Progress for Providers

Checking your progress in delivering person centred support that promotes independence, wellbeing and self reliance

Reablement

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Walsall Council

Lancashire County Council

Foreword

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Supporting people to be as independent as possible needs to run through everything we do in social care and all services must work in person centred ways to get this right. This is not only better for people who need support but, in the current financial climate, is an important way that we can use public money where it is needed most.

As more people are needing social care support, there is growing pressure on budgets and the demand for short term 'reablement' support is therefore increasing. This focused support to achieve outcomes is critical in promoting a person's independence, confidence and wellbeing and can play a vital role in preventing their readmission to hospital or specialist services.

The need for a range of support providers that can respond to a variety of needs and support people to increase independence in person centred ways, has therefore never been greater and I welcome this self–assessment tool as a way of assisting provider organisations to meet that challenge.

Progress for Providers

Checking your progress in delivering person centred support that promotes independence, wellbeing and self reliance (reablement)

Introduction

The tool is designed for any organisation that enables people to be more independent. This may include very short term support, often described as 'reablement', as well as longer term support that reduces paid support in a person's life over time.

The standards it includes are based on the principles described in 'A New Reablement Journey'[1] (see a graphic summary of this process on page 33) and has been developed as a result of a number of organisations implementing those principles coming together to share their learning and shape what best practice looks like.

Terminology

We think the term 'reablement' is unhelpful but it is commonly used. In this document we use the term to refer to any short term support that focuses on maximising a person's independence. As such, it may also refer to support that is described as 'recovery', 'rehabilitation' or 'enablement'.

Local terminology differs considerably and we use the term 'Support Plan' to refer to what may also be called a 'Reablement Plan', 'Care Plan' or 'Recovery Plan' which addresses the person's short term outcomes (usually 6 – 8 weeks but can be longer). Plans to achieve specific outcomes around independence need to reflect the same principles of good Support Plans for anyone with a Personal Budget (the difference being that, in most cases, for people with short term support needs a budget may not be known.)

We refer to the term 'purchasers' to include any funding authority and this may include social workers, commissioners, care managers, care coordinators, contract officers etc. as well as people funding their support themselves, or with a personal budget.

How to use the tool

For small organisations this self–assessment tool can be used at a local level with managers, owners or trustees to help prioritise areas for change and develop a local action plan. Larger organisations may choose to do this exercise nationally

[1] A New Reablement Journey (Ambrey Associates and Helen Sanderson Associates) April 2011

looking at the whole organisation or in specific departments or areas. The tool complements *Progress for Providers: checking progress in delivering personalised services* as good practice in delivering personalised services is a vital part of delivering good practice in reablement.

Once completed, the scores suggest the next steps for the organisation to consider and develop this into an action plan for change.

There are eight sections. These are:

1. Leadership and strategy

a. Vision

b. Strategy

c. Business Model

2. Creating a culture that promotes independence

a. Culture

b. A Person centred approach to risk

3. Community focus

4. Short term support planning and review

a. Planning for independence

b. Person centred reviews

5. Working in partnership

a. Working with other agencies

b. Working with purchasers

6. Human resources

a. Selecting and recruiting staff

b. Supporting, supervising and appraising staff

c. Workforce development

7. Marketing and communication

8. Reviewing and improving what we do

a. Improving people's lives and achieving their outcomes

b. Hearing what people think of our service

Each of the 8 sections covers a key area of change and has five statements to choose from. You choose the statement in each section that best corresponds with your progress to date. (statement 1, 2, 3, 4 or 5).

For example:
If you are **getting started** you are likely to tick the first one or two statements.
If you are **making some progress**, then perhaps the third statement.
Good progress is likely to mean that you would tick the fourth box.
Excellent progress would mean that you are ticking the 5th statement.
Few organisations would be able to score 5's in every area.

What next

Once you have assessed your progress you can use this information to develop an action plan. The action plan should describe how you are going to develop and change and move towards statement 5 (excellent progress). For example, if you score a 3 in one area your action plan would focus on how you could move from 3 to 4 or 5. Progress for Providers can therefore help you to decide where to focus your energy and resources.

You might want to record your scores electronically, to compare them over time, or see a summary from several managers. We can send you a free format to use on Excel so that you can create pivot tables from your scores. Please email Kerry@helensandersonassociates.co.uk if you are interested in this.

Please also contact Kerry if you want any support implementing this within your organisation or training and support to achieve your action plans.

We hope you find this useful as a way of thinking about the progress you are making using person centred practices to achieve change.

