A new reablement journey

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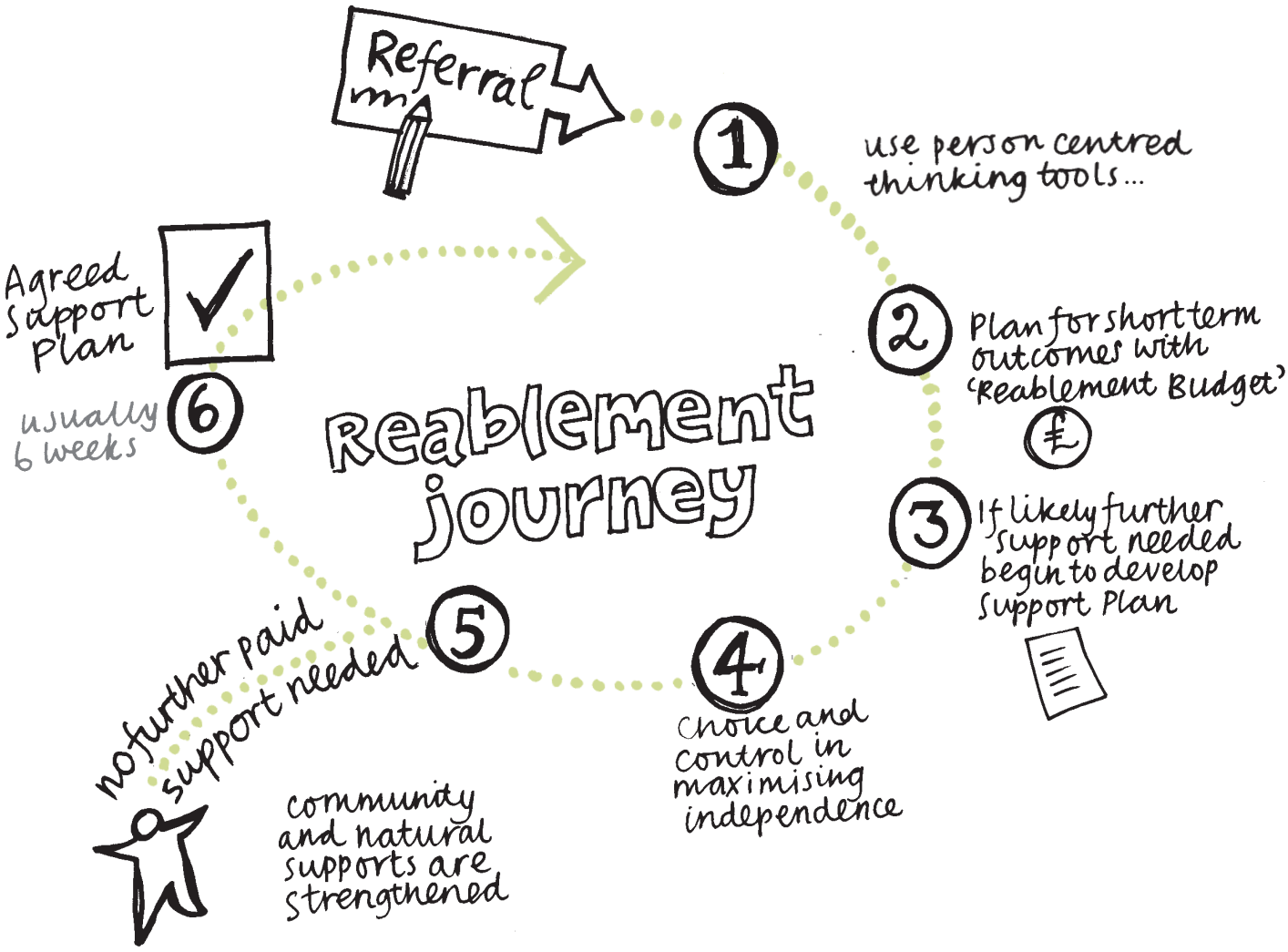

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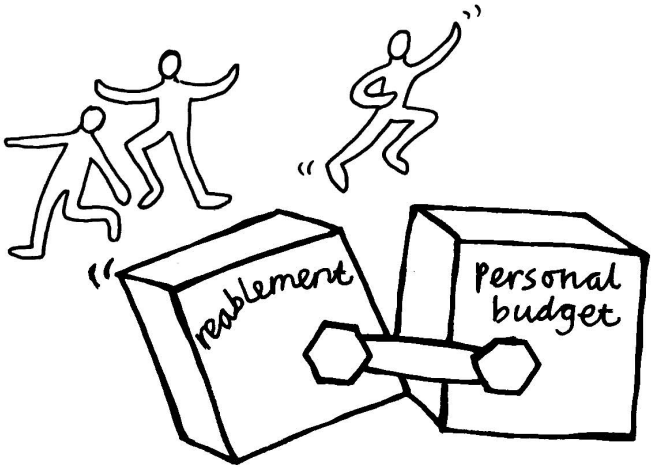
Introduction

This paper aims to stimulate discussion and thinking about a different way of offering reablement. It doesn't contradict the current approach, but builds on it, suggesting that we can take reablement to a new level in order to maximise its benefits. This involves re-defining reablement, challenging our thinking about who should be able to benefit from it and for how long; and how much the person is involved in owning and steering the process. It means we move away from time-limited constraints and focus on outcomes, offering the person choice in how those outcomes are achieved. A person-centred approach to maximising independence then becomes something that runs throughout the whole customer journey, with an intensive period of enabling support during the first six to eight weeks for many. The experience for the person then becomes much smoother, enabling activities to happen when it is right for the person, rather than them having to journey across different service 'boxes'.



