

April 2011

Review date: April 2014

Reablement: a cost-effective route to better outcomes

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Key messages

- Reablement is generally designed to help people learn or relearn the skills necessary for daily living which may have been lost through deterioration in health and/or increased support needs. A focus on regaining physical ability is central, as is active reassessment.
- People using reablement welcome the emphasis on helping them gain independence and better functioning, although evidence on user and carer views needs to be strengthened.
- Reablement improves outcomes, particularly in terms of restoring people's ability to perform usual activities and improving their perceived quality of life. From a social care perspective, there is a high probability that reablement is cost effective.
- Reablement achieves cost savings through reducing or removing the need for ongoing support via traditional home care. However, there is currently little evidence to suggest that it reduces health care costs.
- Managers and care workers are generally positive about reablement, valuing its flexibility and the more responsive way of working with people.
- Occupational therapy skills are central to reablement. These can be accessed by training reablement staff rather than having an occupational therapist as a team member.
- Complaints about reablement mainly relate to handover (to a traditional home care provider) and a lack of help with domestic tasks.
- The delivery of reablement depends on suitably trained care workers. Care workers require specific training in reablement. Ongoing refresher training or shadowing of experienced workers is vital to sustain this approach.
- Requirements for training, closer supervision of care workers and longer, more responsive and flexible visits all contribute to the greater costs of reablement compared with conventional home care. However, the higher price of reablement is likely to be offset by longer-term savings from reduced social care-related needs.

Introduction

This is one in a series of research briefings about preventive care and support for adults. Prevention is broadly defined to include a wide range of services that:

- promote independence
- prevent or delay the deterioration of wellbeing resulting from ageing, illness or disability
- delay the need for more costly and intensive services.

Preventive services represent a continuum of support ranging from 'primary prevention' aimed at promoting wellbeing, through to 'secondary' or early intervention, and on to 'tertiary services' such as intermediate care provided by health and social care professionals. Tertiary services are aimed at minimising disability or deterioration from established health conditions or complex social care needs.¹ The emphasis is on maximising people's functioning and independence through approaches such as rehabilitation, intermediate care and reablement. This research briefing focuses on reablement.

What is the issue?

Reablement is a key service because it represents an investment which may produce savings, and because it appears to meet the wishes of people who use services. It has been defined as 'services for people with poor physical or mental health to help them accommodate their illness by learning or relearning the skills necessary for daily living'.² However, the issues people face may include limited functioning which is not readily thought of as illness. Restorative care is another term used in the USA³ and in Australia.⁴ The focus 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.

A reablement intervention usually lasts between six and 12 weeks and for the initial six-week period is not chargeable.⁵ Common areas of focus are dressing, using the stairs, washing and preparing meals. Reablement is usually commissioned and delivered through adult social services and receives referrals traditionally made to conventional home care, either from the community or via hospital discharge. Although reablement overlaps with intermediate care, its focus on assisting people to regain their abilities is distinctive. Some schemes (e.g. an 'intake' reablement service) accept all those referred for home care, other than people who are unlikely to benefit (e.g. because they need immediate end of life care). Some schemes operate a more selective focus on those who will benefit most. No single leading model has yet been identified.² Apart from one mention of a manual⁴ and some observational data from a recent study,⁶ there are very few systematic accounts of what practitioners actually do. The emerging practice messages from the Social Care Institute for Excellence (SCIE)⁷ indicate that reablement is rapidly evolving. In contrast to this lack of detail on practice, there is extensive material available in the UK on the implementation of reablement services.⁸

Why is it important?

The importance of investment in preventive services has long been recognised and has cross-party support. At the Fifth International Carers Conference in 2010, Secretary of State for Health Andrew Lansley placed renewed emphasis

on the need to 'keep people as independent as possible, for as long as possible'.⁹

As one means of prolonging or regaining independence, reablement has received policy support in recent years, and the Department of Health (DH) has recently announced a £70 million investment in reablement, channelled through the NHS.¹⁰ The government Spending Review and 2011/12 NHS Operating Framework have provided further funding to primary care trusts (PCTs) for the financial years 2011/12 and 2012/13 to develop local reablement services, in partnership with councils, in the context of post-discharge support plans.¹¹

In the context of demographic trends, reablement is particularly valued for its potential to decrease demand on home care services¹² and its potential cost-effectiveness.¹³ Professional support for this initiative derives from the theory that reablement responds to the wishes of the majority of people to retain independence and control over their lives, including living at home.¹⁴

A key question is whether investment in reablement services can fulfil the imperative to reduce demand for long-term support, achieving savings to the public purse and at the same time improving people's quality of life. The implicit aim of reablement is to reduce the number of care hours required to support a person at home or to develop their independence so that they can remain in their own home instead of being admitted to residential or nursing care. One of the main issues to be explored in this briefing is whether there is evidence that people using reablement services share these aspirations and whether by reducing the need for home care and improving people's independence, this necessarily improves their overall wellbeing.

