“Housing providers can play a vital role in rehabilitation and reablement…”

THE HOME CURE

Claudia Wood
Jo Salter

DEMOS

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Contents

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Claudia Wood
Jo Salter
June 2012

Foreword

As some of the most significant reforms for a generation take place, the health, care and social housing sectors now find themselves on the brink of large scale transformation. For service providers of all kinds this will pose challenges. We will need to adapt. It will call for more innovation and improvements in services and support for people to ensure we continue to transform lives.

One key area for a more radical approach will be reablement services. Already, some health providers have begun to appreciate the benefits of working more collaboratively with other organisations to redevelop their approach to reablement and provide improved services. But, this is still relatively uncharted territory and the effectiveness of these services – particularly as the new environment emerges – is still not well understood and calls for more research.

So why has Midland Heart become involved? As one of the largest housing, care and regeneration providers in the country with nearly 32,000 homes, our aim is to transform lives through 'housing, care and more' by helping customers to live independently. What we do – and have been doing for some time – is more than just provide homes and short term care. Instead, we have developed and sought to deliver a wider range of innovative services to enable our customers to live independent lives and realise their potential. As this report highlights, this established expertise could help to support and deliver reablement services much more holistically with a greater emphasis on connecting individuals back to their community.

Housing and care providers can be valuable partners in delivering a better and more joined-up approach, contributing a great deal of experience from a diverse palette of skills – in extra

care, mental health, wellbeing, homelessness, worklessness, housing management and neighbourhood regeneration.

This report by Demos is timely, evidencing the potential wider role housing and care providers can play in delivering reablement services. In addition to this, changes in the commissioning structure mean it is now the ideal opportunity to develop and open this market further.

Chris Munday
Executive Director, Midland Heart Care & Support

Executive summary

In an era of unprecedented cuts to local authority budgets and centrally funded public services, instances of new government investment are infrequent and noteworthy. So when the Coalition Government chose to not only honour the previous government's commitment to £70 million for reablement services, but also add a further £162 million from Department of Health efficiency savings, it became clear that reablement was a central plank in the Government's plans for driving improved efficiencies through the integration of health and social care services.

However, reablement remains something of a nebulous concept, interpreted and applied differently across the country. It is broadly understood to be: 'Services for people with poor physical or mental health, to help them accommodate their illness (or condition) by learning or re-learning the skills necessary for daily living.'[1] In practice, reablement is an intensive care package, lasting up to six weeks, which is used to help often older people to regain their independence at home after a stay in hospital, to facilitate swifter discharge and to reduce the risk of the need for ongoing care (either domiciliary or residential). It currently lies firmly within the remit of social services, and is provided by (usually in-house) home care teams. Changes to commissioning structures this year will see health commissioners responsible for reablement services to support those leaving hospital and settling back at home.

Evidence suggests effective reablement can facilitate swifter discharge and reduce the need of ongoing home care support by up to 60 per cent. The cost savings to both health and social care services are substantial. However, evaluations show the performance of different schemes varies considerably, and some evidence suggests that reablement services in their current configuration are not delivering significant cost savings because

of the high cost of the initial reablement intervention. While reablement moderately reduces care costs over the longer term, it does not always reduce health costs – in other words, it is less effective at reducing the risk of hospital readmission.

This may be due to a range of limitations with the current reablement offer that we have identified through the course of this research, including a narrow application of reablement to focus just on 'within the home' tasks, rather than enabling older people to re-engage with their community networks; a cliff-edge of support ceasing after the six-week period without adequate steps taken to ensure that a 'reablement ethos' follows to maintain the good work achieved during the intervention; delays in access to equipment and adaptations; and a lack of flexibility and personalisation with the reablement support on offer.

Demos wanted to examine whether reablement could achieve better outcomes by addressing these weaknesses, and what role social housing providers might play in this. As reablement is perceived very much as a short term social-care-based intervention, led by domiciliary care workers, the wider role a person's home can play in (mental and physical) recovery after hospital discharge, and in maintaining independence, can often be overlooked.

Key opportunities to improve outcomes through non-specialist home-based support and improvements are missed, and important stakeholders – from housing associations (which provide homes for 5 million people), to extra care, supported housing and retirement village providers – are often left out of commissioning decisions and the critical conversations between health and social care services when it comes to discharging someone from hospital and putting reablement in place. It also means those with more complex needs – whose reablement may require more than therapy, but actually re-location to a more suitable home – may be under-supported and vulnerable to readmission to hospital.

As the commissioning on reablement has just transferred from local authorities – the majority of whom also deliver reablement services through in-house teams – to clinical commissioners, we believe now is the optimum time to review

how commissioners make decisions on how reablement is delivered, what we expect it to achieve, and who might be best placed to achieve it.

Methodology

In this report, we re-examine the concept of reablement as a 'home care intervention' and explore how better outcomes may be achieved through a more integrated approach – one which brings together health, social care and housing support following hospital discharge or an accident in the home.

To do this, we first reviewed and analysed the existing evidence on different reablement schemes, including many evaluations, examples of good practice and weaknesses in current delivery. We then carried out a series of interviews with commissioners and providers of reablement care, and social housing providers, to explore their perceptions of the current reablement offer, prospects for reform, the role of housing in reablement, and any perceived barriers to joint working. A full list of the experts we interviewed for this project can be found in appendix 1. We then also worked with Midland Heart, a housing and care provider, which provides accommodation for over 70,000 people across 54 local authorities, to interview six older people living in sheltered accommodation and one tenant living in general needs rented accommodation about their reablement journeys. This gave us an insight into the way in which reablement is currently being delivered to social housing tenants.

Findings

From this evidence gathering, we were able to establish the following points:

- There is some confusion around what exactly reablement means, with health and social care professionals sometimes using different terminology. There is also considerable variation between reablement commissioning and delivery in different local authority areas, and some are better at incorporating

housing into their reablement strategy than others, but the picture is patchy at best.

- There is an appetite for a broader definition of reablement, which includes helping people to go out into the community and reconnect with their hobbies and friends, rather than just fulfilling functions of living in the home. This approach could allow housing providers to play a larger part in helping to reable their tenants in the fullest sense, because of their wider knowledge of the local community.
- A 'reablement ethos', focusing on helping people stay independent and active, is vital to help maintain the positive impact of reablement once the six-week intervention period had ended. Housing officers and support staff could be key to this by reinforcing the messages of the reablement team among social housing tenants long after they have withdrawn their support.
- Including housing providers early on in reablement conversations could help speed access to appropriate equipment, adaptations, telecare or reablement accommodation where required, maximising the impact of reablement interventions.
- 21 per cent of people over 65 and 24 per cent of people aged 75 or over live in social housing. Social housing providers with a care arm could, therefore, offer a valuable service to their tenants in the form of reablement.
- There is no real reason why housing with care providers could not train their staff in the skills that would enable them to deliver reablement contracts directly, as well as work with existing reablement teams located in home care service teams. However, housing with care providers interested in moving in to this field will have to be proactive with health commissioners who have recently taken responsibility for local reablement services.

Recommendations

Based on these findings, we believe the following recommendations will improve the effectiveness of current reablement services, through leveraging the strengths of social housing providers.

Recommendation 1

There needs to be *further evaluation of reablement practice to identify best practice and 'what works'* in achieving the best outcomes, and greatest cost efficiencies, over the longer term. In particular, there needs to be greater scrutiny over current schemes' ability not just to speed discharge from, but also to reduce readmission to hospital, as this remains an overlooked but critical element of the cost savings reablement might achieve.

Recommendation 2

There needs to be a more *coherent and consensual understanding of what reablement entails*. While local discretion and room for innovative interpretation is welcome, reablement services – those delivering and receiving them – would benefit from greater standardisation in training, accreditation, team composition and good practice on what reablement should seek to achieve. This will no doubt be aided by the more robust evidence base recommended above, and could help expand reablement practice (and raise awareness) among a wider range of professionals.

Recommendation 3

As part of this standardisation, there needs to be a wider, *more holistic approach to reablement* embedded as best practice. Such an approach strives to achieve independence in one's community, not just in one's home. This means using reablement to help people maintain or regain their social networks, and reconnect with past activities and hobbies. Housing providers could be key to this wider concept, by working with reablement teams to facilitate people's links with local community and voluntary services, peer support groups, leisure interests and so on.

Recommendation 4

Housing with care providers (extra care and social housing providers with in-house care arms) interested in moving into reablement should *train their staff in reablement and proactively*

pursue reablement contracts with clinical commissioners, with a clearly articulated offer based on a more holistic approach and seamless links to equipment and adaptations and transition support in the form of housing and support staff.

Recommendation 5

Those housing with care providers whose care teams start to provide reablement services must ensure they *share this expertise across their organisations*, allowing their general needs housing officers to learn the principles of the *'reablement ethos' to sustain and reinforce the benefits of reablement*, and to learn how to recognise when a tenant might benefit from reablement.

Recommendation 6

In the majority of cases, however, housing with care providers will not directly provide reablement services. Therefore, *when providing services to social housing tenants, existing home care reablement teams must engage with social housing providers*. This includes ensuring that scheme managers or the appropriate staff are present in review and planning meetings, so housing officers and/or housing support officers are kept informed of ongoing support and the objectives being set by reablement teams.

Recommendation 7

Local structures should also be developed to ensure reablement teams and housing providers have ongoing channels of communication, and not just at the individual case management level. Housing support staff could be a key source of 'community referral' for reablement teams, as well as an important partner in raising awareness of middle way options for those reablement clients who are not eligible for an ongoing package of care but may require assistance after the reablement period ceases. To assist in building professional knowledge sharing channels, hospital discharge planning should include, as standard, alerting a person's social housing or extra-care landlord to the hospital stay

and imminent discharge, and informing them of the presence of any reablement planning.

Recommendation 8

Finally, and perhaps most importantly, clinical commissioning groups must think more creatively about how reablement is delivered and who delivers it. There is considerable potential for reablement to become more cost-effective and achieve improved outcomes, and now is the time, as they take responsibility for reablement commissioning, for health commissioners to re-evaluate what reablement currently achieves and what potential is untapped to achieve more. Looking to a wider range of reablement providers, and providers who work in partnership with other stakeholders to achieve more person centred support, is an important step towards identifying 'what works' in reablement.

1 Reablement and the wider policy context

What is reablement?

The key themes of social care reablement – prevention, personalised services, joined-up working between health and social care, and promoting independence – have been political buzzwords for successive governments. Reablement itself is a relatively new manifestation of these themes – and so has received less critical attention.

Though all health and social care is 'reabling' in one sense, reablement in social care currently refers to a specific type of service. The dominant definition is the one used by the Care Services Efficiency Delivery (CSED) programme, which defines reablement as: 'Services for people with poor physical or mental health, to help them accommodate their illness (or condition) by learning or re-learning the skills necessary for daily living.'[2]

In the USA and Australia, reablement is known as restorative care, which emphasises its role in restoring independent living skills, which may have been lost after a period of illness or injury.

The boundaries between reablement, as defined above, and other related interventions in health and social care (including intermediate care, occupational therapy and traditional domiciliary care), are blurred, as is the definition of reablement itself, and some local authorities have adopted their own working definitions:

- Denbighshire County Council: 'A process which supports an individual to achieve their maximum potential to function physically, socially and psychologically through support and intervention'
- Newport City Council: 'The active process of regaining skills, confidence and independence'

- Knowsley Metropolitan Borough Councils and NHS Knowsley: 'The restoration of optimal levels of physical, psychological and social ability within the needs and desires of the individual and his/her carer'[3]

It is clear that some of these definitions are much more wide-ranging than the CSED baseline suggests, particularly with regard to social abilities and the importance of an 'enablement ethos'. As we will argue later, these two areas are where the CSED definition is most limited, and where a broader understanding of reablement would open up a range of innovative working practices.

An evaluation of an early homecare reablement pilot in Leicestershire, carried out by De Montfort University in 2000, attempted to clarify some of these distinctions.[4] This report distinguished between prevention, rehabilitation and reablement – all three are aimed at people with poor physical and/or mental health, but the aim of each function varies:

- *Prevention* aims to avoid unplanned or unnecessary admissions to hospital or residential care. Prevention can include both short- and long-term low-level support.
- *Rehabilitation* aims to help people recover after a period of ill health.
- *Reablement* aims to help people accommodate their illness or disability by learning or relearning the skills necessary for daily living.

In practice, the reablement services offered by many local authorities are performing all three of these functions.

There is no single model of reablement (we describe some of the main variations in greater detail in the next chapter), but all reablement has two key features that distinguish it from wider social care. First, it is intended as a short-term intensive service. Reablement is generally offered for between six and 12 weeks – though the period can be even shorter if the individual is not deemed to need the full six weeks of treatment – during which time reablement teams visit frequently. At the end of the reablement period, users are assessed for an ongoing package of

social care, though the intention is for reablement to reduce the need for ongoing care.

Second, the aim of reablement is not to do things for people, or to provide assistance, as in traditional homecare, but to show people how they can do things for themselves. Reablement workers may deliberately 'stand back' and offer encouragement without actively assisting people in carrying out daily tasks. The range of tasks covered is broadly similar to conventional domiciliary care, and may include things like cooking, washing and moving about.