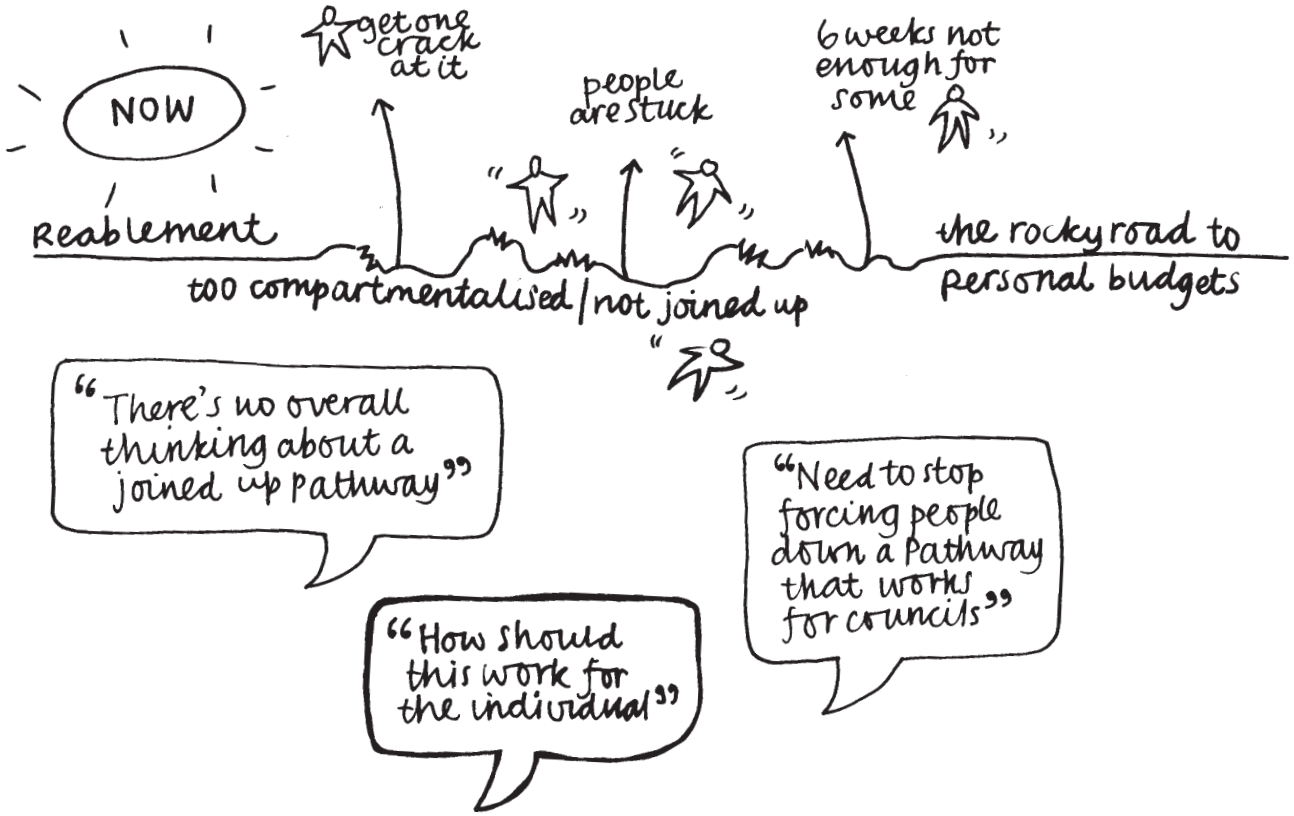
1. Why do we need to get more out of reablement?

Reablement services have been shown to offer considerable benefits for many people who have been supported to regain skills rather than be 'cared for' in a traditional sense. An intensive period of coordinated 'enabling' support focusing on outcomes and drawing on the expertise of a number of professionals can achieve positive results, both for the person, and for organisations.

So far we have mainly focused on reablement as a service and usually one directly provided by statutory organisations and for a narrowly defined group of people. But in times of considerable change in society and public services, as well as increased expectations from us as citizens, reablement must respond to new challenges:

- What we all want as our needs change is to have control over our lives and as much independence for as long as possible - services have to be able to respond to this expectation.

- The changes in social care to offer 'personalised' support as part of the government's programme to transform services mean that people and their families should be offered choice and control in how they achieve outcomes, with support to exercise that control as needed and with much greater transparency of information. These principles should run throughout all services.
- Demographic changes means the numbers of people likely to need social care support will increase significantly. Current services that are already stretched are not likely to have the capacity to meet increasing demand. We need to focus on preventing as many people as possible needing ongoing support.
- In the current financial climate we need to consider whether services are as efficient and effective as they could be. Reablement is the main mechanism to prevent people already in need becoming continually reliant on services, so efficiency and effectiveness needs to be maximised.



2. Why this is important - for people

There are some systemic, structural and cultural factors that mean that we are not getting the most out of the current investment in reablement, despite the focus on the issue. These factors are best illustrated from an individual perspective:

Nellie is 86-years-old and until a recent fall, was an active and lively, fiercely independent person with a good network of support. Since her fall, Nellie lost some of her confidence and strength. She had a stay in hospital and was assessed by the hospital social worker who organised the Council's reablement team to get in touch with her. She had another assessment and was told that she would have two visits a day when she would be helped to get up in the morning, prepare a meal and get ready for bed. On the second day at home, she had a visit from a new social worker who did another quite lengthy assessment.

Nellie liked the carers but she met many new people and they weren't able to get to know her as they were able to spend only a very short time with her to do the essential things.

Nobody was able to find out who Nellie was, what made her tick, what friends and support she had around her, or what was important to her. After five weeks, Nellie's ability to do more for herself had increased, but she was still going to need some support. The social worker visited again and asked more questions similar to the first visit. She was told about Personal Budgets and asked to fill in a Self-Assessment Questionnaire. She was also told that the current carers could only be with her for six weeks and that she would now be supported by a new care service. She was also told that she would now need to pay something towards this service and that a Fairer Contribution assessor would visit her soon to work out how much.

The social worker told her that she would be informed of the amount of her Personal Budget and that they could plan how she used it, but in the meantime would organise for the new care agency to visit her. After three weeks, Nellie had still not heard back from the social worker. The new carers were visiting but they had already been told what she needed so they just came and did the tasks. They were nice but didn't have a real understanding of who she was and what was important to her.

Nellie's story highlights some of the difficulties people experience with current reablement services. These are summarised below and illustrated with Nellie's own views:

There are too many assessments and these are not coordinated. People are asked the same questions many times and have to meet a lot of professionals at a time when they are at their most vulnerable.

All these different people tramping through my front door, I don't know who they all are but they keep asking me the same things all the time. It's so tiring.

People are often not actively involved in their reablement plans and have poor information - it remains a service that is largely 'done to' the person.

What the heck are they going on about… 'reablement'? I don't understand what's happening, I don't want to be a bother but I don't want to go to any day centre and I wish they'd listen to me instead of just making me cups of tea - they don't even know how I like it!

Some of the forms people are asked to complete appear to be suiting the needs of the system not the person (e.g. some people have to fill in a Self-Assessment Questionnaire twice for no benefit to them).

Forms, forms and more forms being stuck under my nose. There's this big file they write in each time they come, not sure what that's for!

People feel like they are on a conveyor belt and that their 'needs' are of interest but not who they are as a person, often because carers are on a tight timescale to complete tasks in the allotted times.

At night they come, whizz in, then whizz out like a whirlwind. I could have done with a hand lifting the clothes out of the washing machine today; so hard but I didn't feel I could ask, they're so busy… They're lovely girls though.

Reablement services tend to adopt a 'one size fits all' approach with little, if any, choice over the nature of the support or who provides it. There's little consideration of the value of friends and support networks in maintaining the person's wellbeing, or activities and opportunities in the community they could benefit from.

I would rather my Jess could pop over sometimes and help me with some of this; I'd feel happier with someone more familiar but it costs a lot for her to get here and I know she can't afford it.

