HEALTH & SOCIAL CARE MORAY

Eligibility Criteria Policy

(Accessing adult social care support via Health & Social Care Moray)

POLICY

2020/21

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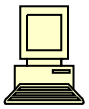

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1.0 Introduction

Because most Authorities/Partnerships in Scotland no longer provide ongoing social care support for people assessed as having care needs putting them at low or moderate risk (although advice, information and other time-limited preventative support such as home from hospital support and reablement may be provided to help prevent, reduce or delay the need for ongoing support), and because of the considerable financial and legislative changes in social care since the current framework was developed, it may be an opportune time for COSLA and councils to review the eligibility framework to ensure that it is still fit for purpose.

We need to develop a strategic approach to prevention in order to sustain provision of social services. In 2011, the Christie Commission concluded that Scotland needed to 'devise a model of public services that is both financially sustainable and is capable of meeting the significant longer-term challenges'. It also proposed that a radical shift towards preventative public spending was essential. In September 2011, the Scottish Government set out an ambitious vision to enable everyone to live longer, healthier lives at home or in a homely setting by 2020.

Central to the vision is a focus on prevention, anticipation and supported self-management. The Scottish Government also set up the change fund to stimulate work on prevention, specifically in re-shaping care for older people.

We firmly believe that prevention is the key to meeting the growing demands for social care services within finite resources. Some challenges are:

- Funding pressures- a lack of funding because resources are locked into current service models to meet existing demands and best value may not materialise for some time after implementation of new strategies
- Social Worker/Community Care officer time - a lack of social worker time – a concern that social work has become crisis based
- Managing friends'/relatives' expectations – for example, some relatives prefer Health & Social Care Moray (HSCM) to provide a full care package of residential care rather than

have their relative go through a reablement programme to allow them to live more independently at home.

- Cultural differences between councils and the NHS – a common perception among a number of social workers in our focus groups was that the NHS is more risk averse and less used to giving staff responsibility to take the initiative on the care of individuals.

Some prevention initiatives

Common prevention activities include:

- **Re-ablement (Moray Partners in Care (3 Tier) Policy - Tier 2 – See Section 5.5)** – involves encouraging people using services (often people leaving hospital) to develop the confidence and ability to live more independently and be less reliant on social care. This is usually up to twelve weeks of intensive help; it commonly results in people requiring less or even no ongoing support. The change fund initially funded this project but the council now funds it as the savings justify the investment.
- **Using technology (Moray Partners in Care (3 Tier) Policy - Tier 1 – See Section 5.5)** - enable people to continue living in their own homes for longer and to give reassurance to their unpaid carers and families. All councils provide a community alarm service. More advanced telecare systems use movement sensors and smoke detectors to alert the service to potential problems or prompt people to take medication. Examples include: – a GPS device to help relatives or unpaid carers to find a vulnerable person if they get lost – extreme temperature and flood sensors fitted in kitchens – sensors to alert an unpaid carer when the person gets out of bed – removable sensors, called 'just checking', placed at doorways to monitor movement and assess lifestyle patterns.
- **Signposting and referring to other services (Moray Partners in Care (3 Tier) Policy - Tier 1 – See Section 5.5) – At initial contact for example** an initial conversation over the phone which results in trying to resolve lower level care needs as quickly as possible. This could be through signposting to a voluntary sector or community based service, or through services provided by Adult Social Care to support peoples' independence, such as telecare including the community alarm, occupational therapy, care at home, day services, equipment and adaptations. Some initial conversations will lead to formal needs

assessments where requested or when social care staff assess that the level and type of support being discussed may require this.

- **Strengths-based assessment and use of a Progression Model** (**Moray Partners in Care (3 Tier) Policy - Tier 2 – See Section 5.5)**
    - "Progression" assumes that people prefer to be less, rather than more, dependent and that most people with a learning disability are able to learn at their own pace. The model also takes account of the fact that people can lose skills, for example through progressive conditions. Care and support planning should help people achieve the maximum level of independence to which they aspire. It is important to match the service response to current need but also to work to reduce them over time, helping individuals gain confidence and skills, and so reduce long term needs.
        - Specific assessment of a person's abilities and needs in respect of daily living activities.
        - Differentiation of "maintenance" needs (what is required to safely support current functional abilities) and "development" needs, things that help the person acquire the ability to be more independent and thus have lower needs in the future.
        - Personal Outcomes-directed support planning.
        - Positive risk management.
        - Outcome based reviews.

2.0 Aims, Objectives and Scope of the Policy

- This policy applies to service users of Health & Social Care Moray (HSCM) Adult Social Care
- This policy sets out HSCM's eligibility criteria for Adult Social Care support. Eligibility criteria are statements about the conditions and circumstances which may relate to individual cases and are eligible for access to Adult Social Care support.
- This Policy is primarily for service users and members of the public who are considering being assessed for Adult Social Care support. It will also assist Council staff with the process of targeting Adult Social Care support at those in greatest need or highest risk in our community.
- The policy sets out the rational for applying eligibility criteria and the four categories of risk (**Appendix One**) that are used to prioritise individuals at assessment. These categories are in line with national guidance produced by the Scottish Government and COSLA in relation to

eligibility criteria and waiting times for care/support. The eligibility criteria looks at both the severity of risk and urgency of intervention needed to respond to these needs.

- To balance their budgets, councils prioritise funding and staff to those people most in need by setting eligibility criteria and assessing each person's needs against these criteria. Councils have discretion on the thresholds for care they use locally. The level set in each council will depend on the resources available.
- To clarify for HSCM and those acting on behalf of HSCM, who should use the Eligibility criteria and in what circumstances.
- To determine eligibility for support from HSCM Adult Social Care services, service users will be required to undertake an assessment of needs.
- Service users, if they have eligible care needs, will then also be required to undertake a financial assessment (for chargeable care and support only – i.e. not for Free Personal Care or Reablement) in line with HSCM's 'Non-Residential Care Contributions Policy' to establish whether they will be required to make a financial contribution towards the cost of meeting their eligible assessed support needs and personal outcomes.