Jenny Pitts and Helen Sanderson

Contents

1. Leadership and Vision

Vision

Tick one box ✓

1	Our organisation has no meaningful vision that determines how we work. We are primarily a care provider organisation that promotes itself as delivering home based care and support.	☐
2	Our organisation has no meaningful vision that determines how we work. We primarily deliver home based care and support although managers do encourage staff to work in a way that promotes independence and community involvement although this rarely results in a reduction in levels of support.	☐
3	Our organisation promotes itself as delivering short term 'reablement' support although there is no clear vision that describes what this means and how we will work and there is no recognition of the importance of community. Promoting independence in self–help skills is a key part of our organisation's role but this is not reflected in other work our organisation does.	☐
4	One of our organisational aims is to promote independence. This primarily relates to short term support we offer and although we do aim to support everyone to be as independent as possible, it is not made explicit that we see a reduction in our input as a success factor. Our organisation acknowledges the importance of community in a person's life but it isn't clear how this impacts on our day to day work.	☐
5	One of our organisational aims is to support people to be as independent as possible and live the life they choose in a variety of person centred ways, thereby aiming to reduce their need for our input over time. Reducing this dependency defines our success and runs through everything we do, whether we are providing short, medium or long term support. Our organisation recognises the importance of community in a person's wellbeing and our vision reflects our role in strengthening people's community networks as a key part of promoting their independence.	☐

Strategy

1	We have not considered the impact of promoting people's independence on our organisation;	☐
2	Our organisation is aware that working in a way that reduces people's dependence on our support will have an impact but this has not translated yet into recognising the need for a strategy about how we will address this impact in a positive way.	☐

		Tick one box ✓
3	As an organisation we have identified our need to develop a strategy that describes how we will work as an organisation to promote people's independence in a range of ways but as yet this work is not developed.	☐
4	We have a strategy that sets out our vision to support people to be as independent a possible. This is not yet developed into a costed plan with milestones against which we can review our progress.	☐
5	To achieve our vision in relation to promoting independence and wellbeing we have a strategy that sets out what we need to do and brings together all areas of work into a costed plan with milestones against which we review our progress.	☐

Business Model

1	Our organisation is geared towards providing long term care and support. Changing this business model will be disruptive and may meet with resistance.	☐
2	As an organisation we provide both short term 'reablement' support and long term support. We have a different approach for each type of work and do not have a business model that addresses or encourages any potential to reduce our input for people receiving longer term support.	☐
3	Our organisation recognises that maximising people's independence in various ways is what we are about. However, the business model remains focused on supporting people long term rather than encouraging a reduction in our input.	☐
4	Operationally, we support people to grow in independence and we see a reduction in the need for our support as a success factor. As an organisation this approach is not embraced by all departments or senior colleagues and is not reflected in our business model.	☐
5	Our organisation is geared towards supporting more people for a shorter time, or on a reducing basis. Members of our governing body, all departments/senior colleagues (finance, contracts, workforce etc.) understand this business model and work in a joined up way to encourage and support the achievement of greater independence, self reliance and well being for people we support, so that they can live the life they choose.	☐

2. Creating a person centred culture that promotes independence and wellbeing

Culture

Tick one box ✓

1	Our organisation does not recognise the importance of cultural change in our aim to offer short term 'reablement' support.	☐
2	We know that in order to promote independence there needs to be a cultural shift to understanding better what we mean by independence but as yet we have not embarked on this change, nor identified how that cultural change will be communicated.	☐
3	As an organisation, we have begun to discuss what the cultural changes need to look like in order for us to effectively promote independence. But we have not yet engaged with our staff, people we support and other stakeholders to shape these ideas and nor have we begun to implement these changes in a planned way.	☐
4	As an organisation we have gone a long way towards addressing the cultural changes that are required internally to support people's independence in person centred ways, but we have not yet changed our communication nor engaged with people we support, their family carers and other stakeholders to understand what this means to them and their expectations of us as an organisation.	☐
5	We have worked with our staff, people we support and other key stakeholders to identify and understand the person centred cultural change that needs to occur throughout the organisation. We make sure that people we support have clear information about our service and what they can expect from us. We have looked at all the ways we communicate throughout the organisation and have made sure that the same key messages are being given throughout and that a person centred culture is being created and modelled by leaders in our organisation.	☐

A person centred approach to risk

1	As an organisation we are naturally protective and do not encourage people we support to take risks in their lives.	☐
2	Our organisation recognises that risk taking can be essential in increasing independence but we do not have the policies and procedures that support this approach and individual staff members do not always feel supported by the organisation in taking risks.	☐

