social care
institute for excellence

Role and principles of reablement

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SCIE improves the lives of people of all ages by co-producing, sharing, and supporting the use of the best available knowledge and evidence about what works in practice.

About us

The Social Care Institute for Excellence (SCIE) is a leading values-driven improvement agency. In recent years we have evolved from a largely government-funded body to a fast-moving, high-profile more commercial organisation and thought leader.

We are independent and people-focused, operating at policy and practice levels with a huge database of 'what works' good practice and e-learning tools and resources. Working beyond and across social care and health and children's and adults' sectors, we contribute to the development and implementation of better care, support and safeguarding at national and local level. We support commissioners and providers in developing and embedding practices which are innovative, have impact, and enable effective scrutiny and accountability.

We offer a wide range of tailored and flexible improvement support, working collaboratively with associates and partner organisations. SCIE's future success depends on our ability to continue developing our range of large and small commercial projects covering consultancy, training, evaluation and research to complement our government-funded commissions.

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We believe that the five factors below, in combination, make us a unique and essential improvement partner for the Department of Health and Social Care and our range of customers across sectors and at national and local levels.

We:

- are independent, people-focused, driven by co-production principles and ways of working, and in children's services by hearing the voice of the child
- operate at policy development, strategic and operational levels, with a golden thread of what works in practice
- benefit from huge reach and a vast knowledge/evidence base including e-learning tools and resources alongside topical blogs and articles
- offer a range of flexible and tailored input (training, consultancy, topic expertise, research, evaluation, facilitation, coaching)
- work in highly collaborative ways, including levering in others where this might lead to better solutions and outcomes.

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Introduction

This briefing is an overview of the role and principles of reablement in the social care sector. It is designed for those working in reablement or commissioning it, but may also be useful to carers and people receiving reablement.

As well as describing what the roles and principles of reablement are and the different models used to deliver it, the briefing illustrates the shift from traditional home care towards personalised, outcome-focused care and describes the principles of effective reablement.

Reablement is a strengths-based, person-centred approach that promotes and maximises independence and wellbeing. It aims to ensure positive change using user-defined goals and is designed to enable people to gain, or regain, their confidence, ability, and necessary skills to live as independently as possible, especially after an illness, deterioration in health or injury.

Key messages

Reablement:

- leads to improved health and wellbeing
- uses a strengths-based, person-centred approach
- may be appropriate to support timely discharge from hospital or enable an individual to remain living at home if, due to illness or disability, they have increasing difficulty with daily life activities
- is non-means-tested, where the person will qualify for reablement if they meet the eligibility criteria, regardless of income or capital
- is time limited, where short-term support is provided, usually for up to six weeks, but possibly for a shorter period depending on progress
- focus should be on achieving outcomes rather than completing care tasks
- goals or outcomes should have meaning to the individual and be aimed at promoting wellbeing, autonomy, independence and choice
- plan should be determined by both the long- and short-term outcomes the person has identified
- aims to help reduce or eliminate the need for future care services.

What is reablement?

Reablement, which is generally provided in the person's own home or care home, is a goal-focused intervention that involves intensive, time-limited assessment and therapeutic work over a period of up to six weeks (but possibly for a shorter period). It involves a process of identifying a person's own strengths and abilities by focusing on what they can safely do instead of what they cannot do anymore.

Since 2010 the UK Government has substantially invested in reablement services through NHS funding. It is now set within the context of the Government's broad prevention agenda, which aims to promote wellbeing and help reduce unnecessary hospital admissions, re-admissions and delayed discharges.

In England, reablement is seen as a core element of intermediate care that:

- promotes faster recovery from illness
- prevents unnecessary acute hospital admissions and premature admissions to long-term care
- supports timely discharge from hospital
- maximises independent living and reduces or eliminates the need for an ongoing care package.

From this information, meaningful functional goals and outcomes are developed with the individual, to promote wellbeing, autonomy, independence and choice. It aims to 'enable people to be and to do what they have reason to value'.

