Models of Reablement: a mixed methods evaluation of a complex intervention
The MoRe project

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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 to continue living in their own homes, or an increase in its intensity. It contrasts markedly with traditional homecare. Despite significant government investment and policy directives over the past decade, research on reablement is limited.

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

Objectives

Work package 1 (WP1): To map services and develop a typology of service models.

Work package 2 (WP2): To evaluate up to four service models, as identified in WP1, investigating outcomes, predictors of outcomes, costs, cost-effectiveness and the reablement process.

Work package 3 (WP3): 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 method observational study of three reablement services each representing a different service model.

The outcomes evaluation: Outcomes, socio-demographic and health data were collected on referral (T0), at discharge (T1), and six month 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). Outcomes assessed were: health-related (EQ-5D-5L) and social care related (ASCOT SCT-4) quality of life, practitioner-reported functional status (Barthel Index), self-reported functional status (NEADL scale) and mental health (GHQ-12).

The economic evaluation: Data on service and resource use, out-of-pocket costs and use of informal care was collected using an instrument (the Services and Care Pathway Questionnaire (SCPQ)) 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

WP1 data identified reablement services which reported working with people with dementia. Semi-structured interviews with service leads, reablement assessors and front-line staff from nine services were conducted.

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

Results

Work package 1

Over 200 services were identified and data collected from 143 (71%) services. Their organisational base was either Local Authority (53%), NHS (4%), integrated services (15%), or an out-sourced provider (14%). Most (52%) were stand-alone services. Two-thirds of services were wholly in-house; where out-sourcing did occur, this was typically for delivery of reablement home visits. Services clustered around two further characteristics: the scope of reablement input and skill-mix. The great majority of services either provided 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 NICE 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 physio-therapists and, sometimes, other health care professionals. Around a third of services (29%) reported having homecare workers, suggesting the service delivered both homecare 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.

Response rates to questions on the costs was poor. Based on available data, the cost of reablement per case was calculated to be ~£1,700.

Work package 2

Outcomes evaluation

Difficulties with study set-up and slow throughput in some research sites meant 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. Findings should therefore be treated as preliminary.

186 individuals were recruited to the study, with 129 retained at T1 and 64 at T2. Improvements on all outcomes were observed at T1. For those where data was 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 (age, gender, living situation, referral reason, sufficient, co-morbidities, intervention engagement, mental health, informal carer involvement, T0 outcomes) and service (intervention duration, single vs split/multi team arrangement, n-house vs out-sourced 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 out-sourced reablement workers) may be associated with outcomes at discharge from reablement. Small sample size meant 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

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 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 to homecare. Or, in terms of a possible association between a single vs 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.

A number of other issues were raised by staff. First, the impact of the Care Act 2014 and NHS discharge-to-assess policies on the characteristics of their caseloads. Reabling to full independence was no longer the predominant outcome. The merging of reablement and assessment functions, and 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 on-going care needs.

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

In addition to engagement, service user characteristics which staff believed impacted on outcomes included personality, problem-solving skills, mental health, cognitive impairment, the presence of a partner/spouse. Housing tenure was a potential barrier, with installation of aids or minor modifications 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 other aspects of service delivery and practice impacted on outcomes. The importance of flexibility in timing and duration of visits, and an expectation this would reduce over the course reablement, was noted. Some believed this was not sufficiently specified, or incentivised, in contracts without-sourced providers. Views were mixed about the optimum number of workers assigned to a case: advantages to having one or two or, alternatively, multiple workers were both 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 positive outcomes had been achieved through the skills and input of the reablement workers. Six factors were articulated as impacting on outcomes: the service user-worker relationship, workers' reablement skills, service user's confidence in the worker, duration of home visits, willingness, to accept support, and 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 1 to 2 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 downward trend in resource use from the period prior to reablement to 6-month 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 out-sourced providers was associated with higher hospital costs and smaller social care costs compared to those who received in-reablement from an in-house service. Referrals to reablement due to a musculoskeletal problem, fall or infection were associated with lower costs of community health care during reablement. Type of health co-morbidity appeared to affect levels of cost, with arthritis and chronic respiratory conditions associated with higher costs, and cardiovascular conditions lower costs. Increasing age was associated with higher costs of community health care. 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 reablement can offer benefits to people with dementia, though 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 where concerns regarding their ability to manage to home had been raised. Interviews believed these differences in emphasis should be better recognised by commissioners. Interviewees

reported 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 that training on the implications of a dementia diagnosis on providing reablement should be developed and mandatory.

Conclusions

The on-going implementation of the 2014 Care Act means 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 whom reported changes to their services in response to the 2014 Care Act, 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 do not support re-engagement, or introduction to, social activities and facilities. Wider evidence indicates 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 is not sufficiently robust. Overall, findings on outcomes align with previous research (though heterogeneity of measures and outcome time points limit close comparison). They also provide important new evidence on the range of outcome domains which reablement may impact, and trajectories to impact. 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 out-sourced 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 staff's skills and service user/family understandings of reablement are both important to securing engagement. Findings from the economic evaluation should also be treated with caution. They do point to the importance of future research investigating the way individual and service characteristics explored in this study may impact 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 are required.

Research recommendations

- A multi-site, mixed method outcomes and economic evaluation of reablement which 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 which support understanding or remembering of instructions, or stages of executing tasks/activities relevant to reablement, among people with dementia.

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