People who still require some support after a period of reablement are often not told enough about self-directed support and Personal Budgets. Many people using reablement services are elderly and, whilst there are many exceptions of enlightened professionals, there is a pervading view that they will not want, nor be able, to exercise choice and control over any ongoing support.

They're all very nice but I just wish someone would ask me what I want! If I could have the money they're spending on those girls there's all sorts of things I could do with it. I could make sure it was right for me then.

Skills that the person is learning are often not embedded in the context of their day-to-day life and are often focused on personal care tasks, whereas for many, things like getting out and about, shopping and having social contact are just as important to their independence and wellbeing.

I know it's important to look after myself and I want to do that, but I need to get to the shops and see my friends again. I'd miss one bath for that!

Reablement services are usually under pressure to meet goals within a set timescale (often 6 - 8 weeks) and need to 'move people on' after that time. But, for those who need support beyond that time, there is inadequate preparation for the person to be very involved or to enable that move to be a smooth transition.

I've been told these carers are finishing soon but they don't know yet what will happen after that. I hope they don't send a bunch of new folk. I'm sick of all these strangers in my house.

Not knowing until the end of their reablement how much, if any, Personal Budget they might have, means there is little, if any, time to plan in a meaningful way before an alternative service is needed.

Well now I've been told I've got this budget but it's got to start next week! They want me to spend it on this new agency of carers. I'm sure they're very good but I want to do other things with it too.

Many people are still regaining independence gradually and may need longer than the allotted time to achieve goals in certain areas. But often this 'reabling' support doesn't continue, meaning that the chance for greater independence in that area can be lost.

I went for a short walk today and I think I'll manage to get further as I get stronger and I want to keep aiming for this. I'm better when I have a goal to work to but it would be nice to have someone there every so often just to reassure me.

Many people simply don't get an opportunity to have a reablement service. Often, due to their circumstances they are not considered "appropriate" for reablement due to the tight criteria that those services operate, or due to a lack of capacity in those services.

Mavis, down the road, well she just had carers come in and do things for her twice a day. I know that she could do more if she had to. Now she's stopped trying altogether; it's like she's just given up.

3. Why this is important - for organisations

As well as not working well for people, reablement services often do not work as well as they could for organisations, despite their potential to resolve many of the current pressures. This, arguably, is not due to a lack of funding.

- In many areas, organisations just don't have good information on the effect that reablement is having on achieving outcomes for individuals or its cost benefit in alleviating organisational pressures.
- By not maximising the use of reablement, the numbers of people who need longer-term support is

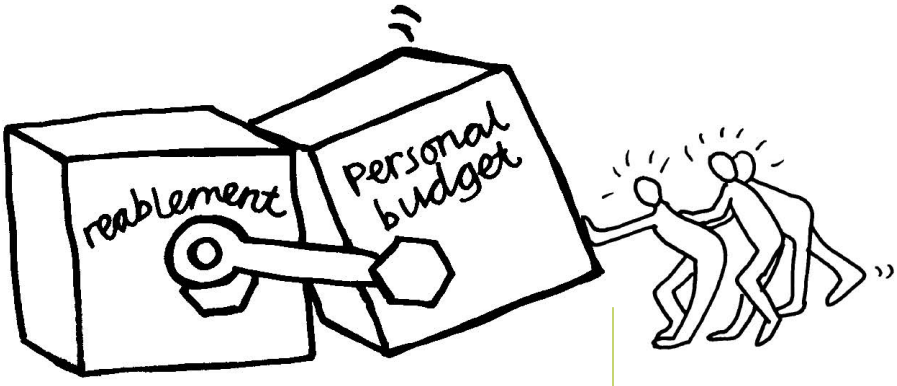
higher than it needs to be and that support is at higher levels than it needs to be.

- Too often there is inefficient use of worker time with multiple assessments, travelling time and duplication.
- Reablement typically takes a one-dimensional approach of need and support and we miss opportunities to look at what natural, mainstream or community supports could be available to support the person to reconnect with friends and their community.
- Reablement services are usually more expensive than domiciliary homecare. Yet during a reablement period, there are many tasks carried out that are not 'reabling'. They instead could be carried out by alternative carers with whom the person can begin to build a relationship if there is a need for ongoing support.
- Most reablement services are very similar to domiciliary homecare, even though the approach should be different. This means that most intensive activity is when people are getting up and going to bed. In between those hours, there is often inefficient use of staff resources.
- People who need support following a period of reablement are often not fully supported to exercise choice and control in creative ways. The effect on organisations is that the person has no opportunity to get the best value out of their budget, such as by using it in ways other than buying care. Therefore we often see a re-purchasing of traditional services through Council Managed funds which offers no additional value whatsoever to the funder.

4. The reablement journey - what could it look like?

If we regard 'reablement' as a concept rather than a service, it is hard to argue that more people should not be able to benefit from a short-term intensive period of support to promote their independence and wellbeing. This would reduce or remove the need for continued support. We need to think about reablement as something that everybody should have the opportunity to benefit from, but that can exist alongside other support if necessary. Reablement services then become one way that people could achieve certain short-term outcomes, but they are not the only way. In addition, people should not delay planning to meet longer-term needs which are evident, simply because they are increasing independence in other areas by using reablement services.

