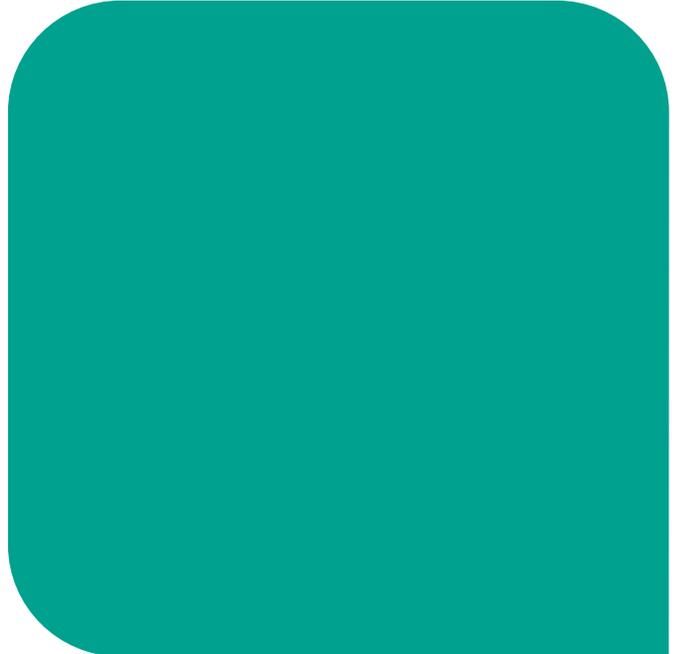


# Maximising the potential of reablement



The Social Care Institute for Excellence (SCIE) was established by Government in 2001 to improve social care services for adults and children in the United Kingdom.

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## About this guide

This guide is based on research and practice evidence about the effectiveness and cost-effectiveness of reablement.

The guide is based on:

- SCIE's **Research briefing 36: Reablement: a cost-effective route to better outcomes** which was based on a review of research evidence published in December 2010 and practice visits conducted in spring 2010.
- SCIE's **At a glance briefings on reablement** examining the implications of reablement for key groups including: GPs, commissioners of adult social care, occupational therapists, reablement providers and families of people using reablement.
- An updated review of relevant effectiveness and cost-effectiveness studies, published after SCIE's 'Research briefing 36', plus qualitative research on the views of people using reablement.
- Government advice on funding arrangements for reablement and Department of Health (DH) funded guidance on implementing reablement.
- Practice visits to four reablement teams providing support to people living with dementia.
- The Project Advisory Group, whose role was to review the way the guide was produced and written to ensure it reflected the realities of practice.

## Research methodology

Research evidence was drawn from approximately 10 studies (including two randomised controlled trials and two non-randomised controlled trials).

Inclusion criteria:

- Published since January 2011 until November 2012.
- Literature from UK and overseas, where the setting is a developed service infrastructure.
- Controlled evaluations of reablement (or 'restorative home care') where the comparison or 'control' is domiciliary care and where reported outcomes include: service outcomes such as care hours required and hospital readmission rates; activities of daily living and other scale measures such as 'timed up and go'; final (quality of life) outcomes.
- Economic evaluations.
- Studies of user and carer views of reablement.

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## Overview

- Reablement is meant to help people accommodate illness or disability by learning or re-learning the skills necessary for daily living.
- Although a focus on regaining physical ability is central, addressing psychological support to build confidence as well as social needs and related activities is also vitally important and often neglected.
- Funding for reablement continues to be channelled via the NHS to encourage integrated working between local authorities and health. Local authority commissioners should be working with their clinical commissioning group (CCG) counterparts to negotiate use of the monies.
- Everybody involved in planning, referring to and providing reablement will need to operate differently than is the case in the traditional context of home care.
- Reablement requires a move away from commissioning on the basis of time and tasks. Instead, reablement should be commissioned on the basis of the outcomes that the service will support the individual to achieve.
- Reablement workers must learn to stand back and encourage people to regain or re-learn the ability to do things for themselves.
- There is consensus that reablement is not effective unless care workers undergo specific training to understand the principles of delivering a reablement service.
- Achieving the full potential of reablement relies not only on the internal organisation of the service but also on how access to other professionals and supporting services is organised.
- Although research evidence says little on the subject, there is growing practice interest in supporting people living with dementia through reablement.
- If a person has ongoing support needs at the end of reablement, it is crucial that subsequent services continue to provide support in a way that maintains any progress that person had made.

## Introduction

Reablement should not be limited to a focus on regaining physical independence but should also address people's broader social and psychological needs to build their overall confidence and maximise their quality of life.

### Guide focus and audience

This guide is for people who plan, refer to and provide reablement. It is not aimed at people using reablement or their families although they might find it useful in understanding what to expect from those planning and delivering their support. People using reablement and their families play a fundamental role in the success of reablement, an issue that is addressed throughout this guide.

SCIE and Carers UK have produced a short [guide to reablement for families and carers](#).

Reablement is sometimes seen as a distinct service (with dedicated staff and systems) and sometimes as a philosophy for the provision of all adult social care and support.

The focus of this guide is the former: supporting the commissioning and delivery of distinct reablement services. However, the recommendations are also useful for encouraging a more 'reabling' ethos in the wider domiciliary care market and across all of adult care and support.

### The scope of reablement

Reablement is one service on a continuum of intermediate care. This continuum spans acute and long-term care and responds to a range of health and social care needs. Other 'intermediate' services can include rehabilitation, rapid response and supported discharge teams.

Although there is no single delivery model for reablement, it is generally designed to help people accommodate illness or disability by learning or re-learning the skills necessary for daily living. These skills may have been lost through deterioration in health and/or increased support needs.

Reablement services are generally provided for a period of up to six weeks although people often meet their goals in a far shorter period of time. The focus is on promoting and optimising independent functioning rather than resolving health issues. It is about helping people do as much for themselves as possible rather than doing things for people that they cannot do.

### Recommendations

- Active, ongoing assessment is a fundamental aspect of reablement. It ensures that support is tailored to the often fluctuating nature of people's recovery.
- Although a focus on regaining physical ability is central, addressing psychological support to build confidence as well as social needs and related activities is also vitally important and often neglected.

- Reablement has been criticised for failing to meet people's social needs, which are often central to their perception of independence.

### **Recommendations**

- An important part of people's recovery is the resumption of hobbies and social activities, seeing friends or walking to the local shop for their daily paper. It therefore follows that reablement is not restricted to support provided in people's homes. Reablement may take place in the wider community, for instance with a trip to the shops or an outing to a local café.
- Reablement services must ensure the scope of their work recognises these wider needs and can support people by removing obstacles to community participation – for example, enabling them to walk down their front steps safely or accompanying them the first time they return to a social group or club.
- Reablement services have an important role to play in signposting people to other suitable services or activities in the local community. They can help enormously by accumulating and sharing good local knowledge about activities, clubs, groups and transport services.

In some areas, there are formal 'community connector' services, which link people up to local services, addressing social and psychological needs.

### **Case study: community connectors**

Richard was assessed as having mental health support needs and had been attending a day centre for a number of years. He was at risk of becoming socially isolated within his community. Following reassessment the community connector looked into more meaningful community options for him. At first Richard was very anxious about leaving what he had known for a number of years and his family expressed concerns. The community connector supported Richard in accessing public transport and travelled with him until he became confident with using the service independently. Richard was introduced to other community options such as an art class in town, and is now regularly attending this and other groups.

## Policy context

### Overview

Since 2010 the government has supported reablement through specific funding streams. The funding has been directed via health to encourage integrated planning between local authorities and health. Local authority commissioners need to work with their colleagues in CCGs to negotiate use of these monies to support the ongoing development of reablement. Online resources are available to help inform the development and/or ongoing monitoring of reablement services and a selection of these can be found in the Further resources below.

### National policy context

The importance of investment in preventive services has long been recognised and has cross-party support. At the Fifth International Carers Conference in 2010, the then Secretary of State for Health, Andrew Lansley, placed renewed emphasis on maintaining independence:

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.

