Fair Access to Community Care (Adults) Policy

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SECTION A - INTRODUCTION

1 POLICY OBJECTIVES

1.1 These policy objectives are underpinned by the East Dunbartonshire Health and Social Care Partnership (HSCP) vision and values. The HSCP's vision statement is: "Caring together to make a positive difference". The HSCPs values are:

- Respect
- Honesty
- Integrity
- Professionalism
- Empathy & Compassion

1.2 The HSCP provides a range of Community Care support services to individuals with varying levels of support needs. A person-centred assessment is undertaken to establish support needs. The HSCP is committed to maximising personal independence so will assess what individuals are able to do for themselves and any informal support they have from family or friends. It will also consider support that is available in local communities. Access to formal support is determined by agreed Eligibility Criteria, with funding being made available where an individual has been assessed as having critical or substantial needs and where the reduction of these risks requires formal support in part or in whole. The HSCP has a responsibility to provide or secure suitable services to a standard satisfactory to meet eligible needs, through this collaborative approach. It also has a responsibility to ensure there is fair and equitable allocation of the available resources.

1.3 The HSCP supports over four thousand adults with formal support, ranging from low-level advice and support to extremely intensive round-the-clock care and support with specialist health input. Where an individual has certain complex needs[1] there can be significant variation in the costs of supporting the individual depending upon the model of care used to provide the support. This policy aims to ensure there is a fair and financially sustainable allocation of resources to individuals who require support and the models of care that will be considered, particularly when an individual requires a significant amount of support in their daily living. The policy does not in itself impact on eligible service levels, but focuses on the service types and approaches to providing this support.

2 POLICY APPLICATION

2.1 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 (with due regard to the Adult Support and Protection (Scotland) Act 2007). The policy applies to planning for children and young people who are leaving school and will subsequently be subject to the adult community care policy environment.

[1] As a general rule, someone will be assessed as having complex needs when in addition to support with specific tasks to meet their outcomes, an individual requires support on a regular or ongoing basis for their safety and wellbeing or the safety and wellbeing of others.

3 RELATED LEGISLATION, POLICIES AND PROCEDURAL MECHANISMS

3.1 East Dunbartonshire Health and Social Care Partnership's responsibilities to adults (aged 16 and over) and older people are set out in the following legislation, policies and operational mechanisms, which are subject to change:

- 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
- The Equality Act 2010
- The Mental Health (Scotland) Act 2015
- The Carers (Scotland) Act 2016

3.2 Other related policies and mechanisms:

- 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
- Fair Access to Community Care (Adults) Policy (2018)
- Eligibility Criteria for Adults and Young Carers Support (2018)

4 LEGISLATIVE CONTEXT

4.1 The main duty to provide community care services derives from Section 12A of the Social Work (Scotland) 1968 Act:

"*Where it appears to the local authority that any person for whom they are under a duty, or have a power, to provide community care services may be in need of any such services the local authority shall:*

- *make an assessment of the needs of that person for those services; and*
- *decide, having regard to the results of that assessment, whether the needs of the person being assessed call for the provision of any such services, taking account of:*
    - *care provided by [an adult or young] carer,*

- *the views of the person whose needs are being assessed (provided that there is a wish, or as the case may be a capacity, to express a view)"*

4.2 The Social Care (Self Directed Support) (Scotland) Act 2013 introduced choice and control in the provision of community care support. The Act places a duty on local authorities to offer people who are eligible for community care a range of choices over how they receive their community care and support. It allows people in many circumstances to choose how their support is provided to them, and enables people, if they wish to do so, to organise this support themselves. It also requires that the local authority must provide information, including the available budget, to individuals to assist with their decision. If an individual chooses options 1 or 2, the local authority must make available a relevant amount to enable them to make choices about their support. It should be noted that payment made available by the Local Authority should be an amount that the local authority considers to be a reasonable estimate of the cost of securing the provision of support.

4.3 The Equalities Act 2010 was passed on 8 April 2010. The Act protects the following characteristics (referred to in the Act as "protected characteristics"):

- age;
- disability;
- gender reassignment;
- marriage and civil partnership;
- pregnancy and maternity;
- race;
- religion or belief;
- sex;
- sexual orientation.

