Short Term Service (Home Care)
Operational Practice Guidance
Derbyshire County Council - Adult Social Care

Contents

If you would like to make any comments, amendments, additions etc please email ASCH.adultcare.policy@derbyshire.gov.uk

1. **About the Short Term Service (STS)**

The Short Term Service (STS) is used to:

- support a person to gain or re-gain their independence with independent living tasks in their own home
- support a person to improve their level of independence through maximising their own strengths and/or through identifying the best approach to supporting them
- support a period of assessment
- respond to an urgent presenting need in the community whilst further assessment can be carried out by adult social care or others (see below)

1.1 The Short Term Service should be used in the following circumstances:

- to facilitate a discharge from hospital
- to prevent a hospital admission
- as a new home care response to support a new assessment of the person's need for care and support or increase independence
- as a new or additional home care response where there is a significant change in need for a person already in receipt of care services

1.2 Eligibility for the Short Term Service

As a preventative service the Short Term Service is available to those who would benefit. They do not need to be eligible under the national eligibility criteria.

Prior to a referral to the Short Term Service, consideration must be given to what else could help the person meet their needs and achieve their goals. Where appropriate, the person may be signposted to alternative services rather than being offered support from the Short Term Service.

The service is free at the point of entry.

1.3 Guidance on responding to an urgently presenting need in the community

The Short Term Service can be used to respond to an urgent presenting need in the community whilst further assessment can be carried out by adult social care or others. Where this is the case, it must be established that the support can be delivered safely by the care workers (community) (CWC) within the Short Term Service.

The Short Term Service should not be used for people at the end of their life, but there may be exceptions to this. Case specific decisions should be

discussed between the referrer, domiciliary services organiser (DSO) and any relevant health professionals.

Where the person's support has been provided out of hours on behalf of NHS Continuing Healthcare or the person subsequently is assessed as requiring Continuing Healthcare funding (including via a fast-track), a request must be made at the earliest opportunity for the support to be transferred to a provider commissioned directly by NHS Continuing Healthcare. Any new support provided to a person on behalf of Continuing Healthcare must be reviewed by the DSO in line with the Home Care Admissions Procedure to ensure support can be safely and effectively delivered.

1.4 Guidance on using the Short Term Service as a new or additional home care response where there is a significant change in need for a person already in receipt of our services

Each person's situation should be considered on an individual basis and in discussion with the person and their existing care provider.

There will be circumstances where there is such a significant change that services should be ended with the existing provider and a new referral made to the STS for the full package of care.

Note that you will be required to provide a two-week notice period to a contracted agency. This can be worked, if planned, or it can be paid if it is an urgent move to Short Term Service.

Where it is appropriate for the existing care provider to continue with their current service, best practice would be for the additional support/calls to be referred to STS for a time limited input. This must be agreed with the existing care provider, as they may not be able to accommodate this whilst adhering to their policies for minimising cross infection.

1.5 Guidance on increasing support from the Short Term Service for a person already in receipt of a short-term service

Where a person's needs increase during the period of short-term service, the care may be increased accordingly. This must be agreed by the DSO to ensure the service can meet the person's need. In making this decision, the DSO must also work with the Scheduling team to ensure there is sufficient capacity in the service to provide this, and that the available capacity has not already been planned for another person.

2. Referring to the Short Term Service

2.1 How to make a referral to the Short Term Service

Referrals to the STS can be made by adult social care practitioners through completion of a 'short-term assessment and plan' or 'hospital short-term assessment and plan'.

Referrals can also be made by other trusted assessors by completing the trusted assessment (D2A) documentation.

Referrals must contain sufficient information about the person's needs and risks for the DSO to be able to safely start a service, and they may request additional information.

See 'Home Care Admissions Procedure' for more details.