Reablement has since received policy support as one means of prolonging or regaining independence and to facilitate its wider roll-out, the Department of Health (DH) invested £70 million in reablement in 2010 [2]. The government spending review and 2011/12 NHS operating framework provided further funding to the then primary care trusts (PCTs) for the financial years 2011/12 and 2012/13 to develop local reablement services, in partnership with councils, in the context of post-discharge support plans [3].

Subsequently, the 'Care and Support' White Paper [4] announced that £859 million would be transferred to local authorities by the NHS Commissioning Board during 2013/14. This funding is often known locally as the '256 monies', because the payments are to be made via an agreement under Section 256 of the 2006 NHS Act [5].

Although the payments are not ring-fenced for reablement the DH stipulates that they must be used to support adult social care services, which also have a health benefit. It is therefore clear that the investment is intended to support services like reablement and other means of improving the hospital/care and support interface. One of the main conditions of the transfer is that local authorities can demonstrate how it will make a positive difference to social care services and outcomes for services users compared to service plans in the absence of the 256 monies. It is clear that the emphasis is on ensuring the funding is used cost-effectively, which requires local authorities to measure the costs of the services they invest in and the outcomes achieved as a result.

## Local implementation of reablement

The majority of reablement services are funded by local authorities (71 per cent in 2012) although, increasingly, some are being co-funded with health. A central tenet of government funding for reablement has always been that investment in adult social care benefits health services and improves overall health gain. As this argument gains recognition, the balance between jointly funded and solely funded schemes may shift.

### Recommendation

- Local authority commissioners should be working with their CCG counterparts to negotiate use of the 256 monies. Health and wellbeing boards are the logical place for discussions to take place between the NHS Commissioning Board, CCGs and local authorities about use of the monies.

The allocation of funding to local authorities is a recognition of the upfront investment needed to provide this more intensive support. Reablement is more costly to deliver than conventional home care and, unlike home care, it is not a chargeable service. This is in accordance with Section 15 of the Community Care (Delayed Discharges etc.) Act and the Community Care (Delayed Discharges etc.) Act (Qualifying Services) (England) Regulations 2003 (2003/1196) (the '2003 Regulations').

Almost all reablement services were started in-house (often developed from existing in-house domiciliary services) although, as the market matures, consideration is being given to outsourcing reablement. In 2012[6] 24 local authorities reported to have outsourced reablement in various ways (compared with 110 still operating in-house). In addition, several were in the early planning stages of outsourcing, testing the market and so on.

### Recommendation

The following tips may be helpful in setting up and monitoring a reablement service:

- Commissioners will be helped, when establishing a reablement service, by identifying the baseline performance of current provision. For example, the existing in-house home care service. The Care Services Efficiency Delivery (CSED) programme provides some useful benchmarking formats and advice.
- When setting up or reviewing a reablement service, use a standard framework such as the toolkit published by CSED. This is based on local authorities who piloted the use of reablement across England. The toolkit is set out in eight sections describing the project steps that help lead to a successful reablement service.
- The connection with other community-based services, such as intermediate care, needs to be reviewed, especially if they have been developed on a needs basis rather than planned. Bury NHS and Adult Care Services has an integrated model with the connections between many community services identified in its document on reablement.

## Further resources

The full text of Andrew Lansley's speech to the Fifth International Carers Conference can be accessed via the [DH online archives](#).

- [The 'Care and Support' White Paper](#).
- [The local authority circular outlining investment in reablement via NHS support for social care \(2010/11–2012/13\)](#).
- [The local authority circular setting out arrangements for the funding transfer from the NHS to social care in 2013/14, including arrangements for the 256 monies](#).
- [The local authority circular explaining the position on charging for reablement](#).
- [The CSED toolkit for reablement archive](#).
- [A discussion paper about outsourcing reablement, by Gerald Pilkington Associates](#).
- [The Bury NHS and Adult Care Services' business case for reablement](#).

## The required culture change

### Overview

Everybody involved in planning, referring to and providing reablement is expected to operate differently than in the traditional context of home care.

#### **Recommendation**

- Reablement is not a bolt-on service: it must be integrated within the context of local support services including health, housing and social care. This requires everyone involved to work in partnership from the scoping and planning stages of a new service to referrals and delivery of individual support plans.

### People involved in planning and referring to reablement services

This section looks at changes in the way people need to work when they are planning, establishing or procuring a reablement service. In some places, they may be known as 'commissioners' where other local authorities have 'procurement teams'.

#### **Recommendation**

- Reablement requires a move away from commissioning on the basis of time and tasks. Instead, it should be commissioned on the basis of the outcomes that the service will support the individual to achieve.

This greater flexibility and focus on outcomes can be emphasised in service contracts. For example, in one borough, the reablement provider is paid a lump sum to use in whatever way is necessary to support a person in achieving desired outcomes. This gives the provider flexibility to deliver intensive support at the beginning of a service and then adjust input according to the person's changing abilities and confidence. It is therefore implied that the commissioning authority is paying the provider to achieve certain outcomes as opposed to performing certain tasks during set visiting times.

In this context, the importance of maintaining good, honest relationships between commissioning authorities and reablement providers cannot be exaggerated. Commissioning on the basis of outcomes achieved rather than hours provided is a clear departure from traditional commissioning arrangements and requires trust and transparency from both commissioner and provider. This will help ensure reablement is seen as an opportunity rather than a threat.

#### **Recommendation**

- In order to encourage a focus on outcomes in the provision of reablement, commissioners should consider offering incentives to providers (based on these outcomes). At the same time, perverse incentives to extend the reablement period should be minimised.

### **Case study: commissioning for results**

One county council has a payment model for reablement that is based on providers achieving 'no further action' (NFA). Providers are given a basic amount of money for each person referred to them and have to ensure a certain proportion of their service users are NFAs in order to receive a top-up payment. NFA means that for a 90-day period the individual does not require support from any formal health or social care services such as hospital admission or home care services. If they fall below the designated proportion of NFAs the provider loses money.

### **Recommendation**

- Where incentives based on outcomes are offered, commissioners should ensure the outcomes are measured in relative terms against service users' baseline needs. This is important because the basis for including or excluding people with certain needs or conditions varies significantly between reablement services.
- The model for the employment of reablement care workers should be assessed to ensure it is fit for this new means of commissioning.

The 'zero hours' contracts held by many care workers may be too inflexible for the purposes of reablement. The risk of this type of contract is that it does not provide an incentive for the reablement worker to reduce the amount of support a person needs, as they would be reducing potential earnings. Employing reablement workers on 'set contracted hours' may offer a better alternative and greater stability for the worker, although from a commissioner's perspective, it will be more costly.

### **Recommendations**

- The same flexibility should be possible in the independent sector. Where reablement is outsourced, the commissioning authority should procure services in a way that enables private providers to employ reablement workers on the same flexible contracts as their in-house counterparts. This includes paying for travel time and for time spent in training.
- On the whole, there should be clear communication between the commissioning authority and local providers, beginning at the initial development phase, so that commissioners can be sure their procurement plans will attract tenders to support the roll-out of reablement.
- Those planning and procuring reablement need to be realistic about the pattern of investment and savings they can expect. The need for training, closer supervision of care workers and more responsive, flexible visits all contribute to a greater upfront investment in reablement compared with conventional home care. However, research demonstrates savings of 60 per cent on social care spend following a period of reablement [7-8] and in practice local authorities have reported even greater savings.

### **Referrals to reablement services**

Research on the effectiveness of reablement tends to focus on the role of reablement managers and frontline workers where research and advice on planning and investing in reablement addresses the role of commissioners. Far less research centres on the task of referring to reablement, normally undertaken by social workers, whether in hospital or the community. This recommendation is therefore based on what is known about the importance of people having a clear understanding of reablement and working toward goals that are relevant to them:

#### Recommendation

Those referring to reablement should ensure that:

- they know how reablement fits within the context of other local health, social care, housing or equipment services
- they know any referral requirements for the reablement service (e.g. whether they are limited to referrals from the community or from hospitals or whether they exclude referrals on the basis of particular criteria)
- they include in their assessments a holistic understanding of the person's strengths
- they know enough to describe reablement, including its role in maximising independence and its time-limited nature (usually a maximum of six weeks)
- they have sufficient information about the outcomes of reablement to be able to convey hope about improving physical, social and/or psychological wellbeing
- they encourage independent sector care providers to deliver any ongoing support in a way that maintains the progress a person has made during a period of reablement
- they encourage all providers of adult social care to deliver support in a way that maximises people's control over their own lives and ability to do things for themselves.