What does the research show?

The outcomes of reablement

Key point

- Reablement is significantly associated with better health-related quality of life and social care-related outcomes compared with conventional home care.

Research evidence demonstrates that reablement improves independence, prolongs people's ability to live at home and removes or reduces the need for commissioned care hours (in comparison with standard home care). The best results¹⁵ show that up to 62 per cent of reablement users no longer need a service after 6–12 weeks (compared with 5 per cent of the control group), and that 26 per cent had a reduced requirement for home care hours (compared with 13 per cent of the control group).

Although these are clearly positive results, they were recorded at the end of the reablement service and it is arguably more significant to look to studies that show lasting benefits. For example, in one study 76 per cent of reablement users did not need services up to four months after completion.¹⁶ An Australian study by Lewin,¹⁷ using a randomised design, went further by providing results both at the end of the reablement service and 12 months later. Seventy-eight per cent of those receiving reablement (or 'restorative' care) no longer required a support service after three months (compared with 31.1 per cent of the control group) and then later on at 12 months, 85.8 per cent no longer required a service (compared with 57 per cent of the control group). Furthermore, over two years, the reablement group was less likely than the control group to use hospital emergency services.

Outcome results vary, however, and we need to take into account that some people with a high

need for assistance on referral to reablement will not benefit as much as those with lower support requirements, or may need a longer-term intensive service. In one study,¹⁵ a third of users continued to require the same number of hours as at the outset, and in 5 per cent of cases an increase in hours was required. The reablement users in this study were matched with the control group in terms of age and care hours required at the start of the service. However, there is no agreed threshold for entry to reablement services and it is possible that people's functional abilities at entry may affect the benefit they derive from the service.

Outcomes also seem to vary depending on whether people are referred to reablement via hospital discharge or directly from the community. One account suggests that selective 'discharge support' schemes have higher rates of success than 'intake' services,² but another reports that community-based users, and those with 5–10 hours assistance requirements at intake benefited more than those referred from hospital.¹⁵ Unfortunately, due to low follow-up response rates, a Social Policy Research Unit (SPRU) and Personal Social Services Research Unit (PSSRU) prospective study⁶ was unable to examine the outcomes of reablement for people referred to the service via these different routes. From a practice perspective therefore it is not currently clear whether to focus the service on hospital discharge or on people living in the community.

A common theme in the research evidence for reablement is the sometimes exclusive use of service outcomes as a measure of success, namely, care hours required following the intervention. Service outcomes are an important measure. However, we also want to know whether reablement improves outcomes for individuals, and this requires the measurement of the impact on people's wellbeing. These, 'final outcomes' are concerned with changes in the

individual's life rather than changes in the service.¹⁸ The SPRU/PSSRU prospective study took this more comprehensive approach to examining the success of reablement, using the following measures:

- perceived health
- perceived quality of life
- health-related quality of life (using the Euro-QoL 5D or 'EQ-5D')
- social care-related outcomes (using the Adult Social Care Outcomes Toolkit – ASCOT¹⁹).

Self-perceived health has been found to be a reliable predictor of objective health and closely associated with overall wellbeing. The SPRU/PSSRU researchers used a perceived health question based on a five-point scale suggested by Robine et al.²⁰ Respondents in both groups were asked at baseline and follow-up to rate their general health using five categories ranging from 'very good' to 'very bad'. Overall, a smaller percentage of people in the reablement group perceived their health to have improved at follow-up and a higher percentage felt their health had declined. This does not necessarily mean that reablement made people worse, but it does mean that it did not add anything to the standard service in terms of improving people's wellbeing.

Perceived quality of life was measured on a seven-point scale ranging from 'so good it could not be better' to 'so bad it could not be worse'. At baseline, there was no difference between the reablement group and the home care group in their perceived quality of life. However, at follow-up, perceived quality of life was statistically significantly better among the reablement group compared with the home care group.

The EQ-5D was used to gauge changes in users' health-related quality of life in terms of five specific domains:

- mobility
- self-care
- ability to undertake usual activities
- pain and anxiety
- depression.

At follow-up, the reablement group reported better health-related quality of life on all five domains and general health. The difference was statistically significant. Notably, the greatest difference was in the ability to perform usual activities, where 23 per cent of reablement users were unable to perform usual activities compared with 43 per cent of people using conventional home care.

