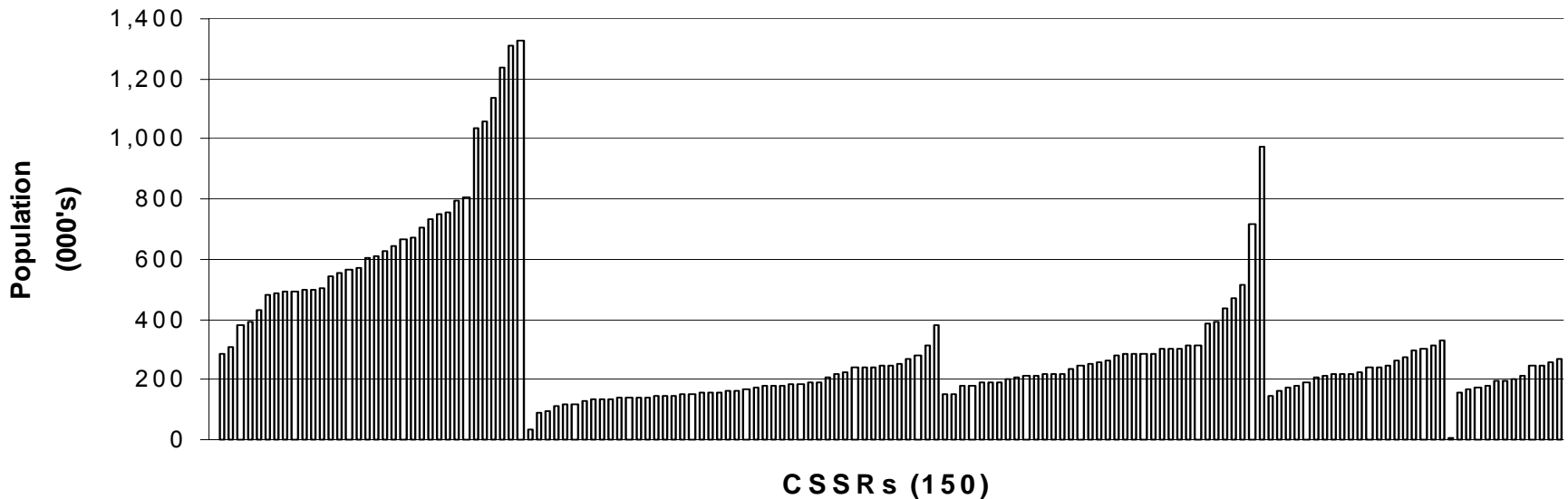
# HEMECARE RE-ABLEMENT: Social Care in England (2)

## 150 Councils with social service responsibility

- Single tier authorities
  - 46 Unitary councils (formerly part of county councils)
  - 36 Metropolitan Councils (large towns and cities)
  - 20 Outer London councils
  - 13 Inner London Councils
- Two tier authorities
  - 35 Shire / County councils
    - 238 District councils (housing, planning, leisure, waste, environmental health)

