

EDUCATION AND SOCIAL CARE SERVICES

Reablement

POLICY & PROCEDURE

JANUARY 2012

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The Equal Opportunities Officer
Corporate Policy Unit
The Moray Council
High Street
Elgin, Moray
IV30 1BX
Tel: 01343 563321
Email equalopportunities@moray.gov.uk

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1.0 Background

The reablement service is a new approach to delivering Internal Care Services to older people and other service user groups in Moray social care services. The reablement service encourages service users to engage with the service and take an active part in their own care and independence. The service is a short-term service (up to six weeks) that the majority of people will use prior to being reviewed for their longer-term care needs. It is intended that all eligible service users will receive a period of reablement in order to maximise their opportunity for independence prior to the provision of long term care. The usual financial rules contained within The Moray Council's Charging Policy will apply during this time, in particular, that personal care is free to people aged over 65.

A number of studies have been carried out that have demonstrated the benefits of a Re-abling approach, most notably the De Montfort University (Sep 2000) Leicestershire County Council, External Evaluation of the Home Care Re-ablement Pilot Project. These note two significant benefits; - that care hours are reduced for a majority of service users; that the reduction is maintained for at least 2 years.

A reablement pilot was carried out in Moray from November 2009 and reviewed in March 2010. The pilot was based in the Keith/Speyside area, the final report noted that: - *'A number of people have been successfully re-abled and no longer require homecare input. The paperwork and documentation is in place and supports the work. There is a baseline evident from the initial assessments through to the end of the enablement service. The outcome therefore is measurable.'* The report concluded that the process and documentation would support reablement and that staff had the required skills to deliver reablement in Moray.

Local Authorities throughout the country are demonstrating how the development of reablement services can support independent living maximise independence for people and also deliver value for money.

1.1 Policy Context

Promoting Independence was discussed in the 1998 White Paper Modernising Social Services, which expressed the government's aim to 'put a new emphasis on helping people achieve and maintain independence wherever possible... to improve their health and social functioning rather than just "keeping them going"'.

The terminology was extremely important, as the paper described the idea of moving away from a culture of dependency towards one of enablement: 'the guiding principle of adult social services should be that they provide the support needed by someone to make most use of their own capacity and potential. All too often, the reverse is true, and they are regarded as services which do things for and to dependent people' (DH 1998).

The 'National Service Framework for Older People' (DH 2001) emphasised services that prevent premature admission to long-term care, while in 2006, 'Our Health, Our Care, Our Say' promoted the principles of delivery of care closer to home, and improved rehabilitation (DH 2006), principles which are central to the development of reablement services. The outcomes focus which is prominent in the White Paper is also a core feature of the reablement approach to social care.

Reablement also fits well with the policy of joint working between health and social care services (DH 2007), with a number of reablement schemes demonstrating innovative approaches to joint working and a skill mix of both health and social care workers. Reablement also fits well with the concept of Intermediate Care as defined in section 1.3.2 below.

In Scotland the Long Term Conditions Collaborative: Improving Complex Care, March 2009 specifically mentions reablement as one of the ways of modernising and improving Home Care services. In the same year the Evaluation of City of Edinburgh Council Home Care Re-Ablement Service, November 2009 was published and clearly shows both immediate and long term benefits of adopting a reablement approach.

1.2 Purpose of document

This framework sets out clearly the circumstances that make individuals eligible for reablement. The framework is based on the impact of eligible needs on factors that are key to maintaining an individual's independence as outlined in the Moray council's Eligibility Policy (www.moray.gov.uk). It also serves to define the target groups; clarify the pathway into and out of reablement; define the process and procedures; clarify the roles and responsibilities of different professionals and unpaid carers and put in place a robust performance management framework based on targets.

1.2.1 Aim

To help people who have been assessed as having care needs to maximise their level of independence by learning or relearning the skills necessary for daily living.

1.2.2 Objectives

The objective of re-ablement is, through the use of timely and focused intensive interventions are:

- **to maximise service users long-term independence, choice and quality of life.**
- **to minimise ongoing support required,**
- **and thereby,**
- **to minimise the whole-life cost of care.**
- **that all eligible service users will receive a period of reablement.**

1.3 Definition of terms

1.3.1 Reablement

Reablement is sometimes referred to as homecare re-ablement, enablement or re-enablement.