> *Reablement is a person-centred approach within health and social care that helps individuals to learn or re-learn the skills necessary to be able to engage in activities / occupations that are important to them.*
>
> ***Reablement: key issues for commissioners of adult social care (SCIE)***

Reablement was further defined in a study funded by the National Institute for Health Research (NIHR) Health Services and Delivery Research (HSDR) programme.

> *To restore previous self-care skills and abilities (or re-learn them in new ways) that enable people to be as independent as possible in the everyday activities that make up their daily lives (e.g. cleaning the house, shopping, or bathing and dressing themselves) rather than having someone (e.g. an informal or formal carer) do things 'to' them or 'for' them.*
>
> ***Reablement services for people at risk of needing social care: the MoRe mixed-method evaluation (NIHR and HSDR)***

One of the key principles of reablement is to support people who are at risk of needing social care or an increased intensity of care to regain functioning, maintain life skills, rebuild their confidence and promote wellbeing.

Home care and reablement

Reablement is often considered an alternative to traditional homecare for:

- individuals returning home from hospital or other inpatient care setting following a period of illness; or
- individuals where there is evidence of declining independence or ability to cope with everyday living due to deteriorating health.

It is a way of empowering people to do things for themselves rather than having things done for them, as in traditional homecare, which can lead to dependence on a care package.

The use of a reablement approach, and subsequent interventions, can ultimately result in reducing or preventing the need for traditional homecare. However, homecare still has its place following a period of reablement or when reablement is inappropriate, but the ethos of reablement needs to be continued.

Table 1 The differences between traditional home care and reablement

Traditional home care	*Reablement*
Often a long-term provision.	Usually a short-term intervention.
Means-tested.	Non-means-tested.
Usually uses a ‘doing for’ approach with little or no attempt to develop self-care skills.	Uses a ‘doing with’ approach, which involves supporting people to do things for themselves.
No goals are set.	Goals-orientated, which are co-producted with the person receiving reablement.

The reablement service

Reablement services are delivered using different models. Which model used often depends on local needs such as population and demographics, as well as the existence of similar support services and the resources available.

Many reablement services are commissioned and provided by local authorities; however, in some cases, they are joint-funded by the local clinical commissioning group and the local authority.

Reablement should be offered as a first option for people being considered for home care if it can improve independence and wellbeing. For those already receiving home care, reablement should be considered as part of the review or re-assessment process.

Models of delivery

Broadly, there are two categories of reablement service:

- **Intake and assessment service:** support a wide range of users including hospital and community referrals.

- **Hospital discharge service:** primarily support people on discharge from hospital.

Intake and assessment service

Intake and assessment services tend to operate a ‘de-selective’ model, where all those referred for home care undergo reablement unless it is agreed they will not benefit. For example, if someone has end of life care needs, they will be de-selected.

Practice example – Swindon Borough Council

Swindon Borough Council has used reablement and ‘transformed’ the way it works with its older population to help them remain at home longer. The service aims to avoid residential and nursing placements when it is not in a resident’s best interests and reduce delayed discharges.

- The new service model makes reablement available upon initial referral to adult social care, as well as on discharge from hospital.
- The service was redesigned to increase capacity, enabling more older residents to access reablement per year.
- The role family, neighbours, telecare, equipment and communities play alongside formal care is seen by them as an important part of a strong social care system.
- In order to progress with this approach, they built stronger links between the domiciliary care providers and their assessment and care management teams, so they could find the best way of helping people: some formal care (i.e. home care) and some informal care (i.e. that provided by the family) sitting side by side.

Source: **Swindon Borough Council (2019)**

Hospital discharge service

In comparison, hospital discharge services usually operate on a more selective basis. They support only those people who are judged likely to benefit from reablement. For example, discharge from hospital of someone who lacks confidence in their abilities following a fall which resulted in injury.

In recent years some of the hospital discharge services have broadened their role and evolved into a ‘de-selective’ model – and, similarly, some intake and assessment services have become more selective (perhaps due to financial pressures).

