



Liverpool City Council

# **GUIDANCE ON ASSESSMENT AND ELIGIBILITY CRITERIA, AND INDICATORS FOR COMMUNITY CARE SERVICE PROVISION**

**If this document is provided to a member of the public, a copy of the complaints procedure and the charging policy should also be included.**

## CONTENTS

<b>INTRODUCTION .....</b>	<b>4</b>
<b>PART 1: ELIGIBILITY .....</b>	<b>7</b>
1. IDENTIFYING ELIGIBLE NEEDS .....	7
2. PROCESS FOR IDENTIFYING ELIGIBLE NEEDS.....	8
STAGE 1. - DECIDING IF A PERSON SHOULD RECEIVE A COMMUNITY CARE ASSESSMENT .....	8
STAGE 2 - DECIDING WHAT THE PERSONS NEEDS ARE WHEN ASSESSED .....	10
STAGE 3 - AGREEING THE PROVISION OF SERVICES TO MEET ELIGIBLE NEEDS .....	11
STAGE 4 - REVIEWING (RE-ASSESSING) A PERSONS NEEDS .....	11
APPENDIX A - ELIGIBILITY CRITERIA FOR SERVICE PROVISION.....	14
<b>PART 2: INDICATORS FOR PROVISION OF SERVICES .....</b>	<b>15</b>
INTRODUCTION.....	15
<b>HOME CARE (GENERIC) .....</b>	<b>16</b>
1. ELIGIBLE NEEDS .....	16
2. GENERAL .....	16
3. CLEANING.....	17
4. OTHER SERVICES .....	17
5. PREVENTATIVE SERVICES .....	17
<b>SPECIALIST DOMICILIARY CARE SERVICES.....</b>	<b>18</b>
<b>SUPPORT WORKERS FOR ADULTS WITH LEARNING DISABILITIES.....</b>	<b>19</b>
<b>DAY CENTRES INCLUDING DAY SERVICES PURCHASED FROM THE INDEPENDENT SECTOR .....</b>	<b>20</b>
SPECIALIST DAY CENTRES.....	21
- Intermediate Care Day Centre	
- Day Services for Older People with Mental Health Needs	
<b>EMPLOYMENT SUPPORT SERVICES.....</b>	<b>23</b>
<b>PROVISION OF TRANSPORT FOR ADULTS.....</b>	<b>24</b>
<b>CARE HOMES AND CARE HOMES (NURSING) – GENERAL APPLICATION OF CRITERIA.....</b>	<b>26</b>
<b>SHORT TERM BREAKS .....</b>	<b>27</b>
1. RESPITE CARE .....	27
2. SHARED CARE.....	27
3. SHORT-TERM CARE .....	27
<b>CARE HOME INDICATORS.....</b>	<b>28</b>
1. PHYSICAL.....	28
2. MEDICAL .....	29
3. BEHAVIOURAL AND EMOTIONAL INCLUDING MENTAL HEALTH.....	29
<b>CARE HOME (NURSING).....</b>	<b>31</b>
1. PHYSICAL CRITERIA.....	31

2. MEDICAL CRITERIA .....	32
3. BEHAVIOURAL AND EMOTIONAL INCLUDING MENTAL HEALTH.....	33
<b>NHS FUNDED NURSING CARE.....</b>	<b>34</b>
<b>RESIDENTIAL INTERMEDIATE CARE.....</b>	<b>35</b>
<b>RESIDENTIAL TRANSITIONAL CARE .....</b>	<b>36</b>
<b>CONTINUING NHS HEALTH CARE.....</b>	<b>37</b>
<b>PROVISION OF EQUIPMENT.....</b>	<b>39</b>
<b>ADAPTATIONS.....</b>	<b>40</b>
<b>INTERMEDIATE CARE.....</b>	<b>41</b>
<b>CRITERIA FOR NON – UNIVERSAL SERVICES FOR PEOPLE WITH LEARNING DISABILITIES .....</b>	<b>45</b>
<b>BIBLIOGRAPHY .....</b>	<b>49</b>
<b>RELEVANT LEGISLATION .....</b>	<b>50</b>

## INTRODUCTION

1. In line with the recent Guidance 'Fair Access to Care Services' (FACS) (LAC (2002)(13)), the Council has reviewed and revised its eligibility criteria. From April 2003 these revised eligibility criteria for adult social care must be used and case reviews must be commenced. By April 2004 reviews of service users, and their carers, in receipt of services at the start of April 2003 must have been completed. The FACS Guidance is issued under Section 7 (1) of the Local Authority Social Services Act 1970. This means that Councils are expected to comply with the Guidance.
2. This eligibility criteria framework is based on risks that arise from need associated with various forms of disability, impairment and difficulty. It seeks to promote the independence of those seeking its help. It links a persons assessed need for Community care services to both immediate and longer-term risks a person would face if such services were not provided. These criteria adopt a preventative approach to adult social care. It should be used in conjunction with other procedures adopted by the Council, in particular the "Protection of Vulnerable Adults" Procedures.
3. The expectation laid out in FACS is that " Councils should assess [a persons'] presenting needs, and prioritise their eligible needs, according to the risk to their independence in both the short and longer term, were help not to be provided. Councils should make changes in their practice to take a longer-term preventative view of [a persons'] needs and circumstances. With regard to their resources and other local factors, councils should focus help on those in greatest immediate or longer-term need."
4. Policy and practice guidance has been issued for assessment and care planning. This includes the Department of Health (1991), "Guidance on Care Management and Assessment" that supported the introduction of the National Health Service and Community Care Act. More recently, policy and practice guidance has been developed for particular groups, through the National Service Frameworks for mental health, and for older people; in the "Valuing People" strategy for learning disability services, and in relation to carers assessments.
5. There are various Acts of Parliament under which local authorities can provide or arrange community care services. The *NHS and Community Care Act 1990* refers to four other Acts which define community care services. These are:
  - Part III of the *National Assistance Act 1948*;
  - Section 45 of the *Health Services and Public Health Act 1968*;
  - Section 21 of and Schedule 8 to the *National Health Service Act 1977*;
  - Section 117 of the *Mental Health Act 1983*.

The rights of disabled people to certain services are also set out in the *Chronically Sick and Disabled Persons Act 1970* and the *Disabled Persons (Services, Consultation and Representation) Act 1986*

There are three different circumstances under which the local authority must carry out a care assessment. These are set out in Acts of Parliament:

- if you appear to the local authority to be in need of a community care service (*NHS and Community Care Act 1990*, section 47);

- if you are disabled (*NHS and Community Care Act 1990*, section 47; and *Disabled Persons (Services, Representation and Consultation ) Act 1986*, section 4);
  - if you help to look after someone else (*Disabled Persons (Services, Representation and Consultation) Act 1986*, sections 4 and 8; *Carers (Recognition and Services) Act 1995*, section 1; *Carers and Disabled Children Act 2000*)
5. The Policy Guidance on the Carers and Disabled Children Act 2000 states that: “ Local Councils have the power to supply services direct to carers following assessment. Carers have the right to an assessment of their needs, even where the person cared for has refused an assessment for, or the provision of, community care services, provided the person cared for would be eligible for community care services.”
  6. In determining eligibility for assessment FACS states that: “... councils should set a low threshold when deciding whether or not it appears to them that any person for whom they may provide or arrange community care services, may be in need of such services.”
  7. FACS also states: “Councils are ... reminded that they may take their resources into account in assessing a person’s need for the services listed in Section 2 of the Chronically Sick and Disabled Persons Act 1970, and in deciding whether it is necessary to make arrangements for those services. However, this does not mean that councils can take decisions on the basis of resources alone. Once a council has decided it is necessary to provide services to meet the assessed need of a person with a disability through services listed in Section 2, then it is under a duty to arrange those services”. This means that the aim of eligibility criteria is to ensure that the Council can provide or commission services to meet eligible needs, subject to its resources, and that within Liverpool City Council boundary, people in similar circumstances receive services capable of achieving broadly similar outcomes.
  8. In developing and implementing these eligibility criteria for Adult Social Care, Liverpool City Council will discharge its duties and responsibilities under the Sex Discrimination Acts 1971 and 1975, the Disability Discrimination Act 1995, the Human Rights Act 1998, and the Race Relations (Amendment) Act 2000. FACS states, “Assessment [and care planning] should not unfairly discriminate against individuals on the grounds of their age, gender, ethnic group, religion, disabilities, personal relationships, or living and caring arrangements, or whether they live in an urban or rural area. However, councils should take account of these factors in so far as they have a bearing on either presenting needs or the type and intensity of any care that is provided.
  9. The Council charges for many of the services it provides. Where individuals are assessed to pay for services this would be in line with the councils agreed charging policy. This will be available on request and charges will be clearly shown as part of a written care plan.
  10. This document outlines both the process of assessment to identify eligible needs (Part 1), and eligibility criteria for the individual services that the Council provides or commissions (Part 2). In producing these criteria, the expectation is that the Council will move towards a position that ensures consistency and equity for services provided. At the same time, in interpreting the criteria there will always be an element of professional judgement. If a service user applies for judicial review it will be the professional judgement exercised in applying these criteria in relation to the service

users and carers presenting needs that will be called into question. The criteria are designed to support staff in exercising this professional judgement.

