Organisation and delivery of home care re-ablement: what makes a difference?

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What is known about this topic
- Home care re-ablement is high on the English health and social care policy agenda.
- Re-ablement services help people regain skills and confidence to live more independently.
- Re-ablement services are likely to have positive impacts on the use of services and longer-term cost savings.

What this paper adds
- Re-ablement seems to have more benefits for people recovering from falls and acute illnesses.
- Effective re-ablement services require good initial staff training and ongoing supervision; clear outcomes for users and flexibility to adapt these as needs change; and prompt supply of equipment.
- Wider environmental success factors include shared vision; access to specialist support and adequate capacity in long-term home care.

Abstract
Home-care re-ablement or ‘restorative’ services are a cornerstone of preventive service initiatives in many countries. Many English local authorities are transforming their former in-house home-care services to provide intensive, short-term re-ablement instead. The focus of this paper is on the organisation and content of re-ablement services and the features of their organisation and delivery that have the potential to enhance or detract from their effectiveness. Qualitative data were collected from five sites with well-established re-ablement services. Data included semi-structured interviews with senior service managers in each site; observation of 26 re-ablement visits to service users across the five sites (four to six in each site) and a focus group discussion with front-line staff in each site (in total involving 37 front-line staff). The data generated from all three sources were analysed using the framework approach. All five services had developed from selective pilot projects to inclusive ‘intake’ service, accepting almost all referrals for home-care services. A number of features were identified as contributing to the effectiveness of re-ablement services. These included: service user characteristics and expectations; staff commitment, attitudes and skills; flexibility and prompt intervention; thorough and consistent recording systems; and rapid access to equipment and specialist skills in the team. Factors external to the re-ablement services themselves also had implications for their effectiveness; these included: a clear, widely understood vision of the service; access to a wide range of specialist skills; and capacity within long-term home-care services. The paper argues that re-ablement can be empowering for all service users in terms of raising their confidence. However, the move to a more inclusive ‘intake’ service suggests that outcomes are likely to be considerably lower for service users who have more limited potential to be independent. The paper discusses the implications for practice.

Keywords: disabled people, older people, re-ablement, restorative, service effectiveness

Introduction
Home care re-ablement is high on the English health and social care policy agenda and is a cornerstone of the government’s preventive service initiatives. Home care re-ablement is defined as ‘Services for people with poor physical or mental health to help them accommodate their illness by re-learning the skills necessary for daily living’ (Kent et al. 2000). The need for greater investment in preventive and rehabilitation services for older people was recognised over a decade ago (Kings Fund 1999, Lewis & Mine 2000) as the challenges of a rapidly ageing population, growing public expectations and advances in technology were escalating (Wittenburg et al. 2004, HM Government 2007, Allen & Glasby 2009). Such changes led to greater demands for care services and increasing pressure on hospital beds at the time when there were relatively few alternatives to extended
hospital stays and a reduction in rehabilitation facilities in acute hospitals (Nocon & Baldwin 1998). The Audit Commission (1997) described this as a ‘vicious circle’ of spiralling costs, inefficient use of scarce resources and a failure to enable older people to live as they preferred – independently in the community.

There is a lack of clarity over what constitutes preventive services and the relative cost effectiveness of different programmes (Curry 2006). This reflects the fact that prevention has different meanings in different contexts (Windle et al. 2010). Prevention can include identifying and responding to risks of dependency, reducing acute hospital admission and promoting good health and healthy living (Godfrey 1999).

The National Health Service (NHS) Plan (Secretary of State for Health 2000) announced significant investment in new intermediate care services aiming to prevent unnecessary hospital admissions, facilitate timely discharges and prevent premature admissions to permanent residential and nursing care. The wide diversity of intermediate care services has made systematic evaluation of effectiveness very difficult (Barton et al. 2005). However, qualitative evidence from service users suggests that intermediate care can make a significant difference to their lives (Godfrey et al. 2005).