There is sometimes overlap between reablement and other areas such as Intermediate Care, Rapid Response, Prevention and Rehabilitation, but it is important not to confuse these approaches to care.

- The definition of reablement adopted here is 'services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living' (Care Services Efficiency Delivery (CSED 2007a). (www.dhcarenetworks.org.uk/csed)). These skills are based around activities of daily living and can include: getting dressed and undressed; getting into and out of bed; using the stairs; washing and personal grooming; using the toilet; preparing meals. Reablement services should be outcomes-focused, and are provided for a defined maximum period of time, often six weeks (CSED 2007a).

1.3.2 Intermediate care

- Intermediate care services seek to address one or more of three main priorities:
 1. Prevent admission to hospital
 2. Speed up hospital discharge, and
 3. Prevent or delay admission to long-term residential care

Intermediate care is a function that encompasses a range of services that are:

- Targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long term residential care or continuing NHS in-patient care.
- Provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery.
- Based on cross-professional working, normally clinician led and with a single assessment framework, single professional records and shared protocols.

The following table permits comparison and better understanding of the two models.

| | INTERMEDIATE CARE | HEMOCARE RE-ABLEMENT |
|--------------------------------|---|---|
| PURPOSE | A range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living. | To help people to accommodate their illness or condition and maximise their level of independence by learning or relearning the skills necessary for daily living. |
| MODEL OF CARE / SUPPORT | Patient has a defined clinical need. Normally adopt a health model of care. | Client has a social care need for support that may or may not arise from a clinical need. Normally adopt a social care model of support |
| SKILL SET | Clinician led with multi-professional teams including nurses, therapists, etc. | Teams formed from enablement staff with or without therapy input within the team. |
| FORM | Bed based: as in specific intermediate care centres or in care homes. Community: as in people's homes or day rehab. | Community based: Hospital discharge support: only work with people discharged from hospital and often on a selective basis as part of the efforts to speed up hospital discharges. |

| | INTERMEDIATE CARE | HEMOCARE RE-ABLEMENT |
|-------------------------------------|--|--|
| | | Intake and assessment: forms part of the mainstream pathway for people in potential need of social care support and so work on a deselective basis |
| CLIENT GROUP | All adults that fall within the purpose of the service as defined above. Some services focus on clients with specific medical conditions only. | Most services support all adults but the main focus is on older adults. |
| LOCATION OF SERVICE DELIVERY | Residential as in step up and step down beds. Community: as in hospital at home or supported discharge at home. Daycare: as in day rehabilitation. | Most widely in people's homes. A few examples are emerging where this is extending to both residential bedded units and daycare settings. |

Rapid Response - will support the intermediate care process by responding rapidly to a crisis.

Prevention - is concerned with the provision of information and low level input to people with poor physical or mental health in order to maximise their ability to maintain their own independence.

Rehabilitation - is concerned with helping people with poor physical or mental health to get better or to better manage their illness or condition.

Further definitions are available from the CSED website. www.dhcarenetworks.org.uk/csed

2.0 The Policy

2.1 Principles underpinning the Policy

The guiding principles behind reablement are:

- **helping people 'to do' rather than 'doing to or for' people.**
- **outcome focused with defined maximum duration.**
- **assessment for ongoing care packages cannot be defined by a one-off assessment but requires observation over a defined period.**
- **all eligible service users will receive a period of reablement.**

2.2 Application of the Policy

2.2.1 Service user eligibility

People who receive a reablement service will already have been screened for eligibility in terms of the Moray Council eligibility criteria for Community Care and these criteria will also be used for assessing eligibility for reablement. Also, the reablement service is for those people who meet the following additional criteria:

- People aged 16 and over, who have an assessment of needs and a package of care provided by the Moray Council, Community Services Department.
- People who are being discharged from hospital; and, people who are living in the community and who have been identified at a referral, assessment or a review as benefitting from a re-abling approach.
- The main focus of work will be with older people including older people who have a mental health problem and who are receiving a home care service.
- People who have a learning disability; people who are on the autistic spectrum; and, younger people who have a physical or a sensory disability or a mental health problem where opportunities for reablement can be identified and introduced on a case by case basis.