## PART 1: ELIGIBILITY

### 1. Identifying Eligible Needs

These eligibility criteria describe the full range of eligible needs that will be met by the Council, having taken resources into account. For these purposes "eligible need" is defined as those presenting problems and issues, faced by a person, for which the Council will provide services because the need falls within the Council's eligibility criteria and it has the resources to meet the need.

The decision as to whether someone has eligible needs, and how they will be met, is based on an assessment. The eligibility framework for meeting these needs is divided into four bands, as follows:

#### **Critical – when**

- ❑ Life is or will be threatened; and/or
- ❑ Significant health problems have developed or will develop; and/or
- ❑ There is, or will be, 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
- ❑ There is, or will be, an inability to carry out vital personal care or domestic routines; and/or
- ❑ Vital involvement in work, education or learning cannot or will not be sustained; and/or
- ❑ Vital social support systems and relationships cannot or will not be sustained; and /or
- ❑ Vital family and other social roles and responsibilities cannot or will not be undertaken.

#### **Substantial – when**

- ❑ There is, or will be, only partial choice and control over the immediate environment; and/or
- ❑ Abuse or neglect has occurred or will occur; and/or
- ❑ There is, or will be, an inability to carry out the majority of personal care or domestic routines; and/or
- ❑ Involvement in many aspects of work, education or learning cannot or will not be sustained; and/or
- ❑ The majority of social support systems and relationships cannot or will not be sustained; and/or
- ❑ The majority of family and other social roles and responsibilities cannot or will not be undertaken.

#### **Moderate – when**

- ❑ There is, or will be, an inability to carry out several personal care or domestic routines; and/or
- ❑ Involvement in several aspects of work, education or learning cannot or will not be sustained; and/or
- ❑ Several social support systems and relationships cannot or will not be sustained; and/or
- ❑ Several family and other social roles and responsibilities cannot or will not be undertaken.

### **Low - when**

- ❑ 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.

## **2. Process for identifying eligible needs.**

There are 4 stages in the process of care management at which decisions are made, to identify the needs of the person.

- **Stage 1:** Deciding if a person should receive a Community Care Assessment, and the time scales within which it will be carried out.
- **Stage 2:** Deciding what the persons needs are when assessed
- **Stage 3:** Agreeing the provision of services from the range available to meet the persons assessed needs
- **Stage 4:** Reviewing (re-assessing) a persons needs

### **Stage 1. - Deciding if a person should receive a Community Care Assessment**

When a referral is received, the following indicators should be used to determine whether or not a person should be assessed for community care services:

(a) The person should be:

- Aged 18 or over and be Ordinarily Resident in Liverpool (subject to the relevant guidance), or be staying within the City Council boundary on a temporary basis.

**and**

- Have a learning disability, or
- Have a physical (including sensory) disability, illness, or injury, or
- Have a mental health problem, or
- Misuse drugs / alcohol or
- Are an older person and experiencing physical or mental frailty

**and**

- Appear, due to the problems and issues they face, to be entitled to the provision of Community Care Services by Liverpool City Council and to need the provision of such services.

(b) Or

- The person is a carer who provides regular and substantial care for a person who may be eligible for a Community Care Assessment

(c) Or

- The person may have a right to an assessment under the Disabled Persons (Services, Consultation and Representation) Act 1986.

Assessments should be prioritised in line with the time scales set out below. For people in the community, an initial assessment should be completed within three weeks of allocation in all priority groups. The exception to this is for people in a short stay acute hospital, where all assessments should be started within two working days of receipt of the referral, and completed within seven days. The time scales for allocation are for guidance only, and are the maximum time that should elapse. Judgement must be exercised as to the priority for allocation, particularly in Priority Group 2, where timely allocation could prevent a situation from deteriorating.

- **Priority 1 - Immediate:** (assessment begun within 48 hours of receipt of the referral). The person appears:
  - To be at, or pose, a risk of serious harm.
  - There has been an allegation, disclosure or concern about adult abuse.
  - To be neglecting their own care, so putting themselves at significant risk of harm.
  - To need an assessment under the Mental Health Act 1983
  - To need an Appropriate Adult under the Police and Criminal Evidence Act
  - To require urgent intervention to prevent the breakdown of their care arrangements that would put them at serious risk
  - To have deteriorated from a previously stable state that puts them at significant risk of harm.
- **Priority 2 - Substantial:** (Initial assessment begun within 4 weeks of receipt of the referral). The person appears:
  - To have care needs which have significantly increased
  - To be a self-funder in a care home/care home (nursing) who has fallen below the financial threshold
  - To have significant unmet care and support needs in relation to maintaining their independence
  - To need assistance in the near future due to deteriorating circumstances
- **Priority 3 – Moderate** (aim to allocate within 8 weeks of receipt of the referral). The person appears:
  - To need to plan their long term care needs due to the frailty of their current carer
  - To need intermittent support for themselves or their carer
  - To be socially isolated
- **Priority 4 - low** (offer advice and guidance, and referral to other services). The person appears:
  - To be able to access preventative services to overcome the issues and problems they face
  - To be in a stable situation

People who fall into this category should be offered appropriate information and support to enable the person to obtain preventative services.

## **Stage 2 - Deciding what the persons needs are when assessed**

It is important to point out that priorities for assessment are crucially different from, and do not always correspond to, the framework for eligible needs outlined in section 1. Crisis situations can change rapidly and may or may not need high levels of care to be provided on a continuous basis after the assessment. Less urgent assessments may uncover circumstances not known by the person making the referral that subsequently require high levels of care to be provided. During the process of assessment the eligible needs should be identified in the bands outlined. These describe the seriousness of the risk to independence if needs are not addressed. People falling within levels critical, substantial or moderate would have their needs met through community care services. People falling outside these could access the range of preventative services available.

The eligibility framework makes no reference to age, gender, ethnic group, religion, disabilities, personal relationships, or living and caring arrangements as in themselves they do not threaten independence. The needs band of an individual person is determined by comparing the risks to their autonomy, health, safety, ability to manage daily routines and involvement in family and wider community life with the detailed criteria.

In determining eligibility, account should be taken of the support from carers, family members, friends and neighbours, which may be available to the individual in meeting their needs. Consideration should be given to involving a family member or carer in the interview, to validate information provided. During the assessment process, no assumptions should be made about the level or quality of support that may be available, or the willingness of informal carers to continue to provide care. The person may require community care services in addition to the support offered by carers, or instead of carer support if they are unable or unwilling to continue to provide this support. Carers needs must be included as part of the assessment process, and they should be offered an assessment in their own right where they provide a substantial amount of care.

Where people are eligible for services, their assessed needs, and associated risks to independence, should be recorded, and agreed wherever possible, by them or their representatives, and the outcomes that service provision is expected to achieve. This should include the assessed needs and expected outcomes of the care, and the associated risks to independence of the person, that might be identified. Where people meet the criteria for preventative services, help and advice should be given to assist them in obtaining these services.

As they have been defined here, the Needs Band Criteria take account of:

- the City Council's current resource position
- local expectations
- local costs
- agreements with other agencies
- other local and national factors

People, and their carers, who are not eligible for help should be informed that if their circumstances change, they might be re-assessed. Where people are eligible for help, they should be informed that the care package provided might be changed to meet any

change in needs. This could be an increase in service, different services, or a decrease in service.

Where a person, or their carer, is unhappy about the way the assessment and care planning process is undertaken, or about decisions made, or about the way the care is provided, they must be given full information on the complaints procedure in order to challenge these things. They must also be provided with information about advocates. In the first instance, complaints will be addressed with a view to resolving them internally. Where this is not possible, a person who is independent of the staff who made the decision about service provision will investigate the complaint.

### **Stage 3 - Agreeing the provision of services**

Once a person's assessment is complete and the Needs Band for Community Care Services determined, agreement will be reached as to the services that will be provided to meet their needs. An indication of the type and extent of services that could be provided for each band of need, and the expected outcome of this service provision, is indicated in Appendix A.

In agreeing these services, account will be taken of the preferences of the service user and their carer, and the outcomes to be achieved. Services can be provided to meet the needs of a carer, based on a carer's assessment. The views of the carer should therefore be fully taken into account when making these decisions. It should be remembered that people's ability to maintain their independence could vary over time, and from day to day. In agreeing the provision of services, the outcomes should be identified, and the care package established in such a way that it takes account of this variation. The care plan should identify this, and services providers sought who can accommodate this variation on a day to day basis within the care package.

Part 2 of this document provides indicators for the provision of each service, and an indication of the level of service that could be provided for different needs bands. This approach ensures consistency across different service user groups whilst allowing a degree of flexibility that ensures people's needs can be appropriately met. These indicators are not intended to constrain the response made. The assessment and care planning process remains needs led, and individual solutions should be sought to the needs identified, if necessary using a range of services to respond to identified needs. The outcomes to be achieved based on the needs identified, and the care package to achieve these outcomes will be recorded in a care plan. A copy of the care plan will be provided to the service user.

