



**Reablement - A review of evidence and
example models of delivery
NHS Doncaster Clinical Commissioning Group**

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FINAL

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Version control

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This review has been produced for NHS Doncaster CCG by Yorkshire and Humber Commissioning Support. Full details of the review are available from email: jill.rutt@nhs.net

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As part of a wider assessment of Intermediate Care services, Yorkshire and Humber Commissioning Support has been asked by Doncaster Clinical Commissioning Group (CCG) to prepare a detailed review of reablement services. The resulting review includes published information and example delivery models, with the aim of aiding the CCG in determining how to develop its own localised model.

Through the use of reablement services, Doncaster aims to maximise independence and improve quality, utilising resources effectively to get best value for money whilst improving and simplifying the system for patients and healthcare professionals.

As with intermediate care, there is no blueprint for the provision of reablement services although the consensus is that they are short-term interventions to enable people to develop confidence and practical skills to carry out daily living activities and thus prevent people being admitted to hospital or long-term residential care for as long as possible.

The review indicates that although there is a limited amount of very high quality evidence available, there are pockets of evidence which suggest that reablement services are cost-effective, have positive outcomes for the user and for health and social care staff, and can be delivered in many different ways. The latter means there are inconsistencies across the country in relation to spending on reablement services and what is defined as a reablement service.

Some of the defining features of a reablement service are described as:

- Helping people to do things for themselves, rather than doing things to or for people
- Time-limited
- Outcome-focused
- Setting and working towards specific goals agreed with service user
- Treats assessment as something that is dynamic not static
- Builds on what people currently can do, and supports them to regain skills to increase their confidence and independence.
- Aims to maximise users' long-term independence, choice and quality of life
- Aims to reduce or minimise the need for ongoing support after the period of reablement

Summary

The review examines the literature relating to the long-term impact of reablement services, the role of the occupational therapist, rapid response services, and provides key pointers for implementing / improving a reablement service. It also presents the latest information from the National Audit of Intermediate Care, in particular the results relating to reablement services. A number of examples of practice from around the country are included for both reablement services and specifically, rapid response services. The review also includes literature relating to the views of service users.

The review demonstrates that although there is no single 'gold standard' delivery model for reablement, there are a number of examples nationally of different service delivery models. It is not clear from the evidence how effective these models are. These may be helpful to consider when looking at service options but caution must be taken in classifying them as 'best practice' models of delivery.

Background

In recent years, an increasing number of reablement services have been developed by local authorities and/or the NHS. It is believed that reablement services can lead to major improvements in the well-being and independence of vulnerable people, as well as enabling cost effective care provision.

Reablement services “provide personal care, help with activities of daily living and other practical tasks for a time-limited period, in such a way as to enable users to develop both the confidence and practical skills to carry out these activities themselves” (Glendinning et al 2010).

There is sometimes confusion between organisations as to what exactly is included in reablement (Bridges and James, 2012); there is overlap with other forms of intermediate care services; and reablement services themselves can take many different forms.

One attempt to differentiate between intermediate care services and reablement suggests “A reablement service is about enabling people to regain or retain self-care function for themselves, rather than providing input that replaces that function” (Parker, 2014). This definition emphasises the “restorative, self-care element” of reablement.

The Reablement For All (2010) learning guide differentiates between intermediate care and reablement as follows:

“Intermediate care patients have a defined clinical need, and intermediate care services are clinician-led. In contrast, reablement service users have a social care need (which may result from a clinical need) and reablement services are not clinician-led, and tend to adopt a social model of support. Reablement users can include people who have been through a period of intermediate care. However, reablement users also include those who have not been in hospital, and are not at high risk of admission to hospital or a care home, but who need support to continue living independently. Many people who would not be eligible for intermediate care may be able to access reablement.”

There is no single delivery model for reablement. Reablement services may include services such as personal care, practical support, prompting for medication, teaching people exercises to help regain mobility, providing information and signposting, and obtaining equipment for users. They are very much tailored to the individual’s needs and preferences.

Background

Reablement services are important as they aim to:

- Enable longer term avoidance of unplanned hospital admission
- Reduce use of home care services
- Avoid admission to long-term care
- As long as there is a restorative element involved, enable early supported discharge after acute admission (Parker, 2014)

A number of reablement services are currently provided within Doncaster including

- STEPS, where patients receive up to 6 weeks of free reablement support in their own home (social care provision only)
- Adult and Communities – Wellbeing Team / Adult Contact Team / Community Officers providing low level social support
- Social Prescribing – CVS / SY Housing Association providing social support for clients referred by GPs

This review involved a robust and systematic search of the research evidence for reablement. It should be noted that reablement is not limited to intermediate care, however, in this review, we concentrate on the intermediate care aspect. The review also outlines some examples of practical approaches that have been taken within reablement. These are by no means an exhaustive list of examples and their quality cannot be guaranteed. The review also includes examples of rapid response services.

This review aims to utilise the evidence to aid Doncaster CCG in determining how to develop a localised model which enables people to receive services in their community rather than entering acute sector managed care.

The following search terms were used:

- Reablement / Re-ablement
- Rapid response

The following resources were searched:

- NICE
- Cochrane Database
- Social Care Institute for Excellence
- Medline
- Embase
- HMIC
- Google

Published Evidence

NICE has not yet issued any guidance relating to reablement services, however, a guideline is under development. A scoping workshop for the guideline was held in April 2014 and a Chair and Topic Adviser for the Guideline Development Group are currently being sought. Entitled 'Regaining independence (reablement)', the guideline is expected to be published in July 2017. It will look at short term interventions to help people to regain independence.