Social care-related quality of life was measured using ASCOT, an indicator that reflects people's need for help and outcome gains across nine domains. The domains range from basic areas of need such as personal care to social participation and involvement and control over daily life.¹⁹ The researchers were able to examine whether people's levels of social care need had increased, stayed the same or decreased between baseline and follow-up in both groups. The biggest difference was found to be in people's ability to undertake usual activities: 39 per cent of reablement users had lower levels of need compared with 21 per cent of people in the comparison group. Overall social care needs were also calculated, giving a mean score. After all confounding factors were accounted for in the analysis, the results showed that people in the reablement group reported statistically significantly better social care outcomes at follow-up than people using conventional home care. The researchers concluded that 'There is a good probability that reablement improves ASCOT outcomes, although this possibility is not quite as high as in the EQ-5D outcomes case' (p 83).

Lewin's Australian study also goes beyond service outcomes by employing measures of instrumental activities of daily living (IADL) and a mobility test (Timed Up and Go) in a sub-study of 350 people. The findings reveal that, on the mobility measure, the reablement group showed greater improvement than the control group at three months, and, on the IADL measure, greater improvement at 12 months.¹⁷

To summarise the impact of reablement, the SPRU/PSSRU research found that, although it did *not* improve self-perceived health, reablement was significantly associated with better health-related quality of life and social care outcomes compared with the use of conventional home care. The Lewin study showed that reablement results in greater improvement in mobility and IADL. The crucial question will be whether these improved outcomes can be achieved at an acceptable cost to the public purse. This will be examined in the section 'Costs and cost effectiveness of reablement' (see below).

People's views about reablement

Key points

- People who use services generally welcome the improved independence reablement provides.
- Some carers report that reablement increased their confidence with their own caring responsibilities.
- Negative views about reablement tend to mirror those often expressed about conventional home care.
- Managers and frontline staff welcome the opportunity reablement provides to work flexibly and responsively with people.

There are few studies focused on the views of people using reablement.¹² However, one account reports 'high degrees of satisfaction by users and their families',² while a systematic review of outcomes-focused services suggests strong support from reablement users.¹⁴ In the SPRU/PSSRU study, respondents said that one of the greatest benefits was the social contact provided by the reablement workers. Where particularly good relationships had developed, reablement users described the care workers as having a positive motivating effect, encouraging their progress or improvement.

Among a representative sample of reablement users in another study, the majority 'were very positive about the new service and were all satisfied with any reductions in hours of service that resulted at the end of the reablement period. Clients were also particularly pleased at the speed with which any equipment they required to assist them in their homes was put in place' (p 36).¹⁵ By contrast, some reablement users in the SPRU/PSSRU study were frustrated with long waits for larger pieces of equipment such as stair lifts, bathroom adaptations and wheelchairs. Others were annoyed that equipment was not taken away when it was no longer needed.

It is conceivable, particularly for isolated individuals, that a reduction in the amount of care worker visits might lower their sense of wellbeing. Reablement users living alone are reported to have experienced the service differently and more negatively in the SPRU/PSSRU study. Many people living alone were frustrated about unmet needs for help with housework or shopping. In a few instances they also reported that 'improving social contact' was an agreed goal of their reablement, although there was little evidence they had received help in this area. These people reported a high degree of loneliness which

seemed to increase their reliance on the care workers and heightened feelings of loss and uncertainty at the end of the reablement period.

Other problems are reported about handovers and lack of help with domestic tasks. Some of those who had ongoing support needs were concerned about the handover to the new provider at the end of reablement and others about the perceived absence of assistance with domestic tasks at the start of reablement.¹⁵ Some people were disappointed with having to change their eating habits and with receiving very limited advice on new approaches to food preparation, which effectively meant having to rely on a microwave instead of an oven and eating sandwiches and simple snacks.⁶

Few studies report carers' views, although one suggests that carers need to be motivated to engage with reablement, while another records the negative view of one carer about her husband's care.¹⁵ The SPRU/PSSRU study investigated carers' views in more detail, interviewing 10 carers across five reablement sites. All but one lived with the person they cared for and most reported onerous responsibilities, which did not generally diminish during reablement. Nevertheless, they described some personal benefits including learning new skills and approaches to meeting the needs of the person they support. This led to some carers feeling more confident about their caring responsibilities. Women in particular valued the emotional support they received from reablement workers, although conversely two men caring for their wives felt that they had not received enough emotional support and practical advice on domestic tasks.