> *The service I manage works with the hospital social work team – the hospital has two very busy elderly care wards including an assessment unit. Our focus is to try and reduce the length of stay in the acute setting to avoid delayed discharges and to prevent elderly patients picking up hospital-acquired infections. We use reablement to*

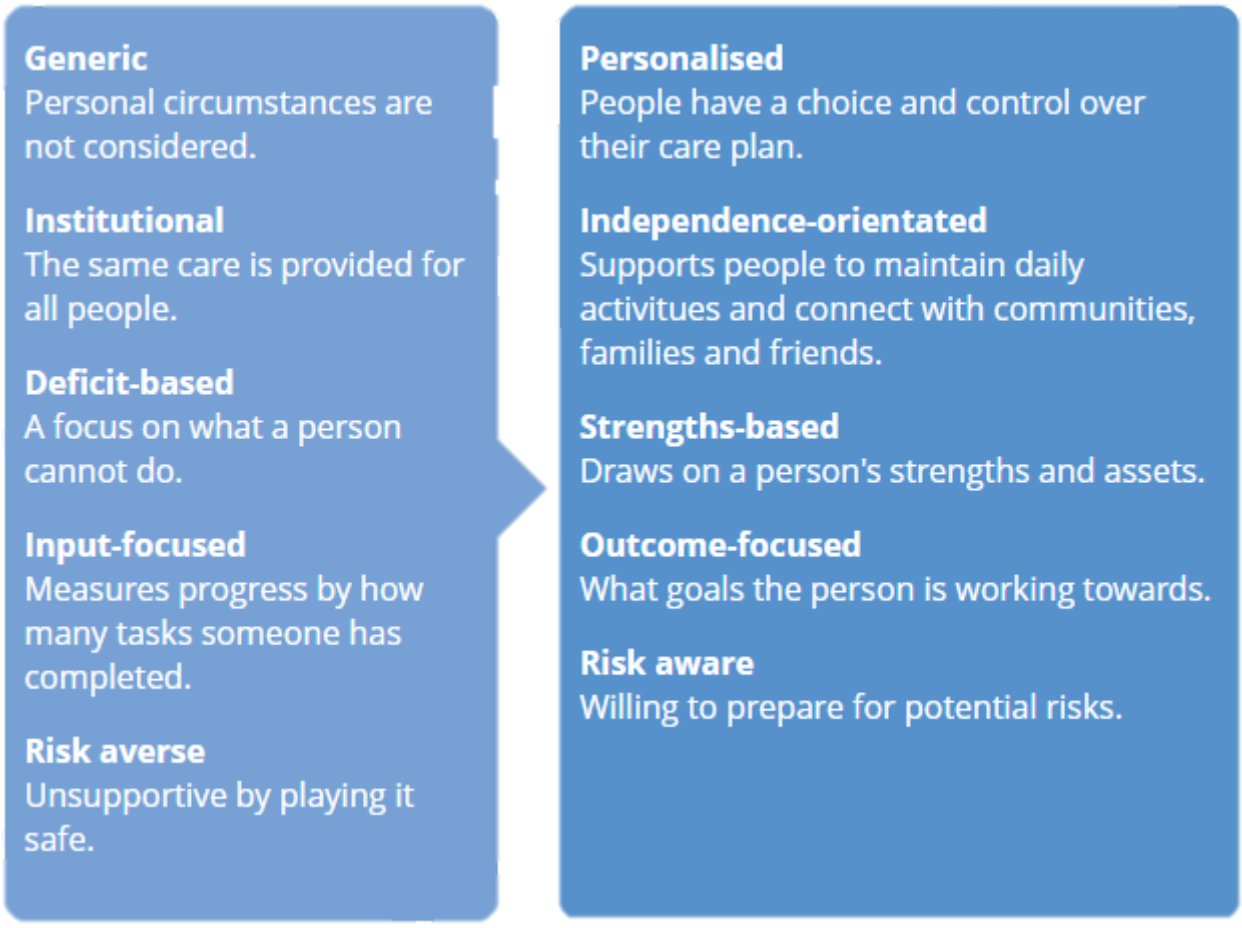
support these wards and this means we only accept service users with reablement potential (selective model) based on criteria we have set – i.e. those that we think can return to their maximum functional capacity within six weeks of reablement.

