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<th>Issue number</th>
<th>Date</th>
<th>Author</th>
<th>Principal Changes</th>
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<tr>
<td>1</td>
<td>April 2011</td>
<td>Tracy Davis</td>
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<tr>
<td>1.1-1.6</td>
<td>October 2012 – Jan 2013</td>
<td>Tracy Davis, Greg Slay</td>
<td>Removal of matrix; guidance brought in line with current case law and best practice from around the southeast of England</td>
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**Feedback:**
Our customers expect first class service and we aim to provide it. We therefore welcome feedback about our policies and procedures. If you have any comments about this document please e-mail: socialcare@westsussex.gov.uk
Equality and diversity

As part of our commitment to equality and diversity, and in line with the requirements of the Equality Act 2010, the county council will ensure that all customers of our services are treated with fairness, dignity and respect irrespective of any of the following protected characteristics: age, race, gender, disability, sexual orientation, gender reassignment, marriage or civil partnership status, pregnancy/maternity status or religion and belief.

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Introduction

1. **Our policy approach to assisting customers**

1.1 Our customers are expert in understanding their own needs and how best to achieve the social care support they need – both within their own homes and/or within the wider local community.

1.2 Sometimes – perhaps because of the complexity of the immediate issues that need to be sorted – people ask for specialist help from the county council. When this happens it is our responsibility as a local social services authority to work through the issues with them. Our intention always is to get to the point where the customer can take responsibility for organising and managing their social care needs.

1.3 For those who are eligible for support from the county council, we provide personal budgets to enable customers to meet their own needs. This personal budget may be supplemented by independently sourced assistance from the NHS, private, voluntary and/or independent sector organisations.

1.4 Some of our customers lack the mental capacity to make specific decisions about their social care needs. Consequently, we will discuss any arrangements needed with relatives including with anyone holding a Lasting Power of Attorney. Alternatively, some may have a Deputy appointed by the Court of Protection to deal with these matters on their behalf.

2. **Legislative background and context**

2.1 The initiative for the development of self-directed support originated from organisations led by, and/or representing, people with disabilities.

2.2 The requirement for the assessment of adults who may have community care needs is set out in S.47 (1) NHS and Community Care Act 1990. Our policy on Self-Directed Support, revised in 2012, provides more detail; that document is publicly available on the county council’s website (visit: westsussex.gov.uk and type ‘self-directed support’ in the search engine).

2.3 The relevant national guidance that helps the county council to ascertain whether a customer or prospective customer has eligible social care needs is the Department of Health’s ‘Prioritising Need in the context of Putting People First: a whole system approach to eligibility for social care, England’ guidance that was published in 2010. This national statutory guidance replaced what had previously been known as the ‘Fair Access to Care Services’ guidance. The 2010 guidance includes four eligibility threshold levels, of which the county council now provides a response to adults who have either
'critical’ or ‘substantial’ levels of assessed need. The four threshold levels are set out in full in Appendix 1 of this Practice Guidance.

2.4 Local social services authorities have discretion over the eligibility bandings against which they choose to provide social care services – and are expected to draw up their own local eligibility criteria (such as this document). Local authorities are however expected to prioritise needs that have immediate and longer-term critical consequences for independence and well-being ahead of those needs that have substantial consequences. West Sussex County Council has decided that it will provide services for individuals whose presenting needs for social care are assessed as falling within the ‘substantial’ and/or ‘critical’ bandings. Presenting needs that fall within these particular bandings are termed ‘eligible needs’.

2.5 The 2010 Prioritising Need guidance also states that the evaluation of a person’s needs should take full account of how those needs and risks might change over time - and the likely outcome if help were not provided. This should include consideration of the impact upon the person of any changes in the circumstances of any carer or carers that may be involved.

A draft Care and Support Bill was published in 2012. The draft Bill sets out the Government's plans for streamlining the current range of adult social care statutes, particularly – but not exclusively - the 1948 National Assistance Act. The draft Bill does not include changes to existing arrangements for long-term care funding, for which a separate announcement will be made in due course. A national eligibility framework is proposed in parallel with the legislative changes. None of these changes is likely to be implemented before 2015-16.

3. Status of this practice guidance

3.1 This practice guidance replaces our local ‘Fair Access to Care Services Adults’ Services Eligibility Criteria Interim Guidance’. That earlier guidance document had been published in April 2011. Amendments have been made to it to reflect that this is no longer ‘interim’ guidance as well as to comply with current case law.

3.2 The 2010 national guidance is particularly pertinent to customers with fluctuating and/or long term conditions. Paragraph 63 of the Department of Health’s ‘Prioritising Need’ guidance requires councils to consider a person’s needs over time - rather than at a single point - in order that their needs are properly taken into account.