Evidence about user and carer views of reablement is not currently robust. Although the

SPRU/PSSRU study's attention to users' (n = 34) and carers' (n = 10) views represents a step in the right direction, those interviewed were not drawn from the main reablement sample. It is therefore impossible to analyse the in-depth data about people's experiences of reablement against the quantitative outcome results. However, the information suggests that people usually benefit from improved independence and increased motivation and confidence. As with conventional home care, people's experiences seem closely associated with the quality of the relationship they develop with their care workers. Similarly, some of the adverse reports may apply to any home care service with handover points or limited support for domestic tasks, but reablement throws these issues into sharp focus because it emphasises a handover after a certain period and that the goal is to encourage people to undertake their own domestic tasks. This suggests that reablement teams must manage people's expectations from the outset, explaining not only the particular ethos of reablement but also its boundaries in terms of the nature and length of support.

Managers' and frontline workers' views about reablement are generally positive. One study reported that staff valued the increased flexibility of the reablement approach, better interprofessional working and better management.¹⁵ Data from the Care Services Efficiency Delivery (CSED) Programme's interviews with managers²¹ suggests they valued the impact on users and services. Managers and frontline staff interviewed for the SPRU/PSSRU study believed the greatest benefit could be seen among people recovering from acute illness, falls or fractures. In contrast, people with chronic or deteriorating conditions, including dementia, who required ongoing support, were less likely to show significant improvements in their independence.

Organisational implications

Key points

- Home care staff form the foundation of a reablement service, although specific training and ongoing supervision is essential to ensure a strong grasp of the 'reabling ethos'.
- Occupational therapy skills play an important role in the delivery of reablement, although there is no evidence to suggest that including occupational therapists in a reablement team is essential to successful outcomes.

The funding and organisation of reablement varies. Some services are joint health and social care schemes, whereas others involve social services only. The existing skills of home care staff are the key resource,¹³ but research has identified teams which include occupational therapists or which train home care staff in occupational therapy skills. An Australian scheme differs again as it includes a nurse, physiotherapist and occupational therapist, just one of whom works with the individual.⁴ One of the early UK studies indicates the key role played by the reablement coordinator trained in occupational therapy.²²

Although occupational therapists are commonly associated with reablement, it is unclear from the available evidence whether their skills are essential to successful outcomes.² Thirty per cent of users in one study had support from an occupational therapist¹³ and in another service, where therapists were employed within the team, care workers valued this close working and regular advice.¹⁵

Managers and staff value input from occupational therapists in terms of ensuring

prompt access to equipment, which was judged more important than having therapists as permanent members in the reablement team.⁶ There were complaints that without access to equipment via occupational therapists the reablement service was delayed and, crucially, so too was the progress of people using reablement. The input of occupational therapists was also valued for training care workers to assess for smaller pieces of equipment, thereby reducing some unnecessary delays.

Occupational therapy skills are clearly viewed as important, although in terms of delivering reablement care workers are the bedrock of the service. In the UK, councils with social services responsibilities (CSSRs) designate NVQ Level 2 as the base qualification for reablement care workers.² However, there is a consensus that specific reablement training must complement qualifications so that care workers grasp the 'reabling ethos', which is distinct from the spirit of standard home care. One study suggested that staff with less experience in traditional home care work made better reablement workers and were more likely to facilitate self-help.²³ In the study's five reablement sites, the researchers observed that many frontline staff with long histories of working as traditional home helps or care workers faced a big challenge in learning to stand back instead of intervening when a person was struggling with a task, such as dressing or washing (see also the next section).

While formal training was valued by reablement workers, those who had shadowed more experienced staff found this particularly helpful in understanding reablement and coping with the biggest challenge of standing back and watching. This has obvious implications for training, so that staff understand and adhere to the enabling ethos, and for ongoing refresher training or mentoring to ensure this is sustained over time.

Managers should be alert to the possibility that staff with different types of care experience may need more support than others when joining a reablement team.

The need to grasp the distinct objectives of reablement is not limited to new reablement staff. CSED interviews with managers also point to the need to encourage a culture of reablement among independent providers² and another study pointed to the risk that handover to a more traditional home care service might undo the progress made by using a reablement approach.¹⁵

What will people do differently as a result of reablement?

Key points

- Service managers should ensure greater flexibility than conventional home care would normally offer; they should provide more intense supervision and allow for the constant assessment of people's needs.
- Care workers must learn to stand back and encourage people to regain or relearn the ability to do things for themselves.
- People who use services should be fully supported and informed so that they have a clear understanding of what is involved in receiving reablement compared with conventional home care.