Once discharged from intermediate care, local authorities are responsible for the provision of ongoing social care. There has been a steady increase in the proportion of home-care services purchased from independent sector providers, from 2% in 1992 to more than 73% in 2005 (Commission for Social Care Inspection (CSCI) 2006, p.4). These changes have enabled councils to develop home-care re-ablement services, usually through reconfiguring their former in-house home-care services. Although intermediate care services tend to focus on the reacquisition of physical abilities, re-ablement services take a social model approach aiming to maximise independence by removing environmental barriers and helping people to regain practical skills and confidence. The assumption underlying re-ablement is that enhancing independence and practical skills reduces needs for ongoing service support. The policy commitment to home-care re-ablement services is signalled by recent announcement by the Secretary of State for Health (Department of Health 2010) of £70 million extra funding for the NHS to support people back into their homes after a stay in hospital.

The notion of independent living is supported in research. Scholars of disability studies have argued for a move away from dependency-based services to support that focuses on the goal of independent living (Morris 1997, Helgoy et al. 2003, Barnes & Mercer 2006). Similarly research relating to older people suggests that service provision should be dominated by a concern for independence rather than a ‘dependency’ model (Baker 2006, Lewin et al. 2006). Social support, autonomy and control are said to promote independence in older adults (McWilliam et al. 2000, Seeman & Crimmins 2001, Parry et al. 2004, Baker 2006). However, there is some evidence that maximising long-term independence may not always be consistent with the wishes of some service users (and/or carers) who may welcome the regular social contact with home-care workers (Petch 2008).

The interest in prevention and rehabilitation is not unique to the UK. Programmes have been developed in other countries such as Australia, USA and New Zealand with the specific objective of reducing individuals’ need for ongoing home care (Baker et al. 2001, Tinetti et al. 2002, Lewin et al. 2006 and Parsons et al. 2007). Although the existing research showed a reduction in the use of home-care services for re-ablement service users (Kent et al. 2000, Newbronner et al. 2007, Ryburn et al. 2009) likely to result in longer-term cost savings (Cormnan et al. 2005), it still remains unclear how long any reductions in service use can last and what elements of a service work best, for which groups of people and at what costs.

This paper arises out of an in-depth longitudinal study investigating the longer term impact of home care re-ablement. An important part of that investigation, the focus of this paper, is to find out what re-ablement services involve and what particular features of their organisation and delivery may enhance or detract from their effectiveness.

**Methods**

Sites were selected from responses to a ‘screening’ questionnaire, which was sent to all English local authorities with responsibilities for adult social care services. The key criteria for the selection of a study site was availability of local resources (e.g. staffing) to undertake data collection and the willingness of re-ablement and other staff to work with the research team and to share outputs with other councils on a named basis.

The re-ablement service sites taking part in the study all had well-established services. Table 1 describes the five sites. Details of the overall design and methods used in the study are reported elsewhere (Rabiee et al. 2009). This section gives the details of the methods used in gathering qualitative data on the organisation and content of re-ablement services from the five councils offering home care re-ablement.

**Data collection**

Qualitative data were collected between January and June 2009 through three strands: interviews with service...
managers and observations of re-ablement activities and focus group discussions with the front-line staff. This offered opportunities for triangulation in subsequent stages of the fieldwork. Table 2 shows study samples for the interviews, focus groups and observations.

**Interviews with service managers**

Semi-structured interviews conducted with eight senior service managers focused on the content and delivery of the re-ablement service; and explored managers’ views on the factors promoting and hindering the impact of re-ablement. Five interviews were conducted face-to-face and the remaining three interviews over the telephone. Interviews took between one-and-a-half to two hours. All interviews were tape recorded, with the participant’s consent and subsequently transcribed.

**Observations of re-ablement activities**

The interviews with managers were followed by observation of re-ablement visits to users’ homes. The observations aimed to obtain a first-hand picture of the practice and processes of re-ablement, particularly the balance between providing a service for the client and encouraging clients to participate and carry out tasks for themselves.

Sites were asked to arrange for the researcher to observe visits to service users with a range of characteristics in terms of referral routes, gender, age, disabilities/illnesses, ethnicity and living circumstances. The visits included service users who were new to adult social care services and those with previous histories of service use. Observations included service users who were at different stages in the course of a re-ablement episode to see whether the nature of the re-ablement intervention differed, across the sites, over the course of the episode. Written consent was obtained from clients at the start of the observation. The researcher wrote short notes during the visits and expanded these notes, elaborating on key points, later.