Reablement and intermediate care: the health and social care spectrum

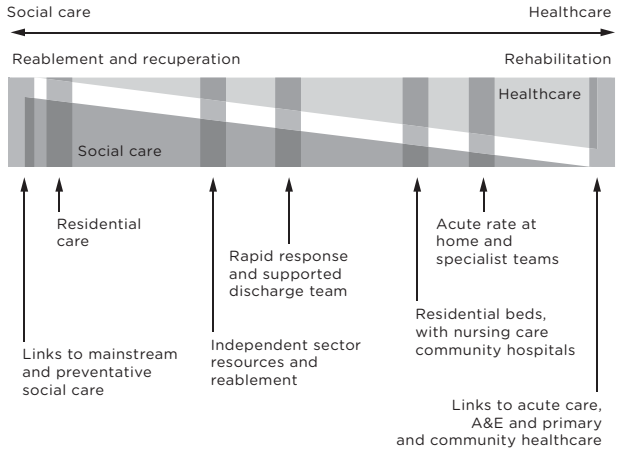
Reablement also shares some of the functions of intermediate care, and there is some confusion about the distinction between the two areas – particularly as there is no single service delivery model for either. According to the most recent Department of Health (DH) guidance, *Intermediate Care – Halfway Home*, issued in 2009, intermediate care has the overall aim of preventing unnecessary hospital admissions, reducing delayed discharges from hospital by offering appropriate hospital discharge support, and avoiding admission to long-term residential care homes.[5] It is a function, rather than a particular service, and in practice, encompasses a wide range of services, which may include some level of reablement.

The DH perceives intermediate care as a service continuum between health and social care, linking in to social care reablement at the social care extreme of the spectrum, as illustrated in figure 1.

Later the DH amended its earlier definition of reablement. As part of the CSED Homecare Reablement Toolkit in 2010, CSED describes reablement as:

A different phase on the continuum of care, whether that be different groups of people or the same people at a different stage of their 'recovery'. In reality, the intermediate care and homecare reablement phases for specific individuals may overlap.[6]

Figure 1 **The continuum of intermediate care (adapted from Brophy 2008)**



Source: Department of Health (2009), Intermediate Care – Halfway Home: Updated guidance for the NHS and local authorities

Among the local authorities that we spoke to for this research, there was clear recognition of this overlap between health-focused intermediate care and social-care-focused reablement. In several cases, local authorities and primary care trusts (PCTs) were already moving towards a more partnership-based approach to health and social care, with integrated commissioning and delivery, pooled budgets and single management systems in place.

However, the two services are still generally divided along commissioning lines – with intermediate care traditionally commissioned by the PCT and reablement by the local authority adult social care department. This distinction is not rigidly applied, as local authorities also tend to apply the guidance set

out in the Community Care (Delayed Discharges) Act 2003 on charging for intermediate care, which states that intermediate care must be provided free of charge for the first six weeks. For charging purposes, therefore, intermediate care and reablement are often used interchangeably.

The reablement process, from commissioning through to delivery, is examined in further detail below, but first we will explore the background and origins of reablement.

A history of reablement

The previous Labour Government first introduced reablement in response to a bed-blocking crisis in the early 2000s. 'Bed-blocking', or delayed discharge, occurs when a person is medically fit to be discharged from hospital, but appropriate community support is not available, so the person remains in hospital longer than necessary. Under the NHS Executive's Patient's Charter, the NHS is committed to consider any ongoing health or social care needs, and put a support plan in place before discharging a patient from hospital. Patients cannot be discharged until arrangements for appropriate after-care are in place.

Delayed discharges not only create unnecessary stress for patients who are waiting to be allowed home (and their friends and families) but also put pressure on the health system by increasing costs to the NHS – the cost of providing a hospital bed is approximately £260 a day on average – and increasing waiting times for people with more urgent needs.

In 2000, a National Audit Office (NAO) report showed that delayed discharge resulted in 2.2 million days of delays each year.[7] The introduction of reablement services led to falling rates of bed-blocking between 2003 and 2009 before figures began to rise again more recently. This rise has been variously attributed to cuts to local authority budgets for elderly care, closure of care homes and an ageing population.[8] The most recent figures show that there were more than 71,000 days of delays in England in March 2012, an increase of 7.5 per cent in the same month in 2011, which cost £18.5 million. Overall, lost bed days had increased by 10 per cent over the previous 12 months.[9]

The implementation of Labour's *NHS Plan* in 2000 made significant advances around hospital discharge support, including the introduction of intermediate care services.[10] These were aimed at people leaving hospital, giving them the option to recover and regain independence at home, thus speeding up hospital discharge. The new services also helped older people to remain in their own homes for longer, rather than being admitted to long-term residential care.

The NHS Plan announced £900 million of NHS investment in intermediate care between 2000 and 2004. The new range of intermediate care services covered rapid response teams, rehabilitation units in hospitals, specialist accommodation for recuperation, telecare and integrated home care teams – including reablement. Particular emphasis was placed on integrated working between community health and social care teams. The Health Act 1999 set the precedent for this by enabling local authorities and the NHS to work together through pooled budgets, lead commissioning and integrated delivery of services. *The NHS Plan* built on this by making it a requirement for all local authority areas to implement joint working in this way. Through the National Performance Fund, £50 million was made available to reward improved performance as a result of greater social services joint working arrangements, rising to £100 million in 2003. In addition to intermediate care, the 2000 *NHS Plan* also established care trusts, which have the power to commission and deliver both primary and community healthcare and social care.

In the 12 years since reablement was first introduced as part of intermediate care services, it has been widely implemented. The most recent update of the *Homecare Reablement CSSR Scheme Directory* in April 2012, showed that of the 152 councils with social care responsibilities surveyed, 106 (70 per cent) had a reablement service in place, while 30 councils (20 per cent) were in the process of establishing one.[11]

Since the new Coalition Government came to power in 2010, reablement – and joined-up working between health and social care more generally – has been high on the government agenda, playing an important role in various strands of

government thinking. However, wider reforms to the health and social care systems – and ongoing deficit reduction measures – are also presenting serious challenges to the current reablement model.

The shifting landscape – new government policy

The Coalition Government has embarked on an ambitious reform agenda across many public services and the welfare state. Nowhere was this more apparent than in the Health and Social Care Act, which received Royal Assent in March 2012. The controversial act, introducing a raft of changes to the local structures commissioning health services, shifting public health responsibility to local authorities and opening the delivery of health services to a wider range of providers, has created considerable upheaval and structural change at local level, which is likely to continue for the foreseeable future.

Alongside this, the government has committed to a Draft Social Care Bill for the 2012/13 parliamentary period, as well as an imminent white paper on social care. But all of these changes must be understood against a backdrop of radical reform to the welfare system, and large-scale cuts to public spending – both of which will impact on the ability of the health and social care systems to support the government's agenda for health and care reform. Local authorities have been receiving an average of 7.1 per cent less funding from central government since 2010, so they have fewer resources to spend on community and social care services for disabled adults and children, and older people. Demos research found that local authorities were coping with these straightened times in different ways, from raising user charges, to restricting eligibility, to closing services outright.[12]

Rising demand and cuts to traditional state funding for social care are resulting in escalating levels of unmet need. Research for Age UK suggests that of the 2 million older people with care needs in England, around 800,000 receive no formal support, and current government austerity measures could push this figure above 1 million by 2020.[13]

Grants to third sector organisations have been also radically cut back in most local authorities – for example there has been a 17.5 per cent cut in Liverpool. It is estimated that children's charities across the country are set to lose £405 million in funding over the next five years,[14] and that 2,000 charities will be forced to close.[15]

Such cuts are prompting questions about the ability of local authorities in particular to deliver the government's vision for health and care reform – the debate on personalisation in health and care is becoming more polarised as some argue personalisation is unachievable in the face of a funding crisis in social care, with others claiming personalisation is becoming a cost cutting tool in and of itself.

Yet in spite of this, reablement is one area where the government is not cutting back. While the previous Labour Government committed to providing an extra £70 million for reablement services, the Coalition Government not only honoured this commitment, but added a further £162 million from Department of Health efficiency savings.[16] In the October 2010 Spending Review, the Government also announced an additional £2 billion of funding for social care by 2014/15, with £1 billion of this coming through the Personal Social Services Grant to local authorities (rolled into Formula Grant), and another £1 billion through the NHS. The NHS funding will be used to fund social care services commissioned through the NHS, including reablement services.[17]

This funding is accompanied by a change in the way reablement is to be commissioned – responsibility for this will shift to acute trusts in 2012/13. As we explain in the next section, this may be a source of disruption and an increased focus on reablement being used to prevent hospital readmission rather than to promote independence, potentially excluding some groups who would benefit from reablement services.

Where does social housing fit in?

Within this debate on the cuts to social care, structural reform of health services, and new funding for reablement focusing on the integration of the two, it is easy to overlook the role housing plays in this context. Yet the fact remains that housing is fundamental to the Government's health and care vision, as it plays such a large part in promoting people's health outcomes. It is recognised that the suitability of a person's home is fundamental to their ability to live independently and delay or wholly remove the need for domiciliary and residential care. There have therefore been more attempts to include housing within the integration debate. More often, people are talking about 'health, care and housing' when describing the integration of services to promote wellbeing, particularly of older people. This is in part being spurred by the imminent nationwide creation of health and wellbeing boards, which will draw their membership from the NHS, public health, social care and elected representatives. They will be responsible for drawing up joint strategic needs assessments and joint health and wellbeing strategies. In December 2011 the National Housing Federation issued a statement asserting that housing has 'an important role' to play within health and wellbeing boards, and reporting that it had written to all early implementing boards in the south east to ensure that housing would be included in the discussions.[18]

While housing in general is very important, the particular role of social housing providers cannot be underestimated. Today, there are over 2,000 registered social housing providers, making them the main providers of affordable and social housing in the UK. Housing associations provide 2.5 million homes for 5 million people. While anyone can put themselves on the waiting list for social housing, the law states that in order for a provider to attain registered provider status, certain groups of people must be given 'reasonable preference', including those who:

- are homeless or about to lose their home
- live in very poor conditions
- have medical conditions that are made worse by where they live
- have been injured while serving in the armed forces

- need to live in a certain area to avoid hardship
- are at risk of violence or threats

Recent Demos research concluded that, given the range of groups for whom social housing landlords provide affordable homes, the current economic downturn meant they were at the coal-face of tackling the rise in a range of social problems from unemployment and family breakdown to mental health and substance abuse.[19]

However, social housing providers are not just seeing demand for affordable and supported housing thanks to the negative effects of the economic downturn. In response to growing demands from older and disabled people to be cared for at home, and an ideological shift from institutional to community care, the number of residential care services fell by 10 per cent, while the number of domiciliary care services increased by a third, between 2004 and 2010. For those who do not own their own home or who may be settling into a new home for the first time, social housing has become an increasingly important player in making this shift possible, by integrating care and support with a person's own affordable independent accommodation. The Centre for Disability Research estimates that 10 per cent of those with learning disabilities receive Supporting People funding to live independently in their community,[20] while 21 per cent of people aged 65 or over live in social rented housing, and this increases to 24 per cent of people aged 75 or over. *Digital by Default 2012*, a report by Housing Technology and Race Online 2012, found that 31 per cent of social housing tenants were retired.[21]

Social housing providers, therefore, have a direct interest in the provision of health and care services, given such a large proportion of social tenants rely on these services or are at a greater risk of needing them in the future. In many cases, social landlords have expanded their remit to offer an ever broader range of support services to meet the problems faced by their tenants. The Health Committee of the National Housing Federation states that around half of their members provide care and support services to their tenants in addition to affordable

housing. These services range from very intensive personal care services delivered in specialist settings to more general services such as training and help with finding a job, schemes to combat social isolation, and support for people with drug and alcohol problems.[22]

Box 1 **Midland Heart**

Midland Heart is a large social housing and care provider, whose strap-line – 'housing, care and more' – reflects their wider remit to provide more than just 'bricks and mortar'. They own and manage over 32,000 homes across 54 local authorities providing a range of services to over 70,000 customers each year. As an example, activity and functions provided by Midland Heart include:

- *7,500 specialist care and support units for older people, individuals who are homeless or at risk of becoming homeless, people with learning disabilities and those who require mental health services*
- *in addition to providing specialist accommodation, delivering over 1.5 million hours annually of care and support to help customers live more independent lives*
- *floating support and domiciliary care services to over 500 customers at any one time who are living in their own home*
- *an in-house handyperson service, wellbeing service and other additional services such as 'Magic Moments', which uses social activity as a method of customer engagement*
- *over 21,500 general needs rented properties, including a specialist division for regeneration and community engagement*
- *a worklessness division dedicated to improving skills, creating employment and enterprise opportunities*

Source: Midland Heart

There are also several examples of 'reablement-like' services on offer. As we explain above, reablement has blurred

boundaries with other intermediate care, rehabilitation and 'step down' services, to name a few. Where social housing providers also provide types of support services, many fall into the broad reablement category, particularly where social tenants are discharged from hospital. We provide more detail on how social housing providers are playing a role in the reablement agenda in chapter 3. Suffice to say, as health and care increasingly work together in areas like reablement, facilitated by new local health structures, social housing providers could play a larger role for the significant percentage of their tenants who are older or disabled.