# HEMECARE RE-ABLEMENT: Social Care in England (3)

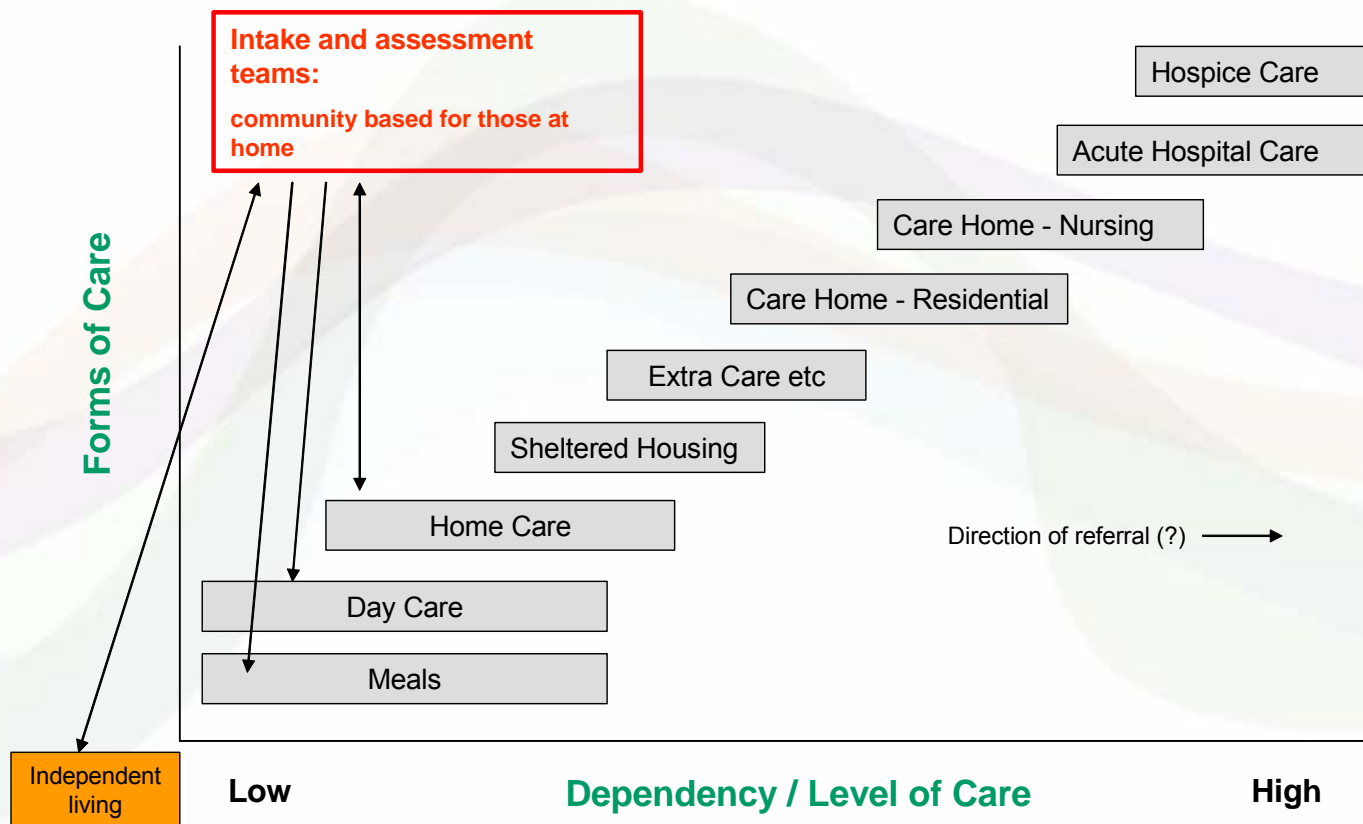
## POPULATION BY CSSR (2001 Census - England 49.1m)



<b>Counties</b> (35)	<b>Unitaries</b> (46)	<b>Metropolitan</b> (36)	<b>Outer London</b> (20)	<b>Inner London</b> (13)
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# HOMECARE RE-ABLEMENT: CSED Proposition

**Home Care Re-ablement: (encouraging a shift to the lowest appropriate level of intervention / support)**



# Homecare Re-ablement: What is it ? – a definition\* (1)

## Prevention

- Services for people with poor physical or mental health
- To avoid unplanned or unnecessary admissions to hospital or residential care
- Can include short-term and longer term low-level support

## Rehabilitation

- Services for people with poor physical or mental health
- To help them get better

## Re-ablement

- **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**

\* Definitions from an evaluation report by De Montfort University, 2000

# Homecare Re-ablement: What is it ? (2)

## **Common principles and features:**

- helping people 'to do' rather than 'doing to or for' people
- outcome focused with defined maximum duration
- assessment for ongoing care packages cannot be defined by a one-off assessment but requires observation over a defined period

## **Objectives are:**

- to maximise users long-term independence, choice and quality of life
- to appropriately minimise ongoing support required and, thereby, minimise the whole life-cost of care

# Homecare Re-ablement: What is it ? (3)

## Examples of some of the elements

- personal care such as washing, dressing, continence promotion, getting in and out of bed
- cooking, preparing meals and helping to eat
- building confidence
- shopping, pension collection, laundry and other household tasks
- coping with poor memory
- social and leisure activities
- Indoor and outdoor mobility

# Homecare Re-ablement: Why Do It ? \*

- **Increasing demand for homecare**
- Hours increased by approx 80% (1993 – 2004) albeit users reduced by approx 28%
- Demand projected to increase even in 'improved health' scenario due to lag between improvements in life expectancy and healthy life expectancy
- Councils unable to lift the 'bar' much further: most at substantial and above already
  
- **Availability of Care Staff**
- Demographic changes = proportion of people within age bands that historically deliver and support care will reduce so recruitment to match demand impossible
  
- **Release of Care Home beds (= resource) as care moves closer to home**
- Main drivers for admission to care homes are cognitive impairment and disability which increase disproportionately with age
- Demand projected to increase even in 'improved health' scenario
- More rather than less beds will be required
  
- \* Wanless Social Care Review: Securing Good Care for Older People: various chapters and presentations at Kings Fund

# HOMECARE RE-ABLEMENT: Does it work ? (1)

Homecare Package at First Review *	
Care package req'd post 1 <sup>st</sup> review (6 wks)	Matched service users (control group)
Discontinued	5%
Decreased	13%
Maintained	71%
Increased	11%
Total	100%

\* Leicestershire De Montfort study 2000

# HOMECARE RE-ABLEMENT: Does it work ? (1)

Homecare Package at First Review *		
Care package req'd post 1 <sup>st</sup> review (6 wks)	Matched service users (control group)	Re-ablement Pilot (selective)
Discontinued	5%	62%
Decreased	13%	26%
Maintained	71%	10%
Increased	11%	2%
Total	100%	100%

