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Befriending and Re-ablement Service: A better alternative in an age of austerity

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Review

Introduction and Context

In this paper, the authors assess and evaluate the Befriending and Re-ablement Service (BARS) that has been developed on Merseyside, UK, in the Metropolitan Borough of Sefton by Age Concern Liverpool and Sefton (ACLS) and partners. Research was conducted into a range of aspects of BARS via a multi-method approach that included semi-structured and unstructured interviews with stakeholders, street interviews and a cost-benefit analysis of this service. As we shall show below, results were highly promising. But before the main results are presented and discussed it is useful to provide some context in which care provision for older people has become such a major issue across many societies across the globe.

Accordingly, in recent decades it has become clear that longevity is becoming a major feature of most societies worldwide. It would seem that population ageing began in Europe in the late nineteenth century, in France and Sweden (Rowland 2009), but more recently has become associated with the likes of Japan, where 'super-ageing' has become noticeable (Cook and Halsall, 2012) and the world's largest country in terms of population, China, is forecast to have 332 million people aged 65 or over by 2050 (ibid, p. 5). Despite the caveat that persistence and resurgence of so-called 'diseases of poverty', allied to conflict and differential impact of climate change as the twenty first century unfolds, may limit longevity via neo-Malthusian checks (Dummer, Halsall and Cook 2011), nevertheless population ageing is now widespread. The impact of this is high, and many decision-takers have become concerned with the economic cost of supporting an ageing population. However, as Cook and Halsall note:

“While some, perhaps many, older people require support systems to be in place, there are others who are able to maintain independent living for a considerable life span” (Cook and Halsall 2012: 6).

In addition, there are those who could maintain independent living given the right level of support. The research reported below shows clearly that most participants would certainly prefer to live in their own home for as long as possible, recognising that to do so they would need support. One problem with independent living, however, is that without such support, “independent living can mean lonely living, especially when mobility becomes poorer” (ibid, p. 2). And loneliness can be a killer, or at least a

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3 major contributor to ill-health (AgeUK 2013; Alspach 2013; Dickens et al. 2011; Dury 2014; Sample
4 2014; Victor and Bowling 2012), with links to depression, which in turn is connected to over-eating,
5 smoking and increased alcohol intake, while blood pressure for example is higher in lonely members
6 of society (Dury 2014). As the head of the Campaign to End Loneliness has noted:
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10 “(Loneliness)...is as harmful to health as smoking 15 cigarettes a day and increases the risk
11 of conditions such as dementia, high blood pressure and depression” (Alcock Ferguson cited
12 in Murray 2015: 2).
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17 Dury (2014) refers to two models that have been employed to reduce levels of social isolation and
18 loneliness, namely Mentoring and Befriending. The first of these requires a volunteer to mentor an
19 individual on a short-term basis, with all the complexities of interpersonal relations that can occur
20 between two people, possibly with too much directing from the mentor and therefore, with mixed
21 results. The second model is the one that will be analysed here, not least because at present:
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26 “there is little research providing an understanding of what interventions may be most
27 appropriate to reverse the deteriorating effects of social isolation and loneliness” (Dury 2014:
28 127).
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32 One such piece of research is provided by Lester *et al.* (2012). This wide-ranging study of different
33 locations across the UK noted that, increasingly, befriending services are perceived as ‘central to
34 healthy ageing strategies’ (*ibid.*, p. 308). The authors concluded that befriending facilitated a sense of
35 belonging which they termed ‘emotional connectedness’ as well as engagement in the wider social
36 world, ‘social connectedness’. These and other positive benefits of befriending services are echoed
37 by Mulvihill (2011). The study we report below also shows the importance of these features to those
38 who are befriended in Sefton, UK.
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47 In addition, re-ablement is another important feature of our study (Lewin, Alfonso and Alan 2013).
48 Analysis by While (2011) notes that many re-ablement schemes “began as initiatives to manage
49 people being discharged home from hospital or recovering from an illness or accident” and have a
50 range of benefits to clients of such services, enhancing health, independence and confidence. They
51 are also cost effective via prevention of higher health care costs should such services not be available.
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56 In all such initiatives, the broad aim is to enhance active ageing, reducing dependency levels and
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3 enhancing well-being and quality of life. In Denmark, Fersch noted that “the “hottest” re-ablement
4 concept is called “every-day rehabilitation” (Fersch 2015: 126) in which home-care staff (re-) train frail
5 older people. It seems that this re-ablement discourse is driven primarily by economic imperatives,
6 with the downside being that any of those older people who do not conform to the drive for re-
7 ablement, independence and self-help because they believe in their right to service provision can be
8 perceived as being somehow ‘undeserving’ in an echo of the ‘undeserving poor’ idea from Victorian
9 Britain (Durbach 2000).
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18 It is in the light of such issues as those above that we move on to summarise the methodology of the
19 current research project before presenting the main findings of the BARS evaluation. For the sake of
20 practicality, we shall focus particularly on the qualitative interviews with carers and clients, and also
21 the cost-benefit analysis. In the ‘age of austerity’, the latter is of major relevance, especially given the
22 above average cutbacks that are occurring in Sefton and elsewhere, both within the UK and in many
23 other countries such as Greece, Spain, Italy and the US. From the start, it is noted that, as Findlay
24 (2002) suggests, evaluation has been built into the BARS programme from an early stage, with the
25 authors contacted by Age Concern Liverpool (now ACLS) to develop objectives for BARS via a series
26 of evaluations and reports on institutional provision in this area, and of the views of 800 older people
27 across various wards of Liverpool (Barrett and McGoldrick 2013).
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38 From this research, the main aim of BARS is to provide a quality service at fair cost, directed to
39 current and anticipated need of older people and their carers in Sefton. BARS complements and
40 enhances Sefton’s Health and Wellbeing Strategy as shown in Figure 1. Two important elements
41 include ongoing consultation and research to enhance monitoring, assessment and evaluation of
42 good practice, and encourage improvement and innovation, plus collaboration with a range of
43 appropriate organisations including Sefton Council, NHS Sefton and other public sector and voluntary
44 sector organisations
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3 The specific objectives of BARS are to:

- 4 • Support older people to realise their aspirations
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- 6 • Enable older people to live safely and independently in their own homes
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- 8 • Reduce social isolation, loneliness and poverty
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- 10 • Predict and anticipate their problems to prevent later, more costly, interventions
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- 12 • Encourage active ageing and well-being
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- 14 • Support carers.
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18 There are three main directions within the objective. Firstly supporting positive factors in well-being,
19 including mental and physical health, ageing actively, coping well, having strong family and social
20 contacts; and early, preventative interventions, including re-ablement. These interventions can be
21 important in improving quality of life and forestalling later and more costly action. The second direction
22 involves countering negative impacts on older people's well-being. These include poverty,
23 deprivations, ill-health and loneliness; discrimination; poor environments and resources, both in
24 homes and in neighbourhoods. The third direction relates to assessing what ACLS might do further to
25 enhance Sefton older people's well-being, within ACLS and with key public sector and voluntary
26 organisations" (ibid, p. 15).
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36 These aims, objectives and directions are realised via multifaceted training of BROs who are
37 allocated to those who seek, or are referred to BARS. Figure 2 shows the stages in this process. As
38 the diagram illustrates, loneliness, bereavement, ill-health or self-harming, among other reasons, are
39 all triggers for referral. ACLS then discuss the issues with the person concerned and allocate the BRO.
40 A home visit is important, as is the utilisation of the Older Person's Outcomes Star to help pinpoint the
41 needs and aspirations of the older person (Outcomes Star 2010).
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Research instruments

The principal research tools in this investigation involved the use of semi structured and unstructured interviews with key informants in both face to face and telephone settings in 2014. Participants were drawn from across a number of stakeholder groups including service users, local council employees, carers and ACLS representatives. The fieldwork was prefaced by a series of meetings, encounters and regulatory matters such as University Ethics Committee approval and Disclosure and Barring Service (DBS) checks that sought to put the research on a transparent, ethical and agreed footing. The preliminary ground work also sought to reassure potentially vulnerable participants about the research and alleviate fears about house-calls by so-called bogus officials.