		Tick one box ✓
3	Our organisation has a positive risk taking policy but the way that policy is implemented is not person centred and remains bureaucratic and cumbersome. Staff members do not always feel supported by the organisation in supporting a person to take risks.	☐
4	As an organisation we have a positive risk taking policy which enables staff members and managers to feel supported in promoting risk in a well managed way. However, we need to have a more person centred approach to supporting risk and the policy needs to become further embedded across the organisation.	☐
5	As an organisation we understand that taking risks is inevitable when promoting independence well. Our approach to risk is based on listening to what is important to people and supporting them in positive ways to take steps towards greater self reliance and wellbeing. This approach is embedded across the organisation and all staff are clear about their responsibilities in this respect. Positive risk taking is strongly encouraged and we accept that this will not always be successful.	☐

3. Community focus

1	As an organisation we focus very closely on certain support tasks like keeping people healthy and safe and regard this as our primary responsibility.	☐
2	As an organisation we are aware of the need to promote community connections and citizenship but are not sure how to go about this or how this will fit into people's roles.	☐
3	Our organisation has begun to think about promoting community connections and citizenship, to work out how staff roles may need to change and to understand why this is important for both the organisation and the people we support.	☐
4	Our organisation is actively looking at how we promote community connections and citizenship and recognises that this needs to be a clear priority for our work. We have some examples of supporting people to make community connections and we are learning from these.	☐
5	As an organisation, we understand the importance of community in a person's life and of working alongside other organisations to effectively support people to feel part of that community. Our staff see this as an integral part of their role. We engage with a range of community organisations and ensure that at a local level there is a good working knowledge of local groups and resources.	☐

4. Short term support planning and review

Planning for independence and wellbeing

Tick one box ✓

1	People have Care Plans that focus on their health, safety and physical wellbeing. They do not include goals relating to the person's independence.	☐
2	We use Care Plans throughout our organisation but recognise that we need to change these tools to be more outcome focused and person centred. We have started the process of identifying these changes.	☐
3	People receiving short term support have Plans that address how goals relating to independence will be achieved. If the person is likely to need further support beyond this short term input this planning process has to start again.	☐
4	Everyone we support has a Support Plan which includes outcomes to enhance their independence. For people receiving short term support we aim to develop this Plan with them and any new support provider to evolve into a longer term Support Plan if needed.	☐
5	We ensure that everyone we support has a person centred Support Plan to achieve outcomes linked to increased independence and wellbeing. For people receiving short term support from us, we ensure that if further support is needed beyond that time, the Support Plan evolves to become one that is supported with a Personal Budget. For people whose independence is increased to the extent that they need no further input from us, we support them to develop their Plan to reflect how they aim to maintain their independence and prevent the need for future support.	☐

Person centred reviews

1	For people receiving short term support we do review their progress but this tends to be ad hoc and not recorded in a formal way. If they go on to need no further support we have no further contact with them once our support is no longer required. Annual reviews sometimes don't happen for people receiving longer term support and, when they do, they are led by professionals or senior staff and the person is not always fully involved or communicated with. These reviews rarely result in new goals being set or a consideration of whether the support needs to change or reduce.	☐

		Tick one box ✓
2	For people receiving short term support, we do review their progress with them but the format of the review is constrained to looking solely at their self-help skills and does not consider other aspects of their life. If they need no further support after the short term period, we have no contact with them once our support is no longer required. Annual reviews take place for people receiving longer term support but these tend to be professionally led and rarely consider new goals to enhance independence or whether the level of support could reduce if independence increases.	☐
3	For people receiving short term support we review their progress but this does not always involve the person in the review process. We are starting to include broader aspects of their life in these reviews and not solely focus on self help skills. If people need no further support from us we do occasionally contact them to see how they are getting on but this isn't formalised or recorded. For people receiving longer term support from us we do review their progress towards independence goals but this is a professionally led meeting and we rarely consider, as part of this, how our input can reduce.	☐
4	People receiving short term support are fully involved in frequent progress reviews. These are person centred but our documentation doesn't fully reflect that. If a person no longer needs our support, we make sure we contact them, usually within six weeks, to see how they are getting on but this too needs to be formalised and recorded. People with longer term support have person centred reviews where we look at independence goals but this doesn't yet translate into a consideration of whether our support might reduce or change.	☐
5	We regularly review people's progress with them, looking at what's working and what's not working and we agree with them how our input needs to adapt to their changing needs. For people receiving short term support, we consider with them, at least weekly, whether they still require our support and whether they are likely to need further paid support to achieve outcomes. At least four weeks after a person is no longer receiving our support we contact them to see how they are doing and put them in touch with other sources of information and assistance if needed. People receiving longer term support have regular person centred reviews in which we consider with them how their independence can be promoted further and how our support could reduce as their independence and natural support networks increase.	☐