3.0 Related Policies/Procedures/Legislation/Plans/Strategies

In general, HSCM may provide Adult Social Care support to individual adults with needs arising from physical, sensory, learning or cognitive disabilities and impairments, or from mental health issues. HSCM's responsibilities in this respect are governed by the following legislation:

- The Social Work (Scotland) Act 1968
- The Community Care (Direct Payments) Act 1996
- The Social Care (Self-Directed Support) (Scotland) Act 2013
- The Carers (Scotland) Act 2016
- The National Outcomes for the Integration of Health & Social Care
  HSCM SDS Policy supports in particular Outcomes 1, 2, 3, 4, 7 and 9 of the National Outcomes for the Integration of Health and Social Care
- Regulation of Care (Scotland) Act 2001
- Community Care and Heath (Scotland) Act 2002

- The Adults with Incapacity (Scotland) Act 2000
- The Community Care (Direct Payments) (Scotland) Regulations 2003 (SSI 2003 No. 243)
- The Community Care (Direct Payments) (Scotland) Amendment Regulations 2005 (SSI 2005 No. 114)
- The Mental Health (Care & Treatment) (Scotland) Act 2003
- The Mental Health (Care and Treatment) (Scotland) Act 2003 (Modification of Subordinate Legislation) Order 2005 (SSI 2005 No. 445)
- National Health Service Reform (Scotland) Act 2004 (asp 7)
- Adult Support and Protection (Scotland) Act 2007
- The Community Care (Direct Payments) (Scotland) Amendments Regulations 2007 (SSI 2007 No. 458)
- GDPR and Data Protection Act 2018
- Freedom of Information (Scotland) Act 2002
- The Human Rights Act 1998
- Equality Act 2010
- Public Sector Equality Duty
- The NHS and Community Care Act 1990
- Independent Review of Free Personal Care and Nursing Care In Scotland – A Report by Lord Sutherland (April 2008)
- Circular CCD8/2001: Guidance on Single Shared Assessment of Community Care Needs
- Circular CCD3/2008: National Minimum Information Standards for Assessment and Care Planning for Adults
- National Community Care Outcomes Framework
- National Eligibility Criteria for Adult Social Care and Waiting Times for Personal & Nursing
- Contributions Policy for Non-Residential Care
- The Moray Council Self Directed Support Policy and Procedure.
- The Moray (Partners in Care) 3 Tier Policy.
- Case Recording Policy and Procedure

Plans and Strategies

Moray Council Corporate Plan (2018 - 2023)
http://www.moray.gov.uk/downloads/file119976.pdf which is the council's primary statement of what we aim to achieve and the resources required to do this. It sets out the council's vision, values and priorities and the context for implementing these. This is strongly linked to;

Moray 10 Year Plan (Local Outcomes Improvement Plan – LOIP)
http://www.yourmoray.org.uk/downloads/file118306.pdf - which provides a vision and focus for our Community Planning Partnership. It aims to tackle the greatest differences in outcomes between and within Moray communities and to focus on where we can add greatest value by working in partnership and alongside the community to deliver our agreed priorities to meet the needs and aspirations of local communities in Moray.

The National Health & Wellbeing Outcomes (high-level statements of what health and social care partners are attempting to achieve through integration and ultimately through the pursuit of quality improvement across health and social care**).**
https://www.gov.scot/Topics/Health/Policy/Health-Social-Care-Integration/National-Health-WellbeingOutcomes .

Living Longer Living Better in Moray 2013 – 2023 (A Joint Commissioning Strategy for Older People) http://hscmoray.co.uk/uploads/1/0/8/1/108104703/living_longer_living_better_2013-2023.pdf (Care at Points of Transition Pathway, Key Service Developments, Workforce Development)

Carry On Caring 2016 – 2019 (A Strategy for Unpaid Carers) (Adult Carers Strategy)
http://hscmoray.co.uk/uploads/1/0/8/1/108104703/carry_on_caring_2016-2019.pdf
'To be empowered, educated and supported to enable unpaid carers to care for themselves as well as those they care for. Unpaid carers will have a voice, choice and control to be equal partners in care'.

Moray Partners in Care (3-Tier Policy)/**Moray Community Care Model**
Working in partnership with the wider community and other agencies to deliver improved choice and control for people over how they live their lives. Prolonging and maximising independence and less reliance on formal support, including focussing on early intervention and prevention. A personalised approach to achieving the positive outcomes each person is seeking to achieve.

Moray Integration Joint Board (IJB) **- Health & Social Care Moray Strategic Plan 2016 – 2019** http://hscmoray.co.uk/strategic-plan.html – (key development areas including embedding reablement in practice and, prevention and reablement as a recurring theme in Joint Commissioning Strategies in adult care).

4.0 About our Eligibility Criteria

- Social care resources are finite and should be targeted at those with the greatest level of need. The overall purpose of an eligibility criteria is to assist local authorities to demonstrate equity, consistency and transparency in both the decision making process and the allocation of resources.
- The NHS and Community Care Act 1990 requires local authorities to publish information about services, for whom they are intended and how to access them. Published eligibility criteria are a public statement of how social care services will respond to needs by establishing different levels of priority for access to care.
- Local Authorities have a duty to assess all individuals where it appears they may be at risk and in need of support. The provision of on-going support is dependent on the outcome of the assessment.
- Access to Adult Social Care support is through an Assessment. This may be carried out by health and social care staff and in conjunction with the client. The Assessment involves discussing the client's strengths/abilities and current support network, care needs and the personal outcomes they want to achieve and with their permission we may share relevant information with others who may be involved in the client's care.. The person who assesses the client's care needs will be able to explain in more detail what will happen.

- The support that may be offered depends on an individual's personal circumstances. There is a wide range of support provided, some of which are:
  - Home care
  - Day care
  - Support for people with mobility difficulties
  - Falls prevention
  - Aids and adaptations for people with disabilities
  - Accommodation Services
  - Respite/Replacement Care
  - Community Learning Disability Team
  - Community Mental Health Team
  - Specialist advice and information

4.1 Who will receive on-going support?

We give priority to people who are assessed as being within the critical and substantial categories. Eligible social care needs are those assessed at these risk levels which the service user's assessment has identified are not already being met through their existing supports including family, friends and unpaid carers.