A review protocol has been published via the Cochrane Library which sets out details for a proposed systematic review which aims to assess the effects of home-care 're-ablement' services compared to usual care, or to a wait list control group, in terms of maintaining and improving the functional independence of older adults (Cochrane et al, 2013). The full review has not yet been published. The protocol confirms that there has not been a systematic review that has focused specifically on the effectiveness and cost effectiveness of 're-ablement'-based interventions and that this review is intended to answer such questions as "does 're-ablement' reduce health service utilisation (such as hospital re-admissions); do specific subgroups benefit more than others (e.g., younger populations, and those with lower levels of need); and is there evidence to support personalisation of the service?"

Another review protocol (Whitehead et al, 2013) is looking at how reablement services are configured and how they affect individuals. The systematic review is seeking to identify studies that compare an intervention to reduce dependency in personal activities of daily living with routine input or usual care as the control. However, once again, the full review has not yet been published.

The Social Care Institute for Excellence (SCIE) has published a SCIE guide based on research and practice evidence about the effectiveness and cost-effectiveness of reablement (SCIE, 2013). It draws on approximately 10 studies published between January 2011 and November 2012 including 2 randomised controlled trials. The underpinning research for this review shows that "reablement is a very promising practice". In particular, there is good evidence that reablement 'improves service outcomes (prolongs people's ability to live at home and removes or reduces the need for standard home care)". Studies indicate a slightly higher cost than traditional home care but suggest a strong probability of

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cost savings in the long term. There is a lack of clarity regarding the resources required to deliver reablement services.

The guide indicates that there is moderately good evidence that reablement improves outcomes for users in terms of their ability to perform daily activities or improving morale. Although the evidence is not as strong as for service outcomes, users are pleased with the focus on enabling them to gain independence and level of function. There is a lack of evidence regarding the effectiveness of reablement in improving outcomes for people with dementia.

The guide makes more than 50 recommendations for maximising the potential of reablement covering the following topic areas: local implementation of reablement; the required culture change; providers of reablement (service managers and frontline workers); importance of goal setting; skills mix and supporting services; workforce development; role of families in supporting the reablement process; outcome measurement – what does successful reablement look like?; supporting people living with dementia; and successfully ending a period of reablement. Full details can be found in the document itself and it may be of interest to the CCG to explore this guide in more detail.

The Women's Royal Voluntary Service has published a report which looks at the extent to which different local authorities and health boards across Wales have developed reablement provision (Bridges and James, 2012). It found there was no standard Welsh Government definition of reablement, and no statutory requirement to issue returns on reablement. For local authorities, the most striking finding was the inconsistency between different councils in their spending (ten-fold variations) on what they defined as reablement services. Evaluation and measurement are almost entirely quantitative. The report makes the following recommendations with regard to reablement services for Wales but these are worth considering for England as well:

- “There is a need for a common framework on reablement, to make it clear to public bodies what is meant by the term and what features ought to be evident in any reablement service. Bodies can still develop services which reflect local circumstance and need, but there must also be core elements of reablement which are present across Wales. There must also be consistency in how the types and performance of reablement services are reported so that comparisons can be drawn between different health boards or different local authorities.

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- Health boards in particular still consider well-being through the prism of a medical model of health, rather than reflecting the social aspects of well-being which are critical to an individual's quality of life. We would suggest that self-assessment tools are incorporated into any outcome measure so that the more subjective social elements of well-being can be gauged.
- Consideration should be given to providing dedicated funding for reablement in Wales, to match similar funds in other parts of the UK. Reablement offers long-term economic benefits for short-term interventions – but there has to be an acceptance that truly effective reablement requires money in order for appropriate services to be developed.
- Good reablement services are, by definition, multi-sector. More needs to be done to encourage public bodies to involve the voluntary sector in the development of reablement services.

Reablement for All (a group of organisations working together on delivering the reablement agenda) has produced a learning guide for frontline staff (2010). This guide explains what reablement is, who it is for and who provides it; the policy context; the different kinds of services, benefits of reablement; and examples of services. The document also sets out the differences and similarities between reablement and the following services: intermediate care; home care (domiciliary care); prevention services; and rehabilitation services.

The learning guide identifies the following as defining features of a reablement service:

- Helping people to do things for themselves, rather than doing things to or doing things for people
- Time-limited; the maximum time that the user can receive reablement support is decided at the start. In most reablement services, this is for six or eight weeks.
- Outcome-focused: the overall goal is to help people back into their own home or community.
- Involves setting and working towards specific goals agreed between the service user and the reablement team.
- Support is tailored to the individual user's specific goals and needs
- Often involves providing intensive support to people.
- Treats assessment as something that is dynamic not static. A user's care or support package cannot be decided on the basis of a single, one-off assessment, instead the user should be observed over a defined period of time, during which their needs and

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abilities may well change, with a reassessment at the end of the period of reablement.

- Something should have changed by the end of the reablement intervention; the service is working towards positive change.
- Builds on what people currently can do, and supports them to regain skills to increase their confidence and independence.
- May involve ensuring people are provided with appropriate equipment and/or assistive technology, and understand how to use it.
- Aims to maximise users' long-term independence, choice and quality of life.
- Aims to reduce or minimise the need for ongoing support after the period of reablement

The guide indicates that reablement support can occur in a variety of places and be delivered by staff from different professional backgrounds:

- Some services are funded by adult social services departments, some jointly funded by local authority and NHS
- Some services are provided in house e.g. home care staff, in others provided by inter-disciplinary teams from local council and NHS, some by independent home care providers, some by housing associations, day centres and so on.
- Most services are provided in the individual's home but can also be provided in sheltered housing, extra care housing, residential care and day centres.
- Services can be delivered by a multi-agency teams or a team from one organisation. The exact nature of the team depends on what service has been commissioned but can incorporate home care staff; reablement support workers; occupational therapists (OTs); physiotherapists & physiotherapy technicians; social workers; district nurses; community psychiatric nurses (CPNs); psychotherapists; people with training and experience working with people with dementia (EMI); and staff from third sector organisations.
- In some areas reablement is provided as part of the wider intermediate care service, whilst in other areas it is a completely separate services.

