THE COST EFFECTIVENESS

OF

HOMECARE RE-ABLEMENT

A discussion paper to explore the conclusions that can be drawn from the body of evidence

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The final report to the Prospective Longitudinal Study [1] commissioned by the Department of Health's Care Services Efficiency Delivery programme (CSED) has provided further insight and understanding about the nature and beneficial impacts of homecare re-ablement. However, some of the report content has resulted in a lack of clarity and so this paper seeks to set out some of the background to the report and provide clarity on the learnings that can be gained with regard to the cost effectiveness of homecare re-ablement services.

EXECUTIVE SUMMARY

Contrary to impressions set out in various articles, the report does not indicate that homecare re-ablement as an approach has little financial benefits for a council. However, what it does illustrate is that councils should undertake a baseline exercise to establish an understanding of the local position and then to operationally performance manage their service to ensure that it is and remains cost effective whilst maximising the benefits of independence for as large a number of people as possible.

- The report illustrates variations in the number of contact hours, durations and cost of service for a phase of homecare re-ablement based on specific people in five specific services.
- Despite all of this, the report states that when compared with people who have undergone conventional homecare, those passing through homecare re-ablement achieved, on average, a 60% reduction in their ongoing homecare needs.
- The focus, therefore, should be to achieve that level of performance whilst appropriately minimising the cost of the homecare re-ablement phase
- The demands placed on health by the people in this study undergoing a phase of homecare re-ablement were not statistically different during the initial and follow-up periods to those who undergo conventional homecare. What is clear, however, is that referrals from hospital irrespective of which service they enter (homecare re-ablement or conventional homecare), have a higher demand for ongoing health support than do referrals from the community, and that these demands include some re-admissions within days of their previous discharge.

[1] 'Homecare Re-ablement Prospective Longitudinal Study Final Report', CSED (Dec 2010)

Background

As with all reports, it is important to understand the purpose and focus of the study because this sets the context within which the report should be considered, and the extent to which the learnings can be applied to local situations.

As a basic principle, the prospective longitudinal study sought to build on the previous work of the Homecare Re-ablement workstream within the CSED programme, including the Retrospective Longitudinal Study[2], and started from a premise that homecare re-ablement can have a substantial benefit for the majority of people that undergo a phase. Therefore, the prime focus of the study was to identify those issues that could influence practice and improve outcomes rather than to determine whether it 'worked' or not. Thus, the key focus of the study were:

- *To provide robust research evidence on the immediate and longer-term benefits of home care re-ablement, including:*
    - *User-level benefits (e.g. improved independence, quality of life, mental well-being).*
    - *Service-level benefits (e.g. reduced demand for services, use of less expensive services).*
- *To identify the factors that affect the level and duration of benefits for service users of a period of re-ablement (e.g. features of the re-ablement service; type and level of services used after re-ablement).*
- *To identify any impact on and savings in the use of social care and other services, that can be set against the costs of re-ablement services.*
- *To describe the content and costs of home care re-ablement services.*

Thereby improving independence, reducing the level of variability between schemes and appropriately minimising ongoing contracted hours

Given this purpose, the sites enrolled to participate in the study were chosen so that they provided a range of services to inform practice, rather than all being, necessarily, best performers. Two of the homecare re-ablement services in this study also featured within the previous Retrospective Longitudinal Study commissioned by CSED, but the other three did not.

Report Content

The report's quantitative content is based on data collected from and about specific people who agreed to participate in the study, and the selection process to enlist

[2] 'Retrospective Longitudinal Study', CSED (Nov 2007)

these people is set out within the report. This applied to both the intervention (re-ablement) and comparison (conventional) service sites, and is important because the data reflects the summation of specific individuals within specific services and so one needs to consider to what extent the results are representative of (a) the individual services, (b) homecare re-ablement services in general and (c) are illustrative of well performing services. Further, a council reading the report also needs to consider to what extent the data reflects their situation.

For instance, it is clear from the report that

- the majority of referrals (75%) within the re-ablement services were from hospital whilst the proportion in the comparison sites was lower (55%) (see table 3.9): the average within homecare re-ablement services across the country is thought to be closer to 45% to 50% and it is understood that two of the larger homecare re-ablement sites have confirmed that the % reported for their participants in the study overstates the general proportions in their service. Thus, it is important to look at casemix adjusted data in the report and not the simple raw data in the sections that compare the costs to conventional homecare packages.