As a consequence of being unable to achieve the outcomes identified during the assessment, there is, or there is likely to be in the near future, a significant/major impact on the adult's independence, health and/or wellbeing. Such as focusing on:

- *Neglect or physical / mental health*
- *Personal care and domestic environment*
- *Participation in community life**
- *Support from/for Unpaid Carers*

*Participation in community life relates to:
The ability (or otherwise) to sustain involvement in vital aspects of work, education, learning, family, social roles, responsibilities and social contact due to the impact of care and support needs.

Adult Social Care will provide information, advice, guidance and signposting (Tier 1 of the Moray Partners in Care (Three Tier) Policy) to support those people assessed as within the moderate or low risk categories including information about alternative sources of support and how to access them.

People in these lower risk categories may qualify for help from a range of other services including welfare benefits, health, housing, transport and leisure. Local voluntary and community services may be able to assist.

If the person is not eligible for on-going support at this time, this does not mean that they can't get help in the future and as such they should contact the ACCESS TEAM on **01343 563999.**

5.0 The Assessment and Support Pathway for Self-Directed Support (SDS)

- Self-directed support (SDS) is the mainstream approach to supporting individuals and their unpaid carers who are eligible to access social care support services.
- Self-directed support places the individual at the centre of the assessment and planning process and recognises that they are best placed to understand their own needs, make choices and take more control of their lives.
- Under SDS, individuals will have greater choice and control. If assessed as having eligible needs, individuals will be offered four options for the way they access social care and support. These options are described below and will be fully explained by the person carrying out the assessment.

Please see the Statutory Guidance accompanying the Social Care (Self-directed Support) (SDS) (Scotland) Act 2013

The key stages in the assessment and support pathway are outlined below:

5.1 Referral

First contact with the Adult Social Care service is usually with the Access Team. An assessment is requested because the person or their unpaid carer feels they need help.

5.2 Screening

At the point of referral a member of staff will seek details about the individual circumstances and may offer some advice and information in addition to informing any subsequent needs assessment by social care staff. The aim is to begin the assessment process as early as possible by recording as much detail about each individual case at the earliest opportunity. Eligibility cannot be decided at the referral stage as there is a duty to offer/provide a needs assessment if the person requests this or appears to be in need of social care support. Within that context the aim will be to target those assessed as having the highest need for support and to try and ensure that priority is given to meeting those needs without delay. Every effort will be made to avoid delays and to keep any waiting time as short as possible.

We will try to avoid making people wait on a waiting list (for assessment and support) and we will ensure that those with the highest needs receive support first.

Adult Support & Protection

The Access Team (and an Advanced Practitioner) screen all Stage 1 ASP referrals and Police Concern Reports. If they believe, from the info received (and checking any recording on CareFirst) that the person is at immediate risk of harm then the information/document they have received is sent to the Adult Protection Unit in line with the 'Grampian Interagency Policy & Procedure for the Support & Protection of Adults at Risk of Harm'..

At a wider, organisational level, Moray Council is moving towards developing a multi-agency Adult Support & Protection 'Vision for Moray' within the parameters of the overarching Grampian-wide Policy/Procedure. That is based on the insights and themes identified in the

Adult Support & Protection Final Self Evaluation Report, an Audit of Case Files and a Council Officer Social Work Questionnaire, resulting in a 12 month action plan that will lead to an improvement in the way that Adult Support & Protection is provided in Moray from 2020.

This process will involve;

- Reviewing the remit and membership of the Adult Support Protection (ASP) Committee
- The established of any required sub-groups (e.g. Performance).
- A description of the duties and responsibilities of the key positions on this Committee and the rationale for the interface with the Chief Officer Group (COG)
- Reviewing the Core ASP Process with the aim of ensuring that it adequately reflects multi-agency input and covers the whole ASP process including monitoring and review
- Reviewing the Out of Hours (OOH's) process to ensure that it is aligned with the Moray Policy and the Core ASP Process
- Developing a written procedure that includes and agrees the multi-agency input required for applying the 3 point test, multi-agency requirement for conducting Investigations
- Developing a manual that can be shared between all partners that outlines the core process, defines the terminology used by all Moray partners, clarifies information sharing between partners and includes the procedure for conducting ASP meetings, Case Conferences and implementation of Removal, Banning and Assessment orders
- Through the Commissioning Team, review the contract to help ensure that formal advocacy services are as accessible as possible to people involved in the adult support and protection process.

Managing Waiting Times

It is for relevant social care staff to consider how each individual's needs match against eligibility criteria in terms of severity of risk and urgency for intervention. However, the NATIONAL STANDARD ELIGIBILITY CRITERIA AND WAITING TIMES FOR THE PERSONAL AND NURSING CARE OF OLDER PEOPLE suggests the following definitions and related timescales;

In these definitions, the timescale descriptions are used to indicate that services are likely to be required as follows:

- **Immediate** – required now or within approximately 1-2 weeks;
- **Imminent** – required within 6 weeks;.
- **Foreseeable future** – required within next 6 months;
- **Longer term** – required within next 12 months or subsequently.

The National Eligibility Criteria for Adult Social Care and Waiting Times for Personal & Nursing Care document recommends these are the minimum expectations on local authorities. Both COSLA and the Scottish Government encourage local authorities to seek to provide support within their available resources, beyond this minimum level, and particularly to consider the benefits of preventative and lower intensity interventions (Tiers 1 and 2 of the Three Tier Policy).

5.3 Assessment

This is a process, an on-going discussion, (not necessarily a single event) where we will gather relevant information about individuals and their circumstances. This assessment will include information about the client's activities of daily living, their health and also income/benefits checks as people may later be asked to pay for, or make a contribution to the cost of support.

The aim of the Assessment is to identify positive/personal outcomes for the individual to work towards. The Assessment process is underpinned by the Talking Points personal outcomes approach and focuses on quality of life and change outcomes. The assessment process will involve identifying an individual's strengths, needs, risks, capacity and define their personal outcomes.

If the individual has **eligible needs**, we will:

- Provide information and options so the service user can choose how the needs will be met
- Carry out a financial assessment for chargeable support that may require a contribution.
- In all appropriate cases, **preventative, rehabilitative and/or progression model measures** should be put in place, such as telecare or reablement (Tier 2 of the Moray Partners in Care (Three Tier) Policy).