In undertaking an assessment and planning the care to meet the eligible needs identified, full consideration should be given to ethnic and cultural issues identified. The care package should be sensitive to these issues, both in terms of the type of care provided, and the care provider identified.

### **Stage 4 - Reviewing (re-assessing) a persons needs**

From April 2003, the Council must review the circumstances of all adults in receipt of social care services, provided or commissioned by the council or purchased with direct payments. All service users should have received a review by March 2004. There should be an initial review within 3 months of a service user starting to receive a service, and

thereafter, reviews should take place on at least an annual basis or more frequently if circumstances warrant this.

Reviews should:

- establish how far the services provided have achieved the outcomes, set out in the care plan;
- check the quality of the provided services, and whether they are meeting standards;
- re-assess the problems and issues of individual service users and their carers;
- Check the service users and carers satisfaction;
- help determine their, and their carers, continued eligibility for support; and
- comment on how people are managing direct payments, where appropriate.

Some people currently receiving a Community Care Service may fall outside of the remit of the revised criteria for services. Existing packages of care should be reassessed against these criteria:

- (a) if there is a change in need, or
- (b) at the next review of the current service provision.

If as a result of reassessment there will be a proposed withdrawal or reduction in service it is essential that the person be given reasonable notice as well as advice and support in attempting to find alternative services if required. FACS also states that “Councils should exercise considerable caution and sensitivity when considering the withdrawal of services, following implementation of the Fair Access guidance, where reviews of needs and services have not been carried out for some time. In some individual cases it may not be practicable or safe to withdraw services, even though needs and associated risks may initially appear to fall outside eligibility criteria. In addition, before proceeding with closure, councils should check any commitments they gave to service users at the outset about the longevity of service receipt.” Information should also be given on the complaints procedure, so that the individual person, or their carer, has the opportunity to challenge the decisions made. The test that is to be applied at review is:

- (i) Do the current services meet the assessed need of the person and/or their carer
- and**
- (ii) If the services were removed, would the person and/or their carer meet the critical, substantial or moderate needs band within the foreseeable future?
- or**
- (iii) Is it necessary to provide one-off, short term, time limited, or occasional services to prevent the person, or their carer, meeting the critical or substantial needs band within a period of six months?
- and**
- (iv) Are suitable services otherwise available?

Where it is appropriate to continue to provide services to ensure that the person does not meet the critical, substantial or moderate needs band, the actual service must be reviewed to ensure that:

- (i) The services represent best value and could not be provided in a more cost efficient manner, e.g. through provision of frozen meals, provision of equipment etc.
- (ii) The amount of service provision is proportionate to the assessed needs and does not create inappropriate dependency on statutory services or undermine the person's independence or autonomy.
- (iii) The service is risk appropriate, i.e. it does not undermine the person living with an acceptable level of risk, or in contrast, denies the level of risk, leaving the person in a potentially unsafe situation.
- (iv) Options have been considered to promote independence, particularly where the person has the potential to learn new skills, or where services are being provided but there are no significant risks.
- (v) That the amount of care being provided by a carer is sustainable.

## APPENDIX A

<b>INDICATORS FOR SERVICE PROVISION</b>		
<b>Level of Assessed Need</b>	<b>Types of Service to Meet Need</b>	<b>Expected Outcomes</b>
<p><b>Critical</b> People who are in a crisis situation, or are at serious risk, or pose a serious risk to other people</p>	<p>Person may be offered:</p> <ul style="list-style-type: none"> <li>• Joint assessment with health colleagues to agree appropriate response to health care needs in their own home;</li> <li>• admission to alternative living situation on a short or long term basis;</li> <li>• rehabilitative services;</li> <li>• intensive care package;</li> <li>• equipment, or adaptations;</li> <li>• support to ensure use of services provided (e.g. transport, escort);</li> <li>• individualised support during the day;</li> <li>• admission to continuing care;</li> </ul>	<ul style="list-style-type: none"> <li>▪ Risks to life and threat of harm removed/ substantially reduced.</li> <li>▪ Aim to achieve long term stability.</li> <li>▪ Aim to maximise independence.</li> </ul>
<p><b>Substantial</b> People, or carers, who are having significant difficulties coping or are at significant risk of harm.</p>	<p>Person may be offered:</p> <ul style="list-style-type: none"> <li>• Admission to alternative living situation on a long or short term basis;</li> <li>• Rehabilitative services;</li> <li>• Intensive care package;</li> <li>• Equipment, or adaptations;</li> <li>• Appropriate support during the day;</li> <li>• Support to ensure use of services provided.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Risks to life and threat of harm substantially reduced.</li> <li>▪ Aim to achieve long term stability.</li> <li>▪ Aim to maximise independence.</li> </ul>
<p><b>Moderate</b> People, or carers who are finding it hard to cope but there is some risk to their health, safety or independence</p>	<p>Person may be offered:</p> <ul style="list-style-type: none"> <li>• Domiciliary Support;</li> <li>• day support outside the home;</li> <li>• short breaks or respite care;</li> <li>• support to ensure use of services;</li> </ul>	<ul style="list-style-type: none"> <li>• Situation remains stable.</li> <li>• Long term risks reduced</li> <li>▪ Stress on carer reduced.</li> </ul>
<p><b>Low</b> People whose quality of life could be improved but their current situation is stable and there is no risk to them or their carer</p>	<p>People would receive advice about preventative services available. Examples include:</p> <ul style="list-style-type: none"> <li>• Advice/advocacy</li> <li>• Frozen meals, shopping service, Careline</li> <li>• Leisure services</li> <li>• Voluntary organisations</li> </ul>	<ul style="list-style-type: none"> <li>▪ Situation remains stable.</li> </ul>

## **PART 2: INDICATORS FOR PROVISION OF SERVICES**

### **INTRODUCTION**

In this section the range of services available is outlined, and indicators given for the level and type of needs they are designed to meet. In all cases, these are intended as guidance only, and not to constrain professional judgement. In agreeing the services to meet needs, there should be a clear link between the needs identified, the outcomes to be achieved, and the services to be provided. In all cases the services provided should be of a type, and at a level, that meets the needs in a way that promotes or maintains the independence of the individual. Services should be provided at the minimal level required to meet eligible needs. For this reason, some services would not normally be provided for some needs bands. Whilst service user choice is important, it is not pre-eminent, in that if a particular type of service (e.g. admission to care) would over provide for the individual's needs, it should not be considered as an option for meeting those needs. This may lead to disagreement with the service user and carer, that can be recorded in the care plan. If there is disagreement about the care plan, the service user and carer should be encouraged to use the complaints procedure to resolve this, if necessary.

This approach is outlined to ensure consistency across different service user groups whilst allowing a degree of flexibility that ensures people's needs can be appropriately met. These indicators are not intended to constrain the response made. The assessment and care planning process remains needs led, and individual solutions should be sought to the needs identified. In interpreting the criteria and these indicators, there will always be an element of professional judgement. If a service user applies for judicial review it will be the professional judgement exercised in applying these criteria and indicators in relation to the service users and carers presenting need that will be called into question. The criteria and indicators are designed to support staff in exercising this professional judgement. This task should be undertaken in consultation with their line manager. If a social worker determines that the most appropriate response requires a significant deviation from these criteria and indicators, this should be discussed with the line manager, and the decisions made, and reasons recorded in the case file.

## HOME CARE (GENERIC)

### Needs band:

- **Critical**
- **Substantial**
- **Moderate**

### 1. Eligible needs

The individual person needs physical or motivational assistance with: -

- a) **Washing:** Needs assistance of at least one person
- b) **Dressing:** Needs assistance of at least one person
- c) **Eating:** Needs some supervision or prompting with preparation and/or consumption of frozen meals
- d) **Mobility:** (General) – Needs supervision and assistance from at least one person
- e) **Toileting:** Needs assistance from at least one person and help to maintain hygiene.

### **NOTE:**

An individual person may need help with one or all of the above, at varying intervals, which will be determined during the needs led assessment. An individual person may also need assistance and encouragement with the above for motivational reasons because they are lacking confidence, or for mental health reasons. People with a learning disability may need help to establish a routine. The needs band will determine the intensity of care offered. As an indication, for generic home care services, the following levels of service may be considered:

**Critical:** Over 10 hours service a week, and visits up to 7 days a week.

**Substantial:** 5 – 10 hours service a week, and visits up to 5 days a week.

**Moderate:** 2 – 5 hours service a week, and visits up to 3 days a week.

This is an indication only, and is not to be applied rigidly. For example, it is conceivable that someone in the substantial band will need services over 7 days, even though they do not require more than 5 hours care. The intention is that the service meets identified needs, within the general guidance given above.

The level of care provided will be agreed in conjunction with informal carers, and will take into account any contribution that they are able to make to the care package.

### 2. General

Meals should be provided through the frozen meals service. If necessary, support should be provided to heat and serve the meal.

Where people may require assistance on an unpredictable basis, consideration should be given to the installation of a community alarm.