4.4 The Act prohibits discrimination (whether direct or indirect) against people who possess one of the protected characteristics. Direct discrimination takes place where a person treats another person who has a protected characteristic less favourably than he or she treats or would treat others not possessing the protected characteristic. Indirect discrimination occurs where a provision, criterion or practice is applied which would put a person possessing a protected characteristic at a particular disadvantage.

4.5 Individuals who are assessed as needing Community Care supports often do so due to disability. While assessment of need is individualised and person-centred (and eligible services so provided), the HSCP has an obligation to ensure that it treats people fairly and equitably in terms of levels of support with which they are provided.

4.6 The HSCP Board is delegated with the powers and duties of the Council and Health Board through an "Integration Scheme", which is established by Parliamentary Order, in relation to a wide range of health and social care functions. The HSCP is accordingly required to perform its statutory duties under the terms of the 1968 and 2013 Acts, while exercising its discretion in performing these duties. It must also ensure that policy and practice is fair and equitable in line with the Equality Act 2010.

4.7 The HSCP has a duty to assess needs and must ensure that assessed eligible needs are being met, but they do not have to fund the support requested by an individual or their guardian, attorney or carer if the assessed need can be met in a more cost effective manner. The HSCP is not required to fund more expensive models of care where support can be provided effectively by alternative models of care.

SECTION B - FAIR ACCESS TO COMMUNITY CARE (ADULTS) POLICY

5 ASSESSMENT OF NEED AND ELIGIBILITY FOR COMMUNITY CARE SERVICES

5.1 The East Dunbartonshire HSCP takes a person-centred, outcomes-based approach to needs assessment and support planning.

5.2 Not all assessed needs will meet eligibility criteria for statutory funding. Normally, only outcomes that reduce risks to a moderate level[2] can be allocated funding for support.

5.3 Outcomes not associated with eligible needs will be used to inform and shape how eligible support is best provided.

6 RESOURCE ALLOCATION

6.1 The Social Work (Scotland) Act 1968 requires local authorities to ensure that resources are made available to meet eligible needs to a standard that will satisfy the local authority that the individual's needs are being met.

6.2 The allocation of resources is determined to be a "relevant amount", as defined in the Social Care (Self Directed Support) (Scotland) Act 2013 as "the amount that the local authority considers is a reasonable estimate of the cost of securing the provision of support for the supported person".

6.3 In East Dunbartonshire, we have adopted an 'equivalency model' to determine this relevant amount for the allocation of resources under self-directed support. This means that through assessment the HSCP decides what support it would normally provide to a person with social care needs and then monetise that service so that it can be offered in the form of a personal budget. The equivalency calculation is applied whichever one of the four SDS options is chosen, meaning that no individuals will be placed at a disadvantage. Following completion of the assessment an individual will be made aware of the resources available to them. This will ensure that the individual is clear about resources as they begin the support planning process.

6.4 Any individual who is not satisfied with the level of resources they have been allocated should in the first instance discuss this with the practitioner and their manager. If agreement cannot be reached, the individual should be made aware of the Health and Social Care Partnership's Complaints Policy and Procedure.

6.5 A 'Schedule of Rates' equivalent to the costs of delivering or arranging services in the traditional way (SDS Option 3) will be established and maintained. This will be used in the first instance to determine the relevant amount to deliver or purchase the support required to meet the needs of the service user and to determine the personal budget under SDS.

6.6 Where the service user chooses a more expensive support service with hourly rates exceeding the relevant amount it will be necessary to make adjustments within their Individual Budget either to:

- Reduce the total hours of support purchased; or
- Make alternative arrangements to meet any resulting unmet need arising from any reduction in support hours purchased e.g. support from family,

[2] East Dunbartonshire Eligibility Criteria Policy for Adults and Community Care Services

service user/carer 'topping up' support costs from their own financial resources.

6.7 In exceptional circumstances, application of the Schedule of Rates may be insufficient to identify or purchase a suitable service for some people with very specific needs and/or circumstances, either for the HSCP to directly arrange, or as the basis for calculating an equivalent personal budget value.

6.8 In any such exceptional situation, consideration must be based on the whole circumstances of the service user including:

- His or her assessed needs e.g. level of complexity, unpredictability of behaviour;
- Reference to the HSCP's eligibility criteria in relation to critical or substantial priority/risk.
- Other relevant factors evidencing that assessed needs cannot be met by a support provider at the relevant rate e.g. difficulty recruiting or purchasing, need for support staff with specific additional skills who would be unavailable at the standard rates.