Hospital service manager

Reflecting the shift

The chosen model should reflect the shift towards prevention, wellbeing and person-centred, outcome-focused care that is strengths based.

Figure 1 The move from generic care towards person-centred, strengths-based care



Practice example – South Tyneside

South Tyneside – Adult Social Care provides an example of how a reablement approach, which emphasises the promotion of independence, can be integrated into service delivery.

It has removed the traditional ‘assessment for services’ approach and created a new culture where practice is based on the three conversations model.

The ‘three conversations model’ provides a set of tools to enable the committed, principled and skilled workforce to have conversations based on what people want to tell them, not what they want to ask them. The South Tyneside approach encourages people to make the best use of support from their own community, including family and friends, and voluntary organisations.

South Tyneside has developed a model to ensure that people can get the right level and type of support at the right time to help prevent, reduce or delay the need for ongoing support, and maximise peoples’ independence.

Source: **South Tyneside**

Who is reablement for?

Reablement can be used with a variety of different people including those with physical disabilities, dementia and learning disabilities. Whilst a referral to reablement should be based on an individual’s needs rather than medical diagnosis, there are some authorities that use the selective approach and only target people who are most likely to benefit, by regaining physical function and improving their independence. For this reason, people with certain conditions, such as dementia, tend not to be offered reablement. This group of people may be offered reablement depending on their individual circumstances, in authorities which operate a de-selective approach.

Reablement for people living with dementia

The Government’s policy for those people living with dementia is to support them to live well by keeping them actively engaged in their daily life for as long as possible. This can be achieved through a coordinated, personalised reablement approach, incorporated into their routine care, drawing on the person’s strengths and considering their declining abilities.

There needs to be attention to staff training to ensure they have adequate knowledge of assessment and how to build on the remaining ability of the person with dementia.

Reablement for people with a learning disability

A reablement approach can also be successful when used with people living with a learning disability.

Practice example – Imagine Act Succeed

The Imagine Act Succeed (IAS) reablement service in Oldham supports adults with a learning disability. It works in more person-centred ways to further independence, community connections and self-reliance.

The emphasis of the service is to build on the person's own resilience and independence. A key role for staff is to enable people not only to maintain existing friendships and relationships, but also to support the development of new social networks in the community.

Source: **Imagine Act Succeed (IAS)**

The reablement team

Another principle of reablement, which ensures an effective service, is having a reliable team. This is dependent on having the right structure, roles and a fully competent team of people who understand and operate within the ethos of reablement. Research has shown that staff skills and knowledge of reablement principles are regarded as key to successful reablement.

The reablement team often consists of reablement assessors, reablement support workers and occupational therapists. However, in some areas, other disciplines such as physiotherapy may also be included.

Reablement assessors

Reablement assessors or occupational therapists will carry out the assessment process, which involves measuring the person's base line in all aspects of activities of daily living. The support plan will then be developed along with the person who uses services in the hospital or at home and identifies the outcomes they would like to achieve.

Occupational therapists

Evidence from research and practice suggests that the most successful reablement teams have occupational therapy input. There is no single agreed way of involving occupational therapists. They could contribute to the reablement team in different ways:

- as trainers of reablement workers
- as assessors before and after a period of reablement
- as reablement team managers.

Occupational therapists may not be part of a reablement team, but they may be co-located so their expertise is easily accessible to reablement workers.

Practice example – Coventry Reablement Service

The basis of the whole adult care service in Coventry is to help people to gain or regain their independence.

For those who approach the council for help (whatever their age), where it appears, they are likely to have care and support needs as a result of a physical impairment or old age frailty, the process will start for them with an assessment with an occupational therapist. Further to this, the occupational therapist and the individual will identify the goals they might be able to achieve, to gain greater independence as well as the support needs that are required at that time.