## Providers of reablement – service managers and frontline workers

This section addresses those involved in providing reablement, whether as service managers, co-ordinators or frontline reablement workers. The recommendations apply to in-house and independent sector providers.

### Recommendations

- Reablement requires a particular culture change for care workers. They need to start by discussing and agreeing goals with the person using the service and break them down into achievable targets.
- Care workers must learn to stand back and encourage people to regain or re-learn the ability to do things for themselves. In practice, this means learning to observe and not automatically intervening even when a person is struggling to perform an activity such as dressing themselves or preparing a snack.

The crucial skill in delivering reablement is in knowing when to do something for a person (for instance, right at the start of the support package or if they experience a setback) and knowing when to do things alongside and with a person. Compared with conventional home care, this is a new way of working and making the shift can be challenging. If people have a long work history in home care they may find reablement does not appeal to them. On the other hand, with good training and support, care workers often welcome the opportunity to work in this new way and report greater job satisfaction. Please see the recommendations in the section on [workforce development and training](#).

### Recommendations

- Reablement care workers must be responsive to a person's changing needs. They must communicate these changes effectively with their manager so that the amount of support provided is reduced as the person gains independence – or increased if the person's progress is slow.
- Service managers should ensure greater flexibility than conventional home care would normally offer. They should provide more intense supervision to support reablement workers' training and promote the 'reabling' ethos. They should allow for the constant assessment of people's needs and re-adjustment of the level and nature of support provided.
- The more flexible, responsive visits by reablement workers are likely to last longer than a traditional home care visit: managers should account for this in service business planning and implementation.
- Managers also need to plan staffing in a way that allows continuity of reablement care workers. This is also important in the context of a conventional home care service but the need is heightened in reablement which only lasts for a limited period and requires rapport and trust to be established quickly.

- Managers and reablement workers should ensure that people using the service are fully supported and informed so they have a clear understanding of what is involved in receiving reablement. It is particularly important to explain the following:
  - The aim of reablement: for instance, to improve their confidence and ability to carry out day-to-day tasks without help. This means that reablement care workers will be working alongside them rather than doing everything for them.
  - The finite nature of reablement: the service will last for a limited period of time. It is useful to state the usual upper limit (in some places this is six weeks) but be careful not to imply any entitlement to this length of service since some people will reach their goals within a far shorter space of time. Please also see the section on **successfully ending a period of reablement**.
  - The pattern of visits: reablement workers (and associated professionals such as occupational therapists) may visit with much greater frequency at the start of the service when the person may need more support. Visits may last longer at different times and will certainly be longer than a conventional home care visit, with which they may have past experience. For example, it is likely to take longer to support someone to dress themselves than it would to do this for them.
- As well as clear, verbal explanations, information about reablement should be available in a range of different formats at the beginning and throughout the service.
- There are a number of circumstances in which it is particularly important to take extra care explaining what is involved in reablement and what should be expected, for instance:
  - If the person has experienced traditional home care, since they may be used to care workers doing things for them.
  - If the person is adjusting to major changes in their life, has been discharged from hospital or is in great pain. In such circumstances they should not be expected to understand or remember a 'one-off' explanation.
  - If the person lives alone or has little support from family or friends. Such people have no one to listen to the explanation with them and subsequently explain or reinforce it.

# The importance of goal-setting

## Overview

Successful reablement depends on the development of person-centred goals toward which people will work with the support of the reablement service. Although there is no single tool for goal-setting in reablement there are certain principles that should underpin the process.

Goal-setting is essential to the success of reablement. There is no single universally accepted tool for goal-setting, although focusing on people's strengths and what they want to be able to do is a good basis for the process.

## Recommendations

- Having established people's needs and strengths, goal-setting involves three main steps: identifying an end point (the goal or achievement), working out what steps are needed to reach that end point and, finally, establishing what structures must be in place to facilitate goal attainment.
- Occupational and physiotherapists play a fundamental role in goal-setting. They should either be deployed to carry out this task or train reablement workers to carry it out themselves. Please see the section on the [skills mix in a reablement service](#).
- The 'SMART' principles also provide a useful guide to goal-setting. SMART goals are:
  - Specific – it's easier to accomplish a specific goal than a general one. For example, 're-join my old lunch club and attend twice a week'.
  - Measurable – there should be concrete criteria for measuring progress toward the attainment of goals.
  - Attainable – when people identify goals that are really important to them (e.g. 'be able to cook Sunday lunch for my family again') they are more likely to develop the attitudes and ability to reach them.
  - Realistic – goals should represent an objective that people are willing and able to work toward. They should also be set at a sufficiently high level that they represent real progress. Of course, progress is relative.
  - Timely – goals should be grounded within a time frame (e.g. 'by the end of the week I will be able to button my own cardigan').
- Although the SMART principles provide a good framework, they should be applied in a way that is responsive to each individual's needs. Above all, goals must be person-centred and developed with as much participation as possible by the individual.

- Goals are a joint undertaking between the individual and the reablement service. Having a written agreement, signed by both parties, is one way of formalising people's commitment to achieving goals.
- Where appropriate, the individual's family and friends should also be involved in goal-setting. Any conflicting or opposing views about suitable goals must be negotiated sensitively and with professional judgement.

The concept of independence is often central to goal-setting. However, there is no single, standard definition of independence.

### **Recommendations**

- It is important to acknowledge that an individual's definition may be very different to the way a professional would define independence.
- It is therefore crucial that reablement managers and frontline workers have a clear understanding of the individual's priorities and the aspects of their life they believe are central to feeling 'independent'. If the person's own aspirations and definition of 'successful' reablement are not clearly understood, there is a risk they will become demoralised when they see they are not being helped to achieve their personal goals.
- Whether goals have been formally 'signed up' to or simply discussed and agreed, they should be constantly reiterated throughout the period of reablement.
- Although goal-setting is very important, working toward those goals must be done in a flexible, responsive way. During a person's recovery there are bound to be fluctuations in their health and social circumstances. Although a reablement worker may normally encourage someone to perform their personal care or cooking they may need to provide more hands-on help in the event of illness or a deterioration in that person's condition.
- If progress toward goals is completely stalled there should be a full review of the person's needs. Goals may need to be redefined and support levels may need to be adjusted.

## Skills mix and supporting services

### Overview

Achieving the full potential of reablement relies not only on the internal organisation of the service but also on how access to other professionals and supporting services is organised.

The overall skills mix of a reablement team is important. Although care workers are the foundation of a reablement service, social workers, nurses, physiotherapists and occupational therapists make important contributions and decisions need to be made about how to involve them.

### Recommendation

- Nurses, physiotherapists and occupational therapists do not necessarily have to be involved as full-time team members within a reablement service. However, it is crucial to ensure that professionals with appropriate skills can be accessed by the reablement service in a timely manner. For example, research found [7] that although it is not critical for occupational therapists to be embedded in the service, they have an important role in the delivery of reablement.

Having said this, it is important to note that while occupational therapists are commonly associated with reablement, it is unclear from available research evidence whether their skills are essential to successful reablement. However, we do know from research and practice evidence that managers and staff value input from occupational therapists, especially in terms of ensuring prompt access to equipment.

### Recommendation

- There is no single model for how occupational therapists should be included in a reablement service – examples from a range of authorities include [9]:
  - Incorporating them as core team members. Reablement care workers appear to value the close working relationships when occupational therapists are team members and particularly welcome advice and input at progress reviews.
  - Occupational therapists as trainers. The input of occupational therapists is highly valued for training reablement care workers – for example, to assess for smaller pieces of equipment, thereby reducing unnecessary delays. Occupational therapists can also give essential training on assessment, goal-setting and maintaining a ‘reabling ethos’.