\* Leicestershire De Montfort study  
2000

# HOMECARE RE-ABLEMENT: Does it work ? (1)

Homecare Package at First Review *			
Care package req'd post 1 <sup>st</sup> review (6 wks)	Matched service users (control group)	Re-ablement Pilot (selective)	Re-ablement Roll-out (intake)
Discontinued	5%	62%	58%
Decreased	13%	26%	17%
Maintained	71%	10%	17%
Increased	11%	2%	8%
Total	100%	100%	100%

\* Leicestershire De Montfort study 2000

# HOMECARE RE-ABLEMENT: Does it work ? (2) – the body of evidence so far

	Leicestershire Intake *1 Mod & above	Dudley Intake *1 Mod & above	Milton- Keynes Intake *2 Subs & above	Poole Intake *2 Mod & above	Salford Intake *1 Mod & above	Wirral Discharge *2 Subs & above
% no package	50%	21%	55%	44%	62%	81%
% reduced package	18% to spec serv with 16% reduc  29% ongoing with 30% reduc	26%	11%	13% < 4 hrs / wk  1% 4 to 7 hrs / wk  1% > 7 hrs / wk	31%	9%
% main. Package		23%			1%	
% incr. package		7%			1%	
% to other care		13%	33%	41%	5%	9%
Overall red'n hrs	58%	42%			80%	

\*1= Fair Access to Care Services (entitlement criteria) applied at entrance to homecare re-ablement

\*2 = Fair Access to Care Services (entitlement criteria) applied at exit from homecare re-ablement

# HEMOCARE RE-ABLEMENT: The CSED Documents

As a result of its work with CSSRs, CSED has produced a body of evidence which was launched at a workshop and is available via its website (to ensure tracking)

- Executive Summary
- Discussion Document containing information from 5 case studies and 13 additional information sites
- Supporting documents: evaluations, evidence of benefits, example documents.

# HEMOCARE RE-ABLEMENT: Subsequent work – an update

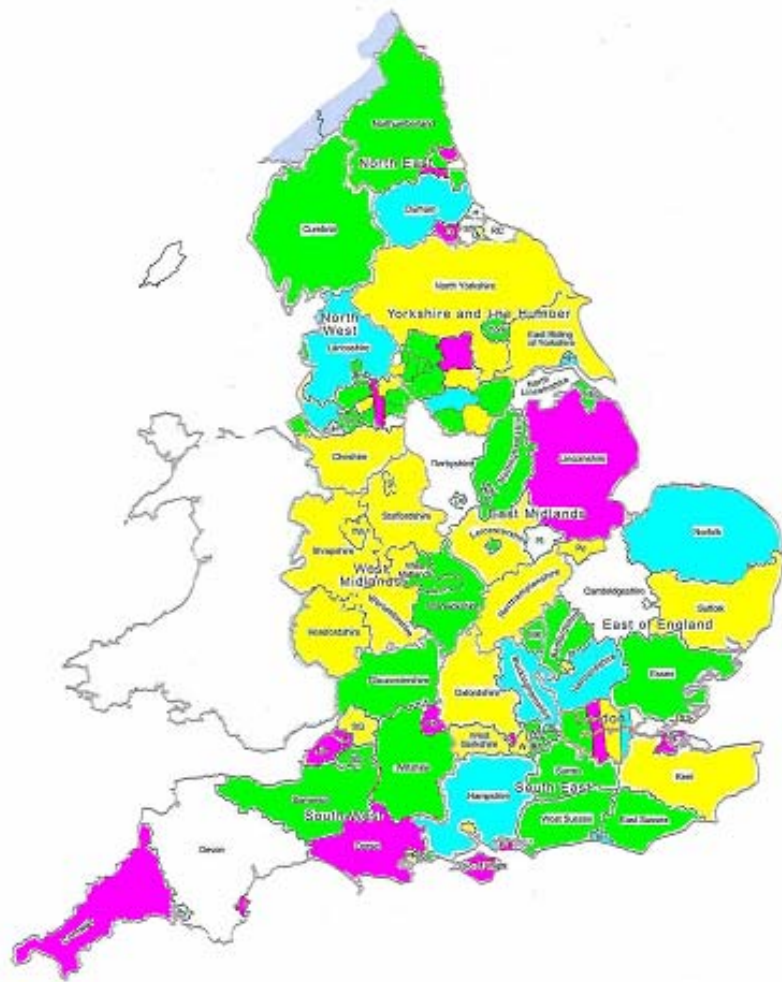
## Assessment tools and satisfaction surveys

- Summary published in August 2007 contains
  - 7 examples of functional assessment tools used within CSSRs
  - Summary of outcome measures / standardised assessment tools
  - 8 examples of satisfaction survey tools

