TRANSFORMATION OF COMMUNITY CARE

PREVENTION AND REABLEMENT - A REGIONAL MODEL

This model will be implemented within the Older Persons’ Programme in the first instance, but there is an expectation that it will be rolled out to all adult services, albeit on a phased basis.

OBJECTIVES

- To restore personal autonomy in the activities of daily living considered the most critical to the individual service user.
- To rebuild their confidence and support the regaining/development of daily living skills.
- To promote the person’s access to services in local communities and integration into the local community.
- To shift the balance of care increasingly towards the provision of support in the community.
- To increase the range of preventative services which will reverse or delay deterioration in the level of independence in both physical and social functioning.
- To respond to individual crises in such a way that maximises the option for the person to stay in their home.
- To promote a seamless service between statutory, independent and voluntary services.

SCOPE OF THE MODEL

- A reablement approach is valuable for all adult client groups although the time scale for involvement and methods of intervention will vary.
- Reablement will eventually replace Home Care as a service for significant numbers of older people; the staff needed to provide this service will be re-located from existing Administrative, Home Care and Professional Teams.
BASIC REQUIREMENTS OF THE MODEL

PREVENTION

1. In order to maximise the use of voluntary, independent and informal services in the community it will be necessary to develop and maintain a data base of services.

2. This data base will be held within the Contact Service but also by appropriate third sector organisations.

3. There should be an information plan in place which will provide information on both Statutory and Third Sector services using a variety of methods including online.

4. The provision of these services and information will allow:
   - People to seek assistance and services without necessarily being formally referred into Statutory Services. This will contribute towards better demand management on Statutory Services.
   - Facilitate the contact service to resolve enquiries by redirection to non statutory services.

CONTACT SERVICE

This will be more than referral management, since it will involve screening; diverting people to other agencies who may have the legal responsibility to address the person’s enquiry; signposting the person to services in their local community which may meet their need without recourse to reablement; and referring person on to conventional services where there current level of need warrants this.

1. Once the model is fully operational, the Contact Service will provide the only point of access into the following services:
   - Social care services for older people
   - Community nursing services
   - Hospital based social care services for older people

2. The Contact Service will aim to resolve as many enquires as possible within the contact service and will provide the following;
• Record all enquires and referrals dealt with on an agreed CRM system
• Basic advice and information on services available in a local community.
• Redirect enquires to other Trust, Independent and Voluntary services as appropriate
• Carry out screening/initial assessment using NISAT Contact Screening and arrange agreed simple services directly.
• Screen and refer older people directly into the reablement service without recourse to NISAT.
• Screen and refer people who are excluded from reablement into other appropriate services, at which time NISAT would be used and access criteria applied.

3. An agreed screening tool will be used by trained contact centre staff who will be supported by relevant professional staff.

4. The contact service will develop and maintain a data base of relevant statutory, independent and voluntary services

REABLEMENT SERVICE

1. Reablement is a philosophy of service provision and does not relate to just a specific home based reablement service, it informs the whole approach to how all services are provided regardless of service setting or discipline.

2. The reablement service will work as an independent service separate from domiciliary care provision. This would not preclude domiciliary care managers being part of the service.

3. Evidence strongly confirms that the large majority of older people (90%) who are referred for home support services will benefit from a home based reablement service.

4. The default position will be that older people requiring home support services will first be offered a period of reablement unless specifically excluded. Based on current practice the exclusions include end of life care and some service users with significant dementia although the concept of promoting independence can still inform the way in which these service users are supported.

5. Access to the service will not require complicated assessment, referrals will normally be screened through the contact service.
6. The service will provide both a step up and a step down response eg as part of intervention to avoid an unnecessary admission to hospital or residential care.

7. The service will assess the home care support of a current service user where there has been a request for an increase in service provision and consider the potential for reablement before any decision to increase a care package.

8. The service will be strongly informed by the service users own goals and a capacity to help service users to regain the ability and confidence to carry out essential activities of daily living

9. Activities of daily living should be the basis of the reablement plan which will provide a consistent and measurable approach.

10. It is important that other forms of support, such as assistive technology and supported housing are considered which may be incorporated into the long term care planning stage for service users who need continuing support after reablement.

11. Where reablement intervention is likely to lead to the need for no ongoing service, consideration should be given to facilitating access to informal/voluntary services with support from the contact service.

12. The service will have involvement and input from professional therapists. The extent and nature of their involvement may vary with individual Trusts but it is critical that leadership is given to ensure that a clear understanding of reablement philosophy and practice is achieved and maintained.

13. The majority of the direct intervention with service users will be carried out by trained reablement assistants, who, particularly in the early stages of work with a service maybe required to provide both personal care and reablement support. Provision of personal care by non reablement staff in the reablement process should be avoided as this may compromise the reablement intervention.

14. Reablement assistants will be trained /accredited to NVQ3 or equivalent

15. The development of a clear care pathway into home based reablement is critical to the success of the service. This is particularly true of the care pathway between intermediate care and reablement. The scope and function of intermediate care may vary between the Trusts and there maybe potential overlap between some existing intermediate care services and the proposed/developing reablement service. Agreement will need to be reached as to the care pathway into reablement so that the maximum number of service users can benefit from both services.

16. It is also important that all other staff involved with service users understand the reablement service and approach both in the community and in secondary care.
17. The reablement service should have in place a system of monitoring the progress of individual service users through the reablement phase and monitoring the costs of the service. This is necessary to assess the overall performance of the service and the costs of individual reablement episodes. Without this the financial breakeven point will not be known and there will be no basis for predicting the potential financial savings that may be generated.

18. The reablement service should have in place an agreement with the crisis intervention service as to its role in providing immediate follow up to crisis intervention where the aim of the intervention is to keep the service user in their own home (which may include a residential Home). The reablement service will not be required to provide a separate crisis intervention service but to have the capacity, for example, to commence reablement intervention within 24 hours of the involvement of the crisis service to support the goal of keeping the service user in their own home.

19. Short term provision of ADLs may be necessary as part of the reablement intervention. Arrangements will need to be in place to facilitate timely provision of ADLs following discharge from hospital or crisis intervention.

20. The service will need to have in place a performance management framework which includes outcomes from reablement and service costs. The performance management framework will have service user feedback built into the process.

21. Trusts will need to have a commissioning and investment strategy which will ensure a continuum of preventative services to which older people can be signposted.

22. If the person still has care needs at the end of a reablement programme, there should be a clear procedure to cover their referral for assessment under NISAT and development of a plan for conventional home care.

23. As part of discharge and referral to conventional services, any protocols should include the offer of services on a self-directed basis.