



Reablement: a guide for frontline staff

What is this learning guide?

This guide gives an introduction to reablement. Over the past decade, there have been increasing numbers of reablement services developed by local authorities, often in partnership with the NHS. More and more evidence is showing that reablement can lead to major improvements in the well-being and independence of vulnerable people. However, not all areas yet have reablement services, and reablement services are offered to different groups of people, and work in different ways, in different parts of the country. Many people – including staff, potential service users, and the general public – are still confused about what the term ‘reablement’ actually means.

This guide explains what reablement is all about, what is different about reablement, who provides and funds these services, and the kinds of people who use reablement services, and who work in them.

This guide was commissioned by the [North East regional Improvement and Efficiency Partnership](#) (NE IEP), as part of its Excellence in Reablement project. The NE IEP has been working with the 12 local authority areas of the North East of England to support them as they develop and extend their reablement services. It was funded by the Department of Health’s [Care Services Efficiency Delivery](#) programme (CSED) and developed by the [Office for Public Management](#) (OPM).

The Reablement for All logo was developed for a regional conference in December 2009, as part of the Excellence in Reablement project. The logo reflects the commitment of local authorities and the NHS in the North East to make reablement services available, not only to older people, but to all who could benefit.

The guide can be read on-screen, or its pages can be printed if you prefer a hard copy.

On-screen, underlined text indicates a hyperlink that will take you either to another part of this guide or to an external website.

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Who is this learning guide for?

The guide has been produced for frontline staff in social care and health in the North East of England. It is designed to help staff working with people who may get support through reablement, now or in the future. So you may find this guide especially helpful if you work with: older people; people with a physical or sensory disability; people with a learning disability; people with dementia; people being discharged from hospital; people at risk of needing to go into a hospital or care home; or people living in sheltered housing, extra care or a care home.

However, we hope it will be useful to anyone who wants to find out more about reablement.

What is covered in this learning guide?

The learning guide is split into this introduction and seven other sections, and covers:

- an explanation of what reablement is, who reablement is for, and who provides it, and the policy context
- the different kinds of reablement service
- the benefits of reablement to users and clients, to staff, and to local authorities and the NHS
- what it is like to work in reablement
- what it is like to go through reablement
- examples of access, referral, assessment and reassessment processes, reablement support plans, the kinds of information reablement services should collect, reablement services in the North East, and reablement services in other parts of England
- where you can find out more about reablement.

- Introduction • [The definition and ethos of reablement](#) • [How is reablement different from other services?](#) • [Who is reablement for?](#)
- [Policy context and links with personalisation](#)

What is reablement?

Introduction

'We must place renewed emphasis on keeping people as independent as possible, for as long as they feel able, not least by providing earlier support. People need to feel help is there as soon as problems occur... We have to maximise the potential of reablement, telecare and other innovations which can dramatically improve people's lives while also being highly efficient. Some local authorities have picked up this challenge, others have not. We need to accelerate this change so that these services and this approach is the norm.'

Rt Hon Andrew Lansley MP, Secretary of State for Health, speech on 'The Principles of Social Care Reform', July 2010

Support for reablement was given strong backing by the previous government and has continued to be a policy priority under the Coalition government.

Reablement services have been set up by local authorities in many parts of the country. The [Care Services Efficiency Delivery](#) programme (CSED) estimates that by March 2010 over 80 per cent of English local authorities had some form of reablement service, with the remainder all in the process of developing a service. Although led by adult social services, they are often developed in partnership with the NHS, and sometimes other organisations including charities and the independent sector.

Some reablement services have developed out of traditional home care (domiciliary care) services, whilst others have evolved from hospital discharge or intermediate care schemes. Some work with a very wide range of people (for example, everyone who has been referred to the local authority for support from adult social services), whereas others focus on a very specific client group (for example, older people being discharged from a particular hospital, or people



diagnosed with dementia). Reablement support can take place in a variety of places, and be delivered by staff from a range of professional backgrounds.

Despite these differences, what all reablement services have in common is a shared ethos, of working proactively with their users over a defined period of time, to achieve goals set by the user and reablement team together, and with the overall aim of maximising the user's independence, choice and quality of life, and reducing their need for support in future.

The definition and ethos of reablement

There is no single, straightforward definition of 'reablement'. Reablement has been described and defined in many different ways. For example:

'Reablement can be described as an 'approach' or a 'philosophy' within home care services – one which aims to help people 'do things for themselves', rather than 'having things done for them'.'

(Care Services Efficiency Delivery programme (CSED), Homecare Reablement, Prospective Longitudinal Study, Interim Report 1 of 2, CSED, Department of Health, Oct 2009)

'Services for people with poor physical or mental health to help them accommodate their illness by learning or relearning the skills necessary for daily living.'

(Care Services Efficiency Delivery programme (CSED), Department of Health)

'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.'

(Reablement for All Best Practice Framework, report by the Social Work Co-operative for the North East regional Improvement and Efficiency Partnership, 2010)

'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 Local Health Board, Wales)

Even though there is no single definition, there are several essential elements that are defining features any reablement service.

- Reablement is about helping people to do things for themselves, rather than doing things to or doing things for people.
- Reablement is time-limited; the maximum time that the user can receive reablement support is decided at the start. In most reablement services, this is for six or eight weeks.
- Reablement is outcome-focused: the overall goal is to help people back into their own home or community.
- Reablement involves setting and working towards specific goals agreed between the service user and the reablement team.
- Reablement is a very personalised approach – the kinds of support given are tailored to the individual user's specific goals and needs.
- Reablement often involves providing intensive support to people.
- Reablement treats assessment as something that is dynamic not static. This approach means that you cannot decide a user's care or support package on the basis of a single, one-off assessment, instead you need to observe the user over a defined period of time, during which their needs and abilities may well change, with a reassessment at the end of the period of reablement.
- Reablement approaches assume that something should change by the end of the reablement intervention; you are working towards positive change.
- Reablement builds on what people currently can do, and supports them to regain skills to increase their confidence and independence.
- Reablement may also involve ensuring people are provided with appropriate equipment and/or assistive technology, and understand how to use it.
- Reablement aims to maximise users' long-term independence, choice and quality of life.
- Reablement aims to reduce or minimise the need for ongoing support after the period of reablement.

Examples of reablement support

The kinds of support given through reablement services are typically more varied than traditional home care support, and are tailored to the individual user's needs, goals and preferences. They can include:

- personal care, for example help with washing and dressing
- practical support, for example help with preparing meals
- domestic support, for example help with making beds, washing dishes
- prompting for medication (reminding people to take medication; checking that they've taken it)
- assessing risk and ensuring a safe home environment, for example in relation to layout or equipment
- obtaining equipment for users, such as grab rails, walkers, trolleys
- teaching people exercises to help regain mobility, strength and confidence, and supporting and encouraging them to practise the exercises
- taking people out for a walk or to go shopping
- problem-solving to support independence; finding practical solutions
- supporting users to increase social contact, for example referring or informing users about lunch clubs, day centres, social activities
- advising on reducing the risk of falls
- helping people to budget and manage their money
- providing information and signposting for example to services such as Dial-a-Ride.

How is reablement different from other services?

If you work in home care or intermediate care, or in other services providing care and support to vulnerable people, you may think that reablement does not sound very different from what you do now. In many ways, this is true. Reablement has both many similarities, and some differences, compared with other services such as intermediate care, home care, prevention services, and rehabilitation.

However, one of the biggest differences is in the culture and ethos of reablement services – reablement services are very focused on improving people's health, well-being, confidence and independence – their whole aim is to help people regain the ability to live as independently as possible. Everyone involved in reablement services needs to be supporting and motivating users to achieve these changes, every time they work with them.

Differences and similarities with intermediate care

'Intermediate care' is a term covering a variety of services that support patients in the transition from hospital to home, or from depending on medical care to no longer needing such care. The aim of intermediate care is to reduce the length of hospital stays, and/or to prevent the need for admission to hospital or to long-term residential care, by providing alternative support for a limited period of time.

Reablement is not the same as intermediate care. Intermediate care patients have a defined clinical need, and intermediate care services are clinician-led. In contrast, reablement service users have a social care need (which may result from a clinical need) and reablement services are not clinician-led, and tend to adopt a social model of support.

Reablement users can include people who have been through a period of intermediate care. However, reablement users also include those who have not been in hospital, and are not at high risk of admission to hospital or a care home, but who need support to continue living independently. Many people who would not be eligible for intermediate care may be able to access reablement.

Intermediate care is free for the first six weeks, whereas some reablement services are free and others charged for. In some areas, reablement services are provided as part of the broader intermediate care service, so reablement is viewed as one element of intermediate care. However, in other areas, the two services are seen as separate and distinct.

Differences and similarities with home care (domiciliary care)

Many reablement services have been developed out of traditional home care, and are delivered primarily by home care staff. However, reablement is much less task-based than traditional home care. With reablement, the aim is to help the user regain skills and abilities to maintain their independence, rather than simply to ensure that the defined task has been completed to a high standard and to the user's satisfaction.

Where a traditional home care approach might be to wash and dress a user, prepare a meal for them, and then assist them to eat it, in contrast a reablement approach might involve providing moral support, encouragement, reassurance and some physical assistance to a frail user to wash and dress themselves, to prepare their own meal and eat it. Reablement recognises that many users' needs and abilities will change day-to-day, and of course some assistance will often be necessary. However, the overall aim of reablement is to help the user practise and regain skills.

This different approach means that reablement often requires more intensive support at the beginning – such as more care hours, and input from a greater range of professionals – compared to traditional home care. It also means that staff will need to provide skilled observations of any changes in the user's condition and abilities, and be able to record these effectively in the support plan. Staff need to draw on a wider range of skills than are needed in traditional home care, including being able to motivate and encourage users to try things and in some cases, to take risks.

Differences and similarities with prevention services

'Prevention services' is an umbrella term, covering a very wide range of services aimed at supporting people's health, well-being and independence. Prevention services include screening services (for example screening for breast, cervical and bowel cancer), vaccinations and immunisations (for example flu vaccinations for older people, and childhood immunisations), and the promotion of healthy lifestyles (for example health education about exercise, nutrition, and how to achieve and maintain a healthy weight). Prevention services do not always require users to have a formal referral or assessment.

Reablement can be seen as one element of prevention services, but prevention is a much broader term, and covers a much wider range of services than just reablement.

Differences and similarities with rehabilitation

CSED explains that rehabilitation services are for people with poor physical or mental health, to help them get better.

The Welsh Social Services Improvement Agency says that rehabilitation is '... the process of restoration of skills by a person who has had an illness or injury so as to regain maximum self-sufficiency and function in a normal or as near normal manner as possible. For example, rehabilitation after a stroke may help the patient walk again and speak clearly again. The word comes from the Latin 'rehabilitare' meaning 'to make fit again'.'

Reablement, in contrast, is not only for people who have had an illness or injury. Reablement can also be available to people with lower level needs, or who have had a gradual deterioration. Reablement focuses as much on a person's emotional and social needs as on their medical needs.

Who is reablement for?

Reablement has the potential to help many different people, including older people, people with physical disabilities or sensory impairments, people with learning disabilities, people with mental health difficulties and people with dementia.

In practice, each local authority that is setting up or developing its reablement services will have to decide – in conjunction with the NHS and others, if appropriate – who its reablement services will be for. Many reablement services are targeted at specific groups, such as those aged over 65. Some reablement services are specialist ones, delivered by staff with special training and expertise, working exclusively with people with dementia for example. Others are open to all people aged over 18 who live in a certain area, and could benefit.

The Reablement for All Best Practice Framework for the North East¹ recommends that authorities ‘could usefully assess the coverage of reablement and associated services to ensure that all client groups have access.’ This does not have to be done through one single service; one way to ensure all client groups have access is through a combination of general and specialist reablement services.

The [section on reablement services](#) gives more explanation of the different kinds of reablement service, and the different groups of users that they support.

Policy context and links with personalisation

Reablement has strong links with other developments in social care, and especially personalisation, personal budgets, and *Putting People First*.

