Scrutiny Review of Reablement Service

Adult Social Care and Health Select Committee

Final Report

October 2025

Stockton-on-Tees BOROUGH COUNCIL

Adult Social Care and Health Select Committee
Stockton-on-Tees Borough Council
Dunedin House
Columbia Drive
Thornaby
Stockton-on-Tees
TS17 6BJ

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Select Committee – Membership

Councillor Marc Besford (Chair)
Councillor Nathan Gale (Vice-Chair)
Councillor Stefan Barnes
Councillor Carol Clark
Councillor John Coulson
Councillor Ray Godwin (until April 2025)
Councillor Lynn Hall
Councillor Jack Miller
Councillor Vanessa Sewell
Councillor Sylvia Walmsley (from April 2025)

Acknowledgements

The Committee would like to thank the following people for contributing to its work:

- Councillor Pauline Beall (Cabinet Member for Health and Adult Social Care) – Stockton-on-Tees Borough Council (SBC)
- Rob Papworth (Strategic Development Manager, Adults & Health) – SBC
- Angela Connor (Assistant Director, Adult Social Care / Principal Social Worker) – SBC
- Gavin Swankie (Service Manager, Integrated Early Intervention & Prevention) – SBC
- Susan Dixon (Integrated Interim Care Team Lead, CQC) – SBC
- Jem Bagdatlioglu (Consultation Officer) – SBC
- Kathryn Warnock (Head of Commissioning and Strategy) – NHS North East and North Cumbria Integrated Care Board (NENC ICB)
- Jill Foreman (Head of Community Services) – North Tees and Hartlepool NHS Foundation Trust (NTHFT)
- Matt Wynne (Care Group Director, Healthy Lives) – NTHFT
- Selinda Chouhan – Peopletoo
- Jasmine Tamer – Peopletoo
- Lucy Owens (Chief Executive) – Catalyst
- Megan Stevens (Project Co-ordinator) – Catalyst
- SBC Reablement Service staff who responded to the Committee's survey

Contact Officer

Gary Woods (Senior Scrutiny Officer)
Tel: 01642 526187
Email: gary.woods@stockton.gov.uk

Foreword

We are pleased to present this Scrutiny Review of Reablement Service final report – a service that truly embodies the values of independence, dignity, and compassion which sits at the heart of adult social care. This review highlights not only the remarkable achievements of our dedicated teams but also the strength of collaboration across our health and care system.

Reablement is about more than recovery; it is about restoring confidence, enabling choice, and helping people live the lives they want in the place they call home. The evidence gathered during this review demonstrates the positive impact this service has on individuals and families, with over three-quarters of people regaining independence after support. These outcomes are a testament to the commitment and professionalism of our workforce and partners.

As we look to the future, the opportunities identified in this report – from embracing technology to expanding our reach – give us every reason to be optimistic. We know the challenges ahead are significant, but with innovation, partnership, and a shared determination to put people first, we can continue to transform lives and strengthen our communities.

Thank you to everyone who contributed to this review. Your insights and dedication will help shape a service that not only meets today's needs but anticipates tomorrow's. Together, we are building a system that empowers independence and delivers care with compassion and excellence.

Cllr Marc Besford
Chair
Adult Social Care and Health Select Committee

Cllr Nathan Gale
Vice-Chair
Adult Social Care and Health Select Committee

Original Brief

Which of our strategic corporate objectives does this topic address?

The review will contribute to the following Council Plan 2023-2026 key objectives (and associated 2023-2024 priorities):

A place where people are healthy, safe and protected from harm

- Support people to remain safely and independently in their homes for as long as possible and offer help to people who are feeling lonely.
- Engage with individuals, families, carers and communities when developing adult social care support and continue to collaborate with the NHS to ensure health and care services work effectively together.

What are the main issues and overall aim of this review?

'Reablement' is a short period of rehabilitation which usually takes place in a person's own home.

National evidence suggests that supporting early and safe discharge from hospital into a reablement-type service delivers better outcomes for individuals when compared to longer periods of hospitalisation or immediate transfer into care at home. It is also cost-effective for health and adult social care services, both reducing pressure on bed-capacity in hospitals and the need for large packages of ongoing community or residential or nursing care. Research has continued to evidence that most people prefer to remain in their own homes and communities.

Locally, the Reablement Service provides support for people with poor physical or mental health to help them manage their illness / condition by learning or re-learning the skills necessary for daily living (so that they can remain in the community). The service seeks to ensure that people can maximise their independence when they need it – this can include both 'step-up' care (escalation of need for people already supported to live independently) as well as 'step-down' (to avoid hospital admission or ensure safe discharges). It also promotes and supports people to be more independent and reduce the need for long-term service provision for as long as possible.

The offer is provided free (as mandated by the Care Act 2014) for the person receiving support for up to a maximum of six weeks. A person with ongoing care and support needs following this six weeks will be financially assessed for their ongoing contribution to their care.

There are a number of Stockton-on-Tees Borough Council (SBC) *Powering Our Future* (POF) projects that link to this review; 'Supporting People to Live Independently' and 'Early Intervention and Prevention'. The final report produced by the Adult Social Care and Health Select Committee will be submitted to these workstreams for their awareness.

The aim of the review is to identify whether the Reablement Service offered by the Council is:

1) maximising independence for people being discharged from hospital and living in the community.
2) reducing the need for ongoing, more intensive support in people's own homes and reducing the need for admission into 24-hour care.
3) working effectively with NHS provision that supports people on a reablement pathway.
4) using technology as effectively as possible.

The Committee will undertake the following key lines of enquiry:

- Which organisations are involved in the planning and delivery of the existing local Reablement Service and what role do they play?
- How much does the service cost the Council and its partners, and how is it funded? Is current funding sufficient for future projected provision?
- What is the previous / current / anticipated capacity and subsequent demand for use of the service?
- How is the service promoted and how do people access it / how are they identified as potentially benefitting from it?
- How does the Council and the NHS monitor the impact and effectiveness of the service?
- What technology is used within current service provision? What options are there to incorporate technology in future service provision?
- Is there an opportunity to involve the VCSE more in the reablement pathway.
- Feedback from service-users and their families / carers – how easy was it to access; did the service help an individual's independence; was Council and NHS provision provided in a seamless way?

Provide an initial view as to how this review could lead to efficiencies, improvements and / or transformation:

- Maximising independence and reduced need for more intensive support at home or within 24-hour care provision.
- The use of technology is an effective enabler for people's independence and supports people to live their lives as independently as possible.

1.0 Executive Summary

1.1. This report outlines the findings and recommendations following the Adult Social Care and Health Select Committee's scrutiny review of Reablement Service.

1.2. 'Reablement' is a short period of rehabilitation which usually takes place in a person's own home.

1.3. National evidence suggests that supporting early and safe discharge from hospital into a reablement-type service delivers better outcomes for individuals when compared to longer periods of hospitalisation or immediate transfer into care at home. It is also cost-effective for health and adult social care services, both reducing pressure on bed-capacity in hospitals and the need for large packages of ongoing community or residential or nursing care. Research has continued to evidence that most people prefer to remain in their own homes and communities.

1.4. Locally, the Reablement Service provides support for people with poor physical or mental health to help them manage their illness / condition by learning or re-learning the skills necessary for daily living (so that they can remain in the community). The service seeks to ensure that people can maximise their independence when they need it – this can include both 'step-up' care (escalation of need for people already supported to live independently) as well as 'step-down' (to avoid hospital admission or ensure safe discharges). It also promotes and supports people to be more independent and reduce the need for long-term service provision for as long as possible.

1.5. The offer is provided free (as mandated by the Care Act 2014) for the person receiving support for up to a maximum of six weeks. A person with ongoing care and support needs following this six weeks will be financially assessed for their ongoing contribution to their care.

1.6. There are a number of Stockton-on-Tees Borough Council (SBC) *Powering Our Future* (POF) projects that link to this review; 'Supporting People to Live Independently' and 'Early Intervention and Prevention'. The final report produced by the Adult Social Care and Health Select Committee will be submitted to these workstreams for their awareness.

1.7. The aim for this review was to identify whether the Reablement Service offered by SBC was:

a) maximising independence for people being discharged from hospital and living in the community.
b) reducing the need for ongoing, more intensive support in people's own homes and reducing the need for admission into 24-hour care.
c) working effectively with NHS provision that supports people on a reablement pathway.
d) using technology as effectively as possible.

1.8. The Committee found that, rooted within legislation (Care Act 2014 s2) which requires Local Authorities to prevent, reduce or delay needs for care and support for all adults (including carers), 'reablement' was one of several short-term offers involving NHS and social care services (alongside home-based, bed-based, and crisis response care) which come under the wider umbrella of 'intermediate care'. The Care Act regulations compel Councils to provide reablement support free-of-charge for a period of up to six weeks (this was for all adults, irrespective of whether they had eligible needs for ongoing care and support).

1.9. Reablement involves the provision of assistance within a person's own home. This assessment and support service helps an individual to do tasks (e.g. washing, getting dressed) for themselves rather than relying on others, with support workers operating alongside the person while they regain skills and confidence. The aim was to maximise independence (doing tasks 'with' them, not 'for' them), and the service can be used to support discharge from hospital, prevent re-admission, or enable an individual to remain living at home.

1.10. The SBC Reablement Team was expanded in October 2024 as the Council continues its focus on early intervention and prevention as part of its ongoing *Powering Our Future* (POF) initiative. Visits to service-users occur up to four times per day, with Senior Support Workers holding regular weekly reviews with individuals to ensure they were on track to achieve their goals and adjust their support plan accordingly (they were also able to assess and order low level equipment to aid independence).

1.11. Other relevant stakeholders include the NHS North East and North Cumbria Integrated Care Board (NENC ICB), which has a key role in overseeing the health and care 'system' to plan, design and deliver intermediate care services (including reablement) following hospital discharge, with the local priority on people gaining and maintaining independence for as long as possible. The North Tees and Hartlepool NHS Foundation Trust (NTHFT) was another key partner within local integrated services, working alongside SBC to provide an Integrated Single Point of Access (ISPA). There was also a well-established Integrated Discharge Team (contributing to the Trust having one of the top performing Emergency Departments in England – a reflection of the strength of pathways in place to get people home), as well as a Community Integrated Assessment Team (CIAT) which worked in collaboration with the SBC Reablement Service.

1.12. A significant majority of referrals into the SBC Reablement Service came directly from hospital (with the rest from the community). The service may be accessible if an individual has a temporary illness / accident, a crisis, a change in their (or their carers') circumstance, or to avoid unnecessary admission to hospital. Where a 'need' (not a 'want') had been identified, individuals would be referred following an assessment via a health or social care professional – any subsequent support could be tailored to the individual, and its duration was dependent upon their progress (i.e. this free service could be less than the maximum six-week period). For those not in hospital, it was not clear how the Council or its partners identified individuals who may benefit from the service.

1.13. In terms of public awareness and promotion of this type of provision, there were several references over the course of the review to the vagaries around the term 'reablement' itself. The Committee recognise that this is accepted health terminology, but there is clearly a need to fully explain and promote what reablement actually entails so the public have a better understanding of how these services can help them or a loved one. In addition, published NHS survey data suggests local Trusts have work to do in providing clarity around available options following discharge – this was reinforced by customer feedback presented to the Committee, as well as the Reablement Service staff who reported that the people they support were often unaware of local provision. Furthermore, Adult Social Care Outcomes Framework (ASCOF) data showed that the proportion of older people (aged 65 or over) offered reablement services following discharge from hospital (measure 2D2) was consistently lower in the Borough compared to regional and national scores for every year since 2019-2020 – this is perhaps surprising given NTHFTs stated recognition that the Borough's reablement provision played a key role in the ongoing strong local performance around hospital discharge, much of which reflected the established partnership between NTHFT and SBC.

1.14. The Better Care Fund (BCF) was used as a mechanism to bring NHS services and Local Authorities together to tackle strains faced across the health and social care system, and to drive better outcomes for people. Reablement services were one of the Stockton-on-Tees BCF schemes to meet one of the two BCF core objectives, namely 'to enable people to stay well, safe and independent at home for longer'. The existing local offer was fully funded via the BCF, with the budget for 2024-2025 (£1.2m) increasing by around 20% (principally due to anticipated changes with the previous Discharge to Assess (D2A) arrangements) compared to the allocated funds for 2023-2024 – the vast majority of these financial resources covering staff salaries. Future funding levels (still to be clarified) will need to reflect the desired ambition to support a greater number of people leaving hospital or to prevent them from having to be admitted in the first place.

1.15. 591 individuals were supported by the SBC Reablement Team between April 2023 and March 2024 (with no waiting list as of January 2025). The recent expansion of the local offer, with SBCs move to bring this fully in-house from autumn 2024 endorsed by the NENC ICB, meant that existing structures were deemed sufficient to deal with the Council's projections on the numbers requiring support (though issues would inevitably follow should these projections be exceeded, as would staff absences as a result of sickness / COVID). However, the expected 20%+ increase of those aged over 65 in the next 10 years will inevitably challenge the status quo.

1.16. Regarding impact and effectiveness, the Committee heard that just over 75% of the 591 people supported during 2023-2024 were independent on leaving the service. Local reablement performance had been consistently better than the regional and national averages over the past four years, with the 2023-2024 data ranking Stockton-on-Tees eighth in the country (top in the region) – this was reinforced by the numerous positive comments from service-users about their own experiences. In addition, the service had been shortlisted for the regional (North East and Scotland) Great British Care Awards in the categories of 'Team Award', 'Newcomer to Care', 'Co-ordinator', and 'Care Manager', and the CQCs last inspection in mid-2021 rated the service 'Good' overall (though this was now quite dated).

1.17. An understanding around the types of technology used as part of current reablement provision was not established, though the reported focus on increasing its use (e.g. pilot assessment of activity monitoring technology, implementation of OPTICA, etc.) demonstrates a recognition of the potential benefits and the continuing evolution of the existing offer. Examples of technology-related opportunities were highlighted to the Committee which should be further explored by SBC and its partners alongside the front-door proposals being considered by the Council in March 2025.

1.18. The Committee was informed that there were no specific reablement services currently being delivered by VCSE organisations, nor was there a large quantity of reablement-related activity happening across the Borough within this sector – this suggests there is an opportunity for greater utilisation of the VCSE sector in local reablement provision. The former Five Lamps 'Home from Hospital' service (which ended in March 2024) was a relevant offer in relation to this scrutiny topic, with Catalyst relaying the opinion from some that its cessation had meant there was now a gap within the community for such provision. SBC has made the decision to expand its own reablement offer, but to meet projected future need, a role for the VCSE sector seems prudent and potentially necessary.

1.19. Information was received in relation to customer feedback and there appeared broad satisfaction with the level of service. As previously highlighted, an issue was frequently raised around a lack of awareness of the local offer and the lack of information provided about it within the hospital setting.

1.20. Views of SBC Reablement Service staff about existing provision were sought as part of the Committee's review. There was high praise for the current arrangements, working in conjunction with other professionals (physio, therapy team), communication (in-house and with clients / families), and support from management and office staff. In terms of improvements, suggestions included better provision of information about the service (within, and upon discharge from, hospital), more detailed information about an individual when a referral is received, the retention of input from physios / therapy team, ensuring continuity of care (as far as possible), and improved out-of-hours provision / staffing. It was also highlighted that individuals were sometimes willing to pay so they could continue to receive support beyond the six-week limit.

1.21. Reflecting upon the timing of this review, the Committee notes the challenges that have arisen when trying to examine a service which is rapidly evolving, with decisions on its future direction being made throughout the Committee's evidence-gathering phase. The Council's use of an external consultant (Peopletoo) to also review local provision during this time has identified a host of additional findings and potential options for future delivery. The Executive Summary of the report detailing the work undertaken by Peopletoo highlights the intention to improve performance monitoring as part of a phased enhancement of reablement and preventative services – the Committee welcomes this, particularly in light of the ongoing delays around SBC performance information being made available to the scrutiny function. Reference is also made on the Peopletoo website (see https://peopletoo.co.uk/case-studies/adult-social-care/enhancing-independence-through-reablement-and-enablement/) to significant financial benefits as a result of their work / proposals – the Committee look forward to seeing the extent to which this claim is borne out.

1.22. Continuing national coverage regarding pressures on hospitals, well-established benefits of people being at home, and the anticipated rise in the number of people aged 65 and over (the main demographic for reablement support) are all elements which emphasise the importance of services like reablement. Managing the flow of those leaving hospitals can be challenging enough given resource limitations, and widening this type of support to help avoid admittance to hospital in the first place will inevitably provide a further stress on the existing service. Whilst the true value of social care is clearly reflected in provision such as reablement, the ambition to widen access (potentially to a 24/7 model and including those with a mental health need, autism or learning disability) will require a significant commitment in terms of funding, and indeed staffing, to make the maximum amount of difference to the wider system and, even more importantly, the individuals and their families / carers whose lives are clearly enhanced by drawing on such services.

Recommendations

The Committee recommend that:

1) The NHS North East and North Cumbria Integrated Care Board (NENC ICB):

a) provides a summary on the gap analysis of the NHS England good practice guidance for ICBs (commissioners and providers) titled '*Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge*' (2023), along with assurance on how it and its partners will be addressing any identified issues (e.g. a self-assessment by all relevant organisations within the health and care 'system').

b) more explicitly outlines the role and importance of reablement services (within the context of the overall health and care 'system') in future iterations of its overarching integrated care strategy.