Further details on the process for referrals, including details of MOSAIC workflow steps, can be found in the "Guidance for Accessing New Home Care via the Care Hub**".**

2.2 Prioritising referrals through the Care Hub

The Care Hub will generally prioritise care sourcing activity in the following order:

i. referrals from hospital including admission avoidance
ii. referrals marked urgent where there is no current support in place
iii. other referrals marked urgent
iv. referrals where there is no current support in place
v. other referrals

Case by case discretion can be applied in discussion with involved parties.

2.3 Holding capacity

Where there is a change in circumstance and the requested support is no longer required, the assessor must notify the Care Hub as soon as possible. Where capacity has been found, but there has been a delay in someone's readiness to start the service, the capacity will be held for up to 72 hours. After this time the assessor will be notified that the capacity is no longer available, and a re-referral will be required if support is still needed.

2.4 Admission to the service

The process for admitting a person to the service is set out in full detail in the 'Home Care Admissions Standard Operating Procedure'

3. Supporting People Through the Short Term Service (Ways of Working)

3.1 The Short Term Service process

The Short Term Service aims to support as many people as possible to access the service to improve their level of independence.

We use a goals-focussed approach to maximise a person's independence.

SMART goals will be set with the person at the start of their support and our skilled CWCs will support the person to work toward these goals.

During the period of support, the person's progress against these goals will be continuously reviewed with the person and their multi-disciplinary team (MDT). As the person progresses, the support will be stepped down to promote their independence in agreement with the MDT.

When the person has achieved their goals or reached their maximum level of independence their level of need will be assessed and next steps agreed with the person.

Where the person does not require ongoing support, adult social care input can be ended. If they require ongoing support, they will be assisted to plan this support.

3.2 Support that is offered

The STS can offer a range of personal and practical support. Prior to referral, the assessor should consider whether the person's needs and desired outcomes can be achieved through other strengths, networks and community resources that are available to them.

Decisions about the appropriateness of the service must be made on the individual assessment and not according to assumptions about a person's diagnosis, age, or disability.

Where there are questions about the person's suitability for the service, the DSO who is making the decision should do so in discussion with the assessor.

3.3 Setting SMART goals

<u>When to set goals</u>
We should aim to set goals with the person within the first 48 hours of entering the service.

<u>Who sets goals?</u>

The goals should be set with the person by a member of the MDT. All members of the MDT have a responsibility to set SMART goals. Each MDT should decide

who is best placed to set the goals for each new person as they enter the service.

Goals should be SMART

***Specific*:** The goal must be well defined, clear, and unambiguous so it can be easily followed.

***Measurable*:** There must be a way to measure the goal so the team can know how the person is progressing towards their goal.

***Achievable*:** The goals must be attainable to reach within the person's time with the STS and within their ability to achieve.

***Relevant*:** The goal must be in line with the purpose of the intervention with the STS.

***Time-bound*:** Each goal must have a target date of completion. Goals are not fixed and can be adjusted if needed, either as a client progresses, or if it is felt the agreed goals are not right for the person once we get to know them better.

Where should goals be recorded?

- on the short-term personal service plan
- in the care records in the personal held record
- where the person's support started before 8 December 2021, the goals should also be recorded on the caseload management tool (MOSAIC)

3.4 Tracking progress against goals

An 'STS goal tracker' app is used by CWCs via their mobile phones to record progress against goals following each visit to the person.

The person's progress against each goal should be recorded using the relevant '**Independent Prompt Assisted Declined (IPAD)'** rating.

I = independent; no support required from worker, is independently achieving the goal

P = prompt; worker reminded the client of the goal and the task to be completed

A1 = assisted; 1 worker has physically helped the client to complete some / part of the task

A2 = assisted; 2 workers have physically helped the client to complete some / part of the task

D = declined; client refused to engage with the task

This live information is available to members of the MDT via the caseload management tool (MOSAIC) once it has been submitted.

The MDT must identify and record key milestones relating to the person's progress against their goals: start date, date goals set, date maximum independence achieved, date of assessment or no further action (NFA) decision and end date.