2 A closer look at the reablement process

As we described above, all reablement services have two defining features – they are time-limited to approximately six weeks, and share a reablement ethos of showing a person how to do things for themselves, rather than doing it for them. However, as reablement is commissioned locally, local authorities and PCTs have considerable flexibility over the precise service model that they use. And as reablement is a relatively new invention, introduced by the Labour Government in the early 2000s, uptake and implementation remain variable across different local authorities. When the directory of reablement schemes was last updated in April 2012, of the 152 councils with social services responsibilities (CSSRs) surveyed:

- 92 (61 per cent) had a reablement scheme in place, but were seeking to extend, expand or amend this scheme
- 30 (20 per cent) were in the process of establishing a service
- 12 (8 per cent) had no scheme in place, but were looking to develop one
- 14 (9 per cent) had a reablement scheme in place, with no plans to extend, expand or amend this scheme[23]

Compared with the previous update in November 2011, more councils had a scheme in place, with significantly more planning to expand their existing schemes.

In addition to reablement services being at different stages of service development in different areas, there is no single established model for the delivery of reablement services. Some areas focus primarily on supporting people following discharge from hospital, while others have extended the role of reablement to offer an intake and assessment service for ongoing social care

needs. Some operate a selective and others a de-selective service; fair access to care services (FACS) criteria are applied differentially; some services are commissioned and funded through local authority adult social care departments.

Of the local areas where we carried out interviews for this project, one commissioned reablement jointly through adult social care and local PCT and delivered services through a newly formed community interest company (CIC); another commissioned services through adult social care and outsourced service provision to a private sector provider, with some smaller third sector providers.

In light of the variation between individual reablement services, there is also considerable confusion around what exactly reablement is, and what it is not. This poses a particular problem for national or regional providers who work across multiple local authority areas with different reablement models. However, as we outline below, the majority of reablement services are currently provided in-house by local authorities themselves.

How is reablement commissioned?

The responsibility for commissioning reablement services currently lies with local authorities with adult social care responsibilities. In some areas, reablement is funded jointly with the NHS. Of the 152 councils surveyed by the CSED in 2010, 90 had reablement services that were funded solely by the council, while 33 had reablement services that were funded jointly with the health services.[24]

As a social care intervention, some local authorities apply FACS criteria to reablement services, whereby only those with needs above a certain threshold are entitled to free reablement services. However, in the majority of cases, the initial six-week reablement period is free of charge. Local authorities who do not charge for reablement use the definition of intermediate care used in the Community Care (Delayed Discharge) Act 2003, which states:

'Intermediate care' means a qualifying service which consists of a structured programme of care provided for a limited period of time to assist a person to maintain or regain the ability to live in his home.[25]

Local authorities are legally required to provide intermediate care free of charge for the first six weeks. Where reablement is offered free of charge, it is because it falls under the definition of intermediate care.

However, from 2012/13, the responsibility for commissioning and providing reablement will shift from local authorities to acute trusts and clinical commissioning groups (CCGs), to reflect the June 2010 announcement that hospitals would be responsible for their patients for a period of 30 days following their discharge from hospital in order to prevent readmission. If a patient is readmitted to hospital within 30 days, hospitals will face financial penalties, as they will receive no additional funding to cover the costs of additional treatment.[26] This funding will be instead passed to PCTs and eventually CCGs for investment in reablement support.[27] In practice, this means trusts will have to plan carefully for hospital discharge, and ensure suitable post-discharge support is in place that will allow people to continue to recover and regain independence after they return home, reducing – or ideally avoiding – the need for future readmission, either to hospital or long-term residential care. This new duty may significantly increase the demand for reablement services – as national figures suggest that around 25 per cent of emergency readmissions to hospital occur within 28 days of discharge.[28]

As a result of this new arrangement reablement services will enjoy a steady stream of funding for the foreseeable future – something few other services can claim. Nonetheless, Sarah Pickup, the current president of the Association of Directors of Adult Social Services (ADASS), pointed out that these new arrangements could lead to disruption in current reablement provision:

What of councils who currently have staff providing enablement homecare services or who have contracts with the private and voluntary sector to deliver these? If acute trusts choose not to use existing services there will be staff to redeploy or make redundant and contracts to re-negotiate.[29]

Other risks include reablement becoming more focused on those at risk of hospital readmission (where acute trusts' incentives lie), rather than a broader approach to include those who have the best chance at living independently and without ongoing support.

How is reablement provided?

To confuse the picture further, CSED has divided homecare reablement services into two types:

- *hospital discharge support* – provides a six-week package of support following discharge from hospital
- *intake and assessment* – unlike intermediate care, which is an extension of the health services, reablement teams may accept referrals from the community, and in many cases, these account for over 50 per cent of their caseload;[30] as with hospital discharge support, a standard six weeks of support is offered, during which time a person is supported to learn or relearn independent living skills

Community referrals can come from a wide variety of sources – health professionals, such as GPs or community nurses, social workers, neighbours or family members, or self-referrals. In some cases, housing officers and housing support workers refer social housing tenants to reablement services, but this does not appear to be the norm, and several local authorities told us that housing officers never make community referrals.

A representative from one local authority adult social care department whom we spoke to for this project told us that if a referral was made by a health or social care professional, staff tended to trust their judgement, and not perform a separate

assessment of a person's suitability for reablement.[31] In other cases (eg self-referral), reablement teams would perform an initial assessment, after which it may be decided that reablement is inappropriate. This may be because the person has advanced dementia, and would be unable to follow instructions, and set and achieve goals, or because their needs are evidently so complex that a package of ongoing care is inevitable.

Reablement was originally introduced with the intention of offering step-down support from hospital (hospital discharge support), but in most cases, an intake and assessment service is offered alongside this. In the 2012 update of the Homecare Reablement Scheme Directory, 17 per cent of reported services only supported people leaving hospital, while the majority accepted referrals from both hospitals and the community.[32] As we noted above, this may not be the case in the future, as responsibility for commissioning reablement passes to acute trusts and clinical commissioners.

For the purpose of reablement, all older people are considered to be at risk of admission to care homes. Therefore most reablement services are predominantly aimed at elderly people, but are also offered to younger people who have suffered an injury or illness (such as a stroke, or an accident resulting in paralysis) that causes them to lose some of their independence. In 2009, following consultation, reablement provision was broadened to include people with mental health problems, including dementia.

Services are either delivered by in-house social workers who have retained as reablement staff or external providers. According to the most recent CSED figures for 2010, the vast majority of local authorities – 114 – deliver reablement services through in-house teams, while 17 councils have either partly or wholly outsourced their service provision, and a further three use a mix of in-house and outsourced providers.[33] Changes between 2010 and 2012 show that outsourcing of reablement services is on the rise – with 24 councils outsourcing services in a variety of ways in 2012. Two other councils, which currently operate an in-house service, are planning to outsource reablement in the future.[34]

Reablement goals vary between individuals, but generally focus on daily tasks, including mobility, personal care, toileting, cooking and social activities.

Box 2

Roger: case study of a sample reablement pathway

Roger is a 70-year-old widower, living alone in a one-bed flat in a sheltered accommodation scheme. He was admitted to hospital after being knocked down by a motorbike while crossing the road at traffic lights near his home, while he was walking to the shops. He sustained a number of injuries, including a fractured hip, which left him with impaired mobility.

Roger spent around three months in hospital – this was the first time he had been in hospital in the previous 12 months. He was discharged back into supported housing, with a social care reablement package. This lasted for five weeks, with reablement staff attending once a day, and helping with tasks around the home including cooking and dressing. In addition to the reablement care, Roger was provided with a new bed, and handrails were installed in the shower.

Roger was very positive about the way in which the reablement team got him back on his feet, however, after the reablement period ended, Roger suffered a few more falls, including once when walking back from the shops. He also felt that he would benefit from having a wheelchair to help him move around more easily, but did not like to ask for help.

Source: Interview with Midland Heart tenant

What makes a good reablement service?

As we have seen above, the interpretation of what reablement is 'for' varies significantly. As a result, and combined with considerable local discretion on the commissioning and delivery of reablement, there is significant local variation in reablement schemes.

It is perhaps unsurprising, then, that our review of existing reablement evaluations identified considerable variation in the

outcomes achieved by different reablement schemes around the country. In 2007, CSED cited an evaluation carried out in Leicestershire by De Montfort University in which the reablement service achieved the following:

- 58 per cent of the reablement group discontinued the care package they received compared with 5 per cent of the control group.
- 17 per cent decreased the package compared with 13 per cent of the control group.
- 17 per cent maintained the package compared with 71 per cent of the control group.
- 8 per cent increased their package compared with 11 per cent of the control group.[35]

A further review of four reablement teams across four local authorities found that between 53 per cent and 68 per cent left reablement requiring no immediate homecare package, and between 36 per cent and 48 per cent continued to require no homecare package two years after reablement – although there was no control group for these outcomes.[36]

The Social Care Institute for Excellence (SCIE) identified further schemes, including one run by Edinburgh City Council, which showed that up to 62 per cent of reablement users no longer needed a support service (compared with 5 per cent of the control group).[37] Finally, a review in 2011 of nine reablement services in the East Midlands found that between 15 per cent and 48 per cent of those completing a course of reablement did not require a further care package, and between 2 per cent and 19 per cent required the same package of care.[38]

CSED and SCIE both conclude that the variation in reablement intake – including the age and conditions of those being 'reabled' – is likely to be a key causal factor explaining why the outcomes of reablement vary so widely. Nonetheless, this cannot explain the entire difference. Variation in process also plays a part. Although CSED produced a toolkit for reablement in 2010, with advice on training of staff, composition of reablement teams and the forms of reablement that could be

used, there are no hard and fast rules in any of these areas. There is no standardised training and accreditation for reablement staff. Some councils set NVQ level 2 as a minimum standard for care workers delivering reablement, but local authorities often have their own training programmes.[39] There is also no set rule about the composition of reablement teams – some have occupational therapists, physiotherapists and speech therapists on reablement teams; others have them on call to consult on particular cases; other have less formal arrangements. Although most reablement is kept in-house, some local authorities outsource this service to private providers.

Overall, this means the 'what' and 'how' of reablement packages are very variable locally, which – combined with different eligibility criteria – drives the wide range of outcomes achieved. As a briefing by SCIE explains:

No single leading model has yet been identified. Apart from one mention of a manual and some observational data from a recent study, there are very few systematic accounts of what practitioners actually do. The emerging practice messages from the Social Care Institute for Excellence (SCIE) indicate that reablement is rapidly evolving.[40]

In its 2011 guide to developing a business case for reablement, CSED suggested local authorities follow the CSED national best practice targets:

- 50 per cent not needing ongoing support after reablement
- 16 per cent needing a reduced homecare package
- 16 per cent continuing on the same package
- 8 per cent needing an increased package
- 10 per cent exiting the service without completing[41]

It is clear that some schemes are already achieving better outcomes than these, yet the 'magic ingredient' to explain why is elusive. There is also a gap in our knowledge on the longevity of reablement outcomes – SCIE's review of evidence in 2011 suggested that there were sizeable reductions in social care usage in some reablement schemes in Australia up to two years after the

scheme had finished,[42] though comparing this to the UK context would have limited meaning. Moreover, the current outcomes measurement of reablement schemes focuses almost exclusively on changes in subsequent social care usage, rather than healthcare, so whether reablement helps to reduce the potential risk of admission, or readmission, to hospital is overlooked. Only one study has attempted to address this with rigour. It concluded:

There was no significant difference between the reablement and comparison group in the costs of the health services used during the subsequent ten months of the study. When baseline differences were taken into account, there were also no significant differences in the duration of inpatient stays or the total costs of healthcare service use when averaged across the two groups over the full 12 months of the study.[43]

The cost-benefits of reablement

The most comprehensive study of the long-term benefits of reablement was carried out by the Social Policy Research Unit (SPRU) at the University of York and the Personal Social Services Research Unit (PSSRU) at the University of Kent, for the Department of Health. This project compared a group of people receiving homecare reablement with a group receiving conventional homecare for a period of up to one year. The Glendinning study has made an important contribution to understanding of the cost-benefits of reablement, and analyses of reablement schemes have relied heavily on this one study, which – though robust – has not yet been refuted or corroborated by further evidence.[44]

The main findings of this research were that although reablement services lead to better outcomes for those using the service, they do not deliver any significant cost savings, because of their relatively high costs.

Costs can be broken down into three categories:

- the initial cost of the reablement intervention

- costs of subsequent social care use, following the reablement period
- costs of healthcare during and after reablement

Glendinning estimates that the unit cost of a reablement episode is £2,088, with a range of £1,609 to £3,575 across the five study sites used. Reablement is more expensive than conventional homecare of the same duration – the mean hourly costs are £20 for reablement and £40 for contact time for reablement, compared with £18 for standard homecare and £22 for contact time for standard homecare.[45]

The average unit costs of social care (excluding reablement costs) for the reablement versus the control group over the course of the 12 months of the study were £1,130 and £2,850 respectively – 60 per cent lower for reablement users than non-reablement users. However, once the cost of reablement is taken into account, the mean cost of social care services used by the reablement group was only £380 lower than the mean cost of social care services used by the comparison group.

Healthcare costs for the two groups were higher for the reablement group in the first eight weeks of the study – £1,600 compared with £1,095 for the control group, because of the number of reablement users who had been referred to reablement following discharge from hospital. However, for the remaining ten months of the study, there was no significant difference in costs – £3,455 for the reablement group, compared to £3,235 for the control group.