CSSR Status Update: published Sept 2007

Retrospective Longitudinal Study: published Nov 2007

# HOMECARE RE-ABLEMENT: National Map of Coverage



- information available from 133 (89%) CSSRs
- 37 (25%) CSSRs have a scheme
- 96 (64%) of CSSRs are in the process of either establishing a scheme, or enhancing or extending an existing scheme

Service in place with no declared intention to extend / expand / amend
Service in place but seeking to extend / expand / amend
Establishing a Service (various stages)
No scheme in place but wish to develop
No information held by CSED

# HEMOCARE RE-ABLEMENT: National Coverage:

	Service in place with no declared intention to extend / expand / amend	Service in place but seeking to extend / expand / amend	Establishing a Service (various stages)	No scheme in place but wish to develop	No information held by CSED
North West	6	9	3	3	1
North East (Northern)	1	3	1	3	4
Yorkshire & Humberside	4	6	2	1	2
East Midlands	1	4	0	1	3
West Midlands	7	5	1	0	1
South Western	2	5	0	6	3
Eastern	4	2	2	0	2
South Eastern	5	7	3	4	0
London	7	13	5	7	1
<b>TOTAL</b>	<b>37</b>	<b>54</b>	<b>17</b>	<b>25</b>	<b>17</b>

# HOMECARE RE-ABLEMENT: Retrospective Longitudinal Study (1)



## Purpose:

1. To determine the duration of benefit for those undergoing homecare re-ablement
2. Inform proposed structured prospective study

## Method:

Undertake a retrospective longitudinal study of those people that were seen during 2004/5 and determine the duration before commencement of a homecare package or any change to their home care package.

# HOME CARE RE-ABLEMENT: Retrospective Longitudinal Study (2)



## Retrospective study

- Conducted during June – August, published in November 2007
- Academic lead by SPRU at University of York working with CSSRs

## Participating CSSRs:

### Intake and assessment schemes:

- Leicestershire County Council (1,362 users)
- Salford City Council (211 users)

### Hospital discharge support schemes:

- London Borough of Sutton (372 users)
- Metropolitan Borough of Wirral (138 users)

# HOMECARE RE-ABLEMENT: Retrospective Longitudinal Study - Main Findings (1)



## 1. In 3 of 4 schemes, (slide 23)

- 53% to 68% left re-ablement requiring no immediate homecare package (4<sup>th</sup> = 94%)
- 36% to 48% continued to require no care package 2 yrs after re-ablement (4<sup>th</sup> = 87%)

(In 1 scheme 55 users that had previously required homecare before re-ablement continued to require no care package 2 yrs after re-ablement)