The 2006 government White Paper *Our Health, Our Care, Our Say* set out proposals for large scale reform of health and social care services. It stressed that service users should have choice and control over the support they receive, and that social care should enhance people’s independence. The paper’s four main goals were:

- better prevention services and earlier intervention
- giving people more choice and a louder voice
- tackling inequalities and improving access to community services
- more support for people with long term needs

The White Paper introduced Individual Budgets (which have since evolved into Personal Budgets), putting users at the centre of decision-making about their social care needs and how these can best be met. The paper also said more resources should be shifted into prevention and health promotion, and more services delivered away from hospitals, and in community settings and people’s own homes. Another priority was to see better co-ordination and integration of services at local level, with more joint planning and delivery from the NHS and local councils.

*Putting People First*² was a joint statement published in December 2007, setting out a shared vision for transforming adult social care. It was signed by six government ministers, the NHS Chief Executive, the Association of Directors of Adult Social Services (ADASS), the Local Government Association (LGA) and other national social care and health organisations. The signatories agreed on the need for a system focused on prevention, early intervention, reablement and tailored ongoing support services. They emphasised achieving better outcomes

¹ Report by the Social Work Co-operative for the North East regional Improvement and Efficiency Partnership, 2010

² *Putting People First, A shared vision and commitment to the transformation of adult social care*, HM Government and others, December 2007

for service users and making better use of resources. A national programme, also called *Putting People First*, was created to improve people's experiences of social care and make the vision a reality. In September 2009, the Department of Health, ADASS and the LGA published five milestones for local councils to measure progress with *Putting People First*.³ Each milestone says what should be happening, and what local councils should be doing by three key dates: April 2010, October 2010, and April 2011. The themes for the milestones are:

- effective partnerships with people using services, carers and other local citizens
- self-directed support and personal budgets
- prevention and cost effective services
- information and advice
- local commissioning.

The milestones require councils to work jointly with health services to develop and implement plans to shift investment towards reablement and prevention services, and to monitor the impact of these changes, by two key dates.

Increasing personalisation of services, making personal budgets available to more people, greater choice and control for users, more tailored support for individuals, cost effective services, and more effective partnerships have all continued to be policy priorities following the change of government in 2010. The Revised NHS Operating Framework for England 2010/11, published in June 2010, emphasised the importance of reablement. In this document, the Coalition government signalled that reablement and support following hospital discharge will be priorities, and that they want to see hospitals working with GPs and local authorities to develop such services to improve patient outcomes and reduce emergency hospital readmissions.

The best reablement services are excellent examples of these new approaches to social care – providing more personalised and tailored support, offering people

more choice and control over the kind of care they receive, helping people to remain independent for longer, and frequently achieving better outcomes for users. Reablement services are also often cost effective and involve partnership working between local councils, the NHS and other agencies. Once someone has been through a period of reablement, they are assessed to determine whether they need ongoing social care, and at this point may be offered a personal budget, so that they can continue to exercise choice and control.

³ *Putting People First, transforming adult social care: progress measures for the delivery of transforming adult social care services*, Department of Health, ADASS and LGA, September 2009

- Who commissions and who provides reablement services
- Access and referral arrangements
- Location
- The make-up of the reablement team
- Time limits for the service
- The Fair Access to Care Services (FACS) criteria
- Charges for services
- What happens at the end of reablement?

How reablement services vary

Many different kinds of reablement service (different service models) exist. There are seven main factors:

- [Who commissions and who provides the service](#)
- [Access and referral arrangements](#)
- [Location – where the service is based and provided](#)
- [The make-up and skill mix of the reablement team](#)
- [Time limits for the service](#)
- [Application of the Fair Access to Care Services \(FACS\) criteria](#)
- [Charges for services](#)

These differences are explained in the sections below. The final section explains [what happens at the end of reablement](#).

Who commissions and provides reablement services

Reablement services are part of the services provided by adult social services departments. Local authorities play a lead role in deciding what reablement services should be available in their areas, and in designing, commissioning and funding these services.

In some areas, reablement services are jointly funded by the local authority and the NHS, and the NHS is also involved in deciding what they should look like, and who is eligible for them, within that area. Under government plans, GPs are likely to become involved in commissioning reablement services in future.



Reablement services are sometimes provided in-house by council staff, for example home care staff. In other cases, they are provided by inter-disciplinary teams bringing together staff from both the local authority and the NHS. For example, staff from home care, social work, nursing and occupational therapy teams may come together to form a reablement team.

In some areas, local authorities have decided to commission independent home care providers to provide reablement services. Sometimes, the local authority will conduct the initial assessment of the user to decide whether they are suitable for reablement, and to draw up the reablement care and support plan, and then independent sector home care staff will come in to provide the day-to-day reablement support. Sometimes other organisations, such as housing associations, or those running care homes, day centres, or advice and support services for older people may become involved as partners in delivering reablement.

Access and referral to reablement

There are two main approaches to access and referral arrangements for reablement. The first is called the *intake and assessment* model (or *wide-access* model), and the second is the *selective* or *targeted* model. If you are trying to work out which approach a particular reablement service takes, then the key questions to ask are:

- Who is the target client group – who is the service for?
- How can people access the service?

A reablement service that uses the intake and assessment model will accept all referrals of adults who are being considered for home care, or for social services support. The reablement service then does its own assessment, and screens out people unlikely to benefit from reablement. The approach of this kind of service is to assume that most people can benefit from reablement. This is also known as a wide-access model, as it takes on, and can be accessed by, people with a wide range of needs or circumstances.

Some intake and assessment reablement services consider every adult who is referred to adult social services (including people referred for possible long-term care in a care home), whilst others consider everyone who is referred for possible home care (domiciliary care) support – still a very large number of people.

The kinds of people who will be screened out by an intake and assessment model reablement service will vary, as each service still has its own access criteria, decided by the local authority that is running the service. People needing end-of-life care will always be screened out, as there is no possibility that a reablement approach will help them. Others who may be accepted by reablement services in some local authority areas, but who may be screened out as ineligible or unsuitable by other reablement services, include: people with severe dementia, people with learning disabilities, or people under a certain age (for example, people under 65).

By contrast, the selective or targeted model focuses on people in a particular situation, or who are referred through specific routes. For example, the service

may focus on people being discharged from hospital, and may require a referral from a specific, hospital-based team. Some services of this kind will focus on people leaving hospital, and also those living in the community who are at high risk of needing to go into hospital or a care home, if they do not get reablement support. With this type of service, the approach is to focus on those people where the benefits of reablement are potentially greatest, or on those users where there is the highest chance of a successful intervention through reablement support. Thus this kind of selective service will take on fewer users, with a more tightly defined set of eligibility criteria. It will only accept those people that are very likely to benefit from reablement.

Location – where the service is based and provided

Not surprisingly, given the emphasis within reablement on supporting people to continue living as independently as possible, many reablement services are provided in the user's own home. However, reablement services can also be provided in other locations such as sheltered housing, extra care housing, residential care, and day centres.

For example, a sheltered housing scheme might have several places kept especially for reablement. People who have been having difficulty coping at home, or who may have been in a hospital or residential home, might come to stay for a defined period of time, so that they can practise day-to-day activities with support from reablement workers, to gradually increase their confidence and independence.

The make up of the reablement team

Reablement is often provided by teams of staff from different professional backgrounds, and with a range of skills and experience (multi-disciplinary teams). In some cases, reablement teams will also be made up of staff employed by different organisations working together (multi-agency teams) for example local authority, NHS and independent sector staff.

In other areas, reablement may be provided by staff from a single organisation, such as a local authority's in-house home care team, although they may work very closely with colleagues in other services such as NHS hospital discharge teams, occupational therapists, and social work teams.

The exact nature of the reablement team will depend on what the organisations that have commissioned the service have decided. Often staff will have special training to learn about reablement and to be able to apply reablement approaches in their work. The kinds of staff who may be involved include:

- Home care staff
- Reablement support workers
- Occupational therapists (OTs)
- Physiotherapists & physiotherapy technicians
- Social workers
- District nurses
- Community psychiatric nurses (CPNs)
- Psychotherapists
- People with training and experience working with people with dementia (EMI), for example specialist home care staff, occupational therapists
- Staff from third sector organisations, for example support workers employed by housing associations, or day centres working with older people.

Time limits for reablement support

Reablement is always time-limited, with an emphasis on working towards clear goals agreed between the service user and reablement team, during the reablement period. In many services, reablement is offered for up to six weeks. The period of reablement can end earlier if the client has achieved their goals and no longer needs ongoing reablement support. Research for CSED found that

across 13 local authorities 'the average duration for the vast majority of people is between 3.1 and 6.4 weeks.'¹

Some reablement services offer flexibility over how long the service is available, based on the needs of the individual user. This is more likely where the service is offered to younger people with physical, mental or learning disabilities and older people with mild or moderate forms of dementia. However, there will still always be clear time limits for each user. [CSED](#) have said that a degree of flexibility should benefit clients who may need a longer period of reablement. Some reablement services are provided for up to 12 weeks, but these tend to be for a more specific targeted group, such as people who have experienced a stroke.

Fair Access to Care Services (FACS) criteria

What are FACS criteria and how do they work?

Government guidance published in 2003 introduced the Fair Access to Care Services (FACS) framework.² This approach was continued when the guidance was updated in 2010.³

The principle behind FACS was that all English local authorities should use the same process for deciding who is eligible for social care support, based on the person's level of need and the risks to their independence over time. The aim was to create a system that was more consistent, fairer, and easier to understand and compare across all the different local authorities in England.

Local authorities have a legal responsibility to assess everyone who is referred to them, or approaches them directly, for social services support. As part of this assessment, the local authority should find out about the individual's needs, their

¹ *Benefits of Homecare Reablement for People at Different Levels of Need*, CSED, Jan 2009

² *Fair Access to Care Services: guidance on eligibility criteria for adult social care*, Department of Health, 2003

³ *Prioritising Need in the Context of Putting People First: a whole system approach to eligibility for social care*, Department of Health, 2010

physical and mental health, the family and support networks that they have, and their wider circumstances.

The government guidance says that, as a result of the assessment, local authorities must determine the person's level of need for social services support, and the risk to their independence and well-being, using the FACS eligibility framework. This means putting the person into one of four bands:

- Critical level of need
- Substantial level of need
- Moderate level of need
- Low level of need.

These are outlined on the next page.

A **critical level of need**, according to the guidance, is when:

- life is, or will be, threatened; and/or
- significant health problems have developed or will develop; and/or
- there is, or will be, little or no choice and control over vital aspects of the immediate environment; and/or
- serious abuse or neglect has occurred or will occur; and/or
- there is, or will be, an inability to carry out vital personal care or domestic routines; and/or
- vital involvement in work, education or learning cannot or will not be sustained; and/or
- vital social support systems and relationships cannot or will not be sustained; and/or
- vital family and other social roles and responsibilities cannot or will not be undertaken.

A **substantial level of need**, according to the guidance, is when:

- there is, or will be, only partial choice and control over the immediate environment; and/or
- abuse or neglect has occurred or will occur; and/or
- there is, or will be, an inability to carry out the majority of personal care or domestic routines; and/or
- involvement in many aspects of work, education or learning cannot or will not be sustained; and/or
- the majority of social support systems and relationships cannot or will not be sustained; and/or
- the majority of family and other social roles and responsibilities cannot or will not be undertaken.

A **moderate level of need**, according to the guidance, is when:

- there is, or will be, an inability to carry out several personal care or domestic routines; and/or
- involvement in several aspects of work, education or learning cannot or will not be sustained; and/or
- several social support systems and relationships cannot or will not be sustained; and/or
- several family and other social roles and responsibilities cannot or will not be undertaken.

A **low level of need**, according to the guidance, is when:

- there is, or will be, an inability to carry out one or two personal care or domestic routines; and/or
- involvement in one or two aspects of work, education or learning cannot or will not be sustained; and/or
- one or two social support systems and relationships cannot or will not be sustained; and/or
- one or two family and other social roles and responsibilities cannot or will not be undertaken.

Local authorities set their own eligibility criteria, based on these four bands. This means they can set the thresholds (cut-off points) for deciding who qualifies for social services support, taking into account the resources they have and the wider needs within their communities.