5. Working in partnership

Working with other agencies

Tick one box ✓

1	Our organisation tends to work within the remit of our contract and we have little contact with other agencies involved in the person's life (such as health, housing, etc.).	☐
2	Our organisation focuses on the tasks we are contracted to provide but we engage with other agencies if necessary as part of our fulfilling those tasks for a person.	☐
3	We make sure we are aware of any other agencies involved in a person's life and seek to communicate with them if there are any issues where we feel a joined up approach is required. We support the person to address any problems or queries with those agencies directly.	☐
4	With the person's agreement we will contact other agencies involved in their life if we are aware of a problem or have a query that affects our input. If requested, we may carry out therapeutic or health related tasks under their direction. Sharing our understanding of what is important to the person tends to only happen by chance and we do not proactively support the person to share this information, although we do recommend they do so.	☐
5	With the person's agreement, we proactively engage with other agencies that are involved in their life in order to ensure a person centred and seamless experience for them. We may carry out therapeutic or health related tasks under their direction that enhance understanding of what is important to the person and how best to support them. We support the person to share that learning with those other organisations involved as appropriate.	☐

Working with purchasers (including people funding their own support)

1	As an organisation we work with purchasers at the stage of agreeing the contract and at contract reviews but, unless there is a problem, we have little other contact initiated by us.	☐
2	Our organisation understands the need to build a positive relationship with purchasers and we try to present a positive view of our organisation but in the main, we focus on contract compliance.	☐

		Tick one box ✓
3	Our organisation seeks to build positive relations with purchasers by being flexible and responsive when they contact us outside of formal contract reviews. We do not proactively contact them or share the successes we achieve with people.	☐
4	We strive to build positive and productive relations with purchasers by building on trust. We inform purchasers when a person no longer requires our short term support but this rarely happens when we reduce levels of support for people receiving longer term support. If we have ideas about how the terms of our contract may need to change to improve the service we offer, we share these ideas with purchasers and seek to enter into discussion with them.	☐
5	We recognise the importance of maintaining positive and productive relations with service purchasers and we strive to do this by building on trust. If a person receiving support from us no longer needs as much, or any, of that support because they are more independent and more connected in their communities, we share this information, even though this may reduce our income as an organisation. If we have ideas about how the terms of our contract may need to change to improve the service we offer, we share these ideas with purchasers and seek to enter into discussion with them.	☐

6. Human resources

Selecting and recruiting staff

1	Staff are employed to fulfil basic functions relating to home care. We are often short of staff and can offer the person little or no consistency in the people who arrive at their home to perform tasks.	☐
2	We recruit staff as home care/support workers but we recognise that maximising independence is an increasing part of their role. They receive some training on this. We aim to offer the person some consistency in the people who support them but are frequently unable to deliver this due to capacity issues.	☐
3	We make sure all staff see maximising a person's independence as a key part of their role rather than just 'caring for' the person and we have started to ensure they have the skills and values to support this. We aim to offer the person some consistency in who supports them and are generally able to deliver this.	☐

		Tick one box ✓
4	We have plans in place to equip all staff with skills to support a person to gain independence in person centred ways. We are starting to gather information about our staff that will help us 'match' them to a person. We have plans in place to ensure a minimum number of people supporting any one person but as yet this is not always achieved.	☐
5	We ensure that all staff supporting people to increase their independence are skilled in person centred practices and understand how this relates to maximising independence and wellbeing. We always try to match staff to the person's preferences, interests and their knowledge of the local community. We keep to a minimum the number of people supporting any one person and try to have a dedicated mini team supporting each individual, all of whom are able to build trust with and get to know the person over the period of our involvement.	☐

Supporting, supervising and appraising staff

1	Staff in our organisation receive supervision no more often than every 3 months unless there is a performance issue. Supervisions and appraisals tend to focus on the supervisor's view of whether there are any problems, concerns or training needed.	☐
2	Staff in our organisation often receive supervision no more often than every 3 months unless there is a performance issue. Supervision and appraisals do address issues from the staff member's perspective and include a consideration of how they are finding the work.	☐
3	Supervision policies aim for monthly meetings but frequently this isn't achievable. Our organisation sees supervision and appraisals as a two–way process, taking into account any issues or concerns from the staff member's perspective. Successes the person has achieved with individuals are rarely mentioned or known about.	☐
4	Supervision sessions generally happen on a monthly basis and are an opportunity for the staff member to share what is working and not working from their perspective as well as their manager's. Managers will occasionally have information of what the staff member has achieved with regards to supporting people in person centred, enabling ways and this may be used in both supervision and appraisals to give positive feedback and consider further development needs.	☐

		Tick one box ✓
5	Supervision sessions happen regularly, are opportunities to consider what is working and not working and to think and problem solve together. Information that includes feedback from people we support and evidence as to how the staff member has contributed positively to support someone to achieve their outcomes, and is working in a person centred way, will be used to shape these discussions and consider any further development needs.	☐

