social care
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At a glance **53**

March 2012

Reablement: implications for GPs and primary care

Key messages

- Reablement focuses on restoring independence rather than resolving health care issues.
- Research findings are positive and show that reablement is cost-effective compared with conventional home care.
- It is the intention of the Secretary of State for Health that clinical commissioning groups should embrace reablement.
- While reablement usually begins in hospital, this is not inevitable as people can be referred from the community, for instance by general practitioners (GPs) and social workers.
- A multidisciplinary team activates a reablement plan with clear objectives and an analysis of likely outcomes. The team could be organised around clusters of practices, with combined health and social care input.
- Flexibility and reassessment throughout the intervention period is necessary to ensure improvements in outcomes. Strategies and services should be deployed that lead to improvements in independence and self-care after an illness.
- People using reablement must be consulted to assess satisfaction and measure quality of life indices through and after the reablement period.

Introduction

This At a glance briefing focuses on research and practice evidence about reablement and explains the implications for GPs and primary care teams. It also provides a case example demonstrating the advantages of reablement at the individual and service levels.

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The focus of reablement is on restoring independent functioning rather than resolving health care issues. In this sense reablement differs from comprehensive geriatric assessment, which develops interdisciplinary treatment plans.

Reablement supports adults of all ages. The objective is to help people do things for themselves rather than the conventional home care approach of doing things *for* people. Reablement appears to be welcomed by people receiving the service, and represents an investment that may produce savings.[1] Research findings are broadly positive.

Implications

The importance of investing more broadly in preventive services, has long been recognised and has cross-party support. In this context reablement has recently received considerable policy support as one means of prolonging or regaining independence and supporting recovery. The Department of Health (DH) announced a £70 million investment in the development of reablement capacity,

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channelled through the NHS. The government Spending Review and 2011/12 NHS Operating Framework 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 and in the context of post-discharge support plans.[2] The idea is that the resources should either be transferred to local partners or distributed via pooled budgets.

What difference does reablement make?

A central tenet of the Spending Review announcements is that spending on social care services benefits health services and improves overall health gain.

In their commissioning role, GPs and primary care teams would be right to question whether this really is the case with reablement – why should you invest in and commission reablement? What difference does it actually make?

The best evaluation of reablement that has so far been published was a controlled prospective study by the Social Policy Research Unit (SPRU) (University of York) and the Personal Social Services Research Unit (PSSRU) (University of Kent).[3] This found that at follow up, people in the reablement group reported better health-related quality of life on all five domains of the EQ-5D (mobility, self-care, ability to undertake usual activities, pain, and anxiety and depression) compared with people in the control group who had received a standard home care service for the same period. The difference was statistically significant.

An unpublished randomised controlled trial of reablement (or ‘restorative care’ as it is called in Australia) also provides evidence of improved physical functioning. In a mobility test (‘Timed Up and Go’) the reablement group showed greater improvements at three months and, on an Instrumental Activities of Daily Living scale, greater improvements 12 months after the intervention.[4] Furthermore, over two years, the reablement group was less likely than the control group to use hospital emergency services.

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It is important to understand the value of reablement in addressing a broader spectrum of needs – not just health and physical functioning. The SPRU/PSSRU study measured social care-related quality of life using ASCOT (Adult Social Care Outcomes Toolkit), which measures eight domains: control over daily life, personal cleanliness and comfort, food and drink, personal safety, social participation and involvement, occupation, accommodation cleanliness and comfort and dignity. By using this measure the researchers could examine whether people’s need for social care had increased, stayed the same or decreased between baseline and follow up in both the intervention and control groups. Again, the

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result was positive. People in the reablement group reported better social care outcomes at follow up than people using conventional home care – the difference was statistically significant. Thanks to reablement people's need for social care support was reduced by up to 60 per cent.

So although we have good evidence that reablement improves health and social care-related quality of life and reduces the need for support, the crucial question for commissioners is whether these improvements can be achieved at an acceptable cost to the public purse: is reablement cost-effective?

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The simple answer, on the basis of the best available evidence, is 'yes'. The SPRU/PSSRU researchers formally analysed the service use data for health and social services (the costs) and the outcome data from the EQ-5D and ASCOT measures (the benefits). Despite higher upfront investment in reablement they concluded that there is a high statistical probability that it is cost-effective.

What can I expect from a reablement service?

Reablement works through an intensive short-term service leading to lasting savings. People normally use reablement on discharge from hospital or are referred by social services, their GP or carers/relatives. The objective is to improve people's confidence and independence and as a consequence show a reduction in their need for health and social care support.