6.9 In the event of any departure from the Schedule of Rates being proposed, commissioning officers must be involved to identify a service to a standard that will satisfy the local authority that the individual's eligible needs are being met, at an amount as close to standard application of the Schedule of Rates as is available. This service will either be delivered or arranged by the local authority, or will be used to establish an equivalent amount for the purposes of an individual budget, in line with the Social Care (Self Directed Support) (Scotland) Act 2013.

6.10 Any decision to make payments above the normal application of the Schedule of Rates must be authorised by the appropriate Head of Service, who will also approve:

- The agreed rate;
- The period during which the agreed rate will apply and be reviewed.

6.11 Any services delivered or arranged at a rate higher than the normal application of the Schedule of Rates will normally be considered temporary. At the time of review, the service-user's needs should be reassessed and re-engagement with commissioning officers must take place to seek to identify a service to a standard that will satisfy the local authority that the individual's eligible needs are being met, at an amount as close to standard application of the Schedule of Rates as is available, at that time.

7 TYPES AND LEVELS OF SUPPORT

7.1 In line with the HSCP's "Eligibility Criteria Policy for Adults and Community Care Services", the purpose of providing support to an individual is primarily to reduce risk to a moderate level. Finite resources mean that the local authority may not be able to provide the level of support an individual or their family may wish. There is an inherent risk in all aspects of daily life and therefore it is not always possible (or indeed appropriate), to completely reduce or eliminate risk in every situation.

7.2 East Dunbartonshire HSCP will aim to maximise the use of shared support[3] to ensure it can deploy available resources for people with eligible need for services, on a fair and equitable basis. We will consequently also use shared support

[3] Shared support is where one or more members of staff provide support to more than one service-user.

approaches when calculating a relevant rate to apply budget equivalence for Self Directed Support.

7.3 There is a general principle that all eligible support to reduce risks to a moderate level must also have a secondary objective to contribute to outcomes relating to the promotion of wellbeing, social development and independent living.[4] In addition to reducing presenting risk, eligible support should be designed to maximise the potential for individuals to develop the skills and confidence to safely manage with less support over time. Capacity for enablement (or reablement) will vary from person to person, but should always be promoted as an ongoing desired outcome of the support provided.

7.4 Formal services should be seen as only one component of a co-produced, community asset-based approach to community care. Maximising community, universal and informal supports and assistive technology is essential to building and sustaining independent living. The HSCP will work with service-users, families and communities in partnership to achieve this.

8 TYPES OF LIVING ARRANGEMENTS

Where an individual requires support at home, this will usually be in one of four types of living arrangement:

(i) Living with family

(ii) Independent living with support

(iii) Supported living models

8.2 <u>Living with Family</u>

8.2.1 Many people with disabilities continue to live in the family home with family members providing informal support. The HSCP will always aim to work in partnership with families in these circumstances, to try to sustain these arrangements when this is agreed to be in the best interests of the individual and where family members can be supported to continue to provide informal care of this nature.

8.2.2 Where an individual is living with family, statutory support may be provided at times when support cannot be provided by family members, or to give family members a break from their caring role, in line with the Carers (Scotland) Act 2016 and subject to the preparation of an Adult Carer Support Plan[5]. In such circumstances, the type and arrangement of support provided should be designed to contribute to the achievement of the personal outcomes set out in their support plans of both the individual and their carer(s).

8.2.3 Consequently, in some cases individuals living with family, who meet Eligibility Criteria, will receive support to engage in meaningful activity and to participate in community life, in order to achieve the personal outcomes set out in their support plan, as well as to provide carer support.

8.2.4 We will support adults with disabilities to live at home with their families unless the cost of doing this exceeds the cost of the most appropriate supported living model. In this event, the HSCP would review the support plan with the service-user and/or his or her guardian or attorney, to consider the options for bringing the support plan

[4] This principle is extended to a duty for people with a mental disorder as defined in the Mental Health (Care & Treatment) (Scotland) Act 2003. In the 2003 Act "mental disorder" means “any mental illness, personality disorder, or learning disability, however caused or manifested”.