Research suggests that everyone involved in the planning, delivery and receipt of reablement will be expected to operate differently. While reablement 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 done' (this view, from Rabiee²³ is confirmed in another study by McLeod¹⁵). Staffing needs to be flexible to allow the time required and continuity of care worker to be maintained.²³ Detailed records of achievement should be made at each contact.²³

The McLeod study also suggests that reablement managers are required to provide more intense supervision, and the higher costs of the reablement service in this study were in part explained by the higher ratio of managers to staff compared with the conventional home care service. The researchers suggest that the increased management input was an important part of the success of reablement.

SCIE's emerging practice messages⁷ also highlight the need for reablement care workers to carry out constant assessment of people's needs, even on a visit by visit basis. Managers will need to encourage this crucial aspect and allow time for it in the allocation of work.

Independent sector providers also need to adapt their service to support reablement.² The concern is that after someone is referred from a reablement team to an independent home care provider, the work to improve independence may not be sustained. There is limited research evidence on this issue but SCIE's emerging practice messages⁷ highlight the fact that some reablement teams are working to ensure that the 'reabling ethos' is embedded with providers delivering ongoing support. In one team, reablement workers mentor home care workers when it appears a person's support needs have increased following handover. Another London borough is renegotiating home care contracts to provide an opportunity to reinforce these reabling messages.

Most of the research suggests that people using services, especially those with extensive

experience of conventional home care, need to adjust their expectations in relation to the goals of a reablement service. The SPRU/PSSRU study highlighted the fact that people who were not motivated to become independent were among those least likely to demonstrate significant improvements – in other words, 'people have got to want to do it'.¹³

Costs and cost-effectiveness of reablement

Key points

- Reablement requires substantial up-front investment, which is greater than the cost of providing conventional home care. A typical reablement episode costs around £2,000 compared with £1,392 for conventional home care, over a comparable period.
- However, among reablement users, up to 60 per cent savings have been demonstrated in the cost of subsequent social care provision.
- There is some evidence that reablement does not reduce health care costs.
- Combined with the outcome data, one robust evaluation found a high probability that from a social care perspective, reablement is cost effective.

Cost-effectiveness analysis

There is good evidence that reablement improves service outcomes (e.g. it removes or reduces the need for ongoing support), and since the publication of the SPRU/PSSRU study in November 2010 there has also been good evidence that reablement improves people's quality of life compared with conventional home care services. Lewin's Australian study points out that reablement delivers improvements in

physical functioning. However, the pressure at this time on local government to make unprecedented efficiency savings means that effectiveness alone is an insufficient basis for decisions about investment. Evidence is required that demonstrates whether reablement achieves better outcomes than traditional home care at a price that is worth paying. In other words, it is vital to understand whether reablement is cost effective. To do this, evidence about the outcomes of reablement must be set in the context of evidence about the costs. Ideally the outcomes used in this analysis should reflect the improvements in people's lives (e.g. wellbeing or physical functioning) achieved through the intervention. It is not enough to indicate a reduction in the costs of services without demonstrating whether outcomes for people using services are improved.

Apart from the SPRU/PSSRU study⁶ and Lewin's¹⁷ ongoing work, none of the other controlled studies measured final outcomes to assess the impact of the intervention. We therefore focus on these two studies to investigate the cost-effectiveness of reablement. In the context of evidence that reablement improves physical functioning, health-related quality of life and social care outcomes, we need to consider the costs involved in delivering these outcomes.

The SPRU/ PSSRU study provides detailed information on health costs and social care costs separately. The SPRU/PSSRU final report found that health care costs were significantly higher for the reablement group during the initial eight-week period (£1,600 compared with £1,095), and that over the subsequent 10 months and the whole 12-month study period, the reablement group still incurred greater health care costs, although those differences were not significant.

During the 12-month study period the reablement group incurred slightly lower overall

social care costs compared with people using conventional home care, although the difference of £380 was not statistically significant. If the cost of the reablement service is excluded, it looks as though the reablement group incurred as much as 60 per cent lower social care costs over the 12-month period compared with the comparison group. However, as long as reablement is funded through the social services budget it makes little sense to exclude the initial investment required for reablement when calculating the total use of social care services. Nevertheless, the calculation does demonstrate that *following* reablement, people's need for social care services is reduced by 60 per cent compared to conventional home care. It also highlights the fact that reablement requires significant initial investment with an average cost per user of £2,000 compared with an average of £1,392 for a six-week period of home care.

When health care, social care and reablement costs were taken together there was no significant difference in the cost of all services used by reablement users and the comparison group over the 12-month study period. Although this shows that the reablement service cost about the same as traditional home care, this does not provide an answer about its cost-effectiveness. For this we can look to the research team's cost-effectiveness analysis.