The Moray Integration Joint Board (IJB) will work to the **Moray Partners in Care (3 tier) Policy** to ensure that people are active agents in securing their own health and well-being; that the provision of social care is not the first response and that the role of the Adult Social Care service will be to focus on empowering the individual to become as independent as possible. The Moray IJB is aware that eligibility may change over time/fluctuate due to changing circumstances or needs.

The Moray IJB must establish whether the adult is **ordinarily resident** in its area, and meet eligible needs of those individuals who are ordinary residents.

Appendix One defines the eligibility criteria applicable after assessment
How eligible care needs are going to be met will be part of the SDS Options discussion to ensure that Self-directed Support choices made by the service user are meeting their agreed personal outcomes (and the individual budget is being used appropriately to meet these personal outcomes).

> Please see the Statutory Guidance accompanying the Social Care (Self-directed Support) (SDS) (Scotland) Act 2013

Diagnosis of a specific condition/disability/illness does not automatically make a person eligible for on-going support. Eligibility will depend on whether the impact of the condition/disability/illness means that the person has care and support needs at the critical or substantial risk level that are not already being met by support from friends/family/unpaid carers or other support networks. .

If someone is not assessed as eligible for on-going support and they disagree with the decision they (or a family member, unpaid carer or independent advocate etc. acting on their authority) can make a complaint stating why they think the decision was wrong. Alternatively they can ask for a re-assessment focussing on any support needs they think were missed or misunderstood in the initial assessment.

5.4 Unpaid Carers

People who are unpaid carers can also ask for a separate Carers Assessment/Adult Carer Support Plan . Whilst the eligibility decision for support for unpaid carers is taken by the council and is based on the same National eligibility criteria stated in section 5.3, the tools to aid eligibility decisions can differ. For example, if supported by Quarriers (commissioned to support unpaid carers) they use an 'outcomes star' assessment tool with seven defined areas (corresponding to National Eligibility Criteria and National Guidance on support for unpaid carers) of the unpaid carers life to assess whether they think the unpaid carer may have eligibility for support and if so, will refer to the council with an eligibility summary/recommendation. This is an aid only and it is for the council to assess whether the support required by the unpaid carer meets the definitions of critical or substantial risk (National Eligibility Criteria) in any one of those seven areas of the unpaid carers life. Unpaid carers will not be subject to a financial assessment and will not contribute to the cost of support they access. More information is available in the Carers Assessment/Adult Carers Support Plan Policy and Pathway to Support/Procedure.

5.5 Moray Partners in Care (3 tier) Policy

The Moray Partners in Care (3 Tier) policy provides an overview of a model for the delivery of integrated health and social care services in Moray that aims to support the achievement of better outcomes for service users, patients and unpaid carers.

The deployment of this model can help support the achievement of transformational cultural change within the health and social care workforce and a greater understanding of what the public can expect from an integrated health and social care service in the future.

Integral to the proposed new model is a vision shared with the Christie Commission for the Reform of Public Services in Scotland. At the heart of this vision is a new relationship between those who provide services and people who access support.

For Health & Social Care Moray, central to this new relationship is the notion that an outcome based conversation should take place with the client. Based on emerging best practice in a number of local authorities in England, and in particular Felixstowe, this model can be described as a three tier process:

- **Tier 1**- Help to help you (information and advice), universal services to the whole community and emphasis on prevention.
- **Tier 2**- Help when you need it (immediate help in a crisis, reablement and regaining independence).
- **Tier 3**- On-going support for those who need it. (This may include the delivery of 1 or more Self-directed Support (SDS) options).

Everyone with the potential to benefit from reablement/rehabilitation should have the opportunity to do so to help regain/retain skills for independent living and prevent, reduce or delay the need for on-going care and support. Where there is an-ongoing need for care and support (Tier 3 - including after a period of reablement) and where these care and support needs meet the critical or substantial risk eligibility criteria, a support plan will be co-produced between staff, service users and unpaid carers where appropriate.

5.6 Support Planning

Following the assessment if there are eligible needs a personal Support Plan will be completed. The purpose of the Support Plan is to consider how the individual's identified personal outcomes can be best met. We will work with the client (co-production) and agree this Support Plan and once it is complete they will receive a copy as will anyone else they want to receive a copy (i.e. unpaid carer).

The Support Plan will outline which needs /agreed outcomes are eligible for support. The Plan will set out which support or activities people choose in order to meet their agreed personal outcomes (as previously stated this is part of the SDS Options discussion and agreement where the service user can choose and direct the support they access to achieve their agreed personal outcomes)

Please see the Statutory Guidance accompanying the Social Care (Self-directed Support) (SDS) (Scotland) Act 2013

5.7 Choosing support under Self-directed Support (SDS)

As part of the assessment and planning process, individuals with eligible needs will have four options explained and offered to them. The following four options will be made available for an individual to choose how they access social care and support using their individual budget (in more rural areas all options may or may not be available from time to time):

- **Option 1 - Direct Payment**
  The Council provides the individual with a direct payment. This money will be used by the individual to purchase care and support to meet their agreed outcomes. This may include employment of a Personal Assistant or directly purchasing services from a provider.
- **Option 2 - Individual Service Fund**
  An individual service fund is when funding is made available to meet an individual's agreed outcomes. The funding is held by the ISF provider chosen by the service user. The individual decides how the funding should be used to meet the agreed outcomes and maintains choice, control and flexibility.
- **Option 3 – Council Arranged Services**
  The Council arranges the support and care that the individual requires to meet their agreed outcomes.
- **Option 4 - Mixed Package of Care and Support**
  The individual has the flexibility of choosing a combination of Options 1, 2 and 3 to meet their agreed outcomes.

Please see the Statutory Guidance accompanying the Social Care (Self-directed Support) (SDS) (Scotland) Act 2013

5.8 Monitoring and Review of Support Plan

- The Support Plan will be monitored to ensure it is being implemented, it is effective and to make any adjustments or improvements as necessary. The level of monitoring required will be discussed and agreed at the support planning stage.
- The Council has a duty to undertake annual reviews where support is provided to meet eligible needs, or more frequently as a response to a significant change in circumstances. The purpose of the review is to ensure the individual is achieving the agreed outcomes set out in the Support Plan. The review process will consider with the individual, and any others involved, the extent to which the support they receive has assisted them to achieve their outcomes, and where appropriate agree new ones.
- At each review the four SDS options will be offered formally again, even if there are no changes required to the Support Plan.
- At any time an individual can ask to change their option or ask for a re-assessment of their situation.

