Agenda No

AGENDA MANAGEMENT SHEET

Name of Committee	**Adult & Community Services Overview & Scrutiny Committee**
Date of Committee	**17 May 2006**
Report Title	**Fair Access to Care Services (FACS) – Using the Criteria - Well-Being Threshold**
Summary	The paper builds on the report and discussion at the last meeting of the Committee. It seeks to outline how fair access criteria work, supply some examples of need falling into the different "risk" categories and indicates how the new "well-being" approach can make a real contribution to independence, well being and choice.
For further information please contact:	Graeme Betts Strategic Director of Adult Health & Community Services Tel: 01926 412198 Michael Hake Interim Head of Service Tel: 01926-412198
Would the recommendation decision be contrary to the Budget and Policy Framework? [please identify relevant plan/budget provision]	No
Background papers	Local Authority Circular (LAC) 2002 13. Reports to Cabinet: 13 March 2003, 20 November 2003 and 24 June 2004, 8 December 2005, 12 February 2006. Scrutiny Reports: 11 October 2005, and 5 April 2006. "All Our Tomorrows: Inverting the Triangle of Care" was published by the ADSS and Local Government Association, October 2003. "Independence, Well-being and Choice" - Department of Health, 2005. "Our health, Our care, Our say" – Department of Health 2006. "A Sure Start to Later Life" – ODPM, 2006-04-21 "A new ambition for old age" - Department of Health, 2006.

CONSULTATION ALREADY UNDERTAKEN:- Details to be specified

Other Committees	☐	
Local Member(s)	☐	
Other Elected Members	☐	
Cabinet Member	☒	Cllr Colin Hayfield, Adult and Community Services
Chief Executive	☐	
Legal	☒	Alison Hallworth, Senior Solicitor
Finance	☒	David Clarke, Strategic Director of Resources
Other Chief Officers	☐	
District Councils	☐	
Health Authority	☐	
Police	☐	
Other Bodies/Individuals	☒	Philip Lumley Holmes

FINAL DECISION No

SUGGESTED NEXT STEPS: Details to be specified

Further consideration by this Committee	☒	
To Council	☐	
To Cabinet	☐	
To an O & S Committee	☐	
To an Area Committee	☐	
Further Consultation	☐	

Agenda No

Adult & Community Services Overview & Scrutiny Committee – 17 May 2006

Fair Access To Care Services (FACS) – using the criteria and the "Well-being" Threshold

Report of the Strategic Director Adult, Health & Community Services

Recommendations

That the Committee consider this report and to:

1. Note the general arrangements for use and interpretation of "Fair Access"; and,
2. Note the preparation for project managing the introduction of the new "well being" threshold; and,
3. Determine how it may wish to monitor the longer-term development and implementation of new arrangements for low intensity support.

1. Introduction

1.1 Fair Access to Care Services (FACS) was introduced in April 2003. The framework sets four bands of eligibility: Critical (High), Substantial, Moderate and Low. The eligibility threshold in Warwickshire was set between the Substantial and Moderate bands.

1.2 The most recent Council performance assessment, previously reported to the Committee, confirmed the need for a new approach that will:

- ✓ enhance the ability to deliver a broader welfare and well-being agenda locally within the resources available; and,
- ✓ use the synergy offered by the structure of the Adult, Health and Community Services directorate; and,
- ✓ receive recognition within the social care performance assessment framework on the relevant indicators.

1.3 The Council's FACS eligibility criteria are set out in the matrix in **Appendix One**. They are fully consistent with the guidance of the Department of Health framework and the wording to be used to ensure national consistency in definitions. In February 2006 a new County approach to Fair Access criteria was agreed. This enables the Council to embrace both the "welfare" and "well-being" dimensions of Fair Access.

1.4 The different bandings reflect the extent and urgency of individual needs.

The top two bands include higher risk factors which are not present in the lower two bands including health and other life threatening conditions (Critical band only), choice/control over environment and abuse. The Moderate and Low bands are focussed on personal care, support systems and involvement in work/education, and social roles and responsibilities. As such, they link closely to the concept of “well-being”.

1.5 From 1 June 2006, the Council will be using a single approach to Fair Access with two inter-related elements. They are:

- ✓ High Intensity Response [Social Care] Threshold
- ✓ Low Intensity Response [Well Being] Threshold

1.6 The application of the eligibility criteria will continue to be based around an assessment of the risk to the person’s independence and well being posed by their needs. The response arrangements will reflect the level of need and risk identified and consideration of how best they might be met within available resources; including, those of the individual [e.g., support networks].

