social care
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Reablement: emerging practice messages

SCIE has reviewed the evidence currently underpinning reablement. SCIE also visited reablement teams in four London boroughs to understand more about how the service can work in practice. By combining the research evidence with what we learned from the local teams, we have identified emerging practice messages.

Summary of emerging practice messages

- Reablement helps people learn or re-learn the skills necessary for daily living, which have been lost through deterioration in health and/or increased support needs. A focus on regaining physical ability is central, as is active reassessment.
- Reablement is becoming the 'default' initial response to presenting needs, rather than a service that is restricted to people on discharge from hospital.
- There is a high probability that reablement is cost-effective; reducing ongoing support needs through sustaining independent living.
- Commissioners and service providers should recognise that results for people with different needs vary although no-one should be excluded from reablement on the basis of their health state.
- People using the service and their families appear to welcome reablement although where care needs are ongoing, extra care should be taken to ensure the subsequent provider continues the reablement ethos.
- In planning a reablement service, a strong priority should be placed on the involvement of occupational therapy.
- Reablement requires care workers to adopt a 'hands-off' approach to supporting people, which is arguably distinct from practice in conventional home care. Managers should provide appropriate training and supervision to support this ethos.
- Although the reduction in ongoing support is a key objective of reablement, commissioners and managers should ensure that the aim of improving people's wellbeing is at the heart of the service.

1. What is reablement?

Definition

Reablement has been defined as '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'.[1] Restorative care is another term used in the US[2] and in Australia.[3]

Aims and objectives

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 six to 12 week intervention, focused on dressing, using the stairs, washing, preparing meals. Our local visits also showed that reablement may include social re-integration. Although reablement overlaps with intermediate care, its focus on assisting people to regain their abilities is distinctive.

Delivery model

No single leading model has yet been identified – there is little systematic account of what practitioners actually do. There is extensive UK material on implementation issues developed through work by the Care Services Efficiency Delivery (CSED) programme at the Department of Health.[4]

Our visits to local teams echoed the research evidence, showing that the specific model of reablement is defined by local circumstances. Often it is closely linked to rehabilitation and a focus on physical care. Active re-assessment is central to the practice of reablement. One authority linked reablement to personalisation and emphasised social inclusion.

Referral process

Some schemes (e.g. an 'intake' reablement service) accept all who would have been referred for home care. Some schemes operate a more selective focus on those who are judged most likely to benefit.

2. Why is it thought to be good practice?

Policy arguments are that:

- Reablement supports a service focus on independence and harnesses the joint input of health and social services (cf. 1998 Modernising Social Services). Reablement is also central to the Government's 'A vision for adult

social care' (Department of Health, 2010), which recognises the role of reablement in making savings to the NHS.
- Home care services will be overwhelmed unless solutions are found that decrease demand
- There is a high probability that reablement cost-effective[5].

From a practice perspective, reablement gains part of its power from responding to the wishes of the majority of users to retain independence and control, including staying at home[6].

3. What happens as a result of reablement?

Reducing the need for ongoing support is the most widely reported outcome and is central to the 'invest to save' argument underpinning reablement.

Research suggests[5] that following reablement people's need for social care services is reduced by 60 per cent compared to if they had used conventional home care.

Other results[7] show that up to 63 per cent of reablement users no longer need the service after six to 12 weeks, and that 26 per cent had a reduced requirement for home care hours.

Some studies show lasting benefit: for example, in one study[8] 85.5 per cent of people no longer required a service up to 12 months after the end of the reablement service. This compares with 57 per cent of people who had used conventional home care.

Reablement also significantly improves people's wellbeing, particularly in terms of restoring their ability to perform usual activities and increasing their perceived quality of life.

Who benefits most?

Results for people with different needs vary. We need to take into account that some people with a high need for assistance will not benefit as much as those with lower support requirements, or may need longer term intensive service. In one 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[9]. Another study used the Fair Access to Care Services (FACS) rating as a measure of need, and found that two thirds were assessed at the same level after six weeks and 12 per cent at a higher level.[10]

Targeting reablement

It is not clear from available research 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 five to 10 hours assistance requirements at intake, benefitted more than those referred from hospital.[9]

The teams we visited all operate an intake model; no person is excluded on the basis of their health or social care needs. Assessment on referral to the services identifies people (e.g. with longer term needs) who may need to move quickly to other support providers. Although research is inconclusive on the issue, there is a shared view among the teams we visited that some people with dementia can benefit from a period of reablement. The teams also support people with terminal care needs, unless palliative care is more appropriate.

