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Improving Social Care in Wales
Gwella Gofal Cymdeithasol yng Nghymru

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Position Statement on Reablement Services in Wales

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Executive Summary

The importance of reablement to the new agenda is reflected in the commitment within the Local Government Implementation Plan for Sustainable Social Services, that SSIA should lead on the production of a comprehensive Position Statement providing an evidenced baseline of current provision across Wales and a benchmark for the development of these services in the context of the requirements within Sustainable Social Services.

The Position Statement was designed to help identify challenges and opportunities for improvement to reablement services and to catalogue effective practice for wider dissemination. The value of this exercise has been recognised by the range of contributing stakeholders who would need to examine how any similar benchmarking work be carried out in the future.

Sustainable Social Services: A Framework for Action' published in February 2011 states:

"We will place re-ablement at the heart of our approach. We believe that by quickly supporting people 'to do' for themselves, we will enable them to recover quickly or develop ways of living that fit their new circumstances"

The development of reablement services is a major part of the principle of improving outcomes for individuals who need support and helping them to maintain their independence. These services also have a vital contribution to make towards developing sustainable model of services underpinned by the new Social Services and Well-being (Wales) Bill and the implementation of a Welsh approach for Citizen Directed Support.

The data received highlighted the following:

- In 2011/12 – 23,505 people received reablement services in Wales.
- Reablement services are operating flexibly with low thresholds for entry. Many people enjoy access to reablement services before any determination of eligibility criteria. The determination of eligibility takes place at the end of the reablement programme for those people who require longer term support. This model was developed through collaborative local authority working and is now nationally supported being the model of care outlined in the Social Services and Wellbeing (Wales) Bill.
- Reablement is characterised by ongoing assessment and as such engenders more efficient processes when longer term support is required.
- Respondees also commented that reablement has reduced demand on acute medical services, but there is a need for joint agreement between partners as to how this can be consistently evidenced. Similarly, reablement services have contributed to the avoidance of inappropriate admission to residential care.

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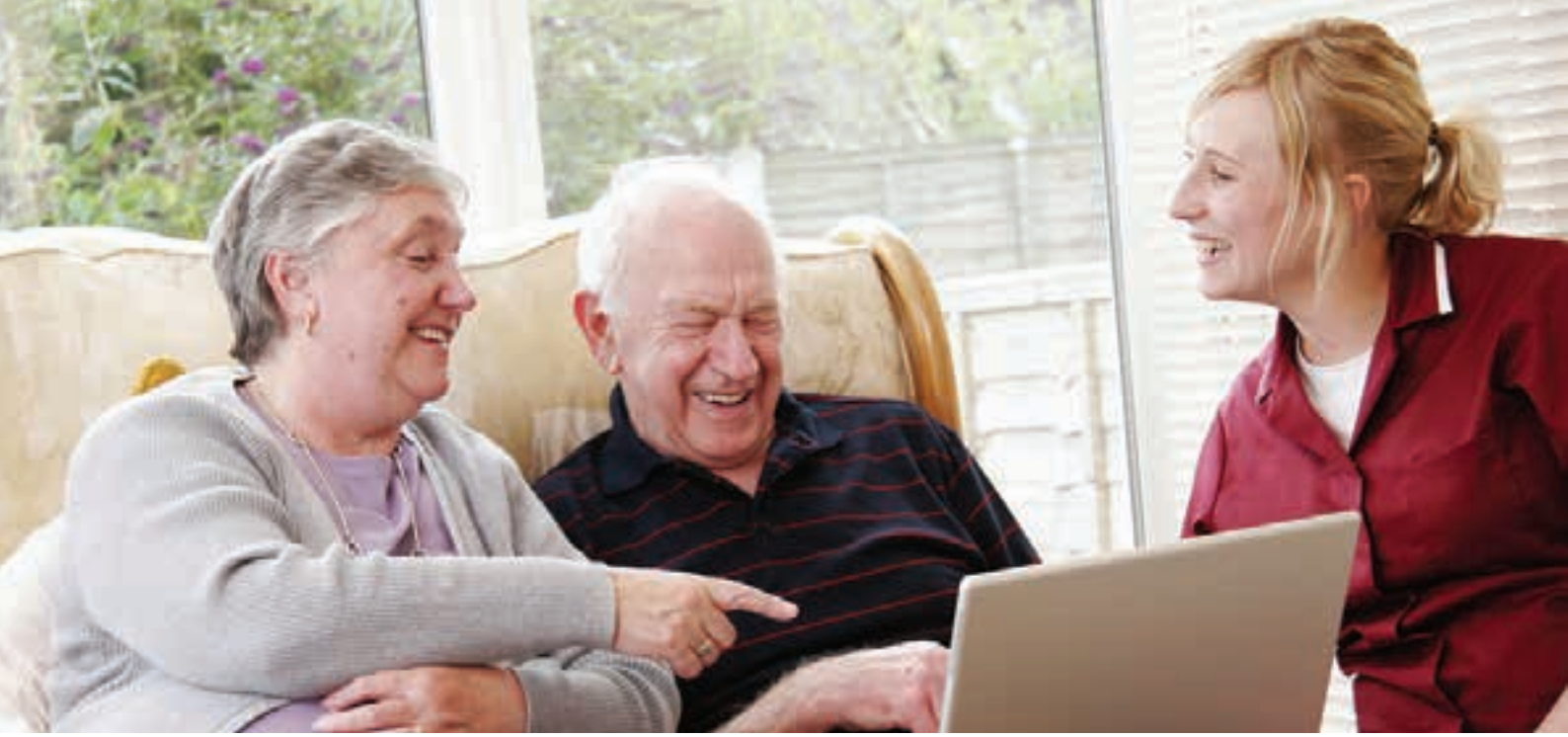

- Data collection has proved a challenge, not least due to the lack of a nationally agreed suite of performance measures. Proposals for such are contained within the report, with recognition of the need for alignment with the forthcoming National Outcomes Framework.
- Problems with capacity to meet need, particularly at times of high demand are noted and there are difficulties responding to needs in some very rural communities.
- The reablement workforce is both committed and competent and working in an outcome focussed way. There is a need to further develop the workforce and recommendations for working with the Care Council are within the report.
- Outcomes from Reablement are extremely positive, with over 70% of people having received Reablement services not needing further ongoing support. This improvement for people also benefits both Local Authorities (LAs) and Local Health Boards (LHBs) and there is need for this shared organisational impact to be recognised with commensurate shared funding.

Key message for reablement in Wales

- Community reablement services are now operating throughout Wales. Some are more established than others but everyone in Wales who could benefit from reablement services should be able to access them within their local area.
- Reablement services across Wales had varying starting points, but they all emanated from a local vision. Many services started as pilots, achieved their stated intent and were mainstreamed, with many planned and delivered jointly between Local Authorities and Local Health Boards.
- Reablement services are delivered predominantly to older people and as such have proved to improve service user and carer outcomes. This success can expand and improve other service areas by transferring the learning from and building on the many existing examples of effective practice.
- Meeting the challenges facing councils and partners in further developing reablement services and taking advantage of the enablers within the existing system will be crucial in ensuring that reablement is a key feature of provision in the future. This will require robust strategic leadership across sectors at national, regional and local levels.
- The majority of LAs have agreed joint strategies with their LHB partner, but there is a need for these to be revisited and formalised, with a clarity as to the express purpose of Reablement within the overall continuum of community based services as these are remodelled.

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During 2012 a detailed questionnaire informed this National Position Statement on Reablement was developed by the Reablement Learning and Improvement Network in partnership with Local Health Boards and the Reablement Alliance.

A summary of the key recommendations can be found on page 30.

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1) Context

The following definition of reablement services was agreed by the SSIA-led Reablement Learning and Improvement Network (LIN) and is adopted for the purposes of this document.

'Services for people with poor physical or mental health or disability to help them live as independently as possible by learning or relearning the skills necessary for daily living'.

Such services are crucial within the organisational and cultural transformation that is necessary if we are to meet the needs of an ever increasing number of older people with significant dependency needs within a reducing financial settlement.

Reablement is a crucial intervention in supporting people maintain their independence at home, reducing demand on acute hospital services and the need for long term institutional care.