- Occupational therapists working collaboratively, an arrangement that may be helped by co-location of teams. In one London borough, although occupational therapists are not full team members, their close working with the reablement team is seen as critical to success. There are robust working relationships with community-based occupational therapists as well as the hospital rehabilitation teams. Joint working takes place where there are concerns about assessment or complex cases.

Those planning reablement services could adapt these models for involving other relevant professionals such as physiotherapists.

'Telecare' refers to systems for the remote monitoring of safety (e.g. fall detectors), lifestyle (e.g. 'just checking' movement sensors) and environment (flood detectors). Sensors in the home connect to monitoring centres which can elicit a response from designated friends or family members, a response team and/or the emergency services. This technology can play an important part in the reablement process. It can help inform the assessment process, manage risk and offer support during and following a period of reablement.

### **Recommendations**

- It is therefore important that telecare assessors and systems are readily accessible to reablement teams.
- To help achieve a seamless connection between reablement and telecare services, the potential use of telecare should be assessed at the same time as the initial reablement assessment takes place. This can be achieved either by reablement workers being appropriately trained or by having timely access to telecare assessors.
- In the same way that reablement workers need rapid access to other professionals and services (such as equipment), they should have rapid access to telecare systems. Supply arrangements should be reviewed to ensure that what is needed can be sourced at the beginning of the reablement period.
- Particularly where people are assessed as needing no ongoing domiciliary support, telecare can contribute to monitoring safety, which can provide reassurance to people and their families. Post-reablement procedures should therefore be in place to ensure that telecare systems are not automatically withdrawn at the end of the reablement service.

In one local authority, telecare introduced during the period of reablement is provided at no charge to the individual. At the end of the reablement service, if there is an ongoing need for telecare, the system remains with the person and still no charge is made.

Although telecare can contribute to monitoring safety and improving people's confidence and independence, its limits should be understood and its use should be carefully considered.

## Recommendations

- Telecare is no substitute for human contact and should not be relied upon to judge changes in a person's wellbeing. If this kind of monitoring is deemed to be required after the reablement service then options such as voluntary sector befriending schemes or hobbies and interest groups should be explored. Please refer to the section on **successfully ending a period of reablement**.
- Additional equipment and services for supporting reablement should only be introduced with the understanding, co-operation and consent of the individual. It would be unethical to introduce systems for monitoring movement and lifestyle if the individual did not understand the nature and purpose of the information being recorded.
- Equipment and systems must be introduced sensitively and with careful explanation about their operation. Where an individual lives alone it may be helpful for installation to take place when a family member or friend can be available so they also develop an understanding of how to operate the system.

## Further resources

- The College of Occupational Therapists position statement **Reablement: the added value of occupational therapists**.
- SCIE has produced two SCTV films about the use of telecare. One film focuses on the **potential benefits of telecare**. The second film explores some of the **ethical issues relating to the use of telecare**.
- SCIE has published a report on the ethical issues relating to the commissioning and provision of telecare: **SCIE Report 30 Ethical issues in the use of telecare**.
- **SCIE At a glance 24. Ethical issues in the use of telecare**.

## Workforce development

### Overview

Some councils set the Level 2 Diploma in Health and Social Care as the minimum qualification for reablement care workers. For information, the Diplomas in Health and Social Care are part of the Qualifications and Credit Framework (QCF), which replaced NVQs in January 2011. The Level 2 and 3 Diplomas in Health and Social Care replace the Health and Social Care NVQs at Level 2 and 3. It is important to note that NVQs awarded (or registered for) before January 2011 are still recognised as legitimate qualifications of competency.

There is however, consensus that reablement is not effective unless care workers undergo specific training to understand the principles of delivering a reablement service.

In addition to their care qualifications, reablement workers will benefit from specific reablement training.

### Recommendations

- Training should be ongoing and feature in a care worker's continuing professional development (CPD).
- Reablement training should include, but not be limited to:
  - an understanding of the concept and ethos of reablement and the knowledge needed as a starting point in the 'reabling' process
  - an explanation of the distinction between the social and medical models of disability
  - a thorough grasp of tools for identifying, agreeing, monitoring and recording person-centred outcomes.
- Reablement staff need training to be sensitive to small changes and incorporate these into reassessment if they are to maximise the appropriateness and effectiveness of the support being provided. They should also be trained to work in partnership with people using reablement and their families in order to help them come to terms with loss or impairment of skills.

There is no single, accredited training programme for reablement and since it is a developing practice there are currently no specific units on reablement within the QCF. There are however, a range of units relevant to reablement which can be packaged into the Diploma in Health and Social Care.

Training and consultancy services are also available and although SCIE does not specifically endorse them, they include companies such as Reablement UK and Bespoke Training Services UK Ltd. The College of Occupational Therapists (COT) consultancy service also provides bespoke training courses on reablement.

Individual councils have developed training manuals and programmes, which they may be willing to share. In addition, the North East Improvement and Efficiency Partnership (NEIEP) has published a guide to reablement for frontline staff.

SCIE has produced two elearning modules for reablement providers. One is targeted at managers of reablement services (or home care managers wanting to deliver support in a more 'reabling' way) and the other is aimed at frontline reablement care workers. The elearning modules are underpinned by evidence from research and practice. They are available for use free of charge.

## Further resources

- Health and Social Care Diplomas and the range of available units are on the [Skills for Care website](#).
- North East Improvement and Efficiency Partnership (NEIEP) [Reablement: a guide for frontline staff](#).
- [Reablement UK](#).
- [Bespoke Training Services UK](#).
- [COT consultancy service](#).
- [SCIE elearning modules for reablement providers](#).

# The role of families in supporting the reablement process

## Overview

A person's family and friends can play a big part in the success or failure of reablement. It is key for the person using the service to be motivated to achieve agreed outcomes and improve their independence. If they live with, or have frequent contact with, family and friends, those people can help to stimulate and maintain motivation.

## Recommendations

- Reablement services must recognise the important role played by families, carers and friends. They are part of the whole care circle supporting the individual and this must be genuinely respected.
- Reablement managers and care workers should ensure that appropriate family and friends receive a clear explanation of the service, particularly in terms of the nature of support provided. There should be a clear description of the aims of reablement.
- Those referring to and providing reablement must be sensitive to concerns that families may have about the 'risks' of this approach. They will need reassurance that their relative is being looked after despite being encouraged to do things independently. At the outset, there should be a frank and sensitive discussion about balancing risk and building independence and this should be reiterated throughout the duration of the service.
- The reablement team should encourage family members and friends to contribute to the reablement process. As well as motivating the person, family and friends might also benefit from practical tips and techniques for providing support in ways that help achieve goals. If they are completely 'signed up' to the concept of reablement, they can help to motivate the person throughout the process. At the end of the service, family and friends can encourage the person to continue using new-found skills so as to maintain their confidence and independence.

## Case study: involving family members in the reablement process – Mr Radcliffe

Mr Radcliffe is an 80-year-old man who lives with his wife. He fell and sustained a left hip fracture, which needed surgical intervention. As a result of the surgery Mr Radcliffe was limited to the movements he was able to do without disrupting the healing process and was provided with information on hip precautions. A reablement care worker initially assisted him with all of his personal care. Mrs Radcliffe is her husband's primary carer at home and wanted to assist her husband's recovery where she could. A care plan was therefore developed to include Mrs Radcliffe in the personal care routine so that she learned the correct way of moving so as not to cause any injury to her husband's hip.

The caseworker provided a further pamphlet on hip precautions so that Mrs Radcliffe could understand what is required to prevent further injury.

The care plan provided a progressive programme that encouraged Mr Radcliffe to regain more independence in his personal care activities and allowed Mrs Radcliffe to assist.

### **Case study: involving family members in the reablement process – Mr Patel**

Mr Patel was referred for reablement from the admissions avoidance team (AAT) in February 2013. Reablement assistants were supporting him with his medication by calling once a day in the morning, but Mr Patel declined support with any personal care.

He had previously been taken to hospital with a chest infection. He suffered a heart attack while in hospital but refused the recommended treatment of having a stent fitted. He was suffering with weakness following ill health and had a chesty cough, although he reported on the occupational therapy assessment visit that he was feeling better than he had been. He lives with his wife.