**Table 1** Summary of five re-ablement study sites

<table>
<thead>
<tr>
<th>Site</th>
<th>Local Authority</th>
<th>Types of local authority</th>
<th>Local FACS criteria at the time of the study</th>
<th>Service organisation</th>
<th>Funding/management responsibility</th>
<th>Initial staff training for re-ablement</th>
<th>Initial staff training for occupational therapists (OTs)</th>
<th>Access to occupational therapists (OTs)</th>
<th>Charging policy</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>R1</td>
<td>Unitary</td>
<td>Critical &amp; sub substantial</td>
<td>Critical &amp; substantial</td>
<td>New specialised service</td>
<td>Adult social care</td>
<td>2 days</td>
<td>No special arrangements</td>
<td>OTs in the team</td>
<td>Free for 2 weeks</td>
<td>Notes</td>
</tr>
<tr>
<td>R2</td>
<td>Metropolitan</td>
<td>Critical &amp; sub substantial</td>
<td>Critical &amp; substantial</td>
<td>A new specialised service</td>
<td>Adult social care jointly with NHS</td>
<td>2 weeks</td>
<td>No OTs in the team but negotiated fast-track responses from OTs outside the team</td>
<td>OTs in the team</td>
<td>Free for 2 weeks</td>
<td>Notes</td>
</tr>
<tr>
<td>R3</td>
<td>Unitary</td>
<td>Critical &amp; sub substantial</td>
<td>Critical &amp; substantial</td>
<td>A new specialised service</td>
<td>Adult social care</td>
<td>2 days</td>
<td>No special arrangements</td>
<td>OTs in the team</td>
<td>Free for 2 weeks</td>
<td>Notes</td>
</tr>
<tr>
<td>R4</td>
<td>Shire County</td>
<td>Critical &amp; sub substantial</td>
<td>Critical, substantial &amp; moderate</td>
<td>A new specialised service</td>
<td>Adult social care jointly with NHS</td>
<td>2 weeks</td>
<td>No OTs in the team but negotiated fast-track responses from OTs outside the team</td>
<td>OTs in the team</td>
<td>Free for 2 weeks</td>
<td>Notes</td>
</tr>
<tr>
<td>R5</td>
<td>Metropolitan</td>
<td>Critical &amp; sub substantial</td>
<td>Critical &amp; substantial</td>
<td>A new specialised service</td>
<td>Adult social care jointly with NHS</td>
<td>2 weeks</td>
<td>No OTs in the team but negotiated fast-track responses from OTs outside the team</td>
<td>OTs in the team</td>
<td>Free for 2 weeks</td>
<td>Notes</td>
</tr>
</tbody>
</table>

*Fair access to care services (FACS) criteria is the eligibility criteria that councils use to decide whether or not a person receives help from the council with social care services.

**Table 2** Study samples for the interviews, focus groups and observations

<table>
<thead>
<tr>
<th>Managers</th>
<th>Observation visits</th>
<th>Focus groups front-line staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>n = 8</td>
<td>n = 26</td>
<td>n = 37</td>
</tr>
<tr>
<td>R1</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>R2</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>R3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>R4</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>R5</td>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>

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Focus group discussions with front-line staff

One focus group discussion was conducted in each of the five sites. Home-care re-ablement workers with different occupational backgrounds and levels of experience in the service and three occupational therapists (OTs), took part in these meetings. Discussions were facilitated by two researchers. They were taped, with the participants’ consent and subsequently transcribed. The discussion focused on staff views on the factors perceived to promote/constrain the benefits of re-ablement services in the shorter and longer terms.

Data analysis

The data generated from all three sources were analysed using the framework approach and by a process of data reduction, data display, conclusion drawing and verifying (Miles & Huberman 1994). The data were summarised onto a series of charts according to analytical categories (both a priori and emergent themes) generated by one researcher based on her readings of the transcripts. The charts were used to summarise overarching themes and draw conclusions. Conclusions were verified by checking with transcripts and through discussions within the research team.

Key features of re-ablement services in the study sites

All five re-ablement services were developed from in-house home-care services. Four sites had set up new specialist re-ablement teams. In the other site, re-ablement was incorporated into the in-house home-care service. This resulted in the home-care workers in that site having mixed roles. They worked with service users who were receiving long-term home-care support and were also expected to use the re-ablement approach for those they identified as having potential to be re-abled.