From the outset, the researchers were confident that the number and breadth of interviews would provide an informative picture of BARS. The qualitative (open-ended) research design aimed to elicit the unrestrained opinions and perceptions of the participants. Qualitative data, when collected by skilled interviewers, is rich, in-depth and conveys the nuanced thoughts of the interviewee when compared to tick-box categories (Seale 2012; Creswell 2012). At the same time, the researchers considered potential problems with reliable information collection, more particularly if home-based clients receiving services from ACLS might be inhibited in their responses. However assurances of confidentiality were re-affirmed and clients appeared not to be inhibited.

The participants for the qualitative discussion were two groups of twenty-five current BARS clients in their homes and six carers, stratified by biography, residential location and at least two to three months experience of BARS. The Older Person's Outcomes Star [1] (OPOS) results fed into one cluster of discussions whilst Adult Social Care Outcomes Toolkit [2] (ASCOT) variables fed into the other. The home-based, mainly qualitative work, gathered fifty participants' assessment of BARS and included the forty participants initially contacted with a further ten to improve locational representation. Twenty-five interviews drew on the Older Person's Outcomes Star results; and twenty-five on the ASCOT criteria which have similarities with this Star version. Both OPOS and ASCOT concern aspects of well-being. In this way, it was hoped to give pointers to the 'social care-related quality of life' (Malley *et al.* 2012).

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3 The in-home interviews relating to ASCOT included categories of the ASCOT questionnaire (Malley
4 *ibid*), with the addition of 'reducing anxiety' (Caiels *et al.* 2010). The ASCOT categories include:
5 control over daily life; personal cleanliness and comfort; adequacy of food & drink; accommodation
6 cleanliness and comfort; safety; social participation; occupation activity; dignity. An ASCOT self-
7 completed questionnaire would not have been practicable for most participants, partly because of
8 frailty, partly because of resistance to form-filling. The four categories of response proved complex
9 when piloted, so the schedule was adjusted, asking for participants' ratings on a scale of one to ten
10 where ten was excellent. This was a familiar scale from completing OPOS. Ratings were given for
11 the pre-BARS situation and then for participants' present position (typically six-eight weeks later).
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21 OPOS includes seven outcomes: Managing money, staying as well as you can, keeping in touch,
22 feeling positive, being treated with dignity, looking after yourself, and staying safe. The older person is
23 asked to rate their position in each area on a ten-point scale. Point one would signify: 'cause for
24 concern'; ten would signify 'as good as it can be'. So a score of ten on the first outcome (Staying as
25 well as you can) might include, for example, eating a healthy diet, keeping in contact with neighbours,
26 friends and relatives or consulting a GP promptly. The OPOS results had been collected by ACLS
27 from older people who had joined BARS shortly before the current study began. In early 2014, twenty-
28 five clients from this cohort were sampled by the authors on the basis of gender, age band and home
29 location. There were two records for each person. The first (series one) was compiled in the seven to
30 ten days after joining BARS when re-ablement and befriending support was in the early stages. Series
31 two relates to the period after six to twelve weeks of BARS support.
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43 Scores for each variable and individual were entered into the Statistical Package for the Social
44 Sciences (SPSS) with illustration through Excel, and a study was made of the scores. Overall,
45 noticeable, sometimes significant score improvements, were recorded, but there were differences
46 between clients and between variables. Even those in frail health who found 'feeling positive' and
47 'keeping in touch' difficult, felt the service had helped their position to stabilise and, in three cases, it is
48 credible that self-harm and hospitalisations were prevented.
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Research setting: why Sefton?

Independent living was the clear preference of most of the older people contributing to this evaluation, but loneliness and isolation may accompany independence, especially if there are health problems and financial constraints. Fulfilling Lives: Ageing Better (Big Lottery Fund 2013) presents the findings of Big Lottery commissioned work from Local Futures which examines factors in older people's isolation risk in England. Age, living alone, poor health, disability, poverty and deprivations emerge as markers of isolation risk and Sefton is included within the isolation high risk category. There is deep elder poverty and deprivation in Sefton, but the borough's inclusion within high risk may also reflect the extent of risk across Sefton's relatively high proportion of older people. Sefton's demography measured in the numbers and proportions of older people, including the often frail fourth agers (Lloyd *et al.* 2014) are projected to increase above national and Merseyside levels.

It is important to study Sefton because it has the highest proportion of residents aged 65 plus and 75 plus of all the metropolitan boroughs in England. Similarly Sefton's fifty plus population represents 41.5 per cent of its total population which is significantly higher than the average for the North West region and England more generally. Table one below summarises a selection of socio-economic indicators that demonstrate why Sefton provides such a key case study. For example, there are 16,625 claimants of disability living allowance who have been claimants for five years or more which is a rate of 6.1 per cent. This figure is lower than the Merseyside average but higher than the North West average. Poor quality of life through physical illness is known to be closely associated with mental health problems and those with mental health problems are twice as likely as the general population to experience a long term illness or disability. If we look at the percentage of population with a long term limiting illness, Sefton's percentage rate is significantly higher than that for the North West and England (Public Health England 2007). Compared to England more generally, there are also high rates of obesity and alcohol-related conditions, while mirroring the North-South divide nationally, there are also North-South divides in Sefton, but in this case it is reversed, with the northern area typified by Southport, which contains higher proportions of wealthier people, while in the south there is Bootle, which has long had a high concentration of poverty.

<Insert Table 1 about here>

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3 The data in Table 1, however, masks these considerable spatial variations in socio-economic
4 condition within the Sefton area. This is particularly marked between north and central Sefton which
5 has an older population with high life expectancy, low benefit needs, low crime rate and low poverty
6 levels and South Sefton which is typically characterised by a younger population with relatively low life
7 expectancies, poor health, higher crime rates and high benefit need. In all, then, even for an
8 international audience, Sefton is an excellent case study within the UK.
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14 15 16 **Evaluating BARS**

17 The research found that the success of BARS, and of the BROs, is clear and can be illustrated in
18 several ways. For example, a case study of Mr M is given in the case history in Figure 3. This shows,
19 for example, that he was referred by his General Practitioner (GP) to alleviate his symptoms of mental
20 distress. His step-daughter works elsewhere, and his brother died the year before. His 'family' is now
21 the people in the Strand shopping centre, Bootle, who now know him and pet his guide dog. ACLS
22 helped persuade his landlord to replace his boiler to good effect, while he sees his BRO monthly "and
23 knows that he can always phone his BRO". He is so pleased with the turnaround to his life that he
24 now publicises ACLS via leaflet distribution, and is evidently much happier with his life situation.
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34 <Insert Figure 3 about here>
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38 As noted above, the OPOS is a key component of BARS. This covers seven areas, namely:

