Getting back on your feet: reablement in Wales

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Executive summary

Reablement is central to the Welsh Government’s vision for social services reform. Previous research has suggested that there are some inconsistencies in how reablement is delivered. This research, based on information provided by health boards and local authorities, has sought to map some of those inconsistencies and to describe the levels of reablement provision across Wales. We have then drawn some conclusions on what the implications might be of these differing patterns of service delivery.

Key findings

• There is no standard Welsh Government definition of reablement, and no Welsh Government requirement to issue returns on reablement. This has led to a lack of comparable information across Wales. There is also some confusion evident between the language adopted by public bodies, with ‘reablement’, ‘intermediate care’ and ‘enablement’ at times being used interchangeably.

• For local authorities, the most striking finding was the inconsistency between different councils in their spending on what they defined as reablement services. Whilst this is in part attributable to vastly differing interpretations of what constituted reablement services, it is still worth noting that budgets varied significantly, with some authorities spending ten times more per head of population than others on reablement services. There was also evidence of inconsistent funding at health board level – although, more encouragingly, funding here was moving in a positive direction, with health boards generally either maintaining or increasing reablement budgets, despite the challenging financial climate.

• When asked about how they measure well-being, it became clear that health boards rely almost entirely on quantitative data. Six of Wales’ seven health boards only use quantitative information to measure patients’ well-being, whilst measurements of social/ well-being were only used in a handful of cases. This is concerning, given that well-being is, by definition, subjective and open to personal interpretation, and also heavily dependent on social/ emotional contentment.

• There is some confusion amongst health boards as to whether social support forms an integral part of reablement provision and, if so, to what extent. Reablement is seen largely as improving physical health and mobility, with comparatively little focus on the benefits of social interventions.

• There is evidence of cross local authority partnership working, particularly in North Wales. In some areas of Wales, there is evidence of change, improvement and further integration of health, local authority and voluntary sector services. There is also evidence of common aspirations to increase referrals and for interventions to be targeted towards the frailest and most in-need.

• The delivery of reablement varied, with some health boards having their own dedicated reablement teams, whilst others locate reablement within larger multi-discipline community resource teams. There was also evidence of some variation evident between health boards in their target groups for reablement.
Recommendations

• There is a need for a common framework on reablement, to make it clear to public bodies what is meant by the term and what features ought to be evident in any reablement service. Bodies can still develop services which reflect local circumstance and need, but there must also be core elements of reablement which are present across Wales. There must also be consistency in how the types and performance of reablement services are reported so that comparisons can be drawn between different health boards or different local authorities.

• Health boards in particular still consider well-being through the prism of a medical model of health, rather than reflecting the social aspects of well-being which are critical to an individual’s quality of life. We would suggest that self-assessment tools are incorporated into any outcome measure so that the more subjective social elements of well-being can be gauged.

• Consideration should be given to providing dedicated funding for reablement in Wales, to match similar funds in other parts of the UK. Reablement offers long-term economic benefits for short-term interventions – but there has to be an acceptance that truly effective reablement requires money in order for appropriate services to be developed.

• Good reablement services are, by definition, multi-sector. More needs to be done to encourage public bodies to involve the voluntary sector in the development of reablement services.
Chapter 1: Introduction

This report looks at the provision of reablement services across Wales, and seeks to examine the extent to which different local authorities and health boards across Wales have developed reablement provision.

Reablement services help people (particularly, but not exclusively, older people) to make the transition back to life at home after a stay in hospital. Services might include physical adaptations to the home, but can also entail social support to provide rewarding activity, opportunities for engagement and participation. These factors are believed to bring significant benefits in terms of physical health (Allen & Glasby, 2010) as well as delivering substantial cost savings to both health and social care services (Wood & Salter, 2012).

Reablement fits within a wider narrative which has stressed the benefits of preventative care. The need for greater investment in prevention and rehabilitation services has been recognised for over a decade (eg, Stevenson, 1999), and has been supported by more recent findings (eg, Glendinning et al, 2010) which suggest there is a high probability that reablement is more cost-effective than conventional home care.

Within a Welsh context, the cost-effectiveness of reablement services has been underlined by organisations delivering reablement services on the ground in Wales (Welsh Reablement Alliance, 2011a, 2011b). Meanwhile, the SSIA1 has identified that 60% of older people who enter a reablement service do not require further services after a six week intensive period of help and assistance (SSIA, 2011a).

It is because of these benefits (both physical and financial) that Welsh Labour promised in their 2011 Assembly election manifesto to “put ‘reablement’ at the heart of our approach to providing services to older people and require local providers to set out their arrangements for reablement services” (Welsh Labour, 2011: 57). This was preceded by a commitment in the social services white paper (Welsh Assembly Government, 2011: 21) to “introduce a requirement for reablement services to be provided across Wales [and] ensure that arrangements are in place for these to be planned and commissioned on a regional basis”, and was followed by a commitment in the Programme for Government (Welsh Government, 2011: 20) to “make reablement a core element of the National Outcomes Framework”. It is clear, therefore, that reablement is central to the Welsh Government’s ambition and vision for reforming health and social care, and that its benefits are recognised by policy-makers.

Yet despite this, previous research (SSIA, 2011a) has indicated that reablement provision across Wales may be inconsistent, with some areas offering much broader reablement services.

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1 The Social Services Improvement Agency – a partnership enterprise set up to support local authorities in improvements in social care in Wales. It draws on the expertise of the Welsh Local Government Association (WLGA), the Association for the Directors of Social Services (ADSS Cymru) and the Welsh Government. In 2011, the SSIA brought in John Bolton, former Strategic Finance Director at the Department of Health, to lead a programme looking at current spending patterns across Wales on services for older people, and suggesting possible new models of service to improve outcomes and efficiency. His report, Better Support at Lower Cost (SSIA, 2011c) has in many ways set a ‘gold standard’ for social services in Wales, including a detailed look at how reablement services could be developed.
than others. The challenge for Welsh Government, therefore, is to develop a more consistent framework for reablement, setting out the key components of effective reablement whilst at the same time allowing local authorities and health boards to adapt to local circumstances. To do so requires political will, but also is contingent upon understanding existing levels of provision so services can be developed at an appropriate pace.

1.1 Purpose of study

The Deputy Minister for Social Services stated last year that effective reablement could reduce the need for home care by 60% (Thomas, 2011: 44). WRVS welcomes this strong support for reablement, and hope that the data in this report will help the Welsh Government to make progress towards its stated goal to “place reablement at the heart of our approach” (Welsh Assembly Government, 2010: 20). However, any vision for effective reablement services or a social services system with reablement at its heart requires an understanding of what provision exists currently so that a ‘road map’ for improvement can be identified.

To address this challenge, WRVS set out to establish a baseline of reablement services in Wales to show the level of services being provided currently. By highlighting the different range of provision across the country and the diverse levels of expenditure in different areas, our hope is that the Welsh Government can more easily recognise the ways in which reablement services need to evolve over the coming years so that everyone across Wales can have access to a good reablement service.

The report examines in detail the responses we received from two sets of FOI (Freedom of Information) requests on reablement services. The first set of questions (submitted in June 2011) was directed to local authorities, and the second (submitted in January 2012) to health boards. The health board questions and responses were much more searching and thorough, and the data much more compelling (not least because all seven health boards responded, whilst some local authorities failed to do so). The findings highlight not only the inconsistent patchwork of services which exists currently, but also the vastly differing understandings of what constitutes reablement, and contrasting expectations of how provision might be developed.

1.2 Research questions

The following questions were sent to the seven health boards in Wales:

- What has been your health board’s budget for reablement in each of the last two financial years? What are the projections for reablement spending over each of the next two years?
- What reablement programmes aimed at older people currently exist in the area covered by the health board? Over the last two years, what has been the change in the number of service users accessing these services? Which specific groups (if any) have been the target of these interventions? What plans exist to increase the number of service users and the number/nature of target groups over the coming two years?
- Which of these reablement programmes focus on social (rather than physical) reablement for older people? How do they improve social/emotional well-being for older people?
• How does the health board measure well-being of older people in the geographical area it covers? What indicators are used? Have the indicators of well-being changed over either of the last two years? Are there any plans to change the indicators over either of the next two years?