For more information on eligibility criteria of needs, please refer to the Eligibility Criteria.

2.2.2 Process

The re-abling process will be as follows; -

- a. Referral for reablement will come via the Adult Social Care Access and Prevention Team or from an area team following service user review. An

episode of reablement will be built into the service package for all service users who are supported by the Access team. For those who are supported by the area teams, opportunities for reablement will be identified at review.

- b. The Care Officer/Social Worker will work with the service user and family, where appropriate, to determine eligibility for services, carry out an assessment to determine the level of need and agree the desirable outcomes for the service user.
- c. The Care Officer/Social Worker will discuss reablement with the service user and unpaid carer, where appropriate and ensure that they are in agreement with the principles of reablement and agree to participate in the process.
- d. The Care Officer/Social Worker will develop a Care Plan that sets out what support is needed in order for the service user to be as independent as possible and to achieve the agreed outcomes. There will be input from unpaid carers, where appropriate; Occupational Therapists (OT) and other professionals to develop this plan. The Care Plan should set out which professionals and unpaid carers will be involved in developing the plan and delivering the reablement service and what their roles will be.
- e. The Care Officer/Social Worker will monitor the reablement process to ensure that all appropriate professionals are carrying out their roles and responsibilities according to the Care Plan.
- f. The Care Plan will be developed into a Service Plan by the Care Organiser/Alzheimers Scotland Coordinator. This will set out a series of goals that have been agreed by the service user. There will be input from unpaid carers, where appropriate; OT and other professionals to develop this plan. The Care Organiser/Alzheimers Scotland Coordinator will provide a copy of the plan to the service user, all participating staff and unpaid carers where appropriate.
- g. The Care Officer/Social Worker; Care Organiser; OT and any other professionals involved will form a multidisciplinary team to support the

service user and the unpaid carer to achieve the goals and for the service user to achieve as much independence as possible. As noted in c. above, the Care Plan should set out which professionals and unpaid carers will be involved in developing the plan and delivering the reablement service.

- h. The goals will be reviewed weekly at a multi-disciplinary meeting via written reports from home carers/Alzheimer's Scotland workers.
- i. The service plan will be amended on a weekly basis as required and a record of all events and activities relating to this will be maintained on CareFirst by the Care Organiser.
- j. The Care Officer/Social Worker will ensure that the service user and unpaid carer, where appropriate is aware of all changes to the service plan and to the current goals.
- k. The Multi Disciplinary team will agree when the service user has met all attainable goals or is unlikely to meet further goals and to set a review date.
- l. During the re-ablement period, the amount of home care help will gradually be reduced. By the end of the re-abling period, the team will know how much the service user can do for them self and what continuing help and support will be needed.
- m. The Care Officer/Social Worker will carry out a review at the agreed end date of the reablement period in order to agree and put in place the ongoing home care or other support required to meet the service user's needs. The Care Officer/Social Worker will be responsible for ensuring that the ongoing care is set out in a Care Plan in terms of outcomes, times, duration and number of carers and that there is a smooth transition between the reablement process and that of delivering ongoing care.
- n. Where ongoing care is required, the Care Organiser will liaise with the Care Officer/Social Worker and put in place a service plan and risk assessments that fully meet the needs of the service user.

Reablement allows greater flexibility for the support staff to use their knowledge, experience and initiative by tailoring the service to the service user's needs as set out in the Care Plan and the goal oriented Service Plan. The plans will be based on service users achieving goals related to activities of daily living, these include:

- **Mobility;** Encourage, assist, and facilitate service users to reach their goals of improved mobility.
- **Hygiene and personal care;** Encourage, assist, retrain, and make it easier for the service users to do tasks for themselves.
- **Food and nutrition;** Make and prepare nutritional meals, encourage service users to eat and drink regularly.
- **Shelter and warmth;** Encourage service users to keep their homes warm, and to wear appropriate clothing.
- **Financial well being;** Support service users and unpaid carers to improve their financial well being by directing the customer to the appropriate support agencies and monitoring their progress.
- **Safety, security and stability;** Minimise risk to service users. Identify risk by completing a risk assessment on the person's home.
- **Belonging and self esteem;** Encourage, facilitate and monitor service users uptake of local activities. Signpost service users to the appropriate agencies.
- **Health, memory and communication;** Encourage, prompt, and monitor physical and emotional well being. Support service users and families to understand what support is available in Moray for those with memory loss or dementia.