- 39 1. Managing money
 - 40 2. Staying as well as you can
 - 41 3. Keeping in touch
 - 42 4. Feeling positive
 - 43 5. Being treated with dignity
 - 44 6. Looking after yourself
 - 45 7. Staying safe.
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53 These are evaluated on a ten-point scale (one being cause for concern, through to ten 'as good as it
54 can be') compiled in the first seven to ten days after joining BARS (Series one in Figures 4 to 9) and
55 then after six to twelve weeks of BARS support (Series two in Figures 4 to 9). Only issue five in the
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3 list above is not given here because respondents felt that they had always been treated with dignity
4 by ACLS if not the wider world therefore they assessed this as ten before and after. For the other
5 OPOS areas, however, there was generally a marked improvement in the scores after BARS
6 intervention, except for the expression of gender differences over managing money. The research
7 found that men generally felt they had no problem managing money; to them, the problem was a
8 shortage of money. Women in contrast were most likely to report problems of money management
9 and lack of money. Both sexes mentioned that pensions were not keeping up with increases in the
10 costs of living.
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20 <Insert Figures 4 to 9 about here>
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23 Figure 4 to Figure 9 shows the progress that has been made via BARS. For instance, all participants
24 said that they looked after themselves better since joining BARS. This could mean: *'daily washing'*
25 *'not looking scruffy'*; *'not living in a pigsty'*; *'eating and drinking sensibly'*; *'stirring yourself to: go out /*
26 *'phone family/friend'*; *'keeping your brain going'*. Most people referred to the need to keep sadness
27 and depression at bay. Pride in appearance signalled: *'you're not on the scrapheap yet'*; *'you just feel*
28 *better'*. Importantly, 'morale' was needed to maintain these efforts, the required human contact to
29 energise but family could live at a distance. BROs, befrienders, cleaners, shoppers, social events,
30 exercise represented *'something to look forward to'* and lifted the spirits. *Looking after yourself* was
31 tied in closely to *keeping in touch* with other people. 'Staying safe' (expressed as 'feeling safe in
32 Figure 9) had improved after BARS, and this feeling came about in a range of ways. For example,
33 greater financial security through income maximisation was important, particularly for poorer BARS
34 clients. Checks on properties by ACLS could give *'peace of mind'* and help people to stay safe,
35 especially where some potentially dangerous situations had been noted and corrected. These
36 included defective boilers, inactive smoke alarms, poor fencing and gates, windows and doors which
37 would not lock properly. Sefton Council had been approached by ACLS about possible aids to, for
38 example, safer bathing, and had received support for this.
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3 Then there was the response of the carers who were interviewed. Figure 10 summarises the situation
4 of Mrs X, and the view of her relatives that, despite the sad outcome, ACLS and BARS had been
5 impressive in trying to resolve a difficult situation. Indeed they recommended BARS to a frail
6 neighbour, with the result that he is now 'much happier'. Other carers, too, were impressed. One said
7 that the BARS support '*has eased my mind*', while another noted that her mum's confidence and
8 ability to get back to normal things had improved with this support.
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16 <Insert Figure 10 about here>
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20 These comments and others show the undoubted value of BARS and their BROs. In the past, such
21 glowing feedback would no doubt have been sufficient to ensure that this support system was funded
22 well into the future. Today, however, funding is so tight that a cost-benefit analysis is also required. As
23 noted previously, While (2011) showed that re-ablement was cost effective. The research presented
24 here undertook a detailed cost-benefit analysis of BARS. This provided potential benefits of £689,065
25 in 2012-13 and £3,279,506 in 2013-14 compared to the alternative costs of care provision without
26 BARS. However, given that home owners could contribute substantially to their own care, these
27 figures are reduced to £2,392,239 for 2013-14 (no change for the previous partial year because no
28 home owners were included in that calculation). These sums equate to a benefit ratio of almost 10:1
29 in 2012-13 and 24:1 for 2013-14 and thus have major implications for this type of intervention in other
30 locations, in the UK and beyond. Whilst there is no widely accepted approach to identifying financial
31 values for the benefits pinpointed in this paper, we have followed the Arvidson et al (2014) approach
32 by making clear how the analysis was conducted and opening the debate for more detailed critical
33 thinking.
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47 **Theorisation and policy implications**