For example, one council could decide that its adult social care services will only be available to people with substantial or critical levels of need. People assessed with low or moderate levels of need may instead be given information about other services and support that they could access in the community (i.e. be signposted to other services). Another council, in contrast, could decide that its adult social care services will be available to people with moderate, substantial or critical needs. Both local authorities are required to use the same national FACS banding system to decide on people's level of need, but the actual services they provide to people in the different bands can vary.

Once the assessment is done, a person has been put in one of the four FACS bands, and a decision has been made about what support the council can offer, then an assessment of the person's ability to pay any charges is made, and they are informed of any charges or contribution that the council will expect.

How do reablement services use the FACS criteria?

There are two main ways in which reablement services can differ, in relation to FACS criteria:

- Whether FACS criteria are applied to users at the start or end of reablement
- The eligibility threshold for access to reablement services

Reablement services can either apply the FACS criteria to users at the start of reablement, or at the end. If they apply FACS at the start of reablement, they will identify potential users in each band of need, and the service may only be available to those with a certain level of need. For example, a particular reablement service might not be available to people assessed with a low level of need, but only be for those with moderate, substantial or critical levels of need.

Research published by CSED in 2009 found around three-quarters (73 per cent) of reablement services apply FACS criteria at entry to reablement.⁴

If a reablement service only applies the FACS criteria at the end of reablement, then this means that they do not take FACS into account when deciding who to accept for the service. This may be because the local authority takes a 'universalist' approach, making reablement support available to a very wide range of people, including those with lower levels of need. They may see this as a good investment for the future – helping to prevent such people from developing greater needs in the longer term. Instead, the FACS criteria are applied at the end of the reablement support, when the user is being assessed for further ongoing support.

Alternatively, a reablement service may not apply FACS criteria at the start because it is a very targeted service, that only takes people referred from a hospital discharge scheme, for example. Anyone referred through this route may, by definition, have a higher level of need and therefore the local authority may decide FACS criteria do not need to be applied until users have finished their period of reablement, and are being assessed for further ongoing support.

Some reablement services apply the FACS criteria to people both at the start and again at the end of reablement. This approach recognises that some people's levels of need may change as a result of reablement.

Research published by CSED⁵ suggests reablement can be effective and benefit people with both lower and higher levels of need.

As the section above explains, different councils will set different eligibility thresholds for access to reablement. Of those that do have a threshold, some are available to people with moderate, substantial and critical needs, and others just to people with substantial or critical needs. It is rare for a reablement service to only accept people with critical needs.

⁴ *Home Care Reablement CSSR Scheme Update*, CSED, March 2009

⁵ *Benefits of Home Care Reablement for People with Different Levels of Need*, CSED, January 2009

Charges for services

Most reablement services are free to clients. CSED found that around one-third of councils with reablement services reported charging for reablement in 2008, and the other two-thirds did not charge.

Some reablement services provide a few days or weeks of support free, and then start to charge, for example after the first two weeks. Some charge a similar hourly fee to that charged for home care, and others charge a flat fee, regardless of the number of hours of care or support provided.

CSED found that hospital discharge-based reablement services were more likely to be free to users, compared to home care based reablement services. This may be because such services are more likely to be jointly funded by the NHS, whose services are free to users at the point of need.

Government plans to penalise hospitals if patients are readmitted within 30 days of discharge are expected to lead to even more hospitals becoming closely involved in funding or providing intermediate care and reablement services in future.

What happens at the end of reablement?

Towards the end of the reablement period, a review is completed with the user, and if appropriate, their carers and family. An assessment is made of the user's ongoing needs. If the service applies FACS criteria at the end of reablement, this will be done too.

What happens next depends on this assessment, and whether the user is eligible for ongoing help. If they do not need ongoing care, they may be given information and signposted to other services and activities in the community. Some people will be formally referred to other services. Increasingly, people needing ongoing social care are being offered self-directed support through personal budgets. The Department of Health requires councils to offer personal budgets to all new service users and carers by October 2010, and says at least 30 per cent of eligible

users and carers in each local authority should have personal budgets by April 2011.⁶

People choosing a personal budget will be given help to assess their needs and create an ongoing support plan, and given an indication of how much money they will receive. People can choose to have cash payments that they manage themselves, or that someone else manages on their behalf. Alternatively, they can choose to have services that the council manages and arranges for them. Once the council agrees the support plan and amount of money, then arrangements can be made for the person – or someone managing their money – to receive payments and pay for the care and support that suits them best. If the person prefers the council to manage everything, then an ongoing care package may be commissioned. Depending on the council's commissioning arrangements, this may be provided by in-house council teams or by independent sector providers. In all cases, the ongoing care and support arrangements, and the user's needs, should be regularly reviewed.

Some reablement services ask users to complete satisfaction questionnaires or surveys when they finish reablement. These should help services learn what they do well and what could be improved or done differently.

⁶ *Putting People First, transforming adult social care: progress measures for the delivery of transforming adult social care services*, Department of Health, ADASS and LGA, September 2009

The benefits of reablement

There is an increasing body of evidence that reablement can generate real and lasting benefits for users, including:

- improving quality of life
- keeping and regaining skills, especially those enabling people to live independently
- regaining or increasing confidence
- increasing people's choice and autonomy
- enabling people to be able to continue living at home
- reducing the need for ongoing care and support.

The sections below explain more about the evidence that reablement users have experienced these benefits.

How reablement benefits users: the evidence

Improving quality of life

Research suggests that reablement has a positive impact on quality of life. One study looked at the impact of reablement across a number of areas of quality of life.¹ The table shows the net improvements – that is, the numbers who improved following reablement, minus the numbers who got worse. In all aspects of quality of life that were looked at, there was a net improvement following reablement.

¹ *Prospective Longitudinal Study, Interim Report 1: The short term outcomes and costs of reablement services*, CSED, Oct 2009



CSED summarised the study, saying that there was a significant impact on people's perceived quality of life, and perceived health-related quality of life, following reablement. 'In the post reablement phase, service users were reporting fewer problems with mobility, self care, usual activities, pain/discomfort, anxiety/depression, and improvements in their general health.'

General health	18%	Mobility	9%
Self care	21%	Usual activities (health)	17%
Usual activities (social care)	8%	Pain and discomfort	13%
Anxiety and depression	7%	Personal care	11%
Control	10%	Meals	11%
Safety	14%		

User satisfaction

Reablement services also seem to have high user satisfaction rates. For example, research by the Social Work Co-operative for a 2010 regional report on reablement in the North East found that in Northumberland 94 per cent of users rated the reablement service as 'good' or 'excellent' (compared to 69 per cent for mainstream home care services), and in South Tyneside 100 per cent of users rated the reablement service as 'good' or 'excellent' (compared to 66 per cent for mainstream home care services).

Increased independence, less need for ongoing support

Increasingly, research is showing that reablement services are effective in increasing users' independence and reducing their need for ongoing support after reablement.

Leicestershire County Council was one of the first to introduce reablement. In 2000, De Montford University did an evaluation. They looked at outcomes for people who had received reablement, after the first six weeks, and compared these with people who'd had a conventional home care package. At the beginning, the pilot reablement service took a selective approach, only taking selected clients by referral.

The results were remarkable:

- Sixty-two per cent of people who had reablement did not need any ongoing care package at the six week review, compared to just five per cent of people who had conventional home care.
- Twenty-six per cent of people who had reablement needed a decreased care package (i.e. fewer care hours) after the six week review, compared to 13 per cent of people who had conventional home care.
- Ten per cent of people who had reablement needed the same level of care after the six week review, compared to 71 per cent of people who had conventional home care.

- And just two per cent of people who had reablement needed an increased amount of care after the six week review, compared to 11 per cent of those who had conventional home care.

Following the successful pilot, Leicestershire developed and extended the service to become an intake and assessment model, taking a much wider range of referrals than the pilot service. This was also evaluated, and the results are shown in the final column of the table below.

Home care package required after 6 week review	People on re-ablement pilot (selective model)	People who had conventional home care (control group)	Re-ablement roll-out in Leicestershire (intake and assessment model)
Care package discontinued	62%	5%	58%
Care package decreased	26%	13%	17%
Care package maintained	10%	71%	17%
Care package increased	2%	11%	8%
Total	100%	100%	100%

The results for the intake and assessment model are not quite as good as for the selective model, because the selective model only takes people very likely to benefit from reablement, whereas the intake and assessment model works with a wider range of people, including those less likely to benefit, or for whom the benefits might be smaller. It is important to remember, however, that a small benefit in terms of reduced care hours needed can still make a very big difference to a user's life.

The difference in outcomes from the intake and assessment model compared to conventional home care are still very significant. This demonstrates that both kinds of reablement service are effective in increasing people's independence and reducing their need for ongoing support.

Leicestershire's Homecare Assessment and Reablement Team (HART) is now very well established. It operates an intake and assessment model for access and referrals. The FACS criteria are applied at the start of reablement, and the service accepts people assessed as having moderate, substantial or critical needs, according to the FACS bands. Further research on users of the service in 2005/06 published by CSED found that, at the end of the reablement phase:

- half of all users of this service did not need any ongoing care package
- twenty-nine per cent needed an ongoing care package, but with an average reduction of 30 per cent in care needed
- eighteen per cent were referred to other specialised services, but with an average reduction of 16 per cent in care needed.

The research found an overall reduction in care hours of 58 per cent.

Evaluations of reablement services in many other local authority areas have found results that echo those in Leicestershire. There is now strong evidence that reablement increases people's independence and reduces their need for ongoing support. The evidence also shows that these benefits apply to people at all the different levels of need.

Lasting impact

Another benefit of reablement is that the positive impact is not just short-term, but appears to last. In 2008, CSED published research looking at over 2,000 people who had received reablement in 2004 and 2005, to see how long it was before they needed any change in their home care package, or needed to start home care if they did not have it when they finished reablement. The people came from four different local authority areas.

In all four areas, over half of users did not need any home care at all, at the point when they finished reablement. Two years later, in three of the four schemes, 36 per cent to 48 per cent still did not need any home care, and in the fourth scheme 87 per cent still did not need home care. In one area, 55 users who had previously needed home care before going through reablement continued to need no home care package two years after reablement.

Of the people who did need home care within two years of reablement, at least a third in each scheme had maintained or reduced their home care package, two years after reablement. In one scheme this figure was 61 per cent of users.

Further studies are taking place to understand more about how long the benefits of reablement can last, for which kinds of users, and from which kinds of service. The evidence so far is that reablement does have lasting benefits for many users.

How reablement services benefit staff

Benefits to staff

Many staff find that working in reablement brings great job satisfaction, and a sense of doing something very worthwhile. It can give people a chance to learn and develop new skills, and to work in a way that allows increased professional autonomy. However, some people do find the transition to working in new ways can be difficult, especially the need to 'stand back' and encourage users to do things for themselves.

The Reablement for All report by the Social Work Co-operative for the North East found that:

'There were both anecdotal and quantified benefits for people working in reablement services. For example a survey of reablement staff in one authority found 98 per cent of staff felt 'extremely satisfied' or 'satisfied' as a result of their work in reablement.'

Research for CSED involved talking to frontline staff and managers working in five reablement services². The researchers found:

‘Reablement workers across all five sites confirmed that they had found it hard at first to change their attitudes and practice, but almost all felt that the reablement approach had increased their job satisfaction, commitment and motivation.’

‘Workers who had recently joined a reablement team were more cautious about these outcomes, but they found it encouraging seeing other workers feeling so positive about the new approach.’

‘Most managers confirmed the increased job satisfaction experienced by most staff who had started using a reablement approach. In one site managers reported that the sickness levels of their workers had decreased.’

Interestingly, the researchers also observed reablement staff at work, and found:

‘Workers identified by the reablement services as being less experienced were those who had spent less time working within traditional home care services. However, in general, these workers appear to involve people a lot more than those identified as being more experienced. This involvement was both in terms of decision making (e.g. asking people what they would want to do on the day) and hands on ‘doing with’ involvement in practical activities.’