The purpose of this revised local practice guidance is therefore to:
Enable practitioners to apply eligibility criteria fairly, consistently and in a way which is transparent to customers;
Enable practitioners to identify and analyse current (and potential) eligible needs, within a framework of evidence based practice;
Reinforce the fair and consistent application of eligibility criteria across Adults’ Services within the existing processes of self-directed support;
Ensure that services are targeted at those in greatest need using resources in the most efficient way;
Enable practitioners to get relevant support to make their own professional judgement.

The Isle of Wight Council case: The Queen (on the application of JM and NT) and Isle of Wight Council, EWHC 2911, reported November 2011.

In accordance with the 2010 Prioritising Needs guidance it is clear that a risk analysis of the presenting social care needs is required in order to identify those needs that can be identified according to the four national banding levels.

The High Court found that, once an eligibility category has been identified, the Prioritising Need guidance does not then go on to permit a risk analysis based on frequency of risk. However the Isle of Wight Council had advised its staff to assess the likelihood of risks occurring over a six-month period. So, for example, if particular risks were assessed as remote (that is, likely to happen no more than twice a year, or not until six months have passed or that there was a less than 1:10 chance of the risk happening) then the person would not have eligible needs for social care support, irrespective of the level of the presenting needs. The High Court ruled that this approach to assisting staff to apply the Prioritising Need guidance was unlawful.

Eligibility

4. Applying eligibility criteria – principles

4.1 Our Self-Directed Support Policy endorses the framework principles originally developed nationally by In Control. The work of In Control (a charitable organization) and six pilot sites across England led to the development of current Government policy on self-directed support, first published in 2007.

4.2 In terms of assessing the needs of individual customers, our approach is focused on:
Working in partnership with customers and their carers at all stages of the assessment process;
Ensuring that the scope of the assessment process is proportionate to the need and fit for purpose;
Establishing the customer’s strength and resources, ability to self care and the limitations they face due to their disabilities or impairments;
Establishing the current level of support available to meet the customer’s identified needs - such as health care provision, support from relatives and family, and support from other informal networks or other organisations;
Checking out the viability or sustainability of others who are currently supporting the customer being able to do so in the future;
Exploring solutions that lie within the adult’s own network or through local community resources; and
Identifying which needs suggest funded social care services may be required (although not necessarily provided by Adults’ Services) according to the risks to the independence and/or wellbeing of the individual customer.

Core principles of self-directed support for customers*

These were articulated nationally as part of the introduction of self-directed support: they have been further refined locally in West Sussex as:

- **Outcome 1** To stay healthy and recover quickly from illness;
- **Outcome 2** To have the best possible quality of life, including life with other family members supported in a caring role;
- **Outcome 3** To participate as an active citizen, increasing independence where possible;
- **Outcome 4** To have maximum choice and control;
- **Outcome 5** To live safely, free from discrimination or harassment;
- **Outcome 6** To achieve economic well-being and have access to work and/or benefits as appropriate; and
- **Outcome 7** To keep their personal dignity and to be respected by others.


4.3 In identifying eligible needs we consider not only the severity of the risks associated with the immediate situation, (today and within the next few days), but also the risks to independence and/or well being that may occur in the medium term, that is, within the next 3-6 months.
4.4 Decisions around eligibility for funded social care services remain with the social care worker with sign off from their line manager. Practitioners will establish eligible needs rather than make judgements about the person who has those needs. The **severity of the presenting need** will determine whether or not the individual has eligible needs. In some cases, a customer might have a range of needs of which only two or three are eligible. This is an important point and needs to be conveyed to customers at the outset of the assessment process. All decisions about eligibility will be clearly analysed, evidenced and recorded on the relevant assessment form – with managers providing support as required in the application of the criteria.

4.5 The fact that there are eligible needs does not automatically mean that Adults’ Services will meet them from its own resources. It may, in certain circumstances, be more effective and/or appropriate for one or more of those eligible needs to be met on behalf of Adults’ Services by another organisation.

4.6 Assessing eligibility within the current framework relies on professional judgement. Within the Prioritising Need framework eligibility bands are expressed as ‘risks to independence’ rather than as specific service needs. This means that in determining whether a need is eligible or ineligible it is with the full consideration of any associated risks to independence. It is essential that the application of these eligibility bandings therefore becomes more consistent and objective.

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**Social work practice and personalisation**

The contribution that social work and social care can make to personalisation was emphasised in practitioner guidance, published in 2010, by the Social Care Institute for Excellence. The guidance noted the following five areas that fall within the remit of social work practice:

- Building relationships;
- Working through conflict;
- Knowing and applying legislation;
- Accessing practical support and services; and
- Working with other professionals to achieve best outcomes.


4.7 Eligibility must also be applied throughout the process, from assessment through provision of funded social care, reassessment and on into initial and
annual review. Eligibility should not however be confused with ‘means and ability’. These are two separate tests. Prioritising Need is a test of eligibility for funded social care and Means and Ability is a test of the financial and other means and ability to make care arrangements. Prioritising Need should be applied before consideration of means and ability. Our local Adults’ Services Means and Ability policy is accessible on the internet (visit: westsussex.gov.uk and type ‘social care adults services policies and procedures’ in the search engine).