Whilst the focus of reablement services is on promoting and optimising independent functioning rather than resolving health issues, it is essential that services are developed jointly and viewed within the continuum of community based primary and social care services. This was emphasised in a model for transformed services for older people in Wales developed by Professor John Bolton in partnership with managers and practitioners across Wales and presented in his resulting report 'Better Support at Lower Cost: Improving Efficiency and Effectiveness in Services for Older People in Wales' (SSIA, 2011).

Reablement is not just about the person's physical ability to undertake the tasks of daily living, it is also about ensuring that mental and emotional wellbeing are also maximised.

It is about helping people do as much for themselves as possible rather than doing things for people that they cannot do. A key message delivered by the Minister at the Social Services Conference in June 2013 was that both Social Services and Health should be developing and promoting a culture by which services:

- maximise diversion and minimise intervention.
- redraw the contract between the citizen and the state, with an emphasis on co-production.
- make reality of the shared ambition between health and social care to focus on early intervention and shared services.

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2) Policy Drivers

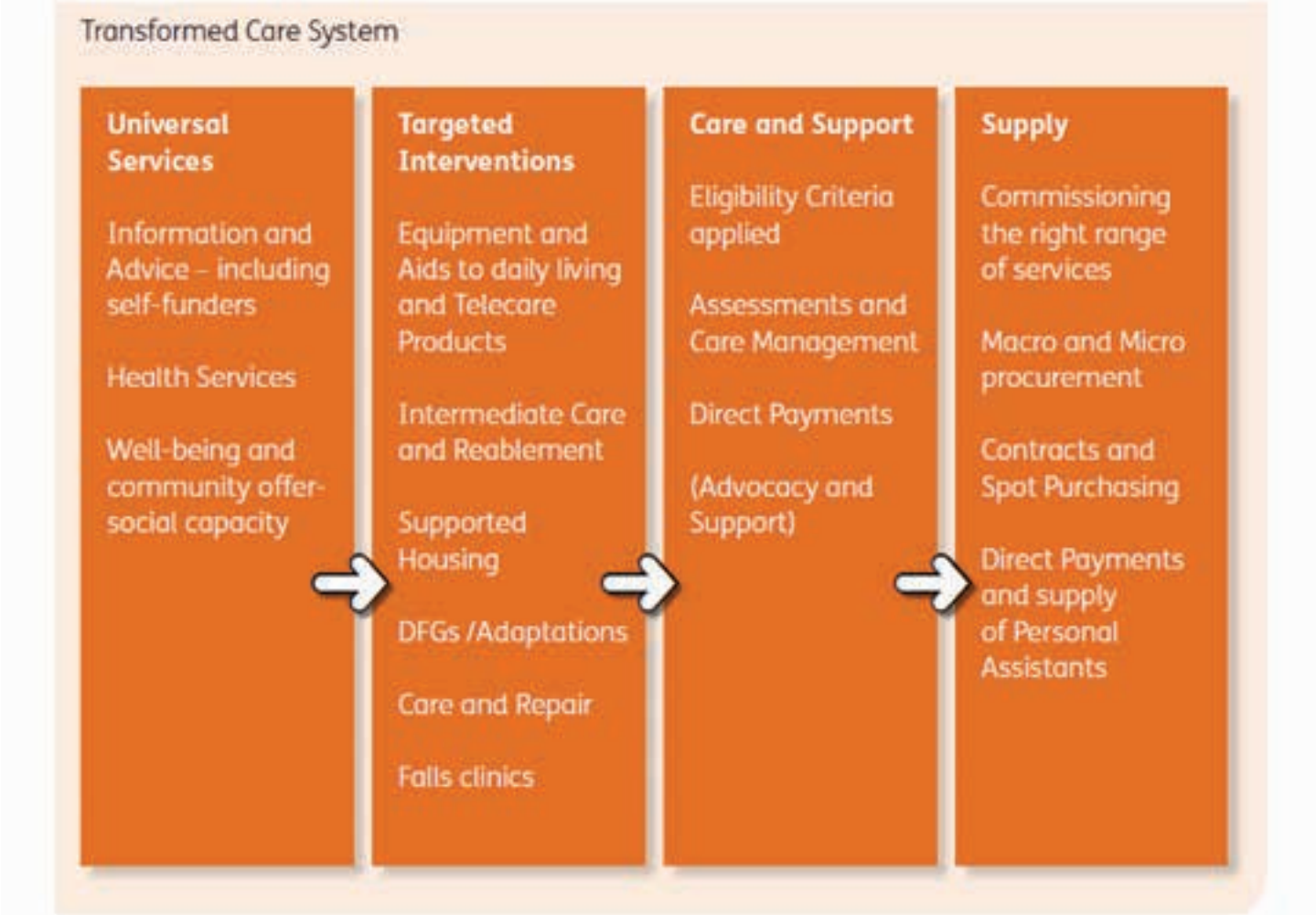
'Sustainable Social Services for Wales: A Framework for Action' (Welsh Government, 2011) states that 'If public services are to meet need, we have to change the terms of the debate. The answer is not a return to the "prevention role" for social services, but recognition that the whole local authority has a responsibility for leading community services and promoting community wellbeing and that it should galvanize the communities' own commitment to enable its citizens to play a full part'.

It goes on to say 'We will place reablement at the heart of our approach. We believe that by quickly supporting people 'to do' for themselves, we will enable them to recover quickly or develop ways of living that fit their new circumstances.

This will also reduce the need to wait for an assessed care package. The role of occupational therapists in helping to deliver reablement services will be key.

Finally, it contains the commitment to 'introduce a requirement for reablement services to be provided across Wales and will ensure that arrangements are in place for these to be planned and commissioned on a regional basis. We expect these services to be jointly led by social services and the NHS'.

The Social Services and Wellbeing (Wales) Bill currently proceeding through the Welsh Assembly will provide the legislative framework for the remodelling of services to deliver the Sustainable Social Services vision.



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Authorities in partnership with other agencies to promote the wellbeing of people in need of care and support and their carers. This will require, among other things:

- Adopting a corporate approach to wellbeing across Council departments.
- The further development of partnership arrangements with the NHS and other agencies, including greater use of integrated budgets to develop and sustain new service models.
- A greater emphasis on early intervention and prevention thereby delivering improved outcomes and reducing – or at least delaying – individuals' need for ongoing social care provision.

More recently key documents from the Welsh Government – *"Delivering Local Health Care"* and *"A Framework for Delivering Integrated Health and Social Care"* similarly exhort partners to work together to strengthen local care services with accelerated pace.

The former document urges an increase in" the focus on prevention, with rapid intervention when necessary", whilst the latter requires attention to be paid to "preventative services that stop an avoidable slide into increasing dependency upon services". Partners should also pay attention to developing "a balanced set of services operating where necessary 24 hours per day, integrating early intervention services, support for independent living, rehabilitation and reablement, intermediate care, end of life care and pathways into specialist services and less often used services".

3) Supporting the development of reablement services in Wales

National support for the development of reablement services has been provided consistently by SSIA since 2007. This has included:

- A National Learning Event 'From the Margins to the Mainstream' drawing on good practice from across the UK and considering the value of reablement within the context of remodelled services for older people.
- Creation of an Action Learning Set comprising representatives from more than 10 councils to share experiences and thinking on reablement – this subsequently became the Reablement LIN with representation from all Councils, which provides a regular opportunity for exchanging intelligence and sharing learning and which also has overseen the development of a number of tools to assist the development of reablement services at a local level including:
- An electronic predictor to help identify financial benefits within a local authority area.
- A standards framework for reablement and self assessment facility to inform development and assist cross-organisational benchmarking and practice exchange.
- Financial support from the SSIA for five councils to take forward reablement services in their area and dissemination of learning.

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The SSIA Business Plan for 2013-14 contains a further commitment to support a number of Demonstrator sites in further developing their reablement services. A specific condition for funding will be that the models receiving support encompass joint approaches by local government and health.

4) Overall Findings

Community reablement services are now operating throughout Wales. Some are more established than others but everyone in Wales who could benefit from reablement services should be able to access them within their local area.

Many services which started as pilots have now been mainstreamed, with many planned and delivered jointly between Local Authorities (LAs) and Local Health Boards (LHBs).

Challenges in expanding and improving reablement services can be addressed by learning from and building on many existing examples of effective practice.

Meeting the challenges facing councils and partners in further developing reablement services and taking advantage of the enablers within the existing system will be crucial in ensuring that reablement is a key feature of provision in the future. This will require robust strategic leadership across sectors at national, regional and local levels.