Good quality training and ongoing support for staff is important in ensuring they can realise the potential benefits of high job satisfaction and effective outcomes. Clear information and communication with users, so that everyone involved has a shared understanding of the nature of the service, how it works and what it is trying to achieve, are also important.

Benefits to local authorities and the NHS

The benefits to local authorities and the NHS of reablement are a direct result of the benefits to users and staff. Introducing reablement has led to significant cost savings for some local authorities, through reductions in the number and size of care packages needed after reablement, and reduced need for care home placements. Although no direct evidence is currently available, there is anecdotal evidence that such activity also has a knock-on impact in terms of fewer hospital admissions for the NHS.

The resources saved in this way can be re-invested into care services. In some areas, local authorities and the NHS have re-invested directly into their reablement services, and expanded these by increasing the geographical area they cover, for example from a locality to a whole county. Some have expanded reablement by widening the access criteria, for example from a hospital discharge based scheme to an intake and assessment scheme, allowing a wider range of people to experience reablement.

Reablement therefore has the potential to create win-win-win situations, with better outcomes for users, higher job satisfaction for staff, more efficient use of resources and reduced costs.

Isle of Wight

The Isle of Wight decided to introduce reablement as part of a wider set of changes to its adult social care services. They introduced free home care for everyone who was eligible and aged 80 or over. The aim was to support people to live at home, and reduce the use of care homes. The council’s in-house home care service became a reablement services, and they also worked with independent sector home care providers to build capacity.

As a result of the changes, in the first year new admissions to residential care reduced by 40 per cent and there were net savings of £2 million. The reductions in the use of residential care continued in following years.

² *Prospective Longitudinal Study Interim Report 2 of 2: The Organisation and Content of Homecare Reablement Services*, CSED, Oct 2009



Service users and staff in the North East talk about reablement

In December 2009, the Social Work Co-operative produced a series of short films for the North East Improvement and Efficiency Partnership. These films feature service users and staff from different parts of the North East, talking about their own experiences of reablement.

To watch them, click on the links below. You will need some kind of media playing software on your computer, such as Windows Media Player. Note that the files are quite large and may take a while to download on slower connections.

Reablement in Darlington [video, 6.3MB]

<http://www.northeastiep.gov.uk/adult/Darlington.wmv>

Reablement in Hartlepool [video, 7.5MB]

<http://www.northeastiep.gov.uk/adult/Hartlepool.wmv>

Reablement in Newcastle [video, 9.2MB]

<http://www.northeastiep.gov.uk/adult/Newcastle.wmv>

Reablement in North Tyneside [video, 8.5MB]

http://www.northeastiep.gov.uk/adult/North_Tyneside.wmv

Reablement in South Tyneside [video, 7.2MB]

http://www.northeastiep.gov.uk/adult/South_Tyneside.wmv



Users' and carers' top ten tips for excellence in reablement

The Top Ten Tips were produced by the reference group for the Excellence in Reablement Project, run by the North East Improvement and Efficiency Partnership, and supported by the Social Work Co-operative. The group was made up of people with experience of health services, social care, social services, or being a carer. The Top Ten Tips give a valuable perspective from users and carers on what reablement services should be like:

1. **Information:** reablement services should be well promoted with clear information about what the service can offer and who is eligible at the earliest times
2. **Culture:** staff should be well trained in promoting independence and should have a reablement ethos, doing 'with' rather than 'for'
3. **Confidence:** self-esteem and confidence are crucial to reablement. They should be the primary focus of each person's plans to incorporate people's wishes and desires.
4. **Social inclusion:** coupled with this, services should promote community activity and social integration.
5. **Avoid discrimination:** reablement should be open to anyone who might benefit, irrespective of their condition or disability. It's not just for older people.
6. **Multi-disciplinary work:** reablement should be well linked in to other services such as rehabilitation and mental health support. This will allow specialist input when needed.
7. **Include carers:** often informal carers need support as well as the 'user'. This team approach helping both together will double the impact of reablement.
8. **Emotional support:** don't underestimate the importance of supporting people with their emotional and psychological needs.
9. **Handovers:** ensure a smooth transition to on-going services (for those who will need them). We don't want all the hard work to be undone and continuity is important.
10. **Group work:** sometimes group work can help people to learn and regain skills – and to support each other.

- Employment backgrounds • Making the transition • What is different? • The challenges • The successes and rewards • Working with families and carers
- Working with other professionals • Using different skills • Working alone • Advice for staff thinking of working in reablement

What is it like to work in reablement?

Working in reablement can mean a big cultural change, and learning new skills. It can be hugely rewarding, but like all jobs, it also has its challenges and frustrations. Staff at Lifeline Services in Darlington shared their experiences.

Employment backgrounds

People can come from all sorts of backgrounds to work in reablement. There is no one set career path.

'I started working in a nursing home at the age of 17, providing care in the community for people who were coming out of institutions to live in the community. I then moved to a charity as a support worker in a secure unit for people with severe mental health problems. I had children, and worked in pubs and clubs for a while. While the children were growing up I started doing NVQs, and progressed to achieving NVQ level 4 and the Registered Managers Award. I worked in the private sector as a home care worker, as this fitted well with bringing up a family. Then I became a home care co-ordinator, and then home care manager, in the private sector. I moved to Darlington Adult Services, joining the Access and Contact Team – we were the gatekeepers of adult services, taking a wide range of calls from people in need, including people in distress, people whose caring relationships had broken down, people needing aids and adaptations. I joined Lifeline as a Team Leader two years ago. It had no reablement service then. Lifeline provides sheltered housing and extra care, as well as assistive technology, Lifeline pendants, and provides 24/7 response services, that is responding when people pull emergency cords or trigger their pendants.'

Julie, Team Leader



'I first worked in retail for ten years, then had 20 years in a customer service / complaints department until being made redundant. I had no previous experience in health or social care.'

Donna, Enablement Officer

'I had done secretarial work, in the hospitality industry. I spent the last 15 years supporting young people working for a local authority youth offending team and Connexions. I'm currently volunteering with the Darlington Youth Offending Service'.

Elizabeth, Enablement Officer

'Initially my background was secretarial. I've worked as a store detective, an ancillary probation worker, and as a supermarket cashier, when my children were young. I did sales and marketing for large international marketing company for 12 years. I do voluntary work at a local hospice.'

Pamela, Enablement Officer

Making the transition into working in reablement

Some staff find making the transition into reablement harder than others. The change can be hard even for people who have worked in health or social care, especially if they are used to quite a structured and predictable way of working with users.

'When my manager spoke to me about the new service, I immediately said I'd like to be involved, and felt very enthusiastic about it. I was already involved in providing assistive technology and had my home care experience, so it seemed to fit well, and I thought it sounded really interesting.'

Julie, Team Leader

'We recruited new people to the team, rather than taking people from existing roles. Because we recruited directly for these posts, people came to them knowing what it was about...they understood from the outset what it was about, because that is how we explained it at recruitment. I think a lot depends on your open-mindedness and how you deal with change.

'[The staff we recruited] were all very enthusiastic and excited about the service. One had worked in health, in another enabling service working with people after hospital discharge, so we thought she would adapt very well. But she found it difficult to cope with the fluidity needed for this job. She found the flexibility very uncomfortable, and the need to be innovative, to be always thinking outside the box. For example, if we have a user who is agoraphobic, but says they would like to go shopping, we might suggest they try internet shopping. She wasn't used to having to think laterally like that. She was used to having someone else do an assessment, then tell her what

she had to deliver. She liked having very clear policies and procedures and a rigorous assessment, but she found the flexibility needed for this role too hard. Ultimately she left.'

Julie, Team Leader

'When I first saw the position advertised I thought it looked a great opportunity but without experience I felt I might not be successful. But with nothing to lose and everything to gain, I gave it my best shot. When I got the call that I had got the job I was leaping about my lounge, sooo happy. I knew I was going to something new so I kept an open mind to all I needed to learn...I feel I embraced everything new.'

Donna, Enablement Officer

'I was very enthusiastic about starting a new challenge in a job that looked very worthwhile and would offer job satisfaction helping others.'

Pamela, Enablement Officer

What is different about working in reablement?

Many staff find that reablement involves a very different approach, and a different kind of relationship with users.

'The service is different because you are not physically doing for the client, you are showing them how to do for themselves so that once we withdraw our service they can carry on. We can demonstrate skills to them and we can source information, enquire about adaptations to their home which would benefit their day-to-day life. We can introduce them to activities and accompany them until they feel confident to go alone.'

Pamela, Enablement Officer

'I think the key difference is that from the outset, its encouraging people to tell you what they want, and what their needs and interests are, and then we go away and get all the information and resources to help them achieve

a positive outcome. They really need to engage with it. We source all the information, discuss it with them, and they decide the next steps. They really are involved: it is very person-centred and the person really is at the heart of it.'

Julie, Team Leader

The challenges of working in reablement

As with any job, working in reablement has its challenges. Different staff will have different views on what is most challenging. There are also challenges associated with setting up a new service.

'I think the worst thing about the service is that it is short term and you can get quite attached to your clients. Often you are the only one around to show any interest in them and they are quite lonely. It can be difficult to withdraw under those circumstances. We do try and put in place a befriending service if the client wishes in order to make the transition easier.'

Pamela, Enablement Officer

'The biggest challenges are dealing with clients who have mental health problems. There are times when it is difficult to get them to engage with the service, for example if they are depressed with low self esteem but would benefit from getting out of their home and perhaps joining a group doing something they used to be interested in like arts or crafts, or perhaps to learn a new skill. Those that we have been able to encourage have benefited greatly and made new friends and found new interests which has helped with their mental health. Some have got into financial difficulty due to poor budgeting skills as a result of their mental health problems and we have assisted by drawing up a budget or signposting to the CAB.'

Pamela, Enablement Officer

'In the whole of the first year, only one user did not engage. She lived in Extra Care, and had support from an Integrated Support Worker. She wanted

to lose weight and improve her mobility. She started on a diet but then she couldn't maintain it. So after about six weeks she stopped. But it was her choice, and we supported it.'

Julie, Team Leader

'Another challenge was marketing the service, both externally and internally to others within the council. We would go and give presentations about our service, and you could see people scratching their heads and saying 'what's it all about?' People just didn't get it. But we just kept plugging away, we don't give in! We would visit and revisit. We set up a spreadsheet to record where we've been to publicise the service, who we'd talked to, what literature we'd given. We monitored, and revisited if a member of staff changed, and we topped up the literature. We made ourselves available and encouraged people to contact us. We did Powerpoint presentations, and went to community events. We did stalls, and gave out posters and flyers. We contacted GP surgeries and dentists, chiropodists, and religious faith groups, and minority ethnic groups. We tried to target places where people in crisis might be, so we spoke to the registrar, and funeral directors, and even hospices, and gave them our leaflets. A lot of staff time went into marketing, we were doing three or four Powerpoint presentations per week. But we had to promote it, because people didn't understand what we were doing. Word-of-mouth is the best advertising.'

Julie, Team leader

The successes and rewards of working in reablement

For many staff, positive outcomes for users and job satisfaction are very closely linked. Many find it a rewarding, enjoyable and worthwhile job.

'Seeing the client complete a task on their own for the first time is very rewarding, however small that task may be.'

Elizabeth, Enablement Officer

'I have introduced a client with dementia to the Arts Centre where she is learning new skills and meeting people. This is stimulating to her and makes her feel good about herself again. Huge success for that client.'

'Each success is great because it means that the client has achieved what they have set out to do and can continue without our help.'

Pamela, Enablement Officer

'It is very rewarding when a client does something for the first time on their own. Also when you have given the client the tools and advice, and they enjoy and succeed...What I like about my job is that we are able to spend time with clients to enable them to return hopefully to normal and gain confidence from falls or illness, or whatever issue they bring to us.'

Donna, Enablement Officer

'We've had lots of positive outcomes. We had a man living in a sheltered housing scheme, who'd been bereaved two years previously. He was socially isolated and he lacked confidence. I went there to do a presentation about our service, and he was sitting in the window. We approached him. He identified that he was interested in rambling, and wanted to learn to use a computer. He was interested in his family tree. We were able to find a group of people his age who did walks from the local leisure centre. And we helped him join the Age Concern computer group, and visit the library so he could do his genealogy. Now he has lots of friends, he uses a computer, he goes on ghost walks, and continues to go to the computer group.'