The fact that the SPRU/PSSRU final report provides a cost-effectiveness analysis based on wellbeing measures gives it a significant advantage over the other controlled studies included in this briefing. Cost-effectiveness in the SPRU/PSSRU research was based on two of the four outcome measures from the study: EQ-5D and ASCOT. The study provides grounds to infer that reablement leads to better outcomes at the same costs, given that it is associated with significantly better EQ-5D outcomes and more

tentatively with better ASCOT outcomes, and that it was not statistically significantly more expensive. However, for formal analysis, the researchers combined the outcome results with health, social care and overall cost data to measure the incremental cost-effectiveness ratio (ICER), or the ratio of cost difference to outcome difference. The researchers established whether the ICER was below a certain threshold (£30,000 and £20,000) and calculated the probability of cost-effectiveness separately using the EQ-5D and ASCOT outcomes.

The conclusions were that reablement is cost effective with regard to improving the outcomes measured by the EQ-5D (personal functioning). Reablement is slightly less likely to be cost effective when the impact on health costs as well as social care costs is accounted for, but still with a very high probability. The slight difference in probability arises because reablement users had higher health care costs than people in the comparison group. Using social care-related outcomes (measured using ASCOT) cost-effectiveness results are more tentative.

The SPRU/PSSRU analysis therefore provides an answer about whether the outcome gains achieved through reablement are really worth the costs associated with the intervention. From a social care perspective the study found:

...we can conclude with a high statistical probability that reablement is cost effective... (p115)

When health care costs are included in the analysis the results are less convincing, although the research still concludes that reablement is more likely to be cost effective than not.

As we have emphasised, the SPRU/PSSRU study is unique in conducting formal cost-effectiveness analysis using the results of final outcome

measures. Lewin also focused on final outcomes and found greater improvements in physical functioning in the reablement group compared with the control group. Lewin also showed a significant difference in the cost of home care provision, with the reablement group requiring fewer hours of ongoing support compared with the control group.¹⁷ We could therefore infer that when assessing social services costs, Lewin's study demonstrates that reablement is cost effective. The final report is not yet available, so it is impossible to tell whether a formal analysis of cost-effectiveness has been undertaken.

Cost studies

As discussed on page 10, most studies rely on service outcomes, such as reduction in commissioned home care hours, and imply that improvements in those outcomes will lead to improved quality of life. The studies should ideally have explicit statements about their assumptions or provide evidence that improved service outcomes equate to improved quality of life. Nevertheless, results from all the controlled studies show or imply longer-term cost savings as a result of investment in reablement, albeit that reablement is generally more expensive to deliver.

Kent²² found that 58–62 per cent of reablement users had their care package *discontinued* at first review, compared with 5 per cent of control group users, and 17–26 per cent had their care package *reduced* at first review, compared with 13 per cent of control group users. Initial costs of delivering reablement are likely to have been higher than the costs of delivering the control service because average care hours provided to control group users at the commencement of the study were 5.5 compared with 6–8 hours for reablement. However, at the first review, the average care hours per week for individual home care users had increased slightly by 1 per cent, whereas

care hours for reablement users had decreased by 28–72 per cent.

Lewin²⁴ reported that there was no significant difference between the direct care costs of the experimental and control groups for the year of the study. However, as 57 per cent of the experimental group no longer needed services at one year whereas 81 per cent of the control group were in need, it is reasonable to expect that the experimental group would show cost savings in the longer term.

McLeod¹⁵ reports that the overall costs of providing reablement were greater than those attributed to the traditional service over the same period. Management costs in particular were markedly higher, mostly due to higher management/staff ratios in the reablement service. However at the end of the reablement period, 41 per cent of service capacity was available for new clients whereas no capacity was released in the control service.

Finally, Tinetti and colleagues³ imply cost savings resulting from reablement users having shorter and less intensive home care episodes. The authors also suggest that capacity gains were made to health services because these users had a reduced likelihood of emergency hospital visits.

All studies therefore suggest that reablement reduces service costs because it reduces the need for ongoing support. Most studies simply infer that these improved service outcomes are associated with improvements in people's quality of life. Until Lewin's final report is available, the recently published SPRU/PSSRU study is unique in linking measures of people's wellbeing improvements with service costs and demonstrating the cost-effectiveness of reablement compared with conventional home care.