The following questions were sent to Wales’ 22 local authorities:

• Please provide us with details of how you intend to respond to recommendation 3.4 in Welsh Assembly Government’s white paper\(^2\), and where you envisage greater co-operation for social services.

• What reablement services are provided in your local authority area? How would you envisage enhancing those services to meet the ambitions of paragraph 3.39 of the social services white paper for Wales? How much money does your local authority spend on reablement services, and how does this compare to your social services budget as a whole?

1.3 Definitions

Before progressing to a presentation of the findings, it is necessary to define some of the terms used in this report, in the interests of clarity.

The very term ‘reablement’ is one which is laden with different interpretations. As one recent report noted, “reablement remains something of a nebulous concept, interpreted and applied differently across the country... There is some confusion around what exactly reablement means, with health and social care professionals sometimes using different terminology” (Wood & Salter, 2012: 11/13/14). This has occasionally led to the term being used interchangeably with the description of ‘intermediate care’, or to being used solely to describe physical support or adaptations to the home, and sometimes to describe a much broader range of social and emotional support mechanisms.

Equally, the term ‘well-being’ is one which is contested and open to interpretation, and it is therefore necessary to be clear about what is meant by the word in the context of this research.

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2 This refers to recommendation 3.4 of *Sustainable Social Services for Wales: a framework for action* (Welsh Assembly Government, 2011), which states: “We expect to see positive examples of the planning of services on a regional or, where more appropriate, national basis. We will work to simplify the planning processes and arrange these across boundaries and we expect to see the number of partnerships greatly reduced. We want to change the question from ‘how might we cooperate across boundaries?’ to justifying why we are not.”

3 This refers to paragraph 3.39 of *Sustainable Social Services for Wales: a framework for action* (Welsh Assembly Government, 2011), which states: “We will place reablement at the heart of our approach. We believe that by quickly supporting people ‘to do’ for themselves, we will enable them to recover quickly or develop ways of living that fit their new circumstances. This will also reduce the need to wait for an assessed care package. The role of occupational therapists in helping to deliver reablement services will be key. We will introduce a requirement for reablement services to be provided across Wales and will ensure that arrangements are in place for these to be planned and commissioned on a regional basis. We expect these services to be led jointly by social services and the NHS.”
‘Reablement’ versus ‘Intermediate Care’

There are many definitions of the term reablement (see Appendix 1). In this section we focus on those used by organisations in Wales. The SSIA (2011b: 5) defines reablement in these terms:

- Services for people with poor physical or mental health or disability to help them live as independently as possible by learning or relearning the skills necessary for daily living.
- Promoting independence
- Supporting people ‘to do’ rather than ‘doing to’
- Outcome focused with defined duration
- Reducing level of ongoing support.

The Welsh Assembly Government referred to reablement in the following terms in its 2011 white paper: “We believe that by quickly supporting people ‘to do’ for themselves, we will enable them to recover quickly or develop ways of living that fit their new circumstances.” (Welsh Assembly Government, 2011: 20). However, to date the Welsh Government has yet to adopt and promote an official definition of the term.

The Welsh Reablement Alliance (WRA) comprises 12 members, including voluntary sector and professional societies, and campaigns to promote the benefits of consistent, effective, integrated services which enable people to maximise their ability to live as independently as possible. Members of the WRA have agreed the following definition of ‘reablement’:

At heart, reablement is about helping people to do things for themselves to maximise their ability to live life as independently as possible. It’s about supporting the whole person – addressing their physical, social and emotional needs. It’s an outcome-focused, personalised approach, whereby the person using the service sets their own goals and is supported by a reablement team to achieve them over a limited period. It focuses on what people can do, rather than what they can’t, and aims to reduce or minimise the need for ongoing support after reablement. (Welsh Reablement Alliance, 2011a)

In the same document, the WRA identifies the components of high quality reablement services:

- The active participation of the service user and their family
- A workforce with an ethos of ‘working with’ people, rather than ‘doing to’
- Integration and collaborative working between health, housing and social services
- Appropriate collaboration with services provided by the third and private sector
- Adequate funding to deliver sustainable outcomes
- Strong leadership of commissioning and delivery
- A focus on prevention and early intervention in order to avert possible crises
- Evaluation which incorporates both social and financial service outcomes
- Training for staff, information and support for families and carers
The Welsh Government defines **Intermediate Care** as follows (Tabberer, 2010: 5):

*Intermediate care describes a range of services providing time limited support to patients (up to 6 weeks) which promote independence by avoiding unnecessary hospital admission or admission to long term care, facilitates timely discharge from hospital and forms a bridge between hospital, home, dependence and independence.*

*Intermediate care is provided on the basis of a comprehensive assessment resulting in a structured individual care plan that involves active therapy, treatment, social work intervention, or opportunity for recovery.*

*Intermediate care involves cross-professional working and agencies working in partnership, with a single assessment framework, single service access criteria, single professional records and shared protocols, although there is no current shared IT system in place.*

**Intermediate Care is not:**
- Longer term rehabilitation
- Rehabilitation that forms part of acute hospital care
- Transitional care that does not involve active therapy or other interventions to maximise dependence, i.e. for patients who are ready to leave acute in-patient care and are simply waiting for longer term packages of care to be arranged, thereby preventing active rehabilitation potential

On the face of it, definitions of reablement and intermediate care are similar in that they both involve short term interventions with the aim of building independence. This confusion was highlighted in a report commissioned by WRVS in 2011 (Elias & Lang, 2011). To clarify confusion between the two terms, the report referred to definitions by the Clinical Services Efficiency Delivery (CSED, 2010). These define ‘intermediate care’ as a group of services aimed at preventing admission to hospital, speeding hospital discharge and preventing or delaying admission to long-term residential care; in contrast, ‘reablement’ seeks to support people and maximise a person’s level of independence so that their need for ongoing homecare support can be minimised. Reablement clients, therefore, include those who may have undergone a phase of intermediate care, but also people who remain within the community requiring support to live at home and have not gone near a hospital or long-term care placement.

Elias & Lang highlighted the blurring between the two terms by professionals as the reason for confusion over whether services delivered to an individual are reablement or intermediary care, since a programme of interventions aiming to promote independence might also prevent hospital admission.

The apparent blurring of these terms by professional bodies in Wales is evident in the findings presented in the following chapters of this report. For the purposes of this report, however, our interpretation of reablement is closest to that of the Welsh Reablement Alliance, as their definition offers a broad and comprehensive reading of the services which contribute towards an individual’s reablement, encompassing physical but also social and emotional support and putting the objectives of the service user at the centre of the process. We feel this is not only
an approach which is supported by a wide cross-section of agencies delivering and promoting reablement in Wales, but also addresses the recommendation of Wood & Salter (2012: 15) that “there needs to be a wider, more holistic approach to reablement embedded as best practice. Such an approach strives to achieve independence in one’s community, not just in one’s home”.

Well-being

The current Social Services Bill (Welsh Government, 2012: 13) proposes defining well-being as follows:

It will be important to be clear about what is meant by well-being. Our intention is to capture the key outcomes for people in need. The working definition we have at present is to define it as encompassing the following:

- physical and mental health and emotional well-being;
- protection from harm and neglect;
- education, training and recreation;
- the contribution made by them to society;
- securing their rights; and
- social and economic well-being.

For the purposes of this report, we have adopted a similar interpretation of the term ‘well-being’, partly for simplicity (so that our use of the term is the same as the Welsh Government’s), and also because the definition proposed in the Bill is sufficiently comprehensive to incorporate the elements which we consider relevant to issues around reablement.

1.4 Organisational context

The boundaries of the seven health boards in Wales are contiguous with local authority boundaries as given in Table 1.1 below. There are four health boards in the relatively populated south: Aneurin Bevan, Abertawe Bro Morgannwg University, Cardiff & Vale University and Cwm Taf. Two health boards (Hywel Dda and Powys) cover rural south and mid Wales; with Betsi Cadwaladr covering six local authorities in the north.

