East Dunbartonshire Health & Social Care Partnership

Eligibility Criteria Policy for Adults and Community Care Services in East Dunbartonshire Health and Social Care Partnership

January 2017

Lead Officer:	Andy Martin, Head of Adult and Primary Care Services
Policy Approved By:	East Dunbartonshire Health and Social Care Partnership
Date Approved:	
Implementation Date:	
Review Date:	

PART A – Policy and Background

Section 1 Purpose

The purpose of this policy is to set out clear guidelines that aim to ensure the equitable allocation of community care resources to the customers of East Dunbartonshire. The policy aims to serve as a procedure for staff and as a reference document for elected members, customers and members of the public.

East Dunbartonshire Council adopted policy and procedures around eligibility criteria in February 2003. This revised policy retains the principles and framework of the existing policy whilst providing some additions in the light of the implementation of other legislation, reviews of procedures and updates in relation to terminology.

Section 2 Related Policies, Procedures, Legislation

East Dunbartonshire Health and Social Care Partnership's responsibilities to adults (aged over 16) and older people are set out in the following legislation:

- The Social Work Scotland Act 1968
- The NHS and Community Care Act 1990
- Community Care and Health (Scotland) Act 2002
- Chronically Sick and Disabled Persons Act 1970
- Mental Health (Care and Treatment) (Scotland) Act 2003
- Adults with Incapacity (Scotland) Act 2000
- The Regulation of Care (Scotland) Act 2001
- The Adult Support and Protection (Scotland) Act 2007
- Children (Scotland) Act 1995
- Data Protection Act 1998
- Freedom of Information (Scotland) Act 2002
- The Human Rights Act 1998 and Equality Legislation
- The Social Care (Self Directed Support) (Scotland) Act 2013

Other related documents:

- Single Shared Assessment Form
- Outcome Focused Support Plan
- Review of Support Plan
- Assessment and Support Management Procedures
- Risk Enablement and Working with Risk Procedures
- Non Residential Charging Policy

East Dunbartonshire Health and Social Care Partnership is directed by the duties and powers conferred in the above legislation (this list is not exhaustive and will include new and revised legislation passed by the Scottish Parliament). Social Work and Health practitioners will refer to, within the individual customer's assessment, the duties and powers being exercised within the appropriate legislation.

Section 3 Scope and Aims of the Policy

East Dunbartonshire Health and Social Care Partnership has a statutory responsibility to assess the social care needs of its population, and to arrange for the provision of support in response to those assessed needs. This policy is about eligibility for community care services to ensure greater consistency and transparency in standards for access to support.

The support that is required to meet customers' needs can be enormously varied; from home based support; to centred-based day care; to residential and nursing care services. Through the use of self directed support options, some support is provided by us directly, either provided by in-house or externally commissioned services; some support is provided from the independent sector and some support services may be organised directly by the customer. However, overall the Partnership pays the majority of the cost of these services, regardless of how they are provided.

Eligibility criteria recognise 'urgency' and 'risk' as factors in the determination of eligibility for community care services. Where a customer is eligible, the urgency of that individual's needs should be kept in focus in determining how to respond to their support needs. It is fundamental that our approach, set out in this policy, ensures that customers who require support will not simply be placed in a date order queue. Response to need will be informed by the continuing systematic review, using person centred tools, for example, outcome focused support plans and review forms, of each customer's needs, including consideration of how urgently service provision is called for and what interim measures may be appropriate pending a more permanent response.

Eligibility criteria are a method for deploying limited resources in a way that ensures that resources are targeted to those in greatest need, while also recognising the types of low level intervention that can be made to halt the deterioration of people in less urgent need of support.

The principles guiding practice in the policy are that supports provided or funded by East Dunbartonshire Health and Social Care Partnership are intended to:

- Retain, support and promote maximum independence;
- Intervene no more than absolutely necessary;
- Compensate for the absence of alternative support or complement existing support;
- Take full account of the risk to the customer if the support is not provided;
- Take account of the customer's personal, community and family assets – personal: financial, skills, experience; community: clubs, libraries, church; family: friends, informal carers, circles of support.