Recommendation 1

The findings and recommendations from this Position Statement should be considered by the National Social Services Partnership Forum and Strategic Leadership Group. Particular consideration should be given to the following areas:

- Ensuring appropriate levels of funding for reablement are available across the system of health, social care and wellbeing to make services sustainable.
- Ensuring that the Social Services and Wellbeing (Wales) Bill and its regulations facilitate and support the further development of reablement services in Wales as part of a wider wellbeing and prevention-based approach.

Implications for political and professional leaders across sectors at national, regional and local level to be clearly communicated via appropriate forums.

Recommendation 2

A National Reablement Steering Group, comprising Local Authority, NHS and third sector and reporting to Strategic Leadership Group should be established to provide focused strategic leadership for the further development of reablement, focusing initially on the following areas:

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- Establishing an agreed definition of reablement.
- Work with the developing National Outcomes Framework, and ensure that appropriate key performance indicators are incorporated.

The Position Statement has been developed from 21 LA and 3 LHB responses to a detailed questionnaire circulated to all councils and LHBs in Wales and supplemented with support and advice from SSIA in relation to completion of the questionnaires.

The Position Statement was designed to help identify challenges and opportunities for improvement to reablement services and to catalogue effective practice for wider dissemination. The value of this exercise has been recognised by the range of contributing stakeholders and a key recommendation is that more focused information gathering following a similar format be undertaken on a regular basis to provide an ongoing picture of the development of reablement services in Wales.

Recommendation 3

Any future review of Reablement Services should be undertaken to ensure that current information on arrangements across Wales is collected and accessible by all relevant stakeholders. Future position statements should:

- Be informed in terms of design and focus by strategic consideration of this initial Statement
- Receive full participation from all key stakeholders, mandated by the National Social Services Partnership Forum and Strategic Leadership Group.
- Focus on key areas of consideration and challenges in relation both to strategy and service delivery.
- Build an effective practice resource for dissemination across Wales and beyond to help drive further service improvements.

From the responses received we know that over 23,000 people received a reablement service in 2011/12, demonstrating that the vision set out in Sustainable Social Services has a high level of ownership within the sector and is becoming increasingly mainstreamed.

The value of reablement services can be measured by their impact. Of those services that reported on outcomes 70% of service users had no need for on going services on completion of their reablement programme.

This figure needs to be recognised as a snap shot in time; as the likelihood is that as more organisations adopt an intake model the numbers requiring ongoing services will increase.

It should also be noted that over time the total number of adult care service users will increase as reablement and other preventative approaches often only delay rather than eradicate the need for ongoing support – a fact recognised in the Explanatory.

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Memorandum to the Social Services and Wellbeing (Wales) Bill (Welsh Government 2013).

Responses also indicate that:

- Significant numbers received a reduced care package following reablement; only a small number required an increased care package.
- Several services reported that reablement had contributed to facilitating hospital discharge and helped avoid unnecessary admissions to care homes.
- Several also reported that there was a reduction in the number of people requiring long term care following reablement.
- The service was also seen to take pressure off care management services as reablement is increasingly becoming the gateway to services.
- A better understanding of the needs and priorities of the individual, through the contribution of reablement services to assessment, is also enabling the development of more relevant care packages for those continuing to need care and support post reablement.

Older people are the predominant users of reablement with some services also available for people with dementia who would benefit from the service, and younger people with physical or sensory disabilities. Achieving this more widely would afford the benefits of the reablement approach to more users over time. In some areas, services are not available for people with learning disabilities or people with mental health problems.

> *"Mrs A has a dementing condition. She was showering twice a week which she did not like. She was low in mood and had not taken part in kitchen activities for some time. Difficulty maintaining interests. Following assessment the agreed intervention was:*
>
> *Encouraging to shower and to make own food including getting her own breakfast, and lunch and tea by making sandwiches and using the microwave and cooker under supervision, actively encouraging her to maintain interests*
>
> *Following the OT programme with the Specialist Dementia Team Mrs A is showering daily; her mood has improved; she is undertaking food preparation safely under the supervision of the staff.*
>
> *Mrs A has continued to retain ADL skills at this level. She has been encouraged to maintain interests e.g. caring for house plants and crocheting.*
>
> *Time Carers spend on the calls has been reduced."*
>
> Case study from Merthyr

One key area also noted was the impact of reablement on the workforce. Benefit was seen in terms of making more effective use of resources and staff having increased confidence due to additional training, having a career structure and feeling more valued.

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"Sustainable Social Services" included an aim that reablement services should be planned and commissioned on a regional basis. Whilst the nature of older people's services and the consistently high volume of demand within local authority areas mean that the value of cross-border commissioning is potentially less than would be the case for more specialised, low volume services, there are examples of joint planning and delivery with the NHS.

In addition, a number of programmes are in place at a regional level to support the development of consistent approaches and standards across services provided by different councils within the borders of particular LHBs. That they should be planned and commissioned on a regional basis is not currently supported. A significant majority of respondents reported that they have no plans to commission reablement services jointly with neighbouring local authorities or on a regional basis. There has been some joint development work between the authorities and LHB in North Wales and examples of shared learning between authorities in other parts of Wales.

Recommendation 4

Regional reablement strategies should be refreshed and developed on a genuine partnership basis across local government, the NHS and other sectors to ensure effective and efficient provision. Opportunities should be taken to formalise arrangements through the forthcoming Statements of Intent between LHBs and LAs in relation to integrated services for older people with complex needs.

Reablement services are funded from a range of health and social care sources, but predominantly they are funded by LAs. The enhancements to the life of the individual from this investment has been found to benefit health services and improve overall health gain Issues of funding are reported to be of concern to LAs Future funding models should ensure equity of cost burdens and benefits across local government, the NHS and other sectors.

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1. Current Services

1.1 Definition

A key issue noted from the responses is the need for a national definition, of both Reablement and Intermediate Care. One which encompasses the provision of reablement in a variety of settings and reflects the multi-disciplinary partnership approach.

The majority of responses received reported that there was an agreement on the roles and purpose of each service and an agreed definition of reablement between the social services and the LHB. However, sometimes this definition also refers to Intermediate care, which can lead to inaccurate performance comparisons. A few respondees also did not report that their definition included social, emotional and mental health.

Appendix 1 provides examples of definitions in current usage.

1.2 Service Strategy and Partnership Working

Reablement services are provided by health and social services. There were no reports of reablement services commissioned from the independent sector although there are some service level agreements with the Stroke Association to provide specialist after care. Recent discussion with the Reablement LIN indicates that one LA is "exploring" the option of commissioning reablement services from an independent provider.

Over half the local authorities have agreed joined strategies with their LHB partners, although many of the signed agreements are now quite dated and given recent learning and developments it would be surprising if some of these did not require some refreshing at the very least.

The proposed requirement within the 'Framework for Integrated Health and Social Care' (see above) for LHBs and Local Authorities to develop Statements of Intent for integrating older people's services by January 2014 provides an important opportunity for formalising joint approaches to reablement.

In order to ensure that the pace of service transformational change is accelerated, it would seem helpful to ensure that all services are underpinned by a formally agreed joint strategy, reflecting a coherent approach to the development of the service.

One response noted that there used to be a Partnership Board overseeing reablement but given organisational changes this had fallen by the wayside and may not be seen as a priority. It may not be appropriate to have a Partnership Board between an LHB and its partner local authorities focusing simply on reablement but it is important that the existing partnership mechanisms consider reablement alongside a series of other services to monitor their impact on the management of demand.

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Reablement alongside other services has a vital contribution to make in providing the right help to the right people at the right time in the right place helping to avoid inappropriate admissions to hospital, facilitating discharge from hospital and maintaining people in their own home in their community.

Whilst regional commissioning was not supported by LAs, there is more enthusiasm about the development of formal partnerships and pooled funds with health. Twelve local authorities have formal partnerships for reablement services and two were considering such in the future, (NB It is not clear such formal partnerships are Section 33 agreements).

Effective partnership working requires mutual trust and confidence in the contribution of partners. Effective reporting arrangements help to build confidence. They increase transparency, and reduce suspicion. They also inform partners about what's working well and what's not working well, where the bottlenecks are or indicate where some further investigation is required to inform any required changes. Responses to the questionnaire, for example, referred to bottlenecks in the system preventing people from moving on.

Improvement in data collection and performance management is another key message emanating from the responses and proposed measures are to be found in Appendix 1.