Julie, Team Leader

'Taking someone from home onto public transport into town a few times, then getting them to go alone on the public transport and meeting them off the bus is a huge step for that person. The next step is to get them to go into town alone, do a little shopping and get home again, then discuss how they felt about the experience.'

Pamela, Enablement Officer

Working with families and carers

Families and carers can play a key role. For some users their support is vital to successful reablement, and it is important for reablement staff to communicate well with them, so that everyone has a shared understanding of the goals and approach.

'Families and carers are generally very encouraging to us. As we go through the reablement, they can see their loved one's confidence improve, and their whole well-being. We get positive feedback, things like 'oh, she's doing so well'. We're very clear from the outset about what we do. We have very clear boundaries and we make it clear we have a start, a middle, and an end. The families know that we're dependent on the person engaging with us, to work effectively. Because we're so clear about what we do, we're never mistaken for a caring service, like home care, by the family members.'

Julie, Team Leader

'Usually families and carers are supportive, but gentle persuasion is required sometimes, as families try to tell the client what is best in their opinion which isn't always the client's view.'

Elizabeth, Enablement Officer

Working in partnership with other professionals

Working in partnership with other organisations is an important part of the role of reablement staff. As users' needs are so varied, reablement staff will get to know a wide range of organisations that can help to support people. It's important that other agencies fully understand the work of the reablement team.

'At the end of the period with us, we'll signpost people on. Sometimes we work with occupational therapy and adults services, as they need aids and adaptations. As awareness of our service is rising, we are working much more with other organisations and teams, we get more and more calls. For example, we work with the community mental health team, and the physical

and sensory impairment team. We're happy to work in conjunction with everyone who wants to work with us. For example, with the Falls Service – we can work on increasing people's confidence. We're thinking of having our staff link more with the discharge management team, and maybe to become involved with the discharge process. It's all about early intervention.'

Julie, Team Leader

'At first they [care staff] were a little suspicious of us, but now they realise we work totally differently to them and I have a good relationship with everyone I need to speak to.'

Donna, Enablement Officer

'Sharing information is vital in this role and in my opinion requires some improvement. Some of the agencies we communicate with are social services, housing, the NHS, WRVS, Age UK, and the library.'

Elizabeth, Enablement Officer

'We work with social services, WRVS, Age UK, mental health teams, housing services, the British Legion, the local hospice...Initially working with colleagues already in this type of service was a little daunting as they appeared to know a lot about everything and I knew nothing. However, I have quickly picked up information and can confidently approach and converse with them on the same level, learning all the time.'

Pamela, Enablement Officer

Using different skills

Reablement staff will often draw on skills and experience from previous roles, as well as receiving training in reablement. Good interpersonal skills are as important as technical knowledge.

'I am used to dealing with people on all levels and sourcing information. However, I have had to update my computer skills and have now built up a

resource library of contacts from various agencies. I am now comfortable in my role as each client presents a different challenge and I have been introduced to various agencies because of this. My maturity and life experiences have also been an asset to my role.'

Pamela, Enablement Officer

'Patience and understanding is required and experience of life and loads of common sense. You need to be resourceful and practical too.'

Elizabeth, Enablement Officer

'I feel listening is the most important with the client. Having my level 2 and 3 in counselling skills, I have learned that sometimes people can say one thing and totally mean another.'

Donna, Enablement Officer

Being a lone worker

Many reablement staff visit users in their own homes. Some will not have worked in this way before, and will require training and support to help them adapt to being a lone worker. It is important to have good systems to support safe and effective lone working.

'I have always been happy to work alone, however, working alone visiting someone at home is very different from dotting around stores. It can be disconcerting as you don't know how a person is going to react especially if they have mental health problems. We ensure our diaries and electronic calendars are kept up to date and we check in via phone periodically throughout the day to our team leader. We can carry a device which alerts the control room if a situation arose.'

Pamela, Enablement Officer

Advice for staff thinking of working in reablement

'I feel you have got to enjoy working with people. Have the right ethics and morals to make sure you give the best possible service to everyone. Have a positive outlook on life, be able to think on your feet, to be able to encourage and motivate someone to try something new.'

Donna, Enablement Officer

'It is a rewarding and worthwhile occupation. You have to like people warts and all. Be patient and understanding and I believe that you need your experiences in life to draw on especially common sense. You also need to be resourceful when accessing information.'

Pamela, Enablement Officer

'It's just about trying to think outside the box. You may come up with something completely off-the-wall. You have to always keep an open mind. Instead of saying, 'We can't do it', you say, 'Maybe we can do that, if it achieves the person's desired outcome. We accept there may be risks involved. Let's go for it!' You have to be innovative. For managers, it's about giving your staff the confidence to go for it – some of the most off-the-wall ideas are the ones that will work. There's no better way of learning than to be on the ground, doing it.'

Julie, Team Leader

What is it like to go through reablement?

Three people who have been through reablement shared their experiences.

Jean's story

Jean, aged 73, went through reablement in 2009, after coming out of hospital.

'I was taken into hospital as an emergency with gallstones in my bile duct and an inflamed pancreas. I was in a critical condition. I was transferred from Hartlepool to North Tees hospital. I had an emergency operation, where they took out my gallstones and bile duct, and then was in critical care for 15 days, and in the High Dependency ward for about another seven or eight weeks. Then I went into Westfield Lodge for four weeks of rehabilitation, before I came home.

Simon, the physio from Hartlepool, came to see me and arranged the rehabilitation. It started in Westfield Lodge, and then the physios helped me after I came home. First I had a walker, and had to go to the gym to do exercises. Then the physios came to my house daily for four weeks. They said it would be for six weeks, but I made such good progress, I only needed four. The visits were for about 30 minutes. I can't speak highly enough of all of them. They were very busy. I'd offer them drinks, but they never had the time.

I could have had more help for six weeks, but I didn't need it because my son and daughter both took time off work to be with me. Altogether, they took about two-and-a-half months. So I didn't need any home help, just the physios. And the neighbours were very good.

The physios took the greatest of care; they treated me as a person, not an object. I was full of fluids, and my legs were really big. I could only wear

velcro slippers and I wouldn't go into the street with them on, so they took me out in the garden instead to practise walking and do my exercises. They were very patient and gave me my confidence back. I'm a very positive person, but when you've just come out of hospital like that, you're so down and so low. But they helped me get my self-respect back. I had a walker, and two sticks.

My goal was to be able to walk again, and be independent. When you have to have two nurses help you just to go to the toilet, you start to lose your self-worth. I couldn't lift my legs to get into bed. But they helped and encouraged me. They got me a hook, so that I could hook my leg up, and after a while I could do it myself and get into bed.

When I was in Westfield Lodge, I saw some people didn't like the exercises, and they'd say 'I can't do it' but I was never like that. My faith helped me a great deal. I always tried to stay positive. Toward the end, my family took me to the park to walk.

When it finished, at first I felt a bit lonely. But I continued to do my exercises, and I still do. My legs were heavy. I still do my leg exercises and my arm exercises that the physios taught me. You've got to have willpower and determination.

My family know I've got a lot of willpower, but they said they were amazed. They didn't think I would do it so quick. That I would walk again without sticks. They helped in every way, their amazement and encouragement really helped.

My daughter used to take me into the bathroom, then she would wait just outside the door. She'd say, 'I'm just outside mum'. But after a while I said

'I've got to get my independence back'. But I understand because I looked after my own mother, who lived to 92. She was my inspiration.

I feel I've got my self-respect and independence back again. It means a lot to me. I can do the cooking, and I can hang the washing out. I can't do all the things in the garden anymore, like bending down, but my family help me. I still have arthritis in my back and hands and legs.

I have lots of friends, and they have encouraged me. I got a card from my old vicar, who retired, and that meant so much to me. My faith and my belief in God has helped me. And all the staff – at the hospital, and at Westfield Lodge, and the physios who came to my house. I'm just so grateful.

I now have the courage to go to the supermarket on my own. It's my independence. I've only been doing that a few months. I still use a stick when I go out – it's a confidence thing. I can even turn the mattress on my bed, now. It's important to set yourself little goals, and to keep doing new things.

I feel like I've had a second chance in life. We've always had dogs, and taken them for walks. Now I can go for a walk along the seafront, on the promenade, and my daughter can take the dog on the beach and I can watch them. To feel the sea breeze on your face, and see the dogs, it's wonderful.'

Alby's story

'I live in Darlington, I'm 86 years old. I'm a former publican. I first heard about the reablement service after my wife died last year. She died in May 2009, two days after my birthday. We'd been together 63 years. I was very depressed after she died, I had what they would call a nervous breakdown.

I knew Julie, and I met her in town quite soon after my wife died. I bumped into her, and she told me they'd just started the reablement service, and that it might be able to help me. So I went to their office, and met them, and they arranged for someone to come and see me. She came once a week for ten weeks. She just came to talk. That's what I needed. There's nothing like one-to-one support, nothing beats it.

I didn't need any exercises or anything like that. I'm very fit, you just have to look at me to see. I'd always done that. I just needed someone to talk to.

My goal was to find anybody who could help me. After 63 years, I had to start something new. To get away from my old life, because the past is the past. I didn't want to become old; old is when you sit in the corner of the room somewhere.

She instigated my involvement with other things. I was really down. I went for swimming lessons – although I still can't swim! I started learning to use the computer. I joined Age UK's befrienders scheme, and now I'm a befriender. I go and see a chap, he's an ex bomber pilot, he's had polio and lost a leg. So I go and visit him. I'm involved with the care home where my wife died, we did up the garden recently – it looks beautiful with lots of flowers.

I've got family. I have one son, two grandchildren and four great-grandchildren. One of them is going to be in the Olympics, the one after next. She's seven years old and she's just won a gold medal. My son lives round the corner. He took my wife's death very hard as well. He was pleased to see me get help. All he wanted was for me to be happy.

After the ten weeks, they stopped the visits. They gave me a list, they give you no end of things. I'm still in touch with them. My proverb – you'll see it up in my house – is 'love, laugh and live.' They gave me my life back, no doubt.'

Mrs A's story

Mrs A, a widow aged 86, wanted to remain anonymous.

'I first heard about the service through a friend who was using it. A year ago last March I had a series of small spasms. I was in hospital for three weeks, and had all sorts of tests and an MRI scan, but they couldn't work out whether it was the nerves or the muscles. They still haven't worked out what it is. I could do personal things, and could put a ready meal in a microwave, but I couldn't get out of the house. My walking was very badly affected. I've only been out of the house on my own once in the last 18 months. My friend thought that the service would be useful for me, so she made contact on my behalf; one person helps another.

When I met Donna there was an instant rapport. She's helped me a lot. I look forward to her coming. She visits once a week on a Tuesday morning, and takes me to the bus stop, and we go into town. I do the shopping and she carries it for me, and we come home on the bus and have a cup of coffee together, and then she goes off to her next client. I really look forward to it.

There were lots of things I wanted to get out of it. I wasn't walking much, only for a very limited amount of time, and a very limited distance. I wanted her to take me out, to get away from these four walls. I was very active before these attacks, I used to be out and about a lot, and was desperate to get out again. Donna was there to help me. First we'd do a little walk, then we'd walk a bit further, and the next time a bit further again. She brought me back into the land of the living.

And we talk as well, we discuss my problems. I've been very lucky in having Donna. Her manager has already agreed that I can see her for a bit longer; for a second six weeks. I know there will be a limit. But the very fact of having her has been a tremendous morale booster for me. It helps me a lot to talk through it. It's not only the physical help, it's the mental help as well, that's so important.'

Learning points from these stories

- Users set their own goals.
- Reablement is about the whole person – addressing their physical, social and emotional needs together.
- Encouraging and motivating people is central to what reablement staff do.
- Support from family and friends can play a major part in successful reablement.
- Reablement can involve supporting people to try new approaches, and to take risks.
- Reablement can have a huge and lasting impact on people's lives.