2.2.3 Roll and remit of professional groups; unpaid carers and service users.

Care Officers/Social Workers – Will have a primary role in the reablement process and will maintain an awareness of the process of reablement through continuous review with each service user until final review at the end of the

reablement period. Care Officer/Social Worker will carry out an assessment of need and write a care plan that sets out what support is needed in order for the service user to be as independent as possible. The care plan will need a significant level of detail about the specifics of the persons care needs and the desired outcomes. The Care Officer/Social Worker will be required to introduce the concept of re-ablement and discuss it in depth with the service user and their family. The Care Officer/Social Worker will be expected to use core social work skills to support the service user and their family to fully participate in the reablement process. In cases where reports are received that highlight issues that are likely to prevent the successful implementation of the goals, the Care Officer will be expected to use core Social Work skills to support the service user or unpaid carer to reflect on their thoughts and feelings about reablement and therefore to fully participate in the reablement process. The Care Officer/Social Worker will also be expected to carry out a general risk assessment that relates to the risks associated with the individual participating in the reablement process. This assessment will inform the specifics of the care plan for the service user. The Care Officer/Social Worker will coordinate the work associated with Reablement for each service user through liaison with other professionals. Unpaid carers may also need support with some of the emotional issues that arise as a result of reablement. This support should be provided by the Care Officer/Social Worker. The Care Officer/Social Worker will carry out a review at the end of the Reablement period in order to determine the ongoing level of care and support that is required to meet the service user's ongoing needs. The Care Officer/Social Worker will put in place the ongoing support required and will ensure a smooth transition between the reablement period and the ongoing care provision. The Care Officer/Social Worker will be responsible for ensuring that the ongoing care is set out in a Care Plan in terms of outcomes, times, duration and number of carers.

Care Organiser/Community Support Organiser/Alzheimer's Coordinator - will set out a series of goals, based on Activities of Daily Living, that have been

agreed with the service user and that are designed to assist them to become more independent. These goals will form part of the Service Plan. The Care Organiser/Community Support Organiser/ Alzheimer's Coordinator may need to carry out a service based assessment in order to clarify service needs and issues and to identify the best way of meeting these needs. The goals will be reviewed and amended weekly based on Home Carer/worker feedback reports. The Care Organiser/Community Support Organiser/Alzheimer's Coordinator will ensure that the details of the original plan and any subsequent changes are clearly communicated to the multi disciplinary team, the home carers and unpaid carers. The Care Organiser/Community Support Organiser/Alzheimer's Coordinator will also be expected to carry out specific, care related risk assessments and put in place risk management plans to minimise identified risks. These risks will have been identified in the Care Plan provided by the Care Officer/Social Worker. Unpaid carers will need to be supported to assist in the process of reablement; in particular they will need training for some of the practical tasks. The Care Organiser/Community Support Organiser/Alzheimer's Coordinator should ensure that the most appropriate professional or home care worker provides this training. In cases where reports are received that highlight issues that are likely to prevent the successful implementation of the goals, these issues should be reported immediately to the Care Officer/Social Worker for their immediate attention. Where ongoing care is required, the Care Organiser/Community Support Organiser/Alzheimer's Coordinator will liaise with the Care Officer/Social Worker and will put in place a service plan and risk assessments that fully meet the needs of the service user.

Home Care/Community Support Team Leaders – The Team Leaders will have detailed knowledge of every service user in their team who is participating in the reablement process. The Team Leader will support Home Carers/Community Support Workers to provide the practical aspects of the care and advise them on elements that require improvement. The Team Leader will carry out a minimum of one unannounced inspection visit to every service user

who is going through the reablement process to ensure that the home care support is being provided appropriately. The Team Leader will provide ongoing supervision to the Home Carers/Community Support Workers at an agreed frequency. The Team Leaders will be responsible for ensuring that the weekly written report about each service user who is going through the reablement process is completed and given to the appropriate Care Organiser/Community Support Organiser/Alzheimer's Coordinator.