#### *Extracts from occupational therapy functional assessment form*

- **Medication:** Happy to accept assistance with medication. Referral reports previously found that he has taken three days' dosage of medication in one go, and family found 28 packets of old medication that he had not taken. Has eight tablets to take each morning – one has to be taken half an hour before eating, which he was aware of. Also has an inhaler and currently on antibiotics. Blister packs have been requested, which will be delivered in a few weeks. Substantial need for support, to administer medication to ensure he takes it correctly and to prevent neglect/overdose in this area. Plan to monitor his ability to manage when blister packs are provided and to see whether Mrs Patel may be able to assist in future.
- **Customer outcome:** to remain living at home and be safe and supported.
- **Options considered:** reablement support to continue with morning calls to ensure medication is taken correctly. Reablement assistants to work with and educate Mr and Mrs Patel when blister packs are delivered, to see if Mrs Patel may be able to support with this task. Mr Patel maintains he does not want support with personal care, although there are concerns that he was previously self-neglecting in this area. Occupational therapist to discuss with social worker.

Mr Patel continued to refuse help with personal care and managed in his own way. When the blister packs were provided, the reablement assistants visited for a few more days to check that Mrs Patel was able to support her husband with his medication. She was happy to do this once it was easier to manage (regular pills in blister packs and antibiotics stopped). Reablement support was therefore ceased after a total of two weeks. With support from his wife, Mr Patel did not require any ongoing support from formal services and was taking his medication appropriately.

## Recommendations

- If family and friends provide regular support to the individual, they should be invited to participate in the assessment process and development of the care plan. This is usually undertaken by a social worker prior to referral to the reablement service. Where conflicts arise, social workers will use their professional judgement and skill to mediate the individual's and the families' views and needs.
- Those referring to reablement and reablement workers should be alert to any concerns family members might raise or attempt to voice. These may relate to the support they feel the individual requires or, crucially, to their ability to continue in a caring role. Those referring to reablement should establish exactly what support family members are willing and able to offer. Those providing reablement should also be alert to the fact that this could change over time.
- If family members and friends provide, or intend to provide, a substantial amount of care, social workers are obliged to offer them a carer's assessment. This will determine whether any help can be given to support them in their caring role and should have been carried out during the assessment phase, before the individual was referred to the reablement service. If it comes to light that this has not happened, the reablement service should inform the social work team.
- Following a period of reablement, a person may require less or no support, both from formal services and from family and friends. The reablement service should encourage the family to consider continuing to provide social support, catching up on local or family news or going on outings.

On the other hand, after reablement, a person may still require ongoing support from formal services and/or family, friends and carers. Even if family and friends express a willingness to provide this support, the reablement service will need to educate them about the sustainability of that support. In other words, families and unpaid carers may need help to accept that the care they can offer now may become too demanding for them to continue in the future.

# Outcome measurement – what does successful reablement look like?

## Overview

Research evidence demonstrates that reablement improves wellbeing and independence, prolongs people's ability to live at home and removes or reduces the need for commissioned care hours (in comparison with standard home care) [7, 10-11]. Research evidence is less convincing about savings to health care [7] although evidence from practice shows that reablement facilitates earlier hospital discharge and reduces hospital readmissions.

## Measuring the outcomes of reablement

However we measure the outcomes of reablement, it is crucial to understand that 'successful reablement' looks different for different people. It may be relative to people's abilities at the start of the service and will depend on other variables, including their motivation to make progress and the goals they wish to set.

Service outcomes such as 'care hours required at the end of the service' are a common measure of the success of reablement and are intended to illustrate the extent to which a person has regained independence. One local authority, which takes this approach, uses 'the number of hours provided in week two of reablement' as a proxy for the number of care hours the person would have needed had they not used reablement.

### **Case study: independence in meal preparation**

Mrs Derbyshire was referred for three calls a day, for reablement with personal care and meal preparation. She has a visual impairment, osteoporosis and arthritis, and uses a walking frame. She wanted to remain as independent as possible.

Following an assessment, reablement care workers encouraged her to participate as fully as she could with washing and dressing tasks, but realised early on that this would be an ongoing need for her.

Mrs Derbyshire had frozen foods delivered but struggled to heat these meals, as she could not read the instructions or see the microwave properly. She was also burning her lunch. The reablement workers:

- moved the microwave closer to the window for additional light
- attached large labels with the cooking times written on them (e.g. '7 minutes') to all her meals in the freezer
- attached raised, florescent stickers to represent 5, 10 and 15 minutes to the microwave dial.

Mrs Derbyshire was then able to prepare lunch independently. Following the six-week programme, her care package was reduced to two calls per day, to assist with her ongoing mobility needs.

Local authorities tend to develop their own data management systems for recording this information, which they may be willing to share with others. They capture data such as the proportion of people requiring:

- no ongoing home care
- a reduced home care package
- increased care hours
- long-term (nursing or residential) care.

### **Recommendations**

- Data should be recorded at the end of the reablement service and then at follow-up points such as 3, 9 and 12 months in order to monitor whether outcomes are sustained.
- Although service outcomes are a popular measure of success, it is important to recognise that they do not provide the whole picture of the impact of reablement on a person's life. It is good practice, therefore, to add measures of the effect on health and social care-related quality of life.

The Adult Social Care Outcomes Toolkit (ASCOT) provides a well-validated measure of the impact of a service (e.g. reablement) on a person's social care-related quality of life. It gives an indication of people's need for help and their outcome gains in the following eight areas (or 'domains').

- Control over daily life (the individual can choose what to do/when to do it, and has control over their daily life and activities).
- Personal cleanliness and comfort (the person feels they are personally clean and comfortable and look presentable or are dressed and groomed in a way that reflects their preferences).
- Food and drink (the individual feels they have a nutritious, varied and culturally appropriate diet and enjoys enough food and drink at timely intervals).
- Personal safety (the person feels safe and secure, free from the fear of abuse, attack or falling).
- Social participation and involvement (the person enjoys meaningful relationships with family and friends and feels involved and part of a community, should this be important to them).
- Occupation (the person is sufficiently occupied in a range of meaningful activities which may include work – paid or unpaid – leisure activities or caring for someone).
- Accommodation cleanliness and comfort (the person feels all the rooms in their home environment are clean and comfortable).
- Dignity (this reflects the negative and positive impact of support and care on the individual's personal sense of significance).

ASCOT was developed by researchers at the Personal Social Services Research Unit (PSSRU) at the University of Kent. It was used to measure outcomes in the UK's most robust study of the effectiveness and cost-effectiveness of reablement. For more information and to download the tools needed to measure outcomes in this way, see the Further resources below.

Another approach to capturing the broader benefits of reablement is to measure its effect on a person's occupational performance. Occupational therapists can reliably measure improvement and outcomes in this area, using standardised techniques. Tools such as the Functional Analysis of Care Environments (FACE) and the Canadian Occupational Performance Measure (COPM) are commonly used in practice. The FACE is a recording and measurement system for health and social care, designed for both clinical and social assessment. The COPM is an individualised outcome measure, designed to detect change in a person's own perception of occupational performance over time. Both instruments are designed for use by occupational therapists so if they are going to be adopted then good links between the reablement service and occupational therapists will be particularly important. With training from an occupational therapist, a 'senior reabler' could also qualify to use these tools.

#### **Case study: measuring satisfaction and outcomes**

Nottingham City Council satisfaction surveys show that 90 per cent of people using the reablement service are satisfied or very satisfied. The service has a strong holistic approach ensuring that links with networks such as faith communities and neighbours are re-established. An outcome tool using a five-step ladder approach is used to ensure that people who use the service are in control and that outcomes are measured by both sides. About 40 per cent of users leave with no need for further services, and as the largest age band is 85–95 this is a very good outcome.

The Outcomes Star is another tool for supporting people's progress towards self-reliance and can be used to work with people to set goals and agree outcomes. The Outcomes Star is based on an explicit model of the steps that a person takes on their journey toward independence ('the ladder of change') and in this sense relates to the objectives of reablement. Unlike the COPM and FACE, the Outcomes Star does not need to be administered by particular professionals, although training is highly recommended and is delivered by the developers.