- Reablement support plans • Access, referral, assessment and reassessment process • Information to collect • Reablement services in the North East
- [Reablement services in other parts of England](#)

Examples

Reablement support plans

There is no standard reablement support plan; rather each service has developed its own plan. The important thing about a reablement support plan is that it should be person-centred with clear goals. It is also very important that all staff use the plan consistently, and constantly review the user's progress in relation to the plan.

Sunderland community reablement scheme

In Sunderland, the community reablement scheme uses a number of documents which together comprise the support plan.

Users are referred to the community reablement scheme with an Assessed Need and Care Plan, completed by a social worker or care manager.

On admission to the community reablement scheme, firstly, an Initial Assessment is completed by reablement assistants. This is used to supplement the referring information, and establish the user's goals. In Sunderland they are using the Derby Outcome Measure (developed by the NHS in Derby) for this initial assessment.

A Record of Goals summarises the goals, and ensures that the user and staff consider any risks that may be involved.

A series of Risk Assessment forms have been developed, and the relevant ones will then be completed, depending on the individual user's needs, abilities and goals. These cover a range of circumstances and topics, such as maintaining a nutritious diet, social outings, and mobility. The example here covers kitchen activities. All completed risk assessment forms are updated with daily recordings.

If an occupational therapist or physiotherapist is involved in the user's reablement programme, then they will complete their own assessment and draw up a



Therapy Plan. The therapy plan becomes the main plan that everyone works to, but reablement assistants continue to complete the Initial Assessment Derby Outcome Measure, so that over time its effectiveness can be evaluated. The Risk Assessments continue to be used, alongside the Therapy Plan, or may be replaced by a new Therapy Risk Assessment if this is needed.

Examples of the [Initial Assessment \(Derby Outcome Measure\)](#), [Record of Goals](#), [Risk Assessment and Management Plan and Review form](#), and [Physiotherapy and Occupational Therapy Activity Planner](#), which together comprise the support plan, are given below.

Other services are welcome to use or adapt these examples as appropriate.

Sunderland Community Reablement Scheme: Initial Assessment Document (Using Derby Outcome Measure copyright 2009 NHS Derby City)

Name			
Date of Birth		Date	
Cognition	Severe disorientation/uncomprehending	4	4
	Marked problem of memory, disorientation of time, place or person	3	3
	Mild but definite problem of memory or understanding	2	2
	Occasionally forgetful but orientated to time, place and person	1	1
	Alert and orientated	0	0
Goal			
Personal Care	Dependent on one or more people with all aspects of care	4	4
	Requires some help with certain aspects of care	3	3
	Requires supervision or motivation	2	2
	Requires assistance with minor aspects of care e.g. (TEDS, socks)	1	1
	Independent	0	0
Goal			
Transfers and mobility	Immobile/ needs hoisting	9	9
	Requires standing equipment and assistance to transfer	8	8
	Requires assistance/supervision to transfer with/without equipment	7	7
	Transfers independently with or without equipment	6	6
	Walks with physical assistance	5	5
	Walks with supervision	4	4
	Independently mobile with wheelchair	3	3
	Independently mobile with frame	2	2
	Independently mobile with crutches or sticks	1	1
	Walks independently unaided	0	0
Goal			
Stairs	Unable to use stairs	2	2
	Able to use with supervision	1	1
	Independent / not applicable	0	0
Goal			

Outdoor Mobility	Unable to mobilise outdoors	2	2
	Independently mobile within garden drive	1	1
	Mobile in the community with supervision or assistance	0	0
	Independently mobile in the community		
Goal			
Food Preparation	Dependent with all meals and drinks	3	3
	Needs help with all meals, able to make hot drinks	2	2
	Able to make snacks (e.g. cereals and sandwiches)	1	1
	Independent (able to make hot meals)	0	0
Goal			
Nutrition	Appetite virtually nil/unable to eat PEG/NG	3	3
	Unintentional weight loss	2	2
	Reduced appetite, with or without weight loss	1	1
	Good dietary and fluid intake	0	0
Goal			
Continence	All help required (incontinent of urine and faeces)	4	4
	Requiring assistance/supervision with continence product	3	3
	Incontinent of urine and faeces but self sufficient	2	2
	Occasional incontinence	1	1
Continent	0	0	
Goal			
Medication	Needs full assistance with medication	3	3
	Needs help to take medication out of packets	2	2
	Needs reminding to take medication	1	1
	Takes medication with or without aids	0	0
Goal			
Professional interventions	Maximum involvement (3 or more visits per day)	3	3
	Daily visits (less than 3)	2	2
	Regular visits (not daily)	1	1
Self sufficient	0	0	
Score Range	0 –30 with 0 indicating fully independent	TOTAL	

Sunderland Community Reablement Scheme: Record of Goals/Risks

Name							
Date Set	Goal No.	Section No.	Activity	Sign	Date Achieved	Sign	

Sunderland Community Reablement Scheme: Risk Assessment and Management Plan for Kitchen Activities

Name				
Date of birth	Date			
Activity or goal proposed	Identified risks associated with activity	Risk 1-4	Control measures strategy or actions to manage activity	Review date
<input type="checkbox"/> Kitchen activities <input type="checkbox"/> To prepare a hot drink <input type="checkbox"/> To prepare a cold or hot snack	<input type="checkbox"/> Poor mobility & risk of falls <input type="checkbox"/> Fatigue <input type="checkbox"/> Poor balance <input type="checkbox"/> Sensory deprivation <input type="checkbox"/> Risk of scalds and burns		<input type="checkbox"/> Prepare clean and well lighted environment <input type="checkbox"/> Inform re correct use of equipment <input type="checkbox"/> Agree specific task and organise items required <input type="checkbox"/> Ensure no interruptions to kitchen via use of no entry sign on door <input type="checkbox"/> Provide clear instructions as required <input type="checkbox"/> Refer to therapy team for advice and support re activity <input type="checkbox"/> Other	
Risk level	Likelihood	Action		
(1) None	Most unlikely	Minimal Risk – None or minimal control measures required		
(2) Low	Unlikely	Low risk – Set control measures to reduce identified risk		
(3) Medium	Possible/likely	Medium Risk – Set control measures to reduce identified risk		
(4) High	Very likely/certain	High Risk – stop activity and set controls immediately – seek assistance where necessary		
*If circumstances have changed due to medical need, functional ability, mental health deterioration or increased risk in presentation a review must be undertaken immediately – see review sheet. New activities should be entered on a new sheet.				
Is service user in agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to express				
		Signature of assessing person		Second signature (where required)

Sunderland Community Reablement Scheme: Goal and Risk Management Plan Review

Activity:

Date	Review Outcome	Further Risks Identified	New Assessment Required	Additional Information	Signature
	<input type="checkbox"/> No change – continue activity	<input type="checkbox"/> Stop activity	<input type="checkbox"/>		
	<input type="checkbox"/> No change – continue activity	<input type="checkbox"/> Stop activity	<input type="checkbox"/>		
	<input type="checkbox"/> No change – continue activity	<input type="checkbox"/> Stop activity	<input type="checkbox"/>		
	<input type="checkbox"/> No change – continue activity	<input type="checkbox"/> Stop activity	<input type="checkbox"/>		
	<input type="checkbox"/> No change – continue activity	<input type="checkbox"/> Stop activity	<input type="checkbox"/>		
	<input type="checkbox"/> No change – continue activity	<input type="checkbox"/> Stop activity	<input type="checkbox"/>		

Sunderland Community Reablement Scheme: Physiotherapy and Occupational Therapy Activity Planner

All activities are risk assessed at the time of planning the activity. The intervention plan is intended to reduce any inherent risks in treatment.

TRANSFERS

Name:				
Activity	Code	Problem Areas	Equipment	
Bed	<input type="checkbox"/>	Weight bearing	Hoist	<input type="checkbox"/>
Chair	<input type="checkbox"/>	Pushing up from chair	Stand hoist	<input type="checkbox"/>
Toilet	<input type="checkbox"/>	Not able to sequence	Turntable	<input type="checkbox"/>
Sitting up in bed	<input type="checkbox"/>	Not able to follow instructions	Slide board	<input type="checkbox"/>
Sitting over edge of bed	<input type="checkbox"/>	Lack of confidence	Frame	<input type="checkbox"/>
Sit to stand from chair	<input type="checkbox"/>	Hearing impairment	Stick	<input type="checkbox"/>
Stand to sit from chair	<input type="checkbox"/>	Sight impairment	Bed lever	<input type="checkbox"/>
Sit to stand from WC	<input type="checkbox"/>	Able to stand but not take step	Crutch	<input type="checkbox"/>
Stand to sit from WC	<input type="checkbox"/>	Reaching down to chair	Raised toilet seat 2 inches	<input type="checkbox"/>
Side to side	<input type="checkbox"/>	Correct stand to sit position before lowering	Raised toilet seat 4 inches	<input type="checkbox"/>
Sit/stand/walk	<input type="checkbox"/>		Free standing frame	<input type="checkbox"/>
Support of 1	<input type="checkbox"/>		Scandia toilet frame	<input type="checkbox"/>
Support of 2	<input type="checkbox"/>		Commode	<input type="checkbox"/>
			Leg lifter	<input type="checkbox"/>
Specific information:				
Signed: _____ Date: _____				
Physiotherapist/Occupational Therapist			Review date: _____	

PERSONAL CARE

Name:					
Activity	Code	Assistance required	Equipment required		
Dressing		Upper reach	<input type="checkbox"/>	Bowl in room to wash	<input type="checkbox"/>
Dressing upper	<input type="checkbox"/>	Lower reach	<input type="checkbox"/>	Perching stool at sink	<input type="checkbox"/>
Dressing lower	<input type="checkbox"/>	Washing face	<input type="checkbox"/>	Bottom wiper	<input type="checkbox"/>
Washing		Washing upper body	<input type="checkbox"/>	Long handled comb	<input type="checkbox"/>
Washing face	<input type="checkbox"/>	Washing lower body	<input type="checkbox"/>	Long handled sponge	<input type="checkbox"/>
Washing upper	<input type="checkbox"/>	Drying upper body	<input type="checkbox"/>	White shower chair	<input type="checkbox"/>
Washing lower	<input type="checkbox"/>	Drying lower body	<input type="checkbox"/>	Sani shower chair	<input type="checkbox"/>
Brushing teeth	<input type="checkbox"/>	Putting on underwear	<input type="checkbox"/>	Powered bath lift	<input type="checkbox"/>
Showering		Putting on upper clothes	<input type="checkbox"/>	Assisted bath (clarence)	<input type="checkbox"/>
Showering upper	<input type="checkbox"/>	Putting on lower clothes	<input type="checkbox"/>	Bath board & seat	<input type="checkbox"/>
Showering lower	<input type="checkbox"/>	Putting on shoes/slippers	<input type="checkbox"/>	Toilet raise	<input type="checkbox"/>
Bathing		Putting on tights/stockings	<input type="checkbox"/>	Toilet frame	<input type="checkbox"/>
Bathing upper	<input type="checkbox"/>	Putting on socks	<input type="checkbox"/>	Scandia toilet frame	<input type="checkbox"/>
Bathing lower	<input type="checkbox"/>	Putting on ted stockings	<input type="checkbox"/>	Easi reach	<input type="checkbox"/>
Hair		Adjusting clothing to toilet	<input type="checkbox"/>	Tights aid	<input type="checkbox"/>
Washing	<input type="checkbox"/>	Managing personal hygiene	<input type="checkbox"/>	Sock aid	<input type="checkbox"/>
Drying	<input type="checkbox"/>	Managing continence pads	<input type="checkbox"/>	Shoe horn	<input type="checkbox"/>
Combing/brushing	<input type="checkbox"/>	Mobility problems*	<input type="checkbox"/>	Button hook	<input type="checkbox"/>
Toilet	<input type="checkbox"/>	Transfer problems*	<input type="checkbox"/>		<input type="checkbox"/>
Specific information:					
* see specific plans					
Signed: _____			Date: _____		
Occupational Therapist			Review date: _____		

KITCHEN ACTIVITIES

Name:

Activity	Code	Problem areas	Equipment required
Hot drinks		Mobility problems <input type="checkbox"/>	Kettle tipper <input type="checkbox"/>
Breakfast <input type="checkbox"/>		Difficulty transferring items <input type="checkbox"/>	Round kettle <input type="checkbox"/>
Micro meal <input type="checkbox"/>		Difficulty carrying items <input type="checkbox"/>	Jug kettle <input type="checkbox"/>
Full meal preparation		Difficulty identifying items <input type="checkbox"/>	Cordless kettle <input type="checkbox"/>
Electric cooker <input type="checkbox"/>		Difficulties with hand grip <input type="checkbox"/>	Saucepan <input type="checkbox"/>
Gas cooker <input type="checkbox"/>		Difficulties with cooker controls <input type="checkbox"/>	Cup <input type="checkbox"/>
Wash & dry dishes <input type="checkbox"/>		Difficulties with micro wave controls <input type="checkbox"/>	Cutlery <input type="checkbox"/>
Ready meal <input type="checkbox"/>		Standing tolerance <input type="checkbox"/>	Cooking utensils <input type="checkbox"/>
		Retrieving items from cupboard <input type="checkbox"/>	Trolley <input type="checkbox"/>
	<input type="checkbox"/>		Perching stool <input type="checkbox"/>
	<input type="checkbox"/>		Cap screw/twister <input type="checkbox"/>
	<input type="checkbox"/>		Cooker: gas <input type="checkbox"/> electric <input type="checkbox"/> micro <input type="checkbox"/>

Specific information:

Signed:

Date

Occupational Therapist

Review date:

Other examples of reablement support plans can be found by clicking the links below:

[Kirkless Support Plan: http://www.csed.csip.org.uk/silo/files/34-new-support-plan-and-tasks.doc](http://www.csed.csip.org.uk/silo/files/34-new-support-plan-and-tasks.doc)

[Kirklees Enabling Team \(Summary Sheet\): http://www.csed.csip.org.uk/silo/files/35-summary-sheet.doc](http://www.csed.csip.org.uk/silo/files/35-summary-sheet.doc)

[Leeds: Re-enablement Occupational Therapy Rehabilitation Plan: http://www.csed.csip.org.uk/silo/files/42-occupational-therapy-rehabilitation-plan.doc](http://www.csed.csip.org.uk/silo/files/42-occupational-therapy-rehabilitation-plan.doc)

[Leeds: Community Support Service User Plan http://www.csed.csip.org.uk/silo/files/44-css-24aservice-user-plan.doc](http://www.csed.csip.org.uk/silo/files/44-css-24aservice-user-plan.doc)

[Leeds: Re-enablement Community Support service Quality of Life Questionnaire: http://www.csed.csip.org.uk/silo/files/45-quality-of-life-questionnaire-casp19start.doc](http://www.csed.csip.org.uk/silo/files/45-quality-of-life-questionnaire-casp19start.doc)

[St Helens: Intervention Care Plan: http://www.csed.csip.org.uk/silo/files/63-intervention-care-plan.pdf](http://www.csed.csip.org.uk/silo/files/63-intervention-care-plan.pdf)

[St Helens: Weekly Monitoring Report: http://www.csed.csip.org.uk/silo/files/64-weekly-monitoring-report.pdf](http://www.csed.csip.org.uk/silo/files/64-weekly-monitoring-report.pdf)

[St Helens: Review of Re-ablement Programme: http://www.csed.csip.org.uk/silo/files/66-discharge-summary.pdf](http://www.csed.csip.org.uk/silo/files/66-discharge-summary.pdf)

[Staffordshire: Care Plan \(SW157\) http://www.csed.csip.org.uk/silo/files/75-care-plan-sw157.jpg](http://www.csed.csip.org.uk/silo/files/75-care-plan-sw157.jpg)

[Staffordshire: Therapeutic Goal Setting: http://www.csed.csip.org.uk/silo/files/77-therapeutic-goal-setting-sw153b.doc](http://www.csed.csip.org.uk/silo/files/77-therapeutic-goal-setting-sw153b.doc)

[Staffordshire: Diary for Care Plan / Amendment \(SW124\): http://www.csed.csip.org.uk/silo/files/78-sw124.jpg](http://www.csed.csip.org.uk/silo/files/78-sw124.jpg)

Reablement access, referral, assessment and reassessment process

The following chart aims to show the most common elements of the reablement access, referral, assessment and reassessment process. However, you may find the reablement services that you work in or with have different processes.

Stage in process	Comments	Stage in process	Comments
1 ↓	<p>Referral to reablement service</p> <ul style="list-style-type: none"> Some (selective) reablement services only take referrals from a small number of sources. Some take referrals from a wide range of sources. A minority take self-referrals. Some reablement services require specific documentation as part of the referral e.g. an assessment, a care plan. 	5 ↓	<p>Reablement support plan/care plan is implemented</p> <ul style="list-style-type: none"> As well as the ongoing care package, this may also involve actions such as obtaining equipment and showing the user how to use it, or signposting to other support.
2 ↓	<p>FACS criteria?</p> <ul style="list-style-type: none"> In some areas, FACS criteria are applied as part of the process of referring the user to the reablement service: only those with a high enough level of need to be eligible are referred. 	6 ↓	<p>Reablement support plan/care plan and client's progress are regularly monitored</p> <ul style="list-style-type: none"> All staff working with the user are expected to observe changes, progress, and problems and record these in the plan and discuss with colleagues as necessary. Some services hold weekly meetings at which users' progress is discussed. Some services have formal reviews after specific time intervals e.g. two weeks or four weeks. Plan may be adapted in light of ongoing assessment of user's needs.
3 ↓	<p>Reablement assessment</p> <ul style="list-style-type: none"> Many reablement services try to conduct these as quickly as possible e.g. within 24 hours of receiving the referral. The assessments are often done in the user's own home. Involvement of users in identifying their own priorities and goals is a key part of the reablement approach. Each reablement service will decide who has responsibility for doing the assessment, e.g. occupational therapists, social workers, care managers. Each reablement service uses its own assessment tools, and some use several assessment tools together. Some use a Single Assessment Procedure (SAP) shared with local social care and health services. Some receive a SAP but supplement it with reablement assessment tools. Some use assessment tools chosen or designed specifically for the reablement service. A risk assessment will usually be included as part of the reablement assessment. Some include a self-assessment tool completed by the user. 	7 ↓	<p>Reablement period ends; review completed with user (and family or carers if appropriate), assessment made of ongoing needs</p> <ul style="list-style-type: none"> Some services apply the same assessment tools at the end of reablement, to compare 'before' and 'after'. The review may result in a written care package, to be part of handover when user is referred on.
↓		8 ↓	<p>FACS criteria?</p> <ul style="list-style-type: none"> If the service applies FACS criteria at the end of the reablement period. Many services apply FACS at entry to and exit from the reablement service.
↓		9 ↓	<p>Referral to other services for ongoing needs to be met, if required</p> <ul style="list-style-type: none"> If no further formal support needed, may be given information about other services, community activities, etc. (signposting) May be offered a personal budget; council and user will work together to develop support plan and ensure personal budget is spent on achieving desired outcomes. If the user does not want to manage own personal budget, then ongoing care package may be commissioned from in-house council teams, or independent sector providers, depending on council's commissioning arrangements.
4 ↓	<p>Reablement support plan/care plan drawn up and agreed with the user</p> <ul style="list-style-type: none"> These have different names in different reablement services. 	10 ↓	<p>User satisfaction questionnaire/survey</p> <ul style="list-style-type: none"> Some services ask users to complete satisfaction questionnaires or surveys.

Information to collect

The government expects local authorities to work with the NHS to start measuring the impact of reablement services, both in terms of user outcomes and also cost effectiveness and efficient use of resources. To achieve this, local authorities need to develop systems to measure things such as:

- the costs of reablement, including costs per user
- the coverage of the reablement services
- outcomes for users
- the impact of reablement on users' need for ongoing care
- user satisfaction

The information will be used to analyse and measure the impact of reablement, and in many cases will inform strategic decisions about whether, when, where and how reablement services are expanded and developed in future. This means that the accuracy of the information gathered is crucial. Social care staff, including those working in reablement, are likely to play a part through, for example:

- collecting and recording information about the numbers of people going through reablement, the type and level of support they received, and their age, gender, address, reason for referral to reablement, etc.
- using agreed assessment tools to assess what a user can do at the start and again at the end of reablement
- asking people to complete user satisfaction questionnaires and surveys
- collecting and recording information about the degree of support, if any, that users require at the end of reablement, and the amount / cost of any ongoing care.

There is no one national set of questions or data to be captured. However, several local authorities in the North East are working together, supported by the Social Work Cooperative, to develop a consistent, shared approach.

Below are examples of the kinds of questions and tools being developed for some North East local authorities. Many of these are in development at the time of writing this learning guide, and may be subject to change – to see the most up-to-date tools being used in your area, contact the reablement service manager.

Costs

- The budget for the reablement service
- The actual amount spent on the reablement service (may be over/under budget)
- The costs per hour of contact time
- The costs per user
- The costs of non-contact time (e.g. admin time, travel time).

Coverage of reablement service

- What percentage of people accessing social care go through reablement?
- What percentage of new referrals to social care go through reablement?
- What percentage of the local population aged over 65 does this represent?

Outcomes for users: Daily Living Measures

(based on questions asked by Social Policy Research Unit, University of York, 2009)

- Ability to get up or down stairs
- Ability to get outdoors and walk down the road
- Ability to get around indoors
- Ability to get in or out of bed or chair
- Ability to use the WC
- Ability to wash face and hands
- Ability to bath, shower or wash all over
- Ability to get dressed / undressed
- Ability to feed self.

Outcomes for users: adapted ASCOT Self Assessment tool

(adapted by Social Work Co-operative)

Please ✓ the statement that applies mostly to you (only ✓ one)	
Control	
I have as much control over my daily life as I want	<input type="checkbox"/>
Sometimes I don't feel I have as much control over my daily life as I want	<input type="checkbox"/>
I have no control over my daily life	<input type="checkbox"/>
Safety	
I feel as safe as I want	<input type="checkbox"/>
Sometimes I do not feel as safe as I want	<input type="checkbox"/>
I never feel as safe as I want	<input type="checkbox"/>
Personal care	
I feel clean and wear what I want	<input type="checkbox"/>
I sometimes feel less clean than I want or sometimes can't wear what I want	<input type="checkbox"/>
I feel much less clean than I want, with poor personal hygiene	<input type="checkbox"/>
Food and nutrition	
I eat the meals I like when I want	<input type="checkbox"/>
I don't always eat the right meals I want, but I don't think there is a risk to my health	<input type="checkbox"/>
I don't always eat the right meals I want, and I think there is a risk to my health	<input type="checkbox"/>
Social participation	
My social situation and relationships are as good as I want	<input type="checkbox"/>
Sometimes I feel my social situation and relationships are not as good as I want	<input type="checkbox"/>
I feel socially isolated and often feel lonely	<input type="checkbox"/>

Please ✓ the statement that applies mostly to you (only ✓ one)	
Occupation	
I do the activities I want to do	<input type="checkbox"/>
I do some of the activities I want to do	<input type="checkbox"/>
I don't do any of the activities I want to do	<input type="checkbox"/>
Accommodation	
My home is as clean and comfortable as I want	<input type="checkbox"/>
My home is less clean and comfortable than I want	<input type="checkbox"/>
My home is not at all as clean or comfortable as I want	<input type="checkbox"/>
Caring role	
I provide others with the kind of support that I want to provide	<input type="checkbox"/>
At times I find it difficult to provide others with the kind of support that I want to provide	<input type="checkbox"/>
I am not able to provide others with the kind of support I want to provide	<input type="checkbox"/>
Level of worry and concern	
I feel free from worry and concerns on a day-to-day basis	<input type="checkbox"/>
I sometimes feel worried and concerned	<input type="checkbox"/>
I feel very worried and concerned on a daily basis	<input type="checkbox"/>
Dignity and respect	
I am treated by other people with the dignity and respect that I want	<input type="checkbox"/>
Sometimes I am not treated by other people with the dignity and respect that I want	<input type="checkbox"/>
I am never treated with the dignity and respect that I want	<input type="checkbox"/>

Impact on demand for care

(based on CSED impact assessment)

User group	No. users (per annum)	START: average care package (hrs per week)	START: range of hours (per week)	END: average care package (hrs per week)	END: range of hours (per week)	Average duration (weeks)
No further service required at end of reablement phase						
Assessed service package at start reduced at end of reablement phase						
Assessed service package at start maintained at end of reablement phase						
Assessed service package at start increased at end of reablement phase						
User did not complete reablement phase e.g. referred to other services including long term care or health, declined service once started, or died before end of reablement phase						
Total						

User satisfaction

(based on the Northumberland START service client satisfaction survey)

- Before you began to receive the service, did you understand what the service was going to do and why?
- Who told you about the service?
- Did you receive an information sheet about the service?
- If yes, did you think the information sheet was: very helpful / helpful / unhelpful / not sure?
- Have your START care workers come at times that suited you?