1.7 The threshold for High Intensity Services has not been changed. Access to high intensity social care services will continue to prioritise people with critical and substantial social care needs. People not meeting the high intensity response requirements would, in future, be eligible to be assessed for low intensity support under the new “well being” threshold. For people to qualify for low intensity support, a simple screening/assessment will need to identify that:

- ✓ Their needs for support to remain independent are likely to continue or to become greater within the foreseeable future; and/or,
- ✓ Without support of some kind there would be an increased risk for high intensity community care services which the provision of support would ameliorate; and/or,
- ✓ The needs identified risk generating unsustainable pressure on principal carers and any weakening or breakdown in such support could result in a requirement for high intensity services.

2. What the Criteria Mean

[a] Simple information for the public, service users and carers

2.1 The use of fairly technical language within the national framework means that understanding “what the criteria mean” in practice is not always easy. **Appendix Two** sets out an easy to follow guide for the public, users and carers in terms of the high intensity support threshold already in place. New information will be produced covering arrangements for low intensity support. Involvement of organisations concerned with the welfare and well being of older people will be pursued as an important means of promoting understanding and take up.

[b] Consistency in Using the Criteria

2.2 **Appendix Three** sets out guidance notes currently in place for staff. These describe the needs that would fall within the four main categories of Critical, Substantial, Moderate and Low. To help ensure understanding and consistency in use of the criteria practical examples are used for staff training purposes. These are used to show how the criteria apply to the dimensions of risk, safety, independence, choice, daily living, carer and family/ support networks that are used. They will be updated as necessary to allow for low intensity support provision.

2.3 **Appendix Four** gives some practical examples of the criteria in action. The initial outlines describe "Low and Moderate" situations. Currently, none of these would qualify for social care help as only "Critical and Substantial" risks are responded to. They would, however, meet the new low intensity support criteria. Possible responses within that framework are given. This has been done as a means of showing how the new arrangements might work and be of benefit to people. These, or similar examples, will be used within the training and briefing to underpin the roll out of the new arrangements.

2.4 **Appendix Four** also gives examples from the "Substantial and Critical" risk categories where intensive social care assistance would be available both now and in the future. This has been done to enable the " Low and Moderate" assessments to be clearly positioned in relation to qualification for high intensity support. The aim is to help people see how the needs and risks differ and why high intensity responses include the actions they do.

3. Implementing that "Bit of Help"

3.1 The new "well-being" threshold applies to the "Moderate and Low" categories of need as set out in the Fair Access criteria. The new criteria will involve a different way of working and embrace the contact principle of "no wrong front doors". This will be important in terms of responding to people asking for information and/or assistance and in helping them find the help they seek.

3.2 Implementation will involve a strong emphasis on an integrated Council response and on partnership working with District Councils, Supporting People and Voluntary Organisations. Promotion of well being involves:

- focussing on aspects of daily living that are of a less immediate risk to independence; and,
- using lower level interventions that can both enhance quality of life and ameliorate risks to independence; and,
- brokering assistance through others where appropriate; and,
- creating an ongoing contact point to make it easier to get in touch should needs increase; and,
- ensuring availability of ongoing advice, monitoring and review; and,
- establishing an ongoing basis for securing views on services and needs through periodic survey work and structured discussions organised through adult social care.

3.3. Implementation work is now at the formative stage. A small project team has been established to prepare the way. The aim is to have the new service ready for launch by the end of June. The intention is that by the end of the year we will be providing a “bit of help” to an additional 1,500 people. The target, subject to available resources and progress, is to have some 2,000-2,500 extra people getting “a bit of help” by the end of 2007. Experience elsewhere suggests that it takes 18 months to two years for this type of approach to get embedded and to start to deliver the benefits that are expected. [See: 3.6]

3.4 As with any new venture there are risks. They include the normal issues around recruitment, engagement, funding and understanding by partner agencies. For low intensity support, the needs assessment, planning and review mechanisms can be much simpler. As part of this, we need to ensure that staff and partners both understand the new approach and are suitably trained to ensure consistency. Data collection and input onto Care First will be needed and consistency of treatment of information secured

3.5 A number of work-streams are being put in place of which the following are the most important:

- Linking with and commissioning through sheltered housing providers and brokerage support.
- Briefing Older Peoples Forums and informing development
- Commissioning services through community and voluntary bodies
- Linking to assistive technology and Supporting People initiatives
- Recruitment and accommodation for staff
- Staff briefings, training
- Documentation, data input and information services
- Feedback and review

3.6 The risks of the new approach are, of course, counterbalanced by significant opportunities and benefits to older people across the County. Warwickshire can be shown as responding positively to the White Paper requirements by addressing older people’s personal support requirements that will enable them to remain well and independent for longer in their own homes. Some of the perceived benefits include:

- The ability to sustain and improve an individual’s (and their carer’s) level of self-efficacy by such interventions supports people to remain independent. This will be particularly important for example in the management of long term conditions.