The guide identifies two main approaches to access and referral arrangements for reablement. The **intake and assessment model** accepts all referrals of adults who are being considered for home care or for social services support. It then screens out anyone not likely to benefit. It can be accessed by people with a wide range of needs or circumstances.

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The **selective or targeted model** focuses on people in a particular situation or who are referred through specific routes. This could be people leaving hospital but also those in the community who have a high risk of requiring admittance to hospital or care home. This type of service focuses on those people who have the potential to benefit the most and therefore is more selective.

Finally, the learning guide contains a section on evidence of benefits to users of reablement services including a study by Care Services Efficiency Delivery (CSED) which found that there was a significant impact on people's perceived quality of life and perceived health-related quality of life following reablement. Other research indicates that the services appear to have high user satisfaction rates, and are effective in increasing user independence and a reduction in the need for ongoing support after reablement. Research also indicates that the benefits are not just short-term but appear to last.

The Care Services Efficiency Delivery programme (CSED) was set up in 2004 to help councils in England with social services responsibilities (CSSRs) to identify and develop more efficient ways of delivering adult social care. Homecare reablement was one aspect of this programme. The resulting body of evidence "demonstrates that significant benefits can be achieved for recipients of homecare, CSSRs and their partners, that many continue to benefit for at least two years. The question for CSSRs and their health partners is no longer should they establish a homecare re-ablement service, but rather, which form of service should be established (Pilkington, 2008). A subsequent study from the programme (Glenridding et al, 2010) set out to examine the immediate and longer term effects of home care reablement and found that use of reablement services was associated with a "significant decrease in subsequent use of social services". However, it appears that the cost savings were "almost wholly offset by the initial costs of the re-ablement interventions". The study concluded though that because of the positive impacts on user's health and social care outcomes, "the probability that re-ablement is a cost-effective service was therefore high".

The Yorkshire and Humber Joint Improvement Partnership (2010) undertook a review of reablement services in the 15 local authorities within the Yorkshire and Humber region with the aim of identifying best practice in relation to the delivery of reablement services in order to share expertise and save time and effort in developing services. The review did not look at the financial savings of such services. The main messages resulting from the review were:

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“Reablement should be everybody’s business, and reablement is not a service that is provided, but a process of continual development and assessment”. 14 examples of best practice were identified from the review. The following elements were identified as being key to the success of these 14 services:

- Developing and maintaining close links with Assessment and Care Management
- Developing close links and recognising the value of Occupational Therapy input
- Developing and maintaining close links with hospitals
- Developing and maintaining close links with Telecare
- Providing comprehensive, multi-disciplinary training for Reablement staff
- Not charging for the service
- Developing and maintaining close links with the independent sector
- Working closely with the Unions on changes to terms and conditions
- Developing clear protocols and communication with staff
- Using electronic call monitoring
- Detailed monitoring and good use of performance management data
- Close links with Intermediate Care
- Empowering frontline staff

Cumbria County Council commissioned a review to inform future commissioning and delivery of reablement services to enable the council to make the best use of resources and provide good value for money (Peter Fletcher Associates, 2013).. The review has resulted in an ‘Investment Plan’ which sets out actions under 9 themes:

- Embedding the reablement ethos consistently across the county
- Improving referral processes and behaviours
- Ensuring reablement is a dynamic process
- Accessing the full range of services to maximise the potential of reablement
- Moving towards a more integrated approach with the NHS
- Securing and acting on customer and carer feedback
- Completing the Business Transformation of Cumbria Care
- Identifying, collecting and using core data to measure and benchmark performance
- Driving the implementation of the investment plan

In Australia, a comparison of the home-care and healthcare service use and costs of older Australians randomised to receive a restorative or a conventional home-care service, found that providing a restorative service (reablement) when an older adult is referred for home

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care has the potential to be more cost-effective than providing the more conventional home care (Lewin, 2014).

A 6 week reablement programme in Glasgow was found to be effective in terms of the positive outcomes achieved. A sizeable portion of service users went on to be independent in the community, and most were able to sustain this over a period of time (Glasgow City Council, 2013).

Doughty and Mulvihill (2013) have developed a digital reablement process which can be used to identify hazards associated with independent living, and the possible consequences of accidents. By measuring and prioritising the risks, appropriate management strategies may be introduced to provide a safer home environment and thus support independence.

However, Slasberg (2010) suggests that effectiveness of re-ablement services is “over-stated” and instead sets out the case that what is actually required is to “create a re-ablement culture where all services are committed to re-ablement”. The paper then suggests how outcomes-based working could be the key to achieving it.

Long-term impact of reablement services

A number of studies have examined the longer term impact of reablement services. In an assessment of the evidence for the long term cost effectiveness of home care reablement programmes in Australia, Lewin et al (2013) found that individuals who had received a reablement service were less likely to use a home care service over the next 3 years. It should be noted that this study was undertaken in Australia and therefore these findings may not be transferrable to the UK. Pilkington (2008) found that for many people the benefits from homecare reablement lasted more than two years. Manthorpe (2011) also looked at the long-term impact of homecare reablement but only for up to 12 months later. She concluded that reablement works for people who need support to regain independence and that it may reduce the need for some social care services and some healthcare costs. Glasgow City Council (2013) and Pilkington (2008) also referred to the longer term impact of services.

