Commission for Social Care Inspection
CSCI

Making Social Care
Better for People

Cutting the cake fairly
CSCI review of eligibility criteria for social care

October 2008

Vision and values

The Commission for Social Care Inspection aims to:

- put the people who use social care first
- improve services and stamp out bad practice
- be an expert voice on social care
- practise what we preach in our own organisation.

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Foreword

The social care system has a finite amount of public funding. These financial resources need to be rationed for the sake of fairness. The current mechanism for doing this is the process of applying eligibility criteria in accordance with the Government's mandatory guidance *Fair Access to Care Services.*

The Commission for Social Care Inspection was pleased to be asked by the Care Services Minister to undertake a comprehensive review of the current eligibility criteria. Over the course of this review we have looked at national policy on eligibility, how it has been implemented locally by councils, and the impact it has had on the lives of people seeking care and support. We are grateful to the many people and organisations that have contributed their views. And our thanks go to the researchers, the Audit Commission and the Social Care Institute for Excellence who have produced the accompanying papers for the review.

In many ways, the policy set out in *Fair Access to Care Services* was based on sound principles that still have validity. For example: the emphasis on a needs rather than service led approach, people with similar needs achieving similar outcomes, taking a human rights approach, ensuring carers needs are taken into account.

Many of the problems identified in this report concern the way the policy has been implemented in the context of increased demand and the unintended consequences it has had, particularly for the growing number of people who have found themselves excluded from the social care system as a result. In some areas, councils have not taken a needs led approach, but have used the eligibility criteria bandings to categorise services on the flawed assumption that so-called 'low-level' services were only required by people identified as having low eligibility. This has meant that some invaluable services have been cut.

We recognise that the size of the 'cake' is limited, whilst the number of people who want a 'slice' is increasing. In the long term, there is no alternative to radical reform of the way the social care system is funded, and this report sets out a range of possible options and their impact on eligibility. However, we are unable to avoid the conclusion that the key issue is not simply the criteria used to assess people's eligibility for publicly funded care and support, but the amount of resources currently allocated – the size of the cake itself.

Our findings demonstrate that the current system of determining eligibility is so flawed, and is so heavily criticised, that immediate changes are needed, particularly as long-term reforms may be at least five years away. So we are proposing, in the short term, that the criteria should be defined differently. This will mean that some people currently excluded from the care system may become eligible for services, while others may not. However, we are recommending that everyone, whether they are eligible for public funds or not, should have proper assistance to enable them to make choices about their care. This will include assessment, advice and information, and should bring together all local resources, including mainstream services as well as specialist care services.

As our reports on the state of social care have shown there is a need for a new settlement between the individual, the family and the State about their respective responsibilities in the provision of care and support services. The Government has recognised this in its consultation document *The case for change – why England needs a new care and support system* (May 2008). The questions about the role of our care and support services in future, including how they will be funded, grow in urgency – as this report shows. Politicians across the political spectrum, both nationally and locally, have a responsibility to work towards an enduring solution.

We look forward to the Government's response to our report.

Dame Denise Platt DBE

Chair

Commission for Social Care Inspection

Executive Summary

1. The Government asked CSCI to undertake this review of eligibility criteria for social care in response to the findings in the report *The state of social care in England 2006-07*, published in January 2008. The report illustrated the poor quality of life for many people who are deemed ineligible for publicly-funded social care. It also showed there are inconsistencies as to who is assessed as ineligible, both within and between councils.

2. The Fair Access to Care Services (FACS) framework was introduced five years ago in England to address inconsistencies across the country about who gets support and to provide a more transparent system. The guidance incorporated important principles about:

    - trying to ensure a needs-led not a service-led approach
    - people with similar needs having similar outcomes, though not necessarily similar services
    - taking a non-discriminatory and human rights approach
    - ensuring carers' needs are taken into account
    - the role of councils in supporting people who are not eligible with information, advice and alternative services
    - adopting a preventative approach.

    Importantly, the guidance reaffirmed that councils should take their resources into account when setting eligibility levels locally (using the national framework it described). In other words, FACS sought to increase consistency and transparency but within a discretionary system whereby each authority could determine its overall funding for adult social care.

