

City of Edinburgh Council
Health and Social Care
Guidance Note on Referrals for Home Care Re-ablement

1. Purpose

There has been some divergence emerging in the approach that localities and hospital teams are taking about moving service users straight to a mainstream home care or care at home service and thus bypassing a Home Care Re-ablement Service. This note has been drafted to provide guidance to assessors and Home Care Teams with the purpose of achieving standardisation of approach across the city.

2. Background

The Home Care Re-ablement policy was endorsed by Committee to consider Home Care Re-ablement for 100% of service users referred for a Home Care Service (Section 4.1 Review of Home Care and Support at Home Services 4th March 2008). Home Care Re-ablement was introduced in October 2008 and implemented across all localities by March 2009. The Home Care Modernisation Project Board had considered the question, in the summer of 2008, of some service users who may not benefit from Home Care Re-ablement and concluded:

- That Home Care Re-ablement should be an inclusive service
- That it would be wrong to treat people in categories, for example, to exclude all people with dementia so that they would not be offered re-ablement,
- That the policy decision made by the Council still stands
- Each case should be considered on their own merit
- The decision not to offer re-ablement would be made initially by assessors with reasons that can be validated
- Any move to Home Care or Care at Home mainstream service without re-ablement should be by exception rather than routine or by category of service user

The evidence of some divergence has been analysed using the Spreadsheets kept for implementation of Home Care Re-ablement.

The objective would be, as an initial position, to target, **as a minimum, an average of 95%** of service users being provided with a Home Care Re-ablement Service. The reasons for service users not receiving a Home Care re-ablement Service should be logged by Sector Practice Managers and reported on a monthly basis.

3. Principles

The principles that underpin the approach should be:

- Home Care Re-ablement is an inclusive service
- Home Care Re-ablement is part of the continuum of the assessment and care management process
- Home Care Re-ablement can be provided for a few days to around 6 weeks
- Home Care Re-ablement works with individuals in their own environment
- All people will potentially benefit from a Home Care Re-ablement Service

- Support for the Home Care Re-ablement Service should be tried in all but a few instances
- Home Care Re-ablement is principally for all people over 65 with intensive/complex as well as straightforward needs. Some adult groups with complex needs provided by specialist providers will not require receiving the Home Care Re-ablement Service.
- Home Care Re-ablement can be used to get the package just right for service users including increasing the care hours where required
- Goal Planning is effective in motivating, increasing confidence and independence for service users
- The eligibility criteria for Social Care are the only criteria that apply; there are no separate criteria for Home Care Re-ablement

4. Practice Guidance

For assessors, each individual's circumstances and potential benefits of re-ablement should be considered on their own merit, however, the following scenarios may assist in arriving at a judgement about suitability for the very small group of people who may not benefit from re-ablement.

- An individual who has been through an intensive home based rehabilitation programme and there is evidence that indicates they are fully re-abled at home and have no further potential for re-ablement.
- An individual at the end of life on the 'Liverpool Care Pathway' who has hours/ days to live and wishes to die at home.
- An individual with a professional diagnosis of dementia (e.g. Consultant Geriatrician, GP), where either there is strong evidence they would lose confidence and motivation or display challenging behaviour by changing the staff providing care and support.
- An individual who has been in hospital for up to 4 weeks or requires an increase in the package of care and will require a restart of their mainstream service would require judgement on whether there would be benefits of re-ablement or not.

All service users where the assessor believes that Home Care Re-ablement is not required should discuss this with the Sector Care at Home/ Home Care Panel for approval.

Assessors should discuss individuals with the Home Care Service Manager prior to Sector Panel decision.

Requests for increases of packages of care should be considered for Home Care Re-ablement first.

Where service users go straight to a mainstream provision of Home Care/ Care at Home then the assessor must arrange a review at the 6 weeks point and refer to re-ablement if appropriate.

For Home Care Re-ablement Teams, there will be issues that lead to local considerations about moving service users to mainstream services without re-ablement.

- Moving service users to mainstream service because of capacity issues in Home Care Re-ablement Team is not acceptable and capacity issues should be managed by the Home Care Service Manager or, if transfer of resources is required, in conjunction with the Home Based Service Manager

5. Conclusion

This guidance note cannot cover every situation but is meant to assist practitioners in understanding the policy objective of the Council to ensure that the vast majority of service users over 65 will receive a Home Care Reablement Service.