Consideration should only be given to providing support when:

- The customer is unable to meet the need themselves and they do not have access to adequate support from the assets described above;
- No other statutory agency has a duty to meet that need;
- Failure to respond to the needs of the carer will threaten his or her ability, capacity or wishes to continue in the caring role;

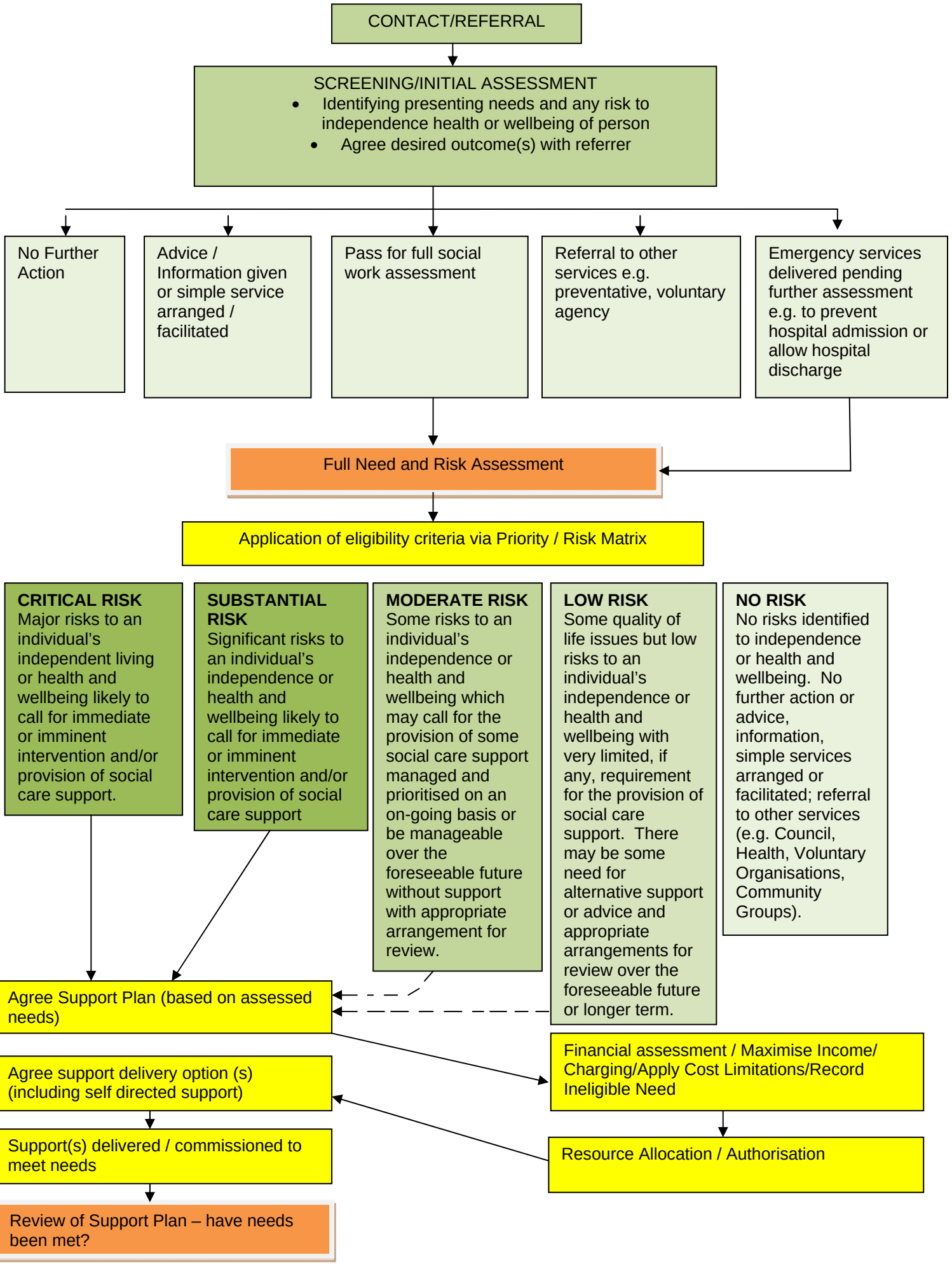
- Failure to respond to that need would place the customer in a situation of unmanageable or unreasonable risk.

The policy set out below considers both (a) the severity of the risks and (b) the urgency for intervention to respond to the risks. Some levels of risk will call for the provision of support as a high priority whilst others may call for some support provision, not as a high priority but managed and prioritised on an on-going basis. Some may not call for any social care support at all as resources using other assets may be the most appropriate way of addressing the need. In other circumstances the assessment may indicate a potential requirement for support provision in the longer term which requires to be kept under review. As part of the process for assessment and considering whether a customer's needs call for the provision of support, practitioners will consider how each individual's needs match against eligibility criteria in terms of severity of risk and urgency for intervention.

PART B – Eligibility Criteria

Section 4 Assessment Progression Flow Chart

The following chart indicates the progression from initial referral to the provision of support. It indicates where the process of determining eligibility falls within the process and illustrates how the intensity of risk and access to support services is determined using the eligibility criteria.