(continued overleaf…)

Recommendations (continued)

The Committee recommend that:

2) **North Tees and Hartlepool NHS Foundation Trust (NTHFT) reviews its discharge processes to ensure that eligible individuals who are ready to leave hospital are made fully aware of local reablement provision and are referred to it upon discharge from hospital.**

3) **Principal links / contacts for Stockton-on-Tees Borough Council (SBC), NTHFT and the voluntary, community and social enterprise (VCSE) sector in relation to local reablement provision are identified / confirmed and shared in order to improve communication between key partners.**

4) **SBC and NTHFT establish required person-centred information on an individual when a referral is made into the SBC Reablement Service.**

5) **Regarding the future local reablement offer, SBC:**

   a) **provides a summary of any differences in the findings of the Peopletoo review and reablement-related commentary from the Care Quality Commission (CQC) following its late-2024 inspection of SBC adult social care services.**

   b) **confirms further planned changes to existing service delivery (structures, workforce) and the funding required to support this, and provides assurance on appropriate training uptake for new and existing staff.**

   c) **explores whether any of its existing social care workforce outside the current SBC Reablement Service structure (e.g. Community Support Workers) can be utilised to increase staffing capacity for reablement provision.**

6) **SBC considers cost-effective options (and the communication of these) for individuals leaving the SBC Reablement Service to ensure a smooth transition from this initial support.**

7) **To increase public understanding of the Borough's reablement offer:**

   a) **SBC and its partners assure themselves that they are adhering to the Social Care Institute for Excellence (SCIE) '*Supporting client and family engagement with reablement*' (2024) guidance, utilising this resource to effectively raise awareness and promote the Borough's reablement offer.**

   b) **SBC undertakes a joint communications campaign (repeated on a periodic basis) with NTHFT and the VCSE sector around local reablement services, making it clear what they involve, how they are accessed (including contact details), and the principal benefits.**

8) **Healthwatch Stockton-on-Tees be asked to consider facilitating a public survey in 2026 to establish the availability of information on the local reablement offer for those who had spent time in hospital and the experiences of those who had received support from the service.**

2.0 Introduction

2.1. This report outlines the findings and recommendations following the Adult Social Care and Health Select Committee's scrutiny review of Reablement Service.

2.2. The aim for this review was to identify whether the Reablement Service offered by Stockton-on-Tees Borough Council (SBC) was:

a) maximising independence for people being discharged from hospital and living in the community.
b) reducing the need for ongoing, more intensive support in people's own homes and reducing the need for admission into 24-hour care.
c) working effectively with NHS provision that supports people on a reablement pathway.
d) using technology as effectively as possible.

2.3. The Committee identified the following key lines of enquiry:

- Which organisations are involved in the planning and delivery of the existing local Reablement Service and what role do they play?
- How much does the service cost the Council and its partners, and how is it funded? Is current funding sufficient for future projected provision?
- What is the previous / current / anticipated capacity and subsequent demand for use of the service?
- How is the service promoted and how do people access it / how are they identified as potentially benefitting from it?
- How does the Council and the NHS monitor the impact and effectiveness of the service?
- What technology is used within current service provision? What options are there to incorporate technology in future service provision?
- Is there an opportunity to involve the VCSE more in the reablement pathway.
- Feedback from service-users and their families / carers – how easy was it to access; did the service help an individual's independence; was Council and NHS provision provided in a seamless way?

2.4. The Committee took evidence from key personnel from within the SBC Adults, Health and Wellbeing directorate, North East and North Cumbria Integrated Care Board (NENC ICB), North Tees and Hartlepool NHS Foundation Trust (NTHFT), and the voluntary, community and social enterprise (VCSE) sector (via Catalyst). Peopletoo, commissioned by SBC to assist in assessing the impact of current ways of working and analyse the best model for continuing to support people to maximise their independence, provided feedback on its own review of local services. The Committee also issued a survey to SBC Reablement Service staff, and other approaches in relation to this scrutiny topic were considered.

3.0 Background

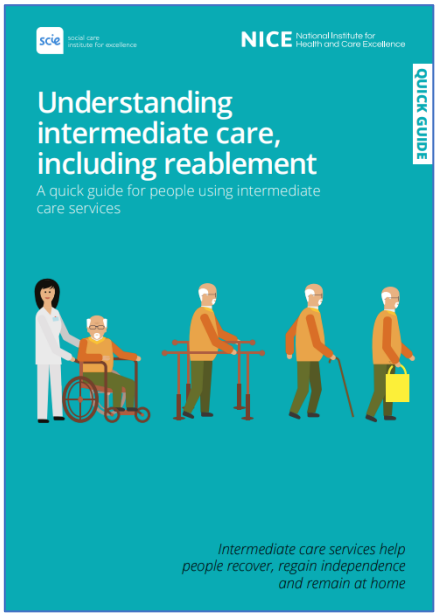
3.1 'Reablement' is a short period of rehabilitation which usually takes place in a person's own home.

3.2 National evidence suggests that supporting early and safe discharge from hospital into a reablement-type service delivers better outcomes for individuals when compared to longer periods of hospitalisation or immediate transfer into care at home. It is also cost-effective for health and adult social care services, both reducing pressure on bed-capacity in hospitals and the need for large packages of ongoing community or residential or nursing care. Research has continued to evidence that most people prefer to remain in their own homes and communities.

3.3 A wealth of information is available in relation to reablement provision. Examples include:

National Institute for Health and Care Excellence (NICE)

- Understanding intermediate care, including reablement https://www.nice.org.uk/Media/Default/About/NICE-Communities/Social-care/quick-guides/understanding-intermediate-care-quick-guide.pdf



National Health Service (NHS)

- Care after illness or hospital discharge (reablement) https://www.nhs.uk/conditions/social-care-and-support-guide/care-after-a-hospital-stay/care-after-illness-or-hospital-discharge-reablement/

Social Care Institute for Excellence (SCIE)

- Role and principles of reablement (Feb 20) https://www.scie.org.uk/integrated-care/intermediate-care-reablement/role-and-principles-of-reablement/

- Reablement: a guide for carers and family (Sep 20) https://www.scie.org.uk/integrated-care/intermediate-care-reablement/reablement-guide/

3.4 Locally, the Reablement Service provides support for people with poor physical or mental health to help them manage their illness / condition by learning or re-learning the skills necessary for daily living (so that they can remain in the community). The service seeks to ensure that people can maximise their independence when they need it – this can include both 'step-up' care (escalation of need for people already supported to live independently) as well as 'step-down' (to avoid hospital admission or ensure safe discharges). It also promotes and supports people to be more independent and reduce the need for long-term service provision for as long as possible.

3.5 The offer is provided free (as mandated by the Care Act 2014) for the person receiving support for up to a maximum of six weeks. A person with ongoing care and support needs following this six weeks will be financially assessed for their ongoing contribution to their care.

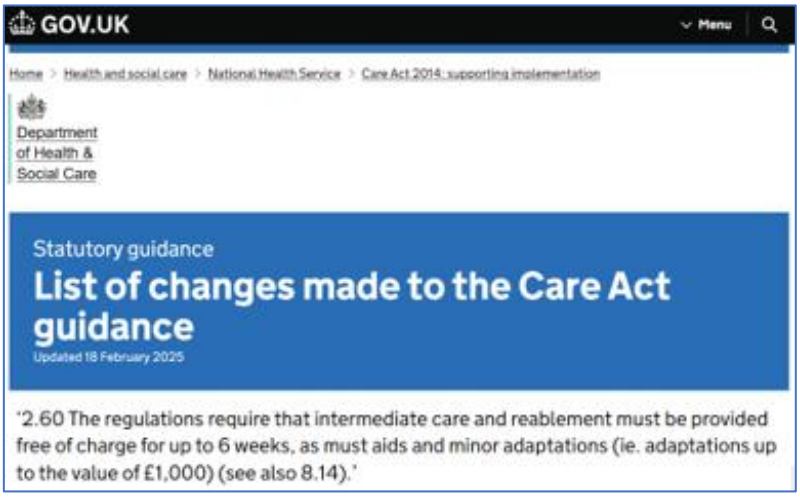
3.6 There are a number of Stockton-on-Tees Borough Council (SBC) *Powering Our Future* (POF) projects that link to this review; 'Supporting People to Live Independently' and 'Early Intervention and Prevention'. The final report produced by the Adult Social Care and Health Select Committee will be submitted to these workstreams for their awareness.

4.0 Findings

Legislative Requirements & National Policy Drivers

4.1. From a legislative perspective, Stockton-on-Tees Borough Council (SBC) had a duty to prevent, reduce or delay needs for care and support for all adults (18 years-old or over), including carers (see Care Act 2014 - Section 2).

4.2. In practice, this meant early intervention to prevent deterioration and reduce dependency on support from others, and reablement was one of the ways the Council could fulfil this duty. The Care Act regulations required the Council to provide reablement support free-of-charge for a period of up to six weeks – this was for all adults, irrespective of whether they had eligible needs for ongoing care and support.



4.3. National Hospital discharge and community support policy had placed increased demand / pressure on 'step-down' intermediate care services, with significant national and regional focus on 'Discharge to Assess' (rather than assessments in hospital) and early discharge (once a patient did not meet the criteria to reside) to support acute hospital pressures.

4.4. To support this approach, the Better Care Fund (BCF) was used as a mechanism to bring NHS services and Local Authorities together to tackle strains faced across the health and social care system and drive better outcomes for people. This was underpinned by two core objectives:

1) to enable people to stay well, safe and independent at home for longer
2) provide people with the right care, at the right place, at the right time

Reablement services were one of the Stockton-on-Tees BCF schemes to meet this first objective, a metric of which was '*the proportion of older people who were still at home 91 days after discharge from hospital into reablement or rehabilitation services*' (see paragraph 4.46).

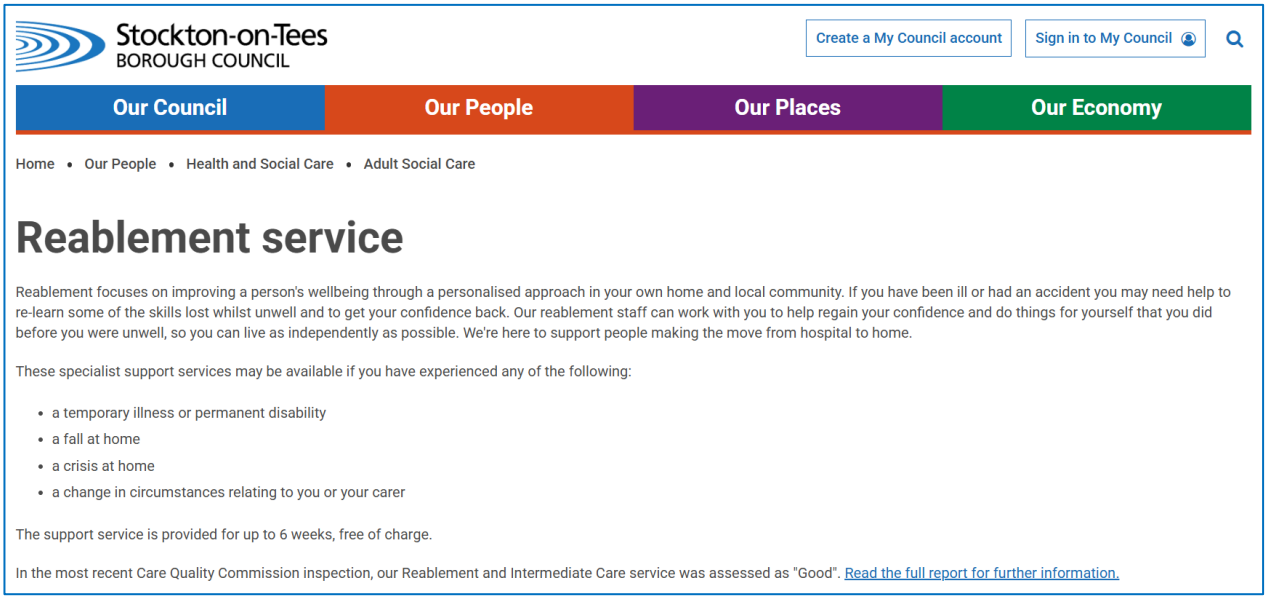
4.5. The BCF framework required Integrated Care Boards (ICBs) and Local Authorities to formulate a joint plan (owned by the Health and Wellbeing Board) which was governed by an agreement under section 75 of the NHS Act (2006). A BCF Delivery Group, in conjunction with a Pooled Budget Partnership Board (PBPB), had oversight of the delivery and monitoring of this plan, reviewing current schemes and agreeing future proposals / business cases – this involved several operational working groups / forums to support transformation (including the ongoing partnership around SBCs *Powering Our Future*-related reablement developments).

4.6. The wider NHS England FRAIL Strategy included a pathway to receiving reablement in the community (see graphic below). This may or may not follow a period of care within a hospital setting, and the delivery of the strategy would require the support of a range of partners, including primary care services and the voluntary sector.

Service Offer & Involved Organisations

Stockton-on-Tees Borough Council (SBC)

4.7. Coming under the wider umbrella of 'intermediate care', reablement was one of several short-term support offers involving NHS and social care services (alongside home-based, bed-based, and crisis response care). Providing assistance within a person's own home, this assessment and support service helped an individual to do tasks (e.g. washing, getting dressed) for themselves rather than relying on others, with support workers working alongside the person while they regained skills and confidence. The aim was to maximise independence (doing tasks 'with' them, not 'for' them), and the service could be used to support discharge from hospital, prevent re-admission, or enable an individual to remain living at home. It was most commonly delivered by social care practitioners.



4.8. In terms of delivery, the SBC Reablement Service consisted of a Manager, a Deputy Manager, four Co-ordinators, an Assistant Co-ordinator, three Senior Support Workers, and 37 Support Workers (courtesy of an expansion in October 2024) who were all dedicated and worked alongside individuals to promote independence. The workforce had a mix of experience, and the service benefitted from good staff retention, with those in post for a number of years able and willing to share their knowledge and expertise with newer recruits.

4.9. With a focus on making every contact count, visits to service-users occurred up to four times per day, with Senior Support Workers holding regular weekly reviews with individuals to ensure they were on track to achieve their goals and adjust their support plan accordingly (they were also able to assess and order low-level equipment to aid independence). Discharge plans and end dates were agreed with individuals, and throughout the duration of their assistance, staff could signpost to other services such as welfare rights, community groups and befriending initiatives so an individual had a support network to help them remain at home and not feel isolated when leaving the reablement offer. Help was also provided with applications for entitled benefits.

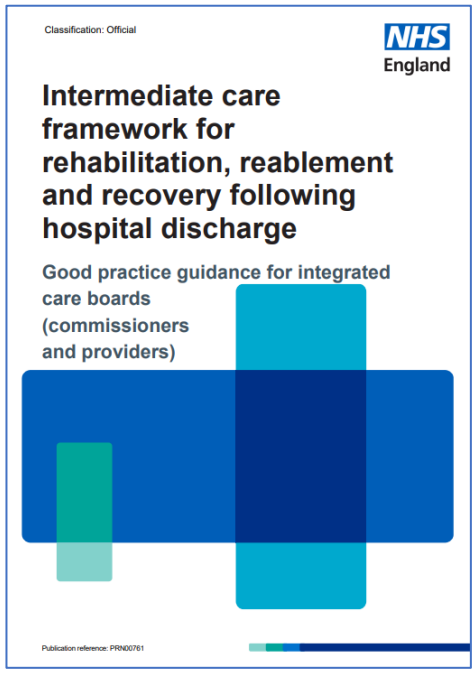
4.10. The Committee asked if the service had any dealings with the North Tees and Hartlepool NHS Foundation Trust (NTHFT) Frailty Ward and, if it did, whether the relationship was working well. SBC officers stated that referrals were received from the Frailty Ward and that the service worked alongside colleagues within that particular NHS function which carried out more healthcare-

related tasks and offered overnight provision (something the SBC Reablement Service did not). Most of those receiving reablement support were aged over 65 years old.

4.11. Reflecting on the number of staff employed within reablement and the number of individuals supported during 2023-2024 (see paragraph 4.37), the Committee praised the hard work and dedication of those providing the service. It was subsequently highlighted that there were only 28 support staff during the 2023-2024 year, a total which had since risen. It was also noted that a robust training offer was in place to support / strengthen the workforce.

NHS North East and North Cumbria Integrated Care Board (NENC ICB)

4.12. The NHS England good practice guidance for Integrated Care Boards (ICBs) (commissioners and providers) titled '*Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge*' (https://www.england.nhs.uk/wp-content/uploads/2023/09/PRN00761-intermediate-care-framework-rehabilitation-reablement-recovery-following-hospital-discharge.pdf) was highlighted to the Committee in November 2024 which included recommended actions for up to March 2025 (see pages 31-33). This document outlined what ICBs needed to do jointly as a health and care system to plan, design and deliver services, with considerations around demand, capacity and expectations.