### 3. Cleaning

Domestic cleaning will only be provided if a service user also requires personal care. Long term housework only services will not be provided. The following can be provided:

- a) Domestic cleaning on a short-term basis as part of a rehabilitation package, e.g. to support discharge from acute health services;
- b) Support and education to enable people to maintain a clean environment for themselves;
- c) Information, sign posting or referral to domestic cleaning and/or welfare rights advice organisation.

On this last point, should an assessment indicate that a person is ineligible for a service provided by the City Council but either:

- there is evidence that assistance with housework is required, or
- the person expresses a wish to receive a domestic cleaning service

the care manager will provide information about local cleaning providers. Support can be given to the service user, if necessary, to purchase domestic help from an agency privately.

Where necessary the social worker/Community Care Worker will facilitate referral to a welfare rights organisation to ensure that the person's benefits are maximised.

### 4. Other services

The Council does not directly provide the following services:

- Shopping only - this service is provided by specific shopping agencies;
- Assistance to have a bath, if this is the only need identified. If people require assistance to maintain personal hygiene or cleanliness, this should be provided. This should be applied in the light of the cultural and religious practices of the person, and culturally appropriate support must be offered.
- An ironing only service;
- A gardening service;
- A window-cleaning service.

**N.B.** Consideration could be given to providing supervision with bathing if the service user meets the critical band for service provision and has major personal care needs met within a care plan.

### 5. Preventative services

People who do not meet the criteria for service provision are able to purchase or obtain a range of other services. Examples include:

- Frozen Meals Service.
- Community alarms
- Advice and advocacy

- Help into employment
- Leisure services
- Information about services provided by voluntary organisations.

## **SPECIALIST DOMICILIARY CARE SERVICES**

Specialist domiciliary care services include:

- Rapid Response Team
- Older people with mental health needs (EMI) home care services
- Mobile nights.

In order to be eligible for a specialist service, service users must meet the criteria for the generic service, and in addition meet the specific criteria, as outlined in the table below.

<b>Service Area</b>	<b>RRT</b>	<b>EMI</b>	<b>Mobile nights</b>
<b>Specific factors</b>	Social care rehabilitation. Service provided for acute hospital discharge, Emergency Response Team (ERT) transfers, and exceptionally a crisis in the community. Time limited, usually up to 6 weeks.	For older people who have a psychiatric diagnosis.	Available from 9.45p.m. to 7a.m. Will cover more than one call during the night hours
<b>Needs band</b>	Critical, substantial or moderate.	Critical or substantial	Critical or substantial
<b>Level of physical disability</b>	None to severe	None to severe	Moderate to severe
<b>Sensory disability</b>	None to severe	None to severe	None to severe
<b>Challenging behaviour</b>	None to moderate	None to severe	None to severe
<b>EMI/confusional state</b>	None to moderate	Moderate to severe	None to severe
<b>Risk/manual handling</b>	None to moderate	None to moderate	None to severe

## SUPPORT WORKERS FOR ADULTS WITH LEARNING DISABILITIES

### Needs band:

- **Critical**
- **Substantial**
- **Moderate**

Support workers should be purchased as part of a service users care plan in the following circumstances.

1. To enable someone usually with mild learning disabilities who lives alone in their own tenancy to maintain themselves in the community. They would be assessed having moderate needs but which would become critical without such support. This will include advice on budgeting and household management, helping with correspondence and appointments and occasionally to provide assistance to participate in other activities or college.
2. As respite for carers on evenings and weekends. This is only funded where the situation is very critical for carers' needs. This would be for six to ten hours a week. The service user could have moderate, substantial or critical needs.
3. Where an individual has complex needs and a day centre cannot meet their needs then a one to one user support service can be purchased. The number of hours will be decided following assessment and care planning. It should follow the following bands –

Critical – Up to thirty five hours – some of which may be paid through Independent Living Fund (ILF).

Substantial - Up to twenty one hours – this enables ILF to be applied for.

Moderate - Up to twelve hours.

#### 4. Group Support

During 2002/3 a block grant from the carers grant has been given to two agencies to set up group activities that will be available for service users who do not need one to one support and are therefore likely to be assessed as having moderate needs.

## DAY CENTRES INCLUDING DAY SERVICES PURCHASED FROM THE INDEPENDENT SECTOR

### Needs band:

- **Critical**
- **Substantial**
- **Moderate**

These indicators apply to those services that are provided by the Supported Living Portfolio, or commissioned from the independent sector by the Supported Living Portfolio. It does not include the range of leisure activities that are available to anyone. There are also activities such as clubs, which are not included in these criteria. For some people, these are more appropriate alternatives to meet peoples needs, and should be considered alongside the more formal day services that are referred to here.

1. Attendance at a day centre, or care home must be based on clearly defined outcomes, identified in the assessment process, and which the specific day centre has agreed it can achieve. Outcomes should include exploring learning and development, and employment goals, as well as mental and emotional stimulation and care and support goals.
2. The person must be living in his or her own home in the community. They would not normally be receiving 24 hour support from paid carers (i.e. people employed by or on behalf of the City Council).
3. Services can be provided as respite for informal carers (usually a family member, but includes anyone who provides care without being employed for this activity), and adult family placement carers (people who care for someone who is not a family member, in their own home on a 24 hour basis).
4. Day centre attendance can be used to reduce the intensity of a domiciliary care package, but should not be used solely to carry out activities that would normally be carried out in a persons own home, e.g. bathing. Day centre provision is available to people with critical, substantial or moderate needs. The needs band should reflect the frequency of attendance. As an indication, people who are assessed as critical for service provision could attend for up to 5/7 days; with substantial needs, people could attend for up to 4 days; and with moderate needs, people should not be attending more than 2 days a week. People assessed as being in the "Preventative Band" will not qualify for a place. The intention is that the service meets identified needs, within the general guidance given above. The level of care provided will be agreed in conjunction with informal carers.
5. Each day centre will vary in terms of the physical environment, staffing levels and staff skills. Attendance will therefore be negotiated with the specific centre, and will depend on both the needs of the individual service user and their carer, and the range of needs of people currently in attendance.
6. Day time attendance at a care home (nursing) can be "spot purchased" for people who meet the above criteria, but who have identified nursing needs that can not be met in a day centre.

## **Specialist Day Centres**

### **Intermediate Care Day Centre**

People would meet the general criteria for day centre admission. In addition, people would be:

1. Over 60 years of age
2. Must be medically stable
3. Will have clearly identified outcomes to be achieved, based on improvements in their self care ability, and /or emotional or social functioning.
4. The maximum length of attendance will be twelve weeks. Towards the end of the twelve weeks a review will be held to determine what further support is required, if any.
5. There will be an agreement that the Centre can provide the care required to achieve the agreed outcomes within the agreed time scales

### **Day Services for Older People with Mental Health Needs**

1. It is the aim of these services to continue to work closely with health care colleagues both in primary and secondary care settings. The service user and carer should not be asked to contribute to a number of different assessments before they can access the service.
2. All service users referred must have a Liverpool address, meet the general criteria for day centre admission, be known to the psychogeriatric services, and have received a full mental health specialist assessment, which has identified an organic or functional mental illness, from either:
  - Consultant psychogeriatrician
  - Community mental health nurse, or liaison nurse
  - Day hospital team
  - Specialist social worker in mental health services.
3. All referrals must come via a nominated social care professional who will liaise with the day centre co-ordinator and arrange attendance.
4. Discussion on applications will take place on a regular basis and allocation of a place will be dependent upon availability.
5. There are separate services for functional and organic illness. For people with an organic illness, the day service provision will be based on recognition that the need for this service is unlikely to be short term. Reviews will take place to ensure that the service continues to meet the persons needs. For people experiencing a functional illness, each service user will:
  - Initially be accepted for a three month placement;

- Will be reviewed in order to monitor and identify the outcomes agreed with them at the original time of placement. This review will guide the necessity for continuing the placement, and/or referral to a more appropriate community resource.

### **Potential Indicators for non-admission to Day Services for older people with mental health needs:**

Service users who may not be considered for a place at the day centre are those:

- who have high levels of challenging behaviour that make it unsafe for themselves or others to be cared for by social care staff;
- who have unstable physical health problems;
- who have unstable psychotic type problems or high levels of psychological distress;
- who pose a serious risk to themselves and others;
- who have physical needs that can not be safely met within the environment of the day service.

These service users will be referred back to the nominated social care professional and alternative support mechanisms will be considered.

### **Carers voucher scheme**

1. This scheme provides breaks for carers who provide substantial and regular care to people with dementia, of all ages, and people with functional mental health needs.
2. Access to the scheme is through provision of a carer's assessment, and the agreement of the Team Manager, EMI team. The assessment can be completed by either health or social care staff.
3. Each voucher buys one hour of support from a dedicated staff group, managed by an independent agency. The number of vouchers allocated to an individual is dependent upon the needs identified.

## **EMPLOYMENT SUPPORT SERVICES.**

### **Needs band:**

- **Critical**
- **Substantial**
- **Moderate**

The following principles should act as a guide when deciding whether an employment based referral is appropriate.