[5] Eligibility Criteria for Adults and Young Carers Support (2018)

cost within the threshold level. If this can be achieved through redesign, collaborative support networks and maximisation of assistive technology, whilst still meeting the service-user's eligible needs and reducing risks to a moderate level, then the service-user would be transitioned over to the new support plan. If service redesign is unable to achieve this outcome, then the service user would be placed on a waiting list for a Supported Living alternative (see 8.6), or the equivalent relevant rate being used to inform a personal budget amount for Self Directed Support 1 or 2. Any change of service type would be impact assessed with a view to identifying any risks and for these risks to be handled appropriately.

Leaving the Family Home

8.2.5 Should an individual, or a Power of Attorney / Guardian acting on their behalf, decide the individual should make plans to leave a family home, they may wish to contact East Dunbartonshire Council's Housing Services and register an application for local authority housing. They should also make a referral to East Dunbartonshire HSCP for an assessment of the most appropriate housing options and support required for daily living. Making a housing application does not necessarily mean that care and support will be provided in any preferred housing option.

8.2.6 Any housing application to Housing Services will be progressed in line with the Local Authority's housing allocation policy and will take into consideration factors such as the age of the individual, housing need, type of accommodation requested and their support needs. Concurrently a community care assessment will be conducted to determine the level of support an individual requires, whether there is a need for supported living, and the appropriate model of care. As there will be a need to match to suitable housing, the allocation of housing may take some time. All requests for housing with support will be considered jointly by the HSCP and Housing Services before an allocation is made.

8.2.7 The individual or their guardian may choose to find their own or privately rented property, however, this should be discussed with East Dunbartonshire HSCP to ensure their assessed care and support needs can be met in any potential property and within eligibility and cost ceiling policies of the HSCP. Unsuitable property may preclude the delivery of care and support due to reasons of safety.

8.2.8 Any urgent housing requests, including circumstances where an individual has been advised they must leave the family home, would require the individual to present as homeless in order to access priority housing.

8.3 **Independent Living with Support**

8.3.1 This relates to individuals living in single occupancy arrangements, or living independently in houses of multiple occupation (HMOs). They may be single tenants, owner-occupiers or living on their own in accommodation owned by family or another person.

8.3.2 An individual is considered to be living independently when it is assessed that they do not require significant amounts of support, and can manage on their own for significant periods of time.

8.3.3 Where eligible support is required it would be for specific tasks. General support to keep risks to a moderate level would normally be incorporated into this support, with Assistive Technology being provided where an individual requires immediate access to support.

8.3.4 We will support people with disabilities to live independently with eligible support in these circumstances unless the cost of doing this exceeds the cost of the most appropriate Supported Living model that includes aspects of shared support. In this event, the individual would be placed on a waiting list for a Supported Living alternative (see 8.6), or the equivalent relevant rate being used to inform a personal budget amount for Self Directed Support 1 or 2.

8.3.5 In the event that an Independent Living with Support option is the service-user's strong preference, a detailed examination of support options should be undertaken to explore if eligible services can be delivered within the cost threshold through collaborative support networks and maximisation of assistive technology, whilst still reducing presenting risks to a moderate level. If this proved not possible, then 8.3.4 would apply.

8.3.6 A caveat to 8.3.4 above would be when an individual is assessed as not being able to share a social space with others due to consistent and substantial stress, distress or aggression in the company of others.

8.3.7 Any change of service type would be impact assessed with a view to identifying any risks and for these risks to be handled appropriately.

8.4 **Supported Living Models**

8.5 There are four models of care for the provision of Supported Living that are detailed below. These models are characterised by the need for more significant levels of support to keep an individual or others safe, compared to Independent Living with Support described above.

(i) Shared or clustered living – this is the default model of support, where an individual will share a property with others or live in a property in such close proximity to other individuals who require similar support, so that substantial or all support can be shared. This would include extra care housing;

(ii) Dedicated 1:1 single occupancy tenancies or owner occupation – supporting an individual in a single occupancy tenancy or owner occupation would only be considered in the circumstances outlined at 8.3.6 above;

(iii) Specialist care – the individual's needs are such that a specialist team is required to provide support to the individual;

(iv) Residential care - residential and nursing care would not normally be considered unless the individual required care over a 24 hour period in a specialist setting due to medical, behavioural or age-related physical or sensory needs that cannot be met in a non-residential environment. Deteriorating conditions that require increasing reliance on high levels of support are usually best provided in a residential care setting. This should also include people whose needs are volatile and fluctuate and are at risk of frequent hospital admissions.