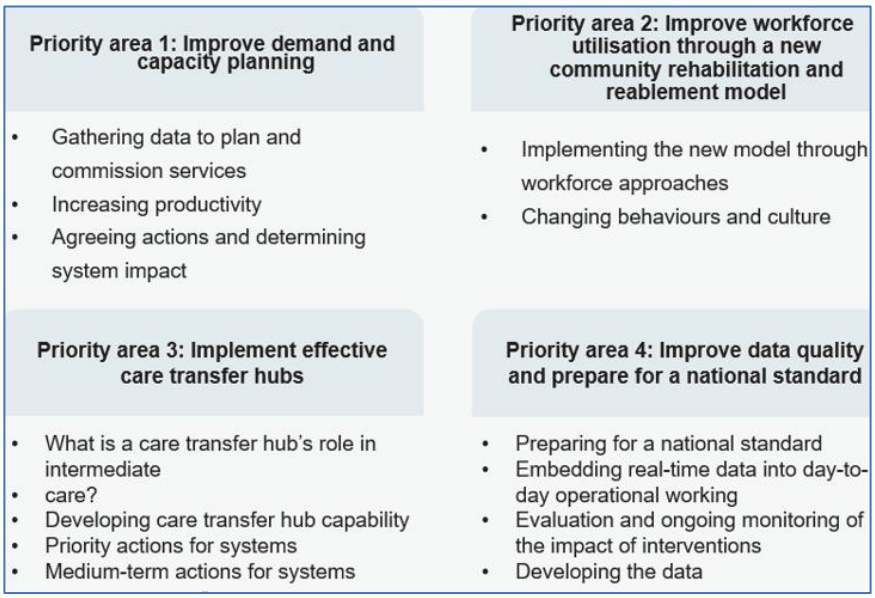
4.13. The 'community rehabilitation and reablement model' (see **Appendix 1**) demonstrated an individual's journey from admission to an acute inpatient / virtual ward, admission for rehabilitation in the community, delivery of rehabilitation interventions and, where required, transition for long-term / ongoing needs. Further NHS England good practice guidance for ICBs in relation to this model (published in 2024) was available at https://www.england.nhs.uk/wp-content/uploads/2023/09/A-community-rehabilitation-model-September-2024.pdf.

4.14. The Committee sought clarity on priority area 4 (improve data quality and prepare for a national standard – see graphic overleaf) of the NHS England good practice guidance for ICBs. In response, Members heard that the development of a standardised dataset would aid the identification and evaluation of the best ways in which individuals can achieve independence. The intermediate care offer could vary across different locations, though the local priority was very much on people gaining and maintaining independence for as long as possible.

4.15. Referencing the recent expansion of the Borough's reablement offer, the Committee questioned whether the ICB supported this development. Assurance was subsequently given that the ICB supported SBCs proposal to bring the service in-house.

4.16. Returning to the NHS England good practice guidance, the Committee asked how the NENC ICB was addressing the recommended actions (up to March 2025) stated within this document. Members heard that a gap analysis had been undertaken against the intermediate care framework as part of the SBC *Powering Our Future* work, and that monitoring of developments relating to intermediate care services was conducted at the ICB place sub-committee, with the local Health and Wellbeing Board having oversight as part of BCF-related updates (the regional Integrated Care Partnership (ICP) also existed to check and challenge the status quo).

Further information was subsequently sought, and provided, around this query, with the NENC ICB stressing that the recommended actions (some of which were difficult to attribute specifically to reablement) required a response and involvement from all partners across the system. Examples of how the four priority areas identified within the good practice guidance were being considered included:



Priority area 1: Improve demand and capacity planning

- Gathering data to plan and commission services
- Increasing productivity
- Agreeing actions and determining system impact

Priority area 2: Improve workforce utilisation through a new community rehabilitation and reablement model

- Implementing the new model through workforce approaches
- Changing behaviours and culture

Priority area 3: Implement effective care transfer hubs

- What is a care transfer hub's role in intermediate
- care?
- Developing care transfer hub capability
- Priority actions for systems
- Medium-term actions for systems

Priority area 4: Improve data quality and prepare for a national standard

- Preparing for a national standard
- Embedding real-time data into day-to-day operational working
- Evaluation and ongoing monitoring of the impact of interventions
- Developing the data

Progress against priority areas…

1) Part of BCF planning
2) The shift in the reablement services in-house by SBC was an example of this
3) Linked to discharge processes – ongoing
4) Implementation of OPTICA (see paragraph 4.76) and other digital solutions

The Committee emphasised the important role of scrutiny in holding services to account.

4.17. In related matters, the Committee noted that the existing NENC ICB integrated care strategy, 'Better health and wellbeing for all' (December 2022) appeared not to make any explicit reference to 'reablement' (though page 47 did acknowledge that adult social care was experiencing significant pressure '*supporting people being discharged from hospital to access the support they need in a timely manner*').

North Tees and Hartlepool NHS Foundation Trust (NTHFT)

4.18. With a focus on 'Home First' principles, NTHFTs priority was to get patients home from hospital as soon as it was clinically safe to do so. Avoiding hospital admittance in the first place was also central to its thinking. To facilitate this approach, NTHFT was a key partner within local integrated services, working alongside SBC to provide an Integrated Single Point of Access (ISPA). There was also a well-established Integrated Discharge Team (contributing to the Trust having one of the top performing Emergency Departments in England – a reflection of the strength of pathways in place to get people home), as well as a Community Integrated Assessment Team (CIAT) which worked in collaboration with the SBC Reablement Service (30 clients on average per month, involving 80 contacts).

4.19. A change in delivery of local reablement provision from autumn 2024 had seen SBC bring the offer in-house. From a NTHFT perspective, late-2024 operational challenges had led to patients staying in hospital longer, though the Trust had worked with SBC for additional support to get individuals home for Christmas.

Voluntary, Community and Social Enterprise (VCSE) Sector (via Catalyst)

4.20. There were no specific reablement services currently being delivered by VCSE organisations, nor was there a large quantity of reablement-related activity happening across the Borough within this sector. When asked, Catalyst recommended services such as Age UK, Mind, and Heart Support (exercise classes), and also had a good relationship with those leading the NTHFT '*Home But Not Alone*' initiative (a volunteer service offering time-limited support following discharge from hospital).

4.21. The former Five Lamps '*Home from Hospital*' service was another relevant offer in relation to this scrutiny topic, though this ended in March 2024. This initiative previously supported people in their own homes following a discharge from hospital and provided financial savings to the NHS due to lower re-admissions. Trusted relationships were built as a result of the same staff member visiting a particular individual, and the service was believed to be the only one which assisted in facilitating access to group activities. A significant amount of positive feedback was received about this offer, with a sense that its cessation had meant there was now a gap within the community for such provision.

The Committee pointed to the recent expansion of the SBC Reablement Service following the cessation of the Five Lamps *Home from Hospital* contract.

Promotion & Accessibility

Stockton-on-Tees Borough Council (SBC)

4.22. The service may be accessible if an individual had a temporary illness / accident, a crisis, a change in their (or their carers') circumstance, or to avoid unnecessary admission to hospital. Where a 'need' (not a 'want') had been identified, individuals would be referred following an assessment via a health or social care professional. Any subsequent support could be tailored to the individual, and its duration was dependent upon their progress (i.e. this free service could be less than the maximum six-week period).

4.23. In February 2025, the Committee was informed of the recent production of a new leaflet which gave details of the Reablement Service (see **Appendix 2**). The Committee expressed some concern on the layout / content, emphasising the need for the maximum period of support (six weeks) to be made clearer.

North Tees and Hartlepool NHS Foundation Trust (NTHFT)

4.24. As an example of the rising demand for this type of care, NTHFT provided a case study resulting in a referral to the Reablement Service (see graphic overleaf). Increasing frailty and complexity of cases across the general population was leading to greater challenges in providing support for those needing these services. This example also involved a referral to the Virtual Frailty Ward (also known as the 'hospital at home' service) for further clinical assessments, treatment and observation.

NTHFT Case Study: Support in the Community

- An urgent referral was received via NEAS Bleep into Community Integrated Assessment Team (CIAT).
- A gentleman fell when trying to walk to the toilet at home with no obvious injuries. He lives with his wife and was independent prior to the fall.
- CIAT arrived within 30 minutes. He was laid on the bathroom floor. A full body screening and clinical observations were taken. He presented with acute confusion. Staff used a slide sheet to move him to the corridor so he could be safely raised from the floor using a Raiser.
- Assessment identified that he required assistance of one with a wheeled zimmer-frame for mobility and his wife was unable to provide support for personal care.

- Referred to Virtual Frailty Ward for further clinical assessments, treatment and observation.
- Referred to Reablement Service for further support.

4.25. In response to a Committee question on the numbers being cared for as part of the 'hospital at home' (Virtual Frailty Ward) initiative, NTHFT confirmed that it currently provided 110 beds across a range of pathways, 30 of which were offered for frailty (as of today, these were all full). In related matters, it was stated that any required assessments of an individual potentially in need of care should be done as early in the day as possible so requirements could be put in place on the same day.

4.26. The Committee queried if there were any established links between reablement provision and end-of-life care. NTHFT noted its work with both Butterwick Hospice (Stockton-on-Tees) and Alice House (Hartlepool) and that individuals can be admitted into these settings from the community.

4.27. In addition to the information provided by NTHFT, the Committee was made aware of recently published NHS surveys which included feedback on the experiences of patients leaving NTHFT hospital facilities:

- Adult inpatient survey 2023 (published in August 2024)
  https://www.cqc.org.uk/provider/RVW/surveys/52

Leaving hospital	Patient Response 6.9 / 10	Compared with other trusts About the same
Involvement in decisions being involved in decisions about their discharge from hospital, if they wanted to be	6.7 / 10	About the same
Family and carer involvement hospital staff involving family and carers when discussing their discharge, if this was necessary	5.4 / 10	About the same

(*continued overleaf…*)

Equipment and adaptions in the home hospital staff discussing if any equipment or home adaptions were needed when leaving hospital	7.8 / 10	About the same
Notice of discharge being given enough notice about when they were going to be discharged	6.9 / 10	About the same
Advice at discharge being given information about what they should or should not do after leaving hospital	7.3 / 10	About the same
Understanding advice understanding the information given about what they should or should not do after leaving hospital	9.0 / 10	About the same
Medicines being given information on medicines to take at home	4.1 / 10	About the same
Care after discharge knowing what would happen next with their care when leaving hospital	6.5 / 10	About the same
Contact being told who to contact if worried about their condition or treatment after leaving hospital	7.6 / 10	About the same
Health and social care services hospital staff discussing if any further health or social care services were needed when leaving hospital	8.0 / 10	About the same
Care available after discharge expected care and support being available when needed after leaving hospital	6.5 / 10	About the same

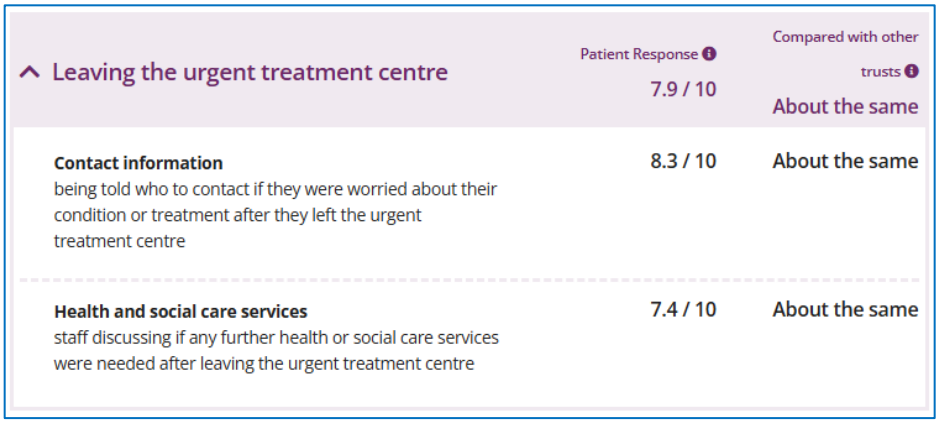
- Urgent and emergency care survey 2024 - type 1 services (A&E) (published in November 2024) (see graphic right)

  https://www.cqc.org.uk/provider/RVW/surveys/55

Leaving A&E	Patient Response 7.6 / 10	Compared with other trusts About the same
Contact information being told who to contact if they were worried about their condition or treatment after they left A&E	8.3 / 10	About the same
Health and social care services hospital staff discussing if any further health or social care services were needed after leaving A&E	6.9 / 10	About the same

- Urgent and emergency care survey 2024 - type 3 services (UTC) (published in November 2024) (see graphic right)

  https://www.cqc.org.uk/provider/RVW/surveys/56



Voluntary, Community and Social Enterprise (VCSE) Sector (via Catalyst)

4.28. Regarding knowledge of this type of provision, Catalyst highlighted those who may be unaware / uncertain about what the term 'reablement' was / meant, as well as the general lack of awareness / information-sharing on the services available (or, indeed, what was no longer on offer).

4.29. Agreeing that the term 'reablement' was not helpful in providing clarity of purpose, the Committee asked if information on VCSE services was available within public places (e.g. GP surgeries, libraries, etc.). Catalyst confirmed that there was some literature / publicity out in the community and also noted previous discussions on directing everything through the Stockton Information Directory (SID) – however, gaps existed, and there was work to do on the public's ability to find relevant information in an efficient way.

4.30. The Committee drew attention to the issue of leaflets becoming dated and not being replaced, as well as the fact that people requiring reablement-related services were more likely to be elderly and may not be as digitally literate. SBC officers acknowledged the need to be more creative in targeting the promotion of existing offers (something which was being addressed by the SBC *Powering Our Future* 'Communities' workstream). Catalyst also noted previous reluctance for some settings (including libraries) to put up posters due to perceived 'clutter'.

Service Costs

4.31. In January 2025, budget and expenditure statistics for the SBC Reablement Service were shared with the Committee – this covered the complete 2023-2024 year, and the current 2024-2025 (up to 31 December 2024) period. The service was fully financed via the Better Care Fund (BCF), with the headline data showing:

	2023-2024	2024-2025*
Budget	£1,016,157.00	£1,206,626.00
Expenditure	£954,537.43	£836,665.31
Variance	- £61,619.57	

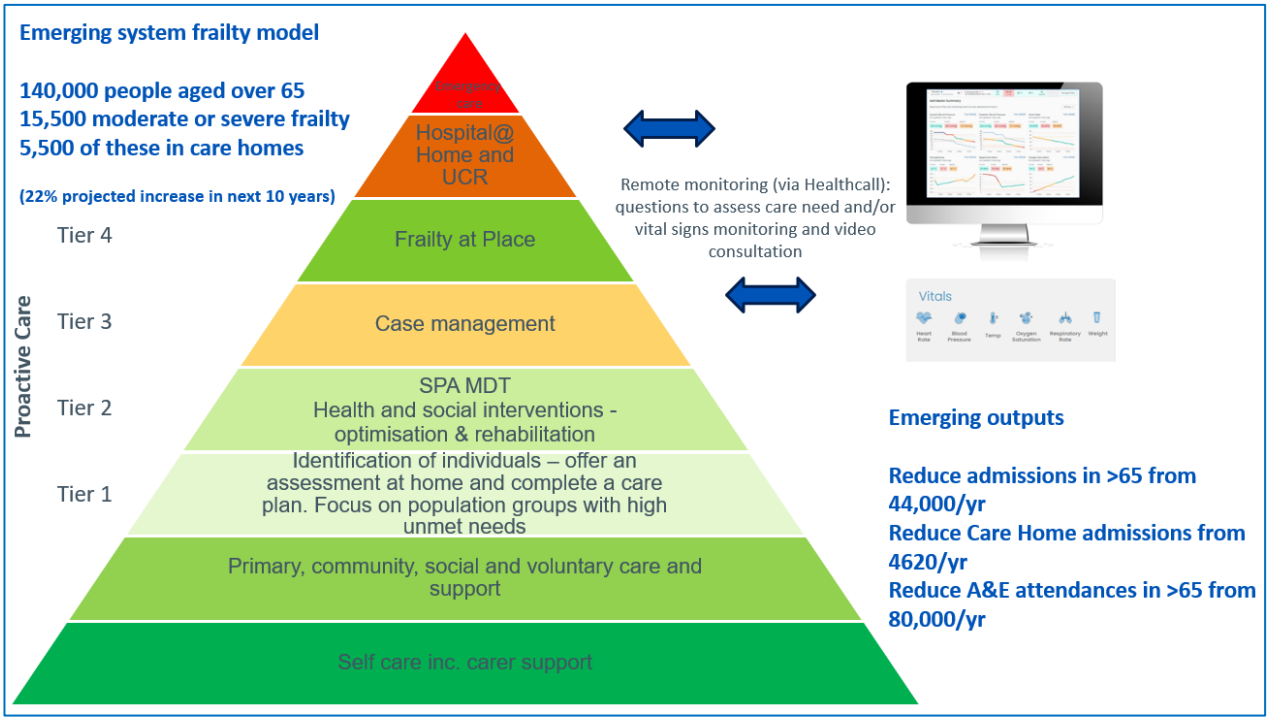
(* up to 31 December 2024)

4.32. The Committee queried if the potential impact on costs of the proposed future service models identified through the work undertaken by Peopletoo would be factored into financial planning. SBC officers stated that 2025-2026 funding requirements were already being considered.

Capacity & Demand

4.33. North Tees and Hartlepool NHS Foundation Trust (NTHFT) highlighted that, whilst there was estimated to be around 140,000 people aged over 65 within the Tees Valley footprint (15,500 of which had moderate or severe frailty and 5,500 of whom were residing in care homes), these numbers were expected to increase by over 20% in the next 10 years.

4.34. In order to meet this rising demand, NTHFT was developing a system frailty model (see graphic below) which involved interventions ranging from emergency care within the hospital environment to self-care (including carer support). Its aim was to help reduce hospital admissions and Accident and Emergency (A&E) attendance for those over 65 years-old, as well as reduce care home admissions. The final model still needed to be approved by the Trust's governance structure.