- the average cost per episode for the people enlisted to the study who under-went a homecare re-ablement phase is reported as £1,510 (see section 8.3). However, Appendix E shows the average costs per phase for everyone seen during the year and these range from £1,609 to £3,575. The weighted average is £2,088 (see table 7.1). Thus, the people involved in the study were less costly than was the average experienced within the illustrated homecare re-ablement services.

- the average reported costs for conventional homecare provided to those people involved in the comparison sites was £570 per person for the 8 weeks (see section 8.3).In the report the study team have confirmed that these costs were arrived at by costing the hours delivered by the local hourly rate (see section 8.2). However, it is not clear whether the rate used was the cost per hour paid or cost per contact hour: there being a significant difference between these two within the re-ablement services (see section 9.2.1). It is unlikely that councils will know the actual contact time for externally provided homecare unless they are using some form of electronic monitoring system. However, previous work by CSED showed that even with external providers there is often a significant difference between commissioned hours and actual contact hours[3] and this has implications for the 'real' cost per hour.

- the report refers to Unit Cost data collated and published by PSSRU (see section 7.3) and the research indicates that the average weekly cost of homecare is £232, if provided in-house, and £180 if provided by an external

[3] 'The Elusive Costs of Homecare', by Starfish Consulting UK in 2002_ commissioned by the Greater London ADSS branch Procurement Benchmarking Group

provider. Using this data, an 8 week phase of conventional homecare would cost in the order of £1,440 even if provided externally. This is significantly higher than the £570 reported and subsequently used within the comparative costing work. Thus, it would be important to consider to what extent the cost of conventional homecare reported in this study and used in the comparisons reflects local experience by councils.

The study experienced a very high participant attrition rate, and one far higher than was experienced in the retrospective longitudinal study. This prevented some of the intended analysis being completed because there were insufficient numbers available to support a robust statistical approach. (e.g. understanding the relationship between outcomes and original need, or the extent to which benefits are enhanced by the inclusion of therapists within the homecare re-ablement team)

Hence, it is important to remember that whilst the methodology used within this report is sound, it is essential that councils establish a baseline for their situation and compare their local experience and costs to those in this report before jumping to conclusions.

What are some of the key points to learn

Non-completers

It is already known from other previous work[4] that the number of people who do not complete their phase of homecare re-ablement varies significantly across services. Also, it is known that the largest source of non-completion (but not the only reason) appears to be admission or re-admission to hospital and that this is, unsurprisingly, most common in services that only or principally take referrals from hospital. This report confirms that issue and shows that the rate of admission to hospital during the first 8 week period is higher in referrals from hospital than from the community – irrespective of whether the service is one of re-ablement or conventional homecare.

As illustrated within CSEDs 'Benefits *of Homecare Re-ablement for people at different levels of need*' document, it is important for a service to actively monitor the number of non-completers and to take actions if they rise or are at an unacceptable level.

Cost of the homecare re-ablement phase

The study indicates that the homecare re-ablement phase is likely to cost more than a conventional homecare package of the same duration, and so it is important that a service is operationally performance managed. For instance:

- It is clear from the report that there was a significant range in average contact hours across the 5 re-ablement services, from 36 hrs to 99hrs, over the

[4] 'Benefits of Homecare Re-ablement for people at different levels of need', CSED (Jan 2009)

homecare re-ablement phase. The average duration across all re-ablement participants was 39 days.

- In part, the number of contact hours will be related to the average duration but that is not always the case. Previous work by CSED [5] shows that some services focus a higher number of hours within a shorter duration than is seen in other services.

Therefore, it is critical that services establish robust operational performance management and that actions are taken to appropriately control the number of contact hours whilst monitoring outcomes.

An evaluation completed by Edinburgh Council[6] showed that the cost of frontline care hours during the homecare re-ablement phase were very marginally lower than was experienced in their comparison group. (This is not inconsistent with comments received from some councils but experience seems to vary across England). However, the costs per person were higher in the re-ablement service because it included an average of £88 for OT services and an additional £155 for management and administration. These latter costs were higher because the re-ablement service had a far higher supervisor / enabler ratio than was the case in conventional homecare (ratio 1 co-ordinator: 40 or 50 home helps), reflecting the change in role for these positions. In the homecare re-ablement service the supervisor / co-ordinator is involved in the assessment and ongoing review process.