5. Initial assessment

5.1 No decision about the allocation of resources will ever be made until after an assessment has been undertaken. The level and complexity of that assessment must be proportionate to the customer’s presenting needs. The first part of the assessment process is completion of the FACE Background Information and Contact Assessment proforma. This proforma is used under licence from FACE Recording and Measurement Systems Limited.

5.2 It is important that customers provide – and practitioners collate - sufficient evidence to be able to make a robust judgement about eligibility within the national Prioritising Need guidance and this local guidance. Our staff need to be able to identify and manage the severity of any presenting risks (including what would happen if needs were left as unmet) as well as address any safeguarding issues and agree the outcomes needed. Practitioners will need to take all the information gathered and work out a customer’s eligibility based on the person’s risk to independence.

5.3 Identifying levels of risk is not an exact process and will therefore vary with each customer and situation. It may be helpful to consider the level of risk that would occur if a service response or other care arrangement (for example, informal care or other arrangements) were not provided or in place.

5.4 Where an eligible need is already being met by an unpaid carer who is willing to continue providing that support, this would be a mitigated need, that is, an eligible need met in a way other than through funded social care. If the customer receives further assessment, such need would be taken into account within the Self or Supported Assessment form completed by the customer and within any carer assessment that is also undertaken. The scoring within the Resource Allocation System would also take account of the support of the carer. No assumptions however should be made about the willingness or ability of a carer to continue in her/his caring role without full consideration.

5.5 When completing the assessment on the Background Information and Contact form, practitioners must ensure they record and evidence the eligibility decisions. The Background Information and Contact form must be completed to demonstrate:
The customer’s presenting needs;
The issues and/or problems identified by, and significant to, the customer (and/or his representative or the referrer) at the initial point of contact with Adults’ Services;
The length of time the need has been experienced;
Any recent life events or changes relevant to the presenting needs;
Any known physical health and wellbeing issues, including disabilities, sensory impairment and/or other health conditions (with medication arrangements if known);
The customer’s emotional health and wellbeing;
The customer’s current support networks and the sustainability of the support available;
Risks that are obvious, already known or have previously been reported;
The need for any assessment of mental capacity where there are concerns about the customer’s decision-making facilities; and
The potential for reablement through the Regaining Independence Service (provided in West Sussex by Essex Cares) or though our in-house Sensory Services’ staff.

**Identification of risks**

A customer who is a chronic smoker, who is known to have memory difficulties and has recently been admitted to hospital after a fall at home, is likely to be at risk of likelihood of further falls and/or at risk of a fire starting in his/her home. Only when provided with this sort of information, recorded on the FACE Background Information Contact Assessment, can we properly assess and plan intervention appropriately.

5.6 **A summary** of the needs and outcomes - with the relevant threshold banding (critical, substantial, moderate or low) – should be identified. This will include eligible needs that can and are to be met in ways other than through funded social care. The summary should also include those presenting needs that were significant to the customer/referrer even if the need itself is ineligible for funded social care.

(Note. There are currently alternative arrangements in place for staff working in Learning Disability Services and in Working Age Mental Health Services. Staff there will input the mandatory fields of the Background Information and Contact form on Frameworki and then record the full assessment using Core Assessment or eCPA documents).

5.7 **The outcome** of the Initial Assessment must be clearly documented and communicated to the customer and/or their representative. If, taking all information into account, it is clear at this stage that eligibility for funded social care is not met, then no further assessment is required. Information, advice
and/or signposting must be provided to assist the customer or representative to access alternative support.

6. Promoting independence

6.1 Adults’ Services has previously agreed that customers whose assessed presenting needs are not currently either ‘substantial’ or ‘critical’ but which are at risk of increasing in severity over the next 12 weeks (so that they become ‘substantial’) will be provided with funded social care support under the ‘promoting independence’ banner. The support provided will be of a short-term duration with a view to ensuring that the needs remain at a ‘moderate’ level of need.

6.2 The promoting independence activities provided will:

✓ Be time-limited in terms of duration of input;
✓ Be free of charge at the point of delivery, that is, not chargeable under Fairer Charging arrangements; and
✓ Prevent dependence on funded care packages to meet this particular need.

6.3 Some practitioners may find it helpful, in thinking about the opportunity to promote independence, to refer to the pointers for information-gathering. This is set out in Appendix 4 of this document.