3. Since then, however, the policy on personalisation has further developed, evidenced by the *Putting People First* concordat. In addition, increasing attention is being paid to promoting general well-being and to targeted prevention, ie investment to support people to prevent or defer the need for more intensive help. These policy developments, alongside councils' increasing tightening of their eligibility criteria in

order to manage their budgets in a cash-limited system, have together highlighted tensions between the implementation of FACS and new approaches to prevention and personalisation.

The findings of the review

4. Analysis[1] of the views of a wide cross-section of people taking part in this review shows there is acknowledgement of the inevitability of rationing, that some means are needed to decide who receives publicly-funded care and support and that the overriding preference is for transparency so that people know what to expect.

5. The repercussions on people's lives of limited access to publicly funded support (ie eligibility) has been a dominant feature of our consultations. For many people, the pressures in the system are simply a reflection of inadequately funded social care, which in turn has impacted on the delivery of FACS, rather than any inherent fault with the eligibility framework itself. There is therefore some backing for the current framework in that it improved the earlier situation by providing a national system offering more consistency and transparency, a means of crystallising local debates on priorities, and a 'whole person' approach to needs.

6. Nevertheless, the majority of the evidence is critical of FACS, some in principle and considerably more in respect of its implementation. Concerns centre on:

   - **A lack of clarity and transparency** in practice, particularly related to the complexity of the framework, so neither professionals nor people using services are confident of their understanding.
   - **A lack of fairness** in the way criteria are applied, due to variations in professional judgements and different approaches taken by councils.
   - **The continuing influence of service-led, rather than needs-led approaches**, although FACS attempted to move away from this. There continues to be a basic misunderstanding that 'low-level' needs equate with 'simple' services, and 'complex' needs always require 'complex' (and expensive) services. One result of this is that some councils have stopped providing or commissioning entire types of 'simple' or 'low-level' service.
   - **Limitations of a risk/needs-based model** that has led to inadequate and unduly standardised assessments and neglect of some groups of people using services. The groups include: people with long-term and/or fluctuating conditions; blind and partially sighted people; young adults who move from children's services; people with Asperger's syndrome/autism; and carers.

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[1] Hudson B and Henwood M (2008) *Analysis of evidence submitted to the CSCI review of eligibility criteria.* London: CSCI

- **Insularity and fragmentation,** where FACS does not include considerations of other important areas such as health, housing and leisure; and there are problems in the interaction with important parallel processes, notably continuing health care, the care programme approach in mental health services and processes for access to learning disability services.
- **Marginalisation of the prevention and inclusion agendas** which are not fully integrated into the framework.
- **Inadequate diversion and signposting** and specific problems when people's needs and circumstances are insufficiently explored at their first contact with the council. 62% of survey respondents who did not meet eligibility thresholds stated they were not given any information about other help that might be available. In addition, some people complained that their means were assessed before their needs.
- **Tension between FACS and personalisation** and apparent incompatibility between the two approaches, where the first is concerned with standardisation, consistency of treatment and explicit decision-making, and the latter with self-assessment, individual choice and control.

7. Whilst survey respondents who had an assessment had a largely positive experience of the process, almost one in five carers and one in eight of those who said they could benefit from social care reported they had failed to have an assessment of their needs. One third of these respondents understood this was because they did not meet financial eligibility criteria for help (suggesting they were asked about their financial resources prior to any needs assessment, which contravenes current policy).

8. The experiences of people who failed to get access to social care or who did not get the support they required mirror those of the people who took part in the earlier CSCI study.[2] People managed as best they could but often at great cost in financial, emotional, personal and physical terms.

9. In contrast to these experiences, CSCI received positive feedback from preventative initiatives such as Partnerships for Older People projects. Councils are investing in a range of preventative and social inclusion services, often funded from budgets other than social care, such as housing and leisure. A recent survey[3] estimated each council is spending on average £1.63 million on adult social care services

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[2] Henwood M and Hudson B (2008) *Lost to the system? The impact of Fair Access to Care: a report commissioned by CSCI for the production of 'The state of social care in England 2006-07'.* London: CSCI

[3] York Consulting (2008) *Local Government Association/Association of Directors of Adult Social Services Report on Adults Social Services Expenditure 2007-08.* Leeds: York Consulting

that people can access without a formal assessment, or without having to meet eligibility criteria. (This is in the context of an average spend per council of £100 million in 2006-07 on formal social care for people of working age and older people.) However, a recent study by the Audit Commission shows only a third of councils are well prepared to address the challenges of an ageing population.[4]

10. An analysis of the FACS bandings and their relationship with actual expenditure indicates that those councils applying a 'moderate' threshold spent slightly more on average per older person than those applying the 'substantial' or 'critical' bands.[5] However, the apparently limited effect on overall budgets of tightening eligibility criteria tends to support the finding that, in practice, there are large differences of interpretation when operating the bandings.