CONTACT/REFERRAL
SCREENING/INITIAL ASSESSMENT
Identifying presenting needs and any risk to independence health or wellbeing of person
Agree desired outcome(s) with referrer
No Further Action
Advice / Information given or simple service arranged / facilitated
Pass for full social work assessment
Referral to other services e.g. preventative, voluntary agency
Emergency services delivered pending further assessment e.g. to prevent hospital admission or allow hospital discharge
Full Need and Risk Assessment
Application of eligibility criteria via Priority / Risk Matrix
CRITICAL RISK
Major risks to an individual's independent living or health and wellbeing likely to call for immediate or imminent intervention and/or provision of social care support.
SUBSTANTIAL RISK
Significant risks to an individual's independence or health and wellbeing likely to call for immediate or imminent intervention and/or provision of social care support
MODERATE RISK
Some risks to an individual's independence or health and wellbeing which may call for the provision of some social care support managed and prioritised on an on-going basis or be manageable over the foreseeable future without support with appropriate arrangement for review.
LOW RISK
Some quality of life issues but low risks to an individual's independence or health and wellbeing with very limited, if any, requirement for the provision of social care support. There may be some need for alternative support or advice and appropriate arrangements for review over the foreseeable future or longer term.
NO RISK
No risks identified to independence or health and wellbeing. No further action or advice, information, simple services arranged or facilitated; referral to other services (e.g. Council, Health, Voluntary Organisations, Community Groups).
Agree Support Plan (based on assessed needs)
Financial assessment / Maximise Income/ Charging/Apply Cost Limitations/Record Ineligible Need
Agree support delivery option (s) (including self directed support)
Support(s) delivered / commissioned to meet needs
Resource Allocation / Authorisation
Review of Support Plan – have needs been met?

Section 5 Priority Risk Matrix

This policy makes use of the four categories of risk within the Scottish Government's National Eligibility Framework.

Critical risk: Indicates that there are major risks to an individual's independent living or health and well-being likely to call for immediate or imminent intervention and/or provision of social care support.

Substantial risk: Indicates there are significant risks to an individual's independence or health and well-being likely to call for immediate or imminent intervention and/or provision of social care support.

Moderate risk: Indicates there are some risks to an individual's independence or health and well-being. These may call for the provision of some social care support managed and prioritised on an on-going basis or they may simply be manageable over the foreseeable future without support provision with appropriate arrangement for review.

Low risk: Indicates there may be some quality of life issues but low risks to an individual's independence or health and well-being with very limited, if any, requirement for the provision of social care support. There may be some need for alternative support or advice and appropriate arrangements for review over the foreseeable future or longer term.

Immediate	required now or within approximately 1 to 2 weeks;
Imminent	required within 6 weeks;
Foreseeable future	required within next 6 months;
Longer Term	required within the next 12 months or subsequently.

The framework acknowledges that, in managing access to finite resources, local authorities; integrated health and social care partnerships and their partners focus first on those people assessed as having the most significant risks to their independent living or wellbeing. Where people are assessed as being in the 'critical' or 'substantial' risk categories their needs will generally call for the immediate or imminent provision of support. Those customers will receive them as soon as reasonably practicable and, in the case of older people in need of personal or nursing care services, not later than six weeks from the confirmation of need for the service.

Section 6 Definition of Risk Factors

The following table provides definitions of risk factors for each of the bands in the national eligibility framework adopted by the Partnership.

Risks relating to neglect or physical or mental health:

Critical	Substantial	Moderate	Low
Serious harm or neglect has occurred or is strongly suspected and client needs protective intervention by social care services.	Harm or neglect has occurred or is strongly suspected	Adult at risk needs to raise their awareness to potential risks of harm	Preventative measures including reminders to minimise potential to risk of harm
Major health problems which cause life threatening harm or danger to client or others	Significant health problems which cause significant risks of harm or danger to client or others.	Some health problems Indicating some risk to Independence and/or Intermittent distress – potential to maintain health with minimum interventions	Few health problems indicating low risk to independence – potential to maintain health with minimum interventions

Risks relating to personal care/domestic routines/home environment

Critical	Substantial	Moderate	Low
Unable to do vital or most aspects of personal care causing major harm or danger to customer or others or major risks to independence	Unable to do many aspects of personal care causing significant risk of danger or harm to customer or others or there are significant risks to independence	Unable to do some aspects of personal care indicating some risk to independence	Difficulty with one or two aspects of personal care, domestic routines and/or home environment indicating little risk to independence
Unable to manage the most vital or most aspects of domestic routines causing major harm or danger to client or others or major risks to independence	Unable to manage many aspects of domestic routines causing significant risk or harm or danger to client or others or significant risk to independence	Able to manage some aspects of domestic activities indicating some risk to independence	Able to manage most aspects of basic domestic activities
Extensive / complete loss of choice and control over vital aspects of home environment causing major harm or danger to customer or others or there are major risks to independence	Substantial loss of choice and control managing home environment causing a significant risk of harm or danger to client or others or significant risk to independence	Able to manage some aspects of home environment leaving some risk to independence	Able to manage most basic aspects of home environment