It is acknowledged that the approach to costing used in the Edinburgh evaluation study will not be consistent with the detailed approach as illustrated in Appendix E of the Prospective Longitudinal Study. However, the Edinburgh report shows (in table 7.2 of that report) that the cost of the 6 week re-ablement phase, including the higher management costs and therapy costs, was £1,050 whilst that for a 6 week conventional homecare service was £810. i.e. the cost differential was not as great as that seen in the Prospective Longitudinal Study.

Other issues will impact on the cost of the phase including the utilisation rates achieved (contact versus non-contact time). The five homecare re-ablement services in the report appear to have a contact ratio of between 45% and 61%. (see tables in Appendix E). We know from work across the country that some have contact ratios as low as 30% as a result of a number of factors, but this is not something that services commonly monitor.

Financial benefits of homecare re-ablement

The report compares the social care costs over the initial 8 week period and then over the 9 to 12 month follow up period and states that on a casemix adjusted basis, the cost of ongoing homecare was approx. 60% lower for those who had undergone

[5] 'Benefits of homecare re-ablement for people at different levels of need', CSED (Jan 2009)

[6] 'Evaluation of City of Edinburgh Council Home Care Re-Ablement Service', Scottish Government Social Research (2009)

a phase of homecare re-ablement than was the case for the comparison group. (see section 8.5). This is consistent with previous work by CSED as shown in various publications.

The report also states that the higher social care costs incurred over the initial 8 week period in these services virtually offset these savings. This conclusion is based on the data referred to in the sections above for which there appear to be some concerns. However, the relevance of this section is that

- councils need to focus on minimising the cost of delivering the homecare re-ablement phase whilst maximising the benefit and duration of benefit gained by the participants.
- the financial benefit is a significant reduction in ongoing care hours, when compared to conventional homecare packages, and so the focus should be on how to get there as cost effectively as possible.
- due to time constraints this study could only follow-up after 9 to 12 months, however, the Retrospective Longitudinal Study[7] completed by SPRU at the University of York, and an independent research team from Acton Shapiro, showed that the benefits of homecare re-ablement, in terms of sustaining changes to homecare packages, lasted for many people for at least two years.

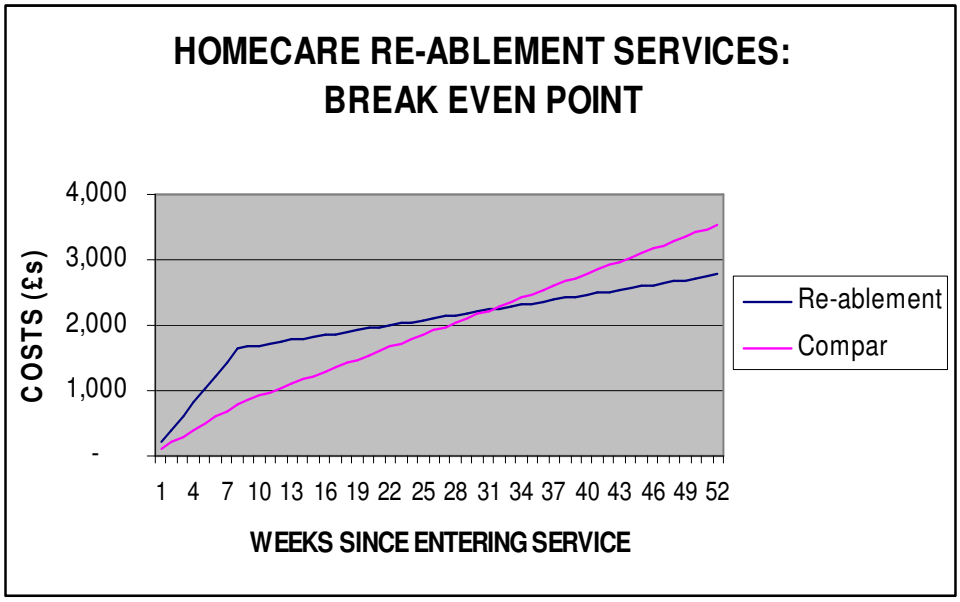
Once again, this focus requires councils to establish a robust operational performance management approach and to take actions based on the outputs.

Break-even point

The report does not draw out the significant break-even point between homecare re-ablement services and conventional homecare.