- Active engagement and review mechanisms will enable the older person to convey and what impact low intensity provision can have on their overall well-being. Quality of life indicators will be implemented as part of the developments to enhance the standard performance targets set by the Department of Health. Future developments can then respond to client feedback, and invest appropriately in future provision.

- Local service developments will be agreed and developed with partners to record valuable information through a joint process. The evidence base of people we serve will therefore increase but in conjunction with our partners.

- By working towards agreements on how lower intensity services can be met jointly there is significant potential for efficiency gains in the use of resources, that in turn should stimulate new ways of working and older people experience better integrated service delivery from agencies.

- The Voluntary and Community sector are integral to the developments. Existing contracts with the sector have the potential to be targeted at specific development efforts at no additional cost.

4. Resource Management

4.1 The introduction of these arrangements is being resourced by five principal means:

- ✓ Co-ordination of existing resources into the new low intensity support package.
- ✓ Government grant funding for the development of assistive technology services.
- ✓ Linking into Supporting People funding for “floating support” and practical help.
- ✓ “Pump-priming” investment from within the approved budget for Adults, Health and Community Services for 2006/07.
- ✓ Investment by partner agencies in direct services agreed to be included within the “pick & mix” approach.

4.2 Delivering a “bit of help” requires a more innovative and integrated approach to help and a style activity that links across different dimensions of quality of life. Predicting demand and supply in these circumstances is not easy and must be done within current funding streams and the additional resources allocated by the council. This is a key aspect of the risk management arrangements for the project.

4.2 Care must also be taken to ensure that conditions attaching to Government grant mechanisms associated with assistive technology and Supporting People continue to be met for work linked to low intensity support. Appropriate contracting mechanisms will be used for shared resource arrangements with providers of sheltered housing provision and related support services.

4.3 Mapping of current resourcing of support services through voluntary organisations is being undertaken. This will be followed by further discussion on focussing activity and outcomes for people more clearly in support of well being and inclusion requirements within the adult social care performance framework.

4.4 The provisional allocation and proposed utilisation of the £0.5M “pump priming” resources approved by the Council is set out below. There is a mix of recurrent and non-recurrent allocations. The intention is that the setting up costs should be translated into ongoing service support in 2007/08.

4.5 **Table One: That “Bit of Help” Pump Priming Resources**

Description of area of activity	Type of Spend	Provisional Allocation £
Service development and setting up costs	Non recurrent	50
Staffing [including recruitment] Costs	Recurrent	75 [1]
Staff/Partner training and briefing	50% recurrent	25
Accommodation/IT for screening, support & review team	Recurrent	50
Contributions to provider assessment/review costs; commissioning of new “bit of help” services such as Brokerage and Information services, & linking to Long Term Care Charter.	Recurrent	300
Total Pump Priming Resources		500

[Note: 1. Part year effect. Full year effect to be met by re-use of setting up costs]

5. Feedback and Review

5.1 Ongoing review and feedback are integral elements of the new approach. Delivery of this project will also be able to be monitored through the social care performance assessment framework [PAF]. Indicator C32, older people helped to live at home, will be one of the principal means by which progress in delivery will be able to be measured.

5.2 Ensuring continuing relevance and being clear about whether or not the service is promoting independence, well-being and choice will be essential. The intention is to link this to a generally strengthened framework for securing user and care feedback and engagement. View of users of “a bit of help” will be sought on a regular basis consistent with the principle of older people having a real say in what we do.

5.3 The longer-term benefit of this approach is the potential to improve the quality of life of older people. It is about a new ambition for well being in later life. It seeks to respond to the challenge of an ageing population so that involvement, independence, choice, dignity and healthy ageing are pursued through joined up action designed to add life to years as well as years to life.

GRAEME BETTS
Strategic Director of Adult, Health & Community Services
Shire Hall, Warwick
April 2006

APPENDIX ONE: Adult Services Eligibility Criteria Framework

Assessment of risk is based on maintaining an individual's independence over time. A person is only eligible for services where needs are identified above the threshold, that is critical or substantial, and they need help to meet those needs. This eligibility criteria framework also applies to carers.