1.3 Service model

Reablement services provide support to people as both an early intervention/preventative measure i.e. after initial contact with social services and also following an acute episode e.g. a fall or at hospital discharge to support independence on the return home.

There appear to be two general approaches to reablement, one targeted and the other a more general intake model.

The targeted model sets out a criteria for access and defining those most likely to benefit may be reliant on other professionals determining suitability for the service. The intake model is less prescriptive about access criteria and all new referrals to social services will be expected to be considered by the reablement service.

There is also variance in the provision of reablement, some being an LA only service with no therapy service involved and others operating on a multi disciplinary basis with access to a range of professionals.

It would be useful in the future to map the above differences as a matrix, setting them against individual outcomes and service costs, so as to consider which model provides best personal and organisational benefits.

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The evidence suggests that many of the reablement services started as pilots using grant monies such as the flexibilities grant, these pilots are now part of the mainstream core services of the Local Authorities.

All the services have procedures in place for dealing with urgent referrals and these are responded to immediately or within a few hours.

The following circumstances describe the priorities for the service:

- Facilitate hospital discharge
- Avoidance of hospital admission
- Frequent falls
- CVA
- Carer stress
- Avoid inappropriate admission to residential care
- Unstable care package.

The service will also take re-referrals from people whom have used the service previously and whose circumstances have changed.

Services are flexible and most services are provided for up to six weeks (42 days) although it can be extended if required.

There are also several 'step up: step down' services operating in residential care services operating in parts of Wales People who have experienced a recent illness or accident may be ready for discharge from hospital but not ready for reablement. Services that allow time for recovery before reablement can begin can make a valuable contribution. In such cases the value of a transition bed geared to begin reablement programme as soon as the individual is ready may help to avoid premature or inappropriate admission to residential care.

In respect of provision for rural areas, difficulties in providing such services have been reported. However two options a) providing the service jointly with Health and b) providing reablement as part of the in-house home care service are being used to address this difficulty.

1.4 Eligibility

The services operate with a very low threshold of entry. Many operate below or outside the 'fair access to care' eligibility criteria operated by local authorities.

It will be vital that the position of reablement services as one dimension of a preventative approach is properly recognised in the context of the proposed National Eligibility framework which is to be introduced under the Social Services and Wellbeing (Wales) Bill. The Welsh Government has undertaken to take forward the key principles contained in the SSIA report 'Access to Care and Wellbeing in Wales'

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(March 2013) in developing the detail of a National framework.[1] The report calls for a 'more flexible and responsive approach to assessing peoples' needs and helping them maintain their independence' and called for a '3 pillared' approach in which citizens are provided, according to need, with better access to information and universal community resources, proportionate wellbeing support for those who need some help and a guarantee of managed support for those who need it. With its low threshold for access reablement should be seen as a proportionate time limited support prior to any ongoing managed support.

Examples of existing criteria being applied at a local level for allocating reablement services can be found in Appendix 1.

1.5 Hours of operation

The hours of operation of reablement teams vary considerably with start times operating from 7am to 9 am and finish times from 3pm to 11pm.

Generally services operate 5 days a week and there is evidence of a wish to extend the hours of operation of reablement services to 7 longer days per week with a mobile service at night.

Whilst this would enable the benefits of reablement to be fully realised and the expansion of the service be of significant impact in addressing the pressures of Unscheduled Care there would also undoubtedly be resource implications.

1.6 Capacity

Whilst all LAs are convinced of the value of reablement services only half of the respondents reported that they were confident that reablement services are available to everyone who would need them.

A similar number also reported that their reablement services had insufficient capacity to cope with demand. The pressures included:

- Availability of therapy, medical and nursing staff.
- Capacity of other services making it difficult to refer on – this was of particular note in hard to reach geographical communities.
- Managing demand – peaks and troughs.
- Delays in moving people on due to delays in assessment and financial panel processes.

[1]Ministerial Written Statement on Assessment and Eligibility Framework by Gwenda Thomas AM, Deputy Minister for Social Services, July 2013

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1.7 Funding

There are concerns about the future funding for reablement services. The importance of reablement services, for both LAs and LHBs, in supporting people in their homes and reducing demand on acute hospital/long term care services is universally acknowledged; but however successful services are in helping to manage demand, demographic pressures mean that the services still have to maintain pace simply to stand still. Furthermore, whilst reablement and other preventative services might be expected to delay individuals' need for ongoing care, it is to be expected that people who receive reablement at any one point in time are likely to have more complex needs at some point in the future. Put simply, effective reablement will not totally eradicate the need within a local area for effective long term care provision. Reablement and ongoing care and support services will always need to co-exist.

Given the current climate of austerity and the emphasis by LHBs on addressing the demand on their acute services and enhancing A+E services there are widespread concerns within LAs about future funding from their LHB partners for reablement services. Many have seen financial and/ or service support to reablement withdrawn.

Allocation of funding needs to be strategically driven, with a balance reached between acute and preventative services and also across LAs and LHBs.

It would provide confidence to LAs that LHBs are committed to maintaining their contribution to reablement services, for this to be acknowledged in the Integration Statement of Intent.

Recommendation 5

Political and professional leaders should prioritise the further development of reablement services as part of remodelled services for older people and other client groups, through:

- Greater integration across health and social care and use of integrated and shared budgets.
- Incorporating reablement services into statements of intent for integrated services.
- Sharing and applying best practice.
- Establishing appropriate arrangements for assessment and providing access to services.
- Developing outcome focussed care plans.
- Improving effective engagement of service users and carers in the planning, designing and evaluation of services.

1.8 Charging

The majority of LAs do not charge for Reablement services, but where the service has been extended for longer than 6 weeks a small minority will charge.

Current financial pressures require that LAs give every consideration to opportunities for maximising their income; however it is considered that a move to charging for reablement would be counter productive and should only be implemented as a very last resort. It is therefore imperative that appropriate levels of funding are identified to sustain effective reablement services, removing the need for councils to resort to charging to address financial shortfalls.

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1.9 Data collection

Another key issue identified was the need to define the range of information we collect to manage the service, to measure the impact on the lives of people who have received the service and also on other services eg acute hospital. The design of this position statement was very ambitious and has provided a plethora of information from which to deduce a good baseline as at January 2013.

We can now determine the priority areas for action, update the information in the baseline and ensure that improved service definitions allow for more robust comparison.

A joint approach to managing performance and applying any performance indicators is vital in relation to integrated services. Any such action needs to align with the forthcoming National Outcomes Framework and the requirements of A Framework for Delivering Integrated Health and Social Care.

Examples of information used to monitor performance is included in Appendix 1.

Further work is required to validate the methodologies for collecting some of this information. It would be helpful for the SSIA/ LIN to collect performance management reports from each service together with a description of rationale and the methodologies for collecting it for the purpose of defining some common performance measures for the future.

2 Reablement Pathway

2.1 Referral

Of the responses received from local authorities the significant majority reported that there are agreed processes for referral to reablement and intermediate care. The actions taken by reablement services to ensure good quality information from referrers can be found in Appendix 1.

In the vast majority of cases reablement services are allocated prior to any formal assessment of eligibility. In some of the responses which stated that an assessment of eligibility was undertaken prior to the allocation of reablement services there was an intention to change practice.

Most services work with the service users and where appropriate their families to identify goals and outcomes to be achieved at the initial assessment. These are recorded in a support plan which in many cases is monitored on a weekly basis with a formal review after 4 weeks.

Consideration will also be given to other services such as community equipment, telecare, etc.

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Whilst most referrals are to support people within community settings, there are also instances whereby people are supported by reablement services to return home from residential settings.

> *"Mrs W was admitted to an EMI residential home following a diagnosis of Korsakoff's syndrome and severe deterioration in her ability to remain safe at home. Admission to EMI care was following a thorough multi disciplinary assessment and several best interests meetings.*
>
> *Over the period of time she had been within EMI care, her ability to make informed decisions improved and during reviews she requested to return home. Confirmation was sought from medical professionals to determine whether this was practicable.*
>
> *A Reablement assessment was completed to identify any areas of personal / domestic activities which required improvement and the level of support required on discharge.*
>
> *A Reablement plan was created and the Reablement approach was adopted by staff at the home in order to prepare her for discharge. A full Reablement package commenced on discharge, which was reduced as routines were developed and Mrs W's confidence in her ability increased.*
>
> *On completion of Reablement, she was independent with all aspects of personal and domestic routines. There was one occasion in the initial days of discharge where she had relapsed however on ending Reablement only one support call per day remained and this was in order to ensure long term safety."*
>
> Case study from Wrexham

2.2 Hospital discharge

In respect of reablement following hospital admission most local authorities reported that on occasion some referrals were made direct to home care and to residential care but this is usually because all other options have been exhausted. Most partnerships are working to avoid direct placements into residential care without reablement and other services being tried first.