Gaps in the research evidence

Key points

- Although the recent SPRU/PSSRU study represents a significant improvement in the evidence base, the volume and design of research on reablement could be improved.
- Available research leaves several unanswered questions including whether there is a single delivery model for reablement, whether and how the service should be targeted, and the acceptability of reablement among specific groups of people.

How the research evidence could be improved

There is good evidence that reablement improves outcomes and is cost effective. However, the volume of research is still limited and its reliability and relevance to practice could be improved. Further research could be strengthened by using randomised designs, demonstrating sustained effects over a 12-month period and longer, clearly linking service outcomes to independently measured wellbeing scores and systematically recording the views of people using reablement and their unpaid carers (family and friends).

Research could support the development of reablement by adjusting its focus to questions such as whether and how it should be targeted and what exactly are the resource implications across all relevant stakeholders. Studies should, for example, focus on services that take referrals from any source, rather than primarily from hospital discharge, and

they should investigate the reasons for variable effectiveness. Further studies should also detail the practices of reablement and the resources and costs incurred by all relevant stakeholders, including people who use services and unpaid carers.

Publication of the SPRU/PSSRU final report marked a significant improvement in the evidence base on reablement and the reliability with which conclusions about cost-effectiveness could be made. Although a randomised study would give greater reliability than a matched group controlled design, the researchers point out that randomisation was not feasible because in any given local authority either reablement *or* conventional home care were likely to be available, not both. Another strength of the work was the use of four outcome measures to assess final outcomes rather than relying exclusively on service outcomes.

Despite these strengths, the research team acknowledges that the study has a number of limitations. Readers should refer directly to pp 127–130 of the report for a detailed explanation of these limitations and their implications. In summary they include:

- lack of randomisation
- poor retention of study participants
- uncertainty of service use data
- possible recruitment bias which may have exaggerated the positive outcomes.

A further limitation is that the study primarily concerns reablement following hospital discharge, with 75 per cent of users in the comparative study having been referred via that route. This is in contrast to the wider range of reablement services now in operation. When combined with the high drop-out at follow-up, this bias toward hospital discharge means reablement requires different research.

The SPRU/PSSRU research team also acknowledge that the value of unpaid care should ideally have been included in the cost-effectiveness analysis. This would have provided a more complete picture of the true costs and benefits of reablement.²⁵ It is possible that in improving people's functioning, reablement effectively reduced the need for unpaid care, thereby achieving savings and strengthening the study's conclusions about cost-effectiveness. However, it is also conceivable that, if reablement reduces assessed need for ongoing formal care, unpaid carers might step in, providing *increased* support to compensate for the potentially isolating effects of reduced face-to-face services. Until research includes the identification, measurement and valuation of unpaid care in the same way other resources are examined, there is no reliable way to understand whether care and costs are transferred to family and friends to make savings to the public purse.

What the evidence does not tell us

The limitations of existing research and gaps in the questions addressed mean that there are several issues that have not been covered. Questions about whether there are common models for the delivery of reablement need to be addressed to support the ongoing development of reablement. Other outstanding issues include whether and to what extent the occupational therapy role is fundamental to achieving successful outcomes, the extent and precise nature of training required for reablement workers, and in what ways the skills required differ from those involved in standard home care. Questions also remain about whether reablement is more or less effective for people with particular needs or who have been referred via different routes, and also whether improvements in people's wellbeing (e.g. independence) are sustained over a longer period.

Finally, little evidence is available on the acceptability and effectiveness of reablement with minority ethnic groups.

Plugging evidence gaps with knowledge from practice

Although the research evidence leaves unanswered questions, SCIE values additional sources of knowledge, such as practitioners and organisations, information from which can be used to plug existing gaps and give a more complete picture. To get a better understanding of how reablement works in practice and to shed light on some unanswered issues, SCIE visited reablement teams in four London boroughs⁷ using a structured data collection questionnaire.

In some areas, messages from the local teams echoed findings from research. For instance, they acknowledged that the specific model of reablement is largely defined by local circumstances, albeit that there is usually a common focus on rehabilitation, physical care and ongoing assessment. The teams also confirmed that reablement is effective in reducing people's need for ongoing support.

The teams were able to shed some light on the question of targeting reablement. Although research is inconclusive on this issue, there was a shared view that some people with dementia *can* benefit from a period of reablement. The teams also supported people with end of life care needs, unless palliative care was more appropriate.

In terms of the organisation and make-up of reablement services, the teams viewed occupational therapy as essential. The input of occupational therapists was valued for training care workers and maintaining a reablement focus in the care and support provided. Managers did not believe occupational therapists necessarily

had to be members of the teams and said their input could be secured through collaboration, co-location or referral.