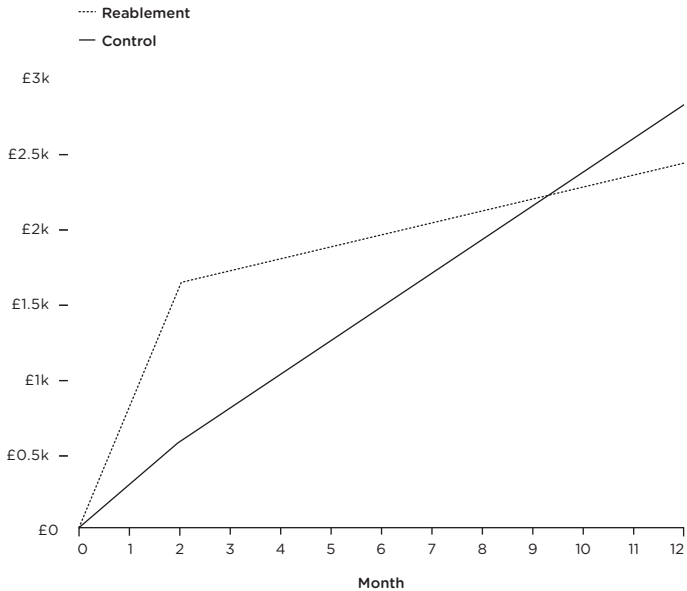
These costs are displayed in figures 2–4.

Glendinning concludes:

Taking total healthcare, social care and re-ablement costs together, there was no statistically significant difference in the costs of all the services used by the re-ablement and comparison group over the 12-month study period [see figure 4].

Though not necessarily *cost saving*, there is evidence that reablement is *cost-effective* at delivering improvements in both health and social care-related quality of life outcomes. When

Figure 2 **Social care costs over the 12-month study period (including reablement costs)**

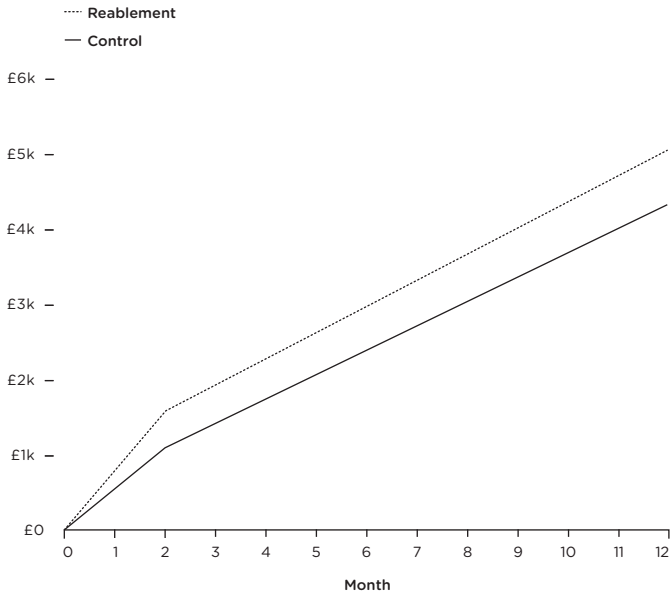


Source: Demos analysis of Glendinning data

asked a range of questions about their physical health and wellbeing (using the EQ-5D standardised measure of health outcomes), before and after the 12-month study period, the group who had received reablement reported a general increase in positive outcomes – particularly in ability to self-care and perform 'usual activities' without problems, and on self-reported general health. On the first two measures, the control group also reported improved outcomes, but to a lesser extent, and there was no change in self-reported health.

When 'willingness to pay' was assessed for these improved quality of life outcomes, using as the threshold £30,000 for each unit increase in quality of life (the standard measure used by SCIE), reablement was found to be 99–100 per cent cost-effective (depending on whether social care costs alone or health

Figure 3 **Health costs over the 12-month study period**

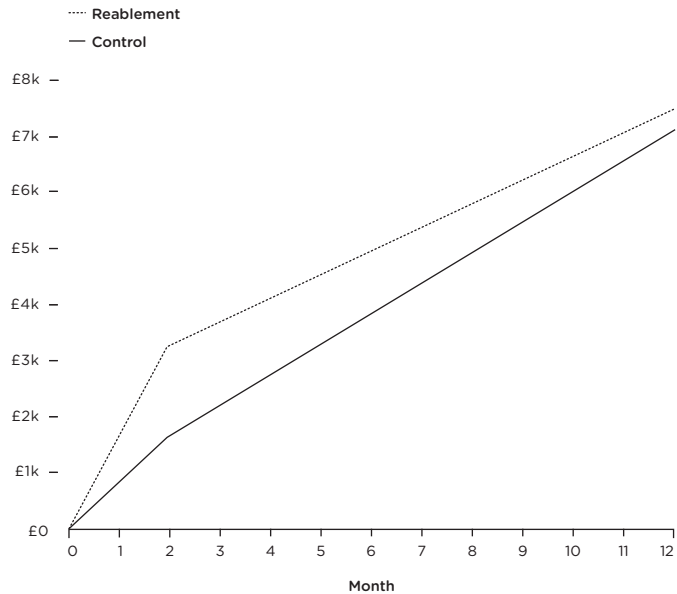


Source: Demos analysis of Glendinning data

and social care costs are taken into account) at improving health related quality of life, and 78–98 per cent cost-effective at improving social care related quality of life.

Reablement users had significantly lower costs associated with ongoing social care – 60 per cent lower than the comparison group – but significantly higher healthcare costs during the first eight weeks of the study. This can be explained by the fact that more people in the reablement group had been referred to services following hospital discharge, rather than from the community, and so they had recently experienced an acute health crisis. After the initial eight weeks, healthcare costs over the next ten months were broadly similar for the two groups.

Figure 4 **Total costs, including health and social care, over the 12-month study period**



Source: Demos analysis of Glendinning data

The Glendinning study concludes that taking social care, healthcare and reablement costs together across a 12-month period, there were no significant cost savings in the reablement group. The benefits of reablement therefore did not lie in its ability to generate cost savings, but its ability to improve quality of life, using both health and social care indicators.

One possible reason for the lack of cost reduction in healthcare is the failure of reablement to reduce subsequent hospital readmissions. Bury Borough Council analysed its data on inappropriate hospital admissions and delayed discharges, in order to project the patients most susceptible to inappropriate admission and delayed discharge where reablement would be

most beneficial. Bury predicted that only a 5 per cent decrease in inappropriate admissions for these target groups was possible, including in this projection quicker discharge – with a projected associated cost saving of £761,184. In total (including reductions in demand for short-stay community care, home care and residential care), savings to Bury NHS were calculated at £869,544, while savings to adult social care (excluding the costs associated with providing reablement) were calculated at £1,522,493 – almost double the health savings.[46] This is in line with the Glendinning study's findings.

Weaknesses of current reablement

The Glendinning evaluation potentially highlights a key weakness of the way that reablement is currently configured – it is unable to deliver significant cost savings in healthcare.

In addition, commissioners, providers and recipients of reablement services interviewed throughout the course of this research highlighted a range of areas where the effectiveness of reablement was being limited. These are inextricably linked to cost savings in healthcare, as improving the level of support received – both during and following a period of reablement – could be expected to keep people out of hospital for longer by laying the foundations for more sustainable reablement outcomes.

Though the overwhelming majority of client feedback is positive, there are some recurring complaints about reablement from people who have used the service. These include the lack of handover at the end of the reablement period, resulting in a 'cliff-edge' of care, and more generally that people did not receive assistance with the things they would have most liked help with.

A focus on the home

Our research suggests that one of the key limitations of reablement is that it is too narrowly applied. In 2007, the CSED team in the Department of Heath spoke to four local authorities

and concluded that access to, and information about, wider social and community support was an important factor, which influenced whether the benefits of reablement was sustained over the longer term.[47] SPRU's 2011 paper led by Glendinning, which built on this longitudinal study, came to similar conclusions, stating:

Some users would have liked more help with improving their mobility and social activities outside the home… To some extent, these limitations reflect the location of reablement services in local authority home care services and the increasing focus of these services over the past two decades on the intensive provision of personal care, rather support with instrumental activities of daily living such as preparing meals or getting about the house. This study suggests that such limitations may not be entirely compatible with service users' priorities and desired outcomes.[48]

Our own primary research corroborates these findings. The clinical commissioners we consulted during this project suggested this was still a problem with the current reablement service offer. These views, in turn, echoed the views of some of the housing providers we spoke to, one of whom said:

The focus seems to be on people's personal care needs rather than their other needs. People are likely to stay well for longer if they can rejoin the community in some way, rather just being made to manage in their home.[49]

This, in turn, was also emphasised by older social housing tenants we interviewed who had experienced reablement support – many commented that they would have liked and benefited from help to get out and about, rather than just focusing on tasks around the home. For example, Roger, the older man whose reablement experience we describe in chapter 2, told us that the reablement team had been helpful in assisting him with dressing, cooking and other tasks in the home, but he would have liked the staff to have helped him get back out and about. He reported he had already fallen over a few times since the reablement team had left, in one instance when he was carrying his shopping home.[50] An older woman we spoke to also reported

she had had reablement support twice following two stays in hospital, but said she did not go out much anymore, as she lacked confidence, and she had given up her painting classes as she was unable to get there.[51]

The cliff-edge of support

Transitions between different services within the health and social care system are a constant target for criticism, and one that reablement suffers from especially, as it is a time-limited service, so service users pass through much more quickly than other health and social care services. Another challenge facing reablement is the fact that its user base is likely to be older or disabled, and accessing a wide range of services from across health and social care (community nurses, GPs, domiciliary care, social care and so on), which require coordination. Existing research looking at reablement service users experience identifies several problems associated particularly with the end of reablement care.

The SPRU and PSSRU study led by Glendinning interviewed 34 reablement service users and five informal carers for people who had received reablement, and reported that the majority of users were sad when their reablement period finished, because they lost a vital source of emotional support. The same views came through very strongly in our own interviews, with people stressing the enormous value of the companionship and reassurance that they gained from reablement staff immediately following hospital discharge, as much, if not more, than the practical assistance with daily tasks. One service user said that it was comforting to know that somebody was looking out for her, and another said that she could not have coped with coming home from hospital without the reassurance that the reablement team provided.

The explicit intention of reablement is to restore independence, and avoid dependency, but this psychological element may increase emotional dependence, even as physical independence returns. The sudden withdrawal of emotional support and social contact after six weeks – particularly for

isolated, older individuals – could be distressing and trigger a reversal in progress made during reablement. As a result, people who are not eligible for ongoing care face an abrupt 'cliff-edge' of support, which can be extremely disruptive. As Caroline Hawkings from the National Housing Federation told us: 'It might be that things aren't coordinated, or it might be that people need ongoing support, but there's an artificial cut-off after six weeks.'[52]

Neil Tryner at Midland Heart also acknowledged that just getting people back into their homes is not sufficient to have effectively 'reabled' them:

There's almost a 'quick fix' of getting you home, but then there's a longer-term piece of work – how do we keep you at home? So it's almost a two-phase return home.[53]

Approximately 40 per cent of people leaving a reablement service require some form of ongoing support, delivered either in-house or by an independent domiciliary care provider. In these cases, their care will revert to the more traditional 'hands on' model, where carers perform tasks for the user. Though clearly this is appropriate in many cases, it may serve to undermine the resilience fostered during reablement, unless the client is encouraged to do things for themselves – in the spirit of reablement – wherever possible.

Lack of personalisation

We described above how service users would have liked more support outside the home, which reablement is not currently good at offering – this is an example of a broader lack of personalisation in reablement. Though the initial reablement assessment and setting of reablement goals is carried out in collaboration with the service user, it seems that there are still some key things that those being 'reabled' have little or no control over.

Service users interviewed by Glendinning's research team complained that they did not receive sufficient help with

domestic tasks at the beginning of their reablement period.[54] This possibly arises from confusion around the distinction between reablement and standard domiciliary care, especially among people who had experience of both services – one of the tenants we interviewed referred to her reablement workers as 'nurses' although they were not health workers. This confusion results in different expectations of the service being delivered.

In our interviews some tenants told us that reablement workers disrupted their daily routine. One woman commented that though the reablement teams had been helpful, she was relieved when they left, because it allowed her to 'do things for myself' again, and in her own time. Several people commented that the timing of visits did not suit them – reablement workers were arriving too early, and clients were intentionally getting themselves up before the reablement staff arrived, so that they were 'ready' for them.

This type of inflexible working style reflects criticisms that have in the past been levelled against traditional homecare, and suggests that reablement is some way behind mainstream social care in advancing the Government's personalisation agenda.

Limited health cost reductions

As Glendinning concluded, reablement intervention did not reduce the overall health costs of the reablement group, compared to the control group – although health costs were higher for the reablement group because a high proportion of this group had been discharged from hospital, rates of hospital readmission were roughly similar between the two groups. This is perhaps the most fundamental weakness of the current reablement service configuration – that reablement is not achieving one of the basic aims of the service: keeping people out of hospital for longer. The cost implications of this are a fundamental concern in the current economic climate. As Jo Webber, Deputy Director of Policy at the NHS Confederation, argues:

In the financial situation that we're in at the moment, if we don't get reablement right then it has a knock-on impact on people ending up in the wrong part of the system.[55]

At this early stage in gathering evidence it is impossible to say whether the weaknesses identified above are contributing to the failure to reduce hospital readmission rates, but it seems likely that providing people with more assistance outside their homes and in fostering social networks, maintaining the reablement 'ethos' after the reablement period has ended, and allowing people more choice over the care they receive will help build much stronger resilience. In at least one case from our customer interviews, gaps in reablement provision (a lack of support outside the home) appear to have resulted in further falls and hospitalisation.