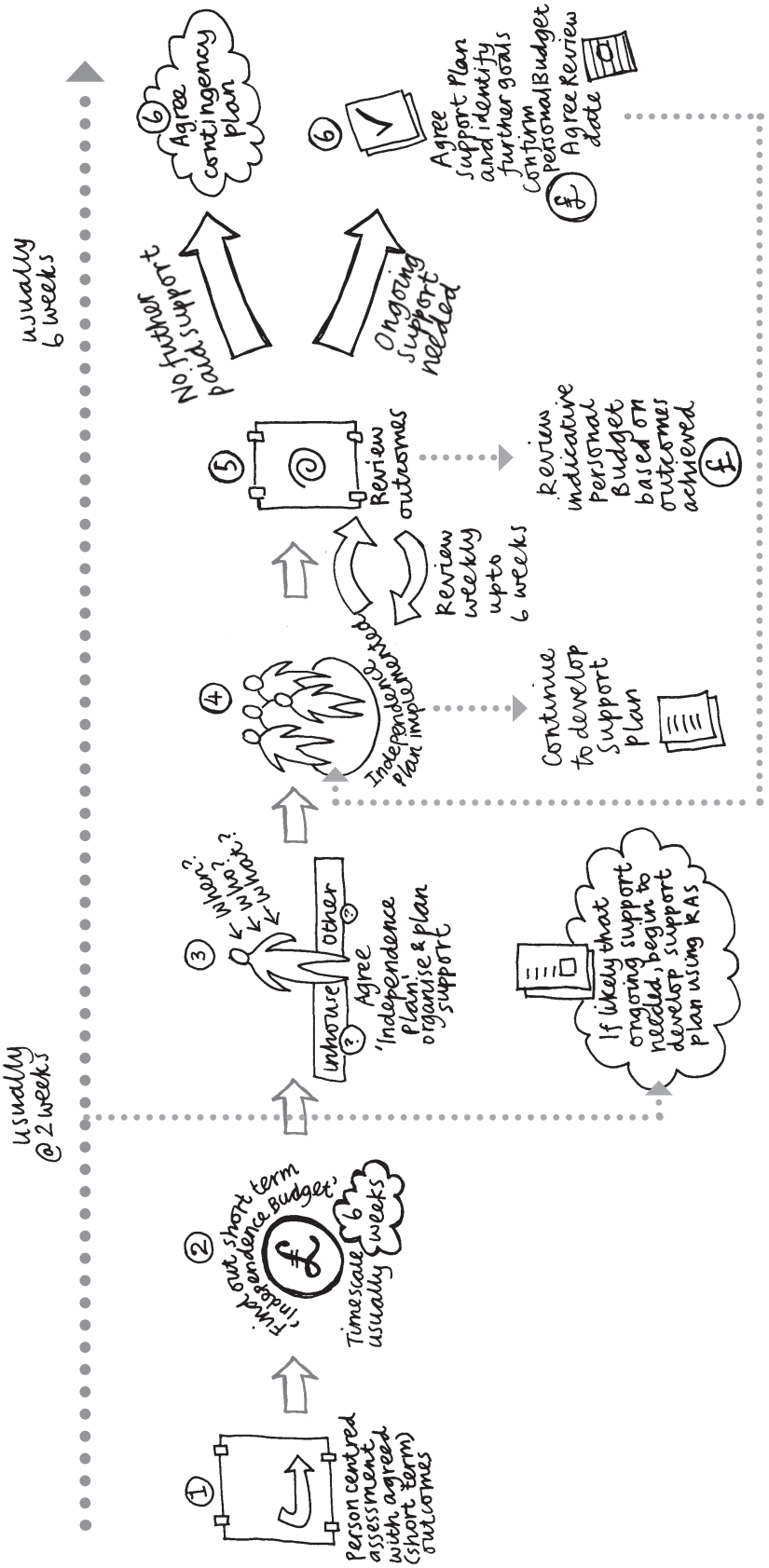
The experience of offering Personal Budgets has shown that people themselves and their families know best what will work for them and can work within a known budget to achieve agreed outcomes. The transparency, flexibility and choice that is available for people with a Personal Budget now need to permeate into the world of reablement. If our aim is to support more people to need no ongoing support, then for many it will be a short experience, but will be no less valuable for that.



Much of the rocky road from reablement to self-directed support is a result of organisations trying to bolt together an existing reablement process with a new self-directed support process.

This has worked to varying degrees, but this paper now proposes a re-think for the customer journey and is based on the following principles:

- Reablement is not a particular service, but is a journey that everyone should be supported through.
- Reablement can therefore be appropriate for anyone, not just older people who require assistance with personal care tasks. It is just as relevant for a younger person with physical or learning disability, or people with mental health issues. The way people maximise their independence will be unique to them and may include such things as support to find employment, housing or to use public transport independently, etc.
- People should be able to self-direct the support available to them to achieve the outcome of maximised independence.
- Plans to achieve those outcomes should be person-centred and owned by the person.
- People should have information about the resources available to them and support to plan and make decisions.
- People should be able to exercise choice in how they are supported to achieve agreed short term and longer term outcomes.
- Different teams, services or experts may need to be involved but people have a seamless experience. There should be minimal 'hand offs' between professionals or services for a person whether or not they have ongoing support needs.
- Achieving outcomes that maximise independence and strengthen natural support networks and community involvement should be embedded in all support planning and reviews and not just confined to the first few weeks of the person's journey.
- There is one person-centred 'harvesting' of relevant information about the person with their full involvement and consent that can then be drawn upon for a range of organisational purposes.
- People will be involved in all discussions and decisions about their care and support and will own the planning process.


usually @ 2 weeks
usually 6 weeks
1
Person centred assessment with agreed (short term) outcomes
2
Initial short term 'Independence Budget'
Timescale usually 6 weeks
3
When?
What?
What if?
Unsure
Other
Agree 'Independence Plan' organise & plan support
4
Independent plan implemented
Continue to develop support plan
If likely that ongoing support needed, begin to develop support plan using RAS
5
Review outcomes
Review weekly upto 6 weeks
Review indicative Personal Budget based on outcomes achieved
No further paid support
Ongoing support needed
6
Agree contingency plan
Agree support plan and identify further goals
Confirm Personal Budget
Agree Review date

5. How this could work for people

In the new model, Nellie's journey would have been very different:

Prior to her return home, Nellie would have had a suitably skilled lead worker who asked her all the relevant questions and basic information and was then able to identify and arrange for her to have a fall alarm. This lead worker would stay in that role throughout her journey. She would have been told very early on the amount of money that was available to meet her short-term needs and what this was currently spent on. This person could have helped her understand what that meant and how it could be used, or they could have introduced her to a person from a local voluntary organisation that could have helped her. She could have chosen to reduce one visit from her carers and pay her daughter's train fare so that she could visit and help her get to bed one night. She could have been put in touch with local volunteers who could have helped her with her shopping and helped her prepare simple meals again. This 'befriending' would have put her in touch with new people in her community who she would get to know. They could have helped her organise a lift to her local church group where she would have met many old friends and had other offers of support.

She would have known that she could start thinking about how she would want to be supported after the reablement carers had left. This would be because she was finding out what was important to her, such as having only a small number of different carers and maintaining the contact with her daughter. She might not know exactly how much money she would have available, but she could have started to plan – finding out which were the good care agencies, thinking about buying a microwave or looking into have lunch in the local pub and organising a lift. All these things she could have planned for, all the while gaining as much independence back so that she could do things for herself.

Nellie's reablement journey would not stop after six weeks. She would continue to work to small goals where she felt she could learn to do things again and this would be agreed with the new carers at the outset. Some tasks she learnt to do again with the help of some new gadgets, such as preparing food and getting dressed, but in other areas she knew that she just wanted to be treated with respect and have as much dignity as possible. She was able to make these things clear in her Support Plan, which she had help to write up.

This shows that by focusing on Nellie and what is important to her, a different journey emerges that puts her in control. Her reablement fits into her life in ways that are right for her and she is more likely to continue to regain her abilities and confidence and maintain them for longer, rather than slipping back after a few months. Getting it right for Nellie in this way is not impractical, nor at the expense of efficiencies for organisations, quite the opposite.