## 2. Of those that required a homecare package within 2 yrs after re-ablement (slide 24)

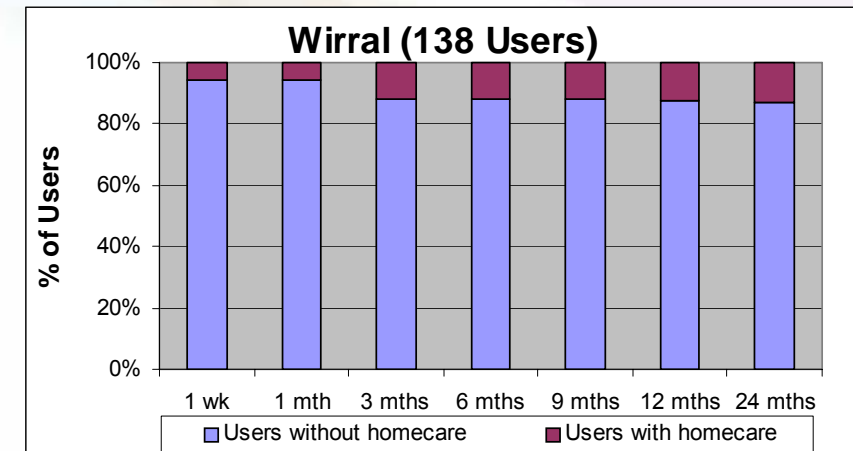
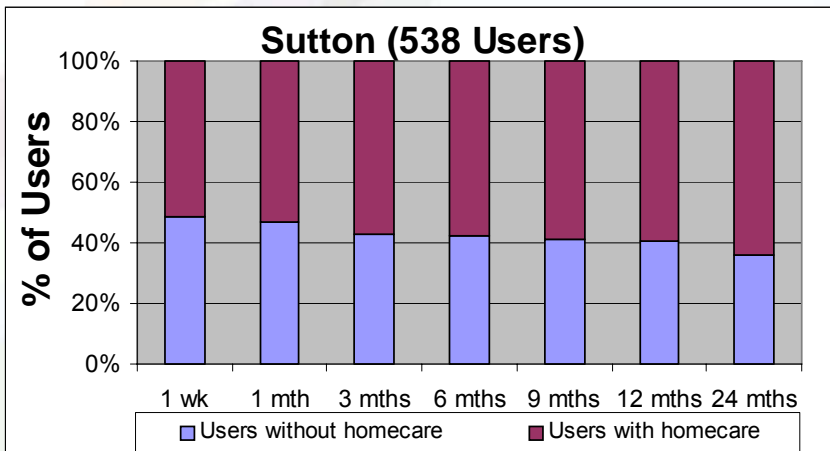
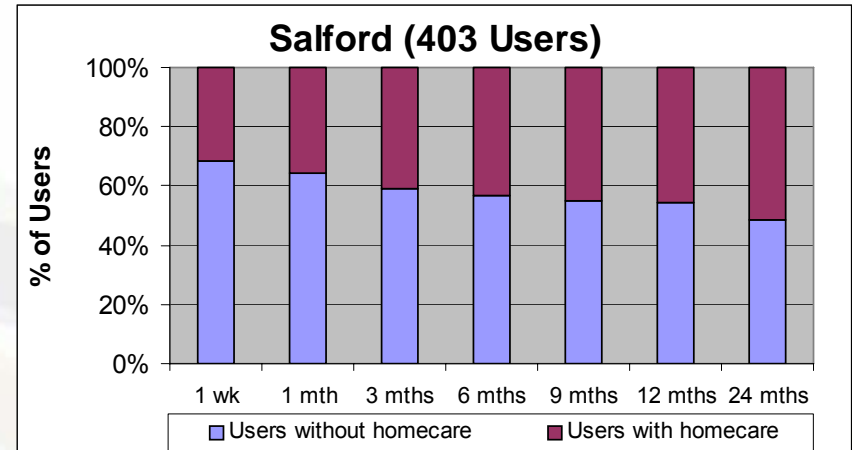
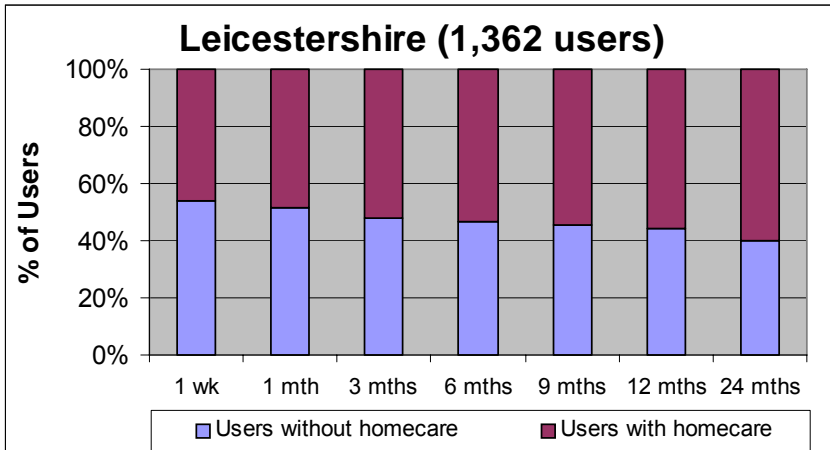
- 34% to 54% had maintained or reduced their homecare package 2 yrs after re-ablement (4<sup>th</sup> = 61%)
- 38% to 41% had transferred to long term care or died 2 yrs after re-ablement (4<sup>th</sup> = 11%)