In judging the success of reablement, commissioners will be concerned with its costs (and cost savings) as well as its effectiveness.

## Recommendations

- When evaluating the impact of reablement in this way, commissioners should be aware that transferred costs can make the service appear more expensive than it really is. For example, moving an already-funded occupational therapist post from another team to carry out the same range of tasks in the new reablement team results in no extra costs at all.
- Overheads should therefore only relate to increased costs caused by reablement. Be aware of any conventions in your financial regulations that may distort the costs of a reablement service and therefore the anticipated 'cost savings'.

## Case study: improving independence and reducing costs

Mr Jones is 79 and has Parkinson's disease, mild arthritis and diabetes. He lives alone in a ground floor flat and until recently was completely independent except for shopping, as he had to give up driving. His daughter now shops once a week for him and assists with cleaning his flat.

Mr Jones recently fell in the kitchen, losing his balance while getting milk out of the fridge. He sustained a fractured femur and was admitted to hospital for a total hip replacement. After three weeks in hospital Mr Jones began to mobilise reasonably well with a walking aid. He was able to get to the toilet without assistance and manage with toilet rails. He could get in and out of his armchair with some difficulty but was unable to get in and out of bed without assistance, and struggled to get dressed, undressed and bathed. He was unable to stand for any length of time so could not cope in the kitchen with meal preparation and making hot drinks.

Mr Jones was discharged home from hospital with a care package of three visits a day to assist with the activities he could not manage independently. He was also referred to the reablement team, and was very keen to try and regain his lost independence. He was assessed by the occupational therapist from the team the day after discharge and a programme of graded activities was planned, to be delivered by reablement assistants.

Mr Jones made good progress over the first month and with support and encouragement started to get dressed and undressed on his own, make himself a hot drink and manage to use the microwave. His confidence grew and following regular reviews by the assistants and occupational therapist the care package was reduced in stages. Within six weeks Mr Jones was able to do everything for himself except get into bed because he was unable to lift his fractured leg over the edge of the mattress. He was also unable to cope with any equipment to assist with this. He could not manage the powered bath lift independently without assistance and opted to have a strip wash twice a week until his bathroom could be adapted with an entry-level shower. He was able to have a morning wash independently by sitting on a stool.

Mr Jones was discharged from the reablement service having had three calls a day, now reduced to an evening visit to assist with getting into bed. Had Mr Jones not improved, this package of three visits per day would have cost £321.25 per week, approximately £16,705 per year. The figures below show the diminishing cost of his

package with the reablement service and the final cost of one evening visit resulting in an ongoing yearly cost of £1,942.76

<b>Mr Jones</b>	<b>Hours</b>	<b>Cost</b>
Week 1	17.5	£321.25
Week 2	17.5	£321.25
Week 3	10.5	£194.25
Week 4	10.5	£194.25
Week 5	7	£134.50
Week 6	5.25	£104.63
Week 7	4.5	£94.05
Week 8	1.75	£37.38
		£1,401.56

These figures are an approximate guide to the potential reduction of costs through the reablement service featured in this case study and should be used with caution in considering overall savings since every case is different.

## Further resources

- [Adult Social Care Outcomes Toolkit \(ASCOT\)](#).
- [Functional Analysis of Care Environments \(FACE\) Recording and Management Systems](#).
- [Canadian Occupational Performance Measure \(COPM\)](#).
- [The Outcomes Star](#).

# Supporting people living with dementia

## Overview

There is a dearth of research evidence on supporting people living with dementia through reablement, not least because those individuals are generally excluded from reablement evaluations. Nevertheless, in practice, there is growing interest in supporting people living with dementia in this way and a general consensus that those people can benefit from a period of reablement. The recommendations presented in this section are therefore based on current knowledge from practice. They should not be read in isolation from the rest of this guide since all the other recommendations for good practice apply for people living with dementia as well as others.

### Recommendation

- People should not be excluded from reablement on the basis of a dementia diagnosis. They should be assessed on the basis of their needs and strengths without prejudice about their potential to be 'reabled'.

Where a person's confidence or abilities have rapidly deteriorated following a bout of ill health or an accident, it is often possible to return them to their 'baseline' quality of life – although to a large extent this depends on family and friends being able to describe what that baseline was (e.g. what they were capable of doing before the precipitating event).

### Recommendations

- It may be that a goal for most people living with dementia needs to be 'preserving and encouraging a more functional state' rather than achieving complete 'independence'.
- Outcomes might more appropriately focus on reducing social isolation, building routine, supporting the carer and learning to live well with dementia as opposed to significant reductions in the amount of support required.
- The importance of working with the individual to develop person-centred goals, in line with the SMART principles, applies here as with any other person using reablement, although the time horizons within which to reach goals may need to be reduced.
- When planning support with people living with dementia (including goal-setting), it is particularly important to see past their diagnosis and gain an in-depth understanding of the person (e.g. their interests, past jobs or hobbies, their family context and the things that motivate them). Life story work may help to achieve an understanding of a person's past experiences.

The Pool Activity Level (PAL) instrument is used by some teams for assessing the abilities of people living with dementia. The PAL instrument is designed for people with cognitive impairment, and is used to plan and deliver support in a 'reabling' way.

## Recommendation

- An enabling care environment can help realise the potential abilities of people living with dementia. Attention should therefore be given to changes to the home or care environment, such as dementia design (e.g. adequate light levels, contrasting coloured floors, glass fronted fridges) and assistive technologies (e.g. medication reminders, voice recorders and memo minders).

Just as there is no single delivery model for reablement, there is no single model for organising a reablement service with the capacity to support people living with dementia. Several models, which are in operation around England and Scotland, are summarised here.

- Intake reablement services to which all new referrals (from hospital and the community) are made, including people living with dementia.
- Intake reablement services which accept referrals for people living with dementia on the condition that they can demonstrate they have 'carry-over' (meaning that the person can retain the memory of something they have learned, such as a technique for preparing a drink, from one day to the next).
- Reablement services dedicated exclusively to supporting people living with dementia – for instance, one that offers short-term intensive home care (including night care) to help people settle in at home following hospital discharge. The aim is to improve the rate of hospital discharge and prevent readmission.
- A pilot reablement project for people with dementia, which includes commissioning a local Alzheimer's provider to deliver practical help and support (e.g. developing coping strategies).
- An enhanced reablement project, which is led by a psychiatric nurse and provides support to people with complex needs, including memory problems (almost 80 per cent of people referred to this service have a dementia diagnosis). The project provides three to five days of intensive assessment, monitoring and reablement, after which the person is most likely to be referred for a standard period of reablement with the borough's main reablement service.

## Recommendations

- Where reablement workers and therapists are supporting people living with dementia, specific training, in addition to reablement training, is crucial. There is no single accredited training programme for using reablement to support people living with dementia; however, the College of Occupational Therapists does provide a one-day workshop entitled 'Challenging the myths: reablement for people with dementia'. Although it is primarily aimed at occupational therapists it is likely that they could tailor the workshop for others working in reablement. There are also many training and awareness programmes more generally targeted at working with people with dementia. Useful links are provided under Further resources below.
- Training on supporting people with dementia through reablement would usefully focus on:
  - recognising the signs and symptoms of dementia
  - tips for dealing with the potential complexities of helping someone with dementia to dress, wash and bathe safely – including ways of encouraging them when they are reluctant
  - the importance of maintaining familiar routines and tips for encouraging independence
  - ways of maintaining their everyday skills and an understanding of the importance of doing so
  - offering help sensitively
  - helping the person communicate
  - dealing with challenging behaviour.
- Finally, It is crucial that local services are available to provide ongoing support, appropriate to people living with dementia.

## Case study: enhanced reablement for people living with dementia

Mrs Yates was referred for enhanced reablement pending discharge from hospital. She suffered from dementia and had fallen in her kitchen at home on 11 January 2011 and sustained a fracture to her pelvis. Her daughter, with whom she lives, was at home at the time but Mrs Yates had attempted to walk without supervision. Mrs Yates's husband also lives at home and also suffers from dementia. Mrs Yates had previously fallen a few weeks earlier and sustained the same injury to the opposite side of her pelvis. She has reduced safety awareness and often forgets to use her walking frame.

