Transforming Outcomes Programme in Adult Social Care: **Spotlight on Reablement**

Health in Hackney Scrutiny Commission Update
2 March 2026

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Context and background

The first phase of the Transforming Outcomes Programme (TOP) in Adult Social Care ran from November 2023 - March 2025, at which point the programme was closed and transitioned to phase 2.

For fuller information on the first phase of TOP, see previous updates to the Health in Hackney Scrutiny Commission; Dec 2023, July 2024, Jan 2025, Feb 2025, Sep 2025.

To contribute to the Medium Term Financial Plan, ASC had targets to achieve savings through successful delivery of the TOP, between 24/25 - 26/27.

Financial performance of the TOP

Financial Year	MTFP savings target (£k)	Actual or Forecast* saving (£k)
2024/25	770	353
2025/26	2,560	2,850
2026/27	5,860	5,332

Projections accurate as of: 17 Feb 2026

Transforming Outcomes Programme

Summary of scope: TOP phase 2

Programme purpose: To change how we provide care and support to better promote the independence of Hackney residents, now, and to ensure this is sustainable in future

Workstream	Status
Understanding demand and maximising prevention To deepen the understanding of current and future demand for ASC and optimise opportunities for prevention	Discovery
Digitising ASC To test and implement digital solutions in ASC, focusing on improving resident experience and access, and supporting staff with more efficient ways of working	Discovery / Delivery
Reablement Implement a social model of reablement that can support more people with a wider range of social care needs, to reduce the need for ongoing support.	Delivery
Enhancing support for carers Following successful launch of Carers Strategy, action implementation and propelling pace of change	Not started

Workstream	Status
Increasing uptake of Direct Payments Further develop the direct payment offer; assuring efficiency and improving access for residents arranging their own care and support	Delivery
Home adaptations To achieve personalised and timely home adaptations funded by the Disabled Facilities Grant in order to increase safety and independence for our disabled residents	Delivered - transitioned to BAU
ASC Preparing for Adulthood To develop a new 14-21 year PfA service to provide an improved experience for children transitioning to ASC	Delivered - transitioned to BAU
Care charging To increase efficiency, equity and accuracy in care charging	Delivered - transitioned to BAU

Spotlight on Reablement

What is reablement?

‘The reablement approach supports people to do things for themselves. It is a ‘doing with’ model, in contrast to traditional home care which tends to be a ‘doing for’ model.

Reablement services help people to retain or regain their skills and confidence so they can learn to manage again after a period of illness.

Reablement is an approach that, irrespective of diagnosis, aims to assist people to continue to live as they wish. It seeks to enable the individual to do ordinary activities like cooking meals, washing, dressing, moving about the home and going out.

Reablement may be used to support discharge from hospital, prevent readmission or enable an individual to remain living at home.

It can be provided for anyone who will benefit from it. It is typically provided for up to six weeks although it is not unusual for someone to need only a couple of weeks of reablement. It is also possible that reablement will last longer than six weeks if full independence could be achieved with a bit more support’ - Social Care Institute for Excellence

Vision and objectives for the new reablement service

Workstream purpose: Implement a social model of reablement that can support more people with a wider range of social care needs to promote their independence, reduce their need for ongoing care and support, and to support the financial sustainability of ASC

Key objectives, outcomes and measures:

Objective	Outcome	Measures
To expand reablement capacity through a scalable, phased implementation model	Increased number of residents able to access reablement, particularly from Pathway 1 hospital discharges and later from community referrals.	Increase no of starts (from avg 4 to avg 20 per week) Improvement in ASCOF 2d(2) 'the proportion of people aged 65 and over discharged from hospital, who received reablement services'
To ensure residents receive high-quality, strength-based, goal-focused reablement support.	Residents gain or regain independence, with less intensive long term care required following intervention. Ongoing care needs are prevented or reduced.	Average package reduction of 8.2 hours post reablement Improvement in ASCOF 2d(1) 'Proportion of people aged 65 and over discharged from hospital into reablement and who remained in the community within 12 weeks of discharge'
To broaden inclusion criteria so residents with higher and more complex needs access reablement	Residents with higher or more complex needs are supported to increase their independence, whilst recognising that 'full' independence (no ongoing care and support needs) is not likely to be an appropriate goal for all	Reduction in the proportion of reablement finishers who have no ongoing care and support needs, post reablement (40% completing requiring ongoing care)

What has been delivered to date and future plans

Phase 1
Nov 23 - June 26

Diagnostic completed.

Dual pathways established: ‘Reablement at Home’ and ‘Reablement Assessment Flats (RAFs).

Reorganisation of staff: staff previously based in the Homerton now providing care in RAFs and a pilot working with a provider to provide Reablement at Home.

Design scalable model for future phases.

No change to activity volume: **~4 starts p/week** whilst new model is embedded and pilot evaluated.

Phase 2
June 26 - 2027 TBC

Grow pilot to work with greater number of providers to extend the reach to offer all pathway 1 hospital discharges reablement.

Implement new workforce model and practice approach to meet increased reach.

Feed learning into full homecare commissioning, which will include specialist reablement provision.

Activity volume increases to **~20 starts p/week.**

Phase 3
2027 - TBC

Extend reach of reablement further by accepting community referrals, through new contract with provider(s).

Activity volume expected to be **~25+ starts p/week** (full modelling required).