After the goals are set, the person is referred to the domiciliary care providers (in the independent sector), who support the person in meeting the agreed goals by using reablement approach. During the process there are weekly meetings with either an occupational therapist or a named social worker and, where appropriate, either these people or an occupational therapy aide will undertake direct work to assist or support staff to meet the pre-agreed goals.

An evaluation of the service has shown there are comparatively low numbers of people in receipt of longer-term support. All three community providers consistently achieve a two-thirds success rate in assisting people in a way that they do not require longer-term support. The evaluation also demonstrates how the approach can help people either to gain complete independence (with some managed risks) or to limit the care and support needs they have.

Source: **Coventry Reablement Service**

Reablement support workers

Reablement support workers are often local authority homecare staff who have received additional training to adopt an enablement approach.

> *When I worked as a home carer, I was often involved in preparing meals for people. Now I work in reablement and my role is to support people in re-learning to prepare meals for themselves after an accident or illness.*
>
> ***Reablement support worker***

Support workers will follow the support plan and work daily with the person receiving the reablement service. Their focus is on observing, guiding and encouraging the person who uses services to do things themselves, to rebuild confidence and improve skills that may have been lost.

Elements of effective reablement

The elements of effective reablement include:

- individual assessment and person-centred goal setting to improve confidence and wellbeing

- interventions to enable engagement in meaningful activities and occupational performance (the ability to desire, recall, plan and perform the required activities, tasks and roles of living). This engagement is achieved through goal setting with the individual receiving reablement
- supporting and enabling risk management and risk-taking to maximise independence and choice
- an ‘outcome focus’ to appropriately minimise the ongoing support required.

Assessment and goal setting in reablement

One of the core principles of reablement is the creation of a realistic support plan. This follows a functional assessment that measures the person’s baseline in all aspects of daily living and involves the person who uses services in identifying the outcomes or goals they would like to achieve.

It is important that the focus is on activities or occupation that the person identifies as important. The person would be asked, ‘What are the most important activities in your life right now?’

Goals can range from very small improvements to more complicated activities to help them recover skills, confidence and independence. They are likely to relate to:

- activities of daily living tasks, such as getting washed and dressed, preparing a drink, light snack or meal
- mobility, such as moving safely around their home or outdoors
- enabling participation in social engagement, such as building confidence to take transport to their chosen activity in the community.

There is a need to review a person’s progress almost daily in order to maintain improvement – revisit goals and amend as necessary. If all goals have been achieved, reablement doesn’t need to continue for the full six weeks (or the full-time period allowed locally).

Reablement interventions

Reablement is often seen as a service that provides adaptations and equipment as a means of support. However, it can also help users connect back to their community and take ownership of key areas of their lives.

The methods used can be split into two categories:

- **Restorative:** the learning or re-learning of skills or behaviours, improving confidence and increasing motivation.
- **Compensatory:** finding a way around a functional difficulty, including adapting the environment and/or using assistive technology, telecare and/or equipment.

Below are examples of how you could implement these methods.

Motivation and confidence building techniques

Following a fall, set small achievable targets to build confidence – such as walking for a short distance, first in the safety of the home and build on this to walking outdoors to the gate and then down to the end of the road.

To increase the motivation to achieve this, the individual may focus on a place they wish to walk to.

Demonstrate alternative ways of carrying out tasks

When putting on a shirt or blouse, always put the weaker arm or the arm with the least amount of movement into the sleeve first.

Show how to use energy wisely

Advise sitting to carry out an activity such as preparing vegetables rather than standing to do this.

Organise the timing of activities to avoid unnecessary trips, for example limiting the need to go constantly up and down stairs.

Adapt equipment to support independence

Equipment:

- raisers for chair, bed, toilet
- kitchen trolley
- perching stool.

Minor adaptations (less than £1,000):

- grab rails, stair rails, half step.

Major adaptations (More than £1,000):

- ramps, stairlift, bathroom adaptations.

Use of assistive technology and telecare

Personal alarms, sensors for epilepsy or falls, medication dispensers with reminder alarms or ‘Just Checking’, which is an activity monitoring system that shows a person’s day-to-day capabilities and where they need support.