Home Carers/Community Support Workers - The Home Carers/Community Support Workers will work with the service user to the agreed Service Plan over an agreed period, with the aim of teaching, encouraging and supporting the service user to do as much for themselves as possible. The carers will only help to do tasks that the service user cannot do by them self. The Home Carers will help the person to attain as high a level of independent living as they can. The Home Carers will provide the Care Organiser/Community Support Organiser/Alzheimer's Coordinator with weekly reports to inform them of progress and to indicate whether the goals that were agreed in the initial care plan need to be reviewed and altered. Home Carers and Team Leaders will support unpaid carers to learn reablement tasks. The Home Carers will also report to the Care Organiser/Community Support Organiser regarding any issues arising from service user or unpaid carer that is likely to prevent the successful implementation of the goals.

Day Services/Day Services Outreach

Day Service staff will receive referrals from Care Officers/Social Workers for their specific participation in the reablement process. The specific input required will be detailed in the Care Plan provided by the Care Officer/Social Worker. A Day Care Officer will develop a service plan which sets out the goals and the detailed steps required to achieving the goals. This service can be provided both within a day service and on an outreach basis in the service users home or in a public setting.

The day service support workers will deliver the activities and monitor the service users progress against the Service Plan. Day Service Support Workers will provide a weekly report to the Day Care Officer. The Day Care Officer will ensure that the Care Officer/Social Worker is informed of progress and of any issues that might prevent the successful completion of the service plan.

Occupational Therapist – An OT Team Manager will receive all referrals for reablement where OT input is required and will coordinate the input from locality based OT's. OT Team Manager will also delegate OT's to assist teams to identify potential candidates for reablement. The most appropriate Occupational Therapist, will provide support if required to the Care Officer/Social Worker to carry out the assessment of need, in particular with regard to the service user's ability to maintain and increase functional independence. They will help to identify any physical, cognitive, social, environmental limitations that might prevent the service user from carrying out tasks and to identify practical solutions to support the reablement process. The OT will also, where appropriate, support the Care Organiser/Community Support Organiser/Alzheimer's Coordinator to complete and to monitor the Activities of Daily Living (ADL) based Service Plan.

OT Assistants – The OT Assistants will work with Home Carers in clearly identified cases to support the reablement process to service users and to support the feedback to Care Organiser/Social Worker with regards to the service users' progress. The OT Team Manager will identify those cases where the OT Assistant will be involved.

Physiotherapists – in some cases there will be issues relating to functional assessment and mobility. In these cases, the Care Officer/Social Worker and Care Organiser/Community Support Organiser/Alzheimer's Coordinator where appropriate should refer to the local community physiotherapy service for

support, information and practical assistance. A Physiotherapist will be identified as a matter of priority to assist the reablement process.

Voluntary Organisations - The Care Officer/Social Worker will be responsible for including any voluntary organisation in the reablement process in individual cases where their input will support the process. The Voluntary Organisation will report their input and progress on a weekly basis to a Moray Council worker as identified in the care plan. The Voluntary Organisation will use the documentation and process that is used by the Home Care and Community Support service.

Specialist Support for People with Dementia – Specialist support for people with symptoms of dementia and their carers is available from an identified Voluntary organisation. This specialist support may include one or more of the following activities; -

- Access relevant information specific to their situation and needs
- Understand and come to terms with living with dementia
- Sustain and strengthen their own natural support networks such as family, friends and others within their social environment
- Access advocacy and support services that will safeguard and enhance their independence and self-determination
- Identify the areas of their life that are most important to their well-being
- Remain active and connected within their own community
- Access self-management training and education, aids and other resources to enhance their coping skills
- Prepare a personal profile to inform the services used, in order that they can be uniquely tailored to individual needs
- Access peer support and learn from others with dementia and other carers
- Identify and address incapacitating sources of stress and anxiety

- Develop coping strategies to reduce the impact of disabilities and maximise independence, self-esteem and well being
- Plan for and take control of their own future
- Determine the nature of support that will prevent crisis situations, such as unnecessary admission to hospital
- Maintain their normal pattern of living activities for as long as possible
- Access appropriate support to remain within their own familiar surroundings for as long as possible
- Access appropriate support at times of transition and other key points in their journey through their illness
- Benefit from a palliative care approach and access palliative care expertise when required
- Access individualised budgets or direct payments and support to determine the nature and pattern of services
- Access information re welfare benefits to maximise available income to purchase support towards self-management.