1. The person is a Liverpool resident, who is currently receiving a community care service from the Supported Living Portfolio, or has been assessed as eligible to receive a community care service.
2. The individual is a person with a disability. This would operate on a self definition basis, but broadly would include anyone with a learning difficulty, a physical or sensory disability, a mental health issue or any other impairment or condition, which results in the person facing barriers to enter or remain in employment.
3. The Employment Team will also work with adults to assist them to access appropriate lifelong learning activities and voluntary employment.
4. The person has expressed an active interest in employment and/or employment would significantly enhance and promote their independence. Employment could include:
  - Voluntary/unpaid work
  - Work placements and visits to find out more about a particular job.
  - Supported employment
  - Part time paid work
  - Full time paid work
  - Other work preparation activities
5. The person is willing to disclose the necessary information for an appropriate agency to work with them to identify and attempt to meet their employment needs.

## PROVISION OF TRANSPORT FOR ADULTS

### Needs band:

- **Critical**
- **Substantial**
- **Moderate**

### Introduction

Officers must work on the basis of the following assumptions:

1. That all service users, regardless of age or disability are deemed, in the first instance, able to travel to the service provided, without financial or other assistance.
2. An appropriate mode of transport, for example supported transport, for example taxi or passenger transport services, are considered after the use of public transport, bus pass, motability, disabled living allowance entitlement has been thoroughly considered and deemed inappropriate. If the physical activity of the service user allows, a central pick up will be allocated and it will be the responsibility of the service user/parent/carer to ensure the person arrives on time. Only in extreme cases will the person be picked up from the home address.
3. Provision will only be agreed for transport from an agreed pick up and return point from within the Liverpool City boundary. Trips outside of the care plan are the responsibility of the service user/parent/carer. Home to service is defined as “pick up address to agreed establishment and return” at the normal service hours.
4. If the service user is in receipt of a motability allowance, this must be made available to them, but transport can not be refused on the sole basis that they receive motability allowance.

*Before Council funded transport is considered the assessor and service user and/or their carer should explore the service user's eligibility for Disability Living Allowance (mobility component) and any use of Motability.*

The Council's assistance has to promote peoples' independence and provide value for money, e.g. by providing travel training. **Wherever possible, the Council will only provide transport, i.e. a taxi or special transport, or an escort until an alternative can be provided**, e.g. until travel training is successfully completed, or a public transport accessible bus is available. Where a person's ability to use public transport depends on travel training being provided, transport will be authorised for a limited period of up to a maximum of six months so that the training can take place.

Continuing provision of transport should be reviewed along with other elements of the care package, at a minimum of yearly intervals. In the event of the proposed removal of transport, six weeks notice will be given to all parties.

### Indicators for the provision of transport:

When carrying out assessments, officers must work on the following basis:

- To receive help with transport, i.e. the provision of a taxi or special transport, the person must first meet the criteria for the service to which they are being taken;
- and**
- The person must be unable to take part in the specific service or activity unless motorised transport is provided;

**and**

- The person is unable to use public transport for any of the following reasons:
  - (i) Difficulty of physical access and the interior design and layout makes this impossible;
  - (ii) To use public transport would mean an unacceptable risk to the health and safety of the person and/or to other passengers;
  - (iii) Assistance is required that can not be provided by the Council, volunteers or carer;
  - (iv) The person has made insufficient progress in travel training.

**and**

- The person does not have access to personal transport; **or** lives with a carer/family (i.e. someone who is not paid to provide care), who has personal transport but is unable to transport the person to the service because of employment or caring commitments, illness or other incapacity.

**and**

- Can not gain access to other voluntary or private transport that is available.

## **CARE HOMES AND CARE HOMES (NURSING) – GENERAL APPLICATION OF INDICATORS**

1. The terminology used in this section refers to care homes (previously residential homes), and care homes (nursing), (previously nursing homes).
2. Use of the indicators should not be a substitute for professional judgement in individual cases.
3. The City Council, the Primary Care Trusts and the NHS Health Trusts are committed to maintaining people in their own home, wherever feasible and sensible. This is in line with the Joint Investment Plan for older people. Admission to care should only be sought when all alternative options have been considered, including intermediate care, and extra-care housing. Intermediate Care must be used to prevent hospital admission, or to facilitate hospital discharges, where an assessment indicates that there is potential to improve.
4. It is unlikely that any **one** indicator would equate with a need for admission to a care home/care home (nursing).
5. Some people may have immediate needs that could be met within a care home. However, if the assessment indicates that they have a deteriorating condition which would mean nursing care will be needed within 3 months, they may be best admitted to a dual registered home, or directly to a care home (nursing). This should be discussed with the person.
6. Nursing input can be provided by the District Nursing Service, to people in care homes, to the level that they would receive in their own homes (normally to a maximum of 4 visits per week). They can also advise staff on the management of health needs.
7. People whose assessed needs are met in a care home, who deteriorate during their residence should be helped to remain in the same home for as long as possible, provided that this does not conflict with the homes registration criteria, and within available resources.
8. For people meeting the criteria, the choice of home remains with them, as per the Choice of Accommodation Directions (Choice Directive). Any admission to care must be to a home accredited by Liverpool City Council, if it is within their geographical boundary, or accredited by the Local Authority where it is situated.
9. The Local Authority pays fees at a fixed level for homes that meet registration standards and the Authority's current service specification.
10. Where care home (nursing) is indicated the skills of a nurse should not just be used to provide care, but to prevent deterioration or further damage and help the person to maintain skills and independence.
11. People meeting the indicators for Care Home Level One should not be admitted to long term care. Level One Care should only be used for carers' respite, short-term care, shared care. When an individual person, for reasons of isolation, loneliness and extreme vulnerability, can not be maintained in their own home, alternative housing e.g. extra-care or sheltered accommodation should be considered in the first instance.
12. There are 5 levels of payment. Levels 1, 2 and 3 are payable for care homes, Level 3 for care homes that provide care to people with emotional, behavioural and mental health needs. Levels 4 and 5 are for care homes (nursing), with level 5 being available for people who have specialist needs.

## SHORT TERM BREAKS

### Needs band:

- **Critical**
- **Substantial**
- **Moderate**

### 1. Respite care

Liverpool City Council is committed to providing respite care to those people who are assessed as requiring it. The general standard for respite care is 21 days in any one year. Respite has a clear beginning and a clear end date. This is set prior to the individual person taking up residence and firmly agreed on a pre-planned basis between all parties. Respite care is primarily to support carers in maintaining the person at home. There are some facilities that have designated respite care beds, and it can also be spot-purchased from care homes that have a vacancy and are willing to provide this service. The criteria is the same for all services:

- (i) The person must meet the criteria for admission to a care home.
- (ii) A carer's assessment must be undertaken, indicating the need for provision of this service.

### 2. Shared care

Shared care is usually agreed by the authority on a long term basis, as a consequence of an appropriate assessment, and is a series of breaks at regularly agreed intervals e.g. one week in four, or one week in six. This will be an ongoing pattern to support carers to enable them to continue caring on a long-term basis, and to assist with keeping people at home. The criteria are the same as for respite care.

### 3. Short-term care

Short-term care can be used where there is a breakdown in care arrangements and care in a residential or nursing home situation is required. This is unplanned, and does not have a clear end date for return home. **However allocation panels need to put an end date in, which can be reviewed prior to the finish and extended as required.**

For all of these a full financial assessment is required, except when someone qualifies for after care services, under sect. 117 of the mental health act, or the person is funding their own care.

All of these apply only to those people who qualify for assistance – i.e. have less than the threshold in savings and whose income brings them below the threshold for support from the local authority. These amounts are updated annually.

## CARE HOME INDICATORS

### Needs band:

- **Substantial or Moderate for Level 1 Care**
- **Critical or substantial for Level 2 Care.**

### 1. Physical

1. The individual person has physical disabilities, which necessitate assistance on a daily basis with most activities of daily living.
2. The individual person has a need for night attendance.
3. The individual person has a need for assistance with mobility to perform basic tasks.
4. The individual person has a need for assistance with personal care tasks.
5. The individual person has a need for protection from frequent falls (approx. weekly).
6. There is a need for the management of regular urinary incontinence.

<b>Care Home Dependency Indicators (to determine level of funding)</b>		
	<b>Level 1 indicators</b>	<b>Level 2 indicators</b>
<b>Bathing</b>	Physical assistance to bathe from one person	Physical assistance to bathe from two people
<b>Washing</b>	Physical assistance/help to maintain personal and oral hygiene from one person	Physical assistance/help to maintain personal and oral hygiene from two people
<b>Dressing</b>	Physical assistance with dressing from one person	Physical assistance with dressing from two people
<b>Feeding</b>	Needs supervision to ensure adequate diet/fluids	Needs physical assistance to feed. Supervision of special diet
<b>Mobility</b>	Physical supervision/assistance from one person	Physical supervision/assistance from two people
<b>Moving &amp; handling</b>	Physical assistance from one person, may require equipment	Physical assistance from two people, can bear own weight or may require equipment
<b>Communication</b>	May require assistance with aids to communication, e.g. hearing aid, glasses.	May be slow to respond (aphasic). May be registered blind, may have difficulties in communicating needs.
<b>Toileting</b>	Physical assistance from one person. Help to maintain hygiene	Physical assistance from two people. Help to maintain hygiene
<b>Elimination</b>	May need assistance with occasional incontinence of urine e.g. pads, stoma care	May be incontinent of urine and occasional faecal incontinence. Needs reminding and physical assistance.