Workforce development

		Tick one box ✓
1	We have some training days in our organisation and these are based on statutory requirements such as lifting and handling and food hygiene. We meet minimum legal and regulatory requirements.	☐
2	We have begun to think about how we might talk to staff about the changing culture of the organisation, their role in this and what new skills we might need to develop to meet new demands.	☐
3	We have begun to think about workforce development issues related to our aim of supporting people to be more independent. We have started to develop a programme of training that helps staff and their managers understand how they can work in person centred ways to achieve this.	☐
4	We understand that offering 'reablement' and working to promote independence across our service means that we need to review our workforce strategy. We are working with senior mangers across the organisation (including back office, non operational functions) to help them think about what this means to them and their role and what new skills and knowledge they may need. We are developing an in–depth training programme as part of our workforce plan.	☐
5	We have developed a detailed workforce strategy and training programme based on input, ideas and involvement of staff, individuals and their families. This includes what will need to change about the way we train, support and deploy our staff and takes into account the specific knowledge, skills and qualities that our workforce need in order to effectively promote independence, wellbeing and deliver person centred reablement.	☐

7. Marketing and communication

Tick one box ✓

1	Our organisation primarily regards commissioners or social workers as its customers and, although we do respond directly to people funding their own care and support, we are mainly focused on winning contracts and selling our service to those purchasers. We provide little or no useful information to people about promoting independence and working in enabling ways.	☐
2	We say that our customers are the people who use our services and their families, but the information we provide does not always match this. We provide information to people using our service but this does not mention how we support them to be more independent. We do not yet actively promote our service to people who may be looking to choose their own support provider.	☐
3	We have started to provide good information to people about what we do, what they can expect from us and how we work to promote their independence. We are not yet directly marketing what we do to people who are funding their own care directly or through a Personal Budget.	☐
4	As well as having good promotional material for people looking to purchase their own support, we have developed good information to people directly referred to our service and we explain what they can expect from us, including how we will work with them to further their independence. We have also thought about the customer service we provide to our commissioners and funding authorities.	☐
5	We provide good information both for existing and potential customers about what we can offer and how we work in a person centred way. We tailor this for our different customers, always making sure they know whom to contact if they need to. We use a range of accessible and user friendly approaches, including social media, which we have developed in consultation with people and families. We give clear messages in all our communication that we aim to reduce the person's dependency on paid support in their lives and will support them to build their confidence, wellbeing and self reliance. We recognise that we have a variety of customers and work with each of them in an individual, person centred way.	☐

8. Reviewing and improving what we do

Improving people's lives and achieving their outcomes

Tick one box ✓

1	As an organisation we don't make a link between the progress of people we support and how we as an organisation need to change and develop. We have a business plan that is reviewed but this tends to happen in isolation.	☐
2	If it is apparent at a person's review that we need to change how we work, we acknowledge this and address it for that person, but it is not used to feed into the organisation's wider learning about how it might need to change. Such strategic discussions tend to happen with no reference to people's experiences.	☐
3	Our organisation does address what it needs to do to better support people but this process tends to focus on performance and financial data rather than any qualitative experience of people using the service. If it is apparent at a person's review that we need to change how we work, we acknowledge this and address it for that person.	☐
4	We use person centred reviews to consider a person's progress in gaining independence and what matters to them. If it is apparent that we need to change how we work as an organisation we address this but it is not used to inform the wider development. Organisational reviews do consider a range of information, including our success in supporting people to achieve outcomes.	☐
5	We use person centred reviews to enable people to think about their lives and their progress in gaining independence and what matters to them. We also consider what we might need to do differently as an organisation. We use information gathered from such reviews to shape what we need to change as an organisation in order to continually improve how we work to be more person centred and to better promote independence and wellbeing (for example, by using Working Together for Change).	☐

Hearing what people think of our service

1	As an organisation, we do not ask people what they think of our service, either whilst they are receiving support or if they have ceased to need our support.	☐
2	Our organisation does send out a questionnaire once people have ceased to need our support, but there is a poor return rate and we do not use the information gathered in any meaningful way to improve how we work.	☐

		Tick one box ✓
3	Our organisation does contact people using, and who have recently used, our service in order to find out what they think. This information is collated and used as part of our regulatory reviews, but it rarely changes how we as an organisation work.	☐
4	We gather information from people about their experience of using our services but this could be done more regularly and the questions could be more probing. We use this information to review and improve how we work as an organisation.	☐
5	We gather information from people about their experience of using our service, whether they were treated with respect, whether we did what we said we would do and whether we provided good support in ways that were important to them. We use this information to continually review and improve how we work as an organisation, for example through using tools such as Working Together for Change.	☐

Action plan

On the following page we have included an action plan. You can use your score to plan your next steps. Look at each section and what the next statement suggests you may want to work towards. You can use this to record what you are going to do to achieve this, who will be responsible for this, and when you want this to be achieved.