Service Users - are an essential member of the reablement team and must be fully aware of and involved in the process of reablement. It is essential that they are included in all communication about the assessment and the initial Care Plan and any subsequent changes to the plan. Service Users may also need support with some of the emotional issues that arise as a result of reablement. This support should be provided by the Care Officer/Social Worker. Where issues arise that might prevent a successful reablement process, the Service User should discuss these with the Care Officer/Social Worker immediately they arise.

Unpaid Carers – Unpaid Carers are an essential member of the reablement team and must be fully involved in the process of reablement. It is essential that they are included in all communication about the initial Care Plan and any subsequent changes. Unpaid Carers will need to be supported to assist in the

process of reablement, in particular they will need training for some of the practical tasks. The Care Organiser/Community Support Organiser/Alzheimer's Coordinator should ensure that the most appropriate professional or Home Care worker provides this training. Unpaid Carers may also need support with some of the emotional issues that arise as a result of reablement. This support should be provided by the Care Officer/Social Worker. Where issues arise that might prevent a successful reablement process, the Unpaid Carer should discuss these with the Care Officer/Social Worker immediately they arise.

All professionals - A high level of multi-disciplinary working and communication is required for the re-ablement process be effective. Multi-disciplinary meeting must be arranged and carried out regularly in every area.

2.2.4 Performance Management

Reablement is set as a 'task' on the Carefirst system and is placed within the timetabled service package options. This means that there will be a record of all service user details and reablement data including; start date; end date; date of every change to the service package; details of the extent of the package at every change; the extent of the package at the end of the reablement phase; the workers involved and it will also link to electronic documents including assessment and care plan when these are available via the system. In situations where the Alzheimer's Coordinator is managing a Service Plan, the details should be passed to the appropriate Care officer for recording on Carefirst.

This will permit a high level of management scrutiny and regular reporting to both the Community Care Performance Management Group and the Reablement Steering Group. This level of scrutiny will also permit accurate reporting of savings achieved through reablement. A performance monitoring report and target statement is attached as appendix ii.

Qualitative information will be gathered by the Care Officer/Social Worker during the service review. The 'Talking Points' model will be used to gather qualitative

information from Service Users. This information is collated and produced on a quarterly basis by the Community Care Performance and Quality Team.

2.2.5 Risk Assessment and Management

The Community Care Department has in place a group of tools which aid workers in assessing risk those include the risk assessment screening tool, specialised risk assessments, chronologies; and a process for the development of risk management plans where appropriate. This is in addition to the care plan, and where an adult may be at high risk due to certain factors. A risk framework is being developed which will encompass the many strands of risk assessment, management and review to support workers in the process of ensuring that service users are supported to take acceptable risks. This framework will detail the guides, policies, procedures, training and tools that formulate and support the assessment and risk management process. This framework will be in place and should be used by all workers by March 2012.

3.0 Strategy and Plans Connected to this Policy

The Reablement Policy also supports the framework for the following strategies, policies, legislation and standards:

Strategies

- Living Longer Living Better.

Policies

- Individual Budgets
- Self Directed Support Policy
- Charging Policy
- Eligibility Criteria Policy

Legislation

- The Social Work (Scotland) Act 1968
- Community Care and Health (Scotland) Act 2002
- The Regulation of Care (Scotland) Act 2001
- Data Protection Act 1998
- Freedom of Information (Scotland) Act 2002
- The Human Rights Act 1998.
- Equality Act 2010.

Standards

- National Care Standards.

4.0 Responsibilities

Heads of Service are responsible for ensuring that employees within their nominated Service Area are made aware of this policy and the conditions of use relating to this policy.

5.0 Equalities Statement

5.1 The Moray Council will not and does not discriminate on any grounds. The Council advocates and is committed to equalities and recognises its responsibilities in this connection. The Council will ensure the fair treatment of all individuals and where any individual feels that they have been unfairly discriminated against, that individual shall have recourse against the Council in line with the Council's grievance and harassment procedures.