Health & Social Care Moray will monitor the timescales from 'first referral' to 'confirmation of need' to keep in line with the National Community Care Outcomes Framework, COSLA and the Scottish Government.

- **'First Referral' means at the point at which the potential need for an assessment is first notified to the council or care needs review is initiated.**
- **'Confirmation of Needs' means at the point at which an individual's needs are identified against the eligibility criteria following the care needs assessment or review.**

6.0 Priority Risk Categories

The Scottish Government / COLSA Guidelines describe **four levels of risk** if assessed needs are not met. These categories are used to help us prioritise an individual's circumstances so that services are targeted at those in greatest need. The person may have a number of needs for support, so their needs may fall into a number of different categories. (See **Appendix One**)

The risk categories are:

- **Critical** - major risks to independent living, health and wellbeing which are likely to require immediate or imminent provision of services.
- **Substantial** - significant risks to independent living, health and wellbeing which are likely to require immediate or imminent provision of services
- ***Moderate** - some risks to independence, health and wellbeing which may call for the provision of some social care services managed and prioritised on an on-going basis or may be manageable over the foreseeable future without service provision, with appropriate arrangements for review.
- ***Low** - some quality of life issues, but low risks to independence, health and wellbeing with very limited, if any, requirement for the provision of social care services. There may be some need for alternative support or advice and appropriate arrangements for review over the foreseeable future or longer term.

***** Resources are not available to meet these needs on an on-going basis. However, preventative support and/or advice specific to the circumstances of each case may be provided, to help reduce/delay on-going support needs and to find alternative sources of support with appropriate arrangements for review, if required.

We provide on-going support to those people who are at the greatest risk in line with the timescales stated in section 5.2 (waiting times).

To ensure that our decisions are fair we use agreed national criteria known as eligibility criteria (**Appendix One**). This takes into account each person's circumstances.

Risks assessed:

- **Neglect or physical or mental health**
- **Personal care**
- **Participation in community life**
- **Support from/for Unpaid Carers, including the ability to continue their caring role**

There may be some need for alternative support or advice (to help prevent, reduce and delay on-going support needs in line with Tier's 1 & 2 of the Moray Partners in Care (Three Tier) Policy) **and appropriate arrangements for review over the foreseeable future or longer term.**

7.0 Equalities Statement

7.1 Health & Social Care Moray will not and does not discriminate on any grounds. Health & Social Care Moray advocates and is committed to equalities and recognises its responsibilities under the Equality Act 2010 and related Public Sector Equality Duty. Health & Social Care Moray will ensure the fair treatment of all individuals and where any individual feels that they have been unfairly discriminated against this can be reported to Health & Social Care Moray (see below).

In relation to equality of information provision, Health & Social Care Moray will ensure that all communications with individuals are in plain English, and shall publish all information and documentation in a variety of formats and languages. Where required, Health & Social Care Moray will use the services of its translation team to enable effective communication between us and the individual. Where an individual has sight, hearing or other difficulties, we will arrange for information to be provided in the most appropriate format to meet that individual's needs. Health & Social Care Moray will also ensure that there are no physical barriers that could prohibit face to face communications.

If there is a complaint against discrimination, click on the link below for reporting form and procedure: http://www.moray.gov.uk/downloads/file62366.pdf.

Equality and Human Rights Commission Scotland
https://www.equalityhumanrights.com/en/commission-scotland
Advice and Guidance section
https://www.equalityhumanrights.com/en/advice-and-guidance.

8.0 Data Protection

8.1 Data Protection Legislation, including the Data Protection Act 2018 (DPA) and the General Data protection Regulations (GDPR), governs the way information is obtained, recorded, stored, used and destroyed. Data protection is the responsibility of everyone and data protection legislation gives individuals rights to know how personal information can be collected, used and stored. Health & Social Care Moray complies with all the requirements of the legislation and ensures that personal data is processed lawfully, fairly and in a transparent manner; that it is used for the purpose it was intended and that only relevant information is used. Health & Social Care Moray will ensure that information held is accurate, and where necessary kept up to date, and, that appropriate measures are taken that would prevent the unauthorised or unlawful use of any personal information.

Any sharing of data between NHS Grampian and Health & Social Care Moray is carried out in accordance with the Information Sharing Protocols between the two bodies. Refer to Practitioner Leaflet v5.0 and the Information Sharing without Consent Protocol.

For more information please see the Council's DPA Guide: http://intranet.moray.gov.uk/Information_management/information_security.htm or http://www.moray.gov.uk/moray_standard/page_119859.html for Subject Access Request information.

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9.0 Freedom of Information

9.1 The purpose of the Freedom of Information (Scotland) Act 2002 is to "provide a right of access by the public to information held by public authorities". In terms of section 1 of the Act, the general entitlement is that a "person who requests information from a Scottish public authority which holds it is entitled to be given it by the authority". Information that a person is entitled to is the information held by the public authority at the time that the request is made. This is a complex area of the law that can overlap with the Data Protection Act and other legislation.

Please see the following link for guidance to the law in Scotland;
http://www.itspublicknowledge.info/Law/FOISA-EIRsGuidance/Briefings.aspx

All FOI requests to Health & Social Care Moray should be directed to **the FOI team** via info@moray.gov.uk. More information is available:
http://www.moray.gov.uk/moray_standard/page_53728.html

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10.0 Human Rights Act and Equality Act

In October 2007 the three equalities commissions: Racial Equality, Disability Rights and Equal Opportunities were merged to form one Commission: **The Equality & Human Rights Commission (Scotland)** https://www.equalityhumanrights.com/en/commission-scotland**.**

More information about the **Equality Act 2010** can be found here https://www.equalityhumanrights.com/en/equality-act**.**

The **Human Rights Act 1998** sets out rights in a series of Articles https://www.equalityhumanrights.com/en/human-rights/human-rights-act including;: Right to life; protection from torture; protection from slavery and forced labour; right to liberty and security; right to a fair trial; no punishment without law; right to respect for private and family life; freedom of thought, belief and religion; freedom of expression; freedom of assembly and association; right to marry; protection from discrimination; protection of property; right to education and right to free elections.