All five services had started as relatively selective pilot projects, with referrals from intermediate care, discharge schemes or the community, and gradually broadened their criteria to become more inclusive and act as ‘intake’ services for all adults over 18 years who were newly referred for home-care services. The only exceptions were service users for whom the service was considered inappropriate, e.g. someone who was at the last stages of their lives or someone with severe dementia. However, although all the services were officially stated to be non-selective at the time of the interview, in practice, they all operated a degree of selectivity. The selection criteria were not explicit and not the same across the services. Limited capacity to respond to demand, pressure from hospitals to prioritise discharges and pressure on managers to demonstrate rapid improvements in functioning were highlighted as the key drivers to be selective. As services developed a more inclusive ‘intake’ role, they also adopted multiple functions. In addition to re-ablement, they provided intensive short-term interventions following hospital discharge, short-term home-care support and extended assessments so that appropriate levels of long-term home-care services could be commissioned.

All five services had retrained their existing in-house home carers. In addition to the initial re-ablement training, the sites offered various ongoing specialist training courses, such as supporting people with dementia or visual impairments. In two of the sites, the managers and more senior re-ablement assistants also received training on how to assess for minor adaptations such as grab rails. All five sites offered home-care re-ablement services for up to 6 weeks, with some flexibility to continue for longer if the user was considered likely to benefit or if appropriate longer-term support were not immediately available. Re-assessments and referrals for ongoing home care and other services were made at the end of the period of re-ablement.

Factors perceived to enhance the success of re-ablement services

The interviews with re-ablement service managers and the front-line staff participating in focus group discussions highlighted a number of factors that they considered enhanced the impact and effectiveness of the re-ablement service in the shorter and longer terms. Although the emphasis placed on different factors sometimes varied between the sites and between managers and front-line staff within a site, this paper reports the common themes raised by all those involved in the discussions.

Service user characteristics

One of the factors impacting on the effectiveness of re-ablement was said to be to whom the service was offered. There was a consensus among managers and front-line staff that the service users who were likely to show greatest benefit from re-ablement were those who were recovering from falls or fractures. Unlike traditional home care, re-ablement reduced the likelihood of this group of people becoming used to having tasks done for them, and thus helped avoid creating dependency. Conversely, re-ablement was considered less likely to produce significant results for service users who were likely to need ongoing support such as people with dementia or mental health problems. This did not mean that no benefits could be achieved for those groups of service
users; rather, that it was much harder to ensure major improvements for those people in a short period of time. However, by focusing on smaller targets and establishing a sense of routine, re-ablement could raise their confidence and eventually reduce their use of services.

Service users’ motivation was considered to be another factor influencing service effectiveness. Most participants agreed that ‘people have got to want to do it’. The age of service users was not considered significant. However, some study participants felt that younger people were more likely to be motivated to maximise their independence.

The content and organisation of the service

Staff commitment, attitudes and skills

The importance of re-ablement being an ‘attitude’ or an ‘approach’ came through very strongly in the managers’ interviews. The ideal re-ablement worker was described by managers as someone with a good understanding of the concept and practice of re-ablement, with the skills to stand back, observe and assess users’ potential for independence, and work closely with them to provide the support they needed to reach their potential. An important part of re-ablement was said to be allowing service users to take control, while simultaneously building up their confidence and convincing them that they could achieve more independence. This could also involve motivating service users to appreciate the value of becoming more independent.

From the managers’ point of view, one of the consequences of retraining the former home-care workforce was resistance from some staff who were not receptive to the new way of working. Both managers and front-line staff thought that the biggest challenge for many was to change their practice from being a care deliverer to being somebody who encouraged and did not interfere when a service user struggled to get something done.

All participants emphasised the importance of initial re-ablement training as well as ongoing training, team meetings and supervision to reinforce the re-ablement approach in day-to-day practice. Most managers felt that staff with less experience of working in traditional home-care services were easier to train and had found the new approach less challenging. Observations of re-ablement visits confirmed that newly recruited workers were more likely than retrained staff actively to involve users in both decisions and home-care activities. Discussions in staff focus groups revealed that what retraining staff had received was not always adequate. Many workers referred to their job as ‘standing and watching’, but it was not clear whether they all appreciated that the observation was part of an ongoing assessment process and an important job in itself.

The focus groups with front-line staff confirmed managers’ concerns that nostalgia for the traditional role of home carer and the difficulty of adjusting to the new role was more pronounced among people who had extensive experience in traditional home-care services. However, those who had been working in a re-ablement team for longer said that seeing the differences they, and others in the team, had made to the quality of some people’s lives had increased their job satisfaction and made them realise how disabling their previous practice had been. A few managers confirmed the increased job satisfaction experienced by some front-line staff.