Apart from some detail from CSED interviews² and the McLeod study,¹⁵ there is little in the research about managing the handover to independent providers where people have ongoing support needs following reablement. SCIE's visits to local teams shed useful light on this. McLeod pointed to the risk that handover to a more traditional home care service might undo the progress made using a reablement approach. Having identified this potential problem, one of the teams now keeps cases open for up to two years following handover to a home care provider. Before a provider can subsequently increase an individual's care package the reablement team must authorise the change and will only do so if they feel the person is being supported to reach their potential independence within a reabling ethos. The team also works with private providers to support care workers in adapting to this less hands-on approach, while another team was renegotiating its contracts with ongoing care providers to ensure the right ethos.

This fieldwork confirmed that the practice of reablement is evolving as it becomes a mainstream service. In particular, it is becoming the 'default' initial response to presenting needs, rather than a service that is restricted to those discharged from hospital. Reablement is also seen as part of the personalisation of services and includes specific approaches designed to address social exclusion among those using mental health services (in addition to its traditional focus on people with impaired physical functioning). As with any substantial research study, practice has moved on from that reported by SPRU/PSSRU and new research will be required to monitor and evaluate the development of reablement as a mainstream service.

Implications from the research

Key points

- There is good evidence that reablement removes or reduces the need for ongoing conventional home care.
- There is good evidence that reablement improves outcomes for people who use services.
- Evidence on user and carer views about reablement needs to be strengthened.

There is good evidence that reablement improves service outcomes, removing or reducing the need for ongoing standard home care. It is feasible to introduce reablement into daily practice in social services and staff welcome the approach. Studies report a higher cost than traditional home care but indicate a strong probability of longer-term cost savings in social care. The most recent UK research⁶ shows investment in reablement does not achieve cost savings from health service use and that when health care, social care and reablement costs are all taken into account there are no significant savings from reablement compared with conventional home care.

It remains unclear whether reablement is a single intervention or a collection of practices, and what skill mix it requires (particularly whether it is essential to have an occupational therapist as part of the team or whether this aspect can be supplied through attachment or training).

There is good evidence that reablement improves people's outcomes, in terms of restoring their

ability to perform usual activities and improving their perceived quality of life. The most marked improvement was in health-related quality of life measured using the EQ-5D, which was found to be statistically significantly higher among people who had been supported through reablement compared with people using home care.

There is moderately good evidence that, where the views of people who use services have been collected, they welcome the emphasis on helping them to regain their independence and level of function. This evidence is not as strong as for service or wellbeing outcomes for three reasons. First, some studies have focused on the evidence on service outcomes (e.g. reduction of hours) without fully linking this to independently collected measures of wellbeing for users (e.g. improvement to activities of daily living scores, or morale). Secondly, not all studies have systematically collected the views of people who use services and their carers. Even where users' and carers' views have been sought, those interviewed have not been drawn from the main reablement group on which quantitative data is available. Thirdly, the results on wellbeing vary, with some studies showing that a significant minority of users do not benefit from, or have increased support needs after, reablement.

Research studies have not been of sufficient size to analyse the impact on subgroups in order to explore this variability, nor to examine whether reablement is more effective when the service is targeted at selected clients or at all clients referred for home care support. As an additional caveat, effective practice reported in pilot studies may not be readily mainstreamed to standard services.

Useful links

Care Services Efficiency Delivery at the Department of Health

www.csed.dh.gov.uk/homeCareReablement/
– outlines its work on reablement including its home care reablement toolkit

Social Policy Research Unit

University of York
www.york.ac.uk/inst/spru/

Personal Social Services Research Unit

University of Kent at Canterbury
www.pssru.ac.uk/index.php

Silver Chain

Australia
www.silverchain.org.au/home-independence-program-rct/
for an outline of its Randomised Controlled Trial (RCT) of a Home Independence Programme.

Related SCIE publications

Social Care TV film on reablement
Due to be published 2011.

Emerging practice messages on reablement
www.scie.org.uk/adults/prevention/reablement.asp

Support materials and resources to develop capacity to deliver reablement
Due to be published 2011–12

SCIE Research briefing 35: Black and minority ethnic people with dementia and their access to support and services
www.scie.org.uk/publications/reports/report38.asp

SCIE research briefing 1: Preventing falls in care homes
www.scie.org.uk/publications/briefings/briefing01/index.asp

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About the development of this product

Scoping and searching

Scoping began in September 2010 and was completed in November 2010.

Peer review and testing

All three authors bring research and topic expertise. Lead author brings expertise in cost effectiveness analysis in social care. The briefing was peer reviewed internally and externally.

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