Key Factors Central to an Individual's Independence	**Critical Risk** to Independence	**Substantial Risk** to Independence		**Moderate Risk** to Independence	**Low Risk** to Independence
Health & Safety including freedom from harm, abuse and neglect.	Life is, or will be threatened; and/or significant health problems have developed or will develop; and/or serious abuse or neglect has occurred or will occur.	Abuse or neglect has occurred or will occur.	***THRESHOLD OF ELIGIBILITY FOR INTENSIVE SOCIAL CARE HELP***	***CRITERIA FOR LOW*** ↓	***INTENSITY HELP*** ↓
Autonomy and freedom to make choices.	There is, or will be, little or no choice and control over vital aspects of the immediate environment.	There is, or will be, only partial choice and control over the immediate environment.			
Ability to manage personal and other daily routines	There is, or will be, an inability to carry out vital personal care or domestic routines.	There is, or will be, an inability to carry out the majority of personal care or domestic routines.		There is, or will be, an inability to carry out several personal care or domestic routines.	There is, or will be, an inability to carry out one or two personal care or domestic routines.
Involvement in family and wider community life including paid and unpaid work, learning, volunteering, leisure and hobbies.	Vital involvement in work, education or learning cannot or will not be sustained. -------------------------------------- Vital social support systems and relationships cannot or will not be sustained. -------------------------------------- Vital family and other social roles and responsibilities cannot or will not be undertaken.	Involvement in many aspects of work, education or learning cannot or will not be sustained. -------------------------------- The majority of social support systems and relationships cannot or will not be sustained. -------------------------------- The majority of family and other social roles & responsibilities cannot or will not be undertaken.		Involvement in several aspects of work, education or learning cannot or will not be sustained. ---------------------------------- Several social support systems and relationships cannot or will not be sustained. ---------------------------------- Several family and other social roles & responsibilities cannot or will not be undertaken.	Involvement in one or two aspects of work, education or learning cannot or will not be sustained. ------------------------ One or two social support systems and relationships cannot or will not be sustained. ---------------------------- One or two family and other social roles & responsibilities cannot or will not be undertaken.

APPENDIX TWO

EXTRACT SOCIAL CARE INFORMATION LEAFLET

What does eligibility for Social Services mean?

Here are some examples.

We would arrange support:

- if you can't get out of your bed or chair or move around without help
- if you find it difficult to look after yourself because you can't prepare meals and drinks
- or wash yourself properly and need help to manage these essential tasks.
- if you are at substantial risk because your main carers relatives, friends or neighbours who provide a lot of help, cannot continue to provide help without support
- for carers who are putting their own health and welfare at risk because of their caring tasks.
- if you are at risk because you are suffering from severe dementia or depression
- if you have been subjected to physical, sexual, psychological or financial abuse, or if there are good reasons to suspect you might be at risk of this happening.

If you have, or are within easy reach of, willing and able support networks (such as relatives, friends or neighbours) or can make arrangements with voluntary organisations, we do not regard you as being at risk.

We give information about other ways of getting help if you do not qualify for Social Services Support .

We don't arrange or fund support if there is little risk to your health and welfare.

We would not normally provide support for:

- cleaning (other than hygienic cleaning)
- shopping
- collecting pensions
- collecting prescriptions
- ironing or other household tasks
- bathing if you can manage a shower or strip wash.

APPENDIX THREE

FAIR ACCESS TO CARE - ELIGIBILITY CRITERIA EXPLAINED

Level of Risk	Dept of Health Definition	What this means	Needs
CRITICAL **The risk of major harm/danger to a person or major risks to independence now or in the foreseeable future (typically within two weeks)**	• Life is or will be threatened and/or • Significant health problems have developed or will develop and/or • There is, or will be, an inability to carry out vital personal care or domestic routines and/or • There is little or no choice and control over vital aspects of the immediate environment and/or • Serious abuse or neglect has occurred or will occur and/or • Vital social support systems and relationships cannot or will not be sustained and/or • Vital involvement in work, education or learning cannot or will not be sustained and/or • Vital family and other social roles and responsibilities cannot be undertaken	Either now or in the foreseeable future (typically within two weeks) a person needs social care support and any one of the following applies: • physically or mentally unable to care for themselves and/or • unable to remain in, or return to, their own home without severe and immediate risk and/or • unable to carry out essential life tasks and/or • unable to maintain safety and security in their own home to avoid severe risk to self or others; • unable to choose or control the way essential life tasks are met; • there is acute mental breakdown or deterioration in enduring mental illness leading to severe and immediate risk to self or others and/or • abuse or neglect which is potentially life-threatening and/or • carer support network is non-existent or has broken down with the result that essential life tasks cannot be met and/or • person is unable to access vital work, education or learning activities and this poses a severe and immediate risk to their ability to live in the community and/or • person is unable to fulfil vital family roles, and this poses a severe and immediate risk to their ability to live in the community	Examples of essential life tasks: Person is unable to: • use toilet; • prepare meals and drinks; • eat and drink; • manage own medication; • get in/out of bed/chair; • maintain personal hygiene; • access essential facilities in own home Other needs: Person is unable to: • communicate needs; • protect self from others; • prevent severe risk of self neglect; • take bath/shower to prevent risk of actual harm or predictable severe deterioration in skin or health; *(see below) • attend vital education, work, learning opportunities; • provide vital level of parenting or carer tasks; • retain accommodation *medical conditions include: ➢ long-term severe urine and/or bowel incontinence ➢ permanent stoma ➢ continuous peritoneal dialysis ➢ long-term pressure ulcers ➢ skin conditions (psoriasis, severe eczema) ➢ epilepsy (potential risk of frequent fits) ➢ exceptions – palliative care