4.35. From a Stockton-on-Tees Borough Council (SBC) perspective, officers assured the Committee in September 2024 that existing reablement structures were sufficient to deal with the Council's projections on the numbers requiring support, but issues would inevitably follow should these projections be exceeded, as would staff absences as a result of sickness / COVID. Resilience was built into plans to counter potential surges in demand, though much was fundamentally down to having enough staff available.

Impact & Effectiveness

Stockton-on-Tees Borough Council (SBC)

4.36. Performance: The SBC Reablement Service was last inspected by the Care Quality Commission (CQC) in May 2021 where it was subsequently given an overall rating of 'Good' (the published report can be viewed at: https://api.cqc.org.uk/public/v1/reports/40ab9f3d-8d99-463f-a538-6e615a29fb73?20210521120000).

4.37. 591 individuals were supported between April 2023 and March 2024, with just over 75% of this number independent on leaving the service (those who needed further care required less intensive support due to the work undertaken by staff). Local performance was consistently better than the regional and national averages over the past four years, with SBC officers noting that the 2023-2024 data ranked Stockton-on-Tees eighth in the country (top in the region). In addition, the service had been shortlisted for the regional (North East and Scotland) Great British Care Awards 2024 in the categories of 'Team Award' (which it subsequently won – see graphic below), 'Newcomer to Care', 'Co-ordinator', and 'Care Manager'.

4.38. In March 2025, the Committee received a further update on performance since the expansion of the SBC Reablement Service (to assist people who were being supported under the Discharge to Assess (D2A) contract through its commissioned Care at Home (CAH) providers once this contract ended on 7 October 2024). Presented data showed that, between 7 October 2024 and 31 December 2024, 203 people were admitted to the SBC Reablement Service. Following support:

- 140 were independent (69.0%)*
- 29 went back into hospital (14.3%)
- 3 went to Rosedale (1.5%)
- 1 deceased (0.5%)
- 24 left with CAH (11.8%)**
- 6 left to be supported by family (3.0%)

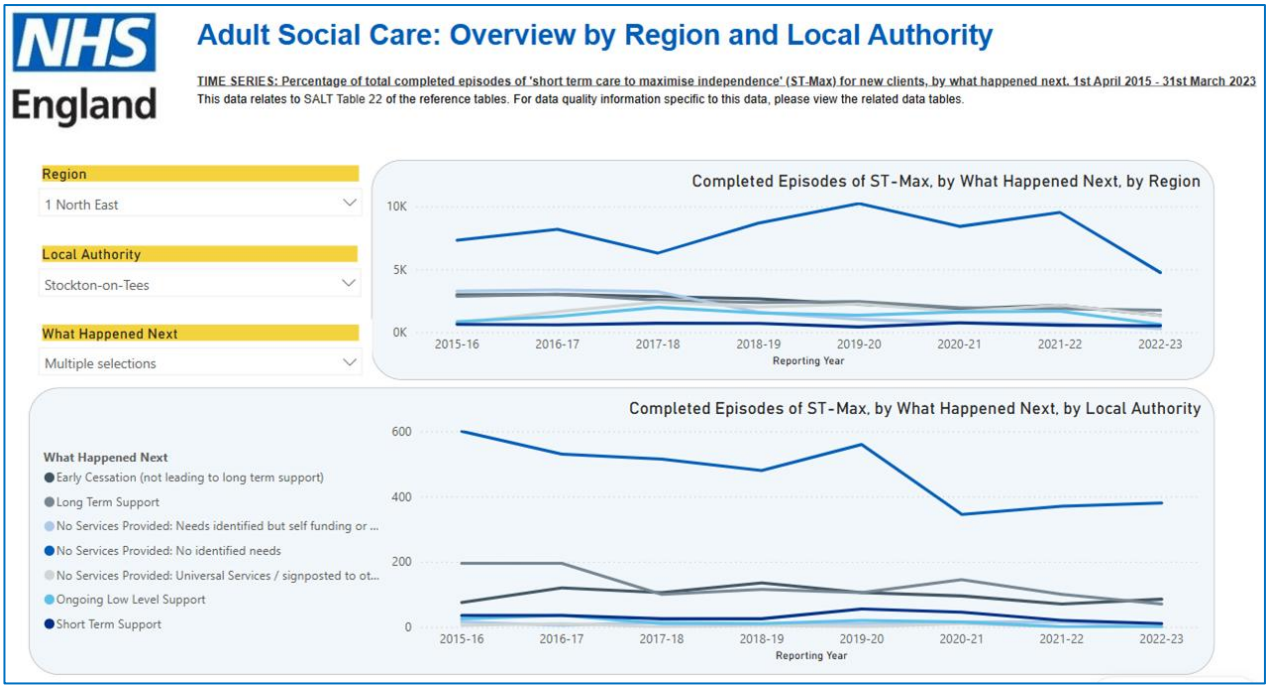
(* *People who left reablement with no care package have been classed as independent. However, 8 of these people were back in services within a month of going home independently*.)

(** *Of the 24 people who left with CAH, 10 were self-funders and 14 were funded by the Local Authority. The average level of support of the packages funded by the Local Authority was 6.4 hours per week*.)

The data for 2023 from the D2A commissioned service before the contract expired showed that 382 people were admitted, of which 113 left with CAH (29.6%), six came into D2A with existing CAH and left with increased hours (1.6%), and 263 were independent (68.8%). Therefore, the data demonstrated that the percentage of people leaving reablement with a CAH package was lower than it was through the D2A service (reducing from 29.6% to 11.8%), and the hours of CAH required were lower for people going through reablement than it was for those going through D2A (reducing from 8.4 hours per week to 6.4 hours per week).

4.39. Nationally collected Stockton-on-Tees performance information was made available to the Committee in the form of NHS England Adult Social Care data (see graphic overleaf). Further NHS England statistics (comparing Stockton-on-Tees against the regional and national averages, and its peer neighbours) were provided in relation to *Measures from the Adult Social Care Outcomes Framework (ASCOF), England* data (see **Appendix 3** and the following link: https://app.powerbi.com/view?r=eyJrIjoiYjI3YjdhZjYtMmVjMi00ZGJiLTk5NGEtZDY3ODUwZjBhZjNlIiwidCI6IjM3YzM1NGIyLTg1YjAtNDdmNS1iMjIyLTA3YjQ4ZDc3NGVlMyJ9):

- 2A: Outcome of short-term services: sequel to service
- 2D1: Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation
- 2D2: Proportion of older people (aged 65 and over) offered reablement services following discharge from hospital



4.40. Customer Feedback: The SBC Adults, Health and Wellbeing directorate was asked to collate views from service-users / families / carers and provide this for the Committee. The following was presented in February 2025:

- How, When and Who?: Reablement had a standard survey that included several set questions and free text boxes to solicit feedback on the service they had received. Guided by the Care Quality Commission (CQC) Assurance Framework, SBC Adult Social Care had updated the questionnaire for 2024-2025 (only two questions from 2023-2024 remained the same). Surveys were issued to all people who had accessed support (from the Reablement Service team and the provision at Rosedale) once the intervention was complete.

- Q3 23/24 & 24/25 Comparator: Noting that around 80-90% of referrals came directly from hospitals (with the rest from the community), data indicated that there had been a large increase in the number of people who had not received (or could not remember receiving) any written information about the SBC Reablement Service before they accessed this support when comparing the same Q3 period from 2023-2024 to 2024-2025. There had, however, been a bigger rise in the number of people who felt 'very or quite satisfied' with the level of support they received from reablement staff between the same period.

- Q3 2024/25 Performance: The majority of survey respondents felt they had been 'very much' involved in, and had had enough chance to influence, the way in which their care was organised (a small minority had answered 'not at all / cannot remember'). Almost all felt the support they received had contributed to making them feel safe, were 'happy' that the outcome of the support they received had met their expectations, and that their overall wellbeing had 'improved a lot' because of the support they had received.

- Commendations and comments: In Q3 (2024-2025), reablement had received 56 compliments from people accessing the service. There were no known formal complaints being considered at present.

4.41. The Committee highlighted the apparent lack of awareness of the local reablement offer (a theme emerging during the course of this review) and emphasised the need for a more understandable term which gave clarity over what this type of service sought to achieve. SBC officers noted that

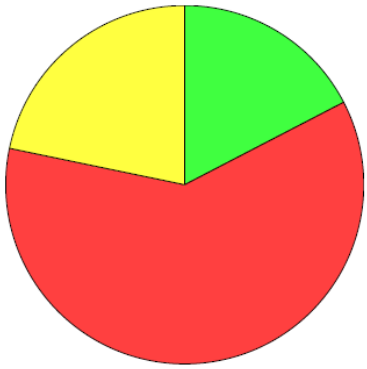
statutory guidance restricted the language used in relation to this form of support, though the possibility of adapting terminology for the general public (which may differ from that used between reablement staff and other professionals) was raised. As referenced earlier in the report (see paragraph 4.23), to address a gap in public knowledge, new leaflets had recently been produced, and the Council could reflect on the Committee's recommendations in relation to this review for future productions. It was also stated that the SBC 'reablement' webpage did have an explainer on it which described what the service involved and what it aimed to do (see https://www.stockton.gov.uk/reablement-service).

4.42. With reference to the provision at Rosedale, the Committee drew attention to the worries of those leaving that setting about going into a care home. There was a need to reassure the public on what support was available within their own home – partnership-working was key in this regard.

4.43. The Committee was informed that the service also received a monthly report (via the SBC 'MyViews' platform) which provided feedback on a host of questions covering matters such as origin of referral, awareness of service, and impact of the support received. Responses to the December 2024 survey included the following:

Before receiving support from the Reablement Service, did you receive any written information about the Service?

Question responses: **23 (100.00%)**



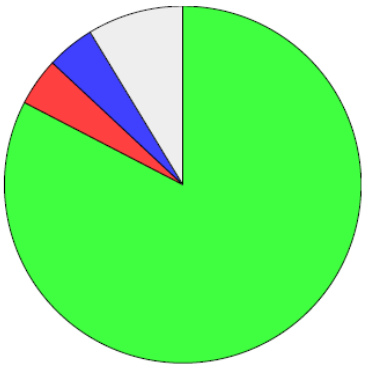
	% Total	% Answer	Count
Yes	17.39%	17.39%	4
No	60.87%	60.87%	14
Not Sure	21.74%	21.74%	5
Total	100.00%	100.00%	23

Table .2

Did the outcome of the support you received from Reablement meet your expectations?

Question responses: **21 (91.30%)**

Did the outcome of the support you received from Reablement meet your expectations?



	% Total	% Answer	Count
I was happy with the outcomes and my expectations were met	82.61%	90.48%	19
I was happy with the outcomes and some of my expectations were met	4.35%	4.76%	1
I was not happy with the outcomes and none of my expectations were not met	0.00%	0.00%	0
Not answered	4.35%	4.76%	1
[No Response]	8.70%	--	2
Total	100.00%	100.00%	23

Comments and / or suggestions in relation to the SBC Reablement Service was also requested and received – observations submitted included:

4.44. Staff Feedback: In order to gain staff views on the current offer, the Committee issued a survey to the existing SBC Reablement Service workforce in January 2025. 26 responses (out of a total of 47) were received, with themes identified for the following questions:

- *Regarding the existing Reablement Service, what aspects work well?*
  - Working in conjunction with other professionals (physio, therapy team)
  - Good communication (in-house and with clients / families)
  - Supportive office staff
  - Record-keeping
  - Signposting to other services
  - Aiding client loneliness
  - Provision of equipment to support independence
- *Are there any parts of the current service which could be improved?*
  - Clients unaware of service
  - Retaining input of physios / therapy team
  - Continuity of care
  - Provision of information about service within, and upon discharge from, hospital
  - Lack of information on individual when referral received
  - Assignment of social worker to team
  - Improved out-of-hours provision / staffing
- *Do you have an opportunity to provide feedback on your experiences as a member of staff and do you feel listened to?*
  - Almost unanimous positivity, with multiple two-way communication mechanisms
  - Open door culture within the team
- *Do you feel adequately supported by your line manager (please explain)?*
  - Very positive expressions of support from management.

- *What are those individuals who you are supporting telling you about the service (e.g. accessing the service / impact of support received / thoughts on leaving the service)?*

  - Grateful for the service – making a real difference to their lives
  - Lack of awareness of service
  - Many want to continue beyond the six-week period and offer to pay to allow this to happen
  - Sad / anxious when leaving the service

4.45. The Committee was also made aware of another in-house survey which SBC Reablement Service staff had responded to in August 2024 (prior to the expansion of the local offer). 15 responses (out of a total of 28 forms issued) were received which indicated:

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Not Answered
Statement 1: I feel supported at work and know who to turn to for support					
87%	13%				
Statement 2: I feel appreciated and valued for the work I do					
73%	27%				
Statement 3: I feel I am kept informed of changes being made to the service					
53%	40%	7%			
Statement 4: I am satisfied with the work pattern and have a good home-life / work balance					
47%	27%	13%	7%	7%	
Statement 5: To help me to progress and meet the demands of my job, I feel that I have access to appropriate training, professional development support, supervision and appraisal					
67%	27%			7%	
Statement 6 : I have good relationships with my colleagues					
73%	27%				
Statement 7: Reablement works well with other professional					
33%	60%	7%			
Statement 8: Reablement staff make a positive difference to the health and wellbeing of people using the service					
87%	13%				
Statement 9: Do you feel like you suffer stress at work? Do you feel able to ask for help if you need it?					
27%	47%	13%	7%	7%	
Statement 10: Do you have an understanding of the mental health resources available to you if you want it?					
60%	33%	7%			
Statement 11: I have no difficulty in reporting any mistakes, incidents or near misses					
80%	13%		7%		
Statement 12. I know that if I make any mistakes or complaints are made about my work, I will be fairly treated.					
67%	33%				

NHS North East and North Cumbria Integrated Care Board (NENC ICB)

4.46. The Committee asked the NENC ICB if there was any flexibility in the duration of the existing six-week reablement offer and to what extent the 91-day metric (see paragraph 4.4) was being met locally. The NENC ICB representative confirmed that the reablement service was available up to a maximum of six weeks but that, in some cases, an individual required support for a lesser amount of time. As far as the national metric was concerned, around 86% of people were still at home 91 days after discharge from hospital into local reablement or rehabilitation services (this placed Stockton-on-Tees as the third best performer in the North East and second only to Middlesbrough within the sub-region).

4.47. A query was raised as to whether the NENC ICB received any feedback on the local reablement service from partners or the public – the Committee was informed that it did not as this was delivered through SBC (it was noted that the ICB was not permitted to hold patient-level data). Discussion ensued around the importance of the relationship between services and those accessing them, a crucial link which can ensure any issues were raised and addressed in a timely manner. The Committee fully endorsed engagement with service-users and those with lived experience in terms of shaping the present and future offer.

North Tees and Hartlepool NHS Foundation Trust (NTHFT)

4.48. Regarding the questions put to NTHFT in advance of its submission, Trust representatives added that, in terms of measuring the success of the existing Reablement Service, this was difficult to comment on given NTHFT did not have access to relevant data. However, it was recognised that the Borough's reablement provision played a key role in the ongoing strong local performance around hospital discharge, much of which reflected the established partnership between NTHFT and SBC. It was also noted that the Trust had received no feedback (either positive or negative) from the public about the Reablement Service – any compliments / complaints would likely be submitted to the Council.

4.49. The Committee asked about the virtual ward model and how this was operating across the Borough. The SBC Director of Adults, Health and Wellbeing commented that, whilst local performance was just behind the national average, it compared well against other regional areas. In related matters, it was also confirmed that high-level BCF metrics were considered by the Stockton-on-Tees Health and Wellbeing Board on a quarterly basis.

Other Approaches / Good Practice

4.50. Developments involving the reablement offer in **County Durham** were relayed in January 2025 (https://www.cdcarepartnership.co.uk/application/files/7117/3634/4616/CDCP_Partnership_Newsletter_Winter_25.pdf (see pages 10-11)). This followed an evaluation of the current service by Peopletoo (brought in by SBC to do the same locally – see paragraph 4.56) which had led to the establishment of a new model to be phased in from the start of 2025.

Consisting of eight key elements, the first involved the adoption of a zoned approach to service delivery, focusing on three zoned areas where demand had exceeded the current provider capacity. The aim was to increase capacity by establishing one new provider of reablement per zone with approaches made to existing providers of support and assistance to people in their own homes (domiciliary care) in these zones.

The remaining elements are shown on the graphic overleaf:

Outcome based - the second element of the new model is to move towards outcome-based commissioning rather than time and task and with the ability to flex up and down packages. This means trialling a new approach paying per reablement episode and closely tracking key performance indicators. We have co-produced a 'goal plan' for provider staff to use to track service user progress.

Out of hours support - the third element will introduce a move to the referrals for reablement only in office hours. Generally, the out of hours element of the reablement service sees low levels of activity disproportionate to the costs of running an out of hours service. In the new service model this process has been simplified with the Short Term Assistance Service (STAS) being expanded to cover any non-complex, out of hours care at home. This change in arrangements has now been implemented.

Trusted Assessment - the fourth element will see the introduction of trusted assessment for non-complex equipment requirements, such as a commodes or shower stools, which will help reduce unnecessary handoffs to health and social care professionals for additional assessments. Reablement staff will be able to order simpler pieces of equipment directly from Medequip as a Trusted Assessor.

Greater use of Technology - the new model will see technology enabled care embedded into Reablement. This includes activities of daily living monitoring system that can help social care professionals complete objective and evidence-based assessments. This will help people to receive the right level of care and support at the end of the reablement episode. Work on the tender documentation is underway.