8.6 **Non-Community-based Supported Living Options**

8.7 Additional detail on the circumstances and uses of accommodation-based care and support options that are not community-based is contained at Appendix 1. This includes:

- Residential care
- Nursing care
- NHS In-patient care

9 ASSESSMENT OF SUPPORTED LIVING CARE MODEL: CHOICE AND SELF-DIRECTED SUPPORT (SDS)

9.1 An individual's assessment will determine the appropriate Supported Living care model that would be funded by the HSCP.

9.2 Supported living models that are based upon shared care arrangements are not suitable for SDS Options 1 or 2 (and so far as relating to those options, Option 4). This is due to the potential impact upon the tenancy rights of other tenants and the overall coordination of care, support and safety within the accommodation or cluster.

9.3 While principles of choice and control should be considered within the assessment, the HSCP cannot provide desired support irrespective of cost due to the finite resources available. Assessments should reflect the views and wishes of individuals and, where appropriate, their carers and legal guardians. However the HSCP will take the cost of providing any support requested by the family into consideration in its decision making. If that request is more expensive than the individual is assessed as requiring then the HSCP will not ordinarily meet the request. The HSCP will determine the funding available based on the most appropriate shared or clustered living model that will meet needs in a cost effective manner, in line with this policy.

9.4 As an alternative to a proposed supported living model, service-users (or their legal guardians, as appropriate) may exercise their right to opt for an SDS Option 1 or 2. In this event, the individual budget will reflect the relevant equivalent rate, which will ordinarily be based upon the cost of the proposed supported living model. Using SDS Option 1 or 2, this funding may be used to develop a support package based on an alternative model providing it is safe, meets individual needs, and can be sustained in the long term. Should an individual wish to fund extra support, or have regular informal support provided as part of their care package, they are able to do so, provided that they are aware that funding for this extra support cannot be made by the HSCP.

10 EXISTING CARE PACKAGES

10.1 Changing circumstances and historical decision-making may mean that individuals are provided with a level of support that exceeds their eligible needs, as assessed at point of review[6]. In these circumstances an individual's updated assessment and support plan should identify the appropriate model of care in line with this Fair Access to Community Care (Adults) Policy and the need to transition to this model (*enter transition period, depending on HSCP Board's decision on implementation*)

10.2 Where existing support services are provided to an individual that do not exceed their eligible needs, but are provided in a way that operate outwith the terms of this Fair Access to Community Care (Adults) Policy and/or exceeds the Schedule of Rates, a review of the overall care and support package should be undertaken and support services transitioned to align with the policies set out in this document. This will normally be undertaken at the time of routine review but may be brought forward to promote fairness, consistency and equity in line with the Policy's aims. In the pursuance of the provisions of this policy, any service transition should be handled carefully, sensitively and appropriately risk assessed.

[6] The East Dunbartonshire Assessment & Care Management Procedures & Standards (2013) provide that support plan reviews should be undertaken as a minimum annually (Standard 10).

11 OUT OF AREA PLACEMENTS

11.1 The HSCP will not normally consider out of area placements. This is both because of an overarching principle that people should be supported to live in East Dunbartonshire wherever possible, and also to mitigate specific risks to individuals that arise from out of area placements. The risks are:

- Individuals may become disconnected from their local community (this risk increases with the length of time the individual is in an out of area placement);
- Distance from family, friends and peer support networks leaving individuals socially isolated;
- Additional direct and indirect costs related to the provision of support;
- Supervision of support being provided can be less rigorous due to geographic distance;
- It can lead to inequity of service provision due to variable costs.