<table>
<thead>
<tr>
<th>Table 1.1: Health boards and Local Authorities in Wales</th>
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<tbody>
<tr>
<td><strong>Aneurin Bevan Health Board</strong></td>
</tr>
<tr>
<td>Blaenau Gwent County Borough Council</td>
</tr>
<tr>
<td>Caerphilly County Borough Council</td>
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<tr>
<td>Monmouthshire County Council</td>
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<tr>
<td>Newport City Council</td>
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<tr>
<td>Torfaen County Borough Council</td>
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<tr>
<td><strong>Abertawe Bro Morgannwg University Health Board</strong></td>
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<tr>
<td>Bridgend County Borough Council</td>
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<tr>
<td>Neath Port Talbot County Borough Council</td>
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<tr>
<td>City and County of Swansea</td>
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1.5 Method

Data collection

WRVS sent Freedom of Information requests to the 22 Welsh local authorities in June 2011, and to the seven health boards in January 2012. Responses were received from 18 of the local authorities and all of the health boards.

Data review and analysis

The responses were in the form of letters and emails, some of them referring to supporting documentation which was also sent to WRVS. Each of these responses was reviewed, and where possible main themes were identified across responses. Sources of information in this report are entirely derived from the responses received from the requests; no other sources of data or information were used.

Owing to wide variations in detail and interpretation within the responses (and, in the case of local authorities, the lower level of responses), it was not feasible to undertake a comprehensive thematic analysis. Instead, common themes are highlighted and this report presents a largely descriptive interpretation of the responses.

It is useful to quote from one of the returns in order to explain the diversity of response, the level
of confusion and wide interpretations of the term ‘reablement’:

The NHS financial systems collect cost/budget information in many different categories and forms but not routinely on reablement. There is no clear NHS costing definition of what elements of our service provision would actually fall under this category. However, we have tried to collect as much information as we can on what we believe would be included in this category.

Having set the context for the research and the method of data collection, it is now possible to turn attention to the responses and our interpretation of them.
Chapter 2: Reablement provision in Wales

2.1 Introduction

Wales’ seven health boards were asked to identify reablement programmes aimed at older people that currently exist in their areas. The 22 Welsh local authorities were asked a similar question: What reablement services are provided in your local authority area?

This chapter presents the findings by health board area in response to this and related questions:
- Changes in the number of service users
- Target groups for reablement services
- Future plans and enhancements

2.2 Reablement programmes and changes in the number of service users

Table 2.1 below presents a brief description of the main programmes or approaches operating in each of the seven health board areas.

Table 2.1: Current reablement programmes aimed at older people in the area covered by the health board

<table>
<thead>
<tr>
<th>Programme</th>
<th>Health board</th>
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<tbody>
<tr>
<td>Located within Community Resource Teams (CRTs)</td>
<td>Aneurin Bevan</td>
</tr>
<tr>
<td></td>
<td>Cardiff &amp; Vale University</td>
</tr>
<tr>
<td></td>
<td>Hywel Dda</td>
</tr>
<tr>
<td>Located within Community Resource and Reablement Teams (CRRTs)</td>
<td>Abertawe Bro Morgannwg University</td>
</tr>
<tr>
<td>Elderly Care Assessment Service</td>
<td>Cardiff &amp; Vale University</td>
</tr>
<tr>
<td>Area based reablement services</td>
<td>Betsi Cadwaladr University</td>
</tr>
<tr>
<td></td>
<td>Cwm Taf</td>
</tr>
<tr>
<td></td>
<td>Powys Teaching</td>
</tr>
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</table>

In three health board areas, reablement services are provided as part of a range of support services by multi-disciplinary Community Resource Teams. In the Abertawe Bro Morgannwg University Health Board area, services are in transition and will lead to fully integrated CRTs. Presently, reablement services are provided by Community Resource and Reablement Teams which form part of the Community Integrated Intermediate Care Service. In the remaining three health board areas, reablement services are provided via Reablement Teams or services.
The following sections summarise the main aspects of these services as identified via the responses from the health boards and local authorities. Where possible, information on changes in the number of service users accessing these services is given; so too are proposed enhancements to the services to meet the ambitions within Sustainable Social Services for Wales (Welsh Assembly Government, 2011).

Community resource teams

These multi-disciplinary community teams provide a mix of support services which, along with reablement, typically include a range of other social care and health services. In Hywel Dda, for example, they provide social care assessment and care provision, enablement/reablement services, community nursing, chronic disease management, community therapy (physiotherapy, occupational therapy, podiatry, speech and language therapy and dietetics), sensory impairment service, carers and support services, welfare benefit service, convalescence beds services provision, day care and commissioned voluntary sector services (lunch clubs, nail cutting etc). Reablement is, therefore, only one of many services provided from these teams and the specific services provided as reablement are not separately defined or identified in the FOI responses.

• In the Aneurin Bevan Health Board area, the CRTs based in each local authority area (two in Monmouthshire) deliver the Gwent Frailty Programme, delivering an integrated model of care which is community based and jointly delivered by five local authorities and the health board. Key components of the service are rapid response, reablement and falls. The multi-agency teams include social workers, occupational therapists, physiotherapists, reablement assistants and trained reablement home carers.

The health board is not able to quantify changes in the number of reablement service users because until recently reablement was provided by both health and social care services and not always a fully integrated service. The response goes on to say that the CRTs currently receive 1,300 calls of which 48% (December 2011) relate to ‘enablement’.

The health board aims to increase the CRT service significantly over the next two years with additional investment to the frailest people in the community.

• There are three CRTs in the Cardiff & Vale University Health Board area along with an Elderly Care Assessment Service (ECAS), all of which target older people.

ECAS has seen a growing number of referrals and patients seen over the past two years from 977 in 2010 to 1,138 in 2011 – an increase of 16%. For CRTs, the health board is unable to provide accurate data for referral trends to CRTs due to recent service integration/reconfiguration.

– Cardiff Council’s response described the components of their reablement service as follows: “Occupational therapy is a key element of the service. It also includes a social work element and a fast track small aids and equipment service.” The council also has contributed to and benefits from the All-Wales Reablement Programme.

• In the Hywel Dda Health Board area, there are seven locality CRTs which are jointly managed and funded across health and social care, delivering tailored packages of care drawn from the full health and social care and voluntary sector multi-disciplinary teams.
The health board stated an intention to increase their focus on people at risk of hospital admission or health decline, to provide earlier interventions to prevent loss of independence or deterioration of well-being.

– In Carmarthenshire, there is a reablement domiciliary care service delivered through an inhouse provider service and a residential reablement service (using 22 convalescence beds in three care homes). These beds are supported by reablement staff on an in-reach basis and by physiotherapists and occupational therapists.

– The Ceredigion service employs four occupational therapists, two physiotherapists and 14 generic reablement assistants registered under the Ceredigion Domiciliary Care Agency.

– There was no response to the FOI request from Pembrokeshire CC.

• Within **Abertawe Bro Morgannwg University Health Board**, the Community Resource & Reablement Teams (CRRTs) form part of the Community Integrated Intermediate Care Service (CIIS) in each of the three local authority areas which were developed as a result of the Trust wide initiative, ‘Designing Intermediate Services’. In their response, the health board identified that over the preceding 18 months services from the health, local authority and voluntary sectors had been integrated into community intermediate care. In the response, reablement goals and services were not separately identified from all roles of the CRRTs.

The Health Board notes that service redesign has led to increased referrals through:

– Improved linkages with the Ambulance service to avoid patients who have fallen attending A&E and the CRT undertaking a falls assessment and providing support and intervention

– Consultant-led ‘hot clinics’

– Falls prevention programmes

– Redesign of stroke care pathways

In future, the focus will be on further integrating health and social care in line with the strategic direction of the Welsh Government – specifically for the frail elderly and people with complex conditions. It appears from the information received that service development is ongoing and will lead eventually to fully integrated CRTs in each of the three local authority areas.