11. The majority of people involved in this review called for a radical reappraisal of arrangements and a new basis for accessing public funds which comprises:

    - an outcomes-based approach
    - compatibility with the personalisation agenda
    - a stronger focus upon prevention and inclusion
    - fairness and clarity of access
    - guaranteed basic national minimum support.

Recommendations

12. From analysis of the findings and a review of models of rationing in this and other countries, CSCI has recommendations which together seek to:

    a) Set 'eligibility criteria' for access to support in a broader context that is more consistent with *Putting People First* and offers **some level of assistance and advice to everyone** seeking care and support.

    b) Given the inescapable need to ration public resources, replace the FACS criteria with a revised system, based on "priorities for intervention", and reinforce the need to make a clear distinction between the assessment of individual needs and any subsequent allocation of public funding.

    c) Introduce a range of measures to support the implementation of the new arrangements, including ways of improving the initial response from councils to people seeking support.

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[4] Audit Commission (2008) *Don't stop me now: preparing for an ageing population.* London: Audit Commission

[5] Audit Commission (2008) *The effect of Fair Access to Care Services Bands on Expenditure and Service Provision*, London: CSCI and Audit Commission

d) Encourage the development of a national resource allocation formula to assist the setting of individual and personal budgets so that, rather than each council devising its own system, there would be a common approach across the country. As a result people would be awarded 'points' in relation to their needs for support on a standardised basis, improving the 'portability' of assessments across the country. Councils would retain the ability to attribute different financial amounts to each point depending on local circumstances.

Recommendation 1: Better arrangements that offer universal support

13. The proposed arrangements to broaden access to support are underpinned by the notion of **progressive universalism**, where all citizens can expect some level of assistance and those with the greatest needs can access additional help. The aim is to de-stigmatise social care as a service only for 'the poor and needy' by identifying:

a) services that *all citizens* can access

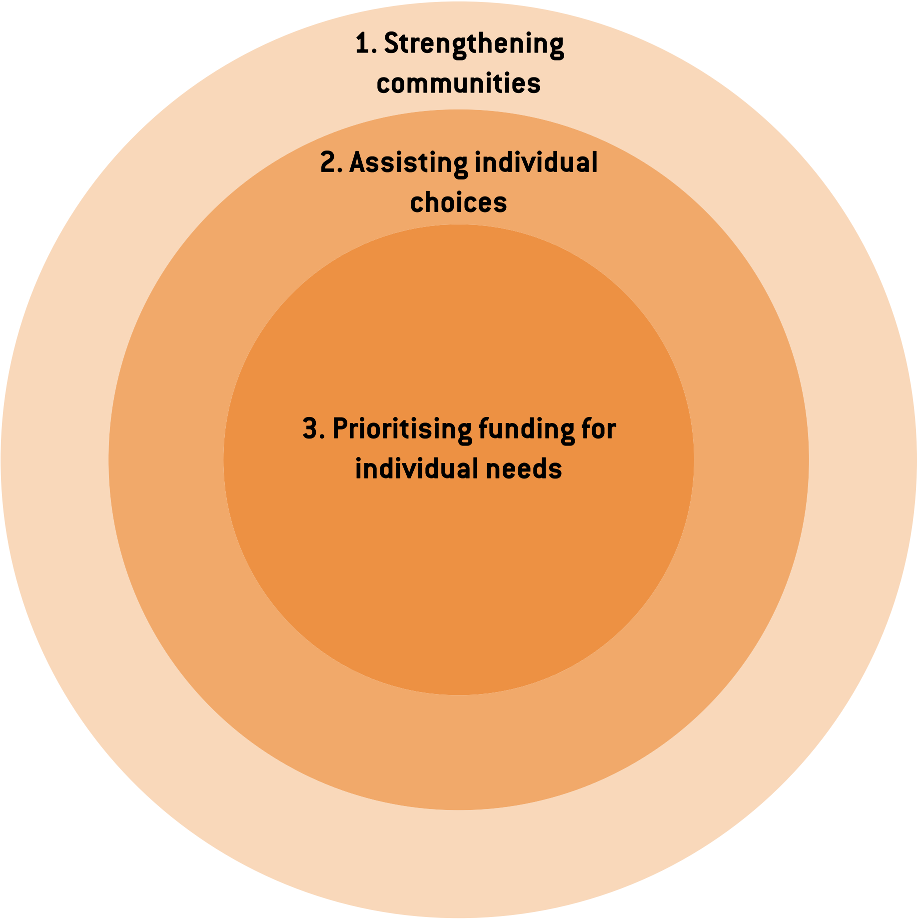
b) information and advice and other help for *everyone* looking for specific support, and