Level of Risk	Dept of Health Definition	What this means	Needs
SUBSTANTIAL **The risk of significant impairment to the health and well being of a person or significant risk to independence now or in the foreseeable future (typically within six weeks)**	• There is, or will be, only partial choice and control over the immediate environment and/or • There is, or will be, an inability to carry out the majority of personal care or domestic routines and/or • The majority of social support systems and relationships cannot or will not be sustained and/or • Abuse or neglect has occurred or will occur and/or • The majority of family and other social roles and responsibilities cannot or will not be undertaken and/or • Involvement in many aspects of work, education or learning cannot, or will not, be sustained	• Person has great difficulty physically or mentally in caring for themselves and/or • Person has great difficulty in carrying out essential life tasks and/or • Person has great difficulty remaining in, or returning to, their own home without significant risk and/or • Person has acute mental breakdown or deterioration in enduring mental illness leading to significant risk and/or • Carer support network is non-existent or has broken down with the result that many essential life tasks cannot be met and/or • Abuse or neglect has, or is likely to occur and/or • Person has great difficulty fulfilling many family roles and this poses significant risk and/or • Person has great difficulty accessing many aspects of work/education/learning activities and this poses significant risk.	Examples of essential life tasks: Person has great difficulty to: • use toilet; • prepare meals and drinks; • eat and drink; • manage own medication; • get in/out of bed; • maintain personal hygiene; • access essential facilities in own home. Other needs: Person has great difficulty to: • communicate needs; • protect self from others; • prevent severe risk of self neglect; • take bath/shower to prevent risk of actual harm or predictable severe deterioration in skin or health; • attend vital education, work, learning opportunities; • provide vital level of parenting or carer tasks; • retain accommodation.

THRESHOLD FOR HIGH INTENSITY SOCIAL CARE HELP

Level of Risk	Dept of Health Definition	What this means	Needs
MODERATE **The risk of some impairment to the health and well being of a person or some risk to independence now or in the foreseeable future (typically within six months)**	• There is, or will be, an inability to carry out several personal or domestic routines and/or • Several social support systems and relationships cannot or will not be sustained and/or • Involvement in several aspects of work, education or learning cannot or will not be sustained and/or • Several family and other social roles and responsibilities cannot or will not be undertaken	• Person is able to maintain essential life tasks, but has difficulties with other daily living tasks and domestic routines and/or • Person's family/friends can meet some but not all the necessary daily living needs and/or • Person has difficulties accessing some aspects of work/education/learning activities but this does not pose a significant risk • Person has difficulties in fulfilling some family roles but this does not pose a significant risk.	Able to maintain essential life tasks, though possibly only with time/effort, but difficulties with other daily living tasks and domestic routines e.g. • Housework • Laundry • Shopping • Bathing • Gardening etc • Social contact
LOW **Promoting a person's quality of life or low risk to independence (typically within 12 months)**	• There is, or will be, an inability to carry out one or two personal care or domestic routines; and/or • Involvement in one or two aspects of work, education or learning cannot or will not be sustained; and/or • One or two social support systems and relationships cannot or will not be sustained; and/or • One or two family and other social roles and responsibilities cannot or will not be undertaken	• Person can manage most daily living tasks but needs some assistance • Person experiences some social isolation • Person has some limitations in their involvement in family or caring roles • Person's quality of life would be improved by some involvement in Work/education/learning	Independent with essential life tasks, but may need some assistance with other daily living tasks and domestic routines e.g. • Housework • Laundry • Shopping • Bathing • Gardening etc • Social contact

APPENDIX 4

FAIR ACCESS TO CARE – SOME EXAMPLES OF THE "FAIR ACCESS"CRITERIA IN ACTION

1. LOW RISK – LOW INTENSITY SUPPORT

1.1 Outline

Glenys is 74 and worked at a local milliners until it closed some 10 years ago. Her partner John "went over" some six months ago. She still feels lost and John's pension ended when he died. The house seems very empty and she does not drive. She likes to keep busy and shops twice a week for herself and her neighbour who is 90 and cannot get about. She doesn't find the buses easy. Glenys does not like accepting lifts as she cannot offer in return. John was also so practical around the house and garden. Glenys worries about things going wrong. They had three children but all live outside the County and Glenys tries not to be a burden. She goes to Bingo with her friend Vera each week but does not like coming back to an empty house in the dark. She keeps thinking about what if she became ill in the night: the phone is downstairs. Telephoned enquiring about help for widows.