6. How this could work for organisations

Being able to offer a new reablement journey will undoubtedly bring challenges for organisations, but arguably, none of these challenges are new or different to those currently being tackled, albeit in different service areas. None of them detract from the central aim of improving service delivery, promoting wellbeing and independence, choice and control for the customer and having efficient business processes across the whole customer journey. The specific challenges associated with each step are outlined on pages 12 -14.

But as well as bringing challenges, the new Reablement Journey would bring significant benefits for organisations. By speeding up and simplifying the process, whereby the person knows the outcomes they need to achieve and the resources to enable them to do this, it is envisaged there will be significant business efficiencies to organisations:

- Less administration and process delays.
- Less risk that the person would deteriorate during that time.
- Less duplication on the part of workers.
- Much greater use of resources such as specialist professionals.
- Potential for more people to have a reablement journey and reduce dependency.
- Potential for existing customers to consider how they could be supported to be more independent.

What happens?

Information is collected once (building on that already known) to get a full picture of who the person is, what's important to them, what they can do now and what they can achieve.

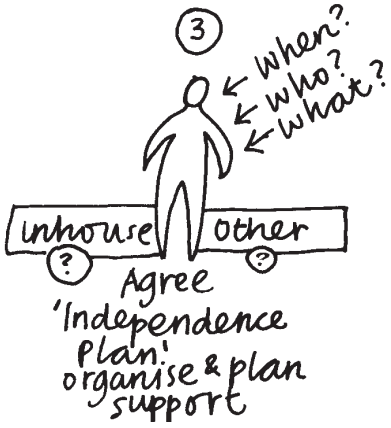
The person finds out how much money is available to help them achieve their short-term goals to maximise independence.

The challenges for organisations

- The need for **person-centred thinking skills** throughout community and reablement teams.
- Coordination of a **single person-centred assessment** tailored so that is it as detailed or as 'lite' as is necessary for the individual, with the lead worker having the necessary skills and ability to draw on expertise as needed.

- a simple method of calculating a person's **'Reablement'** or **'Independence Budget'**. (For example, this could be based on the typical cost of providing 6 - 8 weeks' support and then developed as further data and understanding regarding reablement is established.)

What happens?



The person, with support as needed, plans how they want to achieve short-term outcomes, making use of all their resources.
They agree with their worker if they are likely to need support to meet longer-term outcomes.

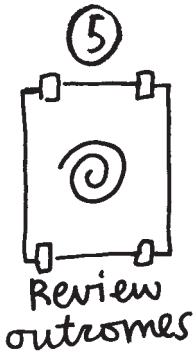
Short-term plan is implemented. If a person needs any support to continue, they are told, roughly, how much money would be available. They can then start to plan, with support, how they would use their budget.

The challenges for organisations

- The ability to capture the full **costs and benefits of reablement services**.
- An **outcomes-focused** approach throughout that allocates resources to the achievement of outcomes with anticipated timescales.
- A system that enables workers to identify **early on** those customers **they believe are likely** to need medium-term, long-term or ongoing support to achieve specific outcomes.

- A change in the **culture** that puts the person in control of their short-term reablement support and enables them to plan for how they want to achieve medium and longer term outcomes.
- The ability to inform the person of an indicative Personal Budget amount before the person completes their reablement with sufficient **time and support to develop a Support Plan** and have that agreed in principle.

What happens?



The person and their worker check progress in achieving the short-term outcomes and confirm whether further support is required and, if so, how much budget would be available.

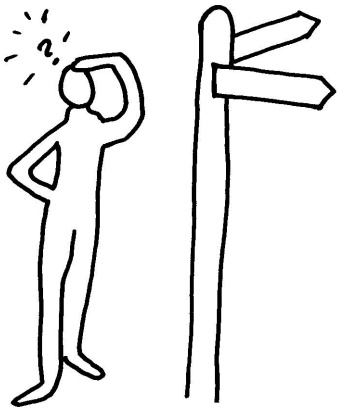
Either, no further paid support is needed and person agrees a plan for how they will maintain their independence and what they will do if things don't go to plan or, Support Plan, Personal Budget and Review date are agreed for longer term outcomes and arrangements put in place.

The challenges for organisations

- **Swift processes** that enable the person's needs to be reviewed following reablement progress; the Personal Budget amount to be adjusted if necessary and support planning to be refined.

- **Collaborative working** with third sector and communities to know what is available in order to support the person to live independently with natural supports.
- Support Plans to be agreed, Personal Budgets to be confirmed and expenditure arranged **without unnecessary delays**.

7. How can we make these changes?



Different organisations will have different areas they wish to focus on in implementing the full Reablement Journey and a recommended starting point would be an assessment of their current situation and readiness for change in certain areas. The extent of the challenge will depend largely on where they are currently.

As with any whole scale change (including, for example, the introduction of Personal Budgets), organisations need to have a number of work strands or projects as part of a change programme and each should have equal weight. Whether these are embarked on simultaneously or one by one is not important, but the desired changes will only be achieved when all are in place. (e.g. process and procedural changes will not be effective unless staff have person centred thinking skills and awareness). Equally, organisations may choose to start small, changing some of the elements first (for example, using person centred thinking to gather person centred information at the beginning that can develop into a Support Plan later), review its impact and learn as they go along; or they may wish to test out a new approach for a small number of people (based on such things as presenting need, geographical locality or working with a particular provider, etc.) in order to learn what works locally.

It is acknowledged some of the changes required will necessitate a very different way of working; for example, the ability to give the person an 'Reablement Budget' will not be easy. But, equally, it need not be over-complicated nor involve the development of new Resource Allocation Systems and reams of data gathering; rather it requires a common sense, pragmatic approach that builds on the information already known about the cost of services. As the system evolves it can become more sophisticated but need not be the reason to delay starting.

"The three great essentials to achieve anything worthwhile are: Hard work, Stick-to-itiveness, and Common sense". (Thomas A. Edison)

8. Person-centred thinking tools to help the reablement journey

There are a range of person-centred thinking tools that workers can use to deliver a more person centred reablement service.

There is some early pioneering work using person-centred thinking and planning in prevention and delivering reablement services in Lincolnshire. Staff members are exploring using person-centred thinking to deliver the Skills for Care 'common core principles to support self-care.[1]' and this is how they're doing it:

Common core principle to deliver self-care (Skills for Care)	How person centred thinking tools can help
Communicate effectively to enable individuals to assess their needs and develop and gain confidence to self-care.	**Develop one page profiles while people are in hospital as a way to record and communicate what is important to the person and the best ways to support them. This shows the individual's and staff members' reflections on their needs and what support the individual requires to develop the confidence to self-care.**
Ensure individuals are able to make informed choices to manage their self-care needs.	**The decision making profile is a way to record important decisions in the person's life and how they can make informed choices about their self-care needs.**
Advise individuals how to access support networks and participate in the planning, development and evaluation of services.	**Using a relationship circle is a way to describe the networks and people in an individual's life who may be able to offer support.** **A learning log is a simple way for everyone to record and evaluate progress.**
Support and enable risk management and risk-taking to maximise independence and choice.	**The person centred risk tool is a way to enable individuals to think about enabling risk in the context of what is important to the person and how they can be as independent as possible and have choice and control.**

[1] *Common core principles to support self care: a guide to support implementation (2008), Skills for Care.*

In the new Journey, Nellie's worker, Jane, was skilled in these areas and the following account is how Jane would have used these skills to draw out a much broader picture of Nellie in order to help her identify the solutions.

