

Reablement services for people at risk of needing social care: the MoRe mixed-methods evaluation

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Scientific summary

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Scientific summary

Background

Reablement is a goals-focused intervention comprising intensive, time-limited (up to 6 weeks) assessment and therapeutic work delivered in the usual place of residence. Its purpose is to restore/regain self-care and daily living skills for individuals at risk of needing social care support, or an increase in its intensity, to continue living in their own homes. It contrasts markedly with traditional home care. Despite significant government investment and policy directives over the past decade, research on reablement is limited.

This study arose from a commissioned call from the National Institute for Health Research's Health Services and Delivery Research (HSDR) programme. The call asked for research that, for the first time, would identify the service models and/or service characteristics that support positive outcomes, and investigate the impact of user engagement and other individual factors on outcomes. The (HSDR) programme also wanted to commission research on reabling people with specialist needs (e.g. dementia).

Objectives

Work package 1

To map services and develop a typology of service models.

Work package 2

To evaluate up to four service models, as identified in work package (WP) 1, investigating outcomes, predictors of outcomes, costs, cost-effectiveness and the reablement process.

Work package 3

To investigate current practices regarding reabling people with dementia.

Methods

Work package 1

A national survey of reablement services in England. The survey, completed by service leads, covered service organisation and structure, staffing, objectives, domains of reablement input, referral and assessment processes, policies regarding people with specialist needs, outcomes assessment and service costs.

Work package 2

A mixed-methods observational study of three reablement services, each representing a different service model.

The outcomes evaluation

Outcomes, sociodemographic and health data were collected on referral (T0), at discharge (T1) and 6 months post discharge (T2). Intervention fidelity and engagement with reablement were assessed at T1 using measures developed by the study (the Hopkins Rehabilitation Engagement Rating Scale – Reablement Version and the Experiences of Reablement Practice Checklist). The outcomes assessed were health-related (EuroQol-5 Dimensions, five-level version) and social care-related (Adult Social Care Outcomes Toolkit – self-completion) quality of life, practitioner-reported functional status (Barthel Index of Activities of Daily Living), self-reported functional status [Nottingham Extended Activities of Daily Living (NEADL) scale] and mental health (12-item General Health Questionnaire).

The economic evaluation

Data on service and resource use, out-of-pocket costs and use of informal care were collected using an instrument (the Services and Care Pathway Questionnaire) developed by the research team and administered at T0, T1 and T2.

The process evaluation

Individual interviews or focus groups were used with service users, family members, commissioners, service managers, reablement assessors and reablement workers. They explored views on impacts of reablement, factors supporting or hindering outcomes, and service receipt/delivery.

Work package 3

Data from WP1 identified reablement services that reported working with people with dementia. Semistructured interviews with service leads, reablement assessors and front-line staff from nine services were conducted.

Quantitative analyses included descriptive and regression statistics. Thematic analyses of transcripts were used to analyse qualitative data.

Results

Work package 1

Over 200 services were identified and data were collected from 143 (71%) services. Their organisational base was local authority (53%), NHS (4%), integrated services (15%) or an outsourced provider (14%). Most (52%) were stand-alone services. Two-thirds of services were wholly in-house; when outsourcing did occur, this was typically for the delivery of reablement home visits. Services clustered around two further characteristics: the scope of reablement input and skill mix. The great majority of services provided either functional reablement (35%) (restoring functional abilities associated with activities of daily living) or comprehensive reablement (65%), which extends input to include getting out and about outside the home and social engagement. Comprehensive reablement corresponds to policy and National Institute for Health and Care Excellence definitions of reablement. Fewer than one in five services (17%) described the skill mix of their service as including occupational therapists as well as reablement workers. Another set of services (29%) had reablement workers but no occupational therapists. A small minority (14%) included occupational and physiotherapists and, sometimes, other health-care professionals. Around one-third of services (29%) reported having home-care workers, suggesting that the service delivered both home care and reablement. These service characteristics were associated with a number of aspects of service delivery and practice, such as whether the service was open referral or selective, typical duration of reablement, assessment and review processes, and destination following discharge.

The response rates to questions on costs were poor. Based on the available data, the cost of reablement per case was calculated to be \approx £1700.