## 2. Medical

1. Where there is a need for the supervision and management of medication on a long-term basis.
2. Where the individual person has continuing or intermittent medical needs which require management from community nursing services, but which also require regular monitoring, which can not be provided in their own homes.

**Community/District Nurses, if there are any, can monitor level 1 medical needs.**

<b>Care Home Dependency Indicators (to determine level of funding)</b>
<b>Level 2 indicators</b>
Administration/management of medication. Nursing interventions can be provided by regular visiting from Community Nurses
May need assistance with aids to respiration.
Medical attention – may need routine or regular attention from the Community health Services

## 3. Behavioural and emotional including Mental Health

1. Where a significant level of cognitive impairment (dementia, disorientation, or learning disability) means the individual person is unable to look after her/his own basic needs.
2. Where the individual person needs protection from the risk of self harm.
3. Where the individual person's behaviour places others at risk if left unsupervised.
4. Where the individual person's behaviour is such that constant supervision is required.
5. Where the individual person's ability to cope is reduced through an adverse effect on self-confidence.
6. Where an individual person needs constant support or supervision.
7. Where the individual person's support network has been weakened or withdrawn.

<b>Care Home Dependency Indicators  Level 3  (To Determine Level of Funding)</b>	
<b>General</b>	There may be responsibilities under the Mental Health Act e.g. Sect. 117, Care Programme Approach or Guardianship.
<b>Behavioural</b>	Daily supervision to prevent risk to self or others. Prone to wandering in home or outside.
<b>Memory</b>	Significant memory loss, misidentifies people, lacks ability to know and understand
<b>Emotion</b>	Needs regular reassurance several times a day to minimise anxiety, orientation and restlessness

## CARE HOME (NURSING)

### Level of need:

- **Critical**
- **Substantial**

### 1. Physical criteria:

1. The individual person would meet the criteria for residential care, but assistance in aspects of physical care would be required from qualified nursing staff, because of their particular medical condition.
2. Where the individual person has a need for prolonged or repeated attention from nursing staff throughout the day/night.
3. Where there is a physical condition that may be amenable to improvement by skilled nursing care.

<b>Care Home (Nursing) dependency indicators (to determine level of funding)</b>		
	<b>Level 4</b>	<b>Level 5</b>
<b>Bathing</b>	Needs the assistance of two people for bathing/bed bath. Special skin care/dressings for wounds	
<b>Washing</b>	Dependent on two people for personal hygiene and oral care	
<b>Dressing</b>	Needs dressing, requiring one or two people	Needs dressing requiring two people. Complex handling issues
<b>Feeding</b>	May have swallowing difficulties. Needs food/fluids giving, may need regular feeding. May require PEG feeding.	May have swallowing difficulties. May require daily IV feed/fluids.
<b>Moving and handling</b>	Physical supervision/assistance from two people. May require equipment, unable to bear own weight. Needs help with repositioning to maintain comfort and prevent pressure sores.	Cannot move unaided, requires two people. Is completely dependent for correct positioning support and mobility.
<b>Communication</b>	Does not understand, difficulty in both receiving and communicating information or needs. May be deaf, may have little speech due to disease or trauma.	Needs constant input to reassure or to ensure essential co-operation in important activities or relationships.
<b>Toileting</b>	Requires toileting may be doubly incontinent. Unable to indicate needs / has lost voluntary control, needs maintenance of hygiene	Is doubly incontinent, unable to indicate needs, has lost (or never had) voluntary control

<b>Elimination</b>	Needs nursing intervention to aid, e.g. enemas, catheters, which need regular monitoring and intervention. Nursing management if incontinent, to prevent infection. Stoma care.	
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## 2. Medical indicators

1. Where the individual person has a need for drug administration/injections, where nursing monitoring, intervention and review are necessary
2. Where there is a need for nursing knowledge and/or skill to prevent problems, which may be life threatening e.g. choking.
3. Where the individual person has a medical condition requiring nursing care to remain pain free.

<b>Care Home (Nursing) dependency indicators (to determine level of funding)</b>	
<b>LEVEL 4</b>	<b>LEVEL 5</b>
Needs nursing administration/monitoring of medication for side effects	
Needs daily administration of medication to prevent pain/disturbance	
Needs wound care/dressings	Wound care/dressings which require 2 people and/or which take more than 20 minutes and/or which require replacing more than once a day
Needs close nursing supervision/review and intervention to maintain stability	
Support with care of tracheotomy, administration of nebulizer, rectal diazepam.	
Medical support may be too intense for Community/District Nurses to provide or the individual person would need at least daily Community/District Nurse input.	Needs nursing treatment, observation, psychological support etc., several times a day throughout a 24-hour period.

Within the Level 4 criteria the Health Service will apply their 3 Level Criteria, Low, Medium and High. See Summary.

Our Level 4 criteria will be within the Health, Medium to High criteria.

### 3. Behavioural and emotional including Mental Health

1. Must be known to specialist psychiatric or learning disability services.
2. Where the level of cognitive impairment requires care that is most appropriately provided by qualified nursing staff.
3. Where the individual person has behavioural problems which puts them at risk to themselves or others and whose needs can not be met by basic nursing home care.
4. Where maintenance in the community is no longer viable due to the individual person disorientation, lack of insight, mental confusion or agitation and where these require 24 hour nursing supervision.
5. Where an individual person has severe and/or frequent mood swings.
6. Severe or volatile mental health problems requiring intensive or very skilled staff input problems should be considered for continuing NHS health care funding.

<b>Care Home (Nursing) Dependency Indicators Level 4 (to determine level of funding)</b>	
<b>General</b>	There may be responsibilities under the Mental Health Act e.g. Sect. 117, Care Programme Approach or Guardianship.
<b>Emotional</b>	Needs monitoring, reassurance and support from qualified nursing staff to remove feelings of insecurity and/or deal with attention seeking behaviour.
<b>Behavioural</b>	Requires constant attention from qualified nursing staff to prevent aggression, disruptive behaviour. May be demanding / uncooperative due to dementia, learning disability or mental health needs.
<b>Memory</b>	Significant confusion, disorientation. Unaware of danger, risk of accidents if not supervised. Requires supervision by nursing staff.

## **NHS FUNDED NURSING CARE (currently for people who are self-funding)**

From 1<sup>st</sup> October 2001, the NHS has been contributing to the Nursing Element of care for those people who are currently self funding in Care Homes (Nursing), and thereafter for all those who self fund their placement in a Care Home (Nursing). The changes will not affect entitlement to state benefits (including Attendance Allowance).

From April 2003 the NHS will also become responsible for contributing to the nursing care element for all people in Care Homes (Nursing).

Social workers need to continue to assess, place and care manage people who are eligible for assessment under the National Health Service and Community Care Act. They will either have a requirement for immediate support because they have capital below the threshold, or will be referred because they are self-funding and have insufficient resources to fund themselves for two years prior to reaching the threshold for public funding.

If self-funders are identified you should notify:

Lead Nurse/co-ordinator  
Free Nursing Care  
Hamilton House  
24 Pall Mall  
Liverpool  
L3 6AL  
Tel 0151 285 2473

who will arrange for a NHS assessment to be undertaken.

The current self-funders will be funded at the lower banding of £35 per week until a full determination of their nursing care needs has been carried out.

### **The Bands:**

The lower band of £35 applies to people who are stable and whose extra care needs can be met with minimal registered nurse input.

The medium band, which is £70, will apply to those people who require the intervention of a registered nurse on at least a daily basis, and may need access to a nurse at any time, but their condition is stable and predictable.

The high band, £100, applies to those people who have complex care needs that require frequent intervention by a registered nurse throughout a 24-hour period and their condition is likely to be unstable.

### **The determination of care has to be undertaken by a NHS nurse**

**N.B. CENTRAL LIVERPOOL PRIMARY CARE TRUST IS ONLY RESPONSIBLE FOR THOSE PATIENTS REGISTERED WITH A LIVERPOOL GENERAL PRACTITIONER. PATIENTS REGISTERED WITH A GENERAL PRACTITIONER OUTSIDE OF LIVERPOOL WILL BE REFERRED TO THE RELEVANT PRIMARY CARE TRUST**

## RESIDENTIAL INTERMEDIATE CARE

### Criteria for referrals:

#### Needs band:

- **Critical**
- **Substantial**
- **Moderate.**

1. Service users must be resident within the Liverpool City boundary.
2. The service is primarily for older people, but service users under pension age may be considered. If the service is required for a younger person, this must be discussed with the Care Standards Commission, and arrangements made for a variation in registration.
3. Service users must be medically stable.
4. Service users must meet the criteria for residential care.
5. Service users should not have more nursing needs than can be managed by a community nurse.
6. The professional making the referral needs to ensure that the service user and their carer is aware that the maximum time normally allowed on the rehabilitation unit is six weeks.
7. Referrals may be made by any of the multidisciplinary team gaining consent from the service user.
8. Service users must have the potential to improve in their physical/mental functioning and ability to manage independently.
9. If a service user has a mental health problem it must be well controlled and should not affect their ability to follow a rehabilitation programme.
10. A service user's level of cognition and perception should be such that they can participate in a rehabilitation programme safely.
11. Service users must be willing to participate in a rehabilitation programme.