Action planning summary

	What we want to work towards (the next statement in the section)
Section 1. Leadership and strategy a. Vision	
b. Strategy	
c. Business Model	
2. Creating a culture that promotes independence a. Culture	
b. A Person centred approach to risk	
3. Community focus	
4. Short term support planning and review a. Planning for independence	
b. Person centred reviews	
5. Working in partnership a. Working with other agencies	
b. Working with purchasers	
6. Human resources a. Selecting and recruiting staff	
b. Supporting, supervising and appraising staff	
c. Workforce development	
7. Marketing and communication	
8. Reviewing and improving what we do a. Improving people's lives and achieving their outcomes	
b. Hearing what people think of our service	

What we are going to do (action)	Who will be responsible for this (name)	When this will be achieved (date)

Detailed action plan

Top priority

Why is this your top priority?

First steps

Who

By when

Who else needs to know/help this to happen?

How will I get their help?

What support will I/we need?

From inside the organisation

From outside the organisation

How will I know I have been successful?

What will have changed? What will you see? What will you feel? What will you hear?

Detailed action plan

Next priority

First steps

Who

By when

Who else needs to know/help this to happen?

How will I get their help?

What support will I/we need?

From inside the organisation

From outside the organisation

How will I know I have been successful?

What will have changed? What will you see? What will you feel? What will you hear?

Detailed action plan

Next priority

First steps

Who

By when

Who else needs to know/help this to happen?

How will I get their help?

What support will I/we need?

From inside the organisation

From outside the organisation

How will I know I have been successful?

What will have changed? What will you see? What will you feel? What will you hear?

Detailed action plan

Next priority

First steps

Who

By when

Who else needs to know/help this to happen?

How will I get their help?

What support will I/we need?

From inside the organisation

From outside the organisation

How will I know I have been successful?

What will have changed? What will you see? What will you feel? What will you hear?

How Progress for Providers contributes to delivering the Adult Social Care Outcomes Framework (DH 2011)

(1A) Social care–related quality of life.

(1B) The proportion of people who use services who have control over their daily life.

(1D) Carer reported quality of life.

(2B) Proportion of older people who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.

(3A) Overall satisfaction of people who use services with their care and support.

(3B) Overall satisfaction of carers with social services.

(3C) The proportion of carers who report that they have been included in discussion about the person they care for.

(4A) The proportion of people who use services who feel safe.

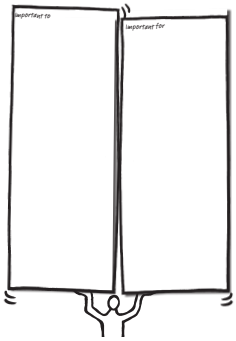
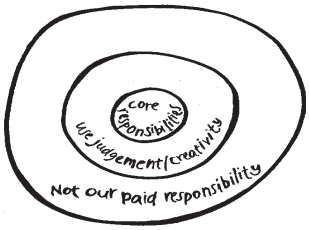
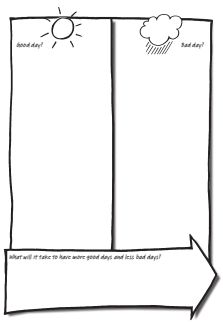
(4B) The proportion of people who use services who say that those services have made them feel safe and secure.

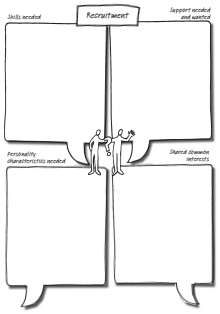
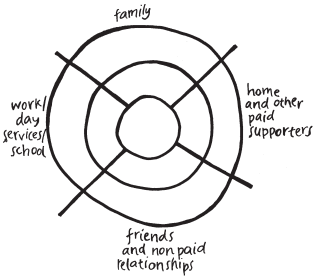
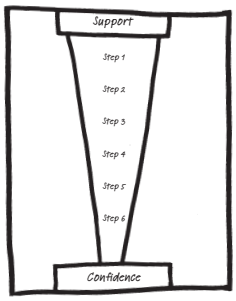
How this tool helps providers meet the Care Quality Commission's Essential Standards of Quality and Safety[2]