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49 The research clearly shows the value of BARS and its BROs. Strengths include, for example, high
50 levels of local knowledge of BARS employees and volunteers. There is also a high level of
51 awareness of ACLS and BARS within the Borough. Over 40 per cent of street interviewees had
52 knowledge of BARS and ACLS services, from personal experience or from friends and family and
53 sixty-three per cent of these people thought that they might use ACLS services as they became
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3 older and more frail. BARS is highly professional and ethical in its staffing, and respondents felt that
4 they could be trusted with confidences, as well as being 'safe' to invite into homes. This
5 professionalism is also evident in high standards and also 'intelligent standardisation'. BARS has
6 established common base lines for key areas such as longitudinal assessment of well-being through
7 OPOS, home environment safety checks with the ACLS Home Safety Inventory and the Anticipating
8 Social Care system (ASC).
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16 The aim of ASC is to try and forestall emergency action by preventing a deteriorating condition
17 becoming a crisis. This way, costly emergency hospital admissions may be averted. BARS staff,
18 including the BROs, have observed the negative impacts on older people, firstly of emergency
19 admission; then discharge without sufficient and fast-moving after-care, and this is a major topic at the
20 time of writing in 2015, with emergency admissions being under pressure of time and costs. They may
21 account for some 60-65 per cent of bed days in England (Purdy 2010), and The National Audit Office
22 (NAO) (2014) points to how hospitals with a higher proportion of emergency admissions are more
23 likely to have poorer financial performance and with admissions that could be avoided in the first
24 place via GP intervention or intervention such as the BARS programme reported here. The Nuffield
25 Trust comments that emergency admission is both costly and 'frequently preventable' (Blunt *et al.*
26 2014). Then, after treatment, delayed discharge following emergency admission can be a further cost,
27 not necessarily warranted, reflecting such factors as a shortage of alternative forms of care (Evans
28 2011; Edwards 2014) and a lack of alignment between hospitals and other health services (NAO
29 2014). There is evidence that greater co-ordination between NHS hospital and primary care; and
30 between social and health care can be more effective means to reducing the need for hospital
31 admissions and stays (Wittenburg *et al.* 2012; Oldham 2013), within a 'dual carriageway' approach
32 (Nuffield Trust 2013).
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49 BARS already offers a form of dual carriageway, with individualised social care packages, drawn up in
50 consultation with older people themselves and carers. These packages form part of an ACLS strategy
51 for avoiding the need for hospital admission as far as possible and supporting older people on
52 discharge. There is evidence that discharge planning with individualised – not routine – packages
53 seem to be effective in assisting recovery and reducing future admissions (Purdy 2010). Re-ablement
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3 and befriending have key roles in the care packages. Both assist the return to independent living and
4 are likely to have positive impacts on the use of services and longer-term cost savings. Re-ablement
5 in particular needs to be linked to mainstream health and social care and supported by professional
6 and cross-agency teams (Glendinning *et al.* 2010; Rabiee and Glendinning 2011). These activities
7 can then be aligned with home care including cleaning, shopping and meals provision.
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14 We can also envisage 'three lane motorways' or expressways as such packages are linked to
15 inclusion of health so that total patient care can be still better streamlined. Technology could also be
16 utilised to offer virtual wards; hospitals at home. The ACLS care packages could be linked with
17 arrangements for health care within homes. In all such development, cost effectiveness will be crucial,
18 and as shown in the previous section, BARS costs are reasonable and offer good value for money in
19 relation to comparators such as those assembled by the Caiels *et al.* (2010), and alternative forms of
20 accommodation, such as care homes in the region. There is the further benefit of BARS that it allows
21 older people the supported living in their homes which is the definite preference of all the older people
22 interviewed in the course of this project. This is linked to the theorisation of 'ageing in place', by
23 Blanchard (2013) for example, in which she presents communitarian alternatives to aging in place,
24 alone, and thus avoid the 'social death' of isolation (p. 10). Similarly Kagan (2014:159) in supporting
25 ageing in place argues that nursing care must be increasingly provided away from the physical
26 settings of the hospital environment. In so doing the individuals care needs are prioritised away from
27 "a world controlled by clinicians". A link can also be made to community health workers and
28 community care givers in South Africa who provide *in-situ* support, counselling and patient advocacy
29 to HIV sufferers (Igumbor *et al.* 2011; Mwai *et al.* 2013; Uys 2002).
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46 As this research has indicated, users of BARS indicated a high level of satisfaction with the core
47 services of re-ablement and befriending, and with complementary home care services organised by
48 BARS. Further, as far as carers were concerned, BARS services were regarded as 'a boon'; 'allow
49 me to sleep more comfortably'; 'helpful to the whole family, not just to dad'; 'mean I can work'. The
50 latter point about continued employability has important implications for local authorities who, as King
51 (2013) notes, have a duty to provide services to carers whose employment is at risk. There is also a
52 link to theorisation of social capital, in which BARS contributes to the social capital of the
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3 neighbourhood or locality (Cook, Halsall and Wankhade 2015) and thus, as Cramm, van Dijk and
4 Nieboer (2013) suggest, acts as a 'buffer' from the adverse effects of being, single and poor, and also
5 aids the wellbeing of older adults. Similarly, the positive effects of neighbourhood social capital was
6 shown in the Netherlands by Mohner, Volker, Flap, Subramanian and Groenewegen (2013, p. 33)
7 who reviewed 32 studies which showed that "people who live in neighbourhoods with more social
8 capital are healthier".
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16 In the aftermath of the Global Financial Crisis which has affected most countries across the world, the
17 indications are that BARS will continue to operate within a context of above national average resource
18 cuts and slowdowns in support for the social and health care upon which older people depend. Three
19 major trends are converging, firstly funding reduction of 8.5 per cent since 2009/10 in older people's
20 social care (Audit Commission 2013) with local authority budgets continuing to be squeezed, a
21 position which is projected to worsen. Secondly, a slowdown in NHS funding has occurred. Kings
22 Fund estimates suggest that, by 2021, NHS spending as a proportion of GDP, will have fallen to the
23 equivalent of 2003 levels (Appleby, Galea and Murray 2014). The newly elected Conservative
24 Government of 2015 promised an extra £8 billion per annum for the NHS but this will have to be
25 funded somehow, most likely from the welfare budget which could affect the social care dimension of
26 provision. The third trend relates to Sefton's demography. The numbers and proportions of older
27 people, including the often frail 'fourth agers' (Lloyd *et al.* 2014) are projected to increase above
28 national and Merseyside levels.
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42 In such adverse circumstances there will be a need to 'work smarter'. There comes a point when
43 'work smarter' is a cynical response to under-resource, however it appears than in Sefton and ACLS,
44 working 'smarter' is already in progress and could be taken further. The Independent Commission on
45 the Future of Health and Social Care in England (Kings Fund 2014) proposed a number of measures
46 to work as effectively as possible in order to make best use of scarce resources. These include
47 establishing a single health and social care system to facilitate entitlements, funding, the
48 commissioning of care and its organisation; and ensuring NHS money is spent on what is cost-
49 effective. The Nuffield Trust (2013) makes a similar point in proposing a 'dual carriageway approach'
50 whereby social and health service provisions 'at the level of the user and carer' through the use of
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3 personal health and social care budgets. These, it is argued, may offer not only greater efficiencies
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5 resulting from co-ordination, but greater effectiveness, also.
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9 On the evidence of this research, BARS facilitates older people's well-being by offering well-
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11 commended support services. Quality control within BARS is being assisted by a range of measures
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13 that include weekly case reviews which examine, in-depth, the established and emerging needs and
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15 aspirations of BARS clients and carers; regular data entry and monitoring; keeping ASC up-to- date
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17 and responsive; plus staff and befriender updates in changing circumstances and policy in Sefton
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19 and nationally. There is also completion of required training, for staff and befrienders, in a wide range
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21 of service areas as well as a focus on health and safety and environmental issues for ACLS staff,
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23 befrienders and visitors. The adherences to these quality controls and standards have resulted in high
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25 satisfaction levels amongst older people, as the above results indicate.
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28 The BARS research has shown that it has six main strengths. Through local knowledge and
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30 awareness, BARS employees and volunteers have been Sefton residents for many years. ACLS and
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32 BARS appear highly visible within Sefton. In a stratified random sample of a hundred over fifties in
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34 Sefton, ninety-eight per cent had heard of ACLS. Over forty had knowledge of BARS and ACLS
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36 services, from personal experience or from friends and family. Sixty per cent thought that they might
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38 use ACLS services as they themselves became older and more frail. This contributes to higher social
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40 capital across the Borough, in a virtuous cycle. Secondly, BARS has demonstrated professionalism
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42 and ethics through the BROs and the volunteer befrienders who are considered 'trustworthy' by
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44 carers and clients which is a quality of tantamount importance when inviting people into your home.
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46 Some analysts, such as Schmeets and te Riele (2014) in the Netherlands, are concerned that trust
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48 and social cohesion is far less than it used to be in the past, and although they could find no empirical
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50 evidence for this, they did discover large gaps between different groups in Dutch society, such as
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52 between those with higher and lower levels of education, so a project such as BARS can contribute to
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54 the cohesiveness of society at the micro-scale. The third strength of BARS relates to high user
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56 satisfaction levels with the core services of re-ablement and befriending, and with complementary
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58 home care services organised by BARS. Improvements in key well-being criteria, following ASCOT,
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60 were noted within six to eight weeks of joining BARS.

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5 The fourth main strength of BARS relates to the support it provides for carers. This was demonstrated
6 to be valuable in many ways by supporting their well-being and ability to cope with the demands of
7 caring, demands of their own lives and the ability to remain in employment. Fifthly, BARS has put in
8 place enables improvisation and standardisation of common measures, practices and base lines for
9 longitudinal assessment of well-being (through OPOS); the ACLS Home Safety Inventory and ASC.
10 This good practice needs to be built upon and replicated. The sixth and final key strength of BARS
11 relates to reducing emergency hospital admissions and re-admissions; and delayed discharges. The
12 aims of ASC are to forestall emergency action by preventing a deteriorating condition becoming an
13 emergency, reduce the high costs of emergency hospital admission and reduce stress to older people.
14 BARS staff have observed the negative impact on older people of emergency admission, then
15 discharge without sufficient and fast-moving after-care provision. Evidence suggests they have had a
16 direct impact on this area via preventative interventions.
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31 From the above discussion, we recommend the following policy directions. Firstly there is scope for an
32 expansion of the geographical reach of BARS. Re-ablement, befriending and complementary services
33 should be further expanded across Sefton. Hopefully this research can also inform a wider
34 geographical reach to other localities. Secondly, re-ablement is a particularly clear area for expansion.
35 Interviews clearly indicated the benefits of re-ablement in sustaining and improving older people's
36 capacity for independent living. Value for money is achieved by independent living over care home
37 alternatives. Consideration should be given to the extension of light-touch re-ablement beyond six
38 weeks for the frail elderly, on GP recommendation. A third possibility is to develop Individual care
39 packages. ACLS should continue to tailor social and home care packages to individual need. It is likely
40 that more social, home and health care will be provided in older people's homes with consequent
41 efficiencies of time and cost. It would also be useful to have the addition of NHS care within packages
42 as needed. This would provide a holistic and efficient service.
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55 But above all else, within a context of decreased funding nationally and internationally, there is a need
56 for a longer-term funding period for BARS. A minimum three-year period, with potential extension to a
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3 five-year period, subject to assessment, would mean cost and time efficiencies. One year contracts
4 for complex professional work are not cost-effective. There are cost efficiencies in not having the
5 annual issue/retraction of redundancy notices to experienced personnel. There is the risk of losing
6 competent, trained staff. Volunteer training and recruitment can be planned more strategically.
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8 Experienced staff, working in established teams, provides more value for money than situations of
9 frequent staff turn-over and short time horizons. ACLS hopes to consider a range of initiatives to
10 enhance staff durability and continuity.
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18 Development of these and other related policies, we believe, can help improve the situation of older
19 people in Sefton and beyond. In a time of austerity it is vitally important that such alternative models
20 of support are introduced, tested and evaluated, as potential solutions to a continued restriction of
21 funding in the public sector in the UK and internationally (Kime, Cattan and Bagnall 2012). But it is not
22 just an economic imperative that drives BARS; it is clear that social imperatives also warrant such an
23 approach as can be seen in the recent Care Act (2014) which emphasises person-centred care and
24 'outcomes-focused services...that aim to achieve the priorities that service users themselves identify
25 as important" (Tiplady and Cook 2014: 406). At the time of writing, in late 2015, there is growing
26 evidence of greater awareness of the need to have greater integration between health and social care,
27 for instance in the plans for devolved funding to the Northern Powerhouse (The Economist 2015), not
28 least to minimise hospital admissions in the first place and to avoid 'bed blocking' within hospitals for
29 those who cannot receive social support once they are discharged. A project such as BARS is, we
30 believe, highly worthy of being a model for other such schemes regionally, nationally and even
31 internationally. We endorse this initiative as an example of social justice in action, aiding the growth of
32 social capital and ensuring safe and secure ageing in place to facilitate living alone with support for
33 those who can and wish to do so.
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Notes