However it should be noted that the majority of respondents reported that there were occasions when it was necessary for a time limited stay in residential care pending transfer to reablement services.

This issue of hospital discharge is of particular importance for self funders, as there may be a danger that this cohort has less engagement with social workers and thus not be afforded the opportunity to fully explore all options. However most responses included reference to the fact that self funders do have equal access to these services, with the most important factor being the potential for reablement and not the financial circumstances of the individual.

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The issue is of specific relevance for colleagues in the NHS. It is crucial that all patients do not make premature decisions about their future, but have the opportunity to examine all options rather than being encouraged to opt for long term residential care because well meaning and anxious relatives think this will be safer for the individual.

2.3 Entry into Reablement

The process of assessment varies between services. In some cases the social worker or other professional completed the initial assessment or screens cases and then refers to a reablement team. The reablement team develop a reablement plan with the service user and adjust the assessment accordingly.

(this is the targeted model of service)

In other cases all new referrals to Social Services are made to the reablement team and the unified assessment is only used towards the end of the programme if the user is believed to require continuing support. Decisions about eligible needs are taken at this point.

(This is the intake model of service).

2.4 Undertaking the assessment

A range of professionals can be involved in the assessment process, dependent on whether the service is multi agency or LA only. Staff can include social workers, occupational therapists, nurses and reablement staff prior to reablement commencing. LA/LHB occupational therapists or social workers are usually involved in the assessment of complex cases.

Further detail re the assessment process can be found in Appendix 1.

Frontline staff continually assess the users progress against their individual goals. Feedback and review is fundamental to maintaining timely progress.

The vast majority of reablement assessments and care support plans identify the outcomes to be achieved. The services have support plans which detail what reablement support is to be provided to meet the outcomes of the individual. The focus on outcomes used by the service is very welcome by both staff and service users and can contribute to providing greater voice and control.

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"Mr J is 85 years old...Daughter contacted Single Point of Access, in afternoon to request community services for her father. Mr J's wife had been admitted to hospital and was his main carer.

Mr J had a range of ailments including being on dialysis 3 times a week, was not managing personal care or meals and having difficulty with stairs. Reablement service was put in the following day and also arranged for meals on wheels, a bath board and Lifeline.

Mr J was provided initially with support three times a day and after 32 days the service ended as Mr J's general wellbeing had improved and he had regained lost skills and independence.

Mrs M lives with son and having suffered a broken wrist one month previously was in plaster. She had previously received some equipment but was concerned that she wasn't managing her personal hygiene needs and at risk of becoming dependent. Reablement service went in next day, provided support for 9 days and some additional equipment to improve safety. Mrs M left service as independent and 4 months later there had been no further contact."

Case studies from RCT

There are arrangements in place to provide reablement services with relevant medical information on service users where appropriate and services report that it is clear who has clinical /medical responsibility for the service user during the period of reablement.

In terms of strengthening natural support networks, most authorities indicated, that reablement services attempted to gain a knowledge of what community support services existed that could support users during and post reablement. A couple of respondents stated that the service would support users to access other services for the first time, e.g. use community transport. Some goals may include accessing some form of community support.

2.5 Reablement period and links to other services

As part of this exercise reablement services were asked about links with other services such as telecare, falls services, footcare services, community equipment, adaptations, sensory impairment services, continence services etc.

It was found that service users can access other services during the period of the reablement programme.

Further details of links with community services can be found in Appendix 1.

Of specific note is the impact that telecare can have on both reablement and the longer term enablement of people in their own homes.

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However it was also noted that Telehealth is not widely available, making this is an area for improvement.

2.6 Monitoring and Review

Most responses stated that there are weekly, often multi-disciplinary, meetings where cases receiving reablement are discussed. These, together with the practice of undertaking interim reviews, was found to ensure a clear focus on outcomes to be achieved and resulted in speedier processes.

Examples of methods for Monitoring and Review can be found in Appendix 1.

In respect of the formal Review at the end of the reablement period, service users were fully involved in discussions concerning any further support requirements. One respondent commented that options and choice were limited for some people living in rural communities. People are given information about services available and the option of using direct payments.

In respect of the above the majority of respondents indicated that it was their policy or practice to offer reablement services prior to direct payments being offered. All respondents reported that people could not use direct payments to purchase reablement services.

2.7 After Reablement

An assessment of eligible needs is usually undertaken towards the end of the reablement programme if it is thought that the individual is likely to need continuing support from services.

When the need is identified that the individual is likely to need ongoing support from home care following reablement, responsibility for finding an appropriate provider usually passes to a care manager/ social worker or to a brokerage service.

Reablement services can contribute significantly to the assessment process where people have ongoing eligible needs. One clear advantage of reablement service in contributing towards assessment is the fact that they work with the individual and family for a period of time and are therefore able to get a more accurate picture of the their strengths and needs together with the outcomes they want to achieve. If support is required at the end of reablement this information can be used to develop the most effective support arrangements.

Reablement services will continue until alternative arrangements through a long term service provider, usually in the independent sector are in place.

Over three-quarters of respondents reported that there are transfer protocols/procedures in place between reablement services and ongoing care provision.

The handover to the new provider varies between simply providing information to having joint meetings between the reablement service, the new provider and the user to providing shadowing opportunities for the new provider.

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The importance of an effective handover to the new provider is recognised so that they can continue to promote the independence of the user.

Following reablement there is evidence to indicate there needs to be a more mature relationship with ongoing preventative services that can continue to support people's independence and address issues of loneliness and isolation.

Several respondents commented on the need for more engagement with the third sector.

A number of these issues are picked up in the report 'Getting back on your feet: reablement in Wales' published by WRVS in August 2012. The report concludes that 'Good reablement services are, by definition, multi-sector. More needs to be done to encourage public bodies to involve the voluntary sector in the development of reablement services', see Appendix 1.

2.8 Evaluation

There was no evidence of independent evaluation of any service , however over half the respondents said that they had conducted evaluations; although some of these are reported as on going exercises through normal performance management processes.

3. Carers

A number of respondents indicated the importance of working closely with family and other informal carers to enable them to both support the service user and also sustain their caring role.

Reablement workers should encourage family members and friends to contribute to the reablement process. As well as motivating the person, family and friends can 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 advice using new-found skills so as to maintain their confidence.

A majority of reablement services reported that they offered training to carers with some examples related to manual handling and independence.

> *"Mr J referred his wife for a support package in preparation for when he underwent cataract surgery. Reablement OT completed an assessment to identify what Mrs J's care needs were.*
>
> *During the assessment it became apparent that as a result of his caring role and his concern for his wife's safety if he was out, Mr J had been unable to maintain his hobby of walking.*
>
> *A period of Reablement commenced to increase Mrs J's skills in washing / dressing / drink and snack preparation. Whilst Reablement staff were present they were asked to actively encourage Mr J to go out for a walk. Therefore consideration for Mr J was an important element of the Reablement support plan.*
>
> *During the Reablement period Mrs J became fully independent with the above tasks reducing the dependency on her husband and when Mr J did go in for surgery no support package was required. Mr J felt able to go out for short walks initially however his confidence increased and by the end of Reablement he was going out for full days knowing his wife was safe and able to attend to her own needs."*
>
> Case study from Wrexham

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In relation to the assessment of the needs of carers the majority of responses indicated that the reablement service undertakes an assessment of the needs of carers. Many of these were, however, qualified to indicate that a social worker undertook the assessment. Several respondents indicated that it was routine to offer to assess the needs of the carer.

Recommendation 6.1

Resources and training for carers should be developed to help them in their caring role and enable them to support the reablement process

4. Feedback from Service Users

The majority of services described how service users were provided with a questionnaire to provide feedback on the service. Their responses then being used to improve the service.