However, to be able to state definitively which factors are contributing to the lack of hospital avoidance – and how this can be improved in the future – there is a need for much more extensive evidence of best practice, including cost-benefit work by individual reablement services. A gap in existing cost-benefit work is that it tends to focus on social care, where cost savings from reablement are considerable. Any future evidence should account for cost reductions (or lack thereof) in health.

Could social housing be the answer?

There are many ways in which these weaknesses might be addressed – reablement training might be standardised to include a greater focus on resilience building and engaging people with community supports, for example. Planning guidance could be issued to ensure reablement teams plan for the transition period after they have withdrawn to ensure their clients do not slip back in the progress they have made.

However, reablement teams do not operate in a vacuum. Addressing these issues purely through internally focused reform is unlikely to be as swift and effective as if the strengths of other stakeholders were leveraged to assist reablement achieve more

ambitious outcomes. Social housing providers, acting as landlords and providers of support for large proportions of those most likely to need reablement, seem a natural partner. As one health commissioner reasoned:

In terms of supported housing, where the landlord and the support provider are often the same... you can therefore assume that housing is actually playing a really important key part in helping people to make that shift from hospital into the community, and they [housing] will work with care provision or reablement services to make that happen.[56]

Recent Demos research looked at how social housing providers could support wider health and social care outcomes, by offering more early intervention and targeted prevention for their tenants.[57] We found that there are a growing number of examples of social housing providers moving beyond the traditional 'bricks and mortar' landlord functions to take a more active role in supporting their tenants to fulfil their social mission. These interventions are often preventative in nature, as housing providers have a pre-existing link with a tenant population who are, by dint of being eligible for social housing, vulnerable in some way.

In 2008 the National Housing Federation ran a neighbourhood audit of the services and facilities being offered by its member housing associations. In addition to care and support services, these included over 6,800 projects and hundreds of community facilities, covering a range of areas – employment and enterprise, education and skills, wellbeing, poverty and social exclusion, community safety and cohesion and the environment.[58] As we describe above, some of these services fall within the broader definition of 'reablement', in that they help older or disabled people settle back home after a hospital stay or prevent hospitalisation when their health deteriorates. Their activities in this field are no doubt prompted by the fact that social housing providers accommodate a significant proportion of the elderly and disabled population, as well as those with generally poorer health and perhaps more vulnerable to accidents and sudden deteriorations in health.

The concentration of potential reablement users in the social housing population is a good enough reason to explore, at the very least, the added value social housing providers might potentially bring to current reablement provision. But as this economic climate rightly prompts every commissioner to investigate ways of getting more for less, and as reablement commissioning is at a critical juncture in moving from local authority to health trust responsibility, it would seem a perfect opportunity for a closer consideration of how the existing skills and reach of social housing providers might add value to, and potentially improve the efficiency of, the current reablement system. The remainder of this report attempts to begin this process.

3 Social housing and reablement

Addressing the weaknesses of reablement

In the previous chapters we explored the benefits and shortcomings of reablement. Our review of existing evaluations suggests that cost savings of reablement to social care are substantial, but more equivocal for longer term reductions in health costs, while our interviews with reablement practitioners, commissioners and those experiencing reablement points to a narrow interpretation of reablement, which might limit its positive impacts.

Within the remit of this project, we cannot be certain that there is a causal link between the shortcomings of reablement we identified and its limited impact on health outcomes. However, it is certainly possible that the current configuration of many reablement services – which do not necessarily build resilience by re-engaging people with their communities and social networks, and boosting self-confidence outside the home – may be a contributing factor to the limited impact reablement has on longer term risks of hospital readmission. It is also clear that some are achieving more significant reductions in the need for ongoing social care than others, suggesting there are variations in delivery that have yet to be fully explained.

With this in mind, we will explore some of the potential solutions to the weaknesses we have identified in the previous chapter, which we hope will sustain the positive benefits of reablement over a longer period. This focuses on building the resilience and wider support networks of those needing reablement, so they are better prepared for the period after reablement is no longer provided. It also focuses on accessing the appropriate equipment and adaptations quickly, and maintaining some continuity of a 'reablement ethos' within any

support that follows on after the formal reablement intervention has ceased.

As we mention above, there are many ways in which these objectives might be achieved, some requiring little or no structural change and little or no cost. For example, existing reablement teams might simply be trained to include a more holistic understanding of reablement, which includes helping people re-engage with their friends and neighbours and carry on with their pursuits and interests.

However, it is clear that social housing providers (particularly housing with care providers) could be valuable partners to and indeed deliverers of reablement. It is worth repeating that 21 per cent of people over 65 and 24 per cent of people aged 75 or over live in social housing – so a key reablement client group are social housing tenants. Housing providers' access to and ongoing relationships with such groups could give reablement schemes greater impact within the older population. But more importantly, achieving a more holistic and sustainable form of reablement and maintaining ongoing 'light touch' support to reinforce the good work achieved by reablement teams could be far easier if housing providers were involved, as it would build on their areas of expertise and important trust relationships, which thus far remain under-exploited. A range of other benefits might also ensue.

Several of the experts we spoke to during the course of this project agreed that it was a good idea to give social housing providers a bigger role – as partners in or providers of reablement – but few knew of many examples of this happening currently. In the following section we explore in more detail how social housing providers might add value to and extend the impact of current reablement provision.

The role of social housing in reablement – potential opportunities and benefits

It's a human need that we feel safe and secure in our housing environment so it makes sense that it is part of the reablement process.[59]

A more holistic approach to reablement

As outlined above, in our interviews providers, commissioners and older people who had received reablement services all raised the same issue: current reablement services often have a narrow focus on 'within the home' capabilities rather than a wider focus on living independently, including engaging in community life. It is likely that this narrow interpretation undermines the sustainability of the benefits of such schemes, as it does little to ensure a person can get out and about, re-engage with their social networks and pursue their hobbies. Such aspects of life are vital to a wider sense of wellbeing, and moreover are linked to improved mental and physical health. As many reablement packages are required when an older person has had a stay in hospital – often following a fall – assistance to be able to tackle the more challenging terrain beyond one's front door is clearly vital if that person is to have a reduced risk of hospital readmission. Our case study of Roger in chapter 2 illustrates this very well. He was hospitalised after being knocked down by a motobike, was reabled and given equipment to carry out functions in his home, but has fallen since his reablement finished, while on his way back from the shops.

Many of the local authority commissioners we spoke to were already thinking about the wider application of reablement, and some recognised the importance of housing providers as partners in this shift. Dudley Council, for example, plans to link reablement services to its strategy for community capacity building. A representative told us:

It's about reablement that isn't about the short-term package of care and support but about the culture within communities… the whole issue of community capacity building is something we're trying to address – whether you call that reablement or not.[60]

This could be a clear opportunity for housing providers, some of whom suggested to us that they would like to be involved with reablement provision but its current narrow focus limited the opportunities for this to happen. Social housing providers could, in fact, be a valuable partner in helping to widen the remit of reablement to consider aspects of people's lives beyond their front door, including re-engaging with one's neighbours, community groups, hobbies and leisure pursuits.

Recent Demos research explored the opportunities for social housing providers to help foster community links and peer support networks, and found many instances of good practice and enthusiasm for these community-focused, resilience building activities.[61] It also found an outlook and ethos among housing officers and support workers, which promoted a more holistic approach to providing support, with these staff often acting as a bridge between health and care, and non-statutory community supports and the voluntary sector.[62] As one housing provider told us:

Our primary role is working with the whole person and looking at helping somebody find a place in the wider community, be socially engaged and meaningfully occupied as well as domestically manage and have their personal care needs met.[63]

Another commented:

There aren't really firmly emerged models out there yet, but it seems that reablement and the prevention that will sit alongside reablement are huge areas of opportunity that could serve a real social purpose.[64]

Housing staff would, therefore, be well placed to work alongside reablement teams to connect clients to opportunities in the community to remain active and engaged, and be a valuable 'add on' to the reablement core within the home. Current reablement teams, with a clear personal care focus, may feel they ought to focus on the necessities of daily living (in the home). They may also be less connected locally to community groups, and are unlikely to be familiar with their clients' neighbours and

friends. By drawing on the local knowledge and wider outlook of housing staff, and using the long-standing relationships they have with their tenants, reablement teams could create a valuable addition to their current offer, which is likely to help sustain the benefits of their intervention by reconnecting people to their community-based supports.

However, it is possible that housing with care providers could deliver reablement packages *themselves*. As mentioned in chapter 2, some housing with care providers already deliver services which are very close to reablement packages. It could potentially be a short step to providing full-on reablement packages.

The direct benefit of this would be that the type of reablement offered by housing with care providers would be very different from the packages typically provided by social-care-based teams. As our research suggests, housing with care staff often have a more holistic approach to providing support,[65] and this ethos, combined with their links to the local community (described above), could make for a more rounded reablement package than those currently on offer by staff more used to providing support within personal care boundaries. We weigh up the potential benefits and limitations of housing with care providers moving in to the reablement field in more detail in the next section.

Smoothing the cliff-edge

Another limitation of reablement is the compressed time frame within which reablement takes place. This (often six-week) intervention is designed to achieve a specific outcome, with an ethos of returning people to greater independence in this period. We do not think continuing reablement over a longer period would be effective, or indeed cost-effective for such a resource-intensive approach. Indeed, Sarah Johnson from the reablement training provider Reablement UK felt that some people stayed in a reablement scheme for the full six weeks not necessarily because they needed it, but because there were no appropriate 'next step' options available.[66]

The problem is not that reablement is too short per se, but that its termination is abrupt. The cliff-edge effect between having regular visits and intensive support and then (often) no support whatsoever can be difficult for older people, if not from a practical perspective then from an emotional or psychological one. Older people we spoke to emphasised that the reassurance that someone was there was the element of reablement support they most valued – the loss of confidence following a fall or accident needed building up and reassurance to regain that confidence. While such reassurance is very valuable to older people, there is no reason why it needs to be delivered by someone trained in reablement. Indeed, to make the best use of resources, ongoing reassurance could readily be provided by non-specialist staff or volunteers once the specialist reablement intervention had achieved the practical level of independence required.

Box 3 **Islington and Age UK Community Enablement Service**

Since July 2011, the London Borough of Islington has commissioned Age UK Islington to deliver a community enablement scheme. The scheme is available to people aged 55 and over, to help them manage independently and delay admission to hospital or residential care.

All referrals are screened for suitability, and an assessment of the older person's needs is then carried out in the following areas:

- managing self
- managing home
- confidence
- meeting people and doing things
- safety
- managing money

The service works with the older person to consider where they are (on a scale of 1–5) in each of these areas, and where on the scale they would like to be by the end of the enablement period.

At the same time, the service undertakes case management support, which could include making referrals and signposting to other services (including health and social services, financial advice and benefits checks, cleaning companies, meals on wheels, winter warmth support and so on).

All older people are reviewed at six weeks, six months, one year and two years to see if further intervention is required and to provide support before a crisis occurs.

The cost is £259,000 per year, of which the Housing and Adult Social Care Department funds £163,000 and NHS Islington funds £96,000.

Source: Islington Council [67]

A key objective for reablement teams should be to ensure that when they withdraw, someone else will provide ongoing reassurance and confidence building (which may take longer than six weeks to achieve), reinforce the messages they have been giving, and maintain the good practices introduced by the reablement specialisms. The social housing tenants we spoke to who had experience of reablement referred to family and friends fulfilling this role, but also mentioned scheme managers, housing officers or key workers helping in this regard. One older tenant we spoke to felt her housing officer's support had a more significant impact than the reablement support she received, citing how the support worker had helped her change doctors, collect her benefits and maintain contact with her family.[68]

Box 4 **Maud: case study of a sample reablement pathway**

Maud is 82 and lives in a one-bed flat in general needs rented accommodation. She was admitted to hospital following confirmation of a serious illness. She spent around a month in hospital and received a reablement service for six weeks following discharge. Before this she had never been in hospital, but was receiving (and continues to receive) one hour a week of

housing-related support, delivered by Midland Heart's floating support team.[69] *Given the nature of her illness, Maud did not feel anything could have been done to avoid admittance to hospital, although she said her housing support worker had helped her to attend the GP surgery to get the condition diagnosed.*

Maud received reablement every day for six weeks following discharge from hospital. The reablement team came to help in the mornings, and Maud said she was already up when they arrived; although the reablement assistance was helpful, she found it frustrating that the times for breakfast, lunch and dinner (when reablement teams arrived to help) were not convenient for her, and the period between lunch and dinner was too long. When describing the benefits of reablement, she emphasised the importance of the reassurance it provided as much as the practical assistance. Although she wanted the support to continue for longer than six weeks, she thought it was inflexible and did not help her with as many tasks as she would have liked.