Jane was assigned to support Nellie on her reablement journey, and before she met Nellie, she was told how much money was available for Nellie to meet her short-term reablement needs.

They met for the first time prior to Nellie's return home and, Jane talked with Nellie about her health, and also about what mattered to her as a person, and how she wanted to be supported. They talked about the money that was available for her support and thought about the different ways that Nellie could get the support she wanted. They used a relationship map to think about the people in Nellie's life who could help out, and mapped the places that Nellie went to locally through a community map. This showed up several possibilities. On Nellie's relationship map was her daughter, and they did not get to see each other as much as they would like. One option was to use some of the money to pay her daughter's train fare so that she could visit Nellie once a week and help her get to bed that night.

On Nellie's community map was her local church that she used to attend each week, but had not been to now for over a year. Madge, her neighbour, was on Nellie's relationship map, and Madge was a member of the same Church. Through using the relationship map and community map, Nellie and Jane decided get in contact with Madge to see if they could organise a regular lift to Church on Sundays and for the Wednesday social afternoon.

They contacted someone from the local voluntary organisation that Jane knew of, to look at whether volunteers could help with her shopping and help her prepare simple meals again. Jane also mentioned that there was a local 'Timebank' where people traded hours of their time to help each other. Nellie used to be a teacher, and could offer to listen to children reading, in return for help with shopping.

The immediate actions were to talk to her daughter about visiting once a week, put in a fall alarm, talk to Madge and the volunteers organiser, find out more about the Timebank and finally to find a carer to support Nellie at other times. Jane has captured the information about who Nellie is, what matters to her and how to support her onto a one page profile. Nellie and Jane decided together who should have this information. They decided to use this as almost a job description for the carer. The one page profile specified exactly how Nellie wanted to be supported. Jane arranged to use this with the carers organisation.

Three weeks later, Jane and Nellie looked at what was working and not working about the arrangements that they had put in place. Nellie was most excited about being back in contact with people in the Church and as a result of Jane chatting to one of her old friends from the church, she had also been put in touch with a local

historian who attended the same church. She was digging out some old photos for him to look at, and in return he'd agreed to help her draw a family tree for her to share with her daughter. Nellie had learned to do some tasks again with the help of some new gadgets, such as preparing food and getting dressed, but in other areas she knew that she just wanted to be treated with respect and have as much dignity as possible.

Nellie decided that she would like a microwave or looking into have lunch in the local pub and organising a lift. Jane and Nellie developed her one page profile into a more detailed support plan with how much money she would use from her allocation to buy these. All these things she planned for, all the while gaining as much independence back so that she could do things for herself.

To make it clear what decisions Nellie made herself and what decisions she wanted to have support in, Jane and Nellie put together a decision making agreement. This, and her one page profile, were used by any carer who supported her, so that they could learn about and respect what mattered to Nellie, how she made decisions, and how best to support her.

Her reablement journey did not stop after six weeks, and she continued to work to small goals where she felt she could learn to do things again. This would be agreed with the new carers at the outset, and this was part of Nellie's contract with them.

9. Conclusion

This paper describes a very different way of promoting people's independence based on a subtle but important change in how we regard reablement. We have described a New Reablement Journey for people: one that positions the re-gaining of independence firmly into the person's life; that builds on who they are as a person; what natural supports they have and what is important to them. The aim is to support people to become as independent as possible, or to regain that independence as quickly as possible by giving them choice and control in how that is achieved. For some people, this may take longer than six weeks, but at the heart of this approach is the aim that independence is continually enhanced, reducing the need for paid support wherever possible. How that is achieved will of course be different for each person.

The New Reablement Journey is therefore an ongoing cycle of promoting independence; identifying short, medium or long-term goals to achieve outcomes is an integral part of Support Planning and Personal Budgets for all but the minority of customers. The diagram on page 21 illustrates this cycle.

This may appear radical when we look at how services are currently structured, but it is hard to argue that such a model does not reflect a better customer experience and improved business efficiencies. We suggest that with the current pressures on services incremental and piecemeal change will only go so far and sometimes innovation requires a degree of

radicalism, but how much and how fast will depend on each organisation. There is a host of support available to assist organisations to work out where they need to prioritise; to manage and implement technical, process and cultural changes at a pace that works for them; and to assist them to embed some of the tools that can underpin these changes and deliver in practice.

We are inviting organisations to contact us if they wish to be part of trailblazing the New Reablement Journey. We envisage a number of organisations, each prioritising different areas, coming together as a community of shared learning. We already have a number of organisations that have expressed an interest in modeling various aspects of the New Reablement Journey but are inviting additional learning sites. In particular, we welcome expressions from:

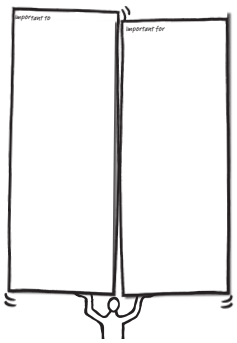
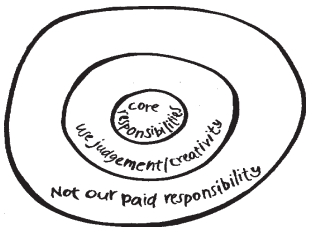
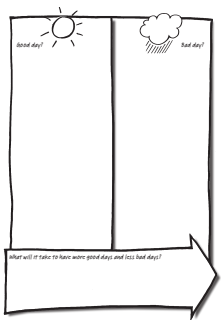
- Local authorities.
- Health trusts.
- Independent sector provider organisations (supporting any age group or disability).
- Social work practice pilot sites.

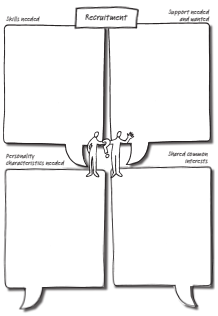
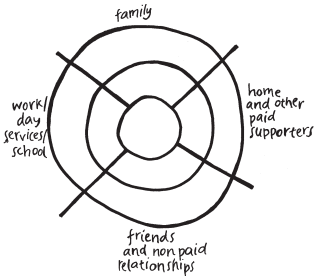
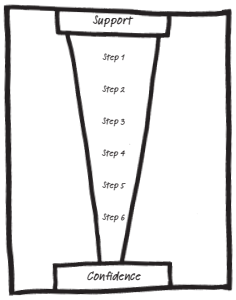
Please contact Jenny Pitts at info@newreablementjourney.co.uk if you would like to find out more or discuss your situation.