4. What do people think about reablement?

Although there are relatively few studies of users' views,[12] a narrative account reports 'high degrees of satisfaction by users and their families',[1] and another review suggests strong support from reablement users.[6] 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. Clients 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 (pp.36–37).[9]

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.[9] We should remember that some of these adverse reports may apply to any home care service with handover points or limited support for domestic tasks, but reablement throws these issues into sharp focus because it emphasises a handover after a certain period and that the goal is to encourage users to undertake their own domestic tasks.

Our local teams all reported that carers' views are positive, especially where reablement means that people need to rely less on their carers, which is a trend identified in one recent study[5].

5. How does reablement fit within existing care and support?

Some reablement services are joint health and social care schemes, some involve social services only.

The role of occupational therapy (OT)

The existing skills of home care staff are the key resource,[13] but some teams include OTs (or train home care staff in OT skills). It is unclear whether OT skills are essential to successful outcomes[11] but 30 per cent of users in one study saw an OT[13] and interaction with an OT was especially valued by care workers in another study.[9]

Occupational therapy skills are viewed as essential in the teams we visited. However, occupational therapists do not necessarily have to be members of the teams. OT input may be secured through collaboration and co-location or referral. OT input may help to keep the reablement focus on tasks and to train carers.

Experience and qualifications

Councils with Social Services Responsibilities (CSSRs) designate NVQ level 2 as the base qualification.[11] (An Australian scheme includes a nurse, physiotherapist and occupational therapist, just one of which works with the individual.[3] An early UK study indicates the key role played by a reablement coordinator trained in occupational therapy.[7]) One study suggested that staff with less experience in traditional home care made better reablement workers.[10]

Data from CSED interviews with managers[1] 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.[9]

The teams we visited confirmed that staff are qualified at NVQ level 2 but that additional training is required to instill the ‘reabling’ ethos. The ethos demands that care workers have a less ‘hands-on’ approach, enabling people to (re)learn activities, gaining the strength and confidence to do them independently. Managers reported no difficulties among staff in ‘doing with’ rather than ‘doing for’ the people they support. Mentoring and training with a focus on meeting user-defined needs helps to keep the emphasis on assisting users to regain their skills and abilities.

Reabling ethos

CSED interviews with managers point to the need to encourage a culture of reablement, particularly among independent providers[11] and another study pointed to the risk that handover to a more traditional home care service might undo the progress made within a reablement approach.[9]

Having identified this potential problem, one of the teams we visited keeps cases open for up to two years following handover to a home care provider. Before a provider can subsequently increase an individual’s care package the reablement team must authorise the change and will only do so if they feel the person is being

supported with a ‘reabling’ ethos to reach their potential independence. The reablement team also works with private providers to support care workers in adapting to this less hands-on approach, while another of the teams was renegotiating its contracts with ongoing care providers to ensure a reablement ethos.

6. What do people have to do differently?

While reablement includes actively assisting people to regain their ability, some aspects require staff to learn ‘to ‘watch’ and not interfere when a service user [is] struggling to get something done’[10] (confirmed in another study[9]). Staffing needs to be flexible to allow time required and continuity of worker.[10] Service recording must be detailed to record achievement at each contact.[10] Independent sector providers need to adapt their service to support reablement.[11] 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’’.[13]

Our local teams drew attention to the need for active re-assessment – almost at every session – in order to maintain progress.

7. Is reablement affordable?

In considering whether reablement is affordable, the costs (and savings) of the services should be assessed against its potential benefits. We know reablement improves people’s quality of life compared with conventional home care services. There is also good evidence that reablement has significant potential to reduce ongoing care and support costs, despite the higher upfront costs compared with traditional home care. The most robust evidence to support these findings was produced by the SPRU/ PSSRU prospective study of reablement[5]. The research demonstrated that following a period of reablement people’s need for social care services is reduced by 60 per cent compared with if they had used conventional home care. The higher upfront costs are illustrated by the average cost per user being £2,000 for reablement compared with £1, 392 for a 6-week period of home care.

The SPRU/ PSSRU study, which included the most robust economic evaluation of reablement, analysed all cost and outcome data and concluded that there is a high probability that reablement is cost effective. This essentially tells us that from a social care perspective it is worth investing in reablement.

A crucial strength of the economic evaluation in the SPRU/ PSSRU study is that it includes outcome data on quality of life improvements. Most other studies of reablement only focus on ‘service outcomes’, meaning the benefits to the service. It is arguably more important to focus on the benefits gained by the individual person using the service. The studies that have only dealt with service outcomes imply that improvements such as ‘reduced care hours’ will necessarily be associated with improved quality of life. The studies should ideally have measured this using

standardised tools, as the SPRU/ PSSRU team did. Commissioners and providers, for their part, should ensure that the overriding objective of the reablement service is to improve people's independence and self-defined wellbeing: this should include using measures of user wellbeing.

Nevertheless, results from all available evidence 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.

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