The support that Maud found most useful was the help she received from her support worker, which she was extremely grateful for, and felt had been more important than the reablement support. Before the support worker was involved (which preceded her hospitalisation), Maud was attending a GP several miles away, who had not provided the help she required. This situation had been causing Maud physical and emotional distress – a situation exacerbated on discharge from hospital, when she was required to attend the GP surgery regularly. This distress is unlikely to have been picked up by the reablement assessment process, but her support worker was able to arrange for Maud to be registered with a different GP much closer to home, who Maud felt was much more supportive.

The support worker also helped to ensure that Maud was receiving the correct benefits, such as Attendance Allowance. Again, the impact on Maud's financial circumstances was particularly important when she left hospital. The support worker had been in regular contact with Maud since the

reablement process ended, and has also helped her to keep in contact with family members, who are providing additional support.

Source: interview with Midland Heart customer

It is clear that housing officers and housing support workers could prove invaluable for older people living in social housing (particularly those without family nearby) in easing the transition to independence and providing non-specialist (but nonetheless very important) reassurance after the reablement teams have withdrawn.

Maintaining the reablement ethos

Both CSED's 2007 and SPRU's 2011 longitudinal studies of four reablement schemes identified the existence of a 'reablement ethos' as being a critical factor in maintaining the benefits of reablement and helping people stay out of hospital once the six-week reablement period had ended. SCIE refers to this in the context of social care provision after reablement has finished: 'If [a] long-term care provider cannot deliver support in a 'reabling' way the individual is likely to lose any progress made during reablement.'[70] However, the same could be said for all forms of support. Given than the majority of those finishing reablement do not then need social care support straight away, housing providers, through housing officers and other front-line staff who see tenants regularly (eg repair teams), could be key to delivering a 'reablement ethos' by reinforcing the messages of reablement teams long after they have withdrawn their support. Sarah Johnson from Reablement UK explained:

Whether it be housing, social care, health, it should be reablement focused. Even traditional home care should be reablement focused. There is no point in someone receiving reablement if his or her home care package is not working in a reablement way or in a way to promote someone's self care.[71]

If housing staff were kept informed of reablement objectives, the client's goals, the equipment and advice being left for the client to maintain their independence, and so on, they could reinforce these messages, provide reassurance and encouragement to remain independent, and also help monitor these tenants.

Previous Demos research emphasised the important monitoring role housing staff had, particularly for vulnerable older people, as they are often the only individuals who visit such older people regularly and gain access to their homes.[72] 'Red flags' can be raised for older people who are observed to be neglecting themselves or their homes following a spell of reablement, who might still lack confidence to get out and about, or whose progress made during the six-week reablement period might slip.

Monitoring by housing staff may prove to be vital in sustaining the benefits of reablement over the longer term and perhaps in reducing the risk of readmission to hospital, which reablement interventions seem to be less effective at achieving.

Again, there is no reason why this more sustainable approach to reablement, and the continuation of a reablement ethos, might not be achieved from housing with care providers actually delivering reablement packages themselves rather than simply working with other reablement teams. A more seamless package could be created, for example, if support staff working for a housing with care provider was able to deliver reablement, and hand over the tenants' cases to their colleagues (for example, general needs housing officers) at the end of the six-week period. More effective communication might be achieved between these two teams of staff working within one organisation than would otherwise be the case, and indeed there is an opportunity for non-specialist housing staff to revert to their reablement-trained colleagues for ongoing advice.

Equipment and adaptions

Research suggests that another obstacle to effective reablement is the lack of access to or potential delays in accessing equipment

or adaptions, so reablement teams cannot train a person to use the equipment during their six-week intervention or the person finds they are left waiting for equipment to be installed after the reablement team has left. CSED and SPRU have identified access to equipment, assistive technology and telecare as vital elements of successful reablement, and this was also raised by one of the older people we spoke to during our interviews, who reported that a three-week delay in securing a bathroom seat set her back.

In estimating the impact of occupational therapists in improving the outcomes of reablement, Zaid Latif concluded that outcomes were improved when occupational therapists were involved, and that a key factor in explaining this was that they had a particular awareness of the need for those receiving reablement assistance having access to equipment and adaptions. His review of reablement schemes where occupational therapists intervened found 58 per cent of their interventions were related to equipment, and 15 per cent to adaptions.[73]

Here again, reablement teams working with housing providers could help overcome the difficulties in accessing adaptions and equipment. Involving housing officers early on with the reablement team's objectives could speed the process of securing adaptations to the home, which are often arranged through social landlords. Housing support officers are also likely to be well versed in the range of equipment and telecare available, and could take a proactive role in ensuring reablement teams are aware of the options available to maximise the impact of their activities. Caroline Hawkins from the National Housing Federation told us that the knowledge of social housing providers is 'proving vital in maximising the technology and providing a fast installation – and also they're training reablement assistants that come from health'.

Reablement accommodation

Another way in which housing providers can add value to reablement is by providing 'reablement accommodation'. Several of the commissioners we spoke to during this research described

pilots where reablement teams were working closely with social housing providers or extra care providers to create this facility. Reablement accommodation is specially adapted accommodation provided temporarily for people receiving reablement support. This can act as a stop gap while the person's home is being adapted, and as a form of 'step-down' support to a more custom-built and safe environment before someone moves back into their home. It can also give reablement teams a chance to train older people to use equipment in a relatively safe environment. David Walden explained:

The process of reablement is about getting people back to normal living and re-establishing their confidence and re-establishing their abilities to do normal things… The more natural and normal the setting the better it is… A sheltered housing flat equipped to do that sort of thing is the ideal setting as an intermediate between hospital and going back to your own home.[74]

Box 5 **Breathing Space (Bedford Citizens Housing Association)**

Bedford Citizens Housing Association has delivered Breathing Space since 2004. The scheme offers older people time to prepare for independent living after a stay in hospital and is located within an existing residential care home near to the North Beds Hospital site. Breathing Space offers:

- *en-suite accommodation, care and support for up to five people at any time*
- *space for people to receive visitors*
- *reablement activities, with a staff team on site, focusing on mobility, confidence-building, reducing falls and social interaction*

Referrals to Breathing Space are from the hospital and ways of exploring self-referral using personal budgets are being considered. The scheme is commissioned by Bedford Council social services through a central government grant. Up to 60 people stay in the scheme every year, for an average of four weeks at a cost of £68 per day, resulting in an estimated cost saving of £5,656 per person compared with continued hospital

stays and readmission. The annual scheme costs £140,000 per year of which the housing association contributes £15,000.

Source: 'Bedford Borough Draft Health and Wellbeing Strategy'[75]

Box 6 **Integrating health and social care in Bath & North East Somerset – Sirona CIC**

Sirona CIC was launched in October 2011 as an integrated health and social care service, formerly provided by Bath & North East Somerset Council and NHS Bath & North East Somerset. Staff teams consist of integrated health and social care managers and staff.

The organisation provides a continuum of care, combining intermediate care and reablement into one service, which ranges from acute physiotherapy, occupational therapy, 'step-down' provision and hospital discharge support, to a package of reablement care aimed at preventing an escalation in care needs or a residential placement.

Sirona is also running several year-long pilots in the region: a reablement project, a project to provide specialist reablement flats and a telehealth project.

The reablement project provides professional support, while a domiciliary care agency, Way Ahead Care, provides the reablement services. The two services have a single management system. The aim is to prevent hospital admission and facilitate discharge, and to prevent unnecessary transfer from extra care housing to residential care, or from residential care to nursing care housing.

Somer Community Housing Trust provides specialist reablement flats (including home adaptations, telecare and so on), while Sirona's extra care services offer hospital discharge reablement services. Users make a positive choice to live in these properties for up to ten weeks. They provide a high level of service, furnishing to hotel standards and social activities.

The telehealth project enables people with chronic conditions to live more independently. It provides a specific

monitor connecting to a phone line, alerts the person to answer a number of health questions, and takes measurements, such as blood pressure.

Source: Bath & North East Somerset Older People Network Meeting[76]

The benefits of reablement accommodation are currently limited to a small number of sites and pilots, but could be made more widely available with a larger number of reablement homes if housing providers (of social housing and extra care housing) became more involved in the reablement agenda. There are also potential benefits to housing providers. For example bedsits, which are increasingly difficult to let over the longer term, could be given a new lease of life as reablement flats. This would enable social housing providers to offer reablement facilities without large capital expenditure. However, the high turnover of dedicated reablement accommodation could prove a new challenge to which housing providers would need to adapt.[77]

Earlier referral to reablement

In chapter 2 we described how there were two main forms of reablement referral – hospital referral, where someone is provided with reablement after a spell in hospital and reablement is used to facilitate swifter discharge, and community referral. There are, in turn, two types of community referral – where a person is provided with reablement following a social care assessment, which suggests they may need social care support, and where reablement is provided to people who are judged potentially to benefit from reablement (for example, an older person with deteriorating health or increasingly limited capacity). The study led by Glendinning found that most referrals among the schemes they reviewed came from hospital (75 per cent) and 15 per cent were community referrals.[78] However, in some areas the percentage of community referral is as high as 50 per cent, and some of the local commissioners we

spoke to during the course of this project stated that, as part of their wider preventative approach to care and support, they were seeking to increase the numbers of community referrals.

Findings from the SPRU and PSSRU review of reablement schemes found that people using a reablement service following a community referral had a greater reduction (46 per cent) in the number of social care hours of care they required after the scheme than those referred after a stay in hospital (37 per cent).[79] This is understandable given that hospital referrals trigger reablement support once a person has fallen, or had an accident requiring hospitalisation. In a sense, the damage had already been done both physically and to that person's confidence. But reablement carried out before such accidents took place, when a person might be only be *at risk* of a fall or increased isolation or frailty, is likely to achieve better outcomes.

While hospital referrals will always be an inevitable part of reablement support and cannot be wiped out, social housing providers could be important sources of community referrals to reablement teams, helping commissioners reap greater preventative cost savings.

The frequent contact and often close relationships housing officers and key workers have with social housing tenants means they are well placed to notice changes to a person's physical or emotional health, whether they are struggling with tasks in the home, and so on. If these front-line staff were briefed in reablement techniques and had a grasp of what was on offer, they would be able to identify tenants who might benefit from such interventions and refer them to reablement teams accordingly. As one local commissioner reasoned, 'Housing providers, and housing officers, are [some] of the people who are a lot closer to the individual than we are.'[80]

There is significant local variation in the categories of people eligible for reablement services; in some local authorities people are only eligible for reablement following a hospital admission or a social care assessment. Many authorities do not provide reablement to those for whom rehabilitation is less clear cut – for example those with dementia. However, social housing staff across the country already navigate complex and locally

variable social care eligibility rules and diverse local third sectors, and getting to grips with the vagaries of the reablement offer in their local area is unlikely to pose a significant challenge.

It is worth considering, however, that where access to reablement is more limited, the importance of the 'reablement ethos' mentioned above is no doubt greater. Social housing staff may not be able to refer their tenants on to reablement services in some areas, but having a good grasp of the principles of reablement (eg encouraging people to adapt and learn to regain their independence and build their resilience and confidence) will help these staff deliver their support in an 'reabling' way, which will no doubt benefit an ageing social housing population.

Working together, or direct provision?

In this chapter we have described how reablement teams might harness the reach and skills of social housing providers as partners in reablement. By co-opting their housing and housing support colleagues, reablement teams might be able to:

- adopt a holistic approach to reablement more easily
- offer a more gradual transition to independence after reablement has finished
- secure a valuable partner in reinforcing the 'reablement ethos' over the longer term
- gain swifter access to equipment, adaptations and reablement accommodation
- gain a new source of community referrals and contact with harder to reach older people

With all of this in mind, it would seem obvious that social landlords and their staff are natural partners for reablement teams, whose job it is to assist people to live independently in the home. Having the landlords of those homes on board and fully aware of reablement teams' activities and goals can only serve to improve outcomes.

However, we found very few local commissioners and reablement practitioners we spoke to had given much

consideration to the potential role housing providers could play when social housing tenants were receiving reablement. Social housing providers themselves reported little if any knowledge of reablement being delivered to their tenants, with the exception of those with mental health needs or learning disabilities, where some joint working was taking place. The needs of people with physical disabilities and older people were felt to be more complex, making it more difficult to draw health and care services together and therefore to work as a coherent unit with housing provision.

We were told housing providers were not often informed when tenants went into hospital, so they were unaware of the discharge and post-discharge planning, and communication between social care teams and housing providers was limited at best. A member of a clinical commissioning group told us: 'People do go into hospital and housing providers aren't told – people just disappear.'[81]

This confirms the messages from earlier research carried out by Demos, which found that housing providers felt their support staff's experience and knowledge of their tenants' support needs were not taken seriously by social care teams, and referrals and assessments were sometimes ignored.[82]

We concluded from this earlier research that improved communications and knowledge sharing between social care and social housing providers were vital to reap significant cost benefits through the earlier detection of health and social care needs.[83] Clearly, a similar argument could be made: where reablement is being provided to social tenants, better communication between reablement teams and the social housing support staff on site is likely to achieve a range of benefits, which could improve the impact and sustainability of reablement. This is in the interests of all involved, not least the older person on the receiving end of these services. Caroline Hawkins from the National Housing Federation raised the possibility of there being even closer and earlier partnership between health and housing teams, before reablement even begins:

Certainly [social housing providers] are supporting reablement services, but in some cases it's more than that, it's almost working in partnership and… it's very helpful to be involved at an earlier stage. To look at what housing associations can do when an operation is being planned rather than being contacted when they're ready for discharge.