6.4 Promoting independence is not a new service. It is an approach that utilises existing services and/or community support, and aims to ensure that the customer remains independent and does not become dependent on more costly funded social care support including longer-term attendance at a day centre, or admission to residential care. Although not exhaustive, examples of what is available under the ‘promoting independence’ banner, include:

✓ The Regaining Independence Service – provided in the county by Essex Cares Limited;
✓ Intermediate care – providing support in the customer’s own home, so that hospital admission is avoided, or to help the customer regain his/her independence after a hospital stay;
✓ Use of telecare - such as personal and environmental sensors in the home that can be monitored remotely by, for example, a community lifeline contact centre;
✓ Use of telehealth – such as monitoring equipment used by people in their own homes to provide real time data on a range of health conditions (including, for example, dialysis management);
✓ ‘Once and done’ equipment or activity, including the immediate order of simple equipment such as a raised toilet seat to sustain a person’s independence at home;
7. **The severity of the presenting needs**

7.1 A typical approach to assessing risks, used across the county council and by other organisations, is to follow this sequence of activity:

- Identify all the hazards that are foreseeable – those things that have the potential to cause harm to an individual in terms of their social care need;
- Identify who may be harmed – the individual customer, a carer or others;
- Identify what control measures are already in place to prevent harm being realised – for example, there is a carer who is providing support;
- Evaluate the risk in terms of its severity and the impact or consequence of that severity being realised;
- Put into place pragmatic measures that reduce the risk of the harm occurring;
- Re-evaluate the risk(s) and establish the residual risk factor.

7.2 In determining the severity of the presenting needs of customers for social care support, the key task is to use **professional judgement** to analyse the evidence of the presenting needs.

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**Professional judgement**

Professional = a person who engages in an activity with competence and skill

Judgement = being able to make an informed decision based on a balanced viewpoint

7.3 A schedule to assist with risk assessment is shown in Appendix 2. In essence, this should be used to check understanding of the severity of the presenting risks and their consequences. Practitioners are expected to be familiar with this schedule as its application to assessments will be tested through periodic practice audit.
7.4 It is the role of managers to monitor the recording of eligibility decisions according to the evidence obtained, and to ensure that all members of staff understand and can apply eligibility criteria fairly and consistently.

8. Further detailed assessment

8.1 In order to complete a further assessment, documentation is available to assist practitioners. These forms are accessible on Framework and include the following:

- Self or Supported Assessment (initially completed by the customer);
- Carer Assessment (can be initially completed by the carer);
- OT/RIS Functional Assessment;
- FACE Overview assessment;
- FACE Risk Assessment;
- FACE Mental Capacity Assessment;
- Continuing Health Care Assessment (Decision Support Tool).

8.2 A Self or Supported Assessment will need to be completed in all cases where funded social care is, or appears to be, required. The Self or Supported Assessment form was amended in April 2011 to reflect the local changes to eligibility thresholds. The completion of the Self or Supported Assessment form follows the completion of the Background Information and Contact Assessment form.

8.3 The Carer Assessment includes questions relating to the impact of the caring role apply to each area of support that the carer provides. This enables information to be gathered and analysed so that it is possible to see any emerging themes for carers. The county council’s legal responsibilities to carers are set out in the procedures for Adults’ Services staff on carer assessment. This is accessible on the internet (visit: westsussex.gov.uk and type ‘social care adults services policies and procedures’ in the search engine).

8.4 We are committed to working together with Children’s Services to meet the needs of the whole family. The approach is known as ‘Think Family’ and is concerned with ensuring that young carers are identified early on. This is so that no social care support arranged for a customer relies on a child or young person (under the age of 18 years) to provide inappropriate levels of care to an adult. Where a young carer is identified, practitioners should contact the West Sussex Young Carers team for further information. The team should be contacted through the central Children’s Access Point, telephone (working hours) 01403 229900. Information about the work of the team is also available on the internet (visit:westsussex.gov.uk/carers).

8.5 The Resource Allocation System was most recently amended in April 2011. It reflects the allocation of resources to fund eligible needs at the substantial and critical banding levels only. It is essential that accurate
information is entered into the input/scoring system on the Resource Allocation System. In addition, where unpaid care is being provided, this must be reflected in the carer’s grid for inputting purposes on Framework. This is still the case where a carer declines to complete a formal carer assessment. This refusal will then reflect support that is already being provided to the customer in specific areas and where no funded social care is required.

8.6 Practitioners should be familiar with the Resource Allocation System guidance in order that they can explain to customers how a personal budget is determined on the basis of the scores allotted to individual levels of assessed and eligible needs. Practitioners must ensure that the Resource Allocation System is completed accurately so that the customer’s needs, unpaid support and/or carer support are all reflected and taken into account in the allocation of resources. Further information about the Resource Allocation System is accessible to staff on the inTRAnet (type ‘self directed support’ or ‘sds’ in the search engine there).

8.7 The assessment information that is inputted to the Resource Allocation System must take account of needs that indicate future or escalating difficulties, and of how risk/need might change over time and the likely outcome if help is not provided. In addition it should be made clear in the assessment whether the presenting needs currently fall within the substantial and/or critical eligibility bandings, or are likely to do so within the next 12 weeks. There may also be external factors that could cause future difficulties for the customer or could exacerbate current difficulties.