Risks relating to participation in community life

Critical	Substantial	Moderate	Low
Unable to sustain involvement in vital aspects of work/ education/learning causing serious loss of independence	Unable to sustain involvement in many aspects of work/ education/learning causing a significant risk to losing independence	Unable to manage several aspects of involvement in work/ education/learning and this will in the foreseeable future pose	Has difficulty undertaking one or two aspects of work/ education/family and/or social networks indicating little risk to

		a risk to independence	independence
Unable to sustain involvement in vital or most aspects of family/ social roles and responsibilities and social contact causing severe loss of independence	Unable to sustain involvement in many aspects of family/social roles and responsibilities and social contact causing significant distress and/or risk to independence	Able to manage some aspects of family/social roles and responsibilities and social contact that poses some risk to independence	Able to manage most aspects of family/social roles and responsibilities and social contact indicating little risk to independence

Risks relating to carers

Critical	Substantial	Moderate	Low
Carer has major physical and/or mental health difficulties due to the impact of carer role causing life threatening harm or danger to themselves or others	Carer has significant physical and/or mental health difficulties due to the impact of carer role causing significant harm or danger to themselves or others.	Carer able to manage some aspects of the caring/family/domestic/ social roles – potential risk to breakdown of their own health identified	Carer able to manage most aspects – has difficulty undertaking one or two aspects of caring/ domestic role but with low risk to carer or client
Complete breakdown in the relationship between carer and client and carer is unable to continue caring or has difficulty sustaining vital or most aspects of the caring role	Significant breakdown in the relationship between the client and carer and carer is unable to sustain many aspects of the role	Relationship between client and carer maintained although at times under strain limiting some aspects of the caring role	Relationship maintained between carer and client by limiting aspects of caring role
Carer is unable to manage vital or most aspects of their caring/ family/work/domestic or social roles and responsibilities	Carer is unable to manage many aspects of their caring/family/work/ domestic or social roles and responsibilities	Carer is able to manage some aspects of their caring/family/work/ domestic social roles and responsibilities	Carer is able to manage most aspects of their caring/family/work/ domestic social roles and responsibilities

Section 7 Moderate and Low Risks

It remains the responsibility of the Health and Social Care Partnership to assess the potential needs of each customer and consider whether those needs call for the provision of some social care support. A customer may be assessed as having being at 'moderate' or 'low' risk, but this may still be considered by the Partnership to require the provision of support. If so, the urgency for such intervention will require to be considered in determining how to respond to the needs identified by the assessment or on-going review.

It is not appropriate simply to place customers who require support in a date order queue. Response to need will be informed by the continuing systematic review of each customer's needs, including consideration of how urgently service provision is called for and what interim measures may be appropriate pending a more permanent response.

East Dunbartonshire Health and Social Care Partnership and our partners will consider whether the provision of support or equipment or other interventions might help prevent or reduce the risk of a customer's needs becoming more intensive and

will operate clear arrangements for meeting, managing or reviewing the needs of customers who are not assessed as being at 'critical' or 'substantial' risk, including:

- Adopting a strong preventative approach to help avoid rising levels of need;
- Embedding preventative strategies at every level of the social care system, informed by assessment of local needs and created in partnership with relevant agencies;
- Timely investment in re-ablement services, therapy, intermediate care and assistive technologies to reduce the number of people requiring on-going social care support;
- An actively managed assessment and review list for those who are intended to receive support;
- A clear timescale for review of needs arising from the support needs assessment;
- Provision of advice on alternative sources of support and request to contact relevant referring agent if needs change;
- Clear information for customers about the support they will receive based on their assessment.

PART C – Cost limitations

Section 8 To Whom Does the Policy Apply?

The policy applies to all service users (over the age of 16) but excludes:

- Young people over the age of 16 where a designated children's service continues to be provided.

In instances where the need for a particular support provided for a child continues to be needed after the age of 16 and can appropriately be delivered by the same provider organisation a re-assessment should be carried out to determine whether the cost limitations should be applied or whether exceptional circumstances apply.

Section 9 When Should Cost Limitations Be Considered?

The flowchart at Section 4 sets out the step process from assessment, application of eligibility criteria, through to support delivery and review. The assessment of need is clearly distinguished from any consideration of available resources for the implementation of the support plan. After the assessment and application of eligibility criteria, full account should be taken of the Partnership's cost limitations when developing the Support Plan. Consideration should be given to best value and other assets i.e. Personal Assets (personal finances, skills and experiences);
Community Assets (clubs, groups, forums); and Carer Assets (family, friends and peer support) when support planning to ensure that we consider the most economic way of meeting eligible needs.