Wraparound therapy support – the new model will include further development of wraparound therapy support for reablement at home. Some early conversations have taken place with CDDFT to look at how best to embed additional therapy support during reablement.

Wider support – work to strengthening support available following reablement support and improved methods for referring into other services. such as VCS, Social prescribing link workers, Wellbeing for Life. Building this resilience help prevent people returning to reablement.

To implement the new reablement model a multi-agency reablement steering group has been set up and a Provider Forum for those providing reablement services will also be established once the services go live.

County Durham: development of new reablement model (January 2025)

4.51. Other examples of reablement-related activity / thinking outside Stockton-on-Tees were highlighted to the Committee in February 2025:

VCSE-related

- **Greater Manchester**: VCSE Home from Hospital Programme https://10gm.org.uk/10gms-work/home-from-hospital/

- **Rocket Science**: Learning from a review into reablement (Jan 24) https://rocketsciencelab.co.uk/2024/01/review-into-reablement/

Scrutiny-related

- **Islington Council**: Scrutiny Review of Adult Social Care Transformation (Jan 23) https://democracy.islington.gov.uk/mgAi.aspx?ID=31147

- **Leicester City Council**: An Overview of the Reablement Service (Mar 24) https://cabinet.leicester.gov.uk/documents/s152094/Reablement%20Service%20Report%2007-03-24.pdf

- **Brent Council**: Reablement Service Update (Apr 24) https://democracy.brent.gov.uk/documents/s141232/8.%20Reablement%20Service%20Update.pdf

Technology-related

- **Access**: Reablement – Everything Care Providers Need to Know (Feb 24) https://www.theaccessgroup.com/en-gb/blog/hsc-reablement-everything-care-providers-need-to-know/ (*note: scroll down for the section on 'How can technology help support community reablement services?)*

- **Totalmobile**: A Complete Care Management Solution for Reablement Services https://www.totalmobile.co.uk/wp-content/uploads/2023/04/A-Complete-Care-Management-Solution-for-Reablement-Services-Providers-Portal.pdf

Other

- **Healthwatch Stoke-on-Trent**: Stoke-on-Trent City Council to review and modernise local reablement services (Jan 24) https://www.healthwatchstokeontrent.co.uk/news/2024-01-25/stoke-trent-city-council-review-and-modernise-local-reablement-services

- **MJ**: 'Time for a new dawn' article (Aug 24) https://www.communitycatalysts.co.uk/wp-content/uploads/2024/08/MJ-article-Time-for-a-new-dawn-090824.pdf

4.52. In addition, the Social Care Institute for Excellence (SCIE) launched a new practical resource (https://www.scie.org.uk/app/uploads/2024/09/Reablement-full-resource.pdf) on 10 September 2024 to support reablement services in delivering better outcomes for people who needed reablement support, their families and social care staff. A **webinar** ('*Helping reablement services boost user engagement and patient outcomes*') was also held on 10 September 2024 which spoke to this resource, the research that underpinned it, and the key recommendations that could help to make a difference (https://www.scie.org.uk/integrated-care/intermediate-care-reablement/reablementwebinar/). Key messages included:

- The need to raise awareness / understanding of reablement provision with health professionals (stressing benefits to them in reducing the likelihood of seeing an individual back in hospital) and family members (who can be as influential as the individual seeking / requiring support).

- Reablement presence in referral settings (e.g. Discharge Hubs).

- Health professionals can be anxious about individuals being exposed to perceived risk (tend to be more risk-averse).

- Local news a good way to promote services, particularly TV which may like a positive story.
- Appears to be a need for a national public education campaign around reablement services.
- Commissioners have a vital role in ensuring consistent messaging / standards of practice (particularly if local provision involves private operators).
- Importance of goal-setting in conjunction with families and recording / visibility of progress (particularly if multiple staff are involved in supporting an individual).

4.53. Department of Health and Social Care (DHSC) 'Hospital discharge and community support guidance' (July 2022) includes a case study on **Surrey County Council** (page 7) which describes how '*They have increased capacity in these reablement services by setting them up in partnership with home care providers. Staff operate the same way regardless of who employs them, so the difference in providers is not felt by the individual*.'

SBC *Powering Our Future* (POF) Developments

October 2024

4.54. In October 2024, SBC officers provided a summary of the reablement review being undertaken via the Council's *Powering Our Future* (POF) initiative, the project proposal of which was signed off by the POF Board in June 2024. As part of the first phase of this work, the commissioned Discharge 2 Assess (D2A) provision was brought in-house earlier in October 2024, and a pilot assessment of activity monitoring technology would begin (the results of which were due to be reported in December 2024 – see paragraph 4.67). Phase two of the review was looking to establish revised models of reablement to accommodate support for people in the community and greater numbers of people being discharged from hospital, as well as those with a mental health need, autism or learning disability.

4.55. With reference to the first phase of the ongoing POF review of reablement, the Committee enquired about what sort of technology was being considered as part of the intended pilot. SBC officers spoke of the use of sensors (subject to an individual's consent) which fed into a dashboard to give a picture of how a person was managing within their own home – this could help understand patterns of behaviour which could then identify risks (including changes in normal routines which may indicate a problem) and any associated support needs.

January 2025

Peopletoo

4.56. The SBC *Powering Our Future* initiative involved a range of transformation reviews, one of which focused on supporting people to live independently. As part of this work, the Council was exploring what reablement services needed to provide to support a broader range of people from local communities. In 2024, SBC commissioned Peopletoo to assist the Council in assessing the impact of current ways of working and analyse the best model for continuing to support people to maximise their independence. Peopletoo had recently completed its work and provided feedback to the Committee in January 2025:

4.57. Project Scope – Reablement / Enablement / Rehabilitation: With a background in working alongside Local Authorities and a view to looking at 'the art of the possible', Peopletoo's focus areas for its project in Stockton-on-Tees included reablement expansion, covering both people

being discharged from hospital and people in the community. To get from where the service was now to where it needed to be, key lines of enquiry included:

- Who / what was the optimum population the reablement service could expanded to in order to accommodate more hospital discharge / community support (return on investment / impact on people's lives)?
- What was the most efficient model to deliver the new service (not just more staff, but technology / good practice)?
- What size / type of reablement service would be needed to make a positive impact on people with a learning disability / autism / mental health needs through a reablement offer?
- What would be the most effective method of delivering the service to people with a learning disability / autism / mental health needs?

4.58. Peopletoo Review Activity: A range of interactions were undertaken which involved visits and shadowing teams, case reviews with professionals within Stockton-on-Tees, conversations with senior and regional leaders, and the analysis / benchmarking of data. Peopletoo encountered no barriers when conducting its work and found a positive culture across the Borough which reflected the openness and honesty of professionals.

4.59. Overview of key findings from Reablement: Peopletoo was currently working with SBC to validate data – once the full report was finalised, representatives were happy to report back to the Committee if required. Prior to this, some headline findings were relayed in relation to improved independence outcomes, increasing referrals, challenges with declined referrals, staff and workforce development, digital and technological integration, benchmarking and performance, and cost and resource efficiency.

Improved Independence Outcomes	• The percentage of clients leaving the service independent increased from 71% in 2023 to 75% in 2024 • Stockton leads in the region, with 70% of individuals requiring no further services post- reablement, compared to 54% regionally and 45% among CIPFA group averages
Increasing Referrals	• Referrals have grown significantly, with an 85% increase in October 2024 compared to October 2023, aligned to bringing D2A service into Reablement. • The majority of referrals come from hospital discharge (66%) • Population aging and health inequalities are driving higher demand for adult social care services. • Capacity in the service can lead to waiting lists and some missed opportunities for early intervention.
Challenges with Declined Referrals	• Of the referrals declined, 73% were declined primarily due to capacity constraints and lack of availability for double- handed care of evening calls. • Bottlenecks in care transitions, delaying timely support beyond six weeks. • Miscommunication about reablement purpose in and duration by referrers leads can lead to mismatched client expectations.
Staff and Workforce Development	• Staff retention is strong, but there are capacity challenges due to sickness, health leave and retirements • Training gaps exist, particularly for working with clients with learning disabilities, mental health issues or autism
Digital and Technological Integration	• While power BI tools are in use, daily operations still rely on excel spreadsheets indicating a need for further digital transformation • There is potential for increased use of assistive technology to improve outcomes
Benchmarking and Performance	• Stockton demonstrates strong performance in promoting independence and reducing transitions to long- term care compared to its peers
Cost and Resource Efficiency	• Average cost per episode of reablement is estimated at £1600, with an average of 22/23 hours of care per episode • There is the potential to increase community referrals by targeting identified profiles with potential for independence. • There is a potential cost avoidance savings by improving referral pathways and expanding service capacity.

4.60. Overview of key findings from Hospital Discharge: Headline findings regarding reablement uptake, delays in hospital discharge, over-prescription and risk aversion, strain on Rosedale Centre, and Integrated Single Point of Access (ISPA) and multi-disciplinary gaps were noted.

4.61. Also covered was an Overview of Overall Opportunities, How this could be implemented (Reablement), and How this could be implemented (Hospital Discharge) – see paragraph 4.78-4.80.

4.62. The Committee sought clarity on when the final report was likely to be published. Members were informed that data was due to be reviewed this week, with a discussion to then be held with senior Council officers. In terms of timings, there was an attempt to align reporting with both the *Powering Our Future* and Committee reviews.

4.63. Regarding engagement with professionals, the Committee asked if Peopletoo spoke to the local Falls Service – it was subsequently confirmed that this team was indeed included within the case review workshop. Peopletoo noted that it was working with 15 Councils across the UK (details of one such example, Durham, was incorporated within the covering report for this agenda item), and also drew attention to the fact that its work in Stockton-on-Tees coincided with the inspection of SBC adult social care provision – it would therefore be interesting to see how far the regulator's findings (once published) echoed what was encountered by Peopletoo.

4.64. Turning to the key findings, Members wondered if the increasing rate of referrals into reablement provision (up 85% in October 2024 compared to October 2023) was reflective of any increase in the total number of people discharged from hospital over the same period. In terms of delays in hospital discharge, the Committee expressed surprise in the quoted '812 days delayed reported within a 5-month period (June-November)' – this was concerning given that local performance had frequently been heralded and held up as an example to others across the UK. SBC officers suggested that the data could likely be attributed to the period around the transitioning of the previously commissioned Discharge 2 Assess (D2A) provision into reablement, and also provided assurance on additional capacity (Comfort Call) that had been brought in to bolster the offer. There was no current waiting list to access the service.

4.65. The Committee asked if Peopletoo were involved with any other Council departments (e.g. Children's Services). Representatives noted some work which was previously undertaken around transitions in Stockton-on-Tees, though that was not as detailed as this reablement-related project.

4.66. In February 2025, Members expressed their desire to see whether the full findings of Peopletoo were consistent with the results of the CQC inspection of SBC Adult Social Care services which took place in late-2024. SBC officers would seek confirmation after this meeting as to when this information (both Peopletoo and the CQC feedback) was likely to be available.

March 2025

4.67. A further update was given to the Committee in March 2025 which outlined the following:

- Reablement Phase 1 (D2A): The original outcomes were to review the mechanisms and services to support people living at home and avoiding the need for long-term residential care. A proposed solution to part of this objective was the expansion of the Reablement Team to support people who were being supported under the Discharge to Assess (D2A) contract through SBC-commissioned Care at Home (CAH) providers once this contract ended on 7 October 2024. While still in the early stages of the new model, the evidence to date had been positive (see paragraph 4.38).

- Reablement Activity Monitoring: Activity Monitoring was a package of equipment that could be installed in a person's home to track their activity throughout the day, which was then monitored remotely through intuitive software. This monitoring could help ensure the safety, health and wellbeing of the care recipients, and involved observing daily routines, physical movements, social interactions, and other relevant activities. Collected data supported evidence-based decision-making to determine the right person-centred care and support, delivered by the right person at the right time, enabling a more targeted approach and best use of limited resources.

The pilot programme looked at 21 referrals for testing out this technology in people's homes which evidenced delays for the need of long-term care, reduced care packages and improved outcomes for clients and their family. It was recognised that a period of cultural change and support activity was required both within Adult Social Care teams and the public to increase take-up and subsequently increase efficiencies and improved outcomes for this emerging technology. To support this, approval was given by the Board to progress with the proposed recommendations outlined below:

- Training for ASC teams and the introduction of Practitioner Guides to upskill staff in the benefits of Activity Monitoring to clients and their support networks (to be delivered in house). To develop skills in utilising Activity Monitoring as an assessment tool and using the new technology.

- Development of marketing materials that can be shared in the public sphere including as part of the new "front door" pathway, on the SBC website, promotion in Stockton News and social media.

- Introduction of key performance indicators for ASC teams and an introduction of Activity Monitoring to be included into Liquid Logic Adults System (LAS) as an intervention tool.

- Continue to utilise One Call to deliver Activity Monitoring whilst recommendation 2 is achieved and review funding options after 6 months / in line with demand.

- Reablement Phase 2: Based on Peopletoo's assessment of the evidence and experience of other Local Authorities, the recommended option to SBC was a phased enhancement of reablement and preventative services, supported by workforce development, improved performance monitoring, and increased use of assistive technology (see table below).

Objectives	What we would recommend based on evidence collected
Objective 1: Who / what is the optimum population we could expand our reablement service to accommodate more hospital discharge / community support (ROI / impact on people's lives)	Expanding the reablement service to support an additional 195 additional clients that can benefits from reablement per year, made up for 142 existing clients at the point of their review or assessment and 53 clients that have progressed through in-house rehab intervention that have potential to benefit further. Reablement support would support these clients to live independently with less intensive support, greater confidence levels and spending less on their care and support needs.
Objective 2: What is the most efficient model to deliver the new service (not just more staff, but technology, modes of working, good practice, etc.)	To deliver an efficient service, we would recommend actions to be taken forward to enhance the existing service, whilst developing an enablement offer alongside. To enhance the existing service: • Implement technology that will reduce Support Workers time spent on non-direct delivery or non-value add activities • Review rostering systems and identify opportunities to maximise the number of slots available to deliver reablement • Maximise outcomes achieved by improving pathways for specialist input such as OT, therapy staff, Community Stroke team

Objective 3: What size / type of reablement service would be needed to make a positive impact on people with LD, Autism, MH needs through a reablement offer?	Stockton-on-Tees supports 565 clients with learning disability (LD) support needs and 356 clients with mental health (MH) support needs, making up approximately 29% of the clients in receipt of care and support. There has been a rise in demand (60%) since 2022 for clients who require learning disability support.
Objective 4: What would be the most effective method of delivering the service to people with LD, autism or MH needs.	Feedback from practitioners across different services suggests that clients with LD, autism and MH needs are likely to respond to enablement more positively when delivered through a trusted individual that can take the time to develop a relationship with the client. Stockton-on-Tees already has a team of Community Support Workers that deliver 1:1 enablement support to clients, however, there is limited standardised data on outcomes achieved to assess the impact of the service. A focused pilot to deliver intensive goal-focused enablement support through the Community Support Workers will provide evidence on rolling out a wider approach.

- Adult Social Care Front-Door Review: The POF-related review aimed to understand how the Council's front-door could be more effective in signposting people to other forms of support (where a Care Act assessment was not required) – this would be part of the wider solution to manage and reduce the dependence on long term care. It had since been concluded that the most appropriate course of action was for the Council to:

  - Commit to developing a digitally enabled front-door model.
  - Develop a formal proposal regarding team structure for the front-door.
  - Embed activity monitoring within Adult Social Care, with SBC operating an 'opt-out' rather than 'opt-in' model (as agreed in January 2025).
  - Enable digital and change management expertise around the development of the Adult Social Care front-door so that learning can be applied to the review of the SBC Children's Services front-door.

  It was felt that the implementation of the above findings could potentially be delivered in-house (with increased capacity) or in collaboration with a commissioned expert company with experience of digital change management. There were considerations to the costs, timescales and skills in these different options for the POF Board to consider.

September 2025

4.68. Following the Committee's decision in April 2025 to defer approval of its Scrutiny Review of Reablement Service final report until it had received the full findings of Peopletoo's review into local reablement provision (as well as the outcomes from the Care Quality Commission (CQC) inspection of adult social care services in late-2024), an informal session was convened in September 2025 to consider the final Peopletoo report (which had been shared with the Committee in July 2025).

4.69. Broadly reflecting the key elements relayed to the Committee in January 2025 following the rapid six-week review of local services, the report included the project background and methodology, commentary on hospital discharge, a list of constraints and interdependencies, service position / performance, best practice models, financial considerations, key findings, and improvement / change opportunities. A set of recommendations (based on the original Peopletoo brief) also featured, as were some 'secondary' recommendations that could inform improved performance and practice through reablement. It was noted that the report had been considered by the SBC *Powering Our Future* (POF) Board earlier in September 2025.

4.70. Looking at the report as a whole, SBC officers stated that there had been nothing ground-breaking which had been found or that the Council were not already aware of. Work was continuing around the local reablement offer to develop the existing service and build greater capacity.

4.71. Noting that a key objective of the work by Peopletoo was to understand and make recommendations for expanding the reablement service to support those people with learning disability, mental health and autism needs, the Committee drew attention to the comment that '*due to the lack of robust evidence, it was not possible to make definitive recommendations on a model for delivery*'. SBC officers confirmed that more time was required to get a clearer picture around this objective.