# HOMECARE RE-ABLEMENT: Retrospective Longitudinal Study - Main Findings (2)

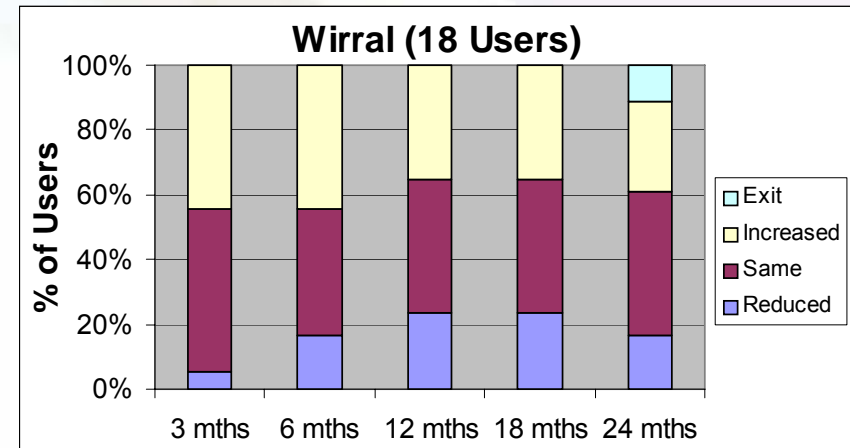
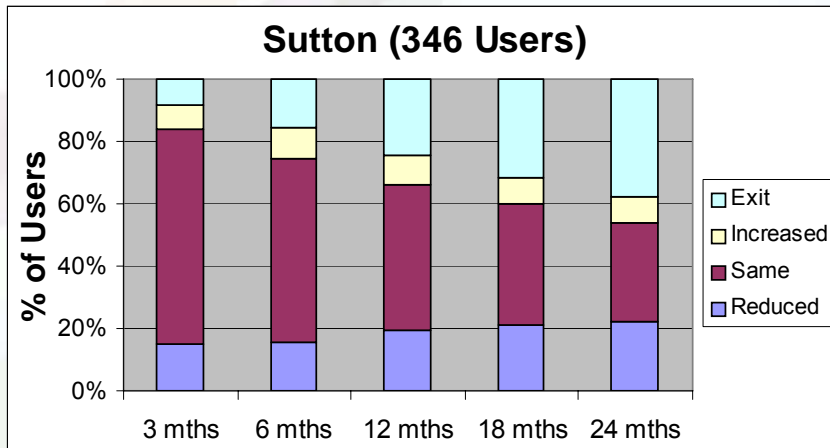
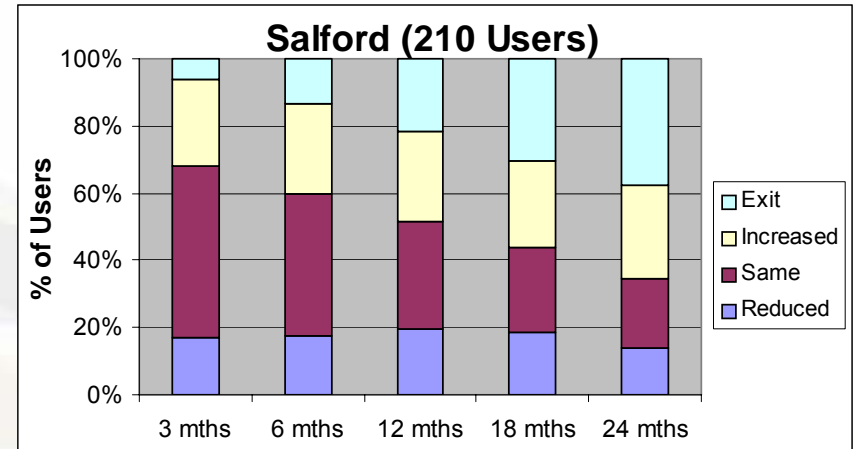
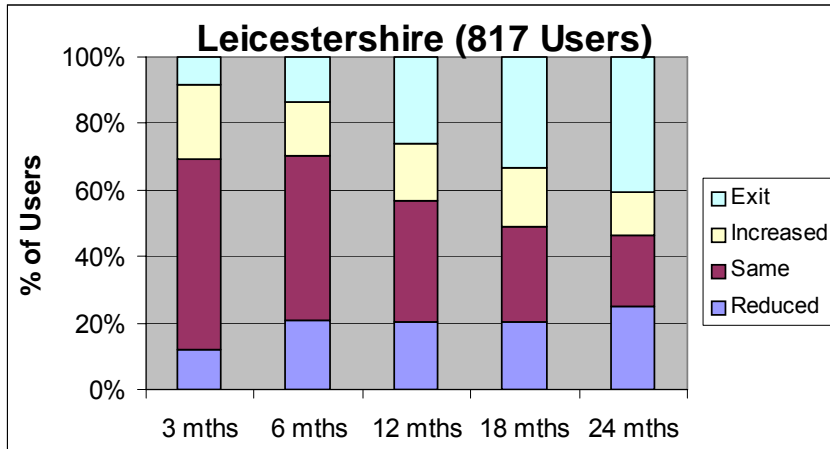


3. Of those > 65 yrs that required a homecare package within 24 mths after re-ablement (slide 24)
  - In 3 of 4 schemes the number that had reduced their package was higher after 24 mths than after 3 mths (4<sup>th</sup> = grew but then fell below 3mth level)
  
4. Of those > 85 yrs that required a homecare package within 24 mths after re-ablement (slide 25)
  - Marked growth in number that reduced their package
  
5. Excluding those transferred to LTC or died (slide 26)
  - In 3 of 4 schemes no dramatic change in mix of intensity over 24 mths