A number of support packages considered by practitioners following the assessment process may require services in the customer's home, which in cost terms, exceeds the equivalent cost of residential or nursing care. It is important therefore that the nature of the proposed support package is fully explored. Full and joint consideration should be arranged with health and other appropriate colleagues to ensure that all supports

possible from community nursing, general practitioner and other sources. This may make the difference between a person requiring to be admitted into residential or nursing home care, or being able to remain at home.

Practitioners, as well as following the priority/risk matrix when applying eligibility criteria, also need to follow this policy in relation to cost limitations.

If for reasons of lack of available finance or lack of available resources the optimum support cannot be arranged, the support plan should note the support that the Partnership can provide at that time. If the support plan does not provide for the optimum support needs a record of ineligible need should be recorded on the support plan for the purposes of future planning and development activities.

Section 10 Application of Eligibility Criteria and Cost Limitations

The need to consider whether a limitation on the cost of a customer's support package will come towards the end of the process including:

- An assessment of need via single shared assessment;
- Determining whether the customer is eligible for support, with reference to the eligibility criteria outlined in this policy;
- Prioritisation of need;
- Identification and costing of support packages to meet assessed needs;
- Calculation on an on-going basis as to whether the total cost of the support package provided exceeds the cost limitations.

Section 11 Calculation of Cost Limits

The policy supports maximum levels of cost for support services in individual cases, unless there are exceptional circumstances:

- *For older adults over 65 years this will be related to the approved rates (net of the customer's contribution) for residential/nursing home places including day activities there at the current rate at the time of calculation;*
- *For younger adults under 65 years this will based on the amount for care in supported accommodation and, where appropriate (based on assessed needs) the cost of a day centre place or day activities (net of the customer's contribution).*

There will be scope for exceptions and the figures utilised will be based on the above descriptions and are suggested maximum levels of resource.

It should be noted that contract standing orders state that any support service costing more than £30,000 per annum has to be approved by Committee and the requirement to tender the contract has to be considered.

<u>Supports to be included:</u>

The calculation for the overall cost of a support package should include:

- All supports delivered within the home;

- Day care/day activities delivered either within or outwith the home;
- Transport/escort costs associated with the provision of home-based and day supports;
- Any other costs identified within the support package.

Costs to be excluded:

The cost of the following should be excluded from the cost limitations:

- Periods of residential or home based respite care where the primary assessed purpose is to assist the carer rather than to benefit the customer and where this is based on a formal carer's assessment;
- Aids and adaptations plus maintenance costs of adaptations;
- Community Alarms;
- Services provided by another department of the Council e.g. drug/alcohol treatment, criminal justice

Funding sources to be excluded:

Support financed through the following funding sources should be excluded in the calculation of support package costs:

- Supports funded by another agency i.e. voluntary organisation; Independent Living Fund;
- Non-recurring 'start up' costs for support packages;
- Support funded for community health care services.

Section 12 Contributions by Customers

Where a contribution is made by the customer for a support service, this will not be taken into account in calculating whether the cost limitation has been reached i.e. the calculated cost of the support package is the gross cost of the services before contributions. Although the levying of customer contributions will reduce the cost to the Partnership, this approach will ensure greater fairness to all customers, in terms of the actual size of the support package received, rather than giving an advantage to better off customers with higher contributions.

Identical support packages may therefore impact very differently on budgets as a result of differential contributions, but this should not have any influence on either the process of assessment or prioritisation.

Section 13 Review of Circumstances

It is important that customers are given advice as early as possible in the assessment process about the eligibility criteria and charging policies.

A process of monitoring and review (see Assessment and Support Management procedures) will be undertaken to ensure a response to changing circumstances e.g. changing needs as a customer's health improves in the period after hospital discharge. Staff will also require to respond to requests for reviews from customers as their needs change and it will also be appropriate for these reviews to consider eligibility

criteria and the application of cost limitations after the needs of the customer have been reassessed.

Households with more than one person in need:

The policy is clear in stating that where two or more people with individually assessed needs reside within the same family unit, each person should be treated separately for the purposes of the cost limitation calculation.

The cost of carers' services should be considered separately where their needs have been separately assessed through carers' assessments and the support provided is aimed primarily or solely to meet carers' needs.

Existing Support Packages:

While this policy applies to all customers, there will be no detriment to those with existing support packages costing beyond the suggested maximum limits prior to implementation of the revised policy.

Cost limit considerations will however apply at the review of the support package and will be based on assessed need when applying the policy.

All support packages will need to be regularly reviewed to confirm that current expenditure is required and whether the total cost can be reduced, for example, where appropriate using an alternative type of support or another provider without detriment to the customer.

Section 14 Exceptional Circumstances

Management have the discretion to authorise support packages that extend beyond the suggested cost limits. This will take the form of a graded approach:

(1) Adult support packages up to a maximum of £40,000 per annum or older people support packages up to the maximum cost associated with long term nursing home care will be authorised by Joint Service Managers for Adult or Older People Services.