4.72. Highlighting Peopletoo's previous reference to staff training gaps (see paragraph 4.59), as well as the report's statement that there was high staff turnover and training gaps (especially for supporting mental health, learning disabilities, and autism), the Committee emphasised the need for the Council to provide assurance around the workforce. SBC officers stressed that training was taking place, with all direct service staff having completed the Oliver McGowan requirements (a mandatory programme on learning disability and autism for health and social care staff), and reablement personnel now involved in daily meetings regarding discharge, weekly meetings around service pressures, and monthly meetings on service performance.

4.73. Discussion turned to the ongoing frustration that decisions around changes to local reablement provision continued to be taken before the Committee had agreed its final report. Assurance was given that there had been no deliberate reason for the delay in sharing the final Peopletoo findings, though it was acknowledged that a lack of awareness and understanding of how the POF Board operated was causing challenges for Members (who subsequently voiced concerns around the limited influence Select Committees / Councillors appeared to have by comparison).

Future Considerations / Options

Stockton-on-Tees Borough Council (SBC)

4.74. Two key areas were identified regarding considerations around the future service offer. The first concerned the issue of 'demographics', with population projections up to 2030 showing that there was an expectation for a consistent increase in the number of people aged 55 and over in the Borough (particularly in the 65 to 69 and 80 to 84 age-brackets). Related to this, a system developed by the Institute for Public Care indicated that 'projected service demand' for both the Borough's residential and nursing care population was expected to grow by 10% over the next five years. Whilst SBCs local market assessment for residential provision anticipated that this growth would be significantly lower, acuity, length of stay, and use of short-term assessment beds to support hospital discharge would impact on the Council's ability to support people to independence.

North Tees and Hartlepool NHS Foundation Trust (NTHFT)

4.75. Reablement provision was a key element in delivering more care in the community, and the Trust (with its partners) was trying to push the boundaries regarding what could be done outside of the hospital environment. Investment in technology to aid in the move from analogue to digital (NTHFT was already working with the existing SBC Reablement Service in relation to telecare) and focusing on preventing people from reaching crisis point (requiring collaboration between partners) were also future considerations.

4.76. From a service structure perspective, a move to facilitating 24/7 access should be central in developing the current offer as it was not appropriate to stop provision at 5.00pm. Continuing with the 'Discharge to Assess' principles so as many assessments as possible were undertaken outside the hospital setting was important, particularly since individuals may be more independent within their own home and not require a significant care package identified whilst in hospital. Developing understanding and management of complex cases, and the use of OPTICA (a secure cloud application, built by North of England Care System Support (NECS) in collaboration with NHS Trusts and Local Authorities, which tracked all admitted patients and the tasks relating to their discharge in real-time through their hospital journey) within the community was also highlighted.

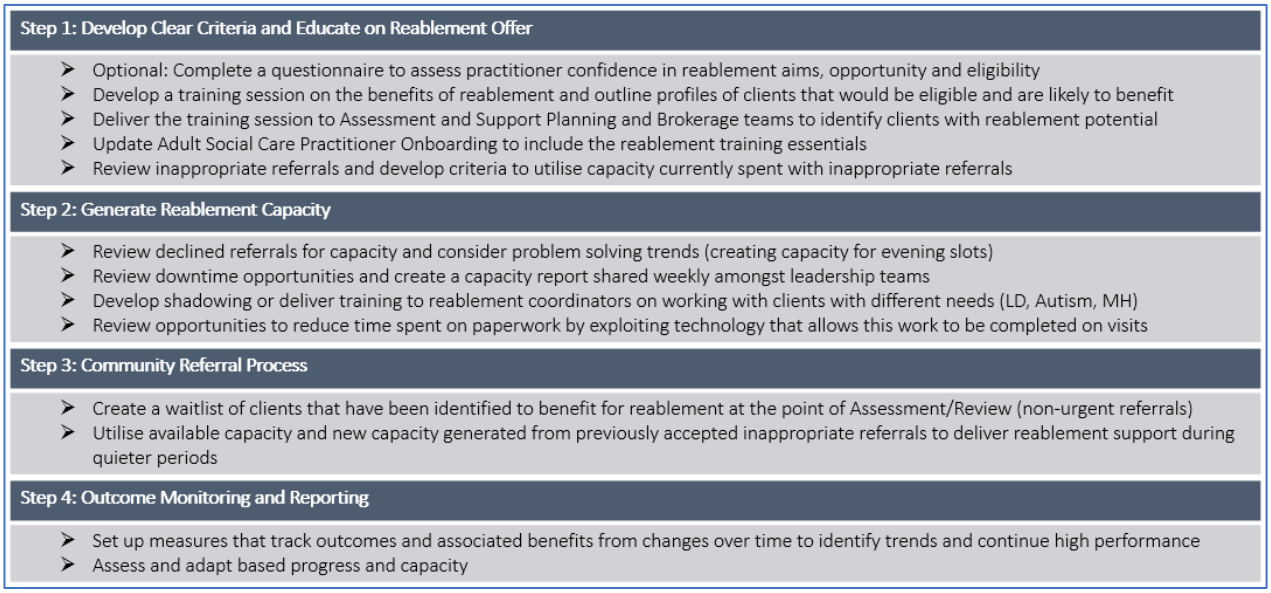
4.77. The Committee asked how the provision of 24/7 reablement care might impact upon the recruitment and retention of staff. The Trust stated that it was aware of pockets of its workforce who would prefer to undertake their duties more flexibly (including nightshifts), though acknowledged that it would need to make specific approaches / adverts to identify interested individuals (whilst not the same type of offer, the ISPA had been operating on a 24/7 basis for around 18 months now). Demand for support within the community would continue to increase, and this would have ramifications for workforce planning.

Peopletoo

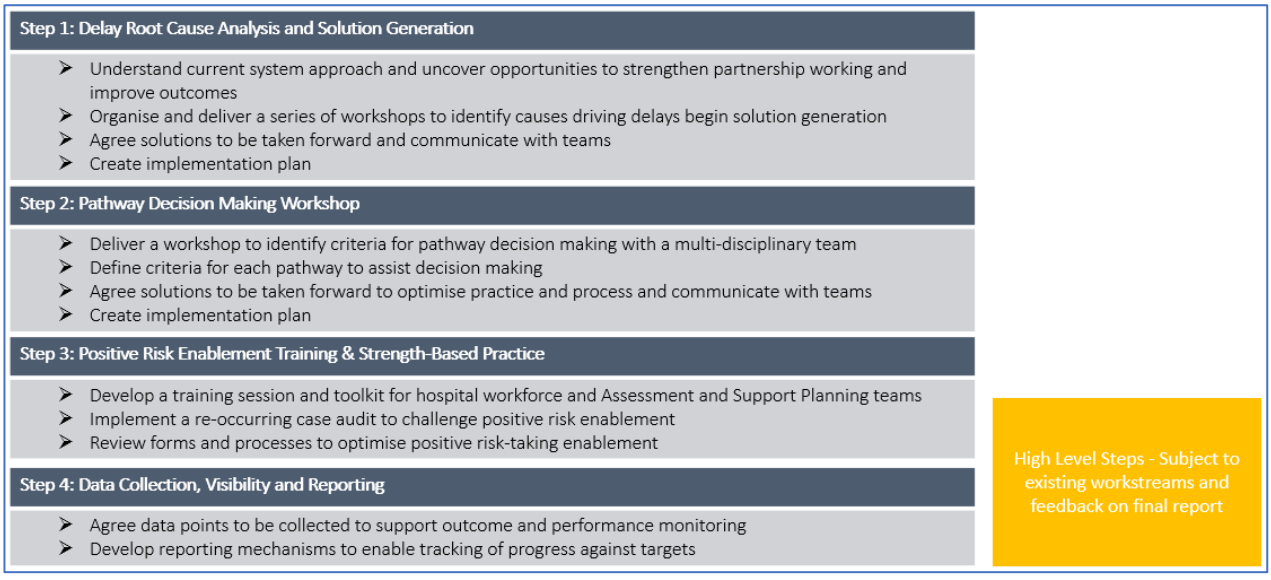
Short Term	Medium Term	Long Term
Pilot Enablement Pathways: - Collate learnings from the enablement support provided at existing Learning Disability Respite and Day Services - Develop a pilot to provide intensive goal-focused enablement to clients currently living at home to support continued independence and progression towards goals - Develop clear KPIs and tracking to monitor and report on progress of Pilot	Enhance Reablement Based Services: - Grow home-based reablement solutions, including home adaptations and technology-enabled care (incl. expansion of One-Call) - Collaborate with local organisations to enhance community support networks - Look at how the capacity for evening and double handed care slots and develop	Embed Reablement as Core Practice: - Transition to a model where all eligible service users undergo a reablement assessment as a standard procedure - Use reablement outcomes as key performance indicators for service evaluation
Enhance Frontline Training: - Equip care practitioners with tools and skills to integrate reablement principles in daily activities - Conduct workshops and refresher courses to embed a culture of enablement and enablement across teams	Optimise Resource Utilisation: - Focus on clients with high potential to benefit such as individuals transitioning from hospital care or those with complex needs	Sustain Financial Savings: - Invest cost savings from reduced long-term care reliance into innovative enablement programs and workforce development - Monitor expenditure trends to ensure sustainability
Streamline Data Collection: - Improve data accuracy and timeliness to support decision-making - Standardise data collection and reporting processes across workstreams	Improve Interdepartmental Coordination: - Integrate PMO insights with operational planning to ensure alignment between strategic goals and frontline execution	Evaluate and Scale Successful Models: - Continuously assess pilot programs to identify best practices - Scale proven enablement models across all relevant service areas

4.78. Overview of Overall Opportunities: Identified activity for the short-term included an enablement pathway pilot, enhancement of frontline training, and the streamlining in the way data was collected. Over the medium-term, reablement-based services could be enhanced, utilisation of resources optimised, and interdepartmental co-ordination improved. Longer-term, actions were proposed to embed reablement as core practice, sustain financial savings, and evaluate and scale successful models (see graphic on previous page).

4.79. How this could be implemented (Reablement): Key steps were outlined focusing on the themes of developing clear criteria and educating on the reablement offer, generating reablement capacity, the community referral process, and outcome monitoring and reporting (see graphic below).



4.80. How this could be implemented (Hospital Discharge): Actions were identified within the themes of delaying root cause analysis and solution generation, a pathway decision-making workshop, positive risk enablement training and strength-based practice, and data collection, visibility and reporting. It was re-iterated that these proposals were high-level steps which were subject to existing workstreams and feedback on the final report (see graphic below).



4.81. With reference to the proposed future opportunities (and how these could be implemented) for local reablement provision within the January 2025 presentation, the Committee queried if these were likely to be replicated in Peopletoo's final report. It was confirmed that a paper was being produced (with costings) for each option – this would be presented to the *Powering Our Future* (POF) Board.

4.82. To create and maintain robust oversight of current and potential future demand within the Borough, the Committee suggested that there may be merit in a single database which relevant organisations could securely access. Members were informed of the existing social care system which recorded reablement-related activity, and that this provided a link between the Council and local hospitals. In addition, a recent decision had been made to introduce the Great North Care Record as a further way of sharing patient information – a dataset had been agreed and would include an opt-out system for individuals. The Committee expressed caution around the well-established challenges associated with making personal data / information accessible.

Voluntary, Community and Social Enterprise (VCSE) Sector (via Catalyst)

4.83. VCSE organisations considering the provision of / supporting such a service needed to have the required capacity to meet demand and full cost-recovery funding (ensuring a good quality and sustainable offer). From a sector perspective, perceptions that VCSE involvement was free or cheap should be addressed (i.e. paid staff were required to recruit volunteers, with incentives for the latter also a factor for consideration).

4.84. Addressing barriers would enable the VCSE sector to be well placed to support SBC with the delivery of local reablement services. VCSE organisations were able to bridge gaps in statutory care (working flexibly without being bogged down with bureaucracy), and there was the potential for a Community Navigator role which linked up the broad range of services that existed to make it easier for families to identify possible support (this had already been discussed with SBC and the NENC ICB – the Wellbeing Hub in Wellington Square, Stockton being a possible base). The sector also had volunteer networks (supported by a Stockton-on-Tees Volunteers website), and Catalyst worked in partnership with SBC (and with input and support of the VCSE sector) to develop a new Volunteering Strategy for Stockton-on-Tees (this needed renewing in 2026). Catalyst was trying to secure funding for strategic oversight of volunteering – this would help nurture a culture of volunteering across the Borough.

4.85. Maintaining their already close partnership across a vast range of issues, SBC and the VCSE sector would continue to help each other in making the Borough a better place. VCSE organisations needed to demonstrate what they could bring to the table, and their support would be aided by the removal of barriers, tackling unrealistic expectations, and the identification of common purposes and mutual outcomes.

4.86. Praising the sector for what it did within the Borough, the Committee asked how volunteers were sourced. Methods highlighted included the Stockton-on-Tees Volunteers website (VCSE organisations were encouraged to upload relevant details), Catalyst attendance at community events (e.g. Eid Fusion), and the Catalyst Project Co-ordinator's role involving engagement with businesses to encourage volunteering. Stressing the benefits of volunteering for both the individual as well as the people they were helping was important, and there was a developing focus on opportunities for young people to offer their time (something which could assist with career development, university applications, etc.).

4.87. Given the Council provided investment towards Catalyst, Members expressed surprise that there seemed to be an absence of strategic oversight between the VCSE sector and SBC when it came to the local reablement offer (prompting the impression that these two entities were working in isolation), and queried whether hospitals and the SBC Reablement Service had a main contact for the sector regarding help at home (and vice-versa). Catalyst gave assurance that it had wide

links with partner organisations within the Borough, as well as an overview of the available support across the VCSE sector (though acknowledged that not all VCSE organisations chose to engage with Catalyst). SBC officers in attendance added that the 'Communities' workstream of the Council's *Powering Our Future* initiative was involved in the refresh of the Volunteering Strategy for Stockton-on-Tees, and the SBC Community Engagement Team had links to VCSE support. The SBC Reablement Service was encouraged to look at the Stockton Information Directory (SID) to identify VCSE organisations which could provide any relevant assistance for individuals – if nothing was available, this would be escalated to SBC Service Managers. The Committee reiterated the need to establish person-to-person links between SBC, local hospitals and Catalyst.

4.88. Welcoming the growth of the SBC Reablement Service, the Committee stated that a number of people required help (often very individualised) beyond the six-week period which the service provided. Whilst funding was always useful, Members felt that support options already existed and could be facilitated via improvements to communication mechanisms between local organisations.

5.0 Conclusion & Recommendations

5.1. Rooted within legislation (Care Act 2014 s2) which requires Local Authorities to prevent, reduce or delay needs for care and support for all adults (including carers), 'reablement' was one of several short-term offers involving NHS and social care services (alongside home-based, bed-based, and crisis response care) which come under the wider umbrella of 'intermediate care'. The Care Act regulations compel Councils to provide reablement support free-of-charge for a period of up to six weeks (this was for all adults, irrespective of whether they had eligible needs for ongoing care and support).

5.2. Reablement involves the provision of assistance within a person's own home. This assessment and support service helps an individual to do tasks (e.g. washing, getting dressed) for themselves rather than relying on others, with support workers operating alongside the person while they regain skills and confidence. The aim was to maximise independence (doing tasks 'with' them, not 'for' them), and the service can be used to support discharge from hospital, prevent re-admission, or enable an individual to remain living at home.

5.3. The Stockton-on-Tees Borough Council (SBC) Reablement Team was expanded in October 2024 as the Council continues its focus on early intervention and prevention as part of its ongoing *Powering Our Future* (POF) initiative. Visits to service-users occur up to four times per day, with Senior Support Workers holding regular weekly reviews with individuals to ensure they were on track to achieve their goals and adjust their support plan accordingly (they were also able to assess and order low level equipment to aid independence).

5.4. Other relevant stakeholders include the NHS North East and North Cumbria Integrated Care Board (NENC ICB), which has a key role in overseeing the health and care 'system' to plan, design and deliver intermediate care services (including reablement) following hospital discharge, with the local priority on people gaining and maintaining independence for as long as possible. The North Tees and Hartlepool NHS Foundation Trust (NTHFT) was another key partner within local integrated services, working alongside SBC to provide an Integrated Single Point of Access (ISPA). There was also a well-established Integrated Discharge Team (contributing to the Trust having one of the top performing Emergency Departments in England – a reflection of the strength of pathways in place to get people home), as well as a Community Integrated Assessment Team (CIAT) which worked in collaboration with the SBC Reablement Service.

5.5. A significant majority of referrals into the SBC Reablement Service came directly from hospital (with the rest from the community). The service may be accessible if an individual has a temporary illness / accident, a crisis, a change in their (or their carers') circumstance, or to avoid unnecessary admission to hospital. Where a 'need' (not a 'want') had been identified, individuals would be referred following an assessment via a health or social care professional – any subsequent support could be tailored to the individual, and its duration was dependent upon their progress (i.e. this free service could be less than the maximum six-week period). For those not in hospital, it was not clear how the Council or its partners identified individuals who may benefit from the service.

5.6. In terms of public awareness and promotion of this type of provision, there were several references over the course of the review to the vagaries around the term 'reablement' itself. The Committee recognise that this is accepted health terminology, but there is clearly a need to fully explain and promote what reablement actually entails so the public have a better understanding of how these services can help them or a loved one. In addition, published NHS survey data suggests local Trusts have work to do in providing clarity around available options following discharge – this was reinforced by customer feedback presented to the Committee, as well as the Reablement Service staff who reported that the people they support were often unaware of local provision. Furthermore, Adult Social Care Outcomes Framework (ASCOF) data showed that the

proportion of older people (aged 65 or over) offered reablement services following discharge from hospital (measure 2D2) was consistently lower in the Borough compared to regional and national scores for every year since 2019-2020 – this is perhaps surprising given NTHFTs stated recognition that the Borough's reablement provision played a key role in the ongoing strong local performance around hospital discharge, much of which reflected the established partnership between NTHFT and SBC.