c) a clearer basis for decisions about the allocation of public funds for people seeking care and support.

There are thus three key elements to the proposed arrangements:

- **Strengthening communities** – reaffirming the role of councils, with a wide range of local partners, in place-shaping, including the provision of services such as leisure and transport which everyone can use, no matter what their age or ability. In addition, councils need to focus attention on market development, quality-of-life and well-being strategies.
- **Assisting individual choices** – so that, in line with current policy and legislation, everyone looking for assistance, including carers and those who choose to fund their own care, can access:
  - good information and advice and, where appropriate, advocacy and brokerage
  - an assessment of their care and support needs
  - wherever appropriate a period of reablement (which seeks to maximise what people can do for themselves)
  - appropriate medical treatment to maximise ability, such as a range of therapies
  - a systematic follow-up to their first contact with social services, to check they have received appropriate help

  - a supply of services of good quality which people both want and feel safe to use
  - if things go wrong, a robust complaints process and, if necessary, effective local multi-agency procedures designed to safeguard people from abuse.
- **Prioritising funding for individual needs –** clarifying that decisions about the allocation to individuals of public funds (which will increasingly be available in many forms, including personal budgets, individual budgets or direct payments) should follow assessment of needs. Those assessments should identify the barriers which prevent people achieving appropriate outcomes, as set out in the White Paper *Our health, our care, our say,* and take account of likely support needed over a period of time (see Recommendation 3 below).



Recommendation 2: Improving the response to people needing assistance

14. It is clear from this review that any arrangements for delivering the broader, more inclusive, approach set out in Recommendation 1 will require councils and others to pay particular attention to:

    a) ensuring a good quality of response at people's first contact with the council

    b) ensuring an assessment is usually initiated by a self-assessment, and that it is not a one-off event but a dynamic process whereby individuals and their families can discuss what they want to achieve, with opportunities to access assessors, advocates and brokers

    c) considering, in appropriate circumstances, a short period of re-ablement/ intermediate care to maximise what people can do for themselves before any decisions are taken about ongoing needs for care and support, thereby avoiding premature decisions about long-term options

    d) applying revised criteria for deciding 'priorities for intervention', designed to trigger any ongoing care and support, after an assessment of need and any period of re-ablement. (see Recommendation 3). This is the point at which there is sufficient information about an individual's future requirements for care and support to apply a Resource Allocation formula, in order to determine their personal budget. The person's own resources might be taken into account at this point.

Recommendation 3: Criteria for allocating public funds to individuals

15. As well as encouraging councils to take the actions described in Recommendations 1 and 2 above, the Department of Health should develop (after consultation) a new system which replaces the current FACS criteria with three 'priorities for intervention' as a means of allocating public resources. These interventions are rated according to the urgency of response needed (and not equated with specific services):

    (i) *immediate intervention* – without immediate support to remove 'barriers to people's dignity and quality of life' a person's well-being would be seriously threatened. An example might be where a person living alone has suffered a stroke and been in hospital, had limited benefit from re-ablement and is no longer able to care for him or herself without assistance.

    (ii) *early intervention* – where problems may develop and threaten a person's well-being within six months if support is not provided. An example might be a situation where a carer providing substantial personal care is unlikely to be

able to continue unless some support is provided either for the carer or the person being cared for.

(iii) *longer-term intervention* – where people's well-being would be threatened within the year without targeted, evidence-based interventions. This might include situations of growing social isolation where the person's mental health might deteriorate.