## RESIDENTIAL TRANSITIONAL CARE

### Needs band:

- **Critical**
- **Substantial**
- **Moderate.**

The aim of transitional care is to facilitate discharge from hospital, or to prevent admission to hospital. The criteria for the service is:

1. Service users must be resident within the Liverpool City boundary.
2. The service is primarily for older people, but service users under pension age may be considered. If the service is required for a younger person, and the registration conditions for the home chosen do not meet their requirement, this must be discussed with the Care Standards Commission.
3. Service users must be medically fit for discharge.
4. Service users must meet the criteria for residential care.
5. Service users should not have more nursing needs than can be managed by a community nurse.
6. The professional making the referral needs to ensure that the service user and their carer is aware that the maximum time normally allowed in the transitional bed is six weeks. If a person is readmitted to hospital, and subsequently returns to the transitional bed, the six weeks placement is the total of the two stays.
7. Referrals may be made to the designated Operational Manager at Royal Liverpool Hospital social work team. The referring social worker must have undertaken an assessment, and completed a care plan. They will retain responsibility for the service user during their stay in the transitional bed, and make arrangements for any ongoing care following discharge.

## CONTINUING NHS HEALTH CARE

One or more of the following criteria need to be met:

- i) The nature or complexity or intensity or unpredictability of the individual person's health care needs (and any combination of these needs) requires regular supervision by a member of the NHS multidisciplinary team, such as a consultant, palliative care specialist, therapist or other NHS member of the team.

NHS funded continuing health care should also be available where nursing care services are fundamental to the provision of accommodation and/or where the service is such that Social Services would not be expected to provide the service e.g. the person is in a persistent vegetative state.

- ii) The individual person's needs require the routine use of specialist health care equipment under the supervision of NHS staff.
- iii) The individual person has a rapidly deteriorating or unstable medical, physical or mental health condition and requires regular supervision by a member of the NHS multidisciplinary team, such as a consultant, palliative care specialist, therapist or other NHS member of the team.
- iv) The individual person is in the final stages of a terminal illness for whom death is likely within weeks to months and whose condition is progressive and causing significant discomfort (see section 5.4 of the Guidance for Continuing Health Care for further details).

### **Please note:**

A need for care or supervision from a registered nurse and/or a GP is not, by itself, sufficient reason to receive continuing NHS health care.

The location of care should not be the sole or main determinant of eligibility. Continuing NHS health care may be provided in a NHS hospital, a nursing home, hospice, or the individual person's own home.

### **How Can a Liverpool Resident Get Continuing In-patient Health Care?**

For older people with mental health continuing care needs and for people with dementia, access is through the EMI Directorate of MerseyCare NHS Trust. All other requests for continuing care funding should be made to the Continuing Care Facilitator following a multidisciplinary assessment.

Following the application of NHS continuing care policy, if a person does not require NHS continuing in-patient care she/he does not have the right to occupy a NHS bed indefinitely.

If a person is assessed as requiring NHS continuing in-patient care, the Continuing Care Facilitator will review eligibility for this on a regular basis. If the patient is assessed as no longer meeting the criteria, the NHS funding will cease and other appropriate packages of care will need to be put into place. This could include a financial assessment for the individual person, except when someone qualifies for After Care Services, under Sect 117 of the Mental Health Act.

## **NHS Continuing Care for People with Dementia**

There are a number of health funded beds for people with dementia, to provide both respite and long term care. The criteria for a place is the same for both types of care. The criteria is:

1. The person must be registered with a Liverpool GP.
2. Known to the psychogeriatric services.
3. Have been assessed by the multi-disciplinary team, and have identified needs that can not be met within the service users home or in any local community facility.
4. Due to the nature of their condition, the service user will exhibit one or more of the following behaviours:
  - Physical aggression to others
  - Sexual disinhibition, such as stripping off clothes, refusal to wear clothes, or other sexually inappropriate behaviour.
  - Violence to objects/environment (destructive behaviour).
  - Intimidating behaviour with threat of aggression, or extreme intolerance to other patients/service users.
  - Anti-social behaviour, e.g. extremes of faecal smearing, inappropriate passing of urine/faeces, excessive noisiness or shouting.
  - Extreme self-harm
  - Night time disruptive behaviour towards others.

## PROVISION OF EQUIPMENT

1. The applicant must be eligible for registration as a disabled person, or have a disability that is permanent and substantial, in compliance with the Chronically Sick and Disabled Persons Act. They do not have to be registered.
2. The equipment must be needed to promote or maintain independence and for safety of the service user or person assisting.
3. Equipment is provided if the disability is permanent or long term and is needed to overcome the disability, promote independence, or help the person assisting.
4. Consideration must always be given to the needs of the people assisting and other members of the household.
5. Equipment can be provided to improve safety.
6. There is additional guidance on the provision of specific items of equipment, which is available from the O.T carrying out the assessment.

## ADAPTATIONS

1. The disability of the applicant must be substantial and permanent, in accordance with the National Assistance Act 1948.
2. The adaptations can only be made at the person's only or main residence.
3. The relevant works must be necessary and appropriate to meet the needs of the disabled occupant.
4. The purpose of the adaptations is to enhance the lifestyle of the person with a disability.
5. There is additional guidance on the provision of specific adaptations, which is available from the O.T carrying out the assessment.

**Adaptations should be considered where the independence of the person with a disability is restricted because their home is partially or wholly inaccessible to them, taking into account the person's responsibilities. For example, if someone has caring responsibilities, they may require access to more rooms in the house than if they live alone.**

## INTERMEDIATE CARE

### Introduction

Liverpool has a number of intermediate care services, funded by both health and social services. Intermediate care services are:

- Targeted at those people who would otherwise face unnecessarily prolonged hospital stays, inappropriate admission to acute in-patient care, or admission to long term residential care.
- Provided on the basis of a comprehensive assessment, resulting in a structured personal care plan that involves active treatment and rehabilitation.
- Designed to maximise independence and to enable patients/users to remain or resume living at home.
- Involve short-term interventions, typically lasting no longer than 6 weeks and frequently as little as 1-2 weeks or less.
- Involve cross professional working within the framework of the single assessment process, a single professional record and shared protocols.

To be eligible for intermediate care, the person must be medically stable, and with the prospect of improvement in their ability to manage independently.

The criteria for admission are different for each establishment. Access is through a single point of contact in the Emergency Response Team, where a Nurse Advisor is available to provide advice and information about the appropriate alternatives. This single point of contact should be used for all referrals to intermediate care services. The range of factors to be considered for each service are outlined in the following table.

<b>Service</b>	<b>Location</b>	<b>Type of service</b>	<b>Age range</b>	<b>Geographical boundaries</b>	<b>Who can refer</b>	<b>Where from</b>	<b>Level of need</b>	<b>Response times</b>	<b>Admission process</b>
<b>Sir Alfred Jones Hospital (28 beds)</b>	Garston	Ward in Community Hospital	18+	Liverpool GP	GPs, Acute wards, ERT, ACTRITE	Community and Acute Wards, A & E	Sub-acute – can take complex health needs	ERT and GPs – immediate. Assessment on ward within 24 hours.	ERT, GPs, and ACTRITE – admit from their assessment. Ward – undertake own assessment.
<b>Ward 10 (30 beds)</b>	Broadgreen	Ward in acute hospital	18+	None	Acute wards, ERT	Royal Liverpool and Broadgreen Hospitals, A & E	Sub-acute – can take complex health needs	May undertake assessment on ward within 24 hours	Sometimes accept tracker nurse assessments, sometimes undertake own assessments
<b>Ennerdale Care Home (Nursing ) (14 beds)</b>	Aintree (Hospital Grounds)	Nursing care, with therapy input	60+	Liverpool GP	ERT, ACTRITE, tracker nurses.	Community and acute wards, A & E	Non-complex nursing needs	Immediate access	GPs via ERT. Admit from ERT, ACTRITE or tracker nurse assessment
<b>Rowan Garth Care Home (Nursing ) (15 beds)</b>	Old Swan	Nursing care, with therapy input	60+	Liverpool GP	ERT, ACTRITE, tracker nurses.	Community and acute wards, A & E	Non-complex nursing needs	Immediate access	GPs via ERT. Admit from ERT, ACTRITE or tracker nurse assessment