5.7. The Better Care Fund (BCF) was used as a mechanism to bring NHS services and Local Authorities together to tackle strains faced across the health and social care system, and to drive better outcomes for people. Reablement services were one of the Stockton-on-Tees BCF schemes to meet one of the two BCF core objectives, namely 'to enable people to stay well, safe and independent at home for longer'. The existing local offer was fully funded via the BCF, with the budget for 2024-2025 (£1.2m) increasing by around 20% (principally due to anticipated changes with the previous Discharge to Assess (D2A) arrangements) compared to the allocated funds for 2023-2024 – the vast majority of these financial resources covering staff salaries. Future funding levels (still to be clarified) will need to reflect the desired ambition to support a greater number of people leaving hospital or to prevent them from having to be admitted in the first place.

5.8. 591 individuals were supported by the SBC Reablement Team between April 2023 and March 2024 (with no waiting list as of January 2025). The recent expansion of the local offer, with SBCs move to bring this fully in-house from autumn 2024 endorsed by the NENC ICB, meant that existing structures were deemed sufficient to deal with the Council's projections on the numbers requiring support (though issues would inevitably follow should these projections be exceeded, as would staff absences as a result of sickness / COVID). However, the expected 20%+ increase of those aged over 65 in the next 10 years will inevitably challenge the status quo.

5.9. Regarding impact and effectiveness, the Committee heard that just over 75% of the 591 people supported during 2023-2024 were independent on leaving the service. Local reablement performance had been consistently better than the regional and national averages over the past four years, with the 2023-2024 data ranking Stockton-on-Tees eighth in the country (top in the region) – this was reinforced by the numerous positive comments from service-users about their own experiences. In addition, the service had been shortlisted for the regional (North East and Scotland) Great British Care Awards in the categories of 'Team Award', 'Newcomer to Care', 'Co-ordinator', and 'Care Manager', and the CQCs last inspection in mid-2021 rated the service 'Good' overall (though this was now quite dated).

5.10. An understanding around the types of technology used as part of current reablement provision was not established, though the reported focus on increasing its use (e.g. pilot assessment of activity monitoring technology, implementation of OPTICA, etc.) demonstrates a recognition of the potential benefits and the continuing evolution of the existing offer. Examples of technology-related opportunities were highlighted to the Committee which should be further explored by SBC and its partners alongside the front-door proposals being considered by the Council in March 2025.

5.11. The Committee was informed that there were no specific reablement services currently being delivered by VCSE organisations, nor was there a large quantity of reablement-related activity happening across the Borough within this sector – this suggests there is an opportunity for greater utilisation of the VCSE sector in local reablement provision. The former Five Lamps 'Home from Hospital' service (which ended in March 2024) was a relevant offer in relation to this scrutiny topic, with Catalyst relaying the opinion from some that its cessation had meant there was now a gap within the community for such provision. SBC has made the decision to expand its own reablement offer, but to meet projected future need, a role for the VCSE sector seems prudent and potentially necessary.

5.12. Information was received in relation to customer feedback and there appeared broad satisfaction with the level of service. As previously highlighted, an issue was frequently raised around a lack of awareness of the local offer and the lack of information provided about it within the hospital setting.

5.13. Views of SBC Reablement Service staff about existing provision were sought as part of the Committee's review. There was high praise for the current arrangements, working in conjunction with other professionals (physio, therapy team), communication (in-house and with clients / families), and support from management and office staff. In terms of improvements, suggestions included better provision of information about the service (within, and upon discharge from, hospital), more detailed information about an individual when a referral is received, the retention of input from physios / therapy team, ensuring continuity of care (as far as possible), and improved out-of-hours provision / staffing. It was also highlighted that individuals were sometimes willing to pay so they could continue to receive support beyond the six-week limit.

5.14. Reflecting upon the timing of this review, the Committee notes the challenges that have arisen when trying to examine a service which is rapidly evolving, with decisions on its future direction being made throughout the Committee's evidence-gathering phase. The Council's use of an external consultant (Peopletoo) to also review local provision during this time has identified a host of additional findings and potential options for future delivery. The Executive Summary of the report detailing the work undertaken by Peopletoo highlights the intention to improve performance monitoring as part of a phased enhancement of reablement and preventative services – the Committee welcomes this, particularly in light of the ongoing delays around SBC performance information being made available to the scrutiny function. Reference is also made on the Peopletoo website (see https://peopletoo.co.uk/case-studies/adult-social-care/enhancing-independence-through-reablement-and-enablement/) to significant financial benefits as a result of their work / proposals – the Committee look forward to seeing the extent to which this claim is borne out.

5.15. Continuing national coverage regarding pressures on hospitals, well-established benefits of people being at home, and the anticipated rise in the number of people aged 65 and over (the main demographic for reablement support) are all elements which emphasise the importance of services like reablement. Managing the flow of those leaving hospitals can be challenging enough given resource limitations, and widening this type of support to help avoid admittance to hospital in the first place will inevitably provide a further stress on the existing service. Whilst the true value of social care is clearly reflected in provision such as reablement, the ambition to widen access (potentially to a 24/7 model and including those with a mental health need, autism or learning disability) will require a significant commitment in terms of funding, and indeed staffing, to make the maximum amount of difference to the wider system and, even more importantly, the individuals and their families / carers whose lives are clearly enhanced by drawing on such services.

Recommendations

The Committee recommend that:

1) The NHS North East and North Cumbria Integrated Care Board (NENC ICB):

a) provides a summary on the gap analysis of the NHS England good practice guidance for ICBs (commissioners and providers) titled '*Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge*' (2023), along with assurance on how it and its partners will be addressing any identified issues (e.g. a self-assessment by all relevant organisations within the health and care 'system').

b) more explicitly outlines the role and importance of reablement services (within the context of the overall health and care 'system') in future iterations of its overarching integrated care strategy.

2) North Tees and Hartlepool NHS Foundation Trust (NTHFT) reviews its discharge processes to ensure that eligible individuals who are ready to leave hospital are made fully aware of local reablement provision and are referred to it upon discharge from hospital.

3) Principal links / contacts for Stockton-on-Tees Borough Council (SBC), NTHFT and the voluntary, community and social enterprise (VCSE) sector in relation to local reablement provision are identified / confirmed and shared in order to improve communication between key partners.

4) SBC and NTHFT establish required person-centred information on an individual when a referral is made into the SBC Reablement Service.

5) Regarding the future local reablement offer, SBC:

a) provides a summary of any differences in the findings of the Peopletoo review and reablement-related commentary from the Care Quality Commission (CQC) following its late-2024 inspection of SBC adult social care services.

b) confirms further planned changes to existing service delivery (structures, workforce) and the funding required to support this, and provides assurance on appropriate training uptake for new and existing staff.

c) explores whether any of its existing social care workforce outside the current SBC Reablement Service structure (e.g. Community Support Workers) can be utilised to increase staffing capacity for reablement provision.

6) SBC considers cost-effective options (and the communication of these) for individuals leaving the SBC Reablement Service to ensure a smooth transition from this initial support.

(continued overleaf…)

Recommendations (continued)

The Committee recommend that:

7) To increase public understanding of the Borough's reablement offer:

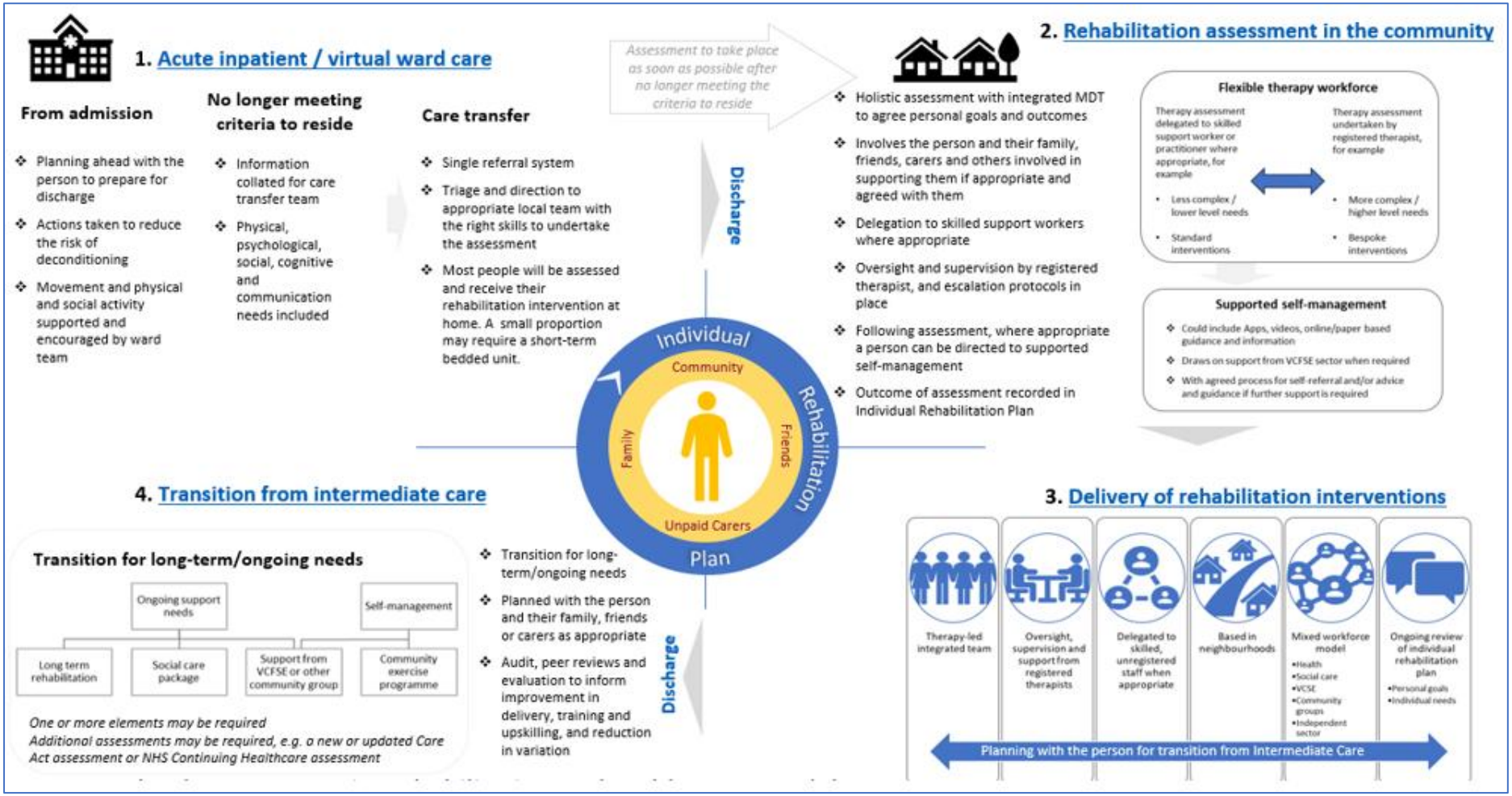
a) SBC and its partners assure themselves that they are adhering to the Social Care Institute for Excellence (SCIE) '*Supporting client and family engagement with reablement*' (2024) guidance, utilising this resource to effectively raise awareness and promote the Borough's reablement offer.

b) SBC undertakes a joint communications campaign (repeated on a periodic basis) with NTHFT and the VCSE sector around local reablement services, making it clear what they involve, how they are accessed (including contact details), and the principal benefits.

8) Healthwatch Stockton-on-Tees be asked to consider facilitating a public survey in 2026 to establish the availability of information on the local reablement offer for those who had spent time in hospital and the experiences of those who had received support from the service.

Appendix 1

Community rehabilitation and reablement model



Appendix 2

SBC Reablement Service Leaflet (February 2025)

What is Reablement?

The Reablement Service offers short-term support to enable you to return or remain at home. Support Workers can help you regain skills and confidence and help you to re-learn everyday tasks such as washing, dressing and meal preparation.

It's all about you

Support Workers work alongside you while you regain skills and confidence so you can get back to doing things for yourself. The aim is to maximise your independence within your own home, supporting you to carry out tasks yourself – doing tasks 'with you' not 'for you'.

Support can be provided free and tailored to you. This could be from a few days or up to a maximum of six weeks and is dependent on your progress. This may be available to avoid unnecessary hospital admission or if you have had:

- a temporary illness/accident
- a crisis
- a change in circumstance relating to you or your carer

Stockton-on-Tees BOROUGH COUNCIL

Appendix 2
(continued)

SBC Reablement Service Leaflet (February 2025)

What we offer

We can support with:

- your personal care needs including washing and dressing
- preparing meals
- supporting you to learn new skills and maximise your independence around the home
- helping you get back on your feet following a stay in hospital
- completing an exercise programme following a therapy assessment
- providing low level equipment following an assessment of needs
- confidence building

Ongoing reviews

You will receive regular reviews with the Senior Support Workers who will visit you at home to look at your progression and adjust your care package to meet your needs.

The reviews look at whether you are likely to become independent or if you may need continuing support at home. If ongoing care and support is needed beyond Reablement, you will be referred to the Social Work Team where you will be re-assessed for a long-term care package which is subject to a financial assessment.

Frequently asked questions

Will I get the service for the full six weeks and keep all my visits?

Every person is reviewed by our Senior Support Workers; your needs are assessed, and visits amended accordingly. Not every person will need the full six weeks; some only need a few days or weeks until they return to independence.

Do I have to pay?

No, this service is provided free by Stockton-on-Tees Borough Council for up to six weeks where there is an identified care and support need.

How do I access the Reablement Service?

Where a need has been identified you will be referred following an assessment via a Health or Social Care professional.

Read the Social Care Institute for Excellence's Reablement Guide:
www.scie.org.uk/integrated-care/intermediate-care-reablement/reablement-guide

www.stockton.gov.uk/reablement-service

07788 566856

Appendix 3

NHS England: Measures from the Adult Social Care Outcomes Framework (ASCOF), England 2023-2024

NHS England

ASCOF time series

Return to contents

Select a measure, council and disaggregation to compare council, region and England values by year.
Note: Time series are not available for all measures. For more details, refer to the comparability over time in the main publication.

Select a disaggregation

18-64 | 65 and over | Total

Select an ASCOF measure

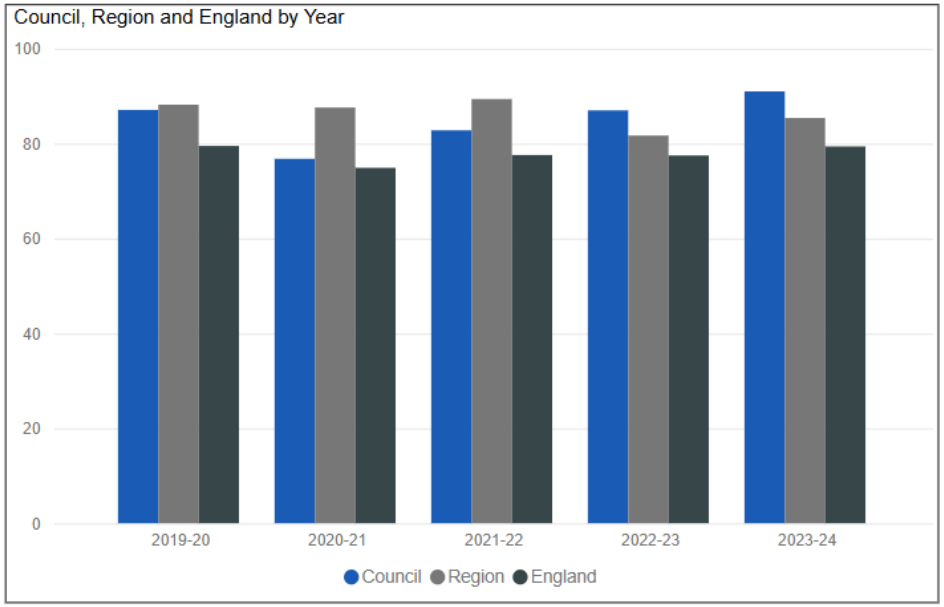
2A: Outcome of short-term services: sequel to service

Select a council

Stockton-on-Tees

Council, Region and England score by year

Year	Council score	Region score	England score
2019-20	87.1	88.2	79.5
2020-21	76.8	87.6	74.9
2021-22	82.8	89.4	77.6
2022-23	87.0	81.7	77.5
2023-24	91.0	85.4	79.4



Appendix 3
(continued)

NHS England: Measures from the Adult Social Care Outcomes Framework (ASCOF), England 2023-2024

NHS England

Local Authority ASCOF map

Select a measure, council and grouping to view councils alongside their region or peer group. For more details of peer groups see the Contents page.