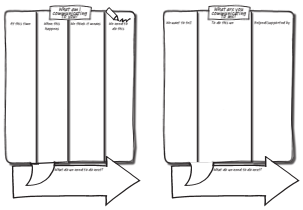
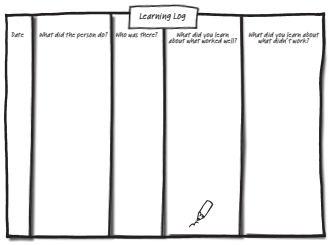
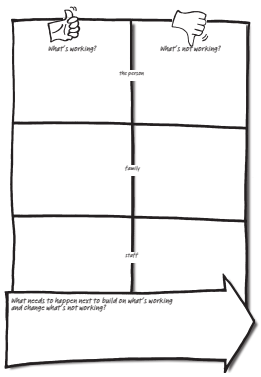
Care Quality Commission outcome	Progress for Providers (Reablement) related section
Outcome 1: Respecting and involving people who use services Outcome 4: Care and welfare of people who use services Outcome 16: Assessing and monitoring the quality of service provision	2. Creating a culture that promotes independence 4. Support planning and review 8. Reviewing and improving what we do
Outcome 6: Cooperating with other providers	5. Working in partnership
Outcome 13: Staffing	6. Human resources
Outcome 14: Supporting workers Outcome 15: Statement of purpose	1. Leadership and vision

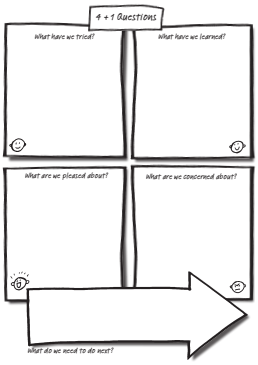
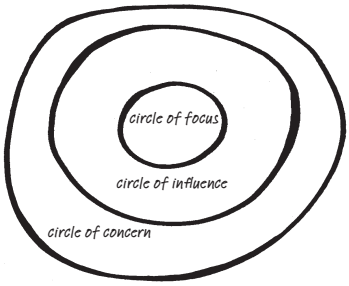
[2] Care Quality Commission: Guidance about compliance Essential standards of quality and safety. (March 2010)

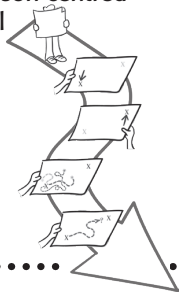
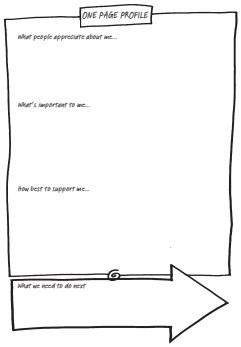
Summary of person centred thinking tools

Tool	What it does	How this tool 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 he needs. 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 him. 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 (judgement and creativity) and what is not their responsibility. Helps a person and his 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 his 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 his qualities and strengths. This helps to counter our tendency to focus on how much support the person needs to what he can contribute and make the most of, as he moves on with his life.
Good days, bad days 	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 he wants to be supported.	Identifies the elements that make a day good or bad, to enable the person and his supporters to work out what they can do together to ensure that the person has fewer bad days and more good days. It can be used to help build up a picture of life before the person started on his reablement, how life has changed and what makes sense now in terms of what is important to the person and the support that he needs.