1. Older Person's Outcomes Star (OPOS) was originally developed and disseminated by Triangle Consulting Social Enterprise Ltd.
2. Adult Social Care Outcomes Toolkit (ASCOT) is a multi-faceted preference weighted measure of social care-related quality of life (Smith 2014).

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Statement of Ethics

The research approach and work with human subjects in this study was cleared by the University Ethics Committee.

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46 projecting expenditure to 2022 on social care and continuing health care for England's older
47 population", Nuffield Trust with LSE and PSSRU, available at:
48 <http://www.nuffieldtrust.org.uk/publications/care-for-older-people-projected-expenditure-2022>
49 (accessed 12 July 2015).
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Table 1. Sefton socio-economic and health profile

Profile indicators	Sefton	Merseyside	North West	England & Wales/ England
Older people (65+ years)¹	57,011 (20.8%)	237,857 (17.2%)	1,171,155 (16.6%)	9,200,000 (16%)
Percentage of area within most deprived 0-20 per cent nationally²	23.7	-	31.8	19.8
Total number and (percentage) claiming Employment Support Allowance/ Incapacity Benefits³	14,870 (8.6)	-	379,415 (5.4)	(6.6)
Total number and (percentage) claiming Disability Living Allowance for five or more years⁴	16,625 (6.1)	96,720 (7)	359,620 (5.1)	-
Lifestyle behaviour: percentage smoking⁵	22.0	29.0	25.0	-
Lifestyle behaviour: percentage categorised obese⁶	56.0	53.0	24.7	-
Rate of hospital admissions for alcohol related conditions, per 1000 population⁷	30.1	-	28.3	23.0
Percentage of population with limiting long term illness⁸	21.0	-	19.6	16.9

Notes:

1. ONS 2012.
2. Communities and local Government, IMD 2010.
3. Merseyside Fire and Rescue Service 2012.
4. Merseyside Fire and Rescue Service 2012.
5. NHS 2012-13.
6. NHS 2012-13.
7. Local Alcohol Profiles England 2011-12.
8. NHS 2012-13.

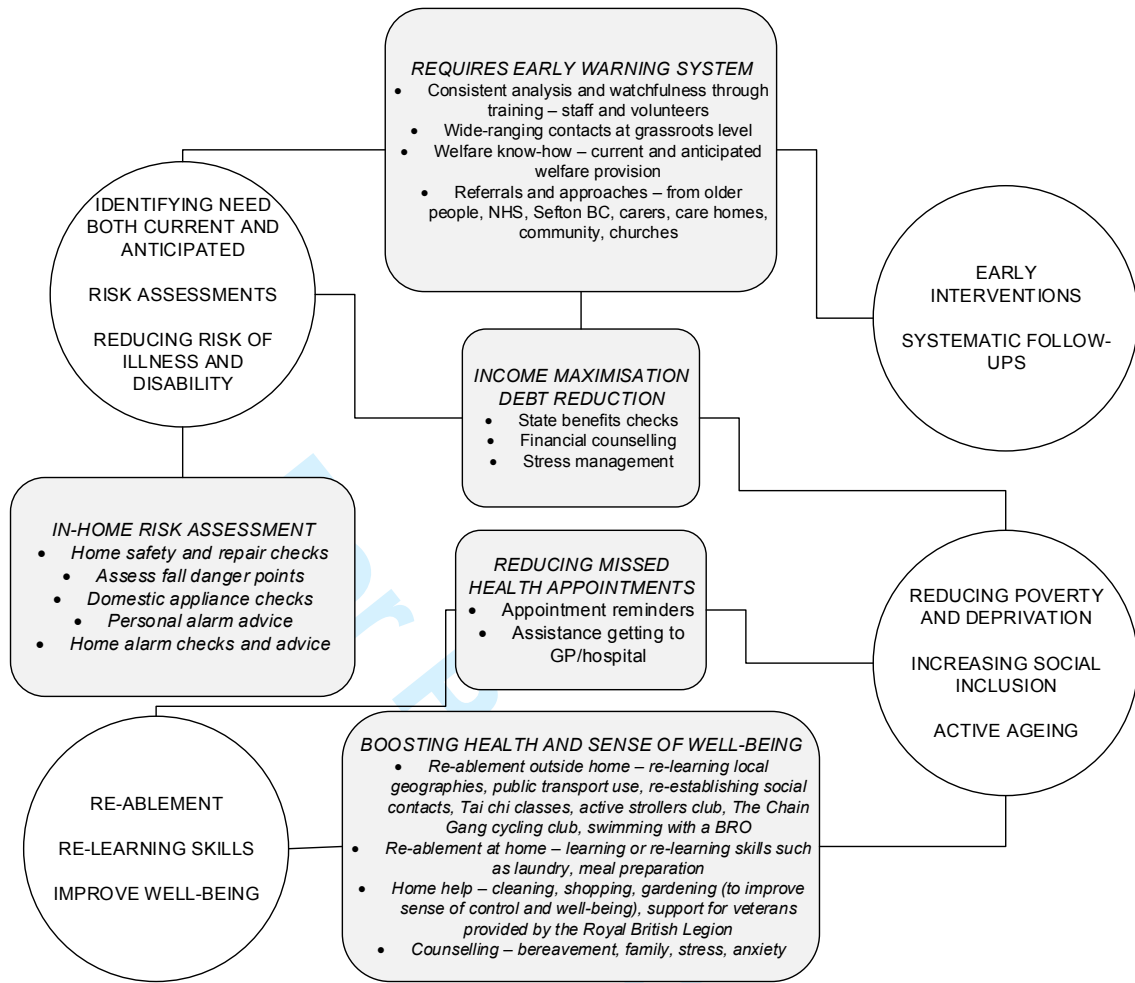


Figure 1. BARS contribution to Sefton's Health and Wellbeing Strategy and cost efficiencies