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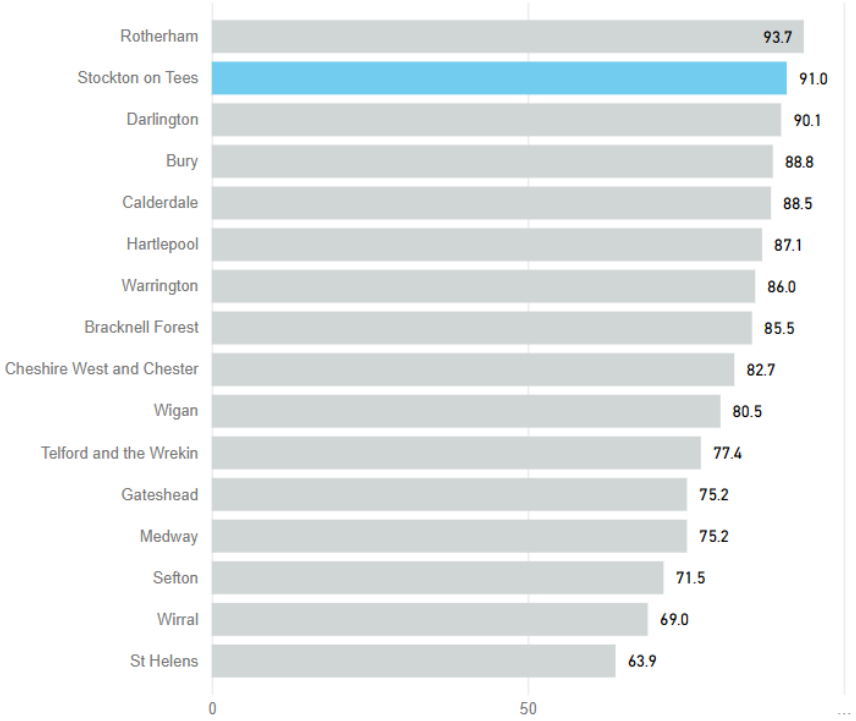
Peer Neighbours

Select an ASCOF measure

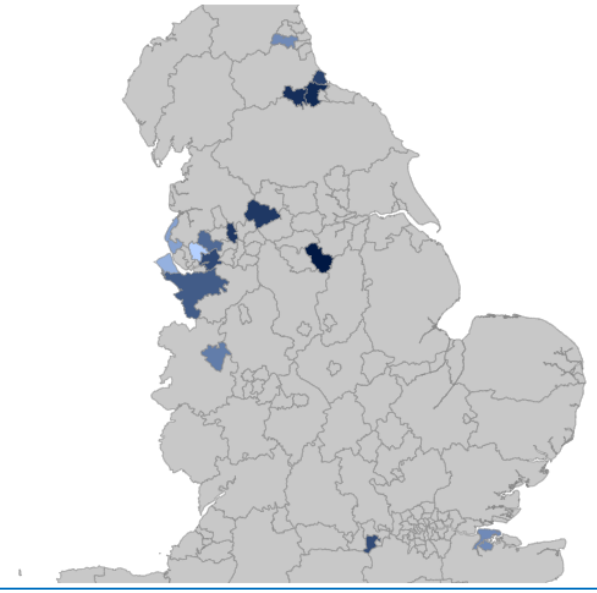
2A: Outcome of short-term services: sequel to service

Select a council

Stockton-on-Tees



Region value	England value
-	79.4



Council name	National rank
Rotherham	16
Stockton on Tees	23
Darlington	26
Bury	34
Calderdale	35
Hartlepool	39
Warrington	44
Bracknell Forest	48
Cheshire West and Chester	60
Wigan	67
Telford and the Wrekin	82
Gateshead	89
Medway	89
Sefton	107
Wirral	117
St Helens	127

Appendix 3
(continued)

NHS England: Measures from the Adult Social Care Outcomes Framework (ASCOF), England 2023-2024

NHS England

ASCOF time series

Return to contents

Select a measure, council and disaggregation to compare council, region and England values by year.
Note: Time series are not available for all measures. For more details, refer to the comparability over time in the main publication.

Select a disaggregation

65-74	85 and over	Male
75-84	Female	Total

Select an ASCOF measure

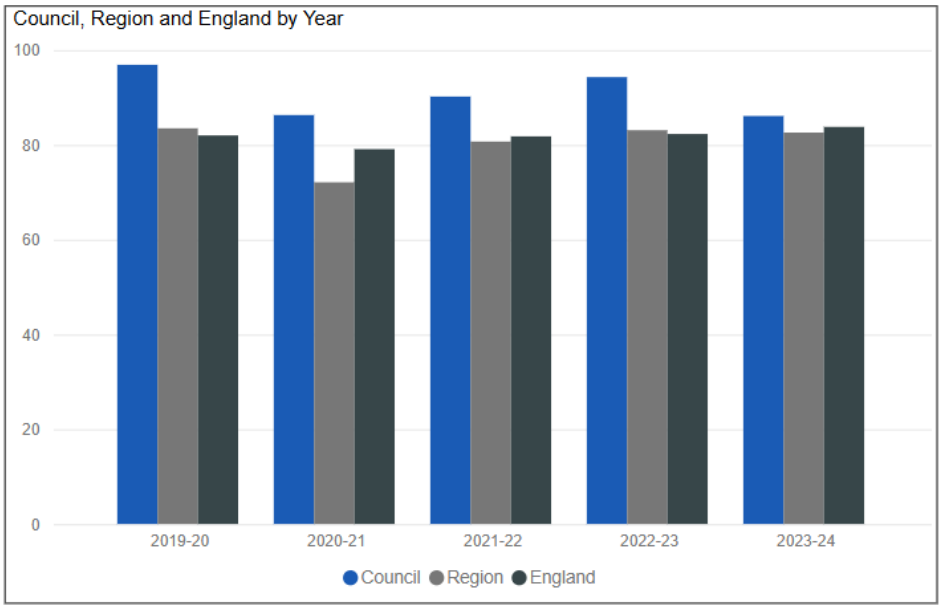
2D1: Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation s...

Select a council

Stockton-on-Tees

Council, Region and England score by year

Year	Council score	Region score	England score
2019-20	96.9	83.5	82.0
2020-21	86.3	72.1	79.1
2021-22	90.2	80.7	81.8
2022-23	94.3	83.1	82.3
2023-24	86.1	82.6	83.8



Appendix 3
(continued)

NHS England: Measures from the Adult Social Care Outcomes Framework (ASCOF), England 2023-2024

NHS England

Local Authority ASCOF map

Select a measure, council and grouping to view councils alongside their region or peer group. For more details of peer groups see the Contents page.

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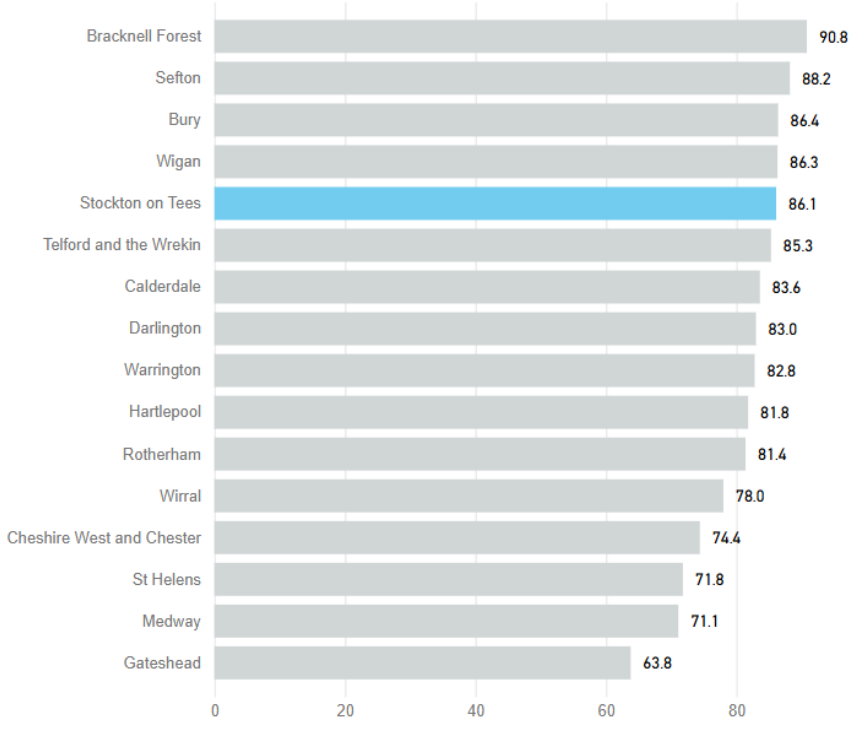
Peer Neighbours

Select an ASCOF measure

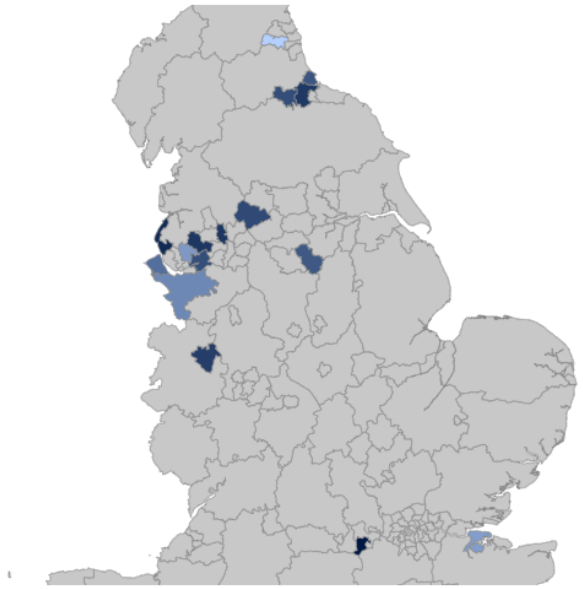
2D1: Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitatio…

Select a council

Stockton-on-Tees



Region value	England value
-	83.8



Council name	National rank
Bracknell Forest	24
Sefton	48
Bury	59
Wigan	62
Stockton on Tees	66
Telford and the Wrekin	73
Calderdale	83
Darlington	87
Warrington	89
Hartlepool	96
Rotherham	102
Wirral	118
Cheshire West and Chester	130
St Helens	138
Medway	140
Gateshead	150

Appendix 3
(continued)

NHS England: Measures from the Adult Social Care Outcomes Framework (ASCOF), England 2023-2024

NHS England

ASCOF time series

Return to contents

Select a measure, council and disaggregation to compare council, region and England values by year.
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Select a disaggregation

65-74	85 and over	Male
75-84	Female	Total

Select an ASCOF measure

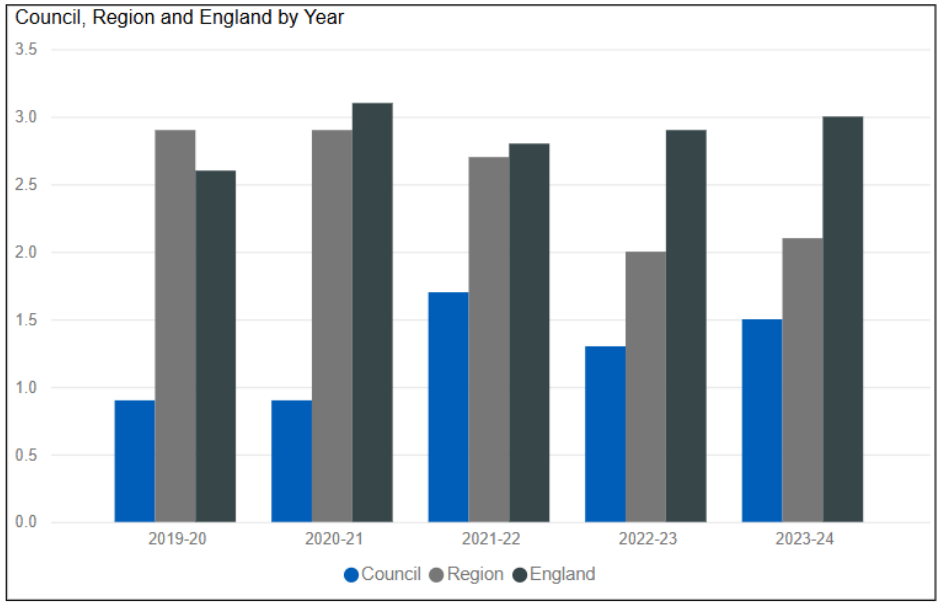
2D2: Proportion of older people (aged 65 and over) offered reablement services following discharge from hospital

Select a council

Stockton-on-Tees

Council, Region and England score by year

Year	Council score	Region score	England score
2019-20	0.9	2.9	2.6
2020-21	0.9	2.9	3.1
2021-22	1.7	2.7	2.8
2022-23	1.3	2.0	2.9
2023-24	1.5	2.1	3.0



Appendix 3
(continued)

NHS England: Measures from the Adult Social Care Outcomes Framework (ASCOF), England 2023-2024

NHS England

Local Authority ASCOF map

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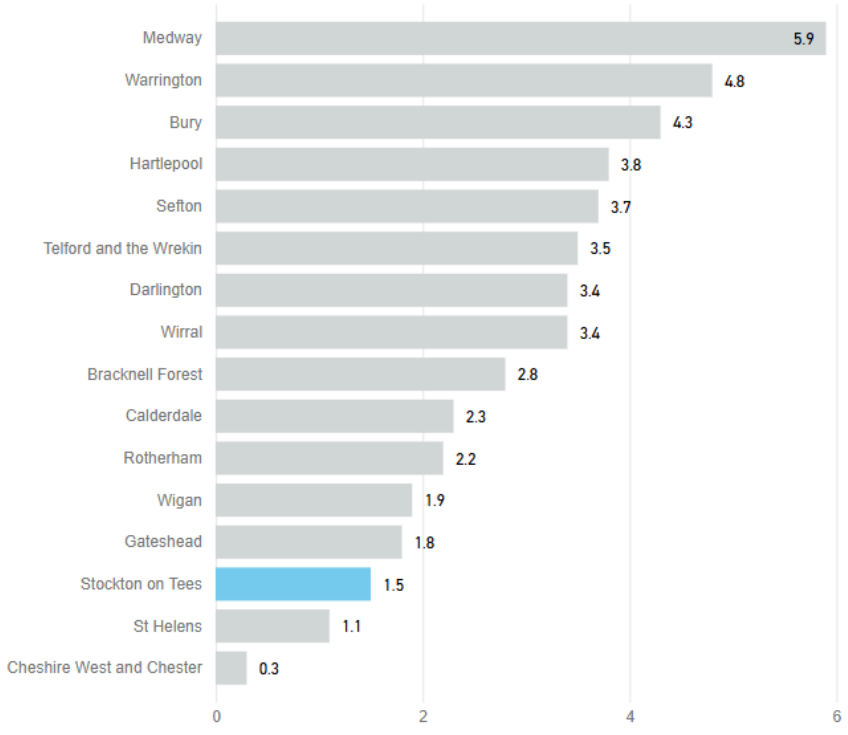
Peer Neighbours

Select an ASCOF measure

2D2: Proportion of older people (aged 65 and over) offered reablement services following discharge from hospital

Select a council

Stockton-on-Tees



Region value	England value
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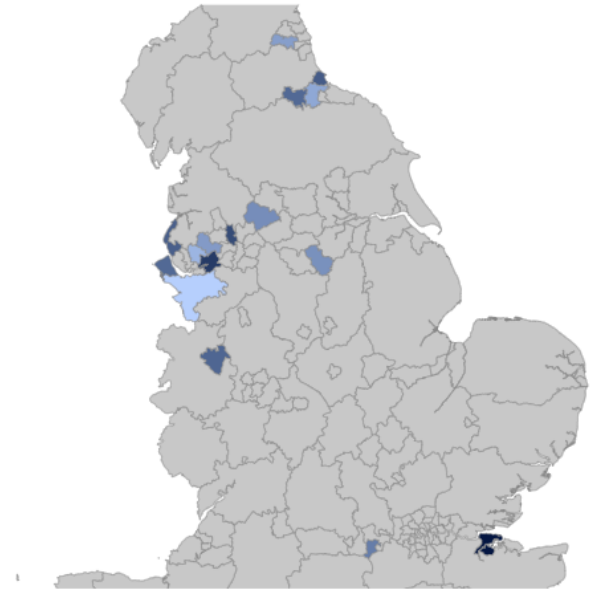

Council name	National rank
Medway	14
Warrington	20
Bury	29
Hartlepool	40
Sefton	44
Telford and the Wrekin	48
Darlington	53
Wirral	53
Bracknell Forest	75
Calderdale	93
Rotherham	95
Wigan	111
Gateshead	118
Stockton on Tees	129
St Helens	141
Cheshire West and Chester	152

Glossary of Terms

ASCOF	**Adult Social Care Outcomes Framework** (NHS England)
BCF	**Better Care Fund**
CAH	**Care at Home**
CIAT	**Community Integrated Assessment Team** (NTHFT)
CQC	**Care Quality Commission**
D2A	**Discharge to Assess**
DHSC	**Department of Health and Social Care**
ICB	**Integrated Care Board**
ICP	**Integrated Care Partnership**
ISPA	**Integrated Single Point of Access**
NEAS	**North East Ambulance Service NHS Foundation Trust**
NECS	**North of England Care System Support**
NENC ICB	**NHS North East and North Cumbria Integrated Care Board**
NHS	**National Health Service**
NICE	**National Institute for Health and Care Excellence**
NTHFT	**North Tees and Hartlepool NHS Foundation Trust**
OPTICA	**Optimised Patient Tracking & Intelligent Choices Application**
PBPB	**Pooled Budget Partnership Board**
POF	**Powering Our Future** (SBC)
SBC	**Stockton-on-Tees Borough Council**
SCIE	**Social Care Institute for Excellence**
SID	**Stockton Information Directory**
VCSE	**Voluntary, Community and Social Enterprise**