If one uses the data shown in the report (see table 8.1) based on all 5 homecare re-ablement sites, break-even for social care costs was reached, on average, 32 weeks after a person entered service. (this includes the initial 8 week period in both cases)

[7] 'Retrospective Longitudinal Study', CSED (Nov 2007)



This comparison includes what appears to be a relatively low cost for conventional homecare in the first 8 weeks, and the data for site R 3 where it would appear that break-even is not reached within the first 12 months because of the relatively high costs incurred during the first 8 weeks.

Other issues will also impact on the break-even point including the level of performance achieved by the service. As a short hand for performance, services often refer to the proportion of people who no longer require ongoing care but underlying this is the mix of

- the % of people who require no ongoing care
- the % of people who achieve a reduction in their ongoing care needs, and by how much
- the % of people for whom re-ablement does not result in a reduction is their ongoing care, and
- the % of people whose care package increases despite the phase, and by how much

All of this is needs to be captured within a standard data template

The Prospective Longitudinal Study does not provide any information on the performance levels achieved by each homecare re-ablement site illustrated but it does state that, on average, there was a 60% reduction in ongoing care hours when compared with the comparison sites (see section 8.5). In addition, we know from work with councils that many are achieving relatively low levels of performance. The higher the performance level, the greater the reduction in total hours of support required post the homecare re-ablement phase.

Ripple effect on use of health services

One of the focuses of the study was to understand whether, and if so, to what extent homecare re-ablement services have an impact on other services, including health. Put simply, does it create greater strain or demand by displacing need, is it neutral or does it also result in benefits elsewhere in the overall social care and health support services.

The raw data in the report appears to show that re-ablement services result in a higher proportion of people requiring input from health over the initial 8 week period. However, when adjustments are made to the data to remove the significant difference in the proportion of referrals from hospital or the community, the report states that the demands on health are not statistically significantly different between the homecare re-ablement and conventional services. Therefore, based on this study, homecare re-ablement services do not appear to have any material impact on the needs of people for health support.

To a certain extent, this is not surprising because homecare re-ablement seeks to maximise a person's independence and is not a health model that seeks to support or improve, for instance, long-term chronic conditions. If a person has an underlying medical condition, such as diabetes, COPD, etc. homecare re-ablement helps them to accommodate this and maximise their independence, it does not 'treat' or 'cure' the condition.

Some services have stated, anecdotally, that their homecare re-ablement service helps to prevent admissions to hospital but, to date, we have not seen hard evidence of that. That is not to say that there is no linkage, merely that we have not seen any evidence that draws a clear line of cause and effect. However:

- we are aware from an evaluation completed by one of the early case studies included in CSED's Discussion Document[8] that a hospital discharge support service reduced average lengths of stay in hospital by approximately 2 days
- it seems more likely that Crisis Response / Rapid Response services[9] will have an impact on preventing inappropriate admissions or re-admissions because that is their focus. In some councils, these functions are part of the homecare re-ablement service and so it seems entirely possible that the service appears to prevent admissions – but the service has a combined function. Homecare re-ablement needs the person to be in a reasonably stable medical state if it is to have any real benefits.
- the study does show raw data for the mix of demand for health support during the initial and follow-up stages. It appears that the re-ablement group did use some health services more but it is not clear to what extent this is as a result

[8] 'Homecare Re-ablement Workstream Discussion Document', CSED (Jan 2007)

[9] see CSED's work on Crisis Response services available on their website

of other factors such as a higher proportion of hospital discharges, or better signposting to other community health services through the closer monitoring of improvements over the initial period.

- we also acknowledge that it can be difficult to draw a direct link between improvements in activities of daily living / instrumental activities of daily living, and changes to admission or re-admission rates.

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GPA was founded by Gerald Pilkington who has over 26 years of experience working in health and social care across the independent sector (acute, long-term care and rehabilitation) and NHS.

Gerald was previously Chief Executive of a not-for-profit group that owned care homes and acute hospitals across England and Wales, and managed others under contract. He has also served as a Trustee and non-executive Director of a not-for-profit hospital.

More recently Gerald was the national lead for homecare re-ablement within the Care Services Efficiency Delivery programme at the Department of Health, supporting 152 English local authorities to achieve their efficiency targets within adult social care.

If you would like to discuss how we might be able to help you to deliver operational and financial improvements do contact us.