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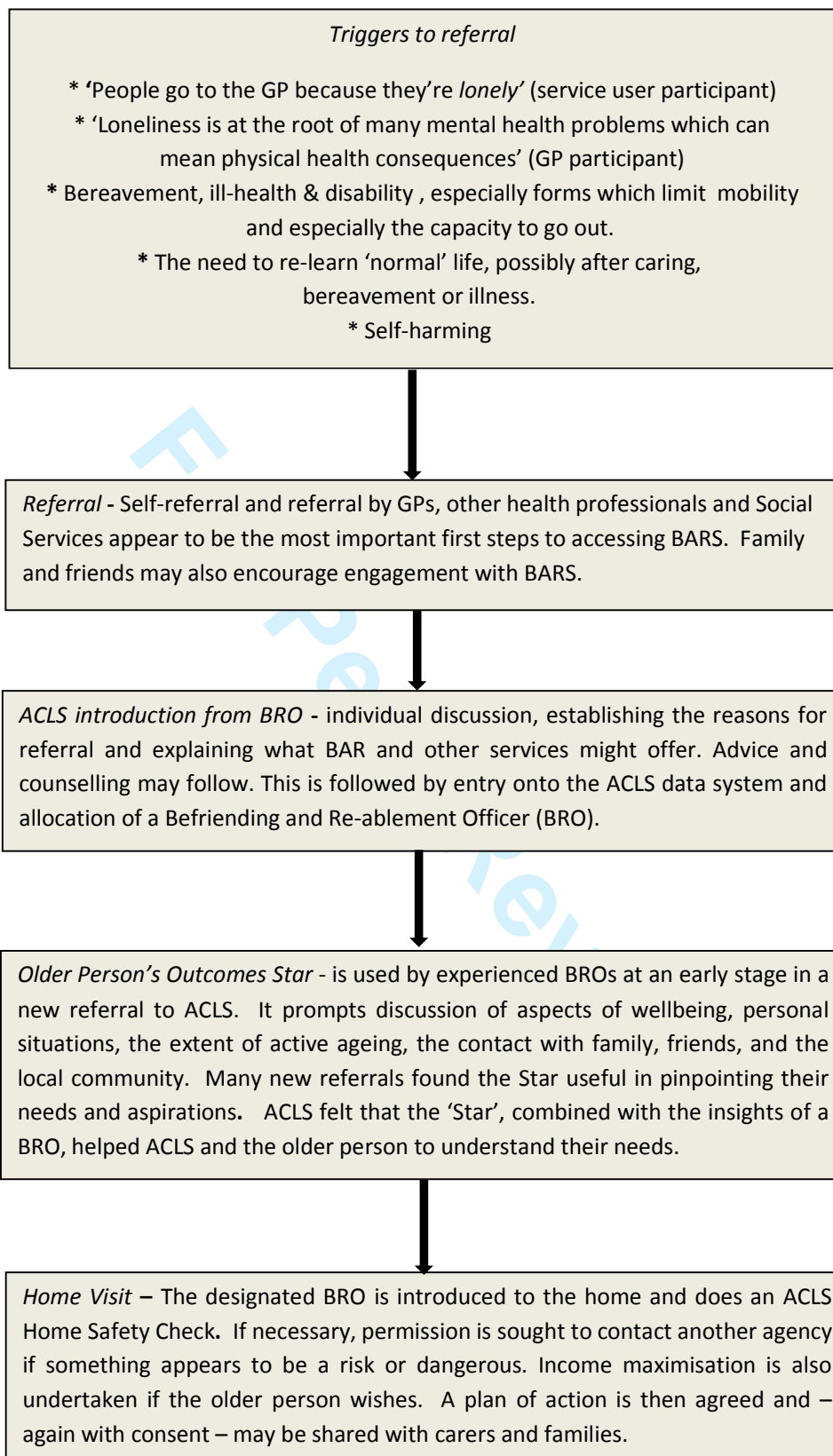


Figure 2. Stages in joining the Befriending and Re-ablement Service.

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4 Mr M has lost his partner and lives in South Sefton in social housing. He has multiple health
5 problems, including depression and anxiety, osteoarthritis and sight degeneration. He likes to walk
6 as far as he can, but he has to keep stopping because of breathlessness. His GP suggested he
7 should contact ACLS to at least help to alleviate symptoms of mental distress.

8
9 He has a step-daughter of whom he is very fond and sees occasionally, but she works away. He
10 has no other family support following the death of his brother last year: 'my family lives in the
11 Strand (a major shopping mall in Bootle). He goes there every day with his guide dog 'for a bit of
12 company – they all know me now and stop to pet my dog'.

13
14 Following the 6-8 weekly sessions from BARS, he has seen one of the Befriending and Re-
15 ablement Officers monthly and knows that he can always phone 'his BRO'.

16
17 ACLS did a home check, which resulted in a projecting heater being moved so that, with his poor
18 sight, he would not keep bumping into it. The landlord was also persuaded to install a new boiler:
19 'the old one didn't give out much heat, so it could be freezing'. Mr M was under-claiming benefits.

20
21 One of his missions in life is to advertise ACLS and its services by taking leaflets to public places.
22 He now feels that he is lucky to have a room with a view (the end of an Edwardian period house
23 and a little tree) and has 'someone to call on'.
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Figure 3. *'The partner goes, but the talk never goes – it is a terrible loss'*

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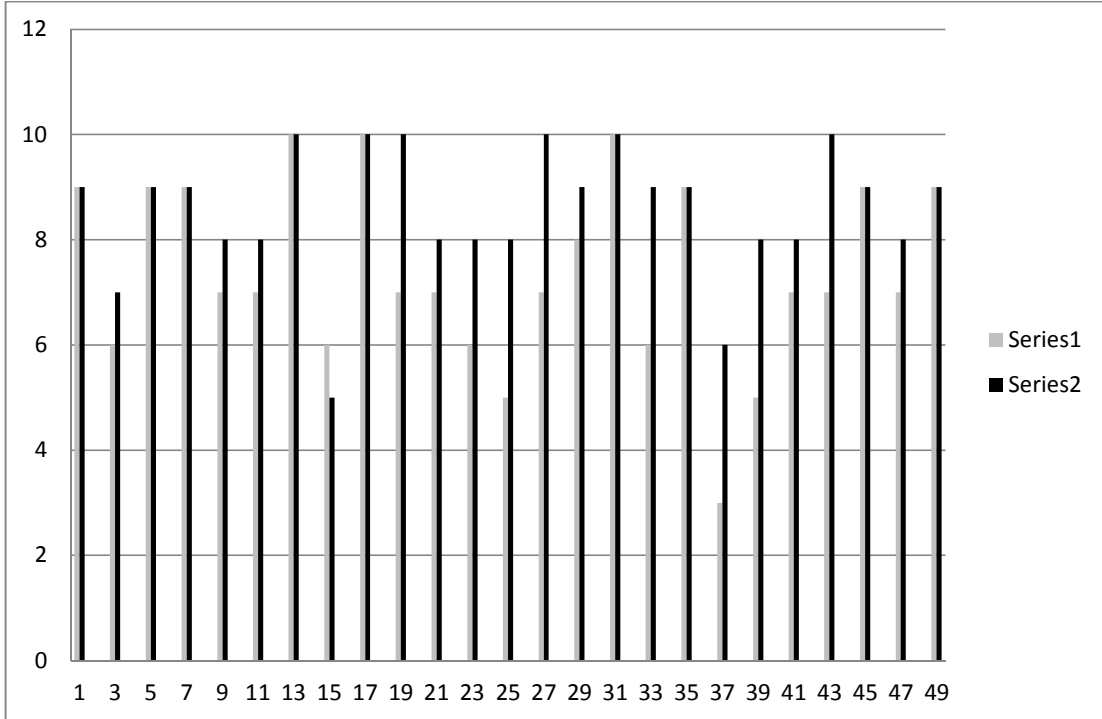