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Occupational therapy

Evidence was found for two studies relating to the use of occupation therapy (OT) in reablement services. In Britain, a critical literature review examining the effectiveness of local authority social services' OT for older people, found OT in social care is perceived as effective in improving quality of life and cost effective in making savings for other social and healthcare services, although it was difficult to disaggregate OT effectiveness from other services (Boniface, 2013). In Canada, a retrospective audit to measure the effectiveness of OT in a well elderly population attending a Community Reablement Unit demonstrated that OT was effective in this population and resulted in increased performance and satisfaction in goals and reducing concern regarding falling (Connolly et al, 2013). It should be noted that this study was undertaken in Canada and therefore these findings may not be transferrable to the UK.

Rapid response services

Rapid response services are designed to keep people out of hospital or long-term care. There is only a limited amount of research evidence relating to rapid response services. Oh and Warnes (2010) carried out an evaluation of a nurse-led rapid response service in South Yorkshire which looked at the views of the rapid response service team members and other care professionals. They found all staff groups to be positive about the service, however, one of the main findings suggests that innovative services need to develop "clear and consensual patient eligibility criteria" which need to be widely understood by all professionals. Oh et al (2009) also evaluated a rapid response service's clinical and therapeutic achievements and patient satisfaction with the service. They found that the rapid response service "identified and responded to several unmet needs, partly through its own treatment and partly by referring patients to other health services".

A number of examples of rapid response services can be found in Appendix 2.

Implementing reablement services

Newton (2012) looked at evaluations from reablement services and identified that motivation was the key to a successful reablement. As a result, he suggests that reablement staff should be trained to identify personal goals with service users and use task-centred goals to achieve them.

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Rabiee and Glendinning (2011) identified a number of features as contributing to the effectiveness of reablement including:

- service user characteristics and expectations
- staff commitment
- attitude and skills
- flexibility and prompt intervention
- thorough and consistent recording systems
- rapid access to equipment and specialist skills
- clear, widely understood vision of the service (external factor)
- access to a wide range of specialist skills (external factor)
- capacity within long-term home-care services (external factor)

SCIE (2013) makes more than 50 recommendations for maximising the potential of reablement services some of which are relevant to implementing services. Further information on the detail of these can be obtained from the SICE guide. SCIE has also produced a number of learning tools and briefings which may help in the implementation of reablement services. A list of these can be seen in Appendix 3.

Pilkington (2008) sets out a list of requirements for the successful implementation of a reablement service. Detailed requirements are set out under the headings of pre-planning, agreed objectives of the new service, resourcing the project, communications and stakeholder management, anticipated timescales, key points to introducing a reablement service and measuring the benefits.

Wood and Salter (2012) examine the concept of reablement as a 'home care intervention' and explore how better outcomes may be achieved through a more integrated approach – one which brings together health, social care and housing support. Particularly relevant for the CCG is Recommendation 8 “Finally, and perhaps most importantly, clinical commissioning groups must think more creatively about how reablement is delivered and who delivers it. There is considerable potential for reablement to become more cost-effective and achieve improved outcomes, and now is the time, as they take responsibility for reablement commissioning, for health commissioners to re-evaluate what reablement currently achieves and what potential is untapped to achieve more. Looking to a wider range of reablement providers, and providers who work in partnership with other stakeholders to

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achieve more person centred support, is an important step towards identifying ‘what works’ in reablement”.

The Care Services Efficiency Development programme (CSED) produced a toolkit in 2010 (updated 2011) to support councils looking to introduce a new homecare re-ablement service or improve an existing service. It includes eight project steps from setting the initial vision through to implementation.

National Audit Results

The National Audit of Intermediate Care (NAIC) has recently published data from its third annual audit. The commissioner report (NHS Benchmarking Network, 2014) describes the findings from the commissioner level audit. From a reablement aspect, the audit covers the following service categories:

Service	Definition
Reablement	Provided to service users in their own homes by a multi-disciplinary team but predominantly social care professionals
Home based services	Provided to service users in their own homes by a multi-disciplinary team but predominantly health professionals
Crisis response	Short term interventions up to 48 hours only

Table 1 – Reablement service categories and definitions (NAIC, 2014)

Results include:

- Average investment in re-ablement services remains at £0.7 million. Most commissioners commission crisis response services, home based intermediate care and re-ablement services.
- There are longer waits in 2013/14 than 2012/13 for service users in both home and re-ablement services. The report suggests this represents a lost opportunity in terms of effectiveness of rehabilitation but also cost of service users remaining in acute care longer than necessary.
- 50% of respondents commissioned designated step up beds. 95% commissioned beds to be used flexibly between step-up and step-down beds.

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- The mean investment for home based services was £1.0 million per 100,000 population. The mean budget for reablement services was £0.7 million
- The split for total budget contributions for intermediate care / reablement was CCG direct contribution 61%, CCG monies transferred to local authority 14%, and local authority contribution 25%.
- Referrals to crisis response services per 100,000 weighted population in 2013/14 showed a mean of 618.
- For home based services, the mean number of referrals to intermediate care services in 2013/14 was 1,014. The mean number of service users accepted in 2013/14 from 45 data submissions was 796. Referrals to home based services have increased in 2013/14 which may suggest a re-balancing of services commissioned from bed to home based intermediate care services in this year's sample.
- For re-ablement services, the mean number of referrals per 100,000 weighted population in 2013/14 was 583. The mean number of assessments per 100,000 weighted population undertaken in 2013/14 was 537.