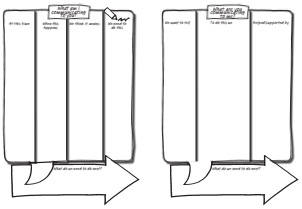
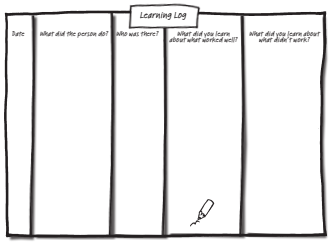
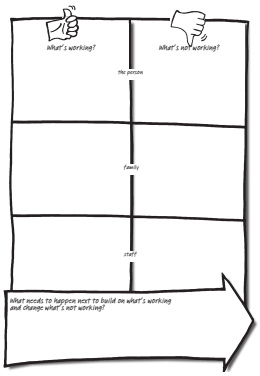

Reablement journey
1
Person centred assessment with agreed (short term) outcomes
2
Find out short term 'Independence Budget'
Timescale usually 6 weeks
3
When? Who? What?
Inhouse
Other
Agree 'Independence Plan' organise & plan support
If likely ongoing support needed begin to develop Support Plan
4
Independence Plan implemented
short term service or support
Support Plan refined + developed
5
Review outcomes
No further paid support needed
Personal Budget amount adjusted if needed and support Plan completed
6
Agree contingency plan
6
Agree Support Plan and identify further goals
Confirm Personal Budget
Agree Review date
Referral
People already using services enter here at their Annual Review

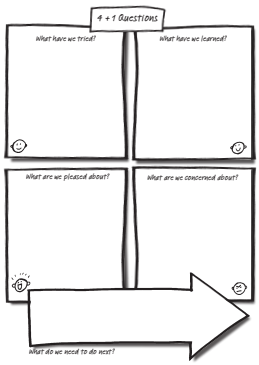
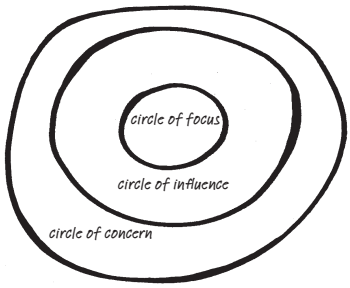
Appendix 1 Summary of Person-Centred Thinking Tools

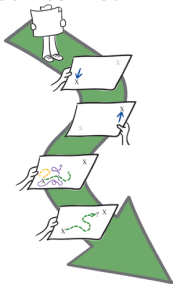
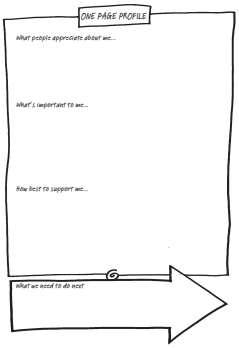
by Alison Short

Tool	What it does	How this tools helps in Reablement
Sorting important to/ for 	Sorts what's important TO (what makes us happy, content, fulfilled) from what's important FOR (health and safety, being valued) while working towards a good balance.	Helps us to stay focused on what matters to the person in the context of medical issues and interventions. Keeps the focus on who the person is, not just on the rehabilitation support that they need. This helps us to see the person beyond the patient and to jointly set goals that take account of what is important to the person and what style of support works best for them. This information can then be used to develop a one-page profile and forms the beginning of a Support Plan and/or a Personal Care Plan if this is needed. A Personal Care Plan looks at the whole of someone's life to ensure that the focus is not just on medical needs but that health and well-being are seen as a whole.
The doughnut sort 	Identifies specific responsibilities: Core responsibilities. Using judgement and creativity. Not a paid responsibility.	Helps supporters and families to know where they can be creative with ideas without fear that they are doing something that would not work for the person they love or are supporting during Reablement. Clarifies the roles of the different professionals and agencies supporting people and families through Reablement. It helps supporters, not only to see what they must do, (core responsibilities) but where they can try things (judgment and creativity) and what is not their responsibility. Helps a person and their family to ensure that they are clear about their role and specific contribution to the Reablement process. It is an approach that supports achieving outcomes. Creating clarity around the roles and responsibilities of those who provide support ensures that the right things have priority for attention and move to action.
Appreciation tool	Identifies what we like about people and how to use this information so the person can contribute to their Reablement.	What we like and admire about somebody can be a starting point for relatives, staff and allies to see who that person is and appreciate their qualities and strengths. This helps to counter our tendency to focus on how much support the person needs to what they can contribute and make the most of, as they move on with their lives.
Good day and bad day 	Helps people reflect on what makes a good day and bad day and informs action planning and goal setting based on what is important to the person and how they want to be supported. to the person and how they want to be supported.	Identifies the elements that make a day good or bad, to enable the person and their supporters to work out what they can do together to ensure that the person has less bad days and more good days. It can be used to help build up a picture of life before the person started on their reablement, how life has changed and what makes sense now in terms of what is important to the person and the support that they need.

Tool	What it does	How this tools helps in Reablement
Matching staff 	Gives a structure for looking at the skills and characteristics that will make for a good match for a person who is receiving support.	Helps people think about what kind of paid and non paid support they want and need during Reablement and after. This helps to get the match of the style, approach and skills of the Reablement worker, as close as possible to the requirements of the person they are supporting and their family. A good match is central to the happiness and motivation of the person requiring support. Helps people to think about the networks and people in their life who may be able to offer ideas, knowledge, resources and support as part of their Reablement.
Relationship circle 	Identifies who is important to the person.	Helps people to think about the networks and people in their life who may be able to offer ideas, knowledge, resources and support as part of their Reablement. Helps a person to think about their lives before Reablement and who was important to them and how they wish these important relationships to be respected and supported now. A person may also start to think about those people they might have lost contact with and would like to contact again. Helps a person to be clear about what role the people identified in their circle could have in supporting them and what support they may need in order to do this. It helps to demonstrate to other professionals - for example occupational therapists and GPs, the significance that these people and networks have in the person's life and how they need to be supported and respected.
Support to confidence 	Helps a person and their supporters, in a task orientated way, to plan the specific steps that matter for the person in building their confidence. Also supports the person being fully involved in saying what they want to achieve and the best way to use support to achieve it.	Step 1 What you want to achieve and why it is important. Step 2 Where are you now? Where do you want to be? This is a continuum from 1 (being not confident) to 10 (being very confident). It helps clarify the starting point and where a person is aiming to be in the six weeks. Step 3 How can we help you in achieving this? Step 4 Who else could we include? This could be family, friends, health professionals, assistive technology and people in the local community. Step 5 How can we do this together? This is a plan of what we will do; e.g. if the person wants to start back at a local tea dance, what support can we give; what support can we get from others? Step 6 Are you feeling confident to do this without paid support. What conditions need to be in place for you to feel confident?