8.8 When it has been identified that an individual has eligible needs it is crucial that the practitioner works with the customer and carer to think creatively about how needs can be best met in terms of support planning. It is important to help customers achieve their own outcomes within the resources available to them (see section 9 below for information about the Resource Allocation System in practice).

**Meeting eligible needs in other ways**

Having an eligible need does not automatically mean that Adults’ Services has to provide social care funding to meet it as long as the practitioner is satisfied that the need can be adequately and safely met in an alternative way.

8.9 Only eligible needs will form the basis of a support plan. The support plan links the needs and risks to the outcomes that the customer wants to achieve. The county council expects to meet eligible needs in the most cost effective manner possible. For example, the provision of equipment and adaptations, and/or telecare equipment should be considered where this may be more economic than the provision of personal care services. The initial
review of the support plan is often key in terms of minimising the risk of creating long-term dependency on funded social care. Where it is apparent at the initial review that needs may no longer fall within substantial or critical bandings it is essential that the eligibility criteria are considered afresh. For further information about support planning, see section 10 below.

9. Resource Allocation Panels

9.1 Team Managers should ensure that practitioners are able to give consistent advice to customers about the purpose and role of the Resource Allocation Panel in a way that is both meaningful and helpful to customers. The work of Resource Allocation Panels is currently under review. Until such time as any changes are introduced, their purpose is to consider the most cost effective way to meet eligible needs across all the requests for funded social care support and to ensure that there is consistency of approach by practitioners.

9.2 The allocation of resources is based on the Resource Allocation System (RAS) but the RAS is not determinative.

9.3 Where a customer has a range of needs - including both eligible and ineligible needs - practitioners must ensure that they only request funding from the Resource Allocation Panel to meet outcomes associated with substantial and/or critical needs. These needs will be evidenced with reference to the information recorded on the Background Information and Contact form, the Self or Supported Assessment form, and the Resource Allocation System.

9.4 Practitioners will need to be clear with customers that Adults’ Services will expect to meet eligible social care needs within available resources in the majority of situations. Practitioners should explore all options for meeting eligible need in order to ensure cost effectiveness.

9.5 A system of Level 2 overrides exists and can, if required, be agreed by the appropriate level budget holder. (Note: this arrangement for overrides is not used within the Learning Disability Service). The system of Level 2 overrides relates to care domains where it is indicated that a customer has a high level of need in that specific care domain. The application of a Level 2 override must only relate to the domain within which a high level of need is triggered (for example, the need for two carers, or for night care, or because of communication needs, or because of needs related to behaviour, or because of parenting needs). Overrides are discretionary amounts but must relate clearly to the assessed needs in each relevant domain – and how the outcomes associated with that domain are to be achieved.

9.6 Level 2 overrides will not be agreed where the support plan does not indicate a requirement for additional expenditure – for example in relation to night care, if there is a carer who is going to provide care during the night and
is able and willing to continue to provide this, then a Level 2 override will not be agreed.

9.7 Local authorities are required to exercise discretion in the operation of the Resource Allocation System when required. Variations need to be agreed by the Resource Allocation Panel or by the appropriate level budget holder/manager.

9.8 Any requests for **funding above delegated limits** must be agreed by the Area Operations Manager.

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<th>Services that are the responsibility of the NHS to provide</th>
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<tr>
<td>Adults’ Services cannot lawfully purchase services which are the legal responsibility of the NHS to provide - such as physiotherapy, hospital care, community nursing provision, continuing healthcare. If such services are indicated, the NHS must provide them.</td>
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<tr>
<td>However, the needs of any carer must still be addressed by Adults’ Services.</td>
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10. **Support planning**

10.1 All **outcomes** identified within a customer’s support plan must relate to, and reflect, **unmitigated** eligible needs. Other information can be included within the support plan for reference – for example, how low or moderate (and therefore ineligible) needs are being met. In addition, support planning should be creative with full consideration given to meeting the eligible needs in a variety of ways.

10.2 In order to maximise the use of **contracted resources** practitioners are required to explore use of such services that are available. This includes for example, in-house specialist day services, and residential care homes managed by Shaw Homes (with which the county council has a contracted number of places available). Other options can then be considered where needs cannot be met within our contracted services.

10.3 Practitioners should consider the use of **assistive technology** (including telecare) within the support planning process. Where use of equipment such as a medication dispenser can replace the need for domiciliary care support whilst containing or reducing the associated risk to independence to an acceptable level, then such equipment should be provided instead of additional domiciliary support provision.
10.4 Support Plans should be always quality assured by a senior practitioner or team manager to ensure they are legal, effective and affordable. This is because not all eligible needs automatically have to be funded by the county council. Where carer support needs have however been identified, the support plan must outline how those needs will be met in practice.

11. Reassessment

11.1 A new Self or Supported Assessment must be completed where there has been a change in the customer’s presenting needs. A new Resource Allocation System allocation will also be required.