The report also raises the following issues/opportunities which CCGs might like to consider:

- CCGs, working with local councils, are in a “unique position to change services for local people”.
- The opportunity to reduce secondary care utilisation is yet to be fully realised
- A small number of health and social care economies are investing at much higher levels, particularly in home based services, than the national average, suggesting higher capacity services are feasible
- CCGs and councils need to ensure “the system in ‘future proof and responsive to demographic changes”
- Services should enable “smooth patient flow throughout the system, without undue blockages and delays”

Strategy examples

A number of organisations have produced reablement strategies. The NHS Wolverhampton City CCG and Wolverhampton City Council strategy (2014) details the reablement and intermediate care intentions of Wolverhampton's health and social care economy. The document also highlights a number of best practice examples and articulates a principles

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framework that will guide reablement and intermediate care activity in Wolverhampton for the next two years.

Hartlepool Borough Council (2012) has been running a reablement service since August 2011 and has produced a strategy for 2012-2015. Similarly, Sunderland City Council (2012) has a strategy for 2012-2015. Telford and Wrekin has a draft strategy, although this is not a dated document so it is unclear how recent it is. It sets out the proposed developments and changes to rehabilitation and re-ablement services in Telford & Wrekin.

Service Delivery Models

Appendix 1 sets out details of some examples of reablement services from around the country. This is not an exhaustive list and the quality of these models is not guaranteed. Where available, a list of outcomes relating to the example is included. These examples illustrate the range of different services provided.

Service User's Views

A number of studies have looked at the views of reablement service users. A study of five established reablement services in England (Wilde, 2013) provided clear evidence that most users and their families felt they had benefitted from the service. However, it also raised issues regarding barriers to maximising effectiveness for some particular groups of service users (for example, those with progressive conditions, sensory impairments, specific cultural needs or who lived alone). It also found effectiveness could be reduced if users didn't understand the aims of the service or if the service failed to support the user with activities or outcomes that were important to them.

An evaluation of a Community Reablement Unit in Ireland (Adamson et al, 2012) found that users reported a "high level of satisfaction" with the CRU service whilst Manthorpe (2011) looked at homecare reablement services in five English local authorities and found people seemed to like reablement services.

Although there isn't a vast amount of evidence in this area, what is available seems to indicate support from service users for reablement services. The box overleaf sets out some key tips from users and carers on what an excellent reablement service should include.

Users' and carers' top ten tips for excellence in reablement (Reablement for All, 2010)

The Top Ten Tips were produced by the reference group for the Excellence in Reablement Project, run by the North East Improvement and Efficiency Partnership, and supported by the Social Work Co-operative. The group was made up of people with experience of health services, social care, social services, or being a carer. The Top Ten Tips give a valuable perspective from users and carers on what reablement services should be like:

1. Information: reablement services should be well promoted with clear information about what the service can offer and who is eligible at the earliest times
2. Culture: staff should be well trained in promoting independence and should have a reablement ethos, doing 'with' rather than 'for'
3. Confidence: self-esteem and confidence are crucial to reablement. They should be the primary focus of each person's plans to incorporate people's wishes and desires.
4. Social inclusion: coupled with this, services should promote community activity and social integration.
5. Avoid discrimination: reablement should be open to anyone who might benefit, irrespective of their condition or disability. It's not just for older people.
6. Multi-disciplinary work: reablement should be well linked in to other services such as rehabilitation and mental health support. This will allow specialist input when needed.
7. Include carers: often informal carers need support as well as the 'user'. This team approach helping both together will double the impact of reablement.
8. Emotional support: don't underestimate the importance of supporting people with their emotional and psychological needs.
9. Handovers: ensure a smooth transition to on-going services (for those who will need them). We don't want all the hard work to be undone and continuity is important.
10. Group work: sometimes group work can help people to learn and regain skills – and to support each other

Conclusion

Although there is no national guidance regarding the provision of reablement services, this review has shown that there is some evidence to support the implementation of such services. There appears to be consensus, but not robust evidence, that reablement services result in positive outcomes for users and staff, they are cost-effective, and that the users and their families are in favour of these services.

There is no gold-standard method of service delivery but instead, there are a variety of ways to deliver, fund and provide such services. There are some upcoming studies which may provide more robust evidence to inform service provision. In the meantime, reablement services are operational throughout the country and these can provide some pointers as to how an effective reablement services may be commissioned and delivered.

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Appendix 1. Reablement services – national examples

Location	Service	Description	Outcome	Reference
Isle of Wight	Introduced free home care for everyone who was eligible and aged 80 or over	Aim: to support people to live at home and reduce use of care homes. The council's in house home care service became a reablement service and worked with independent sector home care providers to build capacity	In the first year, new admissions to residential care homes reduced by 40 per cent and net savings of £2million. The reduction continued in following years.	Reablement for All (2010). Reablement: a guide for frontline staff. Office for Public Management. http://www.opm.co.uk/wp-content/uploads/2014/01/NEIEP-reablement-guide.pdf
Glasgow	6 week reablement programme	Longitudinal study to examine the impact of reablement on stakeholders in terms of satisfaction levels and reablement processes.	A sizeable proportion of service users went on to be independent in the community, and most were able to sustain this over a period of time. Those who had moved onto mainstream home care were mostly on reduced care packages.	Ghatorae, H (2013). Glasgow City Council. Reablement in Glasgow: quantitative and qualitative research. http://www.glasgow.gov.uk/CHttpHandler.ashx?id=15261
Gwent	Frailty programme	Incorporates a reablement and rapid response service	Not stated	Khanna, P (2012). Frailty “The patient will see you now”. [Accessed 16 December 2014]. http://system.improvement.nhs.uk/ImprovementSystem/ViewDocument.aspx?docId=22610&Title=Prof_Khanna-Frailty_The_Patient_will_See_You_Now
Bristol City Council and Community	Intermediate care and reablement services	Short-term interventions that enable people to stay in their own homes via 3 elements: rapid response, rehabilitation	Not stated.	Penfold, J (2014). Rapid response team enables patients to remain at home. Primary Health Care, Jun 2014,