– Bridgend Council predicts that development of the new integrated services will streamline the process of referral and assessment ensuring interventions are delivered appropriately in terms of time and setting, thus avoiding duplication. Referrals will be made through a single point of contact. At the time of the response, the CIIS in Bridgend included the Community Rehabilitation Team, the Community Disability Rehabilitation Team and an Early Response Service. There was also a project underway to incorporate the Council’s enabling home care service, Bridgestart, into the CIIS service, and to develop a Community Resource Team to include both services.

– In Neath Port Talbot, the reablement service is part of the CIIS along with a Home Care and Enabling Team (HEAT) working for disabled and older people where the therapeutic and rehabilitation work have already been undertaken. The reablement service can be provided at home through the Community Reablement Service or in a special residential unit for those needing more support.
In Swansea, a Domiciliary Care Assessment Service promotes the independence of older people following a period of illness or disability, and links with the ABMU Health Board Community Resource Team and the commissioned long-term domiciliary care services. The local authority stated: “Reablement is a central theme of our Transforming Adult Social Services programme which we are currently developing as a corporate strategic project.”

Reablement teams/services

The remaining three health board areas have reablement teams:

- **Powys Teaching Health Board and Powys County Council** run a developing integrated and dedicated reablement service through teams covering Ystradgynlais, Brecon, Radnorshire and Welshpool. At the time of the response, another team was planned for Newtown.

- **The Betsi Cadwaladr University Health Board** works closely with local authorities and voluntary sector organisations in supporting older people to live independently and remain in their own homes. The reablement services are provided by local authorities across North Wales and are therefore not applicable to the health board which does not have a budget for reablement.

Dedicated reablement teams are based in the local authorities (no response from Gwynedd). Again, no precise definition of the services provided through these teams was given:

- In Denbighshire, the reablement team was established in 2009. It complements the Response and Rehabilitation Service and in effect rolls out Phase 3 of the Intermediate Care Strategy adopted by partners within Denbighshire. Denbighshire County Council’s commitment to reablement is embodied in its Reablement Strategy, ‘Reablement Moving Forward’ (March 2011) which proposed a range of actions for Domiciliary Care, Day Services, Care Homes, Housing, Social Care Professional Support, Telecare and Communication. The collection of robust data using qualitative and quantitative performance indicators is identified as important in the Strategy.

- At the time of the response, Conwy was part way through the establishment of a reablement service for older people and people with physical disability and sensory impairment over the age of 18. The roll out of the project into all areas was due for completion in January 2012.

- The service in Flintshire has recently been extended so that unless there is a contraindication for doing so, all transfers from hospital go directly to the reablement service. The council plans to enhance and grow their reablement services through their programme, ‘Transforming Social Services for Adults in Flintshire’ which at the time of the response was in development. The transformation will aim to ensure that from September 2012 a significant number of people who approach Adult Social Care for support will receive targeted interventions for up to six weeks through the enablement service. The county council is also considering whether the reablement service teams should be linked to localities through reablement teams.

- Wrexham: The six directors of social services meet regularly as part of the North Wales Regional Partnership arrangements to ensure that this agenda does not lose momentum.

- **Cwm Taf Health Board** partners each of the local authority areas of Merthyr Tydfil and Rhondda Cynon Taf.
– In Merthyr Tydfil, there is a generic reablement programme. At the time of the response, the council was reviewing its access to services with the intention of delivering reablement and enabling services at the front end of any service delivery. It is anticipated that this will be implemented by April 2012.

– In Rhondda Cynon Taf, there is a generic reablement programme consisting of a joint team with the health board. This complements a range of commissioned services that support people to maintain their independence. It employs physiotherapists and occupational therapists, social care assessment and support. Currently about 70% of people undertaking the programme require no ongoing support from health or social care services. The service also has access to a small number of beds in residential care homes where they can work with people to support them to be able to manage in their own homes.

2.3 Social reablement

The FOI request to health boards asked them to identify reablement programmes focusing on the social rather than physical reablement of older people. The responses from many health boards and local authorities alike emphasised that they provide integrated services which involve holistic assessments and client centred services based on both physical and social needs. However, descriptions of what reablement is and what it provides within those services and teams were not clearly given – and in some cases appeared to be subsumed within or confused with programmes of ‘Intermediate Care’.

Furthermore, a number of responses highlighted the broad service areas contributing to reablement or the broad outcomes achieved and others identified the types of professional delivering reablement; physiotherapists and occupational therapists were mentioned most frequently.

A few responses did, however, mention specific services defined as ‘social’ which are provided as part of their reablement programmes. For example, both Betsi Cadwaladr University Health Board and Cardiff & Vale University Health Board mentioned befriending, and other specific services are mentioned within the following responses:

- Individual goals worked on with service users include visiting the hairdresser, walking the dog, wishing to die at home. (Aneurin Bevan Health Board)
- Services addressing social needs provided by the local authorities include telecare, falls prevention service, carer support, intermediate care. (Betsi Cadwaladr University Health Board)
- “The voluntary sector is linked into a number of the reablement services and supports the social needs of older people”. (Cardiff & Vale University Health Board)
- Interventions can be geared towards improving social and emotional well-being of the individual and may include working on developing confidence, increasing motivation,
improving socialisation, optimising independence with daily living tasks e.g. personal care, cooking, shopping. They also mentioned lunch clubs and nail clipping. (Hywel Dda Health Board)

• “All teams operate to the same service specification with an equal health and social focus. Service users are fully involved in decision making and goal planning”. (Powys Teaching Health Board)

• “The reablement approaches within the Health Board do not specifically focus on the social aspects of reablement but if social activity forms part of the goals within the reablement service, then that aspiration will form part of the overall reablement plan”. (Abertawe Bro Morgannwg University Health Board)

• “Neither of the reablement programmes [in Merthyr Tydfil or Rhondda Cynon Taf] focus on social reablement, however improving physical independence enables the individual to access roles and activities inside and outside the home which they enjoyed prior to their ill health”. (Cym Taf Health Board)

The local authorities in their responses gave general descriptions of the purpose of reablement and the types of occupations and services involved in delivering reablement services to individuals. However, only in two instances did local authorities give examples of a number of social reablement activities. In the brochure for service users delivered along with their response, Neath Port Talbot specified the following:

The following tasks will be undertaken with you if they form part of the agreed therapy plan:

• Shopping
• Collecting pensions
• Light domestic duties

2.4 Target groups

Health boards were asked to identify specific groups which have been the target of their reablement programmes. Table 2.2 summarises the returns from all health boards responding to this question. There is an underlying understanding in all these responses that reablement is provided to individuals who have experienced a deterioration in physical health, activities and daily living, independence, mobility, confidence or social circumstances which have resulted in loss of ability to cope at home.

Three of the responses identified target groups as people with the potential to improve as a result of reablement. Three identified a lower age limit of 18 years whereas one health board (Cardiff & Vale University Health Board) specifically targets older people. Two of the health boards highlighted that people offered reablement services must have the personal motivation to improve; one mentioned that they must have the cognitive skills to participate.
Table 2.2: Groups targeted by interventions

<table>
<thead>
<tr>
<th>Target groups</th>
<th>Health Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>People who have the potential to improve or sustain some or all of their functional ability and independence with intensive short term support</td>
<td>Abertawe Bro Morgannwg University</td>
</tr>
<tr>
<td>Older people who have the potential to improve their independence</td>
<td>Cardiff &amp; Vale University</td>
</tr>
<tr>
<td>Available to any where assessment indicates the individual will maximise their skills as a result of reablement</td>
<td>Powys Teaching</td>
</tr>
<tr>
<td>Adults 18+ who meet eligibility criteria (undefined in response) although most are older people (aged 65+)/frail</td>
<td>Aneurin Bevan Hywel Dda</td>
</tr>
<tr>
<td>Available to anyone over 18</td>
<td>Powys Teaching</td>
</tr>
<tr>
<td>People who are motivated with adequate cognitive skills to participate to achieve agreed goals</td>
<td>Abertawe Bro Morgannwg University</td>
</tr>
<tr>
<td>People who wish to participate in an intervention</td>
<td>Powys Teaching</td>
</tr>
<tr>
<td>People who support specific pathways e.g. stroke/fractured neck or femur pathways</td>
<td>Cardiff &amp; Vale University</td>
</tr>
</tbody>
</table>

2.5 Conclusions

From the data outlined above, there are several key conclusions which can be drawn on current levels and models of reablement provision across Wales.