16. The 'barriers to dignity and quality of life' should be defined as those which may prevent the achievement of the outcomes set out in the White Paper *Our health, our care, our say.*[6] Those outcomes were defined as: exercising choice and control, health and emotional well-being, personal dignity and respect, quality of life, freedom from discrimination, making a positive contribution, economic well-being.

17. A person's needs should be considered over a period of time so that the needs of those with fluctuating and/or long-term conditions are properly taken into account. Many of these people are likely to come within the 'early intervention' group.

18. To get the full benefits from this approach, councils would need to invest some resources at all levels. Given the present local government funding arrangements, including councils' need to manage within their available resources, CSCI accepts that the appropriate resourcing of these categories will need to remain a decision to be taken locally. Given this conclusion, it is important that councils spell out these decisions clearly to their local population.

19. This revised framework assumes the continuation of the present care and support system. It will need further revision in the light of new arrangements for funding and delivering care and support, as a consequence of the outcomes of the Green Paper.

Recommendation 4: A national resource allocation formula

20. The review findings also underline the tension in practice between those seeking a more rights-based, nationally determined system and those wanting a flexible, local and more person-centred approach. In the absence of any decisions on the funding and organisation of a new care and support system, this review has had to assume the continuation of a discretionary, council-based system.

21. Nevertheless, there is a clear link between the determination of eligibility for publicly funded support and the overall design and funding of the care and support system. Accordingly, and in the context of the current discussions towards a Green

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[6] Department of Health (2006) *Our health, our care, our say – a new direction for community services.* London: Department of Health

Paper on a new care and support system, Chapter 6 provides a commentary on some different models of funding and some of the issues which arise in the context of determining an individual's eligibility for public funding. This is designed to contribute to the debate about future systems.

22. Many of those piloting individual and personal budgets for adult social care have been seeking ways of deciding early on in the process what an individual's financial allocation should be, in order to facilitate a person-centred discussion about the use of that allocation to meet their preferred outcomes and aspirations. Indeed, some argue that the Resource Allocation Systems being developed locally (which award points in respect of needs and convert them into a financial amount) might render irrelevant or superfluous any other system for determining eligibility. However, CSCI considers that such allocations should **follow** an assessment of needs that triggers an intervention, since publicly-funded personal and individual budgets are not open to any citizen who seeks one, regardless of need.

23. We understand that there are many different resource allocation formulae being developed, resulting in a lack of transparency for those using services and increased variability between areas. Accordingly, we recommend that the Department of Health should urgently consider developing – with the relevant stakeholders – a single, national, resource allocation formula in order to increase clarity and transparency, as well as equity between different council areas; to reduce variations likely to emerge locally; and to clarify the appropriate response to someone seeking an individual or personal budget. This approach would also reduce development costs. The attribution of financial values to the points generated by a national RAS could remain a matter for local decision, given wide variations in the costs of services in different parts of the country. Particular attention should be paid to the application of the RAS to ensure it focuses on the outcomes sought by individuals and the support required to achieve them rather than on those activities which they cannot perform.

Recommendation 5: Measures to support the implementation of the proposed arrangements

24. CSCI proposes the following actions to underpin the introduction of the new arrangements set out at Recommendations 1-3 above:

    a) Councils should review how they respond to people's first contact with them when seeking advice and help, especially the quality of decision making at that stage (paying particular attention to the values set out in the General Social Care Council's Codes of Practice for both employers and employees).

b) Councils should seek to ensure that people who are assisted by specialist teams, such those with mental health needs and learning disabilities, can also access mainstream health and social care, as well as specific, services.

c) Councils should consider introducing pro-active ways of identifying people who could benefit from information and support (case-finding).

d) Regional Improvement Partnerships and other improvement agencies, including DH's Care Services Improvement Partnership, Social Care Institute for Excellence and Improvement and Development Agency, should continue to aid councils by, for example, sharing good practice, such as the learning from the approaches piloted in the Partnerships for Older People projects and housing–based support initiatives.

e) The Department of Health should ensure that any revised guidance which replaces FACS is communicated clearly to the public as well as to councils, the NHS and the voluntary and independent sectors. This should also reaffirm in clear terms the avenues available to people to challenge decisions, make complaints and obtain redress.

f) Councils should systematically follow-up and monitor the outcomes for people, including those people signposted to other sources of help. This information should also feed their Joint Strategic Needs Assessments and local commissioning strategies.

g) Performance assessment by the regulators, notably the Care Quality Commission and the Audit Commission, should include performance in relation to the overall framework suggested in this report, not least in the context of Comprehensive Area Assessments designed to consider the broader support provided by councils to local citizens.

h) Current work by the Department of Health on social care charging by councils should address the impact on individuals and their families of high charges in some parts of the country which can amount to a further form of rationing, on top of formal eligibility criteria. In this context the Department should also consider the interaction of charges with processes for determining personal budgets.