But an even more ambitious possibility, as we mooted above, is the prospect of more housing with care providers (who already provide floating support services and/or personal care) actually delivering reablement services themselves.

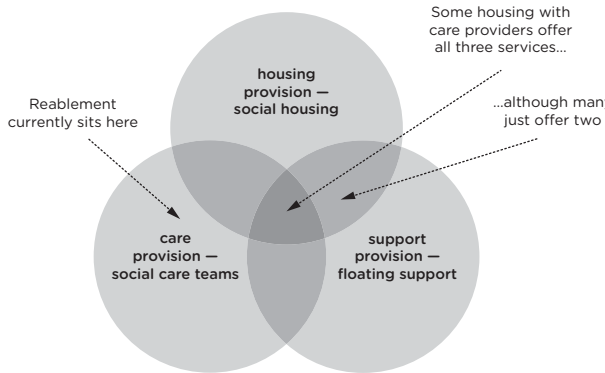
As we explained in chapter 2, reablement services in most areas are delivered 'in house' by local authorities themselves, but some commissioners are planning to move beyond this approach and encourage a larger number of external providers. As commissioning responsibility for reablement shifts this year from local authorities to health trusts, there is a greater possibility of widespread outsourcing of reablement to a more diverse range of providers.

There are potential barriers to such a move. While many of the housing providers we have spoken to through the course of this research would be keen to become more involved with reablement services in some way, not all felt they would be able to have direct involvement with the way reablement was currently (narrowly) configured and that it would need to be broadened to provide them with opportunities to play a meaningful role. One provider told us:

We've been talking to social services about people who are in expensive institutional settings who could be empowered to live much more independently and much more fulfilled lives in the community. That seems to us to be a way we can help reable people.[84]

Some of the commissioners we spoke to also felt housing staff would not be sufficiently trained to provide reablement, and there would be a significant cost implication of achieving this level of expertise. Others did not see the value in duplicating the offer already provided by existing reablement schemes, while other experts suggested that filling voids in tenancies in the

Figure 5 **A Venn diagram showing the three services offered by social housing providers**



current climate was a priority for housing providers, rather than expanding to new service areas.

From this, it is clear that offering reablement services won't be for everyone in the housing sector. But some of this caution no doubt stems from the fact that only around half of all social housing providers offer care and support services,[85] and of this half not all offer personal care (which is where reablement teams currently sit) but rather lower level 'floating support' (figure 5).

Therefore, for at least half of the social housing sector, the prospect of delivering reablement services would not be appropriate or desirable. Staff would be a long way from having the skills necessary to delivery reablement, and considerable investment and cultural change would be required to make this a reality.

However, housing with care providers are potentially much closer to being able to provide reablement. Many already provide services which could be described as reablement in some sense, and even those only providing lower level 'floating support' would require a relatively small jump to move into the reablement field.

There is no reason why reablement must only be located in social services and delivered by domiciliary or personal care teams. Indeed, the SPRU and PSSRU suggested this could in fact be a weakness, leading as it did to the narrow focus on home-based care:

To some extent, these limitations reflect the location of re-ablement services in local authority home care services and the increasing focus of these services over the past two decades on the intensive provision of personal care.[86]

As there is currently no standardised training programme or nationally required accreditation for reablement teams, the delivery of reablement could be open to professionals from a range of health, care and support backgrounds, including housing support.

While it is true that some local authorities set NVQ level 2 in Health and Social Care as an entry qualification for becoming a reabler, having NVQ level 2 and 3 in Health and Social Care is not uncommon as part of the professional development of housing support staff. One housing with care provider told us that they provided financial support for staff to encourage them to take NVQ level 3. Reablement UK, the reablement training provider, also told us that while they had had mainly social care staff taking reablement courses, there had been some representatives from the health and housing sectors. Sarah Johnson explained:

The easiest people to train are the front-line staff because they are open to a more integrated approach. [To succeed in reablement] it's all the other elements that need to be in place.[87]

Therefore, housing with care providers interested in offering reablement could up-skill their staff, many of whom already have the qualifications required by some local authorities to train their in-house staff as reablers. As David Walden from SCIE commented:

There's no reason social support or a housing person couldn't be trained to do that. You have to make sure you're not deskilling the whole thing by not having the appropriate health or social care input when needed. As long as it is done sensibly there could well be a role and it's about widening the locations for reablement and widening the opportunities for reablement.[88]

A lack of an impediment is not the same as a positive invitation to become involved in reablement by commissioners. Recent research by Demos uncovered how housing with care providers are often undervalued, or simply overlooked by health and social care teams, and it is unlikely a housing with care provider will be a health commissioner's first choice when they think of how to deliver reablement, even to social housing providers. Social housing providers wanting to get involved in this service must therefore take the initiative themselves. As Caroline Hawkins of the National Housing Federation told us: 'It's up to housing associations and housing providers to be proactive and try and explain what it is they can do.'[89]

One of the benefits of housing support workers directly delivering reablement, as we explain above, would be that reablers with a housing background might be more attuned to a holistic interpretation of reablement, sensitive to older people's wider social needs and the context of the neighbourhood and local communities in which they live. They may also be able to achieve a more seamless handover to housing officers post-reablement, who can reinforce the benefits of reablement with a 'reablement ethos', and have a more thorough awareness of the possibilities of adaptions and equipment to facilitate reablement goals.

There are potentially wider benefits, however: an increase of providers offering reablement will bring greater capacity and diversity to the market. Stephen Rea, a regional manager for the Department of Health's CSED unit, identified increased capacity in reablement as a key to improved productivity, as it would ensure everyone who might benefit from reablement was able to access it.[90] Increased capacity would also bring with it greater choice. Some of the older people experiencing reablement whom

we spoke to commented on a lack of flexibility in the reablement they received, on the times of visits, the tasks being undertaken, and so on. Having more services to choose from may increase the range of services on offer, and bring in reablement staff with different organisational cultures. This in turn could improve the level of personalisation on offer in the reablement field – an important factor as personal budgets in health and social care are rolled out. Caroline Hawkins from the National Housing Federation agreed with this view:

The big added value of housing is of them knowing a lot about people and their situation, and being able to apply that as their needs change, and being able to respond flexibly and in a personalised way.

Social housing tenants also often have very strong and ongoing relationships with their housing officer or support worker – these tenants, many of whom are older and disabled people and may well require a spell of reablement in the future – are likely to appreciate the option of having reablement services offered by the organisation, and potentially the same staff, with whom they are already familiar.

Would bringing social housing into reablement be more cost effective?

As we outline above, the evidence regarding the cost-benefits of reablement have most thoroughly been explored by Glendinning et al.[91] This research broke down costs into three categories:

- the initial cost of the reablement intervention
- costs of subsequent social care use, following the reablement period
- costs of healthcare during and after reablement

As no evidence exists on the delivery of reablement by social housing providers, it is impossible to establish that this is a more cost-effective method. However, if we consider each of these three cost categories in turn, we can reflect on how the

potential for reduced costs and improved outcomes might be achieved thanks to a greater role of social housing providers.

The initial cost of the reablement intervention

We saw above that the mean cost of reablement per hour is £20, and the mean cost per hour of contact time is £40.[92] This suggests that reablement includes £20 per hour of overheads and additional costs, on top of the direct reablement cost. Social housing providers could help reablement teams reduce this additional cost by, for example, speeding access to equipment or adaptions. However, it is more likely that social housing staff would be able to reduce reablement costs by curtailling the overall number of hours required by reablement teams. This might be achieved by speeding access to equipment, making available a greater range of specialist reablement accommodation (thereby making reablement more effective per hour), and perhaps even by providing non-specialist support alongside reablement teams (for example relating to accessing community activities). This might allow reablement-trained staff to spend less time on non-reablement related activities, which would be a better use of resources.

It is also possible that delivery costs will fall if social housing providers bid for reablement contracts themselves. Reablement might simply be made more effective because of the established relationships and client knowledge housing staff already have, giving them an edge when it comes to reabling these clients. As Caroline Hawkins describes, 'The big added value of housing is of them knowing a lot about people and their situation, and being able to apply that as their needs change, and being able to respond flexibly and in a personalised way.' It is also possible that delivery costs might fall thanks to basic market pressures, as clinical commissioners will have a wider range of providers to choose from when awarding reablement contracts.

Costs of subsequent social care use, following the reablement period

We know current reablement services can reduce the need for post-reablement social care support by up to 60 per cent. However, it is also true that some reablement services do better than others in this regard, with reductions of 50 to 70 per cent. This suggests there is room for improvement in the current reablement offer and that reliance on ongoing support might be reduced further with the right combination of reablement services.

Social housing providers might be able to achieve this combination in a number of ways. For example, if they were able to help reablement clients connect with their neighbours and wider community groups, they might help build social networks proven to be so important in reducing and delaying the need for formal support services, through building personal resilience and reducing loneliness.[93]

From our interviews of social housing tenants who had received reablement, it became clear that reablement is a personal experience – some require practical and physical support, others emotional support, reassurance and confidence building. The detailed knowledge social landlords have of their tenants may enable them to provide a more personalised reablement experience, identifying the most effective way of reabling each individual, and thereby improving outcomes (reducing the need for ongoing care) in the process.

Most importantly, housing staff provide ongoing support and reassurance for tenants who have had a reablement package. If these staff are able to reinforce the messages and good practice of reablement teams after they have withdrawn, and maintain a 'reablement ethos', it is likely that the benefits of reablement will be sustained for longer – thereby reducing the need for support over the longer term.

A final point to note is that if housing providers become more involved in reablement, there is also a greater opportunity for earlier 'community' referrals to reablement services, rather than after hospitalisation. Evidence suggests that people using a reablement service following a community referral (46 per cent) required fewer social care hours after the scheme than those

referred after a stay in hospital (37 per cent).[94] Reablement therefore becomes more efficient (and cost efficient) when provided more preventatively, and social housing providers could help achieve this.

Costs of healthcare during and after reablement

The same drivers that might reduce the need for social care in the months and years following a reablement experience could also reduce the risk of readmission to hospital. Keeping someone engaged with their community means they will be mentally, physically and socially active – proven to help improve health outcomes and thus reduce the risk of reliance on primary health services and hospital readmission.[95] In 1988 Julianne Holt-Lunstad et al found that older people with strong social networks had a 50 per cent greater survival rate and concluded: 'Social relationships, or the relative lack thereof, constitute a major risk factor for health – rivalling the effect of well-established health risk factors such as cigarette smoking, blood pressure, blood lipids, obesity and physical activity.'[96] Maintaining a 'reablement ethos' – reinforcing ways to stay independent and good practice on how to use equipment and remain safe in the home – should also help reduce reliance on health services.

Overall, therefore, it is entirely possible that the greater involvement of social housing providers in reablement services will make them cost effective, by reducing delivery costs and probably improving outcomes and reaping cost savings later on. This is because social landlords represent:

- an alternative form of provision, which can lead to greater choice and competition for commissioners and reablement users, which in turn can drive greater cost efficiency
- a way in which wider community engagement, personalisation and flexibility, and an ongoing reablement ethos can be incorporated into a reablement package – all of which may improve cost efficiencies by reducing the need for health and care services after reablement has ceased

- an opportunity to access more readily a range of equipment and technology as well as specialist reablement accommodation, which can make reablement more effective in achieving positive outcomes

The theory that cost efficiencies might be achieved in this way is as yet untested, as reablement is currently mainly delivered by local authority in-house teams. Nonetheless, the evidence that does exist points to the importance of a wider community focus, access to equipment and an ongoing reablement ethos in improving the outcomes (and therefore cost efficiencies) achieved by reablement teams. And, in turn, evidence suggests social housing providers are likely to be well placed to deliver these elements thanks to their in-depth knowledge of their tenants; experience in building community links and achieving housing-based adaptions; and ongoing presence as older people's social landlords after reablement support ends.

Other reablement teams – be they from social care or health, statutory, commercial or not for profit organisations – might also deliver these additional elements and drive cost efficiencies. Nonetheless, it is certainly an interesting possibility for clinical commissioners, newly tasked with commissioning reablement services in their local area, to look to social housing providers as an alternative source of reablement provision. In so doing, there is an opportunity to leverage the existing relationships and reach that social landlords have with their (generally older) tenant population, and to achieve greater bang for the reablement buck without substantial new investment or the creation of new organisational structures.

4 Recommendations

In the previous chapters we have explored the way in which reablement is being used and some of the weaknesses of the current application. This was followed by a discussion of how closer working with social housing providers could be a valuable way in which some of the limitations of reablement might be overcome.

This focused on the concept of 'sustainable reablement' – embedding the principle of resilience within reablement and ensuring that reablement teams leave their client re-engaged with the wider networks of support. This can enable them to maintain their newly found level of independence and confidence, and act as a source of reassurance, long after members of the reablement team have withdrawn.

Providing such support can be achieved without giving housing and housing with care providers a greater role, but it seems a missed opportunity, particularly for all those older people currently living in such accommodation, that reablement teams are not working with their housing counterparts as a means with which they can sustain their positive outcomes over the longer term, and potentially reduce the risk of readmission to hospital or care later.