Most strikingly, there is no standard definition (whether from the Welsh Government or any other agency) to guide public bodies in Wales on what is meant by the term ‘reablement’. There is also no Welsh Government requirement to issue returns on reablement. This has led to a lack of comparable information across Wales. This is matched by an evident confusion amongst public bodies over the terms ‘reablement’, ‘intermediate care’ and ‘enablement’, with the terms at times being used interchangeably. In addition, reablement is seen largely as improving physical health and mobility – with comparatively few mentions of ‘social’ interventions.

When asked about the targeting of services, we found evidence of variation between health boards in their target groups for reablement. However, there was also encouraging evidence of common aspirations to increase referrals and for interventions to be targeted towards the frailest and most in-need. In addition, there was a complex mix of delivery mechanisms for reablement throughout Wales, with services located either within integrated teams delivering multiple community services, or within dedicated reablement services.

Finally, there was strong evidence of cross local authority partnership working in North Wales. More widely, there was also evidence of change, improvement and further integration of health, local authority and voluntary sector services.

Having established this evidence in relation to reablement provision in Wales, the next chapter will turn its attention to the levels and nature of funding for reablement services.
Chapter 3: Reablement funding in Wales

3.1 Introduction

Reablement services already attract dedicated funding in other parts of the United Kingdom. The SSIA have noted that, in England, “additional funding has been announced... £300m in 2012/2013 and onwards until March 2015” (SSIA, 2012). Elsewhere in the UK, “the Scottish Government’s £70m Change Fund is also providing commissioners with the opportunities to deliver reablement services whilst the Northern Ireland Government’s £18m investment in telemonitoring will also assist commissioners in implementing new models of care” (Tunstall Healthcare, 2011: 5).

In contrast, Wales currently attracts no dedicated funds for reablement. Instead, reablement is funded either through local authority spending or through health board budgets (and, in some instances, through joint working and joint funding).

In order to assess the extent of dedicated funding for reablement in Wales, we asked health boards and local authorities to give details of their reablement budgets. Health boards were also asked to provide budgets for the preceding two years and projections for the next two years, whilst local authorities were asked how much they spent on reablement services and how this figure compared to their social services budget as a whole.

Appendix 2 presents a table which draws together the data provided by all responses and a simple analysis of expenditure per head of population (using mid-year population estimates for 2010) and in the case of local authorities, as a percentage of the total social services budget.

This chapter aims to draw out key findings and themes emerging from the budget analysis. As highlighted in the previous chapter, there is no requirement for health boards or local authorities to submit financial returns to the Welsh Government on reablement alone and there is no single agreed definition of the term in use. This is evident in the budget figures.

3.2 Budget trends

Chapter 2 highlighted the expansion (or, in some areas, the development) of service teams delivering community-based support services. The commitment of health boards and local authorities to the continuing care and support for the frailest in society was evident in every area of Wales. At a time when statutory organisations are under pressure to prune budgets, it is encouraging to learn that these intentions are supported by evidence from the budget data supplied to us. Four of the health boards provided budget information and three of these sent information for more than one year. This information revealed a picture of either stable or

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6 Betsi Cadwaladr University Health Board did not submit data because it has no reablement budget, and Cardiff & Vale University Health Board is in the process of change and redesign as the three CRTS are being rolled out and was unable to provide the information.
increasing Health Board budgets; some local authorities also volunteered information on budget trends which is also relevant:

- Abertawe Bro Morgannwg University Health Board: £5.9m (£11.69 p.h.) 2010/11 and 2011/12
- Hywel Dda Health Board: £0.6m (£7.98 p.h.) 2009/10 and 2010/11
- Ceredigion Council also supplied budget information for more than one year; in both 2009/10 and 2010/11 this was £164,464
- Aneurin Bevan Health Board: £1.4 m in 2009/10 to £2m in 2012/13 (£2.49 - £3.56 p.h.) This represents a percentage increase of 43%. In addition the health board and local authority partners have borrowed £6.9m following a successful bid to the Welsh Government to further invest in frailty services, including reablement, over the next three years.
- Powys Teaching Health Board increased its budget by 60% to 0.83k in 2011/12 from £0.52k in 2010/11 (£3.96 to £6.32 p.h.). It will remain at 0.83k in 2012/13 and 2013/14.
- Flintshire Council also supplied budget information for more than one year. Their recent expansion in the reablement service is reflected in growth from £120,417 in 2010/11 to £274,500 in 2011/12.

### 3.3 Budget levels

As mentioned previously, most local authorities and health boards provided budget information for the services they define as ‘reablement’ or ‘reablement related’. As there is no single recognised definition of the term reablement used by statutory organisations in Wales and no requirement to submit financial returns on reablement to the Welsh Government, it is as well to urge caution when interpreting the data presented in Appendix 2 and comparing across areas since definitions of the term vary widely.

Table 3.1 ranks local authorities by the amount they spend on services that they define as reablement per head of total population. This spend varies widely from £19.88 in Torfaen to £1.58 in Conwy. As a percentage of total spend on social services, ‘reablement’ varies from 4.7% in Torfaen to 0.4% in Conwy.

**Table 3.1: Local authority spend on ‘reablement’ per head of population and as % of social services budgets**

<table>
<thead>
<tr>
<th>Authority</th>
<th>Budget year</th>
<th>Per head of pop</th>
<th>% of Social services budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Torfaen</td>
<td>n/a</td>
<td>£19.88</td>
<td>4.7</td>
</tr>
<tr>
<td>Carmarthenshire</td>
<td>2011/12</td>
<td>£14.70</td>
<td>3.1</td>
</tr>
<tr>
<td>Cardiff</td>
<td>2011/12</td>
<td>£12.31</td>
<td>2.8</td>
</tr>
<tr>
<td></td>
<td>Budget year</td>
<td>Per head of pop</td>
<td>% of Social services budget</td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------</td>
<td>-----------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Caerphilly</td>
<td>2010/11</td>
<td>£10.49</td>
<td>2.6</td>
</tr>
<tr>
<td>Swansea</td>
<td>2011/12</td>
<td>£8.50</td>
<td>2.1</td>
</tr>
<tr>
<td>Rhondda Cynon Taf</td>
<td>2011/12</td>
<td>£5.55</td>
<td>1.4</td>
</tr>
<tr>
<td>Isle of Anglesey</td>
<td>2010/11</td>
<td>£5.38</td>
<td>1.3</td>
</tr>
<tr>
<td>Neath Port Talbot</td>
<td>2011/12</td>
<td>£4.06</td>
<td>0.8</td>
</tr>
<tr>
<td>Wrexham</td>
<td>2011/12</td>
<td>£3.56</td>
<td>1.2</td>
</tr>
<tr>
<td>Powys</td>
<td>2011/12</td>
<td>£3.14</td>
<td>n/a</td>
</tr>
<tr>
<td>Bridgend</td>
<td>2011/12</td>
<td>£2.75</td>
<td>1.0</td>
</tr>
<tr>
<td>Denbighshire</td>
<td>2010/11</td>
<td>£2.34</td>
<td>n/a</td>
</tr>
<tr>
<td>Ceredigion</td>
<td>2010/11</td>
<td>£2.14</td>
<td>n/a</td>
</tr>
<tr>
<td>Newport</td>
<td>n/a</td>
<td>£2.00</td>
<td>n/a</td>
</tr>
<tr>
<td>Flintshire</td>
<td>2011/12</td>
<td>£1.83</td>
<td>0.5</td>
</tr>
<tr>
<td>Conwy</td>
<td>2010/11</td>
<td>£1.58</td>
<td>0.4</td>
</tr>
</tbody>
</table>

n/a: not available; no response or no budget information from Blaenau Gwent, Gwynedd, Merthyr Tydfil, Monmouthshire, Pembrokeshire, or Vale of Glamorgan.