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London Borough of Southwark Adult Social Care Services, South London and Maudsley NHS Foundation Trust and Together	Southwark Reablement Service	Set up in 2012, this service provides short, targeted social care interventions to clients with mental health problems. The service was set up as a pilot in order to evaluate the effectiveness of this way of working. It has a 13 week maximum duration with a mid-point review at 6 to 7 weeks. Support provided includes recovery and support planning, new solutions, and daily living.	The data suggests that the Southwark Reablement Service is having a positive impact on the reduction of clients' needs and reducing the financial cost of their care immediately after Reablement. Additionally, clients are mostly very happy with the service. Further research needs to be completed at a later date to ascertain the longer-term success of the Reablement scheme	Kings College University and University of York (2013). Evaluation of the Southwark Reablement Service http://www.york.ac.uk/media/spsw/documents/cmhsr/Southwark%20Reablement%20Service%20Evaluation%2021.6.13.pdf
North East	Reablement services	Reablement for All learning guide (2010) includes links to videos regarding reablement services in Darlington, Hartlepool, Newcastle, North Tyneside, and South Tyneside		Reablement in Darlington http://www.northeastiep.gov.uk/adult/Darlington.wmv Reablement in Hartlepool http://www.northeastiep.gov.uk/adult/Hartlepool.wmv Reablement in Newcastle http://www.northeastiep.gov.uk/adult/Newcastle.wmv Reablement in North Tyneside http://www.northeastiep.gov.uk/adult/NorthTyneside.wmv Reablement in South Tyneside http://www.northeastiep.gov.uk/adult/Sou

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				th Tyneside.wmv
Oxfordshire	Oxfordshire Reablement Service	<p>Provides practical help to assist people to live in their own homes as independently as possible. Short term designed to help people regain independence after ill health.</p> <p>Help with such tasks as:</p> <ul style="list-style-type: none"> • washing, dressing, bathing and showering, getting up and going to bed • assistance using the toilet or commode as well as emptying and cleaning the commode • assistance with feeding • carrying out health care tasks under the direction of a health care professional. <p>The service is provided by Oxfordshire County Council in partnership with Oxford Health NHS Foundation Trust. Self-referral is possible.</p>		https://www.oxfordshire.gov.uk/cms/content/someone-help-you-live-your-own-home
Community Reablement Unit	Memory Health Group	<p>Memory Health Group (MHG) is part of OT programme for adults attending Community Reablement Unit in 2010. MHG raises awareness of age-related memory changes and to support the individual to develop strategies to overcome memory difficulties in daily life</p>	High client satisfaction	<p>McHugh, G and Connolly, G. (2014). An occupational therapy led memory health group for community-dwelling older adults in a community reablement unit: Evaluation and vision. Irish Journal of Medical Science, September 2014, vol./is. 183/7 SUPPL. 1(S355-S356)</p>

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Vale of Glamorgan	Telecare in reablement service	Use of a proactive telephone calling service	Not stated	Champion, J. (2010). Telecare to support reablement in delaying a need for long-term homecare. Journal of Assistive Technologies, 2010, vol./is. 4/3(60-63),
Milton Keynes	Intermediate Care Service	This service includes Reablement at Home Team, The Reablement and Hospital Discharge Team, Rapid Assessment and Intervention Team, Home to Stay Team and Rapid Response Services	Not stated	http://www.milton-keynes.gov.uk/social-care-and-health/adult-social-care/intermediate-care-services#Rapid response
South East	Reablement review	The objective of the research is to help authorities save time and effort by summarising the learning and good practice from other authorities and providing simple useful links to more detailed support resources and information.		Joint Improvement Partnership South East Reablement Review 2010 http://www.thinklocalactpersonal.org.uk/library/Resources/Personalisation/Local milestones/SE Reablement Review.pdf
Greenwich Community Health Services	Re-ablement	Use of people management within integration of services. Integration services won staff engagement category at HSJ awards in 2011.	Significant savings from people not needing care packages after re-ablement. December 2011, 937 hours saved and reinvested.	Wells, J. 2012. The whole is greater than the sum of the parts. Health Service Journal 26 April 2012.