3.5 Working in multi-disciplinary teams (MDT)

A short-term services team should be made up of the following practitioners working in the same patch/es:

- domiciliary service organiser/s (DSO)
- care workers (community) (CWC)
- occupational therapist/s (OT)
- social worker/s (SW)
- community care workers (CCW)

The team have shared ownership for their caseload and should work together to:

- set SMART goals
- review progress against goals using feedback from MDT members and the caseload management tool (MOSAIC)
- promote the person's independence through identifying strengths-based solutions, giving support and direction on how the person is guided to achieve their goals

They should meet regularly to work together in achieving this

The weekly MDT meeting should be attended by all available MDT members. It should consider the following:

- the support that the person is currently receiving
- what goals the person is working toward
- their progress against these goals
- opportunities to step-down the person's level of support
- opportunities to further promote their independence

Daily MDT meetings should be attended by available MDT members excluding CWCs. These should take place daily where possible, but can take place less frequently where this meets the requirements of the team.
They should consider the following:

- identifying new people entering the service and agree goal setters for them
- identifying anyone whose support can be stepped down or ended
- follow up any outstanding actions from the weekly MDT
- agree roles, responsibilities, and approaches for the next weekly MDT

3.6 Timely ongoing assessment

Timely assessment of ongoing care needs should be carried out at the point the person has reached their maximum level of independence. This enables the person to transfer from the service in a smooth and timely way.

The assessed long-term support should be proportionate to the person's level of need and use the feedback from the STS to support identification of the most independent call length and support activities required.

This ongoing assessment should normally be completed by a SW or CCW within the MDT. Where the person has an allocated case-coordinator outside of the MDT, this worker may complete the ongoing assessment where they can do so in a timely manner.

3.7 Occupational therapy (Adult Social Care) involvement

Occupational Therapists (OT) are an integral part of the MDT. They should offer support to the MDT to set goals and help the team review their SMART goals, they are well placed to support the team to identify opportunities to improve the person's independence and advise on approaches to achieve this.

Where they are undertaking direct work with people using the STS, they should capture this activity using a 'specialist intervention' record in MOSAIC. The MOSAIC workflow step can either be sent to the OT by a member of the MDT (as a referral) or it can be initiated by the OT themselves. The team may agree the best approach on a case by case basis.

3.8 Ordering simple equipment and minor adaptations

Simple equipment and minor adaptations can be assessed for, and ordered by, any suitably trained and competent member of the MDT.

The DSO, CCW and SWs within the STS team should complete the relevant training around 'assessing for equipment' to enable them to do this.

3.9 Links with intermediate care/community therapy services/discharge to assess pathways

The STS will work closely with relevant health colleagues, including OTs and

physiotherapists, to deliver home based services. Engagement with, or referral to, health services may assist a person in achieving their short-term goals and maximise their independence.

4. Using Assistive Technology (AT) as Part of a Short-Term Service

During a short-term service a person may receive Derbyshire County Council (DCC) funded community alarm and/or telecare equipment including calls monitoring. This supports individuals to remain in/return to their own home and increase their independence. After this period, an assessment under the Care Act (2014) will be carried out to determine the person's long-term eligibility for a DCC funded service. Those who are deemed eligible will continue receiving the funded service whilst those who are not eligible under the Care Act (2014) will pay for the service which can be obtained from their local provider.

The assessment outcome should be recorded on the community alarm and telecare review form (on MOSAIC) and communicated via email to the AT team and service provider. This form will allow the short-term AT service to end and the long-term AT service to commence where applicable. Following completion of the community alarm and telecare review form any equipment no longer required will be decommissioned.

Full details can be found in section 9.2 of the Community Alarm and Telecare Practice Guidance

5. Transferring Cases to The Interim Home Care Team

5.1 Interim home care support should be used when:

i) the MDT have agreed the person has reached their maximum level of independence within the short-term service

ii) an assessment and support plan have been completed; and

iii) the person's package of support has been with Brokerage on a lack of provision list for 48 hours

'MOSAIC Guidance for interim support from Direct Care Home Care service: transfer to Interim Home Care teams and receiving interim support from STS teams' can be found here

5.2 When to use the Interim Home Care team

The person may require ongoing support following the short-term service. This may be sourced from a Private Voluntary and Independent (PVI) sector provider by the person themselves or using Brokerage.