11.2 There are certain circumstances where an out of area placement may be appropriate for consideration:

- There is an assessed need for a specialist service to provide support or care that cannot be provided locally;
- The service cannot be provided economically locally;
- An emergency placement is required and the need cannot be met locally. (In these cases there should be a plan to provide an alternative placement within East Dunbartonshire as soon as is reasonably practical);
- There is an assessed need for the individual to move from the local area because of specific risks to themselves or others as a result of them continuing to live in East Dunbartonshire;

11.3 Where an out of area accommodation placement is arranged because of the lack of available or economic alternatives locally, this will be kept under review and efforts made to transition to a local alternative wherever possible. Any subsequent move back to the East Dunbartonshire area would be subject to service-user (or welfare guardian) agreement. For out-of-area day services, Section 6 of this policy will apply.

11.4 East Dunbartonshire HSCP recognises that individuals may wish to move to other areas and the services that may be available in another area may be part of their decision in relation to this. The HSCP would consider a decision to relocate as a personal decision and would provide assistance, but not necessarily funding, to facilitate this. Normally the local authority in which a person is ordinarily resident is financially responsible for the community care services for that person. Scottish Government guidance provides additional information on the responsibilities for providing and funding care and in these circumstances.

12 SUPPORT WITH EDUCATION AND LEARNING

12.1 Local authorities have responsibility for education provision up until school leaving age. Provision of education beyond school leaving age is the responsibility of further education bodies not funded by East Dunbartonshire HSCP. Access to courses is determined by colleges themselves. Where, due to a disability, additional support is needed for learning within the classroom setting this should be provided by the education establishment. East Dunbartonshire HSCP may still have responsibility for funding personal care (e.g. personal care support at lunchtimes).

12.2 Support will normally only be provided to attend colleges local to the area. Individuals or families choosing not to attend a local college would be required to meet additional support and travel costs themselves. In the case of higher (university) education it is accepted that there may be a need move away from the local area to access specific courses. Any such requests will be considered on a case by case basis, subject to eligibility and resource allocation criteria.

13 PREVENTION AND INDEPENDENT LIVING SKILLS DEVELOPMENT

13.1 It is recognised that individuals with disabilities will require support with informal learning and development of independent living skills throughout their lives. Furthermore, the provision of preventative support or support to build an individual's resilience and independence can result in reduced risk and significantly improved quality of life. This can also reduce dependency on (and expenditure by) statutory service providers in the longer term. However, if this type of support is not dynamic, progressive and regularly reviewed, it can lose its connection to personal outcomes and become ineffective. Often this type of support is most effective over well-defined periods of planned enablement activity.

13.2 Preventative work and independent living skills development must therefore be relevant, specific, effective and regularly reviewed. To be funded, any such support will be associated with the mitigation of critical or substantial risk, it must be clearly reflected in the customer's outcome-focused support plan; it must be regularly reviewed, progressed and demonstrate positive benefit.

13.3 The provisions of the Eligibility Criteria state that where eligibility is determined to fall into the Moderate category, the response of social work services will be to provide the individual with advice/information and/or to signpost towards direct access to community resources. Exceptions can be made where the absence of statutory social work involvement will lead to an aggravation of the individual's needs resulting in greater expense to the local authority on a later occasion. In these circumstances a short term intervention focussed on rehabilitation and enablement can be offered.

14 COST LIMITATIONS AND CEILINGS

14.1 Consideration as to whether any cost limitations (or ceilings) may apply to an individual's support package (or equivalent personal budget) will take place after the assessment, application of eligibility criteria and support planning processes have been completed. This ensures that individuals, where they are able and choose to do so, can augment any cost limitations with informal supports and other personal resources.

14.2 References to cost ceilings are included at the relevant places within this document. The information in this section relates to more general policy provisions.

14.3 The HSCP normally operates a cost threshold for community-based support for people who develop frailty and deterioration to their health (whether due to age or other reason) that require increasing reliance on high levels of support. This would include people whose needs are volatile and fluctuate and are at risk of frequent hospital admission. This cost threshold is normally equivalent 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.

14.4 Individuals with a pre-existing diagnosed learning or multiple disability who develop such frailty and deterioration to their health (whether due to age or other reason), and where care costs associated with supporting these specific care needs exceed the approved rate for residential/nursing care (net), this will normally act as the cost

ceiling in these circumstances. This would generally not apply to palliative care or the additional costs of 2:1 (or greater) support. Other support and environment-related factors will also be taken into account to ensure the wellbeing of the individual and others concerned.

14.5 Cost limitations and ceilings should be applied consistently, to ensure fairness and equity. Discretion to depart from these would apply in exceptional circumstances only and would apply on a case-by-case basis only.