> *"Dear Team, where do I start! Just to thank you, thank you, thank you for all the love, care and attention you gave Mam after coming home from hospital. She definitely would not have done so well without your care. As a family we appreciate all that you have done and shall miss you dearly—you were part of the caring family"*
>
> *"With thanks to you all for looking after me and getting me back on my feet again It's been a pleasure (not in these circumstances though" to meet you all – you're a 'Great Team'"*
>
> Case study from Wrexham

Recommendation 7

Local strategic partnerships should build on current good reablement practice for Older People by:

- Exploring opportunities for 24/ 7 provision.
- Ensuring alignment and opportunity for access to third sector support.
- Establishing appropriate arrangements for assessment and providing access to services.
- Developing outcome focused care plans.
- Improving engagement of service users and carers in the planning, designing and evaluation of services.

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Strategic Enablers

Responses to questions about lessons learnt and what would you do differently led to a significant number reporting on the need for better engagement and improved working arrangements with LHBs at both the strategic and operational levels. The need for senior management endorsement for and support to the service through Section 33 Agreements featured strongly. Improved engagement with acute hospital personnel as well as those in primary and community services were also thought to be significant

These comments are captured in the boxes to be found in Appendix 1.

Other Reablement Service Issues

1. **Communicating the purpose of reablement services and changing the culture.**

There has been a considerable amount of work undertaken to communicate the purpose of reablement to stakeholders.

Whilst all respondents considered that all parties had been informed of the intent of reablement, further responses evidencing a subsequent lack of referral to the service questions the understanding of the value of the service.

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Changes are being made to the contracts for domiciliary care with training being provided to ensure that the need to promote and maintain independence shifts long term services from a model of care to a model of support.

Reablement also 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.

Service users and families also need to understand the purpose of the service. For services users the reablement programme may be the first step towards gaining more independence and regaining control and their 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.

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.

2. Extending the ethos of reablement to other services

Whilst it can be expected that the introduction of a reablement ethos has led to a change in the culture of domiciliary services, this change should also permeate through to the wider range of community based services.

There is a broad consensus in favour of extending the ethos of reablement to other services and to some extent this is already happening.

Several respondents believed that the reablement ethos was being imbedded into other services; these included some day care/ opportunities, residential care services, extra care housing, warden services for sheltered accommodation, and some other Supporting People funded services which have a similar goal oriented approach. Some would like to provide the service to more people with chronic conditions and complex needs, including to those with learning disabilities. For these services, the focus should be on "enabling" people to gain daily living skills.

Recommendation 6.2

Broader resources and training materials should be designed to help other services develop a reablement ethos and methodology.

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3. Workforce

As identified above, the success of reablement lies in huge part with the skills, competencies and commitment of staff. For many it will be hard to stand back and encourage people to regain or relearn the ability to do things themselves. Compared with traditional home care this is a new way of working and making the shift can be challenging.

However feedback indicates that whilst helping older people express their needs in the form of outcomes to which they aspire has proved a challenging process, it has won over the frontline staff who really feel that they are working with older people to make a difference.

> *"I've been doing care for 10 years and I love my job and with reablement it got a lot better."*
>
> Staff member from Denbighshire

There is a strongly held view that reablement is not effective unless staff undergo specific training, in addition to their care qualifications, to understand the principles and practices involved in delivering a reablement service.

Feedback indicates that the skills of coaching and mentoring are of specific relevance for reablement as they enable staff to feel confident in standing back and encouraging moves to independence.

Responses evidence that the culture of enablement has been embedded through training and various workshops together with supervision and the development of appropriate procedures. The involvement of therapies in training staff was also highlighted in terms of training and coaching.

Currently there is no nationally agreed and accredited competency framework and/or training programme for reablement.

Employment arrangements

Just under half reablement services stated that all staff were employed by one agency. Where respondents indicated otherwise, their explanations reflected staff being employed by a greater or lesser extent across local authority and LHB. Examples include:

- A member of the OT team is employed by LHB.
- This is an integrated team with some staff being employed by health and others by the local authority.
- This is a multi-disciplinary team and multi-agency service with staff employed from both health and social care.
- This is a partnership service where both health and social care professionals work together for the benefit of the individual.

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Further details re Management Arrangements, Qualifications and Training, Recruitment and Retention can be found in Appendix 1.

Recommendation 6.3

- A minimum set of qualification and training for reablement should be agreed together with any specialist training and qualifications for specialist areas of work e.g. dementia, coaching and mentoring.

4. Language and Communication

If service users are to maximise their potential and reablement opportunities maximised it is crucial to ensure that communication between the service user and provider staff flows smoothly and without hindrance.

This issue is important because language is a need not a choice and integral to the delivery of quality care. The majority of services indicated that they can provide a service through the medium of Welsh and half indicated that the service can be provided through the medium of other languages (including BSL) if required.

As a minimum, provision of reablement services through the medium of Welsh should be in accordance with local action plans drawn up in response to the Welsh Government's Strategic Framework for Welsh Language Services in Health, Social Services and Social Care, 'More than Just Words' (Welsh Government, 2012).

Recommendation 8

- Reablement services should monitor the fit between preferred method of direct communication and frontline staff who can communicate through this medium.

5. Further research

This position statement will hopefully stimulate thinking about areas of research that would be beneficial in terms of developing the service to enable it to contribute to improving outcomes for users, carers and organisations. The questionnaire did not ask a question about what areas of research would be beneficial but the following suggestions come from the responses or have been stimulated by the responses.

They include:

1. Identifying the longer term impact of reablement services. We know that many people no longer need support from services directly following reablement in the short term. People often require further access to reablement later on. For older people it would be beneficial to study their circumstances from their first experience of reablement and onwards through the care system.

2. It would be helpful to conduct research to identify those people who require a longer term programme of reablement together with the key elements of such programmes. People with some form of cognitive impairment or neurological condition, for example, will require a different content and length of programme.

Recommendation 9

Research should be commissioned to ensure a robust evidence base for reablement services and its impact on longer term/acute services.

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Recommendations

ssia
Improving Social Care in Wales
Gwella Gofal Cymdeithasol yng Nghymru

The table below consolidates the recommendations within the Position Statement and identifies the organisation / group best placed to move the action forward.

	Recommendation	Organisation/group to take forward
R1	The findings and recommendations from this Position Statement should be considered. Particular consideration should be given to the following areas: • Ensuring appropriate levels of funding for reablement are available across the system of health, social care and wellbeing to make services sustainable • Ensuring that the Social Services and Wellbeing (Wales) Bill and its regulations facilitate and support the further development of reablement services in Wales as part of a wider wellbeing and prevention-based approach Implications for political and professional leaders across sectors at national, regional and local level to be clearly communicated via appropriate forums	National Social Services Partnership Forum and Strategic Leadership Group
R2	A National Reablement Steering Group, comprising Local Authority, NHS and third sector and reporting to Strategic Leadership Group should be established to provide focused strategic leadership for the further development of reablement, focusing initially on the following areas: • Establishing an agreed definition of reablement • Work with the developing National Outcomes Framework, and ensure that appropriate key performance indicators are incorporated	ADSS Cymru, with the endorsement of the National Social Services Partnership Forum
R3	Any future review of Reablement Services should be undertaken to ensure that current information on arrangements across Wales is collected and accessible by all relevant stakeholders. Future position statements should: • Be informed in terms of design and focus by strategic consideration of this initial Statement • Receive full participation from all key stakeholders, mandated by the National Social Services Partnership Forum and Strategic Leadership Group	ADSS Cymru in conjunction with SSIA

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	Recommendation	Organisation/group to take forward
	● Focus on key areas of consideration and challenges in relation both to strategy and service delivery which would result in published findings reported formally to the appropriate bodies ● Build an effective practice resource for dissemination across Wales and beyond to help drive further service improvements	
R4	Regional reablement strategies should be refreshed and developed on a genuine partnership basis across local government, the NHS and other sectors to ensure effective and efficient provision. Opportunities should be taken to formalise arrangements through the forthcoming Statements of Intent between Local Health Boards and Local Authorities in relation to integrated services for older people with complex needs	Local strategic partnerships responsible for community based services
R5	Political and professional leaders should prioritise the further development of reablement services as part of remodelled services for older people and other client groups, through: ● Greater integration across health and social care and use of integrated and shared budgets ● Incorporating reablement services into statements of intent for integrated services ● Sharing and applying best practice ● Establishing appropriate arrangements for assessment and providing access to services ● Developing outcome focussed care plans ● Improving effective engagement of service users and carers in the planning, designing and evaluation of services	National, regional and local forums for social care and health
R6	1. Resources and training for carers should be developed to help them in their caring role and enable them to support the reablement process. 2. Broader resources and training materials should be designed to help other services develop a reablement ethos and methodology 3. A minimum set of qualification and training for reablement should be agreed together with any specialist training and qualifications for specialist areas of work e.g. dementia, coaching and mentoring	Reablement LIN working with the Care Council for Wales and Carers LIN