Work package 2

Outcomes evaluation

Difficulties with study set-up and slow throughput in some research sites meant that the desired sample size was not achieved. Consequently, we could not compare service models in terms of effectiveness, costs and cost-effectiveness. It also limited the complexity of modelling work used to explore the impact of individual and service characteristics on outcomes. The findings should, therefore, be treated as preliminary.

In total, 186 individuals were recruited to the study, with 129 retained at T1 and 64 retained at T2. Improvements on all outcomes were observed at T1. For those for whom data were available at T0 and T1, improvements in health and social care related quality of life and practitioner-reported functioning were

significant. Outcomes had further improved at T2. Improvements on quality-of-life measures were not statistically significant. However, and in contrast with T1, the change (improvement) in mean score in self-reported functioning (NEADL scale) was significant.

Regression analyses explored the association between individual (i.e. age, sex, living situation, referral reason, sufficiency of financial resources, comorbidities, intervention engagement, mental health, informal carer involvement, T0 outcomes) and service (i.e. intervention duration, single vs. split/multiteam arrangement, in-house vs. outsourced provision, intervention fidelity) characteristics on T1 outcomes. Having sufficient money was associated with both quality-of-life outcomes and practitioner-reported functioning at T1. In terms of age, there was weak evidence of an association with just one outcome (self-reported functioning). There was some evidence of an association between referral reason and social care-related quality of life only. There was consistent evidence of an association between user engagement with reablement and all outcomes. Individual and service/worker characteristics are likely to both contribute to intervention engagement. There was some initial evidence that duration of reablement and aspects of service delivery and structure (e.g. single team vs. separate assessor and reablement worker teams; in-house vs. outsourced reablement workers) may be associated with outcomes at discharge from reablement. The small sample size meant that further testing of these associations using multiple regression was not possible. Furthermore, it was not possible to establish the clinical significance of these findings.

Process evaluation

The findings from the process evaluation aligned with, and typically offered explanations for, the patterns of association between individual and service characteristics and T1 outcomes described above. For example, staff frequently reported that service users and family members had a poor understanding of reablement and this acted as a barrier to engagement, at least in the early stages. Our interviews with service users also revealed some confusion about reablement and its difference from home care; or, in terms of a possible association between a single versus separate assessor and worker teams, assessors working in a separate team model reported concerns or inadequacies with monitoring/review processes and supervision of reablement workers.

Staff raised a number of other issues. First, the Care Act 2014 (Great Britain. *Care Act 2014*. London: The Stationery Office; 2014) and NHS discharge-to-assess policies affected the characteristics of their caseloads. Reabling to full independence was no longer the predominant outcome. The merging of reablement and assessment functions, and the lack of other in-house social care provision for older people, had resulted in increased caseload volume for assessors and a slowing of throughput due to difficulties in transferring on those with ongoing care needs.

There was a strong and consistent belief among staff of the superiority of reablement over traditional home care. Staff skills and knowledge of reablement principles were regarded as key to successful reablement. In addition, staff believed that the social contact occurring during home visits served to reconnect with, and rekindle interest in, everyday life.

In addition to engagement, service user characteristics that staff believed had an impact on outcomes included personality, problem-solving skills, mental health, cognitive impairment and the presence of a partner or spouse. Housing tenure was a potential barrier, as installing aids or making minor modifications could be difficult if the property was rented, particularly from a private landlord.

In addition to the issue of separate assessor and reablement worker teams mentioned earlier, staff believed that other aspects of service delivery and practice had an impact on outcomes. The importance of flexibility in the timing and duration of visits, and an expectation that this would reduce over the course of reablement, was noted. Some believed that this was not sufficiently specified, or incentivised, in contracts with outsourced providers. Views were mixed about the optimum number of workers assigned to a case; advantages of having one or two or, alternatively, multiple workers were articulated. Timely access to

specialist expertise, particularly physiotherapy and mental health, was regarded as important but difficult, if not impossible, to achieve.

Overall, service users reported very positive experiences of reablement. The majority believed that positive outcomes had been achieved through the skills and input of the reablement workers. Six factors were articulated as having had an impact on outcomes: the service user–worker relationship, the workers' reablement skills, the service user's confidence in the worker, the duration of home visits, the service user's willingness to accept support, and the service user being able to review progress. Continuity of workers was not identified as important to achieving positive outcomes.