(2) Adult support packages exceeding £40,000 but less than £80,000 per annum or older people support packages exceeding the cost of long term nursing home care but less than £80,000 per annum will be authorised by the Manager of Adults and Primary Care Services.

(3) Where support packages for adults and older people exceed the cost of £80,000 per annum approval will be sought via the Operational Management Group Team in the first instance.

This graded approach will provide the required process to respond to urgent and immediate circumstances which will be on an individual case by case basis. These require to be reviewed at the earliest opportunity.

The arrangements to exceed the cost limitation will be supported by the individual customer's assessed needs and outcomes and based on the critical and substantial levels within the eligibility criteria (see Section 5 and 6).

Once funding is approved an approach will be taken to develop a personalised support package.

Section 15 Choice and Risk

It is recognised that most people will wish to remain at home. East Dunbartonshire Health and Social Care Partnership encourage the creative and innovative use of eligible funding, personalised to the customer's individual circumstances and lifestyle.

However, as well as considering the use of paid supports the practitioner, customer and their carer/family should also consider other assets:

- Personal – skills, knowledge, own financial resources;
- Community – clubs, peer groups, forums;
- Informal Care and Support – family, friends and circles of support;

as ways of meeting the customer's assessed needs and helping them to achieve their identified outcomes.

However, any choice by the adult (or his/her proxy) around care/support and the setting in which this is received needs to be exercised in the full knowledge of the amount of support that can be provided. The Partnership retains a duty of care towards the customer and is required to take into consideration any risks it identifies to the customer from such a choice, including the decision for the adult to remain at home. Social work and health practitioners and their managers will be expected to consider in all cases the need for a multi-disciplinary case conference to establish a customer's capacity to make informed decisions and/or consider any risks that could arise from those decisions.

Section 16 Management of Resources

The review of this policy is intended to support practitioners and management in their role within with the aspect of overseeing social work resources. The arrangement of any services will continue to depend on the availability of budget and resources. Therefore, if a customer is to be given priority within the eligibility criteria, and the cost of the support package is below the cost limitations, those authorising the provision of supports will still require to have the information that the budget and resources are available to meet the assessed need. Practitioners are required to submit 'Additional Expenditure Required' forms (AERs) to management when there are insufficient resources within the budget.

Section 17 Ineligible Needs

This Eligibility Criteria policy has not affected the level of resources. As indicated above the intention is that existing resources should be allocated on a fairer and more equitable basis. It is equally important to recognise that certain needs will continue to

be ineligible. All needs for support services should be recorded following assessments and reviews, and a proper note kept of needs which are ineligible in line with the policy outlined above and the level of current resources. The information gathered from recording ineligible needs will inform future planning and development activities.

PART D – Service Descriptors

Section 18 Personalisation and Self Directed Support

"Personalisation enables the individual alone, or in groups, to find the right solution for them and to participate in the delivery of a service. From being a recipient of services, citizens can become actively involved in selecting and shaping the service they receive" (Scottish Government, 2009).

Self Directed Support is about making sure that customers with health or social care needs are helped to find support to live the way they wish to lead their lives. Customers and their families can make informed choices. Most people who have social care needs will be able to receive an 'Individual Budget' so that they know what the cost of their support package is and can make the appropriate arrangements to purchase their support depending on the Self Directed Support option(s) chosen by the customer. People will have control over the way the money is spent and will receive as much or as little support to manage their budget as they need.

The support is person centred and works towards the achievement of the customer's individual outcomes. While the supports considered and agreed within the customer's support plan will be personalised to them as an individual, the service descriptors below provide information on the most commonly used support services. The majority of these support services can be arranged using any of the self directed support options (with the exception of long term residential or nursing home care and continuing in-patient health care).

Section 19 Care at Home

Care at home support is provided for vulnerable people who are unable to meet their own needs and require significant support with personal and daily living tasks in order to remain safely within their own homes and who do not have access to adequate alternative support.

Care at home services may provide support to meet the following needs:

<u>Personal Care:</u>

- Personal Hygiene – bathing, showering, hair washing, shaving, oral hygiene, nail care;
- Continence Management – toileting, catheter/stoma care, skin care, incontinence laundry, bed changing;
- Food and Diet – assistance with eating, special diets, managing different types of meal services, preparation of food;
- Problems with Immobility – dealing with the consequences of being immobile or substantially immobile;

- Counselling and Support – behaviour management, psychological support, reminding devices;
- Simple Treatments – assistance with medication (including eye drops), application of creams/lotions, simple dressings, oxygen therapy;
- Personal Assistance – assistance with dressing, surgical appliances, prostheses, mechanical and manual aids, assistance to get up and/or get into bed;
- Transfers include the use of a hoist.