In relation to equality of information provision, the Council will ensure that all communications with individuals are in plain English, and shall publish all information and documentation in a variety of formats and languages. Where required, the Council will use the services of its translation team to enable effective communication between the Council and the individual. Where an individual has sight, hearing or other

difficulties, the Council will arrange for information to be provided in the most appropriate format to meet that individual's needs. The Council will also ensure that there are no physical barriers that could prohibit face to face communications.

If there is a complaint against discrimination, click on the link below for reporting form and procedure, alternatively telephone 01343 567100 to request a reporting form; <http://www.moray.gov.uk/downloads/file62366.pdf>.

6.0 Data Protection

- 6.1 The Data Protection Act 1998 governs the way information is obtained, recorded, stored, used and destroyed. The Moray Community health and Social Care partnership (MCHSCP) complies with all the requirements of the Act and ensures that personal data is processed fairly and lawfully, that it is used for the purpose it was intended and that only relevant information is used. The MCHSCP will ensure that information held is accurate, and where necessary kept up to date and that appropriate measures are taken that would prevent the unauthorised or unlawful use of any "personal information".

7.0 Freedom of Information

- 7.1 The purpose of the Freedom of Information (Scotland) Act 2002 is to "provide a right of access by the public to information held by public authorities". In terms of section 1 of the Act, the general entitlement is that a "person who requests information from a Scottish public authority which holds it is entitled to be given it by the authority". Information which a person is entitled to is the information held by the public authority at the time that the request is made. This is a complex area of the law that can overlap with the Data Protection Act and other legislation.

All Freedom of Information requests are to be sent to the Information Co-ordinator in the Chief Executives Department.

8.0 Human Rights Act

8.1 In October 2007 the three equalities commissions: Racial Equality, Disability Rights and Equal Opportunities were merged to form one Commission: **The Equality & Human Rights Commission (Scotland)**. The main aspects covered in the **Human Rights Act 1998** are:

Right to life; protection from torture; protection from slavery and forced labour; right to liberty and security; right to a fair trial; no punishment without law; right to respect for private and family life; freedom of thought, belief and religion; freedom of expression; freedom of assembly and association; right to marry; protection from discrimination; protection of property; right to education and right to free elections.

The Human Rights Act can overlap with many areas of the Council's policies, any doubts or queries regarding its effect or implications must be referred to the Principal Solicitor (Litigation and Licensing).

9.0 Performance Monitoring

In order to comply with its service commitments, the Council sets performance standards in relation to its policies' and will monitor its achievement of these standards. See section 2.2.4 above, also see appendix ii.

There is no statutory or national responsibility to provide performance information with regard to reablement at this time.

The responsibility for providing this performance information lies with Service Manager (Provider Services), Education and Social Care Department.