11.2 A customer who is no longer eligible for funded social care – because her/his needs all fall within the moderate eligibility banding (or moderate and low bandings) - will cease to be eligible for funded social care from Adults’ Services. Practitioners will need to provide the customer (or their representative) with advice and information sufficient for that person to make other arrangements where necessary. An agreed transition period may be necessary in some circumstances and should be negotiated.

11.3 Some customers or their representatives will be able to make their own alternative arrangements. Others may require detailed advice and information about how they can meet moderate needs differently. Advice and information that could be provided includes information about:

- The use of assistive technology - such as bed/mat/door sensors, medication dispensers, care alarms;
- Possible alternative day activities – such as can be found through third sector provision, such as lunch clubs or afternoon clubs;
- Local independent care providers – such as are listed in the annual West Sussex Care Guide;
- The Prevention and Assessment Teams in West Sussex include health and social care advisory staff who work with people to identify what support might be required to keep an individual or their carer independent and to prevent or further delay the need for more intensive services. Team members provide support to people whose eligible social care needs fall below the eligibility bandings in Adults’ Services; and
- Wellbeing Hubs that provide essential community services and access to support to access information around: smoking cessation, alcohol harm reduction, NHS checks, weight management, physical activity, one to one motivational interviewing, falls prevention, carers support, benefits and pensions advice, sexual health, and emotional well-being (for more information, visit: westsussex.gov.uk and type ‘prevention and wellbeing’ in the search engine).

11.4 Where a customer (or an identified suitable person who is looking after a direct payment on behalf of the customer) employs personal assistants the
personal assistant will have a contract of employment. If the customer wishes to change the personal assistant’s contract of employment there will be employment-related matters that will need to be considered. Where there are specific employment issues and a customer requires detailed advice, practitioners must refer the customer to the Independent Living Association’s Information and Advice Service for this employment advice.

11.5 Where funded social care is provided in response to identified adult safeguarding issues in order to prevent or to minimise the risk of harm or abuse, due consideration must be given to the safeguarding issues. In some instances what appears to be a ‘low level’ service response is provided because of a history of significant safeguarding concerns. Practitioners must ensure they consider what the risks to independence would be if such a service were to be withdrawn.

12. **Review**

12.1 Within all reviews practitioners need to be clear with customers that the review is of needs and eligibility and it is not just about services. Practitioners should also consider whether it is appropriate to involve other part of Adults’ Services, such as reablement services, or whether the provision of assistive technology could be useful.

12.2 Where a change in the customer’s needs or circumstances is identified at review, a **reassessment** should be carried out and a new SOSA/RAS, Carers’ Assessment and Support Plan completed.

12.3 Team managers and senior practitioners must ensure that **accruals** are considered within the review process. This includes accruals within the context of personal budgets, direct payments (and direct payments to a suitable person if applicable) and also virtual accruals through commissioned domiciliary care provision. Consideration must be given to the reasons for the accrual such as whether it is planned and will be used in the near future, or whether it is unplanned and indicative that the personal budget may need to be reduced. (Information about the accruals recovery process is available to staff on the county council’s intranet (type ‘sds accruals’ in the search engine).

12.4 Where an accrual has built up because, for example, planned respite in response to the needs of a carer has not been utilised, the practitioner will need to explore whether the carer’s needs remain unmet and why, or whether they are or could be being met in some other way.

13. **Appeals and Complaints**

13.1 A process for appeals was established in 2011 in response to customer comments as it was felt to be less ‘contentious’ than a formal complaint.
request to the county council. Our approach, and its format, was endorsed by
the Local Government Ombudsman. Local Appeals in relation to self-directed
support and the local application of the national eligibility criteria can only be
made about four specific decision points in our local processes:

✓ Eligibility;
✓ The assessment itself;
✓ The Resource Allocation System scoring; and
✓ Support planning.

13.2 Our customers are encouraged to use the Appeals Process for these
areas but they can also use the county council’s formal complaints route if they
wish to do so. Information about the appeals process is accessible on the
county council’s website (visit: westsussex.gov.uk and type ‘sds appeals’ in the
search engine). All other issues, other than relate to the four decision points
outlined above, can only be dealt with through the county council’s formal
complaints route.

13.3 A customer cannot make a complaint if he/she disagrees with the final
outcome of the appeal and would need to contact the Local Government
Ombudsman at that point if a further concern was raised. Information about
contacting the Local Government Ombudsman is provided to customers when
they are notified of the outcome of the appeal.

13.4 Customers can lodge a formal complaint through the county council’s
formal complaints route if they feel that the appeals process has not been
undertaken appropriately (visit: westsussex.gov.uk and type ‘complaints’ in
the search engine).