Practical Care:

- Shopping;
- Basic food preparation/assistance;
- Laundering of personal and housing items;
- Pension collection and payment of bills;
- Social tasks including talking to customers, encouraging customers to maintain contact with family, friends and community, and establishing routine;
- Assistance with domestic cleaning (should only be provided when this is an essential component of a wider support plan).

Section 20 Carer Support

Carer support may take a number of different forms, and should be informed by a separate carer's assessment. Respite or short breaks at home usually involves the use of care at home support to alleviate pressure on carers, either to enable carers to attend to work, domestic, personal or social engagements, or simply to provide a period of rest. Other forms of respite/short breaks may involve the use of day supports, home based or residential/nursing respite. Accordingly, the eligibility for care at home, day, and home based and residential/nursing respite support should be applied equally to the needs of carers.

Section 21 Housing Support

Housing support services can take a number of forms including:

- Assistance with security of the dwelling e.g. warden services;
- Maintaining safety e.g. making arrangements for servicing of appliances;
- Cleaning of rooms and windows;
- Counselling and support which assists customers to comply with tenancy conditions e.g. nuisance or rent liability;
- Assisting individuals living in supported accommodation maintain social intercourse with other tenants and guests;
- Assistance/advice on life skills e.g. food preparation including food storage, kitchen hygiene;
- Provision of general advice and support on daily living skills.

Section 22 Day Supports

Day supports include lunch clubs, day centre, rehabilitative services and leisure opportunities. Each support service differs in terms of specific purpose and referral arrangements, so services should be contacted directly regarding the suitability of the referral. In general, the following points can be made about day supports:

- Some day supports are subject to registration and inspection. These support services usually focus on providing structured personal and rehabilitative care. Referral to registered day care should form part of an integrated package of community care supports which are preventing a likely admission to residential or nursing home care, or offer respite for informal carers who are in daily contact with customers and provide high levels of support/supervision;
- Unregistered day supports (such as lunch clubs) offer less formal, social opportunities for people with a range of support needs. People needing regular personal care are generally not suitable for unregistered day supports as they tend not to be geared up for the level of support required;
- Customers choosing self directed support options may decide to choose a day support unique to their own personal needs i.e. attendance at a special hobby club, and this would be discussed further in the support planning process;
- The priority for community care is to concentrate on those in the greatest need and on maintaining people in their own homes for as long as possible. The use of day supports should be clearly linked to these principles, both in terms of who should be prioritised for scarce resources, and in determining the particular supports that best serve those in greatest need;
- Consideration should be given to trying to involve community health services actively to meet customer's health needs as an integral part of day support, where appropriate;
- The health care needs of customers should not exceed those normally met by day hospitals, hospices or specialist mental health units.

Section 23 Meals on Wheels

Meals on Wheels is a voluntary service delivered by the RVS. The service is designed for people who live alone or without a full time carer and:

- Are at risk if they use the cooker; or
- Have dementia or confusion and are consequently unable to cook or forget to eat; or
- Require a temporary service to alleviate pressure, for example, on discharge from hospital, or during a temporary illness, or if their main carer is on holiday.

Section 24 Befriending Service

Befriending is primarily about volunteers providing companionship and improving the quality of life for people who may be isolated due to illness or disability. Customers need not necessarily live on their own to be isolated or socially excluded. Befriending should be about promoting choice and participation for customers. It should represent an additional support for customers, rather than being used to substitute formal support services. The following features should also be present in a case being considered for befriending:

- The customer should live in East Dunbartonshire, or be planning to move there;
- The customer should be over 16 years of age;

- The customer should be able to engage in a mutual and communicative relationship with the befriender;
- The customer has to want this support.

Section 25 Respite Care/Short Breaks (including residential and nursing homes)

Respite care/short breaks whether in a residential or nursing home, home based or provided via some other alternative type of support, is primarily a service for carers whose responsibilities (due to the dependency of the person cared for) create pressures which require relief from the caring task. With regard to the prioritisation of needs, this type of support is appropriate where:

The customer meets the criteria for respite/short breaks and:

- The customer lives permanently with the family or others who are in need of respite/short breaks to maintain their caring role, or are temporarily unavailable;

  OR

- The customer lives alone and is in need of respite/short break to prevent the breakdown of community living arrangements.

The amount of respite/short breaks available to the carer/customer should be determined by assessed need.

Social work services should not provide respite/short breaks for the purpose of rehabilitation, assessment of health issues or recovery which are the responsibility of the health service.

Section 26 Residential Care

A residential care placement may be considered when:

- The customer is unable to care for him/herself and to carry out the tasks essential to daily living, even with substantial support from community services, up to the cost limitations set;
- The customer's behaviour presents a risk of physical or mental harm to him/herself or others, or makes them vulnerable to exploitation and this cannot be managed in his/her own home;
- Existing caring arrangements have irretrievably broken down to the extent that a carer is unable or unwilling, even with the support of others, to care for someone unable to care for him/herself, and that this care cannot reasonably be provided by other means;
- The physical environment is unsafe and cannot appropriately be made safe through the provision of equipment or adaptations and suitable community housing provision is not available;
- The cost of support services at home exceeds the cost limitations set.