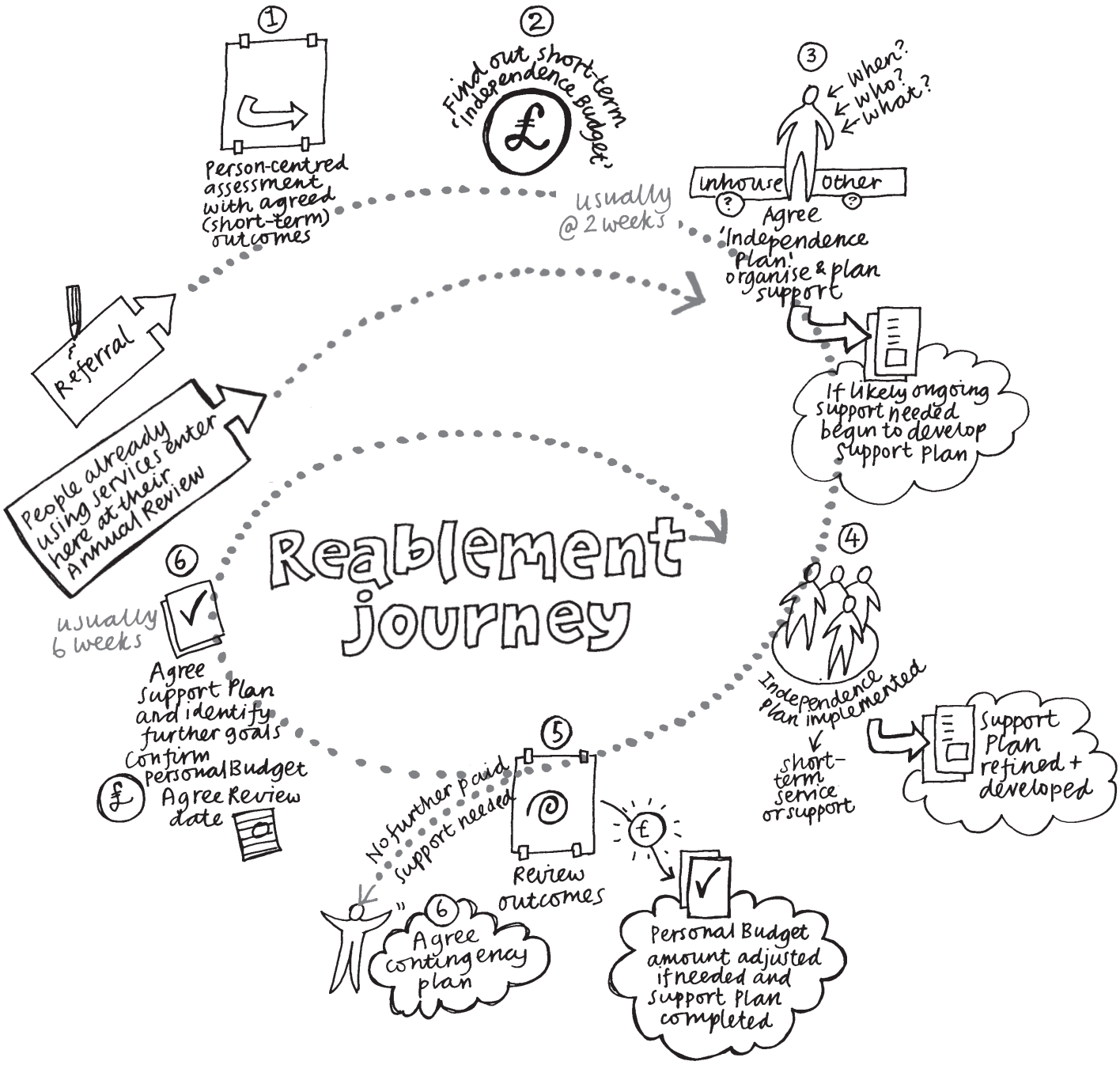
Tool	What it does	How this tool helps in reablement
Matching staff 	Gives a structure for looking at the skills and characteristics that will make for a good match for a person who is receiving support.	Helps people think about what kind of paid and non-paid support they want and need during reablement 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 his 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 his life before reablement and who was important to him and how he wishes these important relationships to be respected and supported now. A person may also start to think about those people he might have lost contact with and would like to contact again. Helps a person to be clear about what role the people identified in his circle could have in supporting him and what support he 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 he needs to be supported and respected.
Support to confidence 	Helps a person and his supporters, in a task-orientated way, to plan the specific steps that matter for the person in building his confidence. Also supports the person being fully involved in saying what he wants 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 tool 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 his reablement and for supporters to find ways to keep him 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, his family and supporters learn together throughout the six-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 he likes to spend his 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 he moves through the reablement process.
Sorting what's working and what's 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 tool helps in reablement
4 plus 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, his 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 him. 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 his 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 he can do to address them.	Can be used when a person is feeling overwhelmed or powerless. It helps the person to focus his time and energy on the things he 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 him. 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 he may be dealing with major life changes. Can be used separately or compositely for the individual and his 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 tool 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, while 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 he 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 he is 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 him to develop his confidence, move towards greater independence, or to direct tailor-made ongoing 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 his 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.

New reablement journey



Resources

Publications

A Practical Guide to Delivering Personalisation, Person Centred Practice in Health and Social Care www.hsapress.co.uk
Person Centred Thinking minibook, Reablement www.hsapress.co.uk
Community Connecting minibook www.hsapress.co.uk

Web resources

Michael Smull, a series of films on each person centred thinking tool
www.youtube.com/user/helensandersonHSA
Think and Plan , a free website for people to use person centred thinking online
www.thinkandplan.com
Michael Smull, a series of films on each person centred thinking tool
www.youtube.com/user/helensandersonHSA
Think and Plan, a free website for people to use person centred thinking online
www.thinkandplan.com
Social Care TV: Prevention: Reablement www.scie.org.uk/socialcaretv/video-player.asp?guid=6886fa01-81da-4963-926c-e1b41c5170f0

Free downloads

The New Reablement Journey www.helensandersonassociates.co.uk/whats-new/a-different,-person-centred-approach-to-reablement-the-new-reablement-journey.aspx
The New Reablement Journey and the Equality and Human Rights Standards
www.helensandersonassociates.co.uk/reading-room/how/person-centred-thinking/reablement.aspx
SCIE At a glance 56: Making the move to delivering reablement
www.scie.org.uk/publications/ataglance/ataglance56.asp
SCIE Research Briefing 36: Reablement: a cost-effective route to better outcomes
www.scie.org.uk/publications/briefings/briefing36/