<b>Service</b>	<b>Location</b>	<b>Type of service</b>	<b>Age range</b>	<b>Geographical boundaries</b>	<b>Who can refer</b>	<b>Where from</b>	<b>Level of need</b>	<b>Response times</b>	<b>Admission process</b>
<b>Walton Manor Care Home (Nursing ) (11 beds)</b>	Walton	Nursing care, with therapy input	60+	Liverpool GP	ERT, ACTRITE, tracker nurses.	Community and acute wards, A & E	Non-complex nursing needs	Immediate access	GPs via ERT. Admit from ERT, ACTRITE or tracker nurse assessment
<b>Leighton Dene Care Home (12 beds)</b>	Fazakerley	Care home with therapy input	65+	LCC boundary	ERT, acute wards, SWs	Community, hospital ward, A & E	Social and personal care needs. Nursing care that can be provided by DN	Aim to respond within 24 hours	Usually undertake their own assessments. Sometimes admit from ERT or tracker nurse assessment
<b>Boaler Street Care Home (8 beds)</b>	Kensington	Care home with therapy input	65+	LCC boundary	ERT, acute wards, SWs	Community, hospital ward, A & E	Social and personal care needs. Nursing care that can be provided by DN	Aim to respond within 24 hours	Usually undertake their own assessments. Sometimes admit from ERT or tracker nurse assessment
<b>Boaler St Day Centre (10 – 15 places)</b>	Kensington	Short term day centre	60+		SWs, Intermediate Care team	Community, hospital ward when discharged	Social and personal care needs. Nursing care that can be provided by DN	Immediate	Admission from SW assessment

Service	Location	Type of service	Age range	Geographical boundaries	Who can refer	Where from	Level of need	Response times	Admission process
<b>Prince Alfred (12 beds)</b>	Wavertree	Transitional beds in care home	65+	LCC boundary	SWs, Intermediate care team	Community, hospital ward	Social and personal care needs. Nursing care that can be provided by DN	Immediate	Admission from assessment
<b>Emergency Response Team (ERT)</b>	Community	Nursing and social care assessment and short term care (up to 72 hours)	60+	Liverpool GP	GPs, A & E, ambulance control, SWs, any professional	Community, A & E	Complex nursing needs and social care	Within 1 hour	Care package established from assessment
<b>Rapid Response Team (RRT)</b>	Community	Social care	18+	LCC boundary	Intermediate care team, SWs	Community	Personal and social care needs	Aim to respond within 24 hours	Care package established from assessment
<b>Intermediate Care Team (ICT)</b>	Community	Therapy and social care assessment on people admitted to intermediate care units and ERT.	18+	?	ERT, Intermediate Care Units	Community and Care Homes in Intermediate Care system	Therapy personal and social care needs	Aim to respond within 1 working day	Respond to referral

\*Acute wards includes tracker nurses

<b>INDICATORS FOR NON – UNIVERSAL SERVICES FOR PEOPLE WITH LEARNING DISABILITIES</b>							
<b>All service users to have a learning disability and be aged between 18 – 65</b>							
<b>Criteria Service</b>	<b>Assessed Needs Band</b>	<b>Challenging Behaviour</b>	<b>Forensic Needs</b>	<b>Assessment</b>	<b>Level of physical disability</b>	<b>Sensory Disability</b>	<b>Additional Criteria</b>
Preesall Way Emergency Accommodation Service	Critical or substantial	Moderate or none	None	Community Care Assessment or Referral by EDT in Emergency	None to Severe	None to Severe	Can cater for health needs such as tube feeding
Keyring Accommodation and Support Service	Substantial or moderate	Some capacity to take people with complex needs or challenging behaviour	None	Community Care Assessment	Has some capacity to adapt the ordinary housing it uses from social landlords	Some capacity	Services users must want to contribute to the social and support aspects of the scheme
Supported Accommodation	Critical or Substantial	From none to severe	None	Community Care Assessment	None to severe	None to severe	
Adult Family Placement	Critical or substantial	Some capacity to take people with challenging behaviour	None	Community Care Assessment	Some capacity but service provided in carers homes that may not be adapted	Yes	
Suffolk Street Intensive support Unit	Critical	None to Severe	Must Have	Joint Health / Community Care Assessment. Joint Risk Assessment (J-RAMP)	Access Limited	Limited	Can take people with dual diagnosis
Individualised Day Service	Critical , substantial or moderate	None to Severe	None	Community Care Assessment	None to Complex physical needs	Yes	Can provide for lifting and handling needs and personal care

Pooled Funding (care package funding that includes health and social care)	Critical	Must have additional complex needs	Yes	Joint Health and Community Care Assessment. Joint Risk Assessment if appropriate	None to Severe	Yes	Eligibility details contained in joint health / social services agreement
Social inclusion (to assist people to participate in leisure activities)	Moderate Must have carers assessment	No	No	Initial only	Mild	Mild	

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**Indicators for Directly Provided Social Care Services for People with Mental Health Needs**

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General

- Service users have a severe and/or enduring mental illness, **or** are suffering ongoing effects of traumatic brain injury (not including a moderate or severe learning disability) and have received the services of the Brain Injury Unit.
- Service users referred have been assessed under the Effective Care Coordination process (level specified below for each service).
- Services are intended to meet the needs of people in the age band 18-65. People outside this age range may be considered in exceptional cases for short term support (provided the other criteria are met).
- Provision of the service depends on the match between the assessed needs and wishes of the service user, and the service or placement available, including assessment of risk.
- Referrals must come from a member of the multi-disciplinary CMHT and be endorsed by the relevant Team Manager (see Day Services for exception to this).

	<b>Assessed Needs Band</b>	<b>ECC Level</b>	<b>Other Criteria (additional to general criteria)</b>	<b>Accessibility (disabled people)</b>	<b>Comments</b>
24 hour Supported Accommodation Schemes (supporting people funded)	Critical or substantial	Enhanced	<ul style="list-style-type: none"> <li>▪ In need of extensive or 24 hour availability of support</li> <li>▪ Not in need of intensive personal care</li> <li>▪ Assessed suitability in relation to others living within the scheme</li> </ul>	Some capacity for disabled tenants ( ground floor bedrooms at each of 7 schemes)	Housing provider has final decision on awarding tenancy
Bentley Road Accommodation Scheme	As above	As above	<ul style="list-style-type: none"> <li>▪ As above</li> <li>▪ Women only</li> </ul>	Not accessible	
Supported Accommodation with visiting support (Supporting People funded)	Substantial or moderate	Enhanced or standard	<ul style="list-style-type: none"> <li>▪ In need of consistent support on a visiting basis</li> <li>▪ Able to call on support as and when needed</li> <li>▪ Assessed suitability in relation to other tenants and/or likely to benefit from mutual support within a grouped accommodation scheme</li> </ul>	Not accessible	Housing provider has final decision on awarding tenancy
Hartington Road Scheme	As above	As above	<ul style="list-style-type: none"> <li>▪ As above</li> <li>▪ People from black and racial minority groups</li> </ul>	Not accessible	
Ullet Road Scheme	As above	As above	<ul style="list-style-type: none"> <li>▪ As above</li> <li>▪ Women only</li> </ul>	Not accessible	
Foley Close Hostel (care home)	Critical or substantial	Enhanced	<ul style="list-style-type: none"> <li>▪ In need of 24 hour support</li> <li>▪ Compatibility with other service users</li> </ul>	Not accessible	
Planned Respite/Short Breaks Service – Cherry Mill	Substantial or moderate	Enhanced or standard	<ul style="list-style-type: none"> <li>▪ Able to care for self in a flat in a supported accommodation setting</li> <li>▪ Compatible with existing tenants of the scheme</li> <li>▪ Not in need of intensive personal care</li> </ul>	Not accessible	
Planned Respite / Short Breaks Service – Rumney Place	Substantial, or moderate	Enhanced or standard	<ul style="list-style-type: none"> <li>▪ Able to care for self in a shared, supported housing scheme</li> <li>▪ May be in need of 24 hour support (as Cherry Mill above)</li> </ul>	Not accessible	

Community Support Teams	Critical, substantial, or moderate	Enhanced or standard	<ul style="list-style-type: none"> <li>• General criteria apply</li> </ul>	Outreach service to people's own homes	
Mental Health Day Services	Critical, substantial, or moderate	Enhanced or standard	<ul style="list-style-type: none"> <li>▪ Referrals may be made by Mersey Care staff, not necessarily members of the CMHT, provided they are endorsed by the Care Coordinator or Team Manager</li> <li>▪ Frequency of attendance will reflect needs band eg 1/2 days, 3/4 days</li> </ul>	Yes – Crown Street and Unicorn Road No – South Drive	<ul style="list-style-type: none"> <li>▪ People in 24 hour support'd homes are eligible</li> </ul>

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### **RELEVANT WEB LINKS**

<http://www.doh.gov.uk/public/letters/laslh.htm>

### **RELEVANT LEGISLATION**

- National Assistance Act 1948
- Health Services and Public Health Act 1968
- Chronically Sick and Disabled Persons Act 1970
- Sex Discrimination Act 1975
- National Health Service Act 1977
- Mental Health Act 1983
- Police and Criminal Evidence Act 1984
- Disabled Persons ( Services, Consultation and Representation) Act 1986.
- National Health Service and Community Care Act 1990
- Disability Discrimination Act 1995
- Human Rights Act 1998
- Carers and Disabled Children Act 2000
- Race Relations (Amendment) Act 2000.