14.6 It should be noted that contract standing orders state that any support service costing more than £15,000 per annum has to be approved by Council Committee on behalf of the HSCP and the requirement to tender the contract has to be considered.

Supports to be included:

14.7 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:

14.8 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;
- A limited Community Alarm service;
- Services provided by other statutory services that are non-social care related.

Funding sources to be excluded:

14.9 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.

14.10 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.

14.11 The cost of carers' services should also 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.

15 CONTRIBUTIONS BY CUSTOMERS

15.1 Where a contribution is made by the customer for a support service in the community, 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.

15.2 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.

16 CHOICE AND RISK

16.1 It is recognised that most people will wish to remain at home. The HSCP encourages the creative and innovative use of eligible funding, personalised to the customer's individual circumstances and lifestyle.

16.2 As well as considering the use of paid supports the practitioner, customer and their carer/family should also consider other assets as ways of meeting the customer's assessed needs and helping them to achieve their identified outcomes:

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

16.3 However, any choice by the individual (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 eligible statutory support that can be provided. The Partnership retains a duty of care and is required to take into consideration any risks it identifies 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 such 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 C – FURTHER DETAIL AND PROCEDURAL PROCESSES

17 ASSESSMENT OF NEED AND ELIGIBILITY FOR COMMUNITY CARE SERVICES

17.1 East Dunbartonshire HSCP takes an outcomes-based approach to assessment, support planning and review. An outcomes-based approach focuses on delivering improved results (outcomes) for people with assessed needs. Traditionally, support was service-led, with formal structured services seen in isolation as being the most effective way to support people. Now the view nationally and locally is that results are more successful if they are outcomes-led. This involves everyone working together to achieve the best possible impact on the individual's life. The philosophy of this approach is one that emphasises the strengths, capacity and resilience of individuals, builds upon informal support systems and includes consideration of wider community based resources.

17.2 An outcomes-based approach will assess needs and identify a range of associated outcomes for an individual, not all of which will meet eligibility criteria for statutory funding. The eligibility criteria in East Dunbartonshire are based on reducing substantial or critical risks. The needs (and associated outcomes) that can be met through reducing these risks to a moderate level can be allocated funding for support. Assessment may also identify other outcomes that are important for the individual, but would not specifically be associated with the reduction of substantial or critical risks, so would not attract statutory funding. However, these should be used to inform and shape how eligible support is best provided and can help to indicate where informal and community support may contribute to improved quality of life.

17.3 There are five main categories of community care support that the HSCP will, where eligibility criteria are met, provide resource to meet risk mitigation outcomes. These categories of community care support are set out below, with reference to the risk types that they are designed to mitigate:

Community Care Support	Risk Mitigation (from Eligibility Criteria)
• Support to be safe during the day • Support to be safe during the night	• Risks relating to neglect or physical or mental health
• Personal Care • Housing Support	• Risks relating to personal care/domestic routines/home environment
• Support to engage in meaningful activity to participate in community life	• Risks relating to participation in community life

17.4 Eligibility Criteria for carer support are also part of the HSCP's policy framework. The risk categories for carers are:

- Health and wellbeing
- Relationships
- Living environment
- Finance
- Access to breaks / life balance
- Future planning

17.5 Eligibility for carer support operates in a similar way to that for individuals requiring direct support. Carers outcomes set out in an Adult Carer's Support Plan that can be met through reducing these risks to a moderate level can be allocated funding for support. For young carers, the outcomes in the Young Carer's Statement eligible for support should be to reduce risks to a low level.

18 TYPES AND LEVELS OF SUPPORT

18.1 In line with the HSCP's Eligibility Criteria, the purpose of providing support to an individual is primarily to reduce risk to an acceptable, moderate level. Finite resources mean that the local authority may not be able to provide the level of support an individual or their family may wish. There is an inherent risk in all aspects of daily life and therefore it is not always possible (or indeed appropriate), to completely reduce or eliminate risk in every situation.

18.2 Community care support can be divided into two main types:

(i) **Task Based Support**: this type of support is focused on assisting people to undertake particular tasks, such as:

- Personal care
- Housing support
- Therapeutic interventions
- Enabling, re-enabling and skills development
- Support to engage in meaningful activity

(ii) **Support to stay safe and well**: this type of support is principally concerned with mitigating risk to the individual, or others, that would arise if an individual was left on their own (for example, risks relating to neglect or physical or mental health.