And

Health care needs do not exceed those that should normally be met by community health services, providing services on the same basis to people in their own homes.

Where there is any doubt of this, a health care needs assessment will be carried out by health personnel before a placement decision is made.

And

The needs of the customer do not fall within the criteria for NHS funded care.

And

Following assessment and discussion of the available options, the customer's choice is to seek residential care.

A residential home placement will also be considered in other very exceptional circumstances where, for clearly documented reasons, the assessment of the care manager and team manager is that this constitutes the most appropriate response to the customer's support needs.

Section 27 Nursing Home Care

A nursing home placement may be considered when the customer concerned has nursing needs requiring skilled general nursing care, and/or skilled psychiatric nursing care, at a frequency beyond that normally met by community health services. However, the customer does not have health care needs requiring NHS in-patient treatment.

And

Circumstances described in the criteria for residential care exist and the requirement for skilled general nursing care arises from circumstances such as the following:

- Where the customer's physical or mental health has deteriorated to a level that needs 24 hour on-site nursing care;
- Where the customer's health is such that one or more of the following technical procedures (the list is not exhaustive) is required on more than one occasion in 24 hours:
    - Administration of medication by injection or syringe driver;
    - Application of sterile dressings;
    - Basic nursing care of the type given to people confined to bed for long periods e.g. prevention of pressure sores;
    - The care and management of incontinence (double or single) which has been assessed as requiring skilled nursing action;
    - Catheter care – insertion, removal and monitoring;
    - Stoma care – review, monitoring and occasional practical intervention;
    - Management of complex prostheses or appliances including artificial feeding;
    - Where the person suffers from a complex psychological, aggressive or difficult to manage state requiring supervision of qualified psychiatric nursing staff.

And

Following assessment and discussion of available options, the customer's choice is to seek nursing home care, or the cost of the comparable home based care exceeds the cost limitations.

And

The person is not assessed as needing continuing health care.

And

The assessment is backed up by General Practitioner/Consultant certification of the appropriateness of nursing home care.

Section 28 Continuing Inpatient Health Care

The consultant (or GP in some community hospitals) will decide, in consultation, with the multi-disciplinary team, whether the patient:

- Needs in-patient care arranged and funded by the NHS;
- Needs a period of rehabilitation or recovery, arranged and funded by the NHS;
- Or should be discharged from in-patient care.

Continuing in-patient care should be provided where there is a need for on-going and regular specialist clinical supervision of the patient as a result of:

- The complexity, nature and intensity of the patient's health needs, being the patient's medical, nursing and other clinical needs overall;
- The need for frequently, not easily predictable, clinical interventions;
- The need for routine use of specialist health care equipment or treatments which require the supervision of specialist NHS staff; or
- A rapidly degenerating or unstable condition requiring specialist medical or nursing supervision.

The decision is fundamentally a professional clinical decision, based on the outcome of the multi-disciplinary assessment. The consultant or GP, in consultation with the multi-disciplinary team, will decide whether the individual is eligible for NHS continuing health care, taking into account the matters raised above.

The large majority of people, after a stay in hospital, will be able to return to their own homes and will not have any on-going care needs; however some individuals may require on-going care. The individual may need a period of rehabilitation or recovery arranged by the NHS or social work services to prevent discharge arrangements breaking down, they may need to receive a package of care in a care home, arranged and funded by social work services, or they may need a package of social and health care support to allow them to return to their own home.

(Ref: Circular CEL 6 (2008))

Health boards and local social work services should have in place clear agreements on how they will resolve disputes (between themselves as purchasers) about responsibility for individual cases for meeting continuing care needs. These arrangements will be within the context of joint planning agreements. In the first instance, concerns should be discussed with team managers, who should in turn raise unresolved disputes with the line mangers.

Revised Scottish Government guidance on Hospital Based Complex Clinical Care has been produced following an Independent Review conducted in 2014-15. This guidance, contained in Circular DL (2015)11, replaces the previous Circular (CEL6 (2008)). The overall objectives of the revised guidance are to:

- *Promote a consistent basis for the provision of Hospital Based Complex Clinical Care.*
- *Provide simplification and transparency to the current system;*
- *Maintain clinical decision making as part of a multi-disciplinary process;*
- *Ensure entitlement is based on the main eligibility question* ***"can this individual's care needs be properly met in any setting other than a hospital?"***
- *Ensure a formal record is kept of each step of the decision process.*
- *Ensure that patients, their families, and their carers have access to relevant and understandable information (particularly if the individual does not need to be in hospital but rather an alternative setting in the community).*