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	Recommendation	Organisation/group to take forward
R7	Build on current good reablement practice for Older People by: ● Exploring opportunities for 24/ 7 provision ● Ensuring alignment and opportunity for access to third sector support ● Establishing appropriate arrangements for assessment and providing access to services ● Developing outcome focused care plans ● Improving engagement of service users and carers in the planning, designing and evaluation of services	Local Strategic Partnerships responsible for community based services
R8	Reablement services should monitor the fit between preferred method of direct communication and frontline staff who can communicate through this medium.	Local Authorities and Local Health Boards
R9	Working with Welsh Universities, commission research to ensure a robust evidence base for reablement services and its impact on longer term/acute services	ADSS Cymru / WLGA working together with Local Health Boards

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Position Statement Detail

A 4. Dementia Case Studies (from Merthyr)

Mrs B

Cared for by her elderly husband. Poor transfers and mobility. Urinary and faecal incontinence and frequent infections. Profound Dementia. Hitting out and spitting at carers.

Intervention:

- Looked at safer ways of minimal handling, mobilising and transferring.
- Encouraged to mobilise on every visit.
- Looked at distraction techniques, singing favourite songs and looked at behavioural approaches to ameliorate challenging behaviour.
- Daily showering more frequently to prevent infections.
- Dressing up in make up clothes, using perfume etc.

As a result of the intervention:

- Husband less stressed.
- Physical and verbal aggression reduced.
- Mood raised.
- Infections less frequent.
- Mobilising and transferring with assistance on every call.

Mrs C

Profoundly demented. Unable to do any Activities of Daily Living. Unresponsive and no meaningful communication. No understanding of instructions and noncompliant due to level of dementia. Son desperately wanting to keep her at home but concerned that she may have to go into care. Turning taps on and flooding bathroom and kitchen. Blocking up sinks with food. Microwave blown up due to inappropriate items being placed in it.

Intervention:

Safety measures put into place from Telecare. Valves put on water pipes so that only carers can put them on. Approaches put into place to enable her to wash and dress more effectively. E.g. mirroring, physical prompting etc. Encouraged her in purposeful activity i.e. making a sandwich. Items repositioned to prevent inappropriate use. At present living safely with 4x calls per day. Washing and dressing with assistance.

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B 1.1 Definitions

a) SSIA have been working with local authorities for some time by supporting a learning and improvement network (LIN). The SSIA definition of reablement is as follows:

- Services for people with poor physical or mental health or disability to help them live as independently as possible by learning or relearning the skills necessary for daily living.

b) The Welsh Reablement Alliance defines eablement as follows:

'At heart, reablement is about helping people to do things for themselves to maximise their ability to live life as independently as possible. It's about supporting the whole person – addressing their physical, social, and emotional needs. It is an outcome focused approach whereby the person using the service sets their own goals and is supported by a reablement team to achieve them over a limited period. It focuses on what people can do, rather than what they can't, and aims to reduce or minimise the need for on -going support after reablement.

c) The Social Care Institute for Excellence (SCIE) defines it as follows:

'services for people with poor physical or mental health to help them accommodate their illness by learning or relearning skills for daily living 2011.

d) Examples from Welsh LAs and LHBs include the following:

"Reablement is a programme of short term assessment and support designed to help people regain or maintain independence. It builds on what individuals can do and supports to regain confidence and independence within a persons own home. It is a free service for a short period, it can be for just one week up to a maximum of 6 weeks. Reablement aims to maximise long term independence, choice, control and quality of life".

"To offer a re-abling service to every service user. To empower people to reach goals they have set for themselves, aiming to provide the best outcomes for individuals by motivating people to regain skills, learn new skills and promote independence. To ensure that when an ongoing need is identified that there is an evidence base for the care we commission. To encourage the independent sector to continue with the re-abling approach when they produce their service delivery plan. Care commissioned is based on a functional assessment and more accurately relates to need with financial resources being better targeted".

"Reablement services are a short term intervention (flexible) to provide opportunities for individuals to identify what outcomes would enable them to live a quality of life acceptable to them. Reablement is usually a service offered to people who have for health or social reasons had their ability to manage everyday life skills compromised".

"Reablement is a range of services that focuses on helping a person regain and maximise their independence by learning or re-learning the skills necessary for daily living and the confidence to retain the optimum level of independence ".

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B1.4 Eligibility

Examples of criteria for allocating the service include:

- Resident in authority.
- Aged 18+.
- Agrees with referral and willing to engage.
- Motivated with adequate cognitive skills to participate.
- Has reablement potential.
- Can manage safely in the home and can understand risks.
- Medically can be managed at home.
- Recent adverse change to health.
- Deterioration in capacity to undertake personal activities of daily living, mobility, confidence, social activities.
- Experienced reduction in their level of independence during episode of hospital admission.
- Requires multidisciplinary approach.
- One service is targeted at acutely ill users.
- Service user with chronic condition at risk of hospital admission.
- Users who have experienced a fall at home or in a care home.

Examples of people who are not seen as eligible for reablement include:

- No reablement potential.
- People in need of acute hospital care (often include people with chest pain and shortness of breath.
- Unwilling or unable to participate.
- End of life terminal illness.
- Open to other services.
- Detrimental to wellbeing.
- Those whose needs are longer term.
- Severe mental health problems.
- End stage dementia.
- Severe cognitive impairment and user cannot engage with programme.
- Unstable medical condition or requires acute hospital care.
- Meets CHC or nursing home criteria.
- Unable to set goals and follow programme.
- Abusing substances through period of programme.
- Low level needs shopping cleaning – referred to third sector.

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B1.9 Joint Performance Measures

Work undertaken with the Reablement LIN identified the following as a possible suite of key indicators to measure the performance of reablement schemes:

- Number of referrals for reablement services.
- Number of referrals for reablement as a percentage of all referrals to adult social care.
- Number of users who experience the Reablement service.
- Number of service users who leave the (reablement) service with no ongoing homecare package.
- % of service users who leave the (reablement) service with no ongoing homecare package.
- % of (reablement) service users who report improved independence and positive experience.
- Total cost of reablement service.
- Unit cost of reablement service.

Other Performance measures/ information could include:

- Numbers, % of people completing a reablement programme.
- Sources of referral.
- Numbers, % of people requiring reduced packages of support following reablement.
- Numbers, % of people requiring no change to their package of support following reablement.
- Numbers, % of people requiring increased packages of support following reablement.
- Average length of reablement programme.
- % of outcomes in service plan that are met (fully, partially) at end of programme.
- From staff questionnaire.
- Staff sickness levels.
- Staff turnover.
- Number of people admitted to step up step down reablement services and outcomes.

  (e.g. destinations).

NB The vast majority of users of reablement services are older people but they do not have exclusive use of the service. We need to decide whether these reports should provide this information for specific user groups. Similarly it may also be helpful to report in relation to LHB localities and not simply in relation to local authority boundaries.

B2.1 Referral criteria

- Having agreed referral procedures.
- Having a single point of access where staff are trained to ask the right questions.
- Providing training to potential referrers on the aims and purpose of reablement and how to refer to the service.
- Extensive marketing of the service.
- Having the aims and targets of the reablement service on the referral form.
- Contacting the referrer if information is inadequate. Most services will not proceed without adequate information. The purpose of contacting the referrer is to ensure that they know how to make referrals in the future to avoid delays.
- One response noted that all referrers tend to be contacted by the reablement team to discuss the referral in detail before the referral is accepted and allocated.
- Students and new staff from all disciplines are encouraged to visit the team.
- One respondent noted the benefits of having rotational staff involved in reablement who can take messages back to their wards and departments.

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B2.4 Assessment process

One authority reported that the lead OT has responsibility for the reablement inputs into weekly reablement reviews and provides guidance to reablement support workers.

One service uses a relationship map to identify people in the user's life who could help out.