This level of variation can be explained at least in part by the following information provided to us by a few of the local authorities:

- appears to have provided budget figures for its contribution to all intermediate care services of which reablement is only a part. It also includes a contribution (not defined) from Aneurin Bevan Health Board.
- includes domiciliary and residential reablement services in their budget information.
- ‘reablement’ budget is the total amount they have committed to the Gwent Frailty Programme.
- budget given here is for their Domiciliary Care Assessment Services (DCAS).
- budget is for their Community Intermediate Integrated Service of which the community reablement service is a part.

Health boards also vary widely in their per head budgets for ‘reablement’ (Table 3.2) from zero in Betsi Cadwaladr University Health Board where the local authorities have full responsibility for reablement services, to £11.69 per head in Abertawe Bro Morgannwg University Health Board. Clearly, budgets vary in terms of the proportional split between local authorities and health boards across Wales suggesting that local partnerships are working out their own priorities and sharing responsibilities accordingly.
## Table 3.2: Spend on ‘reablement’ per head of population

<table>
<thead>
<tr>
<th>Health Board</th>
<th>Year</th>
<th>Reablement Budget</th>
<th>Per head of pop</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aneurin Bevan HB</td>
<td>2011/12</td>
<td>£1,900,000</td>
<td>£3.38</td>
</tr>
<tr>
<td>Abertawe Bro Morgannwg University HB</td>
<td>2011/12</td>
<td>£5,900,000</td>
<td>£11.69</td>
</tr>
<tr>
<td>Betsi Cadwaladr University HB</td>
<td></td>
<td>£0</td>
<td>0</td>
</tr>
<tr>
<td>Cardiff &amp; Vale University HB</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Cwm Taf HB</td>
<td>2011/12</td>
<td>£168,242</td>
<td>£0.58</td>
</tr>
<tr>
<td>Hywel Dda HB Ceredigion only</td>
<td>2009/10</td>
<td>£614,002</td>
<td>£7.98</td>
</tr>
<tr>
<td>Hywel Dda HB Pembrokeshire only</td>
<td>n/a</td>
<td>£969,000</td>
<td>£8.28</td>
</tr>
<tr>
<td>Powys Teaching HB</td>
<td>2011/12</td>
<td>£829,000</td>
<td>£6.32</td>
</tr>
</tbody>
</table>

n/a: Not available

The high budget for reablement in ABMU might be explained at least in part by their explanation that they put together budget costs based on “what we believe would be included in reablement”.

This brief summary of the budget information received further describes a pattern of wide variation in the interpretation of reablement and different models for its delivery in Wales. Unfortunately it is not feasible from the data to draw conclusions about relative levels of prioritisation of reablement spending across Wales without the availability of a formally accepted definition and the structures in place to gather the information. Nevertheless, the inconsistencies we have highlighted help to underline the case for mechanisms to be put in place to allow like-for-like comparisons.
Chapter 4: Measuring well-being

4.1 Introduction

Health boards were asked a series of questions about how they measure well-being of older people. Given the renewed focus on well-being in the Welsh Government’s proposed Social Services Bill (Welsh Government, 2012), the questions were particularly well-timed, and the emergent data can help to inform the debate about how any duty to improve well-being might be measured in the future. The answers received and presented below cover general approaches and methods along with the precise measures and indicators used.

4.2 How is well-being measured?

A responsibility to feed well-being information and data to the Health, Social Care and Well-being Partnerships was highlighted by responses from Abertawe Bro Morgannwg University Health Board and Hywel Dda Health Board. In the case of ABMU, older people’s partnerships in each local authority monitor and assess the well-being of older people. In Hywel Dda the Health, Social Care and Well-being Partnership in each county take the responsibility on themselves to monitor health and well-being.

Cardiff & Vale University Health Board collects well-being information via verbal and written complaints and compliments; patient satisfaction surveys and stakeholder engagement work. Powys Teaching Health Board also conducts patient satisfaction surveys. Only Cardiff & Vale mentions the use of qualitative data in measuring well-being. They also plan on including qualitative feedback from service users and carers under their Wyn Campaign7. All other health boards only mention quantitative measures derived from secondary or published sources.

4.3 Sources of well-being data and Indicators used

The following are sources of well-being data used by health board respondents. The titles of these sources are those given by respondents; their titles have not been verified by us. The two most popular sources are the Welsh Health Survey and data arising from the Quality and Outcomes Framework.

Table 4.1 Sources of well-being data

<table>
<thead>
<tr>
<th>Source</th>
<th>Health Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welsh Health Survey</td>
<td>Aneurin Bevan, Betsi Cadwaladr, Cwm Taf, Hywel Dda</td>
</tr>
<tr>
<td>Quality and Outcomes Framework</td>
<td>Aneurin Bevan, Betsi Cadwaladr, Hywel Dda</td>
</tr>
<tr>
<td>Public Health Wales Observatory document</td>
<td>Cwm Taf, Hywel Dda</td>
</tr>
</tbody>
</table>

7 Formerly known as the Frail Older People’s Service Delivery Programme.
When asked to identify indicators of well-being (NB, not ‘health and well-being’) it is interesting to note that the responses contain no reference to social indicators of well-being (as might have been expected, given that the responses came from health boards). Clearly the concept of ‘well-being’ as perceived by these bodies conforms almost exclusively to a medical model in spite of the integrated models of care and support which are embodied in local and regional partnerships.

The responses also appear to show that different measures are being used by area and that no standard measures of well-being are being applied in all health board areas.

**Table 4.2: Well-being indicators used by Health Board**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Health Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>% treated for high blood pressure, any heart condition, respiratory illness, mental illness, arthritis, diabetes</td>
<td>Aneurin Bevan, Betsi Cadwaladr, Hywel Dda</td>
</tr>
<tr>
<td>Emergency admissions/readmissions</td>
<td>Abertawe Bro Morgannwg, Cardiff &amp; Vale</td>
</tr>
<tr>
<td>Indicators of smoking, obesity, substance misuse, mental health, accident and injuries, immunisation and vaccination, screening, health inequalities</td>
<td>Aneurin Bevan, Betsi Cadwaladr</td>
</tr>
<tr>
<td>Admission to residential or nursing care straight from hospital</td>
<td>Cardiff &amp; Vale</td>
</tr>
<tr>
<td>Chronic diseases (GP registers)</td>
<td>Hywel Dda</td>
</tr>
<tr>
<td>Discharge to usual place of residence</td>
<td>Cardiff &amp; Vale</td>
</tr>
<tr>
<td>Emergency bed days for 65+</td>
<td>Cardiff &amp; Vale</td>
</tr>
<tr>
<td>European Age Mortality Rates</td>
<td>Abertawe Bro Morgannwg</td>
</tr>
<tr>
<td>Multiple Admission Rates</td>
<td>Abertawe Bro Morgannwg</td>
</tr>
<tr>
<td>Numbers dying at home</td>
<td>Cardiff &amp; Vale</td>
</tr>
<tr>
<td>Stroke mortality rates</td>
<td>Abertawe Bro Morgannwg</td>
</tr>
<tr>
<td>Welsh Health Survey - smokers, eating habits, physical activity, rates of long-term limiting illness</td>
<td>Hywel Dda</td>
</tr>
<tr>
<td>Welsh Health survey physical component summary score, mental health component summary score.</td>
<td>Cwm Taf</td>
</tr>
<tr>
<td>Welsh Index of Multiple Deprivation - housing and income deprivation, index of winter deaths</td>
<td>Hywel Dda</td>
</tr>
</tbody>
</table>
4.4 Changes in indicators used

Two further questions were asked of health boards: one about changes in well-being indicators over the last two years, and one about plans to change indicators over either of the following two years. None of the responses answered the question about whether indicators have changed over the last two years and only two – Cardiff & Vale University Health Board and Powys Teaching Health Board – responded to the second question about future changes. Their answers to this question are as follows:

- Beneath the high level indicators (mentioned in section 4.3 above) for Cardiff & Vale University Health Board are performance measures for the discrete projects in the Wyn campaign which are under development and will include feedback from service users and carers.
- Measures of well-being of older people are in development within Powys Teaching Health Board.
Chapter 5: Conclusions

5.1 Introduction

This report has summarised the responses of Wales’ 22 local authorities and seven health boards to requests for information about reablement services. It is clear from the data presented in the previous chapters that there are several areas of inconsistency in service provision and budgeting, and also a strong element of confusion over what constitutes a reablement service. The arena of reablement is one which is fast-changing, and it should be acknowledged that much will already have changed within local authorities and health boards since their responses to our requests. Nevertheless, the findings provide a useful snapshot of the Welsh reablement position, and should go some way to informing the work being done by Welsh Government and other bodies (not least the SSIA and WLGA) to raising the standard of reablement.