If this process is delayed by lack of available provision within the PVI sector, the person can be transferred to an Interim Home Care team within Direct Care in order to free up capacity within the Short Term Service.

Transfer to the Interim Home Care team should take place if the person has been with Brokerage for 48 hours and there have been no offers from PVI sector providers (at this point the person is added to the 'lack of provision' list). Transfer can also take place if a PVI sector provider has offered to start the service but there is a delay in the start date. In this case, the MDT will discuss and agree if it is appropriate to refer to the Interim Home Care team whilst awaiting the start date.

5.3 The process for accessing the Interim Home Care team

The STS DSO will liaise with the relevant interim team DSO to agree these arrangements and transfer a personal service plan to the interim DSO.

The case coordinator will ensure that the appropriate purchase orders are established for any interim support.

N.B. Once a person is receiving an interim service, changes to the number of hours that the person is receiving each week must be agreed by the case coordinator. This will ensure necessary support planning and purchasing arrangements can be made. Any ongoing changes agreed by the case coordinator will be made via a support plan along with a purchase order request for the amended service.

5.4 What to do where there is no Interim Home Care team

If the area does not have an Interim Home Care team or this team does not have capacity to provide support to the person, the person will remain within the short-term service for 'interim support' until they can move on to PVI sector support.

The STS DSO retains responsibility for the person's service and will need to complete a long-term personal service plan for the person.

5.5 Co-funding

Co-funding is applicable from the point the person receives support via an ongoing support plan.

This applies to someone who is receiving care from a short-term Service/interim team when:

- the case coordinator has completed the support plan and financial assessment benefit officer (FABO) referral
- the package of care has been sent to Brokerage for ongoing home care support, and
- the person is on the lack of provision list for more than 48 hours

5.6 Self-funders

A person may be self-funding their ongoing support due to their level of capital. They can also receive support via an Interim Home Care team or an extended stay in the short-term service where they have been unable to source an ongoing package of care via a PVI provider (either privately sourced or via Brokerage).

They will become liable to fund the cost of this support when:

- the case coordinator has confirmed they require ongoing support
- the package of care has been sent to Brokerage for ongoing home care support; and
- the person is on the lack of provision list for more than 48 hours

The person, or their representative, must sign a DCC individual service agreement interim home care confirming this charging arrangement. This must be uploaded into MOSAIC.

Once this is signed, a purchase order will be created by the DSO for "direct care full cost" via a *purchase adjustment request for direct trading adjustment* workflow step.

6. Ending the Service

6.1 Ending the Short Term Service

The short-term service should be ended when:

1. the person has achieved their goals and no longer requires formal support, **or**

2. the person has reached their maximum level of independence and has suitable arrangements in place for their ongoing care, **or**

3. the person has transferred to a care home placement for long-term care or a placement exceeding 72 hours, **or**

4. the person has been admitted to hospital and there is no plan to return home within 72 hours, or at the point it is clear they will be unable to resume a short-term service on discharge

5. the person has died

6.2 When to end support via an interim team or an 'interim service' via the Short Term Service

Support via an interim team or an 'interim service' arrangement via the STS should be ended when:

- the temporary arrangement can cease because suitable provision has been found within the PVI sector to meet the person's needs
- the person's needs change resulting in a reassessment and amendment to their care and support needs
- the person has had any other break in their service provision lasting 14 days or over. An example of this could be a hospital admission, family resuming care or the person going away on holiday for 14 days or more.
- the person has moved into a long-term residential or nursing care setting
- the person has died

6.3 What to do when closing the package

You must ensure the following are actioned timely when closing a person's package to these services:

- end the purchase order for Direct Care home care
- update MOSAIC records
- update Call Confirm Live (CCL), including start and end dates

Author History

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