Tool	What it does	How this tools helps in Reablement
Communication charts 	A quick snapshot of how someone communicates. A way of recording detailed information for people who use words to speak and particularly for people who don't.	Helps us to focus on how a person communicates and what we think different things mean and how we should respond. It is vital in helping the person to direct their reablement and for supporters to find ways to keep them central to the process. Respectfully recording and acting on what we know about the way a person communicates should start from admission to hospital and be added to as the person, their family and supporters learn together throughout the 6 week reablement process.
Learning log 	Directs people to look for ongoing learning. A structure that captures details of learning with specific activities and experiences. Provides a way of recording information which focuses on what needs to stay the same and what needs to be different in how we support people.	Provides a way for people to record ongoing learning (focused on what worked well, what didn't work well) for any event or activity. A simple way to record and evaluate progress. It is often used to replace traditional notes or to help people think about what they want to enhance or change. It provides a way for supporters or those receiving support to evaluate how things are going around specific situations - focusing on what worked and what didn't. Can be used to focus on someone's whole life or specific areas of their life, e.g. someone's health and progress on specific rehabilitation goals or how they like to spend their time. This is a way of recording that demonstrates real progress or where there are difficulties. Helps to stop the doing 'for' rather than 'with' approach by focusing attention on recording what we are learning about a person as they move through the Reablement process.
Sorting what's working/not working now and in the future and family perspectives 	Analyses an issue or situation across different perspectives. Provides a picture of how things are right now and for planning for the future. Forms the basis for goal setting and action planning. Acts as a powerful reviewing tool.	Helps people to clarify what they want and what they don't want now and can help people to look to the future in terms of what would work or not work for them. To see what is happening currently from the perspective of the family and professional involved. By focusing on what is working, it helps people to think about the skills and self care tasks that they can maintain, and the things that are not working can be prioritised in terms of actions. It helps people to think about skills that they could regain during the Reablement process and how they can be best supported to do this. Can be used at any time during the Reablement process to review progress from different perspectives; the person, the family, the professionals and others. It can also be used as part of a Person Centred Review.

Tool	What it does	How this tools helps in Reablement
4 + 1 questions 	Helps people focus on what they are learning from their efforts.	A set of questions that are used when meeting together, in order to gather collective learning. The questions explore what is being tried and learned with the person, their family and professionals. It focuses on what we are pleased about in terms of progress and the concerns that people have and concludes by asking "Given what we know now, what are we going to do next ?" This is a powerful tool that can be used at any point to review progress and is used by managers to help Reablement workers reflect on their practice. It is also an approach that can be used within a person's home to shape information that is being recorded and shared as part of a team approach to supporting them. This provides wider viewpoints of a particular situation leading to tailor-made actions.
Histories 	Helps people reflect on the past and how this information can help to shape what they do next.	Helps people who are supporting the person to remember the achievements to be celebrated and acknowledged in a person's life. Informs supporters about factors and expectations that will affect the person who is regaining their life through the Reablement process.
Decision making agreement	Helps us to think about decision making and increasing the number and significance of decisions people make.	Enables people to be in control and make decisions about the way they wish to live their life and how they can make informed decisions about their own Reablement process. Can inform best interest decision-making and advanced decision-making.
Circle of influence 	Helps the person to identify areas of concern and/or anxiety and what they can do to address them.	Can be used when a person is feeling overwhelmed or powerless. It helps the person to focus their time and energy on the things they can control and helps others to see how they can support in a way that leaves the person with control and decision making that makes sense to them. Can be used early on in the Reablement process to shape goals and to ensure that the person is really being listened to at a time when they may be dealing with major life changes. Can be used separately or compositely for the individual and their family to address separate and shared anxieties and concerns; then using this information to form the basis of goal setting and action.

Tool	What it does	How this tools helps in Reablement
The person centred risk tool 	Looks at risk through a framework of focusing on purpose, people, process and progress to ensure that they can achieve what they want, whilst keeping a balance on being healthy and safe and keeping risk in perspective.	Helps us to enable individuals to think about risk in the context of what is important to the person and how they can be as independent as possible and have choice and control.
One page profiles with action 	A one-page profile is a way to set out information about what people appreciate in an individual, what is important to them and how they want to be supported. It leads to looking at what is working and not working for the person and what needs to happen to change what is not working.	Helps us to record and communicate information that we are learning about, and with, the person when they are in hospital. This information can be added to and acted on as the person progresses through the Reablement process. An effective way to start to gather information that makes sense to the person at the point of referral from hospital. A good way to share information with each other, especially in Reablement, if staff do not see each other when supporting people. Can act as a set of instructions for staff and supporters, about the person's needs and what support makes sense to them to develop their confidence, move towards greater independence, or to direct tailor-made on going support. It is at the heart of a Support Plan and can be expanded on should a person need to use a Personal Budget to meet their personal outcomes. Can be used to develop a Personal Care Plan that looks at the whole of someone's life to ensure that health and well-being are seen as a whole.

"Getting reablement right is paramount to serving people well. In the current climate we have to ensure everything we do is delivering maximum efficiencies and supporting people to be as independent as they can be. The New Reablement Journey describes a modern way of streamlining reablement to become part and parcel of everything we do. More people should have the chance to maximise their independence and have choice in how that is achieved. But reablement is not just about practical self-help; it's about living life as fully as we can; we have to work holistically to achieve that and have a person centred approach. Here in Walsall we're proud to be working on implementing the New Reablement Journey to make this a reality."
Paul Davies, Executive Director of Adult Social Care and Inclusion
Walsall Metropolitan Borough

"Simplifying processes, and making our contact with the 'caring' professions more friendly and relevant to our lives are key to promoting and encouraging independence for disabled people. Any document such as this that outlines how people can be supported and encouraged to take real control is welcomed."
Lorraine Gradwell MBE
Chief Executive, Breakthrough UK Ltd.

"Building on a person's expertise and resources is key to achieving the aspirations set out in Putting People First, and now in Think Local, Act Personal. We know that if a person can be supported to remain involved in their community, strengthening natural networks of support, their quality of life is enhanced as well as their wellbeing and independence. I fully support the broad definition of reablement that this paper adopts, meaning that we look at the whole person and move away from functional assessments of independence. I also welcome the potential for the person to exercise choice and control during that reablement period and the suggestion that this is something everyone should benefit from. Transforming services requires new approaches and means we should question everything we do, extending choice and control, being more person-centred, increasing transparency and working collaboratively; the model set out in this paper goes a long way to doing just that."
Martin Routledge
Former National Programme Manager for Personalisation, Department of Health