But while we suspect that reablement is not fulfilling its potential in reducing ongoing health costs or the risk of hospital readmission, clearly more exploration needs to be done on 'what works' in reablement and what can be achieved. Without this, it is difficult to claim definitively that if housing providers helped render reablement schemes more holistic in their focus and more sustained in their tradition this would reduce the risk of hospital readmission. Nonetheless, based on our review of what evidence does exist, the feedback of older people who have experienced reablement and the local commissioners, providers and other

experts we have interviewed during the course of this research, we believe implementation of the following policy recommendations would not only maximise the impact of reablement, but also demonstrate how the reach and skills of housing providers could be leveraged to achieve more bang for the reablement buck.

Recommendation 1

There needs to be *further evaluation of reablement practice to identify best practice and 'what works'* in achieving the best outcomes, and greatest cost efficiencies, over the longer term. In particular, there needs to be greater scrutiny over current schemes' ability to speed discharge from and reduce readmission to hospital, as this remains an overlooked but critical element of the cost savings reablement might achieve. This will be particularly important as reablement funding becomes linked to health trusts' responsibility for reducing readmissions for 30 days post-discharge.[97]

The Coalition Government has committed to considerable investment in reablement services, based on evidence to suggest this speeds hospital discharge and reduces social care use. But in June 2012 it is very difficult to assess which schemes are doing better than others, and why. A more robust and extensive evidence base would allow local authority commissioners to make more strategic investment in the *type* of reablement that is most effective and get the best outcomes for the resources available. As we move to a system of clinical commissioning and substantially reduced budgets, more evidence-based choices of service are vital.

Recommendation 2

There needs to be a more *coherent and consensual understanding of what reablement entails*. While local discretion and room for innovative interpretation is welcome, reablement services – those delivering and receiving them – would benefit from *greater standardisation* in training, accreditation, team composition and good practice on what reablement should seek to achieve. This

will no doubt be aided by the more robust evidence base recommended above, and could help expand reablement practice (and raise awareness) among a wider range of professionals. It will also ensure people's experience of reablement does not vary significantly by area but that the basic principles and practice are recognisable across local authority borders. CSED's reablement toolkit is a good place to start to create stronger national guidance on 'the how and the what' of reablement, particularly as it includes reference to re-engaging people with community-based activities as an important part of reablement[98] – something we describe in more detail in recommendation 3.

Recommendation 3

As part of this standardisation, there needs to be a wider, *more holistic approach to reablement* embedded as best practice. Such an approach strives to achieve independence in one's community, not just in one's home. This means using reablement to help people maintain or regain their social networks, and reconnect with past activities and hobbies. Housing providers could be key to this wider concept, by working with reablement teams to facilitate people's links with local community and voluntary services, peer support groups, leisure interests and so on.[99]

As reablement is mainly located within personal care teams, a focus on functional ability and a reduction in the need for personal care is understandable. Housing officers and support workers could provide a more community based perspective and supplement this work. This approach may achieve more sustainable results – by prolonging the positive effects of reablement by fostering a support network around an individual and building their resilience after the six-week intervention has ended. It would also be welcomed by those who receive reablement, as there is an unmet demand for this sort of wider support and facilitation as part of reablement services: 'To demonstrate cost savings in the longer term, reablement in itself may need to be more long term and more flexible.'[100]

Recommendation 4

Housing with care providers (extra care and social housing providers with in-house care arms) interested in moving into reablement should *train their staff in reablement and proactively pursue reablement contracts* with clinical commissioners, with a clearly articulated offer based on a more holistic approach and seamless links to equipment and adaptations, and transition support in the form of housing and support staff. The shift of commissioning responsibility for reablement from local authority to health trusts provides an important opportunity for housing providers to demonstrate the added value they might have as reablement providers.

This will improve the capacity and diversity of the reablement sector, and people's choice of reablement offer. More importantly, it will also bring reablement providers into the market that may be more attuned to a holistic idea of reablement, accustomed as they are to linking people to their neighbourhoods and communities, building resilience and seeking non-statutory, community support solutions.

Recommendation 5

Housing with care providers whose care teams start to provide reablement services must ensure they *share this expertise across their organisations*, allowing their general needs housing officers to learn the principles of the '*reablement ethos' to sustain and reinforce the benefits of reablement*, and learn how to recognise when a tenant might benefit from reablement. This would also help more people access the benefits of reablement, even where local authority eligibility criteria means formal reablement packages are not available.

Recommendation 6

In the majority of cases, however, housing with care providers do not provide reablement services directly. Therefore, *when providing services to social housing tenants, existing home care reablement teams must engage with social housing providers*. This

includes ensuring scheme managers or the appropriate staff are present in review and planning meetings, so housing officers and/or housing support officers are kept informed of ongoing support and the objectives being set by reablement teams.

Housing and/or housing support officers can be not only 'extra pairs of eyes' for the reablement team, but also invaluable partners in reinforcing the 'reablement ethos' throughout and after the reablement period. Involving housing providers early on may also achieve speedier and smoother access to adaptations or equipment needed as part of the reablement plan, or generate opportunities for 'reablement accommodation', which can be very valuable for some reablement clients. [Housing providers need] 'recognition and being taken seriously that it may not be a strictly clinical intervention, but is a crucial part of a person's reablement being effective… Some clinical partners understand that more easily than others.'[101]

Recommendation 7

Local structures should also be developed to ensure reablement teams and housing providers have ongoing channels of communication, and not just at the individual case management level. Housing support and housing officers have stronger and ongoing relationships with their tenants, and get into people's homes, far more often than any social worker. They will be a key source of 'community referral' for reablement teams (referral when a person is judged to benefit from reablement but not via a hospital discharge). Those receiving reablement via community referral can achieve larger reductions in subsequent care use as a result of reablement than those referred after hospital discharge, as it is a more preventative intervention.

Where clients are not referred to social care after reablement, there is a risk of a 'cliff-edge' as support ends. Those in reablement teams, with social care backgrounds, may overlook 'middle way' support for those ineligible for social care. Better communication with housing providers would raise awareness of these middle way options – floating support and supporting

people services – to bridge the gap between reablement and total support-free independence.

Health and wellbeing boards could prove to be an important conduit at local level for health, care and housing to communicate to smooth people's pathways into and out of hospital and then into and out of reablement services. Nonetheless, experts we consulted during this project were cautious about placing too much emphasis on boards as a solution to all integration problems – particularly in the current economic climate, which may see boards have a different set of immediate priorities.[102] It is important that reablement and housing providers work to create communication channels which can flourish even where local health and wellbeing structures are not there to facilitate it: 'Housing associations are often working to the same agenda – they're wanting people to maximise their independence and be healthier. That's important to communicate to health and social care partners.'[103]

To assist in this, *hospital discharge planning* should include, as standard, alerting a person's social housing or extra-care landlord to the hospital stay and imminent discharge, and informing them of the presence of any reablement planning.

Recommendation 8

Clinical commissioning groups must think more creatively about how reablement is delivered, and who delivers it. The potential for reablement to become more cost-effective and achieve improved outcomes is substantial, and as they take responsibility for reablement commissioning, it is appropriate for health commissioners to re-evaluate what reablement currently achieves and what potential is untapped to achieve more. Looking to a wider range of reablement providers, and providers who work in partnership with other stakeholders to achieve more person-centred support, is one step towards identifying 'what works' in reablement. Groups should also explore the value of commissioning more 'reablement accommodation' locally, for people with more complex needs, who may not fully benefit

from reablement in their own homes. Reablement accommodation is often sourced from a limited supply of spare rooms in care homes, but social housing and extra care providers are proving to be effective alternative sources.

5 Conclusions

In this time of austerity and significant budget cuts to front-line public services, policy makers in local and national government are seeking new ways of getting more for less, and identifying how to invest scarcer resources in ways which have the biggest impact on outcomes. Nowhere is this more true than in health and social care – and the government's increased investment in reablement embodies this thinking.

The case for reablement is unequivocal. It speeds hospital discharge, the delays of which cost the NHS millions every month, and it reduces the need for ongoing social care by around 60 per cent, easing the burden of an over-stretched social care system. It is a win-win for both health and care. Moreover, it is a driver of integration between the two – one of the Prime Minister's key objectives this year.[104]

But we cannot be complacent and assume reablement cannot be improved. Far from it. The opportunities to get more for the Government's reablement buck have never been greater. As the commissioning of reablement transfers from local authorities to acute trusts, it is the time to scrutinise what we get and re-evaluate what we expect from reablement. As one local commissioner told us: 'Reablement has demonstrated a level of efficiency, but could we improve on that? Yes we can, of course we can.'[105]

From the evidence we have evaluated in this report, two things are clear. The first is that there remain some weaknesses in the current reablement set up – it tends to focus on 'in the home' capabilities and does less to help people reconnect with their support networks and local communities; it can create a cliff-edge once the support has been withdrawn; there seems to be a lack of flexibility on what is on offer; and there are sometimes delays in accessing the right equipment or adaptations. These

weaknesses undermine the good work being done, but there is not enough evaluative evidence on 'what works' in reablement to conclude definitively that if these weaknesses were addressed all reablement schemes could achieve the reductions in ongoing care needs seen at the top end of the spectrum of performance, and that healthcare costs would also be reduced over the longer term.

Nonetheless, it seems reasonable to conclude that a greater emphasis on building resilience and reconnecting people with support networks and activities proven to maintain physical and mental health would lead to the benefits of reablement becoming more sustainable and hospital readmissions being reduced.

The second point we can make is that reablement remains a nebulous concept and its interpretation and delivery varies significantly from area to area. While this can also be seen as another weakness, it actually presents an opportunity in the short term to make substantial changes to the way reablement is delivered and commissioned, and to how it is widely understood. The reablement regime is still new and flexible enough to be open to radical 'first principle' rethinks.

It is important that as we approach a crossroads in the development of reablement, we investigate further 'what works' in delivering improved outcomes, and recognise that a wider range of stakeholders must be involved. In this era of integrated services, reablement cannot remain a home care intervention. Many of the issues reablement teams currently struggle with – connecting people to their communities, accessing equipment and reablement accommodation, and ensuring transition support is available post reablement – can all be helped (for social housing tenants at least) by engaging with social landlords and their staff. These staff have been supporting and developing relationships with the client *before* the reablement team moved in, and will still be there once the reablement team moves out. This value of this consistent relationship and source of reassurance at a time of change in a vulnerable person's life cannot be underestimated.

What we must make sure of, however, is that the evolution of reablement is not a negative one. We must guard against

reablement following the wider trend of focusing only on those with the greatest chance of saving the health and care systems the most money because of the reduced resources elsewhere in the health and care systems. As commissioning moves to health counterparts, this may mean reablement becomes the preserve of those most at risk of readmission to hospital within the 30-day time limit. This would be a huge loss for many thousands of older people who might benefit from having their reliance on ongoing social care (or indeed, informal care) reduced by recapturing some independence:

Reablement is very much an invest to save policy so there are some serious dangers to it obviously in the present climate. People are happy to make the savings but can't find the investment.[106]

In the financial situation that we're in at the moment, if we don't get reablement right then it has a knock on impact on people ending up in the wrong part of the system.[107]

The future of reablement, to reap better and more sustainable outcomes, is not in contraction but in expansion, both conceptually and in the range of stakeholders involved in its delivery. Social housing providers must be a key partner in achieving this.

Appendix 1 Expert interviews

During the course of this research, we interviewed the following individuals from across the housing, health and social care sectors:

Stella Doble, Strategic Director of Adult Services, Sirona CIC
Sue Falder, Business Development Manager for Supported Housing, Orbit
Angelo Fernand, Lead on Mental Health and Housing, Oxfordshire PCT
Caroline Hawkings, Policy Officer (Care and Support), National Housing Federation
Clare Henderson, Assistant Director, Strategic Commissioning, London Borough of Islington
Sarah Johnson, Partner, Reablement UK
Jess Lievesley, Head of Joint Commissioning, Hertfordshire County Council
Carol Moore, Business Manager, Orbit Care and Repair
Sarah Pickup, Director of Health and Community Services, Hertfordshire County Council (ADASS President 2012/13)
Andrea Pope-Smith, Director of Adult Social Care, Dudley Metropolitan Borough Council
Jon Ray, Programme Manager, Older People, Oxfordshire PCT
Andy Shields, Head of Business Development, Home Group
Fenella Trevillion, Head of Partnerships and Transitions, Oxfordshire PCT
David Walden, Director of Adult Services, Social Care Institute for Excellence
Jo Webber, Deputy Director of Policy, NHS Confederation

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This project was supported by:

The Coalition Government has staked a major part of its social agenda on greater integration between health and social care. Despite unprecedented budget cuts, reablement programmes benefitting from the potential for people to recover at home rather than in hospital have been a prime target for government spending. But is this largesse being matched by success stories in home care?

The Home Cure examines whether, through changes to delivery, out-patient home care programmes can achieve better outcomes. Introduced in the 2000s to reduce 'bed-blocking' in hospitals, evidence now suggests that effective reablement can facilitate swifter discharge and reduce the need of ongoing home care support by up to 60 per cent. The savings to both health and social care services are substantial; but in reality performance is patchy. This report finds that reablement services could benefit from deep structural changes to how they are delivered.

Finding that home recuperation programmes need to become more personalised, *The Home Cure* recommends that reablement services have a wider focus on activities outside the home and that they must endeavour to build networks in order to sustain their initial positive impact. It argues that social housing providers are an untapped resource in addressing these priorities – as both a partner to existing home care teams, but more radically, as an alternative reablement provider.

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