11.0 Performance Monitoring

The Moray Integration Joint Board is responsible for measuring performance against the priorities identified in its Strategic Plan. Health & Social Care Moray (its committees, boards and managers) also monitors performance against the national standards set by the Scottish Government. This includes performance information relating to the 9 'Higher' National Health & Wellbeing Outcomes set out as a measure for Integration by the Scottish Government

https://www.gov.scot/Topics/Health/Policy/Health-Social-Care-Integration/National-Health-WellbeingOutcomes.

Health & Social Care Moray also has a responsibility to provide performance information. The Scottish Government, The Integration Joint Board, Audit Scotland, Adult Services Performance Group, Local Intelligence Support Team (LIST) a division of National Services Scotland, The Care Inspectorate and the Adult Care Practice Governance Board require that this performance monitoring is carried out and reported at the required intervals.

It is understood that the monitoring of services and the provision of monitoring information is an important part of the work of Health & Social Care Moray. The responsibility for providing this performance information (and acting on it) lies with managers of the services. All performance information must be sent to the Performance Officer(s) within the Performance department of Health and Social Care Moray.

12.0 Complaints

Social Care in Moray Council is committed to providing high-quality customer services. We value all comments and complaints and use information from them to help us improve our services.

If someone has a concern about our services or wants to make a complaint, it is best to contact the team responsible for the service they are unhappy with and raise the matter with them first.

The person can speak directly to their social worker or a member of staff in their local social work office or call the ACCESS TEAM on **01343 563999** Monday to Friday from 8.45am to 5pm. Email accesscareteam@moray.gov.uk or they can also write to the Access Care Team, Adult Social Care, Moray Council, 2-10 High Street, Elgin IV30 1BY.

HSCM's formal complaints procedure
http://www.moray.gov.uk/moray_standard/page_1379.html

For more detailed advice or to obtain a copy of the procedure in another format contact 01343 543451 or email complaints@moray.gov.uk.

Some of the services delivered by Social Care Services (either directly or on our behalf) such as day care, residential care, housing support services, respite care, foster care and children's care homes are also regulated by the Care Inspectorate.

If a service user is dissatisfied with the standard of care offered by these services, they can complain to the Care Inspectorate http://www.careinspectorate.com/index.php/complaints (online or by telephone 0345 600 9527) as well as making a complaint to us:

Care Inspectorate Compass House 11 Riverside Drive Dundee DD1 4NY
Tel: 0345 600 9527

13.0 Review and Feedback

This policy will be reviewed annually (or sooner if required). Feedback can be sent to the Commissioning and Performance Officer (Policies & Procedures) at Health & Social Care Moray (Garry.Macdonald@moray.gov.uk) and where relevant and practicable will be included in the next review.

14.0 Glossary of terms

The **Moray Integration Joint Board (IJB)** was formed via the Public Bodies (Joint Working) (Scotland) Act 2014 (which legislates for the integration of health and social care). The Board has representation from both health and social care in Moray.

Health & Social Care Moray describes integrated health and social care in Moray under the IJB.

Assessment of needs/care needs assessment – involves a care manager/social worker/community care officer considering with the person and potentially their unpaid carer (or other representative) different aspects or areas of the person's life to explore what tasks or activities they can or cannot carry out with or without support and the impact it has on their wellbeing. It considers the person's strengths, capabilities and support networks, the support the person may already have or which may be available as well as the person's care and support

needs. It explores what personal outcomes are most important to the person. It determines which care and support needs are eligible for support from Health & Social Care Moray. It may also result in the provision of advice and information as well as signposting to other relevant services to support the person to promote their wellbeing and prevent, reduce or delay some care needs. The assessment should be 'appropriate' in that it should be carried out in a way that best supports the person to be involved in or leading the process. This can include supported self-assessment.

Eligible needs – are the actual care and support needs a person has that have been assessed as meeting the eligibility criteria for support. That criteria based on national guidance http://www.gov.scot/Publications/2014/08/5212/6 divides needs into 4 categories which are; critical, substantial, moderate and low risk care needs. If the care and support needs the person has fall within the description of care in the categories that Health & Social Care Moray has agreed to provide support for (critical and substantial care needs) they will be eligible social care needs.

Co-production - means delivering public services in an equal and reciprocal relationship between professionals, people using services, their unpaid carers and families and communities. It is about involving people in the delivery of public services, helping to change their relationship with services from dependency to genuinely taking control.

Outcome focussed planning - This is the process of putting together a support plan that sets out the care, support, services, activities or goods that when accessed will help to achieve the agreed personal outcomes that are important to the service user. It is about the difference achieving the outcome will make to the service user's life by accessing this support.

Self-Directed Support (SDS) – SDS is the support, activities, services or goods a person chooses, purchases, arranges or receives to meet their agreed personal social care outcomes. There are 4 options for SDS including a Direct Payment to the service user from Health & Social Care Moray to purchase and arrange their own support (with help to do so if required).

Unpaid carer – an individual who provides or intends to provide care for another individual (the cared for person

Contributions – this is the amount of their weekly income the person is assessed as being able to pay towards the overall cost of the individual budget for the care and support they need.

Non-residential care – this is care and support that is provided outside of a permanent care home (residential care) and can include care at home and in supported or sheltered housing.

Individual budget – this is the amount of money the council has worked out it will cost to meet the person's eligible care and support outcomes as set out in their support plan.

Financial assessment – this is the process of looking at the capital (including savings) and weekly income the person has to work out how much they can contribute towards the cost of the care and support they are assessed as eligible for (unless that support is free – i.e. free personal care for adults of any age who are eligible or tier 2 reablement support for up to 12 weeks to regain/retain independent living skills).

Direct Payments – is an amount of money (from the individual budget) paid to the service user so the service user (with support if needed) can choose, arrange and purchase the care, support, services, activities or goods required to meet their assessed, eligible needs and their agreed outcomes contained in their support plan.