A small majority of services use brief profiles of users to describe the likes/ dislikes/ things that are important to the user together with potential support from family and community.

Six services used dependency tools as part of the assessment. Some of these have been locally developed and have not been validated. These include – FIM/ FAM, MOTOM, community dependency index, OT COPM and an independent living matrix.

One authority has a new project with Local Area Coordination (Monmouth) and another (Carmarthenshire) is in the process of appointing third sector brokers to assist staff and service users find appropriate community support to promote their independence. One authority (Swansea) works with community connectors to develop community solutions to low level needs.

One service also uses monthly community multi disciplinary team meetings to share information about community resources and developments. The team includes colleagues from the third sector.

A couple of respondents indicated that this was important work but suffers at times of high demand.

B2.5 Links to community services

All services have effective links with community equipment services and most of these services have procedures for dealing with urgent requests for equipment.

Similar links are made with care repair. For adaptations referrals are usually made to a community occupational therapist some of whom focus on adaptations.

There appear be to good links with falls services where they exist. In some cases the Community resource team leads in relation to a falls prevention programme. In some cases the reablement service undertakes a falls assessment. One respondent reported that the falls prevention programme has been included in the training programme for reablement staff. Staff are familiar with the FRAT tool and are able to refer direct to a physiotherapist for further professional screening.

Most services reported that they can refer to a nurse and some could refer directly to a continence advisor. Some have access to ongoing training and advice. The questionnaire did not ask if users discharged from hospital experienced problems with incontinence. Problems of incontinence are embarrassing for the individual and carers and are often the tipping point regarding admission to residential care. Good practice means that we have to promote continence through the individual's journey from hospital to home. The reablement service should monitor outcomes for those people experiencing problems with incontinence.

In relation to footcare one respondent reported that there is a podiatry resource as part of the community resource team and referrals can also be made to third sector footcare services. In another case the Podiatry service has provided training for reablement staff to provide non complicated toe nail cutting where needed during the reablement programme with services provided by the third sector for people with ongoing needs. In a couple of cases there appeared to be no links with footcare services. Reablement services can at least provide advice to individuals as to how they access assistance where there are problems with footcare.

In relation to specialist sensory impairment services there are some good examples of practice. Some services are based on the same site so links are effective. Joint visits were also reported One service reported that where required the sensory impairment service will prioritise referrals from reablement in recognition that the reablement intervention is short term and any support required needs to be available during the reablement programme. One respondent reported that they had support workers (BSL trained) linked with the sensory impairment team.

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B2.6 Monitoring and Review

One authority/service reported that weekly multi-disciplinary meetings are held in each community resource team each week. Individual cases are discussed and plans reviewed to ensure that individual goals are being met. Social workers, therapists, nurses, social care staff contribute to these meetings together with other disciplines when required. This approach endeavours to seek solutions and overcome barriers during the assessment phase to help the individual achieve their personal goals.

Five described more formal monitoring/reviews with for example formal reviews at the end of the 6 week intervention; planned review dates are set on intervention plans.

18 out of 23 responses indicated that there was a formal review process. In some cases the reviews are undertaken by care managers.

Reviews during the programme can include the case manager, service user and family and care worker. In one case the review at 3/4th week review was carried out by a member of the commissioning team. The reviews at the end of the intervention were can involve the reablement case holder, or care co-ordinator, or enablement officer, or social worker. Some services review the case 6 weeks post intervention.

B2.7 After Reablement

In response to the question concerning options after reablement, past activities and social networks could be explored and possibly rekindled. Family members could provide more contact. The most frequent answer was referral to the third sector or possibly to day services.

Referrals are made to the third sector for a variety of services including:

- Befriending
- Lunch clubs, church groups
- Community transport
- Benefits advice
- Shopping & cleaning services
- Support groups for specific conditions, Parkinsons Disease, stroke association for specialist aftercare; Headway.
- Carers support
- Counselling
- Care & repair
- Red Cross
- Age Concern

Some services will introduce individuals to the service as part of the reablement plan. Referrals are also made to pubs and cafes who deliver meals/ snacks.

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Strategic Enablers

What success factors need to be in place

Responses included:

- Needs to be higher level ownership between health and social care for the whole intermediate care spectrum.
- More time devoted to allowing key stakeholders to agree and develop a shared understanding of the key principles.
- To start the service with a section 33 agreement in place – this would have provided a more secure platform on which to deliver the service. (Reference to formal partnerships and pooled budgets together with joint management posts were made in a number of responses.)
- More work with hospitals to improve the quality of referrals.
- Ensure that there is medical support to any delivery model to ensure that there is a recovery element in the planned service and to ensure that other therapies such as nutrition and dietetics, podiatry and dental and especially psychology were available.

What needs to change and improve

- Whole systems approach.
- Strong links with acute hospitals.
- Wholesale education of hospital staff.
- Embed reablement culture across health and social care.
- Reaching into the hospital by increasing resources and moving towards an integrated approach with primary community and secondary care to provide seamless pathways and information and an it system that can be accessed by all health and social care professionals.
- Encourage LHB to commit more therapy resources to reablement.
- Have joined up approach to therapy services.
- Additional CPN and Psychology services to support people affected by cognitive impairment or trauma.
- Clear links between intermediate care and reablement service.
- To have shared outcomes/resources/ continuity of care.
- Pursue a section 33 partnership agreement.

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What are the strategic enablers

- Agreement at senior management level of shared outcomes and resources.
- Agreement with partners at strategic level & supported by formal section 33 agreements.
- Partnership Board in place giving some priority to reablement.
- Resources to relocate services (health and social care) from secondary care.
- Bespoke IT systems.
- One base for staff.
- Ensuring appropriate skill mix.

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D3 Workforce

Management arrangements

It is hard to compare the variation detailed in the 24 responses. 9 could be regarded as being jointly managed / coordinated by health and social care, 5 by the local authority and 2 by health alone. In many instances there is someone with overall responsibility for varying degrees (usually described as having day to day operation of service duties). While for others the responsibility is shared across locality or team leaders or professional groups. There was a distinction made by 2 respondents of operation duties versus more strategic/leadership functions, as well as a number of responses describing professional or clinical management duties/ support. Most teams have access to other professionals.

Qualifications and Training

Two respondents detailed standard training such as induction, manual handling, dignity and respect, challenging behaviour, promoting independence, care of medicines, dignity at work, food hygiene. One of these further described on going competency training around implementation of care plans, recording information, kitchen skills, enabling dressing, gait, pressure area care, washing and showering, supporting someone with stroke, fracture and joint replacement, risk assessment, skin integrity. One described specialist reablement training along with 'usual mandatory domiciliary care training'.

NVQ/QCF qualifications were described by a number of respondents: the level of which depended on the role and grade of staff. NVQ/QCF 2 and 3 indicated by 10 and 11 respondents respectively. Levels 4 and 5 were indicated by 3 respondents citing officers in charge QCF 5, and NVQ level 5 diploma, level 4 leadership and management, registered managers award, and in management which suggests those in management positions only. 6 respondents specified subject areas such as promoting independence, complaints awareness, health and social care, leadership and management.

Other specific qualifications detailed were:

- BTEC qualification for the provision of minor aids and adaptations.
- DSDC – certificate programme.
- Bespoke reablement training.
- Training in provision of assistive technology.
- Protection of vulnerable adults personal safety.
- BTEC in assessing community aids.
- Diploma level 2 in health and social care.
- Calderdale competency training.

The median of staff reported as achieving these qualifications was 90%.

These probably include optional and mandatory training and qualifications. The majority of responses indicated that specialist induction training is provided.

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Examples of additional specialist training included:

- Food hygiene, manual handling, safeguarding, competency specific training for delegated tasks.
- Nutrition and dementia.
- Sensory impairment, dementia awareness, telecare awareness, medication awareness, dignity in care, report writing, person centred planning.
- In-house reablement competencies in place, wheelchair assessment training, equipment installation, therapeutic handling, infection control and prevention, medication and administration.
- EDGE training, medication skin bundle, stoma, oxygen therapy.
- Dementia, positive management behaviour, butterfly training, shadowing- a joint working approach to residential domiciliary care.
- Coaching and Mentoring.

Recruitment and retention

A third of respondents indicated that there were problems in relation to recruitment and retention. The main problems reported included delays in advertising posts, recruiting to posts seen as Welsh essential, recruiting in specific geographical areas and problems in relation to contract hours and tax credit rules.

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