On 7 February 2011 Mrs Yates was assessed by the enhanced reablement nurse while still on the ward to establish her suitability for enhanced reablement when discharged. Her daughter was present at the time. Mrs Yates was medically fit for discharge and her daughter wanted her back home as soon as possible. Physiotherapy and occupational therapy reports suggested that she would benefit from continued rehabilitation. Mrs Yates was accepted for enhanced reablement with four home visits per day following

discharge which was scheduled for the following day. Arrangements were made for the reablement physiotherapist to assess at home jointly with the enhanced reablement nurse on the day following discharge. Referral was made to telecare for assistive technology. Mrs Yates already had a link line pendant alarm but an additional bed and chair sensor with a carer alert pager, and a flood detector, were added to the system.

Mrs Yates was transferred to standard reablement with continued physiotherapy review on 12 February 2011. During the next five weeks she continued to require reablement support to wash and dress in the mornings and to get ready for bed at night. She needed prompting to use her walking frame at all times and supervision with mobility and transfers. Reablers were requested to support Mrs Yates to complete her physiotherapy exercises during visits. Mrs Yates also required supervision with toileting throughout the day. Visits remained at four times daily. To improve access at the front of the house a referral was made for wall-to-floor rails outside the front door and gate. Referral was also made for ongoing community physiotherapy, and ongoing support and review from the community social care team. The last day of reablement was 20 March 2011.

- 3-month follow-up: Mrs Yates continued to live at home. She completed her six-week period of reablement but her daughter declined any subsequent package of care, preferring to look after her parents herself.
- 6-month follow-up: Mrs Yates continued to live at home cared for by her daughter and without any formal package of care.
- 9-month follow-up: Mrs Yates continued to live at home cared for by her daughter and without any formal package of care.
- 12-month follow-up: Mrs Yates continued to live at home cared for by her daughter and without any formal package of care.

## Further resources

- **A life story work toolkit can be accessed** on the Dementia UK website.
- **The PAL instrument** can be accessed via the developer's website.
- **SCIE's Dementia Gateway, featuring free training programmes.** There is a specific section on **suitable environmental design**.
- **The AT Dementia** website provides information about assistive technology designed specifically to support people living with dementia.

## Successfully ending a period of reablement

### Overview

Where a person has benefited from reablement but has ongoing support needs to be met by a conventional home care agency, the concern is that this traditional approach to providing 'care' might undo the progress made during reablement.

### Recommendations

- If a person is assessed as having ongoing support needs at the end of reablement, it is crucial that subsequent services continue to provide support in a way that maintains the progress that person had made. The implication of this is that independent sector providers of home care need to adapt their own service to support the aims of reablement.
- There are a number of ways in which independent home care providers can be encouraged to work to sustain people's independence and any progress they made during their time with the reablement service. One example is a service whose reablement workers mentor home care workers when it appears the person's support needs have increased following handover. Other local authorities have renegotiated home care contracts to reinforce the reabling ethos.
- It will help to ensure a smooth transition to the ongoing care provider if the reablement service ensures all relevant information about the individual is communicated in a timely manner. It may also be helpful for care workers from the reablement service and from the new provider to work together for the last few reablement visits so that they can share knowledge, understanding and skills. If a person's ongoing support needs are going to be met by another (home care) provider, relevant family members should be involved in planning that support.
- If at the end of reablement a person does not meet the council's eligibility criteria for ongoing support, the reablement team and the social worker should consider whether other services such as social clubs or volunteer befriending schemes may still benefit the individual.
- When reablement works well, the 'reabled' person will be able to do things for themselves and they will not be referred for ongoing support, such as traditional home care. Commissioners and providers of reablement should be alert to the fact that for some people, particularly those who do not have many visitors or social activities, this may lead to feelings of loneliness and isolation. This is an example of a successful service outcome (no ongoing need for support) not necessarily equating with a successful outcome from the individual's perspective.

## Underpinning research

### Reablement is a very promising practice

There is **good evidence** that reablement improves service outcomes (prolongs people's ability to live at home, and removes or reduces the need for standard home care). Measured by its capacity to enhance the chances of staying at home, reablement also contributes to user independence and wellbeing. It is feasible to introduce into daily practice in social services and staff welcome the approach. Studies report a slightly higher cost (than traditional home care) but indicate a strong probability of cost savings in the long term. There remains some lack of clarity about the resources required to deliver reablement, particularly about whether the service requires input from professional occupational therapists or whether it can be staffed by trained home care assistants.

There is **moderately good evidence** that reablement improves outcomes for users, in terms of restoring the ability to perform activities of daily living (ADL) or improving morale. Where users' views have been collected, users welcome the emphasis on helping them to regain their independence and level of function. This evidence is not as strong as for service outcomes for four reasons. First, some studies have focused on the evidence on service outcomes (e.g. reduction of hours) without fully linking them to independently collected measures of wellbeing for users (e.g. improvement to ADL scores, or morale). Second, not all studies systematically collect the views of people who use services. Third, few studies record the views of carers. Finally, the results on wellbeing vary, with some studies showing that a significant proportion of users do not benefit, or have increased support needs after reablement. Research has not yet identified what causes this variability, nor whether services show better results in relation to service users discharged from an acute admission, or those requesting standard home care support. Evidence is also lacking about the effectiveness of reablement in improving outcomes for people living with dementia.

The evidence base could be improved with more studies that:

- link service outcomes clearly to independently measured wellbeing
- demonstrate sustained effects over a 12-month period
- detail the practices of reablement, and the resources and costs involved
- systematically record the views of both users and carers
- build up the evidence base so that reasons for variable effectiveness can be identified
- include people with cognitive impairment (including as a result of dementia) so that the benefits of supporting them with reablement can be investigated.

## Evidence summary

### 1. What is the practice?

(Description of the practice.)

Reablement comprises ‘services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living’ [12]. Note that the issues people face may include aspects of limited functioning not readily termed ‘illness’. Restorative home care is another term used in the USA [13], Australia [14] and New Zealand [15]. The focus is on restoring independent functioning rather than resolving health care issues, and on helping people to do things for themselves rather than the traditional home care approach of doing things for people that they cannot do for themselves. Reablement is usually a 6–12 week intervention, focused on dressing, using the stairs, washing and preparing meals, although there is growing recognition of the need for reablement to also address social and psychological needs [16]. Although reablement overlaps with intermediate care, its focus on assisting people to regain their abilities is distinctive. Some schemes (e.g. an ‘intake’ reablement service) accept all referred for home care, excepting only those unlikely to benefit (e.g. because they have end of life care needs). Some schemes operate a more selective focus on those who will benefit most. No single leading model has yet been identified [12]. Apart from one mention of a manual [14], there is little systematic account of what practitioners actually do. There is extensive UK material on implementation issues [17].

### 2. Why is it thought to be good practice?

(A case for the practice.)

Policy arguments are that:

- reablement supports a service focus on independence and harnesses the joint input of health and social services [18]
- home care services will be overwhelmed unless solutions are found that decrease demand [19]
- reablement services have the potential to be cost-effective [20].

The practice theory is that reablement responds to the wishes of the majority of users to retain independence and control, including staying at home [21].

### 3. What happened as a result of the practice?

(An account of outcomes and whether stakeholders want them.)

Reablement improves service users’ independence, prolongs people’s ability to live at home and removes or reduces the need for commissioned care hours (in comparison with standard home care). The best results [10] show that up to 63 per cent of reablement users no longer need the service after 6–12 weeks, and that 26 per cent had a reduced requirement for home care hours. A controlled trial in the UK found significantly better health-related quality of life (measured using the EQ-5D) among the reablement group compared with those using conventional home care for the same period [7]. Notably, the greatest difference was in the ability to perform usual activities, where 23 per cent of reablement users were unable to perform usual activities

compared with 43 per cent of people using home care. In the same study, people in the reablement group reported statistically significant improved social care outcomes (measured using ASCOT) at follow-up compared with people using conventional home care. An Australian randomised controlled trial [11] found that at 3 and 12-month follow-up, the restorative care group was significantly less likely to need personal care than the home care group (3 months: 44.3 per cent vs 16.8 per cent; 12 months: 47.2 per cent vs 20.3 per cent).