Moray Partners in Care (3 tier) policy – this is the policy for Moray in relation to the delivery of integrated health and social care services which aims to support better outcomes for service users, patients and unpaid carers. Tier 1 is 'help to help you' (providing information and advice and other universal services) with the focus on preventing and delaying care and support needs. Tier 2 is 'help when you need it' (immediate help in a crisis and reablement support to help maximise independent living and reduce or delay care needs). Tier 3 is 'ongoing support for those who need it' (for people with ongoing eligible care and support needs and includes Self-Directed Support and Direct Payments).

National Outcomes for the Integration of Health & Social Care – the national health and wellbeing outcomes are a framework for the planning and delivery of health and social care services. These outcomes, together, are aimed at improving experiences and quality of services for service users, unpaid carers and their families. It is both about improving how services are provided and the difference that integrated health and social care services should make for individuals.

Appendix One – Eligibility framework - the four risk levels

Following the Assessment process, an individual's circumstances and needs will be categorised into one of the four risk levels according to the criteria set out below.

Threshold

- **Critical** and **Substantial** risks to be considered for care services, and for
- **Moderate** and **Low** levels of risks to receive information and advice.

Category 1: CRITICAL NEEDS

Neglect or physical / mental health

- major health problems which present immediate threat of harm to self or others
- serious harm or neglect has occurred or is strongly suspected (including financial abuse and discrimination)
- palliative or end of life care needs

Personal care and domestic environment

- unable to meet vital or most personal care needs causing major harm or major risk to independence
- unable to meet vital or most aspects of domestic routines causing major harm or major risk to independence
- homelessness of a vulnerable person
- extensive / complete loss of choice and control over vital aspects of home environment causing major harm or major risk to independence

Participation in community life

- unable to sustain involvement in vital aspects of work/education/learning causing severe loss of independence
- unable to sustain involvement in vital or most aspects of family/social roles, responsibilities and contact causing significant distress or risk to independence

Unpaid Carers

- major health difficulties due to impact of their caring role causing life threatening harm or danger
- complete breakdown in the relationship between carer and service user and carer is unable to continue in their caring role
- carer is unable to manage vital or most aspects of their roles and responsibilities

Category 2: SUBSTANTIAL NEEDS

Neglect or physical / mental health

- harm or neglect has occurred or is strongly suspected (including financial abuse and discrimination)
- significant health problems which cause significant risk of harm or danger
- palliative or end of life care needs

Personal care and domestic environment

- unable to undertake many aspects of personal care causing significant risk of harm or significant risk to independence
- unable to manage many aspects of domestic routines causing significant risk of harm or significant risk to independence
- substantial loss of choice and control managing home environment causing a significant risk of harm or danger to self or others, or a significant risk to independence

Participation in community life

- unable to sustain involvement in many aspects of work/education/learning causing significant risk to independence
- unable to sustain involvement in many aspects of family/social roles, responsibilities and contact causing significant distress or risk to independence

Unpaid Carers

- significant health difficulties due to impact of their caring role causing significant risk of harm or danger
- carer is unable to manage many aspects of their caring, family or employment responsibilities
- significant risk of breakdown in the relationship between carer and service user and carer is unable to sustain many aspects of their caring role

Category 3: MODERATE NEEDS

Neglect or physical / mental health issues

- Some health problems indicating some risk to independence and/or intermittent distress. Potential to maintain health with minimum interventions
- need to raise awareness of vulnerable person to potential risk of harm

Personal care and domestic environment

- unable to undertake some aspects of personal care indicating some risk to independence
- able to manage some aspects of domestic activities and/or home environment indicating some risk to independence

Participating in community life

- unable to manage several aspects relating to work/learning/education that, in the foreseeable future, will pose a risk to independence
- able to manage some aspects of family roles and responsibilities, posing some risk to independence

Unpaid Carers

- main carer able to manage some aspects of caring and family/domestic roles, posing some risk of breakdown in their own health
- relationship between carer and service user under strain at times, limiting some aspects of the caring role or creating some risk of relationship breakdown

Category 4: LOW NEEDS

Neglect or physical / mental health

- Few health problems indicating low risk to independence. Potential to maintain health with minimum interventions
- preventative measures including reminders to minimise potential risk of harm

Personal care and domestic environment

- difficulty with one or two aspects of personal care or domestic routines, indicating little risk to independence
- able to manage most basic aspects of domestic activities and environment

Participation in community life

- difficulty undertaking one or two aspects of work/learning/education responsibilities, indicating low risk to independence
- difficulty undertaking one or two aspects relating to family responsibilities or social support networks, indicating low risk to independence
- able to manage most aspects of family responsibilities and social support networks, posting some risk to independence

Unpaid Carers

- carer able to manage most aspects of their caring and domestic role and responsibilities, indicating low risk
- carer is able to manage most aspects of their family and work responsibilities, indicating low risk
- relationship is maintained between client and carer by limiting aspects of the caring role

The Carers (Scotland) Act 2016 defines an unpaid carer as “an individual who provides or intends to provide care for another individual (a cared-for person)”.

An unpaid carer with care and support needs of their own, due to their own frailty, illness, circumstances or disability will have their needs met (if eligible) via the support/choices outlined in this policy.

In terms of the caring role, consideration must be given to the extent to which the unpaid carer is able and willing to provide or continue to provide care for the cared-for person.

People who are unpaid carers have a right to a separate Carers Assessment (called an Adult Carer Support Plan with effect from 1 April 2018) to identify their support needs as a carer. If the cared-for person resides in Moray, Health & Social Care Moray has a responsibility to prepare an Adult Carer Support Plan for the unpaid carer that sets out the carers identified personal outcomes, needs and any support provided by Health & Social Care Moray to meet those needs.

In Moray a range of support measures for unpaid adult carers is provided through a local commissioned carer support service. This includes advice, information and support with Adult Carer Support Plans as a pathway to eligibility decisions by the council for support to the unpaid carer.

An unpaid carer can therefore have needs met themselves as a person with an illness or disability (or other support need such as training) and have needs met as a carer through their Carer Assessment (Adult Carer Support Plan) if these support needs are eligible support needs..