1.2 Low Intensity response

Glenys presents with LOW needs and would not qualify for high intensity support. There may be issues, however, about confidence following an enormous change. A simple assessment may identify need for advice on benefits. Another phone or a call alarm with some telephone monitoring calls might help. Simple adjustments to lighting and a smoke alarm may reduce anxiety. Advice on reliable traders may be helpful. Glenys is also a potential resource [carer, helper, volunteer visitor or charity shop] and might respond positively to the recognition involved in "being needed".

2. LOW RISK – LOW INTENSITY SUPPORT

2.1 Outline

Jeff and Mary are both 73. They have enjoyed life and the freedom of retirement together. They run the local "painting in retirement group" at their local chapel and are real regulars at the library. Jeff was recently diagnosed with Parkinson's. It all came as a shock to Mary: she thought it was just rheumatism. The medication now helps. The doctor was very kind but did Jeff tell him how he struggles to turn in bed sometimes and how slow he can be in the morning? Only Jeff drives now. Whilst Mary is very practical and has always settled all the bills, she's worried about what to do if Jeff can no longer drive or whether he should drive at all. And what about the holiday in November? Jeff tells her not to worry but she does. Referral from daughter who lives in London and who has sent an e-mail asking someone to check they're ok and feels they need support. Mother emotional on the telephone on Sunday.

2.2 Low intensity response

Current risks would be assessed as LOW. Parkinson's is a degenerative condition and this couple face a number of uncertainties about the future and their lifestyle. They may well have strong social networks that can be drawn upon. There is a real need for information and advice about Parkinson's Disease. Linking to a support group may help. A benefits check may alert to attendance allowance. The risk for Mary is also that the caring role may take over her life if her partner continues to deteriorate. Link with carer organisation and possibly consider carer's assessment. Having an established contact point may be all they need for now.

3. MODERATE RISK - LOW INTENSITY SUPPORT

3.1 Outline

Enid is 89 and lives on her own. Until a minor stroke some three months ago she was reasonably self-caring although with increasing mobility problems. Has odd " dizzy" spells. She is a rather hard of hearing. Relies on others for transport once a week to get pension and shopping. Her son, who is 70 and lives 15 miles away, has had the bed brought downstairs to reduce the risk of a further fall on the stairs. His mother has made a good recovery but he worries about the risk of falls and his mother's tendency to "drop off" since the stroke. He feels she is starting to let things go. There is often out of date food in the fridge. She has microwave but does not use; preferring to use the gas cooker instead. Says she cooks as before but son is not sure. There is a downstairs toilet but no bathroom. Her immediate neighbours have both changed recently and are now young working couples with children. Enid says she would like to get out more - hates being "stuck inside". Determined to cope and to live independently. Thinks her son makes a fuss.

Referral received from son. Parallel referral, also, from practice nurse, who is treating a leg ulcer, following a visit when son was present. She feels Enid is vulnerable and may paint an unrealistic picture about what she can and cannot do since her stroke. Bathing an issue. No reported "dizzy" spells in recent weeks.

3.2 Low intensity response

Enid has LOW/MODERATE needs and would not qualify for high intensity support. Her situation presents some risk to her independence. Low intensity responses could include: equipment for independence, possible further rehabilitation, a call alarm, smoke alarm, environmental hearing check, benefits check, voluntary day centre, stroke club, practical help around the house and in the garden. Possible carer assessment for son. Maintaining contact and telephone review would facilitate monitoring and confidence and track progress or decline. Practice nurse visits can be used as a dimension of monitoring.

4. LOW /MODERATE RISK - LOW INTENSITY SUPPORT

4.1 Outline

Doug is 75. His partner, Ivy, died three years ago. He is an ex regular soldier who served overseas and has a large fund of anecdotes. He was for many years a caretaker. Feels he keeps himself and home reasonably “up together” but now finds the house a bit big, difficult to heat, and thinks the wiring may need fixing. Relies on the microwave since the cooker hob broke. His car is on the drive and is untaxed and uninsured. His eyesight is too poor now to drive and reading, his other hobby, is difficult so he has given up his library ticket. His neighbour, who is over 80, is supportive and helps where she can.

He does not have contact with his eldest son. His grandson did come to stay but was unemployed and they fell out. His other son, who is in Australia, telephones regularly and he writes. Until last year he grew all his own veg. but has done less this year: Ivy was the real cook and the big freezer cost a lot to run. Seldom goes out at night since Ivy died and is reluctant to accept lifts now as he cannot give in return. Meets his pals from the factory for a pie and a pint about once a month. Referral made by new GP who has arranged chiropody and made a referral for cataracts. Doug had not been to the surgery for five years prior to this. Thinks he needs a bit of help but warns Doug seems very proud and doesn’t want charity.