The Reablement For All learning guide (2010) has a section containing examples of reablement documentation which may be useful:

<http://www.opm.co.uk/wp-content/uploads/2014/01/NEIEP-reablement-guide.pdf>

Appendix 2. Rapid response services – national examples

Location	Service	Description	Outcome	Reference
Oxleas NHS Foundation Trust and Royal Borough of Greenwich Adult Community Services	Rapid response service providing rehabilitation to older people	One element of this service is the Community Assessment and Rehabilitation (CARS) which provides up to six weeks rehabilitation and ongoing social care linked to and working with a home care reablement service (seven days a week)		NHS Improving Quality (2014). Improving adult rehabilitation services in England: sharing best practice in acute and community care. http://www.nhs.uk/media/2487824/improving_adult_rehabilitation_services_in_england.pdf
South Manchester CCG	Virtual Ward and Rapid Response Teams	There is scope to deliver out of hospital care and care closer to home for frail elderly, dementia and patients at risk of re-admission as well as people identified by the frailty tool. This business case aims to deliver care out of hospital care and care closer to home for this group of patients through the introduction of a virtual ward and a rapid post discharge support service from the community provider.	The FY14/15 cost of the initiative is £608,151 and it is expected to deliver a net saving of £208,962	NHS South Manchester CCG (201?). Virtual ward and rapid response teams business case. http://www.manchester.nhs.uk/document/uploads/south-ccg/Item%2010.%20Virtual%20Ward%20and%20Rapid%20Response%20Teams%20Business%20Case.pdf
Nottingham	Crisis Resolution/Home Treatment Team (CRHT)	Multi-disciplinary team providing an appropriate professional rapid response to individuals experiencing acute mental illness, until their mental health improves and other support systems are in place. Wherever possible the team will be dedicated towards the prevention of		Nottingham Healthcare NHS Trust http://www.nottinghamshirehealthcare.nhs.uk/our-services/local-services/adult-mental-health-services/crisis-resolutionhome-treatment/

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		admission. Where individuals do require inpatient care, they will be supported towards a quick discharge from hospital. CRHT will endeavour to work alongside individuals to promote recovery and independence.		
Croydon	Rapid response service	Admission avoidance service available 24 hours a day, 7 days a week. The service provides intensive nursing and therapy interventions to prevent exacerbations and in a crisis, provides intensive crisis management to high intensity users. All patients are seen within 2 hours where an urgent response from community services is needed to stop an unnecessary hospital admission. Patients are assessed and a health and/or social package of care is set up to enable the patient to remain at home or they may be admitted to an Intermediate Care bed if they cannot be supported safely at home but do not require admission to hospital.		http://www.croydonhealthservices.nhs.uk/rapid-response-service.htm
Birmingham	Rapid Response Service	Rapid assessment and treatment of acutely unwell patients in community settings. It offers a commitment to providing an initial assessment by the most appropriate clinician within a two-hour response time when required. The service offers a single triage phoneline giving access to the urgent care bureau, providing: <ul style="list-style-type: none"> - bed bureau for Birmingham 		http://www.bhamcommunity.nhs.uk/about-us/clinical-services/adults-and-community-services/rapid-response/

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		<p>hospitals - medical and surgical admissions;</p> <ul style="list-style-type: none"> - direct admissions to community hospital beds / other BCHC bedded units; - admission prevention via rapid response referrals <p>Service is provided by advanced nurse practitioners, nurse assessors, physiotherapists, occupational therapists and clinical case managers</p>		
London	Rapid response	<p>Urgent Care (a social enterprise organisation) provides services which are flexible and adaptable according to local health and commissioner needs. The cars are staffed by experienced Emergency Care Practitioners (Paramedics with two years additional education and training) or Nurse Practitioners with a 2 hour response window to calls (most patients are seen within one hour). Calls come from local health professionals, residential and nursing homes and GPs. Where PCTs have single points of telephone access, calls can be referred through this number – or if not the local Out of Hours numbers may be utilised.</p>	<p>Common calls are for:</p> <ul style="list-style-type: none"> - COPD Exacerbations - Chest Infections - UTIs - Generally unwell - Other respiratory conditions <p>The average age of patients is 81 years of age, and we keep 95% or more in their own homes and away from both the 999 service and local A&Es. We work collaboratively with patients GPs to ensure that they are happy with any proposed treatment. The teams also provide targeted and pro-active support to Nursing & Residential homes during the evenings and at weekends, and also to local intermediate</p>	<p>http://www.urgentcare.org.uk/rapid-response-urgent-care.html</p>

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			care beds/facilities if needed. In our 2010 Patient Survey 50% of patients stated they would have called 999 without our service from Urgent Care service and a further 16% said they would have self referred to A&E Departments.	
Blackpool	Rapid response Service	24 hour nurse-led service for adults who meet the eligibility criteria. The service provides an alternative care option interfacing between primary and secondary care, aiming to prevent hospital admission or facilitate early discharge.		http://www.bfwhospitals.nhs.uk/departments/rapid_response/default.asp
Bristol CCG, Bristol City Council and Bristol Community Health – intermediate tier, multi-disciplinary health and social care service Contact email: jayne.clifford@bristol.gov.uk or	Rapid response service to assess, treat and support individuals in their own home	Integrated management and multi-disciplinary membership. 18 years plus but predominantly older people Registered nurses, physios, OTs, social workers, mental health specialists, pharmacists and re-ablement workers. Offers IV therapy. 7 days – 7.30am-7.30pm. Out of ours team provides cover outside these times but is not a large input. Referrals made through single point of entry and response times guaranteed within 4 hours. Primary focus on ambulatory care sensitive conditions. 3 Rapid Response Nursing teams which include an advanced nurse practitioner.	Over 60% of referrals are from primary care – “acts as a true step-up/admission avoidance service”. Prevents over 4,000 admissions per year. Advance Nurse Practitioners have been introduced to provide clinical support. Further development of the Community IV Therapy service.	National Audit of IC. 2013. Bristol CCG, Bristol City Council and Bristol Community Health – intermediate tier, multi-disciplinary health and social care service. Penfold, J. 2014. Rapid response team enables patients to remain at home. Primary Health Care, Jun 2014, vol. 24, no. 5, p. 8-9.