Figure 4. Managing money

Peer Review

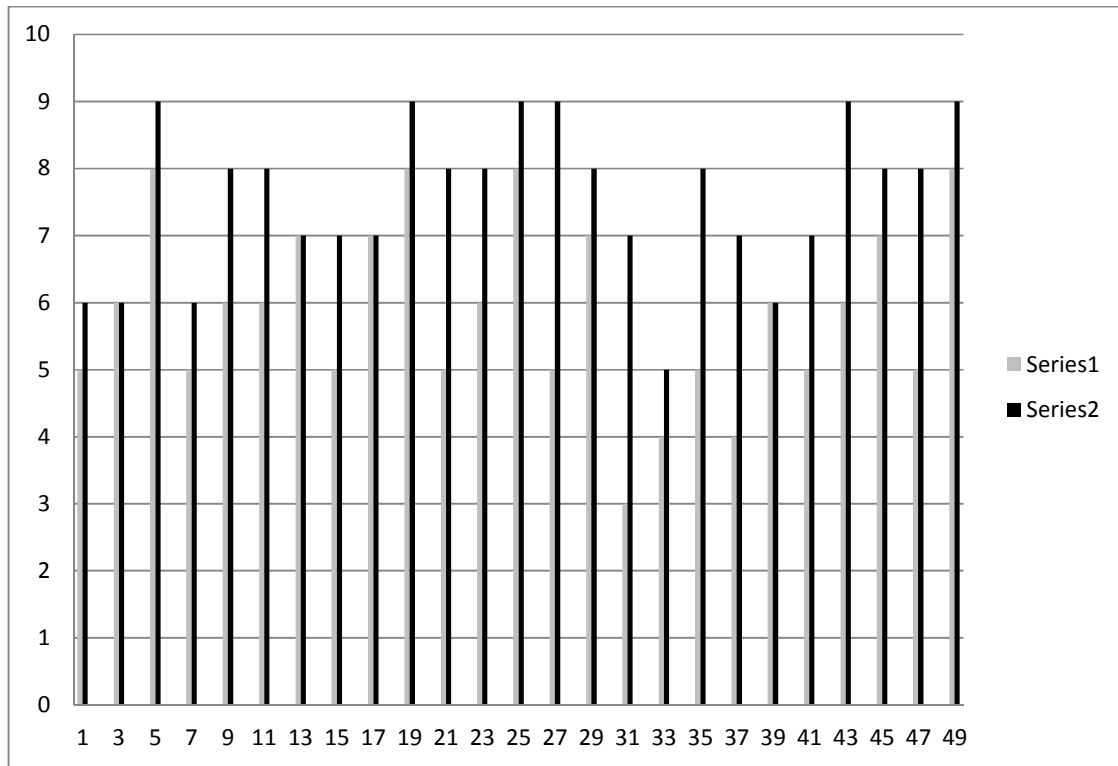


Figure 5. Staying as well you can

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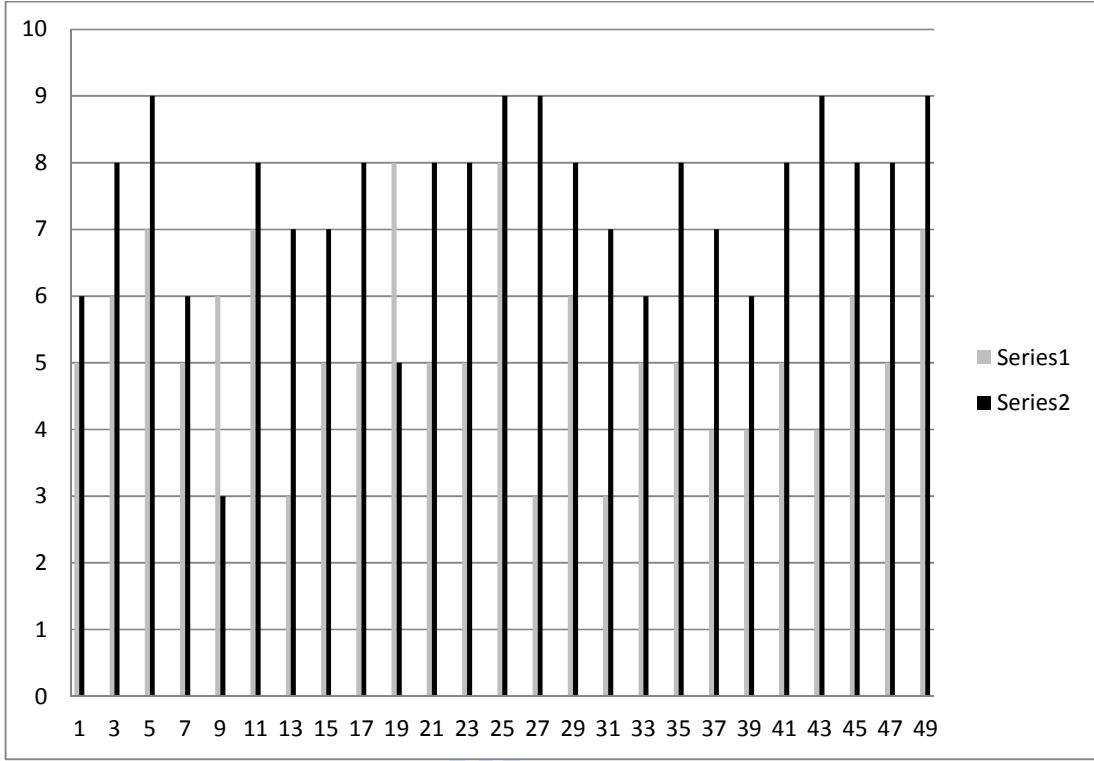


Figure 6. Keeping in touch

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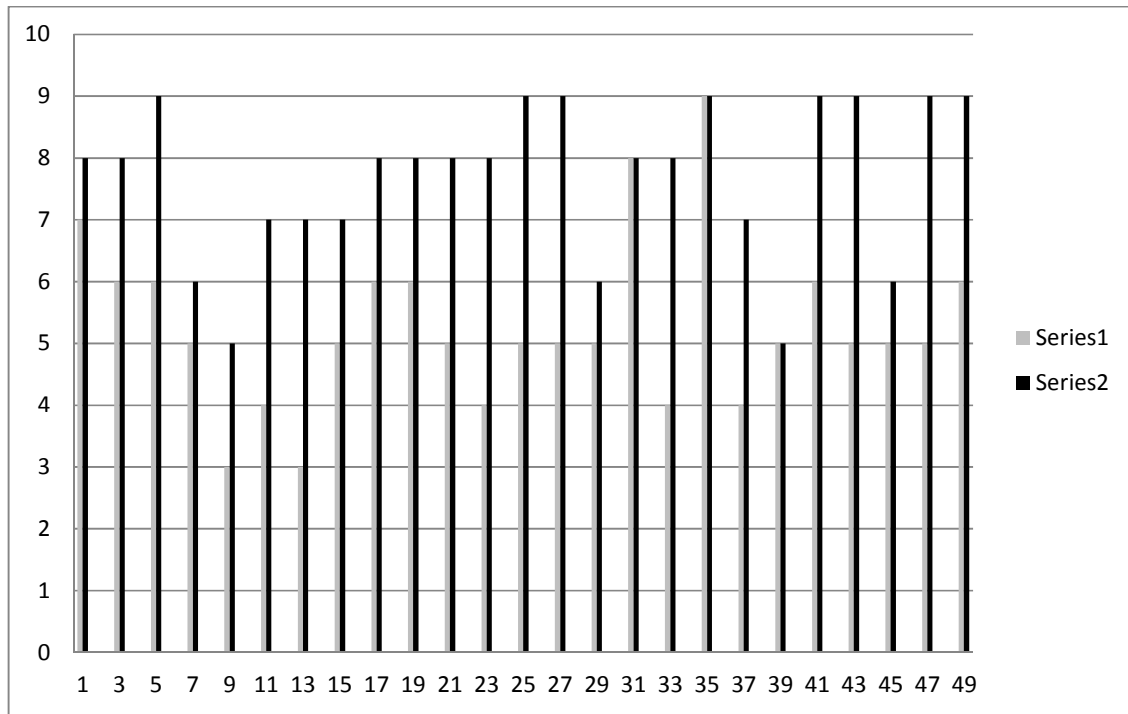