The results are not consistently good, however. Despite demonstrating significant health-related quality of life benefits for the restorative care group (measured using the SF36), a New Zealand study [15] found no change among intervention or control participants on scales such as ADL and ‘timed up and go’. In another study, a third of users continued to require the same number of hours as at the outset, and in 5 per cent of cases an increase in hours was required [8]. In a further study, two-thirds were assessed as having the same Fair Access to Care Services (FACS) level after six weeks and 12 per cent had a higher level [20]. It is not clear whether to focus the service on hospital discharge or people living in the community: one account suggests that selective ‘discharge support’ schemes have higher rates of success than ‘intake’ services [11], but another reports that community-based users, and those with 5–10 hours assistance requirements at intake, benefited more than those referred from hospital [8].

#### **4. What do people think about the practice?**

(An account of processes and whether users and carers find them acceptable, including accessibility.)

One overview suggests few user studies [19]. However, a narrative account reports ‘high degrees of satisfaction by users and their families’ [22], while a systematic review of outcomes-focused services suggests strong support from reablement users [21]. Among a representative sample of reablement users in another study, the majority ‘were very positive about the new service and were all satisfied with any reductions in hours of service that resulted at the end of the reablement period’. Service users were also particularly pleased at the speed with which any equipment they required to assist them in their homes was put in place. However, the same study reports other views among users: some were concerned about handover at the end of reablement and some about the perceived absence of assistance with domestic tasks at the start of reablement [8]. A study of user views [16], taken from a controlled evaluation [7], found that if people did not fully understand the aims of reablement they were often disappointed since they had expectations of being ‘looked after’ in the way one would expect from conventional home care. The study also found that while goal-setting was seen as valuable, it needed to respond to fluctuating needs and situations. People also found reablement to be lacking in its attention to social needs, including improved community engagement. Few studies report carers’ views: one suggests that carers, as well as users, need motivating to engage with reablement, while another records the negative view of one carer about her husband’s care [8].

## **5. Will it work in day-to-day services?**

(Whether the practice is workable on a day-to-day basis - e.g. do providers have the skills?)

Some reablement services are joint health and social care schemes, some involve social services only. The existing skills of home care staff are the key resource [20]. Councils with social services responsibilities (CSSRs) designate NVQ Level 2 as the base qualification [12] (or the Level 2 Diploma in Health and Social Care, which replaced NVQs in January 2011), although additional training in reablement is also essential [23]. In addition to reablement care workers, some teams include occupational therapists (or train home care staff in occupational therapy skills). It is unclear whether occupational therapy skills are essential to successful outcomes [12] but 30 per cent of users in one study saw an occupational therapist [20] and interaction with an occupational therapist was especially valued by care workers in another study [8]. An Australian scheme includes a nurse, physiotherapist and occupational therapist, just one of which works with the individual [14]. An early UK study indicates the key role played by a reablement co-ordinator trained in occupational therapy [10]. One study suggested that staff with less experience in traditional home care work made better reablement workers [24]. Data from Care Services Efficiency Delivery (CSED) interviews with managers [12] suggests they value the impact on users and services. Another study reported that staff valued the increased flexibility of a reablement approach, better interprofessional working and better management [8]. CSED interviews with managers also point to the need to encourage a culture of reablement, particularly among independent providers [12] and another study pointed to the risk that handover to a more traditional home care service might undo the progress made using a reablement approach [8].

## **6. What will people do differently as a result of the practice?**

Staff need to learn 'to 'watch' and not interfere when a service user [is] struggling to get something done' [24] (confirmed in another study) [8]. Staffing needs to be flexible to allow the time required and continuity of care worker [24]. Service recording must be detailed and record achievement at each contact [24]. Independent sector providers need to adapt their service to support reablement [12]. Users need to change their expectations: 'reablement was considered to be more successful if service users were motivated – people have got to want to do it' [24]. Unpaid carers (family or friends) could contribute to the reablement process if they were given advice about how to sustain service users' capabilities and independence [16].

## **7. Is there any evidence on costs and benefits?**

(Whether the practice is affordable: any information on costs and savings.)

The SPRU/PSSRU study [7] is the only one to have conducted a formal cost-effectiveness analysis. It reports that reablement requires higher upfront investment than conventional home care, although the study also identifies savings of up to 60 per cent in the costs of subsequent social care provision among the reablement group. The study also found evidence that reablement does not reduce health care costs, although this may be explained in part by weaknesses in data collection, which relied on self-

reported information on health care use. For the cost-effectiveness analysis, social and health care costs were analysed separately with EQ-5D and ASCOT results. Analysis showed, from a social care perspective, a high probability that reablement is cost-effective. The results are less convincing when health care costs are used, although still more likely than not to be cost-effective.

Although no other study involved formal cost-effectiveness analyses, some report on investment in and savings from reablement. Reflecting the SPRU/PSSRU findings, they show or imply longer-term cost savings as a result of investment in reablement, albeit that the reablement service is generally more expensive to deliver than the control.

Kent et al. [10]. found that 62 per cent of reablement users had their care package discontinued at first review, compared with 5 per cent of control group users. A total of 26 per cent of reablement users had their care package decreased at first review, compared with 13 per cent of control group users. It can be assumed that the costs of delivering reablement were higher than the costs of delivering the control because average care hours provided to control group users were 5.5 compared with 8 delivered to reablement users. Lewin et al. [25]. reported that there was no significant difference between the direct care costs of the experimental and control groups for the year of the study ( $F(1,191) = 2.746$   $p = 0.099$ ). However, as 57 per cent of the experimental group were no longer needing services at one year, whereas 81 per cent of the control group were, it is reasonable to expect that the experimental group would show cost savings in the longer term. Lewin's subsequent randomised controlled trial [11] reinforced these findings: at 3 and 12 months follow-up, the reablement group were significantly less likely to need ongoing personal care than the control (3 months: 44.3 per cent vs 16.8 per cent; 12 months: 47.2 per cent vs 20.3 per cent). McLeod et al. [8]. report that the overall costs of providing reablement were greater than those attributed to the traditional service over the same period – management costs in particular were markedly higher, mostly due to lower management to staff ratios in the reablement service. However, at the end of the reablement period, 41 per cent of reablement service capacity was available for new clients, whereas no capacity was released in the control service. Tinetti et al. [13] imply cost savings from restorative (reablement) clients having shorter and less intensive home care episodes. The authors also suggest that capacity gains were made to health because restorative clients had a reduced likelihood of emergency department visits. In a subsequent study, Tinetti et al. [26] found individuals using the restorative model were 32 per cent less likely to be readmitted to hospital than those receiving usual (home) care on discharge. Finally, King et al. [15] imply that restorative care provides cost benefits because of improved health-related quality of life, plus a statistically significant number of restorative clients requiring reduced care hours (29 per cent) compared with those using home care (0 per cent).

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## Maximising the potential of reablement

This guide is based on research and practice evidence about the effectiveness and cost-effectiveness of reablement.

The guide is based on:

- SCIE's Research briefing 36: Reablement: a cost-effective route to better outcomes which was based on a review of research evidence published in December 2010 and practice visits conducted in spring 2010.
- SCIE's At a glance briefings on reablement examining the implications of reablement for key groups including: GPs, commissioners of adult social care, occupational therapists, reablement providers and families of people using reablement.
- An updated review of relevant effectiveness and cost-effectiveness studies, published after SCIE's 'Research briefing 36', plus qualitative research on the views of people using reablement.
- Government advice on funding arrangements for reablement and Department of Health (DH) funded guidance on implementing reablement.
- Practice visits to four reablement teams providing support to people living with dementia.
- The Project Advisory Group, whose role was to review the way the guide was produced and written to ensure it reflected the realities of practice.

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