Provide information and signposting to services

Social prescribing link worker.

Practical help to reduce social isolation and promote choice

Support the development of new social networks in the community or re-establish and maintaining existing ones.

Managing risk and choice through reablement

Taking risks can be essential to an individual’s progress when re-learning a task or taking part in a chosen activity as part of reablement. Risk aversion often prevents

people from living their lives freely and can create a perception of ‘I can’t’ or can increase anxiety if someone else is worried for them.

The role of workers within the reablement team is ‘to enable people to overcome the barriers that prevent them from doing the activities that matter to them; to take opportunities and not to see risk as another barrier’. It is often the occupational therapist that is involved in the risk assessment and reablement. This is to improve an individual’s abilities in a safe way and ‘avoid a focus on what cannot be done in favour of what can be done with greater certainty, accountability and transparency’.

> *Risk is dynamic and may fluctuate – for example, a small task such as making a cup of tea may suddenly place an older person recovering from a broken hip at an increased risk of falling.*
>
> ***Independence, choice and risk: a guide to best practice in supported decision making (Department of Health)***

In the quote from the Department of Health, the apparent risk should not stop the older person from trying to make a cup of tea. A reablement assessment allows the risk to be managed and the person to achieve their goal.

In the guide it goes on to say that people supporting users of reablement services must:

- help people to have choice and control over their lives
- recognise that making a choice can involve some risk
- respect people's rights and those of their family and carers
- help people understand their responsibilities and the implications of their choices, including any risks
- acknowledge that there will always be some risk, and that trying to remove it altogether can outweigh the quality of life benefits for the person
- continue existing arrangements for safeguarding people.

Outcomes of reablement

The most widely reported outcomes of reablement are:

- a reduction in the need for ongoing support
- a significant improvement in peoples’ wellbeing, particularly in terms of restoring their ability to perform usual activities
- an increase in their perceived quality of life compared to conventional home care services.

For the outcomes of reablement to be sustained, subsequent providers and informal carers need to continue the reablement ethos.

Reablement for users, carers and families

People using reablement services, as well as their families and carers, appear to welcome reablement. Research has shown that those receiving reablement valued the person-centred approach, which focused on what they would like to do to maintain their independence and was flexible to their changing needs and priorities. They felt that the daily contact with support workers helped them to re-kindle and re-connect their interest in everyday life.

Reablement can help families balance caring, paid work and other responsibilities by enabling people to gain or regain their confidence, ability, and necessary skills to live as independently as possible, especially after an illness, deterioration in health or injury. This can reduce the need for support and care from friends and family and lessen the strain on family relationships.

Families and friends need to have a clear understanding of reablement, need to be fully committed to the process and contribute to its successful implementation. Support is available from local services and other organisations such as SCIE to help families and carers become more familiar.

This is particularly important as the period of reablement comes to an end, because there can be anxiety regarding managing alone or transferring to a long-term care service. This can be overcome, in part, by managing expectations about the reablement experience. Everyone needs to be familiar with the ethos of reablement and its boundaries in terms of its nature and length of support.

Measuring the value of reablement

There is significant interest in the value of reablement and measuring its success. The approach used to measure the success of reablement depends on the local context and policies of the local authority. It is also likely to depend on the category of the reablement service (intake and assessment or hospital discharge) and the model (selective or de-selective).

For example, if a ‘de-selective’ model is used (normally seen in intake and assessment services), there will be a notable difference in the number of people who achieve full independence compared with a selection model (often hospital discharge schemes) where people are chosen for their reablement potential.

The value of reablement can be measured through:

- comparing an individual’s functional status at the beginning and end of a reablement period through appropriate outcome measures, such as COPM (Canadian Occupational Performance Model), Barthel Index or NEADL (Nottingham Extended Activity of Daily Living)
- quality of life questionnaires
- Service outcomes, such as:
    - reduction in traditional care home hours
    - unplanned hospital admissions

    - percentage of people able to remain living at home
    - percentage of people requiring long-term support or admission to long-term care
    - lasting benefit – the percentage of people no longer requiring a service up to 12 months post-reablement.
- cost effectiveness – the cost of interventions vs usual care costs and health service utilisation.