This final chapter will seek to draw together the themes which have emerged from the data, and to draw some conclusions and recommendations based on that analysis.

5.2 Reablement provision in Wales

The data outlined in this report suggest that there are vastly differing levels of reablement provision across Wales, coupled with widely differing understandings of what constitutes reablement. With no central guidance on how best to deliver reablement, local authorities and health boards have developed their own approaches, often with very different results.

One example of this can be seen in the different understandings of how reablement should be led. In some cases, reablement was led by multi-disciplinary Community Resource Teams, whilst in other areas, reablement was delivered through a more traditional social services approach. A similar pattern emerged when it came to how reablement should be targeted – with some health boards adopting a social services eligibility approach, and others focusing on patients who could participate in setting their own goals and being an active part of the reablement process.

More importantly, there were vastly different understandings of the importance of social reablement. Although all of the health board responses made reference to social support, in some cases this was not supported by their descriptions of the services being delivered on the ground (or, as we shall discuss in section 5.4, by the mechanisms used to measure well-being). Nevertheless, there were some examples of good practice. Both Cardiff & Vale University Health Board and Betsi Cadwaladr University Health Board offered services in partnership with the voluntary sector which involved schemes such as befriending and telecare.

What these findings suggest is that there is an overwhelming need for a common framework to help drive improvement in reablement provision within Wales. Hitherto, local authorities

8 The SSIA and WLGA are currently engaged in work to establish a thorough benchmark of reablement services in Wales, in much greater detail than we have sought to attain in this report. Our intention is to help inform their work and to raise some of the more fundamental policy questions (on issues such as definitions of reablement and funding) which need to be considered by the Welsh Government.
and health boards have developed their own models according to local circumstance, and that flexibility is to be welcomed – but at the same time, the organic evolution of reablement in Wales has led to an inconsistent and patchy situation where service users in one area will receive very different services from those in another, even if their needs are similar. This is nowhere more clear than in the very different understandings of what constitutes reablement. As Appendix 2 shows, the term is open to all sorts of interpretations, and the services offered by health boards and councils across Wales suggest that they too are confused about exactly what a good reablement service should incorporate. The Welsh Reablement Alliance has already drawn together some of the features which service providers believe should be common to all reablement provision (Welsh Reablement Alliance, 2011a), and it is not our intention to repeat them here – but a broad interpretation, which incorporates the social as well as physical elements of reablement, are vital if Wales is to have high-quality and effective reablement services. There is, therefore, a pressing need for the Welsh Government to develop and disseminate a definition of reablement which can be adopted by those bodies (across all sectors) charged with delivering reablement at the coalface.

Moreover, the situation is one which needs to be addressed urgently – not just for the benefit of service users, but also for the benefit of the public purse. Last year, the Older People’s Commissioner for Wales drew attention to the paucity of discharge planning in Wales, saying that it was “a false economy to leave people in hospital and we have to find smarter ways of working in the current budgetary context” (OPCW, 2011: 15). The Welsh Government (2012) has also accepted that reform of social services needs to happen within the context of acute financial pressures. As we have argued elsewhere in this report, and as the next section sets out, reablement offers a cost-effective solution. In the current financial climate, the question is not why reablement should be widely adopted, but how public bodies can afford not to.

5.3 Reablement funding

The inconsistent pattern of service provision was replicated when local authorities and health boards were asked about funding of their services. Across Wales, there were huge discrepancies between the budgets allocated towards reablement by different health boards, with an even starker picture being painted within local government with some authorities having a budget line for reablement ten times that of other councils in the same region.

As with the previous section, much of this patchiness can be attributed to differing definitions. It stands to reason that an authority/health board taking a wide interpretation of reablement will discover it is spending more on services than one which takes a very narrow interpretation. That in itself is an important finding, and serves to highlight that much more needs to be done to help public bodies coalesce around a single interpretation of reablement. It cannot be right that the Abertawe Bro Morgannwg University Health Board considered its spending on reablement to total £5.9m per year, whilst the Cwm Taf Health Board only identified a budget of £168,242 for services under the same banner.

More encouraging, for the health boards at least, was the extent to which spending on reablement was insulated against efficiency savings. In all of the health boards, reablement spending was either stable or rising in the immediate future. This undoubtedly reflects the
increased focus on reablement in public policy narratives, and the emphasis being placed on reablement by the Welsh Government.

At a local authority level, our findings suggest that the pattern of investment in reablement is inconsistent. When population figures are taken into account, there is a stark contrast between the £19.88 spent per citizen in Torfaen and the £1.58 per citizen in Conwy. As the Welsh Reablement Alliance noted when they gave evidence recently to the Assembly's Health & Social Care Committee (Welsh Assembly, 2012: 5; see also Welsh Reablement Alliance, 2011b), the difference is just as likely to be attributable to different interpretations of which services constitute reablement as it is to be due to much greater resources being deployed to reablement in different areas. As was mentioned in chapter 3, Torfaen included figures for its entire contribution to intermediate care services and included a contribution from the health board; similar patterns emerged from Caerphilly and Carmarthenshire, resulting in reablement budgets which look artificially high. The Welsh Reablement Alliance’s call for a greater steer by the Welsh Government on the services which local authorities should provide is one which we would echo, if only so that these can be addressed in future. This is vital if benchmarking of reablement provision is to be meaningful and allow for direct comparisons to be drawn.

On the wider point of reablement funding in Wales, it is worth reiterating that Wales remains the only part of the United Kingdom with no dedicated funding for reablement services. England has a £300m fund in the current financial year, with Scotland providing a £70m ‘Change Fund’; even in Northern Ireland, an £18m investment into telecare represents a big step towards addressing unmet demand for reablement.

The Scottish example is particularly interesting, as it has already been the subject of research into the efficacy of reablement investment. Highly successful and innovative reablement projects in places like Edinburgh have shown (Scottish Government, 2011) that reablement can reduce the number of care hours required by users, and that reablement gave service users the confidence to undertake tasks for themselves.

In Wales, there is as yet no dedicated funding. There are, however, some small-scale studies which have helped to provide evidence showing that existing Welsh reablement models are making a positive impact. Research from the University of Bangor (Zinovieff & Robinson, 2010) into home-from-hospital service providing transport services and home support in two counties in North Wales found potential annual net savings to the NHS of £100k. Whilst this is very much the tip of the iceberg in terms of service provision and evidence, it further underlines the case for investment in (and leadership of) reablement provision in Wales.

5.4 Measuring well-being

The concept of well-being is one which is increasingly at the forefront of public policy debate. Indeed, the Welsh Government’s proposals for social services reform (Welsh Government, 2012) seek to impose a general duty on local authorities and their partners to maintain and enhance the well-being of people in need. From our own experiences of delivering social support services to older people, with the aim of improving well-being and quality of life, WRVS would welcome the Welsh Government’s acknowledgement that mental/ emotional well-being and social well-being are an integral part of a person’s overall well-being. There is a close association (Allen,
2008) between emotional well-being and physical health, and evidence (Kivelä & Pahkala, 2001) has suggested that older people suffering from poor mental health are more susceptible to suffering physical disabilities.