# HOMECARE RE-ABLEMENT: Retrospective Longitudinal Study – Duration free from homecare



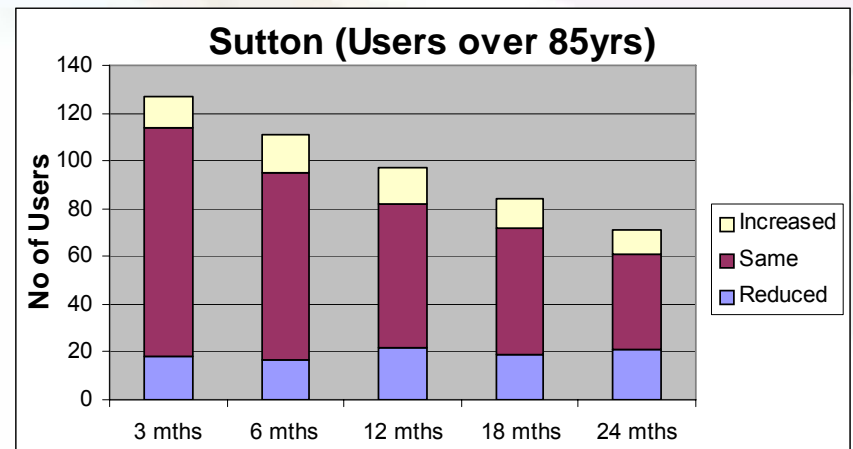
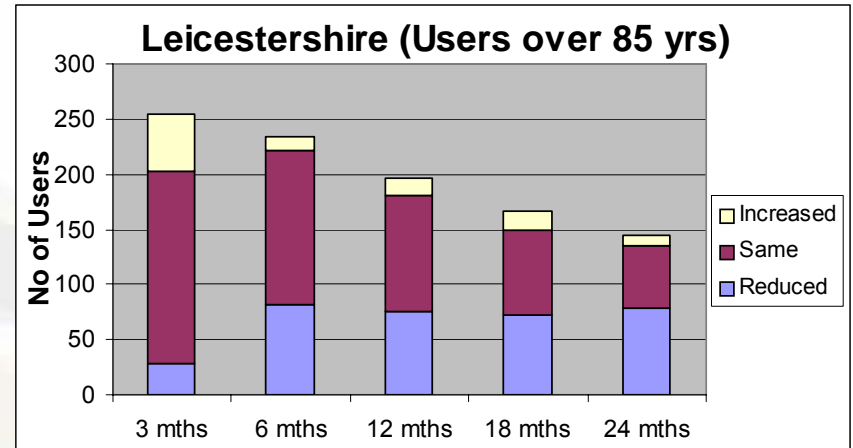
# HEMOCARE RE-ABLEMENT: Retrospective Longitudinal Study - Changes in level of need since re- ablement for > 65s



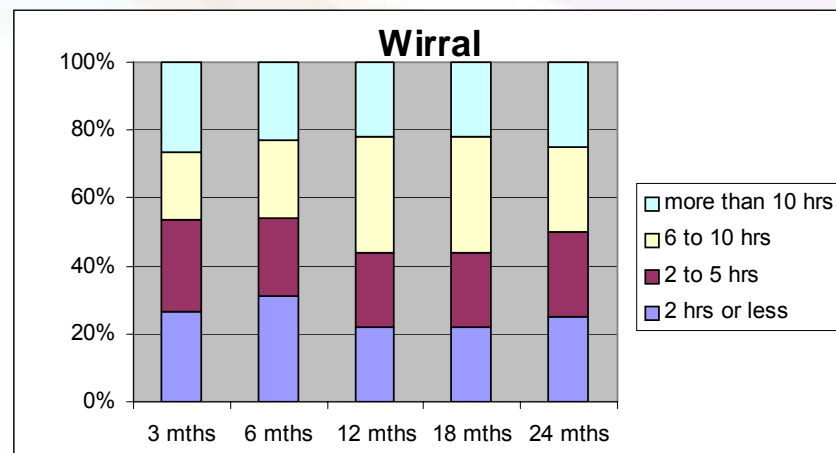
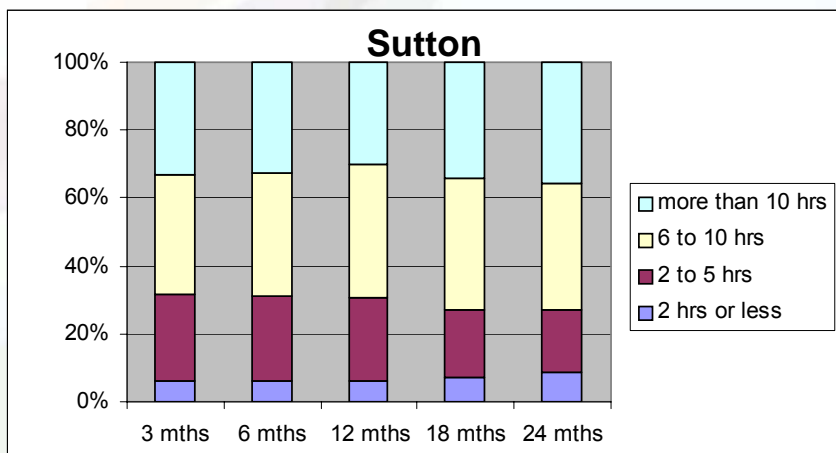
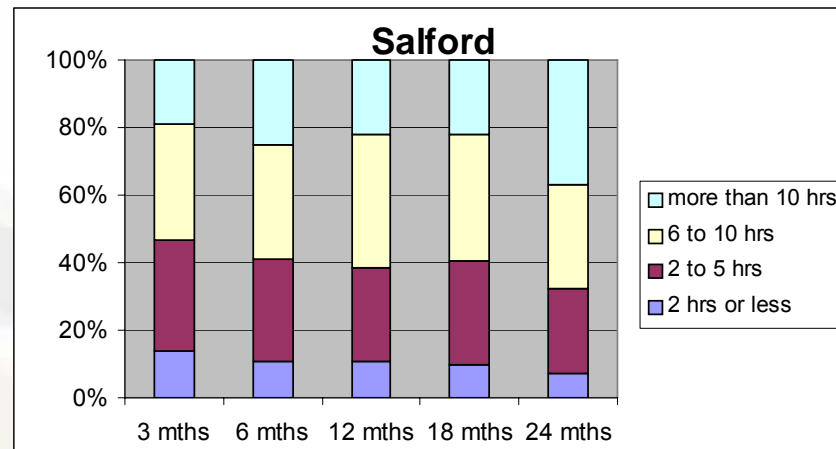
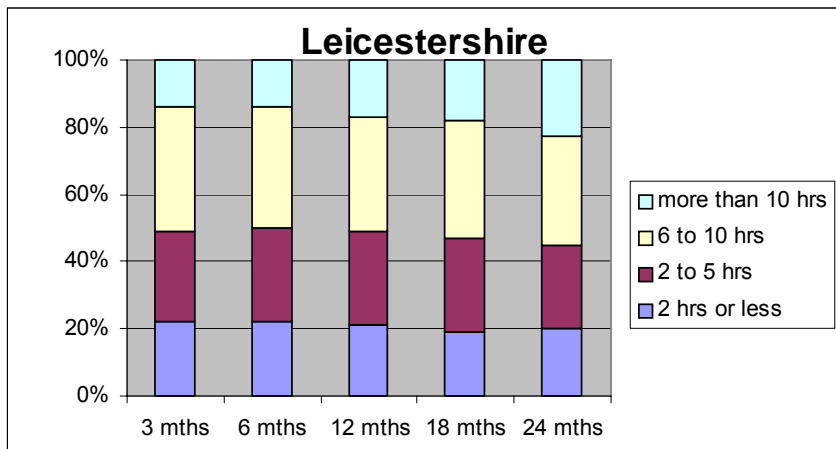
Exit = users transferred to long-term care or died