Flexibility and Prompt intervention

There was a consensus among all participants that re-ablement is a more dynamic process compared with traditional home-care services. As it is intended to offer a short, focused programme of support, any delays could constrain the impact and duration of the benefits of re-ablement.

High-quality assessment before re-ablement started was said to be essential in helping re-ablement teams to set up appropriate support arrangements. Ongoing assessment during the period of re-ablement was also important to enable the team to identify new targets as people’s abilities improved. Both managers and front-line staff expressed concerns about the inaccuracy of hospital predischarge assessments, as they often relied on self-reports.

The importance of flexibility over the timing, duration of visits, the content of home visits and the ability to adjust the service quickly in response to improvements in users’ abilities, was highlighted by all participants. In the four sites where re-ablement was a specialised service, most front-line staff reported having greater flexibility in their re-ablement work compared with traditional home-care services. In contrast, in the site where re-ablement was part of the in-house service, workers did not know which service users were receiving long-term, home-care support and which had been referred for re-ablement. Although re-ablement interventions took longer, they were allocated the same length of time for visits as conventional home care. This suggests that staff in that site were more likely to take a conventional approach which took less time.

Thorough and consistent recording system

A consistent and thorough recording system was thought to be essential in maintaining continuity of the
Managers considered that the recording system should give a clear indication of what the objectives are, what the workers do on each visit, how far the service users have progressed in achieving their objectives and what the risk factors are.

Managers reported anxiety among some staff that recording each visit was a challenging task. The observations showed differences in the way the case recording was done in different sites and between different workers within sites. In some cases the notes were just a couple of lines; in others they took a whole page which could be difficult for someone new to the case to follow. In most cases what was recorded did not include the right information to enable the next worker to build on the progress being made by the service users. Typically, notes mentioned what had been done (like ‘assisted to dress’, ‘made a sandwich’, ‘bed made’), but not how they were done, how the service users were involved in those tasks, or how the nature of support had changed in the course of a re-ablement episode.

Access to equipment and specialist skills in the team

Rapid provision of equipment such as grab rails or walking frames was considered a major part of re-ablement services. Having quick access to OTs to cope with demand was considered to be more important than having OTs necessarily embedded in the team. This would ensure that equipment could be obtained promptly to prevent any unnecessary delays in service users’ progress. Training for front-line re-ablement workers on how to assess for minor pieces of equipment was said to help prevent some unnecessary delays. Having access to a variety of other specialist skills in the team could enable the service to work more effectively with a wider range of users, for example people with dementia and mental health problems.

Expectations of service users and carers

There was a consensus among front-line staff across all sites that re-ablement worked better for people newly referred to adult social care. Previous receipt of conventional home-care services could create unhelpful expectations and resistance to change. Some staff felt that service users’ resistance to re-ablement could be linked to the charges users thought they had to pay for the service, reporting consumerist attitudes of ‘I pay your wages, you do that for me’.

Family members were also seen to be sometimes resistant to re-ablement, preferring styles of intervention that minimised risk to older relatives. They wanted the reassurance of knowing that their elderly parents were being looked after, sometimes despite the wishes of the older person to retain their independence. Most front-line staff felt that explaining the aims of the re-ablement service to both service users and carers prior to their first visit could significantly help manage service users’ expectations and overcome informal carers’ perceptions of risk.

Wider environment

There was widespread agreement among managers and front-line staff that the success or failure of re-ablement was to a great extent dependent on factors external to re-ablement services.

A strong and shared vision of the service

An important success factor for re-ablement services was thought to be the extent to which everyone – re-ablement team, social services care managers and NHS staff – had a shared understanding of the aims and objectives of the service. Some managers felt that there was a danger for the service to be misused. Pressures came from care managers who used the service as a way of supporting people who would not benefit from re-ablement because no other services were available. According to one manager, the fact that about 10 percentage of people returned to hospital at the end of the re-ablement period indicated the inappropriate nature of some referrals for re-ablement.