4.2 Low Intensity Response

Doug has LOW-MODERATE needs and would not qualify for intensive social care help. He presents as having a low risk to independence but one where there is evidence of increasing risk in the medium term. Low intensity support could include: benefits and home energy advice, possible contact with service association, transport, exploring silver surfers, big print library books, smoke alarm and possible day centre involvement. Potential for sheltered housing scheme if interested. Keeping in touch will be important through monitoring and review.

5. MODERATE RISK - LOW INTENSITY SUPPORT

5.1 Outline

Mrs S. is a widow aged 85years and lives alone. Mrs S. walks mainly unaided but suffers from ‘dizzy spells’ and is prone to losing her balance. Sometimes she uses a walking stick. Following a mastectomy she has no feeling in her upper right arm and down the right side of her upper body. By taking care, Mrs S. is able to transfer independently in/out of bed and to and from the toilet. Mrs S. has had cataract surgery. Mrs S. is independent with her personal care although it takes her quite a bit of time and effort. She prepares and cooks her meals, sitting down as necessary. By pacing herself she makes the bed, changes bed linen and does her own laundry. Mrs S. has no family or local support to provide assistance. She has a sister aged 91, who lives in Worthing and keeps in touch by telephone. Mrs S. is in receipt of Attendance Allowance at the lower rate.

5.2 Low Intensity Support

Mrs S. would be assessed as having a MODERATE need for assistance to do shopping and housework. She would not receive high intensity support services. Some assistive technology may be helpful as might be some equipment to promote independence [e.g. raised toilet seat, helping hand etc..] A call alarm may be helpful and a smoke alarm if not fitted.

THE FOLLOWING EXAMPLES INVOLVE "SUBSTANTIAL" AND "CRITICAL" SITUATIONS QUALIFYING FOR "HIGH INTENSITY" ASSISTANCE

6. SUBSTANTIAL RISK – HIGH INTENSITY SUPPORT

6.1 Outline

Beryl is 75. She is widowed. She keeps "herself to herself" and does not know the neighbours. Beryl has severe arthritis which affects her mobility significantly, is asthmatic and she is finding getting in and out of bed very difficult. Beryl helps with shoes only. A bed is downstairs [son] but Beryl insists on sleeping upstairs as it is nearer the toilet. The stairs are " a trial". There has been a pattern of falls. Daughter in law helps on stairs. An extra something to hold onto would help.

Her daughter in law does shopping and pension. She also does most of the cooking and leaves food for the microwave. She does all laundry and cleaning. She stays around whilst her mother in law has a bath following a" fright" and helps her in and out which Beryl says is not necessary. There is no social services contact. Her daughter in law has a part time job so has to juggle with this and family commitments. She now has to go into hospital for an operation and is desperate about her mother in law who insists she will cope and make do.

Referral made by daughter in law who was in tears. She does not know which way to turn and is only telephoning because the woman at the post office suggested it. Her husband would never forgive her if social services put her mother into a home. She is worried about what he will say when he finds out but something has to be done before she goes into hospital for surgery. She has been told to expect to be off work for a month. Does not feel able to talk again to her GP [who is also mother's and husband's GP].

6.2 High Intensity Response

There is a SUBSTANTIAL risk to independence arising from the disruption to carer support. Imminence of admission needs to be established. Mother in law may be reluctant to accept help and response of son will be important. There is a real need for carer assessment and possible ongoing support. Possible responses: carer assessment for daughter in law, occupational therapy assessment, rails, home care or respite care, smoke alarm, call alarm, meals. Day centre may be an option to reduce isolation.

7. SUSTANTIAL RISK – HIGH INTENSITY SUPPORT

7.1 Outline

Marjorie is 93 and lives alone in a privately owned 1st floor flat. She suffers from arthritis and her main difficulties are around this. Her mobility is poor and she uses a walking frame at all times to get around. She is unable to stand for long periods but is able to transfer independently from her chair, toilet and bed. She has had an assessment by an Occupational Therapist and has an electric bath seat and a frame around the toilet to help with these transfers. Marjorie has had cataracts removed from both eyes which has improved her vision, she has difficulty with hearing and is being assessed for a hearing aid. She needs assistance with washing, dressing and making the bed.

7.2 High Intensity Response

Marjorie was assessed as having a SUBSTANTIAL need as she is unable to carry out the majority of personal care and domestic routines.

Carers call each morning to help with washing and dressing. Carers provide assistance if required with making breakfast and a hot drink. She is able to heat up a ready meal in the microwave for a lunchtime meal. A neighbour calls to assist with tea and Social Service carers return at about 6pm in order to assist with undressing and preparing for bed, Marjorie is then able to get into bed when she chooses. One hour per week is allocated to assist with essential housework and bed changing. Her son visits regularly and provides additional support with shopping and money management when required.