My START care workers:	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
Have spent time helping me to do things for myself					
Have done tasks for me that I could do myself					
Have been polite and friendly					
Have respected my dignity and privacy					
Have listened to me and supported me to express my needs and wants					

How do you feel about your ability to do these tasks now?			
Type of task	Now feel more able	No change	Now feel less able
Getting in and out of bed			
Getting dressed / undressed			
Getting washed / having a bath / shower			
Taking medication / tablets			
Going to the toilet			
Preparing a meal			
Shopping			
Housework / laundry			

- Are there any tasks you haven't had help with that you feel you should have?
- Did you understand the purpose of your review?
- Were you satisfied with the outcome of the review?
- Did you feel your views were taken into account?
- Do you think the review was held at the right time?
- Do you know how to make a complaint about the START service?
- Overall, how would you rate the service you have received from START?

In addition, both users and carers are asked for any further comments.

Reablement services in the North East

The following examples of reablement services in the North East are all drawn from research by the Social Work Co-operative report for their report Reablement services in the North East, for the North East Improvement and Efficiency Partnership, 2010.

Northumberland

Northumberland's START service was launched in Blyth Valley in October 2003. It now covers south and central Northumberland and the north of the county. The Tyne Valley and Ashington are not yet covered. START works with older people, including those with dementia and other mental health issues, and with people with physical disabilities. START works closely with care managers and with integrated Community rehabilitation services. The service was thoroughly evaluated after its launch and conducts a regular user survey.

Stockton

The reablement service consists of:

- 200 support care staff
- Rapid response nursing service
- Therapy team
- Independent Living Centre
- Rosedale House which has 10 rehab beds, 8 discharge beds, and 12 assessment beds
- Falls service

The service is for all client groups, but has a smaller number of referrals from people with learning disabilities and mental health problems. The service covers the whole borough. The service is likely to evolve further to take account of factors such as assistive technologies and demographic trends.

Newcastle

Newcastle has a well established reablement service, operating since 2006. A pilot is underway in the west area of the city, to introduce a system where all new referrals pass through reablement. Joint training is in place with the independent sector, provided in partnership with the NHS.

Middlesbrough

The reablement service has been running for five years, and is part of the Intermediate Care service. The service covers the whole borough, and all client groups, although it only receives small numbers of referrals from mental health and learning disabilities clients. The service is likely to change and develop further during this year.

Reablement services in other parts of England

The following examples are drawn from the report *Benefits of Homecare Reablement for people at different levels of need*, CSED, Department of Health, Jan 2009.

Essex County Council

Essex has developed a Domiciliary Reablement Service, delivered by a mixed team of therapists and enablement staff. The FACS criteria are those with 'substantial needs and above', applied at point of entry to the reablement service. Initially all the service users were from hospital discharges, but the service then widened to accept community referrals as well. It initially was available to adults aged 18 to 65, but later removed the upper age limit, and started accepting referrals from Learning Disabilities, Older Persons, and Adults services. Users are referred to the service by the Local Assessment and Care Management Teams, following an assessment.

The results of a six-month pilot are set out on the next page.

Domiciliary support staff in Essex are trained to ensure that people referred for reablement can safely practise the skills they need to manage in their own home, reassuring them and their carers that they can function as independently as possible.

The aim is to help individuals improve or regain their abilities and confidence to carry out daily living tasks in their own homes such as:

- personal care tasks e.g. washing, dressing, toileting
- domestic skills e.g. food and drink preparation, shopping, organising and planning daily routines, using transport, laundry, etc.
- encouraging confidence to enable safe transfers e.g. getting up and out of a chair, in and out of bed, on and off the toilet
- educating service users and their carers in safety awareness to prevent falls or avoidable accidents.
- To enable service users to choose courses of actions that will enable them to achieve their preferred life styles.

The Reablement Service supports around 300 people at any one time, including the delivery of up to 3,000 care and support hours weekly. Locality teams are based at Braintree, Chelmsford, Basildon, Colchester, Tending, Harlow, and Epping.

Dorset County Council

Dorset piloted a reablement service in the Weymouth and Portland locality from September 2007 to March 2008. The County Council's in-house domiciliary support service offered a six week reablement programme for all people referred for home care. The reablement service was only available to those people whose needs already met the FACS eligibility criteria – substantial or critical level of need. Clients were charged for the service, but at a flat rate, not the full home care cost.

Following a positive evaluation, it was decided to develop a service initially in East Dorset, and then roll it out across the county. The service is now available prior to

FACS assessment, and offered as part of a multi-agency intermediate care team. This service is free for up to six weeks.

Gloucestershire County Council

In April 2007 Gloucestershire changed its in-house home care service, and rebranded it as Community STEPS (Short Term Enablement Programmes). The service is available to people with FACS criteria of 'substantial and above' needs, applied at point of entry to the service.

The service began by focusing on supporting hospital discharges, and preventing avoidable admissions to hospital and residential care. The service expanded to provide an intake function for all new referrals. It aims to promote independence and enable people to remain living in their own homes.

The service is short term, with on average six weeks of support. It is chargeable. After the review at the end of the reablement package, if the client/user needs ongoing care, this is provided by independent sector providers.

Herefordshire Council

Herefordshire's Short Term Assessment and Reablement and Review Service (STARRS) provides domiciliary support and reablement to people experiencing a short-term health crisis at home, who without support might have had to be admitted to hospital, and to people in hospital who need short-term support to return home safely. The service is available to adults who have met the Council's eligibility criteria under FACS of substantial need and above, applied at point of entry to the reablement service. The service is delivered by a mixed team, with therapists and support workers. The service is free for the first six weeks.

Norfolk County Council

The Council remodelled its home care service in 2008 and started offering a reablement service called Norfolk First. The service started by focusing on hospital referrals, with the aim of relieving pressure on hospital discharges, and consequent delays in discharge. Norfolk First receives referrals from acute

Results of 6 month pilot April–Sept 2008, hospital discharge

	No. users (per annum)	Average care package hrs per week at start**	Range of hrs per week at start	Average care package hrs per week at end	Range of hrs per week at end	Average duration (weeks)
No further home care package needed	272 (35%)	7.0	1.0 to 24.5 hrs	-	-	4.1
Reduced home care package needed	135 (18%)	10.0	1.75 – 28.0 hrs	6.7	1.0 to 23.5 hrs	6.6
Same level home care package needed	141 (18%)	9.0	1.75 to 31.5 hrs	9.0	1.75 to 31.5 hrs	5.6
Increased home care package needed	29 (4%)	8.6	3.5 to 35.0 hrs	13.4	4.0 to 53.0 hrs	5.7
User did not complete reablement*	192 (25%)	8.9	1.74 to 31.5 hrs	8.9 ***		2.7
TOTAL	769 (100%)	8.4		8.6		4.5

*Did not complete: eg, referred to other services, including long term care or health, declined service once started or died before end of reablement phase.

**The care package at the start is the domiciliary care package that would have been commissioned had the person not entered reablement.

***The care package at exit was generally zero, but in the table it is shown as the same as the care package at start to ensure that only the benefits from reablement are illustrated.

hospitals, community hospitals, and transitional beds. It then expanded to take users based in the community ‘where possible’, and began working with independent sector home care providers to increase capacity, with the aim of providing for all users who meet the criteria for the Norfolk First support service.

Norfolk First provides six weeks of intensive support, to optimise the service user’s independence. All users are subject to FACS assessment at point of entry, and the criteria for eligibility are ‘substantial needs and above’. The service is chargeable. Norfolk First has trained 250 staff who work in the service in assessment and reablement skills. Norfolk First works very closely with occupational therapy teams.

Wirral (Metropolitan Borough)

Wirral operated a hospital discharge support service for several years. In 2007 it expanded this to become an Intake and Assessment reablement service, and changed the name to Wirral Home Assessment and Reablement Teams (Wirral HART). The service increased and handled most hospital discharges, plus assessments in relation to direct payments. Users are assessed using FACS at the point of exit from the service to determine eligibility for further packages of support. Eligibility is for those with ‘substantial or above’ needs.

The role of the team as assessors was embedded, and the team moved from the Care Services division to the Access and Assessment division. It was agreed that

in principle, most people will not receive permanent or increased care without assessment via the HART service. Wirral HART staff had training:

- as assessors for assistive technology
- as referrers for medicines management
- in the pathway for provision of direct payments
- as sign-posters to low level services.

Where to find out more

[The North East Improvement and Efficiency Partnership \(NE IEP\)](http://www.northeastiep.gov.uk)

www.northeastiep.gov.uk

See the adult social care pages of the website for information and resources on reablement in the North East.

The partnership is made up of the 12 North East local authorities and four fire and rescue authorities, working together. Launched in 2008, its work is due to end in March 2011.

[Care Services Efficiency Delivery \(CSED\)](http://www.dhcarenetworks.org.uk/csed/)

www.dhcarenetworks.org.uk/csed/

See the pages on home care reablement on the website.

CSED is run by the Department of Health. It was set up to help councils identify and develop more efficient ways of delivering adult social care. CSED has done a lot of work on reablement, including commissioning and publishing research reports on the different ways councils have implemented reablement, and the benefits experienced by users.

[Association of Directors of Adult Social Services \(ADASS\)](http://www.adass.org.uk)

www.adass.org.uk

See the North East regional pages on the website, and also pages on policy networks, publications and events, for information on reablement, and other aspects of adult social care including personalisation.



[JustAsc?](http://justasc.org.uk)

The Just Asc? website provides a range of tools, resources and information to support public relations and communications for adult social care. The site also provides a forum for communications professionals to share ideas, information and questions. To register email: justasc@northeastcouncils.gov.uk

The Social Work Co-operative (SWC)

www.socialwork.coop

The Social Work Co-operative is a social enterprise that is mutually owned by health and social care professionals, including the social workers and consultants that work through it. Members of the SWC team combine expertise, experience, innovation, and front-line working, and deliver innovative products and consultancy services across the sector. The SWC is known as a regional innovator on reablement in the North East.

Office for Public Management (OPM)

www.opm.co.uk

OPM provides consultancy, coaching and research to organisations that want to improve social outcomes, meet the needs of their communities and respond to change. We work with a wide range of bodies including local councils, the NHS, central government, agencies, charities and not-for-profit organisations. We have a particularly strong interest in health and social care including personalisation, personal budgets, reablement, co-production, supporting service redesign, evaluating outcomes and improving efficiency.

North East local authorities

Find out more about the services offered in each of the 12 North East local authorities.

Darlington Borough Council www.darlington.gov.uk

Durham County Council www.durham.gov.uk

Gateshead Metropolitan Borough Council www.gateshead.gov.uk

Hartlepool Borough Council www.hartlepool.gov.uk

Middlesbrough Council www.middlesbrough.gov.uk

Newcastle City Council www.newcastle.gov.uk

North Tyneside Metropolitan Borough Council www.northtyneside.gov.uk

Northumberland County Council www.northumberland.gov.uk

South Tyneside Metropolitan Borough Council www.southtyneside.gov.uk

Stockton-on-Tees Borough Council www.stockton.gov.uk

Sunderland City Council www.sunderland.gov.uk

Redcar and Cleveland Borough Council www.redcar-cleveland.gov.uk