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lizanne.harland@bristolccg.nhs.uk		<p>Introduced ALERT course which trains staff to spot patient deterioration and act appropriately. Rapid response teams carry out in-reach work at Bristol Royal Infirmary's emergency department. Clinical advice provided over phone by ANPs to rapid response nurses and other team members.</p>		
<p>Berkshire Healthcare NHS Foundation Trust</p> <p>Contact: Claire.barker@berkshire.nhs.uk</p>	<p>Rapid Assessment Community Clinic (RACC)</p>	<p>Services available:</p> <ul style="list-style-type: none"> • Specialist team Including Associate Specialist, ANP, Occupational Therapist, Physiotherapist • 2 Consultant clinics per week • Saturday RACC clinic will be in operation from the 2nd November for a 6 month period • Rapid access to enhanced IC Support Services • Domiciliary appointments • Direct access to community hospital beds • Access to a variety of CHS Including the CHC, Community Matrons and the DN's • Same day transport available <p>Access on site to diagnostics</p> <p>Referrals can be made via the Community Access Point (CAP) 24 hours a day, 7 days a week</p> <p>Assesses each patient within 2 – 48 hours</p>	<p>Over a 35 month period, 733 referrals received – 599 maintained their home environment, 91 were admitted to community hospital bed and 83 advised to admit to secondary care.</p> <p>When given the choice, 82.1% patients preferred their treatment to be carried out in the RACC, 7.1% in the GP surgery and 0% favoured the acute setting</p> <p>Based on ONLY admissions into secondary care being avoided</p> <ul style="list-style-type: none"> • Based on 2011/12 tariff for admitted patient care and outpatient procedures (primary diagnosis costed) • Total annual savings £387,000 	<p>National Audit of IC. 2013. Berkshire Healthcare NHS Foundation Trust – The Rapid Assessment Community Clinic (RACC)</p>

Appendix 3. Social Care Institute for Excellence - learning tools and briefings

Type	Title	Content	Link
Elearning	Reablement for managers	30 minute training package. If you are involved in planning and commissioning services this module will show you how reablement is developing across England and help you consider why it's important to offer the service. If you manage or implement care services you can explore different models of reablement, reflect on staff training and ways to measure the success of the service.	SCIE (2013). Reablement elearning: reablement for managers. http://www.scie.org.uk/publications/elearning/reablement/index.asp
Social Care TV	The business case for reablement	The film begins with a brief introduction to reablement, which we see in operation with Jill Hunter, recently discharged from hospital following surgery. Jill lives in the Central Bedfordshire local authority. As well as seeing how reablement has improved Jill's independence to the point she will soon require no support, we hear from the Operational Manager of Reablement Services about the significant cost savings that reablement has delivered. This is verified with data from research and practice across the UK, presented by experts Gerald Pilkington and Professor Caroline Glendinning. We also see how investment in a 'step-down' reablement unit has facilitated far more hospital discharges, making cost savings in the health sector.	SCIE (2012). http://www.scie.org.uk/socialcaretv/video-player.asp?v=reablement2
Social Care TV	Reablement: an introduction	The film provides an introduction to home care reablement. Reablement is a relatively new service aimed at supporting people to regain independence that may have been reduced or lost through illness or disability. The film focuses on the reablement service in the London Borough of Sutton, known as START (Short Term Assessment and Reablement Team), where we follow the experiences of two people using	SCIE (2011). http://www.scie.org.uk/socialcaretv/video-player.asp?guid=6886fa01-81da-4963-926c-e1b41c5170f0

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		the service and hear from the manager and senior carer. We also hear from health economist Prof Julien Forder about new research evidence on the cost effectiveness of reablement.	
Social Care TV	The role of carers and families in reablement	The film introduces Jill Hunter who was recently discharged from hospital with limited mobility, following major surgery. Jill lives alone and was determined to return to her independent lifestyle. To enable this, Central Bedfordshire adult social care services commissioned their reablement team to work with Jill. We hear from two community reablement workers about the incredible transition people like Jill can make from initially requiring intensive support to being completely independent. We also hear how crucially important it is for families to 'buy into' the reablement ethos and contribute to its success. In turn, Emily Holzhausen (Carers UK) describes how reablement teams must respect and involve families, recognising their role as part of the whole support circle.	SCIE (2012). http://www.scie.org.uk/socialcare/v/video-player.asp?v=reablement1
At a glance briefing	Reablement: key issues for commissioners of adult social care	Outlines research and practice evidence about reablement and describes what is required for successful implementation. It provides links to evidence and information freely available online and presents two case examples of the impact reablement can have on the population and on local authority budgets.	SCIE (2012). http://www.scie.org.uk/publications/atagance/atagance52.asp
At a glance briefing	Making the move to delivering reablement	At a glance briefing summarises research and practice evidence about reablement. It explains how to move from a traditional home care service to a new reablement service. However, it can also be used by service managers who want to continue to provide a traditional home care service but in a more 'reabling' way.	SCIE (2013). . http://www.scie.org.uk/publications/atagance/atagance56.pdf
At a glance briefing	Reablement: implications for GPs and primary care	Focuses on research and practice evidence about reablement and explains the implications for GPs and primary care teams. It also provides a case example demonstrating the advantages of reablement at the individual and service levels.	SCIE (2012). http://www.scie.org.uk/publications/atagance/atagance53.asp

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At a glance briefing	Reablement: a key role for occupational therapists	Summarises research and practice evidence about reablement and explains the contribution that occupational therapists make to reablement services. It provides four case study examples of the different ways that occupational therapists are supporting or leading existing reablement teams.	SCIE (2011). http://www.scie.org.uk/publications/ataglance/ataglance46.asp
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