Figure 7. Feeling positive

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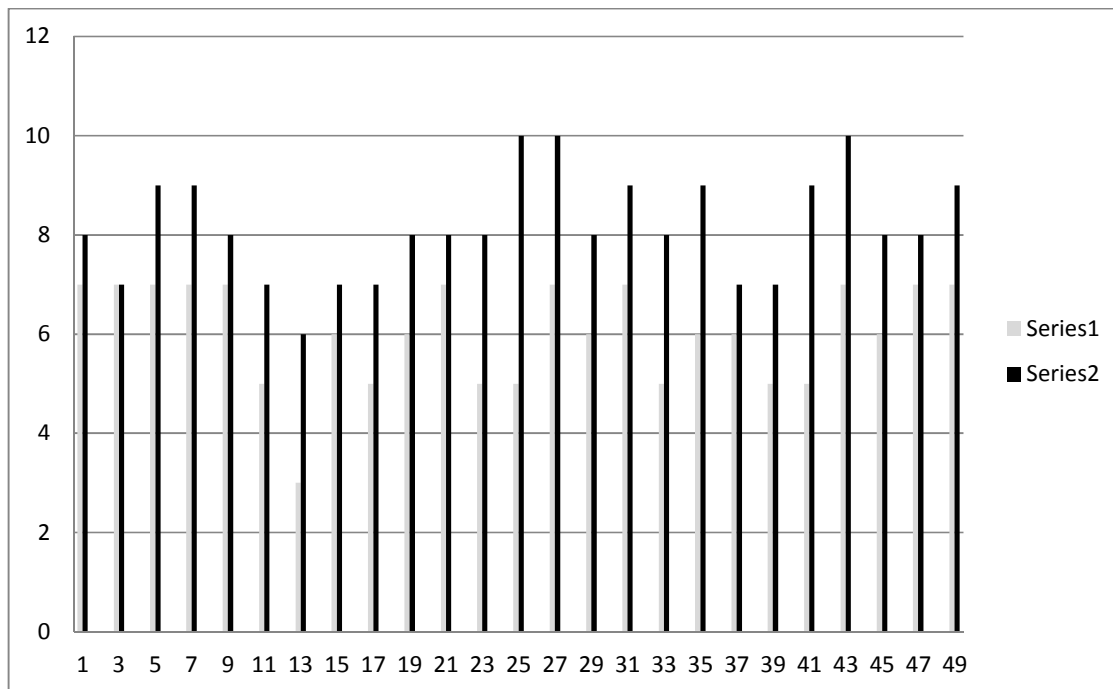


Figure 8. Looking after yourself

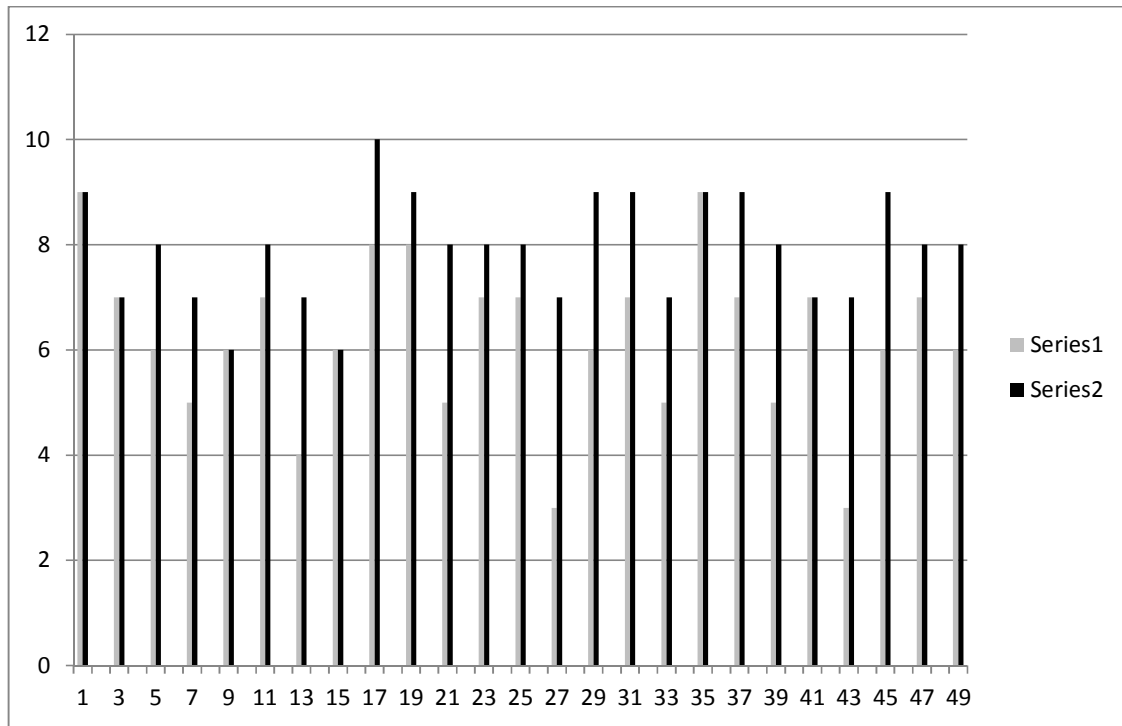


Figure 9. Feeling safe

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5 Mrs X is a highly intelligent person who held a responsible job during her working life. Work was
6 combined with raising a family, supporting her husband in his work, and engaging in community
7 activity. Into her 70s, the family noticed changes: forgetfulness, being unable quite to remember
8 the route home, confusing paid bills with outstanding bills. The family discreetly took over
9 operations she was finding difficult. Thinking this was 'simply' ageing, Mrs X agreed to move into an
10 easily managed apartment as she wished to live independently. The family approached ACLS with
11 a view to getting BARS support.

12 Referral was complicated by Mrs X's willingness / unwillingness to discuss the need for support,
13 losing / hiding information about various sources of support and backtracking on meeting
14 arrangements. The carer described the situation as 'totally chaotic'. With reluctance, Mrs X agreed
15 to discuss matters with her GP. The family wondered if she might have had a transient ischaemic
16 attack (TIA). After investigations, her GP diagnosed Alzheimer's disease – and commented that
17 Mrs X might manage independently for some time, with BARS support. ACLS was approached
18 again and options were talked through. Mrs X then had a stroke and needed nursing care.

19 Her relatives were impressed with the ACLS support, however, and respected the calm way that
20 ACLS had responded to a difficult situation. The family suggested to a neighbour who was getting
21 frail that he should join BARS and he is reportedly 'much happier'.
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27 Figure 10. A carer's perspective
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