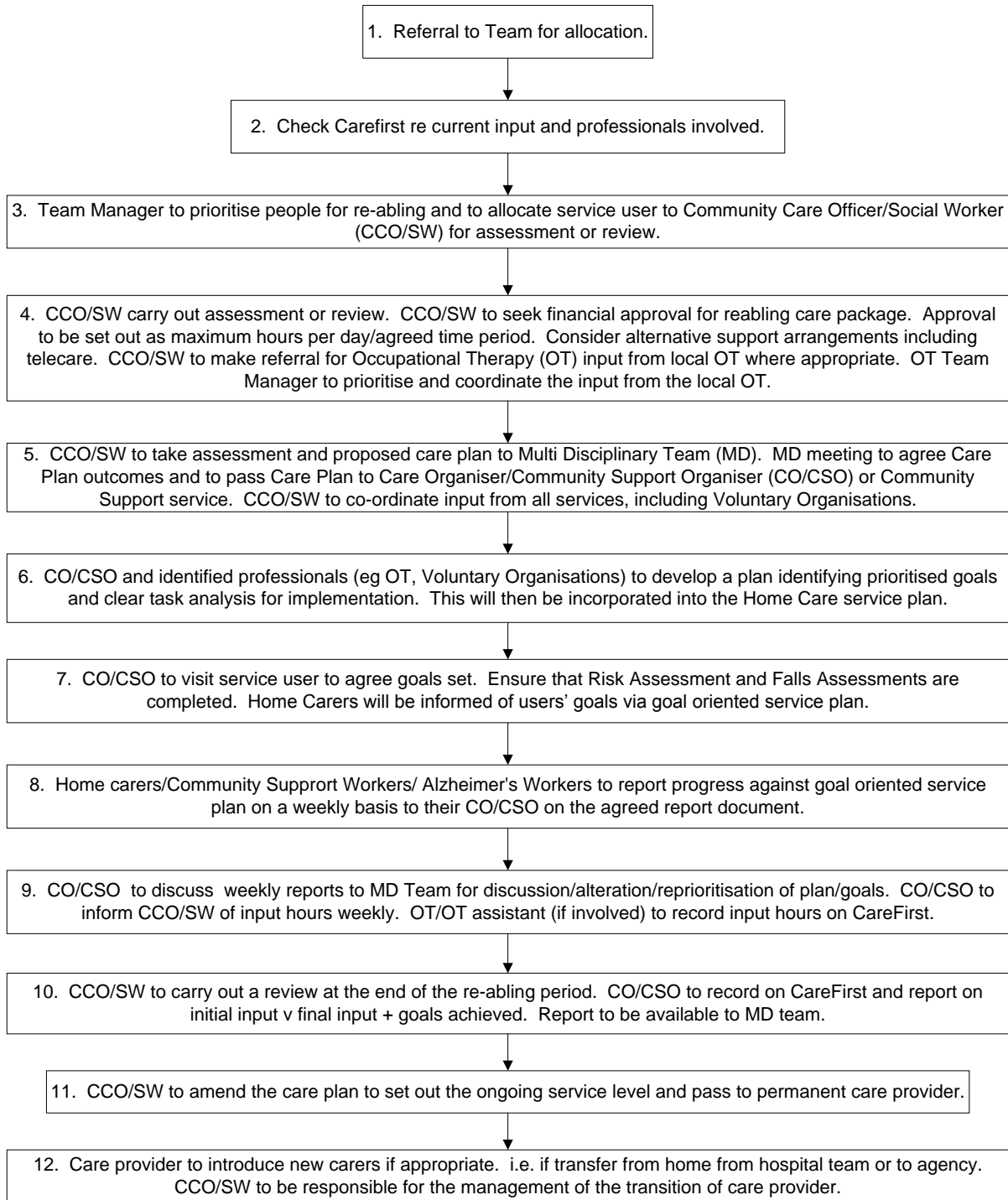
All performance information must be sent to and is collated by the Support Officer (Research and Information) in Community Services and held electronically where possible.

10.0 Review and Feedback

This policy will be reviewed on 1st November 2012 and every 2 years after that.

Feedback can be sent to Service Manager (Provider Services), Spynie Hospital, Elgin.
IV30 5PW and will be included in the next review.

Appendix i. Moray Re-abling process.



Appendix ii. Homecare Reablement, Performance management Targets and Reporting.

| Target Group | Target per month | Number per month | Average package hours start | Average package hours finish | Average duration weeks | Review period target | Review period target achieved | Review period average delay | 100% reduction | 50% reduction | 25% reduction | No reduction | increase | Hospital admission | Died |
|---|------------------|------------------|-----------------------------|------------------------------|------------------------|----------------------|-------------------------------|-----------------------------|----------------|---------------|---------------|--------------|----------|--------------------|------|
| Older Adults 65 - 74 | 3 | | | | | | | | | | | | | | |
| Older Adults 75+ | 8 | | | | | | | | | | | | | | |
| Older Adults with Dementia | 1 | | | | | | | | | | | | | | |
| Adults 16+ with a physical disability | 0.25 | | | | | | | | | | | | | | |
| Adults 16+ with Autism | 0.25 | | | | | | | | | | | | | | |
| Adults 16+ with a learning disability | 0.25 | | | | | | | | | | | | | | |
| Adults 16+ with a mental health problem | 0.25 | | | | | | | | | | | | | | |
| Young People in Transition | 0.25 | | | | | | | | | | | | | | |

The main activity of re-ablement will be with older adults 75+ with considerably smaller numbers of older adults 65 – 74 and adults with dementia. With regard to other groups, it is anticipated that there will be some activity however this will be dependent on individual service user circumstances and need.