18.3 Community care is often a combination of these main types, as separating them in practical terms could often be artificial and duplicative. However, it is important to be clear about the main purpose of the support, as this can affect how it is delivered.

18.4 Task based support (such as support with personal care) may require dedicated 1:1 staff deployment during its provision, whereas at other times support needs might be less intensive or supervisory in nature, so can be delivered via shared support. This would occur where one or more members of staff provide support to more than one service-user. This can include the provision of 1:1 (or more) support when required, but not on a dedicated basis at all times. East Dunbartonshire HSCP will aim to maximise the use of shared support to ensure we can deploy available resources for people with eligible need for services, on a fair and equitable basis. We will therefore use shared support equally when calculating a relevant rate to apply budget equivalence for Self Directed Support.

18.5 There is a general principle that all eligible support to reduce risks to a moderate level must also have a secondary objective to contribute to outcomes relating to the promotion of wellbeing, social development and independent living. This principle is extended to a duty for people with a mental disorder as defined in the Mental Health (Care & Treatment) (Scotland) Act 2003. In the 2003 Act "mental disorder" means any mental illness, personality disorder, or learning disability, however caused or manifested. Eligible support should also be designed to maximise the potential for individuals to develop the skills and confidence to safely manage with less support over time. Capacity for enablement (or reablement) will vary from person to person, but should always be promoted as an ongoing desired outcome of the support provided.

18.6 For clarity, there are a number of ways that support can be provided:

- **Community activities**: support that is available through clubs and activities in the community;
- **Universal resources**: support that is available to all citizens. This would include services such as health and education, as well as some more specific services that individuals can refer themselves to;
- **Informal support**: support provided by family, friends and neighbours. This can range from very intensive to occasional, depending on needs and circumstances;
- **Voluntary sector support** (broad range of support delivered by national and local voluntary organisations and charitable bodies, including lunch-clubs, advice, advocacy and befriending)
- **Assistive technology**: Assistive technology is any product or service designed to enable independence for disabled and older people. It includes telehealthcare services which are health and social care services that can operate at a distance using a range of digital and mobile technologies. East Dunbartonshire HSCP will aim to maximise the appropriate use of assistive technologies. Deployed thoughtfully and appropriately as part of service redesign, assistive technology can:
  - support people to have greater choice, control and confidence in their care and wellbeing;
  - enable safer, effective and more personalised care and deliver better outcomes for the people who use our health, housing, care and support services;
  - help generate efficiencies and add value through more flexible use of our workforce capacity and skill mix and by reducing wasteful processes, travel and minimising access delays.
- **Shared support**: support (including intensive support), where dedicated 1:1 (or more) support is not needed at all times. Shared support is when one or more members of staff provide support to more than one service-user.
- **Dedicated 1:1 support** (or more, e.g. 2:1, 3:1): support where an individual's needs are such that they need dedicated support on a one-to-one basis. Indeed, with certain moving and handling or bariatric care, 2:1 or even 3:1 may be assessed as being needed to undertake these specific tasks. However, this type of dedicated support is generally for *task-based support*, rather than *support to stay safe and well*, and would usually be part of a package of both 1:1 and shared support for the individual.

  Exceptionally, dedicated 1:1 (or more) support may be needed at all times for certain profound and multiple disabilities and/or with complex challenging behaviour. Assessments and support plans that call for continuous 1:1 (or more) support will be subject to specialist, multi-disciplinary and Head of Service oversights and approval.

18.7 Formal services should be seen as only one component of a co-produced, community asset-based approach to community care. Maximising community, universal and informal supports and assistive technology is essential to building and sustaining independent living. The HSCP will work with service-users, families and communities in partnership to achieve this.

APPENDIX 1

Non-Community-based Supported Living Options

1 RESIDENTIAL CARE

1.1 A residential care placement may be considered when a combination of the following applies:

- 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.

1.2 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.

2 NURSING HOME CARE

2.1 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.

3 CONTINUING INPATIENT HEALTH CARE

3.1 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.

3.2 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.

3.3 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.

3.4 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))

3.5 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.

3.6 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).