Economic evaluation

The planned duration of reablement was, on average, 6 weeks, with one or two home visits per day. Actual duration was, on average, 4 weeks. Services most used prior to receiving reablement and up to 6 months post discharge were hospital, community health care and social care. A downwards trend in resource use from the period prior to reablement to 6 months post discharge was observed.

Public sector costs, falling on health and social care, were the largest cost category. Of these, hospitalisations with overnight stays were the largest cost item at all time points. With respect to other costs, the major cost item was informal care. Receiving reablement from outsourced providers was associated with higher hospital costs and smaller social care costs than receiving reablement from an in-house service. Referrals to reablement because of a musculoskeletal problem, a fall or an infection were associated with lower costs of community health care during reablement. Type of health comorbidity appeared to affect levels of cost, with arthritis and chronic respiratory conditions associated with higher costs, and cardiovascular conditions with lower costs. Increasing age was associated with higher costs of community health care. The sample size limited the tests that could be undertaken and the inferences that can be drawn from the economic evaluation.

Work package 3

Staff believed that reablement could offer benefits to people with dementia, although achievement of full independence from social care may not be possible. Seeking to restore functioning in activities of daily living alongside, where required, a comprehensive needs assessment was regarded as an effective approach to supporting people with dementia when concerns regarding their ability to manage at home had been raised. Interviewees believed that these differences in emphasis should be better recognised by commissioners. Interviewees reported that practice often needed to be adapted, and extended, to secure good outcomes. Thus, work to restore routines, practising of tasks, using visual communication tools, and working on social networks and carer support made reabling people with dementia different and, often, more complex. Staff observed that resources allocated to reabling people with dementia and/or commissioning arrangements should be modified to allow for, for example, extended visits, extending the duration of reablement or reducing the number of reablement workers involved. Concerns were expressed, particularly by reablement workers, about levels of training. Generic dementia training was regarded as insufficient and it was thought that training on the implications of a dementia diagnosis on providing reablement should be developed and mandatory.

Conclusions

The ongoing implementation of the Care Act 2014 means that the structure and organisation of reablement provision in England is likely to have changed since our survey was carried out in 2015. However, the heterogeneity of service and practice characteristics observed in the survey may well remain. Indeed, the three services acting as research sites for WP2, all of which reported changes to their services in response to the Care Act 2014, demonstrate the alternative ways reablement is now being delivered. There are two high-level implications from the survey findings. First, not all reablement services are working to the full scope of this intervention and some do not support re-engagement or introduction to social activities and facilities. Wider evidence indicates that any short-term gains to services in terms of lower delivery costs will

be undermined by increasing the risk for poorer health and social care outcomes in the future. Second, very few services are likely to be using standardised measures to monitor outcomes.

Firm implications for health and social care practice cannot be drawn from the outcomes and economic evaluations: our data are not sufficiently robust. Overall, findings on outcomes align with previous research (although the heterogeneity of measures and outcome time points limit close comparison). They also provide important new evidence on the range of outcome domains that reablement may affect and trajectories it may have an impact on. The process evaluation corroborated initial findings from the outcomes evaluation regarding the way individual and service characteristics predict outcomes, something not explored by previous studies. Importantly, some characteristics (e.g. user engagement, mental health, single team vs. separate teams, intervention integrity, in-house vs. outsourced providers) are amenable to change or intervention. Evidence is most consistent for user engagement, suggesting that this merits attention from services. Our findings indicate that both staff skill and service user/family understanding of reablement are important to securing engagement. Findings from the economic evaluation should also be treated with caution, they point to the importance of future research investigating the impact that individual and service characteristics explored in this study may have on costs.

Finally, there was strong support among staff working in reablement for its benefit to at least some people with dementia. This may not be the position adopted by commissioners. Given the multiple ways in which staff reported adjusting aspects of practice and service delivery, it is clear that evidence-informed guidance for commissioners and service leads/practitioners on reabling people with dementia is required.

Research recommendations

- A multisite, mixed-methods outcomes and economic evaluation of reablement that includes investigating the impacts of service, intervention and individual characteristics on outcomes and costs.
- The development and evaluation of an intervention to improve service users' and family members' understanding of reablement.
- A systematic review of practices/technologies that support the understanding or remembering of instructions, or stages of executing tasks/activities relevant to reablement, among people with dementia.

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