In terms of delivering reablement, care workers are the bedrock of the service. However, many reablement teams also include care managers, occupational therapists, physiotherapists or nurses. Occupational therapy skills are key in the delivery of reablement and occupational therapists are involved in or with reablement teams in a range of ways.[5]

The implementation of reablement services is at different stages across England. By the end of November 2010 most councils operated 'intake and assessment' models although around 20 per cent of reablement teams focused exclusively on supporting hospital discharge. In 2010, around a quarter of councils co-funded reablement with health – the remainder were funded solely by the council.[6] However, given the Government's investment in reablement via

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the NHS, the balance between jointly funded and solely funded schemes could shift significantly. Primary care commissioners should be talking to social care colleagues about a truly integrated approach to health and social care.

When someone is referred for reablement they are usually assessed by a senior team member who agrees desired outcomes with the person using the service. The support period lasts for up to six weeks, during which time the person will be encouraged to re-learn essential day-to-day personal care skills and develop their strength, physical functioning and independence. A fundamental aspect of reablement is constant assessment and flexibility so that care is reduced when independence increases or more support is introduced if progress is slow.

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Reablement teams across the country are supporting people with a range of diagnoses including some with dementia and even people with end of life care needs. The message is that people should be referred to reablement on the basis of their health and social care-related needs, not on the grounds of their clinical diagnosis.

Appendix B of the SPRU/PSSRU evaluation[3] describes the profiles, including service delivery models, of reablement services in the five study sites. Although not representative of all reablement teams this is a useful illustration of the range of existing operational structures, eligibility criteria, referral routes, skill mixes and so on.

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What influences the success of reablement?

- At-risk patients who could benefit from reablement should be identified early, for example by community ‘virtual wards’.
- Motivation has been found to be crucial. People who are not motivated to become independent are the least likely to demonstrate significant improvements.
- The effect of reablement may mean that people who use the service will see fewer health and social care professionals on a daily basis, and if they are older and isolated this may not be entirely positive or welcome. Other options exist such as a referral to a local voluntary service lunch club or befriending scheme.
- Spouses and other family members may be unused to this type of approach and prefer to think of their relative being ‘looked after’ in the traditional sense. Their fears should be addressed and you can reassure them that far from being put at any risk, their relative is likely to benefit greatly from improved independence.
- Negative views about reablement tend to reflect the fact that people do not know what to expect from the service. For instance, they

can be disappointed and frustrated that carers will not do things for them such as carry out domestic tasks.

- At the end of reablement, which is a time-limited service, a care package may be handed over to another provider. This can sometimes be a stressful period, with further assessments, new care workers and different visit times. You can help by managing expectations about the boundaries of reablement in terms of the nature and length of support.

Example: Improved quality and lower costs

Mrs O has spinal muscle atrophy. She was referred to Surrey County Council and Central Surrey Health Integrated Rehabilitation and Reablement Service (IRS) for rehabilitation and reablement following a three-week stay in a local acute hospital. The IRS is an integrated service, jointly provided by Central Surrey Health and Surrey Adult Social Care Services.

Prior to this admission, Mrs O was able to transfer from bed to chair, supporting her own weight when being steadied and guided by one person. She lived independently with a twice-daily package to support and manage her activities of daily living. District nurses were delivering care to her on an ongoing basis.

On discharge Mrs O was completely immobile, spending all of her time in a bed chair. Consequently, her pressure sores had deteriorated and she had fluid build up in her legs causing her further problems.

Initially, she was assessed and treated by the occupational therapists and nurses in the IRS. It was clear that reablement would help Mrs O and she received an intensive package which lasted for six weeks. A high/low hospital bed and a ceiling track hoist enabled Mrs O to be transferred on and off her bed for pressure relief and allowed her to elevate her legs at certain times, which reduced the fluid retention. Her nursing needs were initially met by the IRS nurses.

As Mrs O's condition improved, physiotherapists were able to start a programme of weight-bearing and exercises which were continued daily by rehabilitation assistants and overseen by a physiotherapist. During this time personal care was delivered up to three times a day as part of these visits.

Mrs O was able to undertake some standing transfers (e.g. from bed to chair and vice versa) with support, and the fitting of a curved track and hoist in her house meant that other transfers, within and between rooms, could be managed with minimum support and risk.

At the end of her package of care with IRS, Mrs O had regained the skills that were needed to enable her to manage at home to the same level as prior to her stay in hospital, and she was going out of the house again, albeit in her wheelchair.

Without ongoing reablement, Mrs O would probably have remained in long-term care at a cost of between £400 and £750 per week depending on her needs. Reablement also prevented other costs such as further acute hospital admission.

Figures that relate to reablement overall in the mid-Surrey area during 2010 show a positive outcome in terms of quality and costs. Of the 3,896 people who received services, 69 per cent were referred to reablement as an alternative to acute hospital admission or placement, so saving the initial costs and potential long-term costs of care. Following reablement, 71 per cent were able to cope independently again.

Acknowledgements

This briefing has been co-produced with the Clinical Innovation and Research Centre of the Royal College of General Practitioners.

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