Find out more about our Reablement Service

How to refer an individual to the service

Hospital referrals (community or acute) can be made via the ward (where a ward led approach exists) or by the Social Care Hospital Assessment Team or equivalent for your locality.

Community referrals can be made by GPs, Community Health Providers, Community Nurses, Community Social Work teams, Single Point of Referral (SPOR) or Single Point of Access (SPOA), whichever operates in your locality.

For queries and referrals email us on **ECL.referrals@essexcares.org** or call on **03330 135 438.**

www.ecl.org 03330 135 438

Person-centred care

ECL Reablement

A guide for healthcare professionals

03330 135 438
www.ecl.org

Person-centred care

Who are ECL?

ECL (Essex Cares Limited) was established by Essex County Council in 2009. We operate in London, Essex and South East England.

ECL works in a person-centred way with over 50,000 people each year enabling them to live safely and independently within their own homes and interact with their communities.

What is Reablement?

ECL's short-term Reablement services provide a range of care and support to help people to regain confidence and independence.

Is your patient suitable for ECL Reablement care?

Please use the below matrix to help access suitability.

Criteria	Outcome
Clear Reablement candidate where the adult has: • Complex equipment needs (more than minimum/basic equipment) Had a life changing outcome from an illness and require support to develop new living strategies i.e. stroke (Ao2 and Ao1 required) • A primary support reason of mobility – for example following #nof • Demonstrable reablement potential (includes adults with a cognitive impairment) • Double handed care needs, which could be reduced to single handed	Referral direct to Reablement if capacity in service adult will commence a period of Reablement. If no capacity in service adult will be reviewed as per "discharge home with support for further assessment of care needs".
Reablement to Triage where the adult does not meet the clear reablement candidate criteria above but: • Has not had care before • Has had a significant change in care need • The adult has had reablement previously for the same or similar presenting need • Low reablement needs, less complex needs	Referral reviewed at IDT/TOCH with input from Reablement provider to assess adult on individual circumstances. From there, patient will either be referred to reablement or discharged home with support for further assessment of care needs.
Discharge home with support for further assessment of care needs where the adult has: • Previously identified care needs (that may not have yet been assessed) i.e. from a period of reablement prior to admission to hospital • A natural progression of an existing care need • Non weight bearing • Medically optimised but currently not well enough to engage in reablement e.g post operative / significant hospital stay • Has a long term provider already in place and the provider is unable to restart the existing package of care or a small increase in care • Adults who are not engaging in a reablement mindset • Adults who require a more holistic approach – presenting need is not reablement in nature	Adult will be supported home with a domiciliary care provider for a short period of time whilst an assessment is completed in the adult's home environment. The outcome of the assessment could result in the adult being referred to Reablement if they meet the 'Clear Reablement candidate' criteria (e.g., have had a period of recovery and now ready to engage. Provision for any ongoing care needs will be determined.
Increase existing care package • Small increases in care need	Adult will restart existing package of care with a small increase.
Not suitable for reablement • Adults in a terminal phase of their EOL diagnosis • Adults who require CHC	Adult to be referred to the correct pathway to meet their needs.