Research has shown that successful reablement can result in:

- a reduction in ongoing care support or avoid the need for any long-term care support
- a significant improvement in the person's wellbeing, particularly in terms of independence
- an increase in their perceived quality of life.

Practice example – Tower Hamlets London Borough Council

In the London Borough of Tower Hamlets 63 per cent of people using an occupational therapy-led reablement service had their reablement cases closed without needing further support.

It provides a multidisciplinary, short-term reablement service to all adults over 18 in the borough who may have lost confidence, skills or independence following an accident, ill health, a disability or a stay in hospital. The service aims to enable people to re-learn life skills, to rebuild their confidence, to facilitate and consolidate their existing abilities and build on their own resources to enable and promote a healthy lifestyle that is relevant to the individual. This can lead to a reduction or absence in long-term support needed, thereby reducing long-term costs.

Source: **Tower Hamlets London Borough Council**

Further reading

- **Care Act 2014: Guidance for occupational therapists - Prevention 2016** (Royal College of Occupational Therapists, 2016)
- **Caring For Our Future: reforming care and support** (Department of Health and Social Care, 2012)
- **Content and acceptability of an Occupational Therapy intervention in HomEcare Re-ablement Services** (British Journal of Occupational Therapy, 2018)
- **Effectiveness of reablement: a systematic review** (Healthcare Policy, 2016)
- **Evidence-based-interventions involving occupational therapists are needed in re-ablement for older community-living people: a systematic review** (British Journal of Occupational Therapy, 2017)
- **Factsheet 76: Intermediate care and reablement** (Age UK, 2019)
- **Final Report: Reablement and Older People** (IFA Copenhagen Summit, 2016)
- **How can occupational therapists contribute to reablement outcomes? A qualitative study**(British Journal of Occupational Therapy, 2015)
- **Implementing the 'New Reablement Journey'** (Imagine, Act and Succeed (IAS), 2013)
- **Independence, choice and risk: a guide to best practice in supported decision making** (Department of Health, 2007)
- **Intermediate care including reablement: Guidance** (NICE, 2017)
- **Intermediate care including reablement: Quality standard** (NICE, 2018)
- **New horizons: Reablement-supporting older people towards independence** (Age and ageing, 45(5), 2016)
- **NICE impact adult social care**(NICE, 2019)
- **Occupational Therapy: Improving Lives, Saving Money** (Royal College of Occupational Therapists)
- **Outcomes of reablement and their measurement: Findings from an evaluation of English reablement services** (Health & Social Care in the Community, 2019)
- **Project Home There is No Place Like Home: Using Telehealth Technology to Support a Proposed Restorative Care Program in the Community**(Boston University, 2018)
- **Reablement videos on Social Care TV** (SCIE)
- **Reablement resource** (SCIE)
- **Reablement: key issues for commissioners of adult social care** (SCIE)
- **Reablement: a key role for occupational therapists** (SCIE)

- **Reablement services for people at risk of needing social care: the MoRe mixed-methods evaluation** (National Institute for Health Research, 2019)
- **Reablement Services in Health and Social Care: A guide to practice for students and support workers** (Red Globe Press, 2018)
- **Strengths-based approaches**(SCIE)
- **The content of reablement: Exploring occupational and physiotherapy** (British Journal of Occupational Therapy, 2019)
- **Three conversations** (SCIE, 2017)
- **Time-limited home-care reablement services for maintaining and improving the functional independence of older adults (review)** (John Whiley and Sons Cochrane Collaboration, 2016)

SCIE support

We host a one-day in-house course that provides important insights into why and how reablement services can be used to support person-centred care and prevent or reduce need for care and support in the future.

This course is for social care and health staff, including frontline teams and managers from adult social care teams in local authorities, occupational therapists, reablement teams, registered care and support providers, voluntary organisations and housing.

View: Reablement training course

Contact: Contact SCIE to find out more

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