In the responses we received to our Freedom of Information requests, it is clear that there is much progress to be made by public bodies to support this agenda. A large number of different sources were used by different health boards to measure well-being. This in itself is not a weakness, as there is no prescribed measurement or set of indicators from the Welsh Government to measure well-being. What is concerning, however, is that none of the health boards made reference to social indicators of well-being. Instead, their perception of well-being derived from a medical model, despite a recognition (by Welsh Government as well as by academic research) that social well-being is inextricably linked to physical health.

Equally concerning was that no health board suggested that their approach would change over the coming years to address this shortcoming. In their eyes, the indicators on which they are drawing are appropriate, and do not need to change to reflect the emphasis being given to social elements of well-being.

The response of the health boards in this regard is a major weakness, and should raise significant concerns within policy circles about the extent to which health boards (and perhaps other public bodies) are prepared to take forward the well-being agenda in a meaningful and effective way. It is clear that there has to be a dialogue between the Welsh Government and health boards in order to address the problem.

In addition, we would stress that the tools used to measure well-being are critical. Unless well-being is properly measured, and measured in such a way that reflects service users’ views, it will make no difference to the quality of service received. That does not necessarily mean that there has to be a single tool prescribed to public bodies to measure well-being (although that may be appropriate and may help to elicit data which can be easily compared), but any measurement must allow for the qualitative experiences of services users to be reflected.

5.5 Implications

It is worth reiterating that reablement will play an increasingly prominent role in Welsh policy over the coming years. In their 2011 Assembly election manifesto, Welsh Labour promised to “put ‘reablement’ at the heart of our approach to providing services to older people and require local providers to set out their arrangements for reablement services” (Welsh Labour, 2011: 57).

Delivering on this pledge, and on the commitment in last year’s white paper for social services in Wales (Welsh Government, 2011) to introduce a requirement for reablement services, requires three things. Firstly, and most importantly, it will require political will so that the fine ambitions of reablement and existing good practice examples are developed into an achievable reality for every service user. Secondly, it will require a recognition that effective reablement cannot be a cheap option – although the long-term economic benefits of investing in reablement are clear to see. Finally, it will require a recognition that reablement has to be part of a broader step-change in social care; as Pitts et al (2011) have pointed out, it is not enough simply to have a reablement
service – there has to be an all-pervading reablement ethos which underpins the state’s approach to social care.

For reablement to be delivered effectively, and for provision to be consistently strong across Wales, we would make several recommendations based on the findings of our research:

• **Defining reablement:** Before any further work can be done on reablement, there needs to be a single, accepted definition of reablement agreed by the Welsh Government. It is clear from our research that the current confusion over what is meant by the term has resulted in inconsistent understandings and inconsistent services across the country. Furthermore, any definition should incorporate a reference to both physical and social elements of well-being.

  As a starting point, we would strongly endorse the definition adopted by the Welsh Reablement Alliance, namely:

  “At heart, reablement is about helping people to do things for themselves to maximise their ability to live life as independently as possible. It’s about supporting the whole person – addressing their physical, social and emotional needs. It’s an outcome-focused, personalised approach, whereby the person using the service sets their own goals and is supported by a reablement team to achieve them over a limited period. It focuses on what people can do, rather than what they can’t, and aims to reduce or minimise the need for ongoing support after reablement.” (Welsh Reablement Alliance, 2011a)

  This definition not only has the advantage of being wide-ranging and incorporating all the elements which make up reablement, but also draws on the experience and expertise of organisations from across the sectors who deliver reablement services (see also Welsh Reablement Alliance, 2012). Any definition needs to have a consensus of opinion behind it, and the above definition fulfils that requirement.

• **A reablement framework for Wales:** Following on from the point above, it would be highly desirable for the Welsh Government to develop a framework for reablement. This need not be a lengthy or prescriptive document, and nor should it be another strategy document to add to the many already in circulation. Instead, it should be a short, focused piece of work setting out what is meant by reablement, and what features public bodies should seek to incorporate in the services they provide. It might also usefully state the target groups which any service should set out to assist, and how the performance of those services might be measured (see below).

  As a starting point, we would again point to the work of the Welsh Reablement Alliance (WRA, 2011a) who have already set out the key features which they would like to see taken forward in this regard.

• **Measuring well-being:** The renewed focus on well-being is very welcome, and something WRVS would strongly support. However, well-being can only mean something if it is measured in an appropriate way. The findings of this research show that health boards in particular still consider well-being through the prism of a medical model of health, rather than reflecting the social aspects of well-being which are critical to an individual’s quality of life.

  We would suggest that self-assessment tools are incorporated into any outcome measure so that the more subjective social elements of well-being can be gauged. We believe it is perfectly possible to measure well-being in this sense, provided that all interventions are based
around meeting the service users’ own goals. Any measurement of ‘well-being’ should be sufficiently broad that it incorporates social and emotional well-being.

- **Funding reablement:** We welcome the Welsh Government’s desire for reablement to be delivered regionally (Welsh Government, 2011) and for it to be led in a way which allows local flexibility over how services should be delivered. Nevertheless, there is no escaping the fact that other parts of the UK have accepted the need for some central funding of reablement in order that services can be developed.

  The reablement approach is one which offers long-term benefits for short-term interventions. This is true for service users, and also for the public purse – reablement can deliver long-term cost savings, but it is not a ‘cheap alternative’. Investing in services, and helping health boards and local authorities to develop effective services comes at a price. We would therefore urge the Welsh Government to consider creating funds to assist local development of reablement services.

- **Involvement of the voluntary sector:** The voluntary sector has a huge role to play in reablement. This is particularly true in the provision of social support services, but is also true in other areas of provision. By definition, reablement is a multi-sector approach, and more needs to be done to encourage (and, if necessary, compel) public bodies to involve the voluntary sector in the development of reablement services.
Appendix 1: Definitions of ‘Reablement’

To underline the widely differing interpretations and definitions of reablement, here are just a handful of the different definitions which we came across in the process of compiling this report.

At heart, reablement is about helping people to do things for themselves to maximise their ability to live life as independently as possible. It’s about supporting the whole person – addressing their physical, social and emotional needs. It’s an outcome-focused, personalised approach, whereby the person using the service sets their own goals and is supported by a reablement team to achieve them over a limited period. It focuses on what people can do, rather than what they can’t, and aims to reduce or minimise the need for ongoing support after reablement. (Welsh Reablement Alliance).

Services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living. (NHS England – Care Services Efficiency Delivery programme).

This approach is built on the simple premise that when older people become ill or have a medical intervention they can get better. Its basis lies in the disciplines of occupational therapy (OT) and physiotherapy, helping older people rebuild their strength both physically and emotionally after a critical event so that they can live independently once again. The evidence shows that many older people can be aided to a full recovery after a six week period of intensive support. (SSIA).

The use of timely and focused intensive therapy and care in a person’s home to improve their choice and quality of life, so that people can maximise their long term independence by enabling them to remain or return to live in their own homes within the community. This approach focuses on reabling people within their homes so they achieve their optimum stable level of independence with the lowest appropriate level of ongoing support care. (NHS England – Care Services Efficiency Delivery programme).

The essence of reablement is to work with individuals who have support needs to rebuild their confidence, support the development of daily living skills and promote community access and integration. (Social Work Co-operative for the North East regional Improvement and Efficiency Partnership).

The active process of regaining skills, confidence and independence. This may be required following an acute medical episode or to reverse or halt a gradual decline in functioning in the community. It is intended to be a short-term intensive input. (Newport Reablement Team).

A process which supports an individual to achieve their maximum potential to function physically, socially and psychologically through support and intervention. (Denbighshire Council).

The restoration of optimal levels of physical, psychological and social ability within the needs and desires of the individual and his/her family. It requires the expertise of a number of disciplines.
within a comprehensive and integrated service which must span agency boundaries. (East Staffordshire Council).

Relearning the skills necessary for daily living following illness, usually with guidance and support from health professionals, so that there is an improvement in function and increased independence. (Limbs Alive – rehabilitation consultants).
Appendix 2: Spending on reablement by health boards and local authorities

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<tr>
<th></th>
<th>2010 population*</th>
<th>2010/11 Reablement budget</th>
<th>Per head of pop</th>
<th>% of SS Budget</th>
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Source: StatsWales
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