Appendix Two – Eligibility Criteria Flowchart

Notes about timescales linked to the flowchart:

- Referral,
- Assessment
- Provision of support/personal/nursing care.

National Eligibility Criteria does not set a time limit for the provision of an **assessment**. However, timescales are monitored from the time of first referral to confirmation of support needs (via the assessment and matching support needs to eligibility criteria).

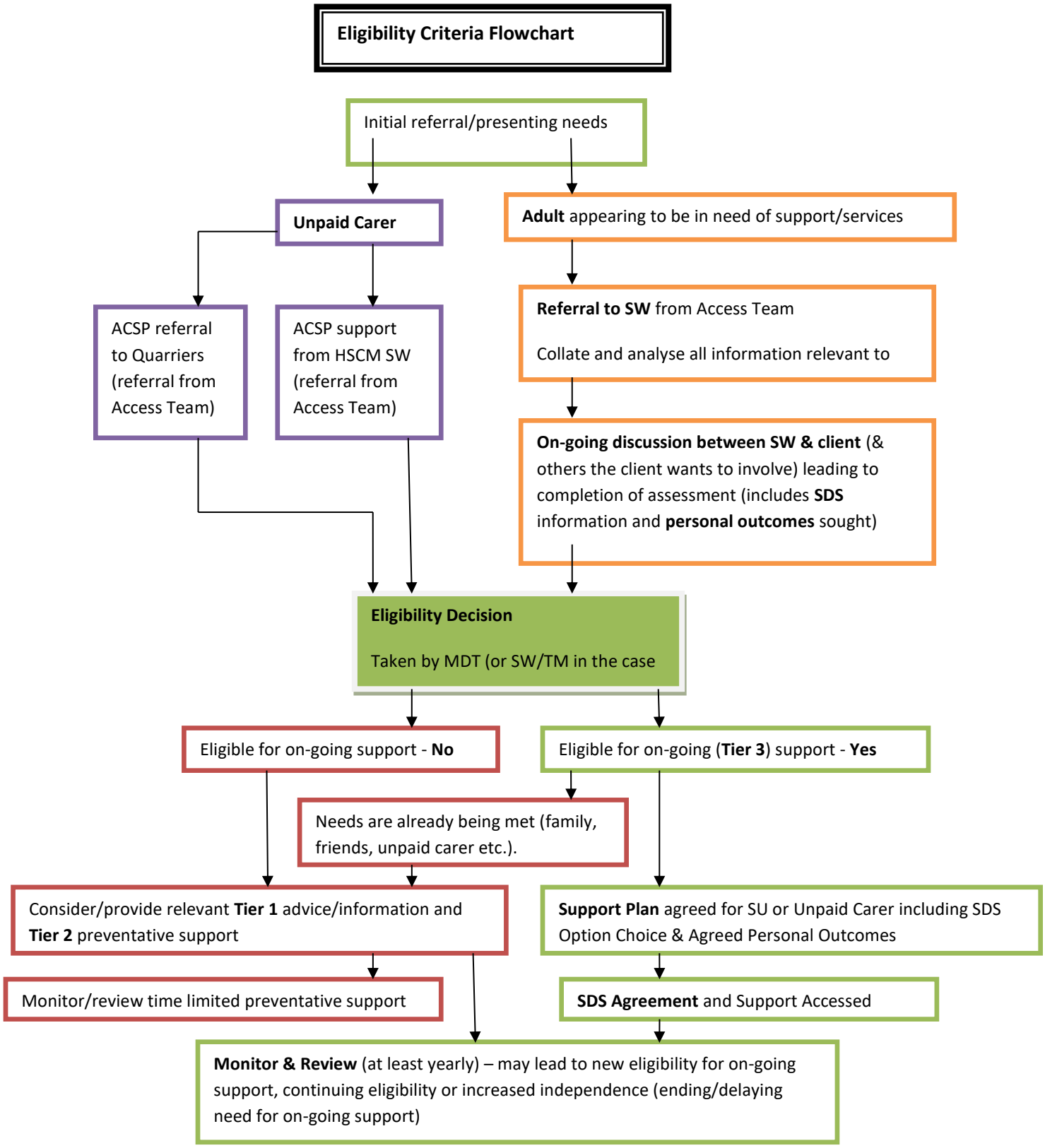
The eligibility framework considers both (a) the severity of the risks and (b) **the urgency for intervention** to respond to the risks. It is for relevant social work staff to consider how each individual's needs match against eligibility criteria in terms of severity of risk and urgency for intervention.

In the 4 risk definitions in the eligibility framework, the timescale descriptions (see below) are used to indicate that services are likely to be required as follows (actual timescale may be less):

- **Immediate** – required now or within approximately 1-2 weeks;
- **Imminent** – required within 6 weeks;
- **Foreseeable future** – required within next 6 months;
- **Longer term** – required within next 12 months or subsequently.

Personal and Nursing Care (where someone has eligible needs) should be provided within a maximum of 6 weeks (42 days).

For Unpaid Carers the Adult Carer Support Plan process/procedure including eligibility decision is set out in the Adult Carer Support Plan Pathway to Support/Procedure. An assessment by the council of critical or substantial risk (as per National Criteria) in one of the seven areas of the unpaid carers life assessed will mean eligibility.


Eligibility Criteria Flowchart
Initial referral/presenting needs
Unpaid Carer
Adult appearing to be in need of support/services
ACSP referral to Quarriers (referral from Access Team)
ACSP support from HSCM SW (referral from Access Team)
Referral to SW from Access Team
Collate and analyse all information relevant to
On-going discussion between SW & client (& others the client wants to involve) leading to completion of assessment (includes SDS information and personal outcomes sought)
Eligibility Decision
Taken by MDT (or SW/TM in the case
Eligible for on-going support - No
Eligible for on-going (Tier 3) support - Yes
Needs are already being met (family, friends, unpaid carer etc.).
Consider/provide relevant Tier 1 advice/information and Tier 2 preventative support
Support Plan agreed for SU or Unpaid Carer including SDS Option Choice & Agreed Personal Outcomes
Monitor/review time limited preventative support
SDS Agreement and Support Accessed
Monitor & Review (at least yearly) – may lead to new eligibility for on-going support, continuing eligibility or increased independence (ending/delaying need for on-going support)