Final note. A Quick Reference guide, and a separate document containing
application examples, have both been produced alongside this more detailed
document. All of these documents can be found on the county council’s website
(westsussex.gov.uk) by typing ‘social care adults services policies and
procedures’ in the search engine.
Appendix 1 – the national eligibility threshold bands

The national eligibility framework is graded into four bands, which describe the seriousness of the risk to independence if needs are not addressed. The four bands are 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.

Interpreting and applying the national bandings

In terms of **critical levels of need**, it is useful to think in terms of immediate levels of risk or risks that will become more severe if not intercepted within the next 24-72 hours maximum:

‘Vital social support systems and relationships cannot or will not be sustained’ (one of eight critical levels of need, see above) *is likely in practice to be associated with*:

✓ Being already unable or will be unable to sustain vital social support systems and relationships – or those already in place are in **imminent danger of breaking down** as a result of which the customer’s physical and/or mental health will be very significantly and adversely affected.

In terms of **substantial levels of need**, it is useful to think in terms of the management of the presenting risks to independence beyond the immediate 24-72 hours and of those risks occurring within the next three-six month period, and which cannot be mitigated through other means:

‘The majority of family and other social roles and responsibilities cannot or will not be undertaken’ (one of five substantial levels of need, see above) *is likely in practice to be associated with*:

✓ A carer being unable or will be unable to continue with **most** aspects of their caring role – including assistance with essential tasks such as help with toileting or the preparation of food or providing assistance with communication because the customer has severe communication difficulties.

**Note.** These are examples and further guidance will be provided through training on the eligibility criteria. It is important that practitioners are able to assess the severity of the risk or risks - and to use **professional judgement** in the interpretation and application of the eligibility criteria.

Advice from more skilled or senior staff should always be sought if required.
### Appendix 2 – assessing the severity of risk of the presenting needs

The table shown below will help practitioners in the exercise of professional judgement (see also section 6 in this document).

<table>
<thead>
<tr>
<th>Impact</th>
<th>Low</th>
<th>Moderate</th>
<th>Substantial</th>
<th>Critical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autonomy and freedom to make choices</td>
<td>There is, or will be, only partial choice and control over the immediate environment</td>
<td>There is, or will be, only partial choice and control over the immediate environment</td>
<td>There is, or will be, little or no choice over vital aspects of the immediate environment</td>
<td></td>
</tr>
<tr>
<td>Health and safety</td>
<td>Abuse or neglect has occurred or will occur</td>
<td>Life is, or will be threatened; Significant health problems have developed or will develop; Serious abuse or neglect has or will occur</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The ability to manage personal and other daily routines</td>
<td>There is, or will be, an inability to carry out one or two personal care or domestic routines</td>
<td>This is, or will be, an inability to carry out several personal care or domestic routines</td>
<td>There is, or will be, an inability to carry out the majority of personal care or domestic routines</td>
<td></td>
</tr>
<tr>
<td>Involvement in family and wider life</td>
<td>Involvement in one or two aspects of work will not be sustained; One or two social support systems and relationships cannot or will not be sustained; One or two family and other social roles and responsibilities cannot or will not be undertaken.</td>
<td>Involvement in several aspects of work, education or learning cannot or will not be sustained; Several social support systems and relationships cannot or will not be sustained; Several family and other social roles and responsibilities cannot or will not be undertaken.</td>
<td>Involvement in many aspects of work, education or learning cannot or will not be sustained; Vital social support systems and relationships cannot or will not be sustained; the majority of family and other social roles and responsibilities cannot or will not be undertaken.</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 3 – case study examples

Note. The scenarios presented here are deliberately brief and there would normally be far more information upon which to base a decision concerning eligibility.

Mr A is 77 and was diagnosed with Parkinson’s last year. His health has been deteriorating since then. He lives with his (older) wife but over the past two months has become increasingly withdrawn, he won’t go out or talk to his wife or extended family. He hasn’t taken any of his prescribed medication because he does not like the side effects. He is clear that he does not want anyone to help him and that he wants to be able to do things for himself at home without help. However he has fallen a couple of times when he got up in the night to go to the bathroom, which is downstairs. He has to wake his wife several times a night to help him on the stairs. He also finds it very difficult to use the small shower cubicle in the bathroom. His wife is at the end of her tether and says she cannot cope for much longer. Mr A does not want to go into care or to hospital but has agreed with his wife that he will accept some help at home.

Assessment outcome:
- **Eligibility = critical.**

Mr A’s failure to eat properly, coupled with his physical condition are both very significant current risks to his health; they are also causing a high degree of stress to his wife and other family members. There is a significant risk that Mr A would require admission to some form of 24-hour supervised care if his wife was no longer able to care for him without external support.

Miss B is 48 and has Downs Syndrome and a learning disability. She lives with her parents. For years she used to go on annual holidays with her family and enjoyed being part of their lives, but these days she is increasingly reluctant to join in with them. This has resulted in some challenges at home as Miss B is not safe to be at home alone, she has difficulty weighing up risks – including risks attached to being a smoker – and is not able to manage roads safely. Her mother and father, both in their late 70s, are becoming more concerned and this is having a detrimental impact upon their health. They have no support network locally, and Miss B is resistant to any change.