Access to specialist skills

Having close relationships with and quick access to professionals and skills outside the re-ablement team was considered another factor making a huge difference to the type and quality of support the re-ablement team was able to offer. It ensured a rapid response to needs as these were identified, enabled a wider range of people to be accepted onto the service and sometimes also contributed to more effective discharges. Of particular importance was having quick access to OTs and physiotherapists. Other professionals outside the team to whom quick access was said to be crucial included care management teams, hospital social work team, district nurses, continence advisors, community matrons and specialists for visually impaired clients.

Capacity within long-term home-care services

To maintain the level of turnover required by re-ablement services, all managers and front-line staff felt that it was essential that service users requiring ongoing support could be discharged promptly so that capacity to
accept new referrals was maintained. In at least three of the sites, difficulties in finding appropriate home-care agencies to provide ongoing support had led to some service users remaining in the re-ablement service for weeks or months after completing a period of re-ablement. In addition to limited capacity within long-term home-care services, there was a widespread concern among most managers that as soon as service users were transferred, long-term care services could ‘undo’ the work of re-ablement by doing things for people again.

Discussion and conclusions

Although research often relies heavily on managers’ reports, the evidence reported in this paper is strengthened by triangulating managers’ accounts with observations and focus group discussions with front-line staff. Drawing evidence from all three sources of data, this paper has highlighted the key features that are likely to contribute to the effectiveness of re-ablement services.

Evidence from all three sources strongly suggests that the effectiveness (in the sense of decreased demand for ongoing care) for re-ablement is significantly influenced by to whom the service is offered. As re-ablement services have developed a more inclusive ‘intake’ role for new referrals for home-care support, they have accepted an increasing proportion of clients who have more limited potential to be independent. There was a consensus among managers and front-line staff that, although re-ablement is empowering for all service users in terms of raising their confidence, its impact on actual self-care abilities is likely to be considerably lower for some service users. Some managers thought the move to a mainstream ‘intake’ role had created some pressures on the re-ablement services as it had significantly reduced the success rate that they had been able to demonstrate in the pilot phase. Yet early selective pilot projects could generate an expectation that they would be able to achieve the same level of success for everyone. This has implications for how ‘success’ is defined, how service effectiveness is measured, what might be expected from re-ablement services and over what period of time. If policy makers and local politicians are only interested in dramatic impacts, then it will not be possible unless the front-line staff have freedom and opportunities to be creative.

Encouraging staff to be creative in solving users’ problems was thought to be an important part of re-ablement. However, this will not be possible unless the front-line staff have freedom and opportunities to be creative. Observation visits revealed that the time pressures on the front-line staff sometimes made it difficult for them to be more creative and motivating. This was particularly the case where re-ablement was not a specialised service and where the time allocated for visits did not take into account the motivating element of re-ablement workers’ responsibilities.

Maintaining effective communication between team members through a consistent and effective recording system was considered to be absolutely crucial in ensuring continuity in the support provided. Any lack of continuity in the support provided can impede development of a systematic approach to encouraging service users to develop more self-reliance and miss opportunities to reinforce and build on newly reacquired skills. Staff training therefore needs to emphasise the importance of communication and establish what constitutes good communication between staff.

Participants in this study reported that re-ablement services have significant potential to be life enhancing. However, achieving that potential depends not only on the internal organisation and delivery of those services but also on external factors that can present real challenges. This is consistent with evaluations of intermediate
care and rehabilitation services, that a whole system approach needs to be adopted (Regen et al. 2008, Allen & Glasby 2009). In this instance, the impact and effectiveness of re-ablement is significantly affected by wider health and social care services that shape referral patterns, service capacity and discharge. A clear message from all managers was that for re-ablement services to deliver their potential, they need to be linked to all mainstream services and supported by professional and cross-agency teams.

Given that re-ablement services are new, and are being widely encouraged in England and elsewhere, these insights have crucial implications for practice. They suggest that services are likely to be more effective if there is clarity about the aims of the service and the conditions under which these aims can best be achieved. The increasingly common intake role of re-ablement is problematic in that outcomes (in terms of reduced long-term service use) may be diluted; but everyone needs to be aware of the (smaller) gains that can arise and not use inappropriate performance measures. Also with an intake service, access to wide range of skills is even more important to facilitate re-ablement with people with a range of support needs such as mental health problems and sensory impairments. Finally, service effectiveness may be compromised if appropriate long-term home-care services are not readily available as this ‘blocks’ re-ablement services and also risks undoing the gains of re-ablement.

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