8. SUBSTANTIAL RISK – HIGH INTENSITY RESPONSE

8.1 Outline

Doris is 87. She lives with her dog on the ground floor of her un modernised semi–detached cottage surrounded by an over grown garden. She does not have any central heating and relies on an electric fire and oil-fired radiators supplied by her nephew.
Doris is slightly incontinent and increasingly confused, cannot manage stairs, and walks in a slow, shuffling manner. Personal hygiene is poor and the bath is upstairs. She likes to use rainwater for her complexion. A commode is in use. She has refused a DFG. Doris loves the TV and it is always on. Home carers, who visit twice a day, find her ever cheerful and unworried about her surroundings but feel she is less “with it”. She always says she sleeps like a top. They help her to dress, change damp clothing and get her ready for bed but suspect she sleeps in the chair. They wish the place could be warmer. They are not allowed to use the phone. They suspect meals prepared tend to be given to the dog: it seems to gets bigger as Doris gets smaller. The back door tends to be left ajar for the dog during the day; although carers shut it at night. Sometimes in the morning it is open.

Following severe breathing problems associated with a chest infection two weeks ago, her GP suggested hospital but this was firmly refused. Whilst concerned about possible self-neglect she feels “Doris is sufficiently with it” for now to make decisions about how she lives, but has asked for more support and that something is done about the coldness and security.

Her nephew, who lives in London, visits every six to eight weeks to help with bills and things. He phoned today, angry and upset. He came on Sunday morning and found his aunt in the garden looking for apples [in November] to make an apple and blackberry pie. There was no heat on in the cottage, his aunt was “malodorous” and there were lots of odd calls on the phone bill. Shortly afterwards, the couple next door also came out and spoke to him. They were worried because since his last visit his aunt had woken them three times in the early hours asking for the woman who used to live there but had died five years ago. They took her back to her cottage each time and did their best to settle her. They don’t mind but they are worried for her.

8.2 High Intensity Response

Doris has been identified as having SUBSTANTIAL needs. A High Intensity Response could include a full review of current care package, general functioning, capacity, falls and occupational therapy assessments with possible use of environmental aids to help reduce risks of wandering, cold, etc.. The likelihood of a voluntary move to another setting could be discussed but is likely to be refused. Discussion with the neighbours may generate some support and contact. The key tasks would be risk assessment and management within a framework mindful of Doris’s needs and expectations and possibly failing mental capacity.

9. CRITICAL RISK – HIGH INTENSITY RESPONSE

9.1 Outline

Fred is 80, lives on his own in a single bedroom, first floor flat. He had a history of dizzy turns, had a call alarm and walked with a stick. The stairs to the flat [no lift] were getting very difficult and made worse by the theft of the chair on the half landing. He was a regular at the Legion Club and, according to his daughter who lives about an hour away, had been talking about a move to somewhere more convenient. A month ago his alarm went but he did not respond. He was found collapsed in the kitchen and had had a stroke. A month later he is still in hospital. He has improved but is doubly incontinent, needs assistance with feeding, has speech and some cognitive impairment . He is not able to mobilise or walk independently. Rehabilitation is being tried but the prognosis is not promising.

The question of hospital discharge has arisen. The daughter is requesting a nursing home. She is worried about his rent and who pays as her father managed his own money and now he cannot really be asked to sign anything.

9.2 High Intensity Response

This man faces a CRITICAL risk situation across all four dimensions of the criteria. A High Intensity response for Fred would include a full multi-disciplinary assessment, with possible use of intermediate care. Without significant improvement, care in a setting offering 24 hour care and nursing support looks inevitable. Proximity to daughter may be helpful. Benefits and other advice also needed urgently. Securing his tenancy during this period to keep options open for Fred may be important.

NOTES

Note: These worked examples attempt to illustrate how terms such as “risk” , “ choice” , “social support” and “ability to carry out personal care or domestic” are used within the Fair Access criteria.

Note: MATCHING NEEDS AND SERVICES [Departmental Guidance]

Staff are asked that, before arranging any services directly from social services resources, to check the following have been considered:

1. the person must have assessed needs that fall within the “critical” or “substantial” levels within FACS eligibility criteria; and
2. there is no other person who is able, or willing, to assist; and
3. no alternative to Social Services’ provision is available; and
4. the person is not eligible for relevant support from “Supporting People”.

It is good practice for practitioners to assist people to find solutions to their own difficulties that will maximise their independence without the need for social care services. Practitioners should explore options and seek the minimum level of intervention/provision to meet the user’s needs. For an Occupational Therapist (OT) this would involve looking initially at alternative ways to undertake tasks, or provision of simple equipment, before considering more specialist equipment/adaptations.

Direct Payments should be considered for <u>all</u> service users irrespective of age and/or disability.