Assessment outcome:
- **Eligibility = substantial.**
- A graded introduction to and intervention by the West Sussex Shared Lives Scheme would enable Miss B to develop her confidence and ability to live independently over time.
- There is a high risk that Miss B’s parents will not be able to sustain their caring role for her, so a further assessment of need and a carer assessment will be required.
Mrs C lives alone following the death of her husband a year ago from a progressive illness. She had given up her part-time job to look after him. She has a lot of support from her son and her daughter both of whom live nearby; however they can only visit in the evenings and at weekends because of their own young family commitments. Her GP is currently treating her for depression and other health issues. Mrs C, who is 59, is alone all day and although she used to be very active in her local community she now refuses to go out. Her family and GP are worried that her isolation is hindering her recovery from depression.

Assessment outcome:
- **Eligibility = moderate.**
  - Mrs C is well supported by her family but would benefit from advice, information and signposting for daytime activities in her local area. Alternatively, Mrs C might benefit from a short period of attendance at one of our specialist day centres under the ‘promoting independence’ banner.

Mr D is 81 years old and now lives alone. His son phoned in to Adults’ Services as his father is having some issues with his mobility. Mr D seems to have lost his confidence in walking following a couple of fairly minor stumbles. Mr D fiercely values his independence and his son wants to know what help he can get to reduce the risk of him falling.

Assessment outcome:
- **Eligibility = low.**
  - Early intervention is required in order to provide advice and information regarding falls prevention and to ensure that Mr D is aware of local retail outlets that will stock perching stools or other relevant equipment for private purchase.
Appendix 4 – promoting independence: assessment pointers

The top ten tips for assessment practice, promoted by the Social Care Institute for Excellence, are:

- An individual seeking or referred for help with a social care need, regardless of their impairment, is entitled to an assessment that is fit for purpose.
- An individual’s financial situation must not pre-empt or influence the assessment of their social care needs.
- Assessments and support planning are focused on ways to achieve agreed outcomes, not driven by needs or impairments.
- Do not filter individuals out too quickly on too little information. Further investigation may reveal eligible needs behind lower level ‘presenting’ needs.
- Think prevention, early intervention, wellbeing and safeguarding: they can prevent or delay needs escalating.
- Think signposting, information and advice as routes to wider choice, whether or not the individual is likely to be eligible for publicly funded support.
- Think personalisation to promote greater choice and control for individuals, and sustain options for carers.
- Suitably adapted housing, smart technology and equipment, improved healthcare, greater benefits take-up and community support can all help to delay or avoid the need for care.
- Think self-directed support, direct payments, personal budgets and co-production as the means to achieve more flexible, personalised solutions.
- Recognise carers and personal and community networks as valued partners in care. Providing support for them is a worthwhile investment.


Gathering sufficient, proportionate information and recording this on the Background Information Contact Assessment form is therefore clearly essential when establishing the customers’ needs. This is particularly the case at first contact. The following are essential areas for information gathering in practice. These are also of particular significance in establishing whether there is the potential for customer to become more independent:

- What is the customer’s actual disability/illness/frailty?
- What does the customer want to be able to do? For example, ‘I want to be able to get in/out of bed, in/out of my chair, make a hot drink, prepare a meal, get upstairs to the toilet…’
- What is the nature of the problem and how is the customer currently managing it? For example, ‘I can’t get in and out of bed unassisted because I can’t lift my legs over the edge of the bed and my husband has to do this for me’
• What is the impact of the problem? For example, ‘I have to rely on my husband to do this for me and wait for him to assist me’
• For how long has the problem existed?
• Has there been recent deterioration and what happened? For example, was there an acute episode such as a urinary tract infection (UTI), fall or exacerbation of their condition or has the deterioration been building up over a period of time?
• How severe is the problem now?
• How frequently does any specific activity need to be done?
• If the problem is fluctuating, what causes that fluctuation - for example, fatigue, pain, and/or joint limitations?
• What are the consequences of not doing the activity? For example, ‘I am dependent on others to assist me with (nature of task)/ I can’t get to the upstairs toilet safely because of a recent fall/ I can’t make a hot drink for myself
• What are the risks to independence? For example, what alternatives could there be to enable the customer to remain at home, and how do the risks limit choice and control?
• Are there any existing environmental constraints in the property? For example, the only toilet is upstairs, or the customer can’t sit down in the kitchen or there are steps down to important facilities such as rubbish disposal or there is difficulty in getting up from the bed
• What is the impact on carers – both informal and formal – particularly in respect of the carer’s own health and ability to assist the customer

The rational for any decision about promoting independence should therefore be clearly evidenced. For further information about assessment, see sections 5-8 and 11 in this guidance document.