Phase 4
TBC

Aim for LBH ASC to have embedded a truly ‘reablement first’ culture.

Consider widening to include a robust ‘enablement’ offer - developing approaches suitable for learning disabilities and mental health. This would embed a short term service to enable residents to achieve time limited goals that matter to them.

How the current service is working - case studies

Reablement at Home

Mr R was admitted to hospital for a lower lobectomy and removal of lymph nodes, with ongoing shortness of breath. At the time of admission he was fully independent. After his hospital stay, he had reduced functioning due to shortness of breath, pain, and impaired balance. He started reablement with 11.5 hours of support a week.

His goals included: To be able to transfer to bath using bath board independently, to be able to complete domestic cleaning independently, to build his walking endurance to confidently be able to walk to church every week, and to be able to walk to the launderette to independently manage his laundry.

After 6 weeks at his final review, Mr. R advised that he thought he had physically done very well on the reablement programme and achieved the goals that were set for him with modified independence/complete independence achieved. Mr. R advised that he is going to continue to practise with the goals that he has achieved modified independence on, to try to achieve complete independence in time.

He ended with 6.75 hours of care (4.75 hour reduction), as he had still had a need for support with personal care due to ongoing chest pain and shortness of breath. Overall he regained significant independence during this time.

How the current service is working - case studies

Reablement at Home

Mr O was admitted to hospital due to a spinal cord injury. Prior to this, he was fully independent.

Mr O started with 15.75 hours of reablement to support with achieving the following goals:

- To be independent with mobilising with 1 or no aids indoors
- To be able independent with toilet hygiene and emptying his catheter
- To become independent with lower body personal care tasks
- To be independent with meal preparation

After 2 weeks, Mr O had made good progress and no longer needed the evening care call he had been receiving. By week 4, he had achieved all of his goals except for becoming fully independent with lower body personal care (which had had partially achieved). After a discussion with the OT, he felt this could be managed with support from his wife alone, and therefore was no longer requiring reablement support.

He ended with no ongoing care and support needs, a reduction of 15.75 hours.

How the current service is working - case studies

Reablement Assessment Flats

Mr P, who has a learning disability and a pre-existing care package, was hospitalised after a fall and diagnosed with deteriorating eyesight and pneumonia. Struggling to adjust to his new sight impairment, the hospital team deemed it unsafe for him to return home due to fall risks.

The Integrated Discharge Service OTs and Social Worker recommended that Mr P be placed in the Reablement Assessment Flats (RAFs). Mr P had capacity for this decision and agreed to be placed in the RAF's.

There, he made significant progress regaining confidence and independence with a reablement approach. After home repairs (including treating mould), he has returned home with commissioned care support. This intervention allowed Mr P to remain in his local community and avoid residential care outside of Hackney. Without the Reablement Assessment Flats, Mr P would not have been able to return home.

How is the programme being delivered?

Working groups

Workstream	Core Focus
Procurement & Commissioning	Ensures the commissioning, contracting, and market arrangements required to deliver a scalable and sustainable reablement offer are in place.
People, Practice & Change	Develops the workforce, practice model, and organisational change required to embed a consistent, strengths-based reablement approach.
Reablement Assessment Flats	Oversees the development, operation, and optimisation of bed-based reablement pathways delivered through the Reablement Assessment Flats.
Systems & Infrastructure	Delivers the digital tools, case management processes, and operational infrastructure needed to support efficient and accurate reablement delivery.
KPIs & Reporting	Defines, monitors, and reports on key metrics to evaluate performance, evidence impact, and inform ongoing programme decision-making.

Health in Hackney Scrutiny Commission

Reablement Board
Chair: Assistant Director of Transformation (SRO)

ASC Transformation Steering Group
Chair: Director of ASC Ops

CLT Transformation Board
Chair: Chief Executive

Financial benefits of reablement

Reablement delivers financial benefit through reducing (or removing the need for) longer term care (and therefore costs) for residents who receive it.

This financial benefit is estimated based on:

- Insight from a local pilot and data that suggests we would expect, on average, care and support needs to reduce by 8.2 hours per week hours after reablement (noting some residents will have much greater reductions, and some far less)
- The number of people we expect to start reablement each week (~20)
- We then project forward this reduction in care hours, for the average duration of a home care package (based on local data)

For example, Mariam is discharged from the Homerton hospital after a fall, requiring 22 hours of care and support at home. She receives reablement support, which helps her regain skills and confidence and work actively towards goals she has set with an Occupational Therapist. Each week, as Mariam's independence increases, she requires a little less support from her Reablement care worker. After 5 weeks, Mariam has achieved the goals set, and is discharged from Reablement. She now only needs 10 hours of care per week moving forward (a 12 hour reduction), which is arranged by Adult Social Care. Without the reablement support, Mariam would continue to receiving 22 hours of support, instead of 10. So the 12 hours of avoided care accumulates each week, and Mariam has regained independence and achieved goals that matter to her.

Based on these assumptions, our projections show, we expect to avoid **£920k*** of care costs due to reablement in 26/27, increasing to at least **~£4m** cumulative benefit in 27/28, and at least **~£7m** in 28/29. To meet these savings targets, some investment in workforce is required - this is being planned and factored into the modelling at present.

**including in overall TOP savings forecast in 26/27 as part of MTFP agreed savings*

Questions and discussion