# HEMECARE RE-ABLEMENT: Retrospective Longitudinal Study - Changes in level of need since re- ablement for > 85s

Of those over 85 yrs,  
the number of users  
requiring less  
homecare than when  
they left re-ablement  
increased.



# HOMECARE RE-ABLEMENT: Retrospective Longitudinal Study - Intensity of Homecare Usage



# HEMOCARE RE-ABLEMENT: Retrospective Longitudinal Study - Factors influencing the impact of re- ablement services



Based on interviews with service managers the main factors are thought to be:

- Independent providers – culture and contracting arrangements
- Re-ablement package – duration and flexibility
- Service users – understanding and attitudes
- Carers – perceptions of risk and need
- Signposting - other services and support
- Culture - across social care services

# HEMECARE RE-ABLEMENT: Retrospective Longitudinal Study - Small Print – caveats and gaps



The ‘Health warning’:

- this is a limited study with only 4 schemes
- it was retrospective and so no control groups
- it also raises some interesting issues (e.g. >85) for which we have no evidenced backed understanding

**Whilst acknowledging these points, we believe that this study adds significantly to the body of evidence, and provides further assurance that there is still a compelling case for CSSRs to consider the introduction of Homecare Re-ablement**

# HEMECARE RE-ABLEMENT: Key Success Factors (1)

- Mindset: communicate re-ablement ethos
- Commissioners: trust to form part of assessment role
- Market: capacity, capability and flexibility
  
- Competencies: define and clarity of roles
- Staff: attitudes, skills, training
- Staff: alternate roles if not re-ablement
  
- Map process: “as is” and “to be”
- Remove bottle necks: entry to, during and exit from service

# HEMOCARE RE-ABLEMENT: Key Success Factors (2) Anticipated timescales



Factors that may affect timescales:

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

# HEMOCARE RE-ABLEMENT: Key Success Factors (3) Benefits

Essential to define and measure benefits

- Baseline the current service
- Quantify the likely order of benefit
- Benefits measurement tool
- Benefits monitoring as part of operational management

# HEMECARE RE-ABLEMENT: Proposed Developments in England



## Prospective study

- To identify those factors that maximise benefit and duration
  - e.g. role of enablement staff, skill mix, access to other services, timing of eligibility criteria
- Results likely April 2010

## Development of re-ablement approach

- Base assumption that social care interventions are time limited
- Application to daycare, extra care, residential care

# HEMOCARE RE-ABLEMENT: Contact with CSED



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