25. Many councils are already delivering elements of the overall approach set out in this report. But our findings suggest that few are delivering all of it to all who might benefit. Much in this report restates councils' existing statutory responsibilities, and indicates that poor decisions about individuals might cost more in the long run if this results in their needing more care later on. Nevertheless, there are clearly resource implications for at least some councils in implementing these recommendations, for instance if they are not already systematically helping all

those seeking advice and guidance. However, it is difficult for us to estimate any additional resources which may be required, given the differing circumstances of different councils, as the Audit Commission's analysis for this review indicates. Moreover, additional resources *have* been made available for adult social care over recent spending reviews, including the £520m Transforming Social Care Grant for 2008-11. It is therefore unclear how far those resources, as well as the local priority accorded to adult social care and moves to reconfigure local services, will be able to resolve the significant underlying funding pressures revealed in many of the submissions to our review. What can be said is that the success of the proposed approach will inevitably depend to a considerable extent on both the availability of resources and how efficiently and effectively they are used.

Conclusion

26. Eligibility criteria are an overt means of deciding who should receive specific public funding to address their support needs. They cannot of themselves address the question of the appropriate funding of the system – the size of the 'cake'. In this sense CSCI considers eligibility criteria to be an important but secondary issue and both this review and other recent analyses suggest that the size of the cake is inadequate.

27. Nevertheless, there are important issues to address in the current system. The recommendations therefore seek to reinforce the direction of policy and to set social care in a broader context, recognising the interaction of a whole range of services which are crucial to the quality of people's lives. The aim is to ensure that, as a minimum, citizens can benefit from services available to all and, if they need more specific support, can be helped to make informed decisions about their requirements. People should also receive a positive and sensitive response on their first contact, and in any subsequent dealings, with their council. The proposals for 'priorities for intervention' offer a new way for councils to ensure that specific resources go to those who need them and to address the confusion in the current system between assessment of needs and the allocation of public funding for ongoing care and support.

Chapter 1

Introduction

1.1 The national framework for determining who may be eligible for public funding for adult social care is called Fair Access to Care Services (FACS). It sets out a system of four bands which describe the seriousness of the risk to independence or other consequences if needs are not met. (Box 1 in Chapter 2 describes the four bands.) Councils themselves can decide how many bands to make available in their area. The CSCI report *The state of social care in England 2006-07* highlighted the poor quality of life for many people who seek care and support services from their council but are deemed ineligible according to local eligibility criteria. The special study for that report also showed that there are inconsistencies as to who is assessed as ineligible, both within and between councils.[7]

1.2 In response to these findings, the Government asked CSCI to undertake a review of the criteria for Fair Access to Care Services (introduced in 2003), their application by councils and their impact on people. Under the terms of reference (see Appendix 1) CSCI was asked to involve the Association of Directors of Adult Social Services (ADASS) and the Local Government Association (LGA) and other stakeholders in the review; and to make recommendations to the Care Services Minister on the findings in September 2008.

1.3 In carrying out a wide-ranging review, CSCI has involved the public, people using services and their carers, councils, care providers, professional bodies, voluntary and independent organisations, government departments, academic and other stakeholders. The review has built upon the earlier research for *The state of social care in England 2006-07*[8] and has included:

- a large consultative event, *Have Your Say about Fair Access to Care Services,* with over 100 different stakeholders[9]

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[7] Henwood M and Hudson B (2008) *Lost to the system? The impact of Fair Access to Care: a report commissioned by CSCI for the production of 'The state of social care in England 2006-07'*. London: CSCI

[8] Ibid

[9] OPM (2008) *'Have Your Say' about Fair Access to Care Services: report of a CSCI consultation event held on 1 April 2008.* London: CSCI

- an online survey completed by just under 3,000 people, including people using services and family carers
- nearly 100 written submissions from interested organisations and individuals, including ADASS, LGA and organisations for older people, disabled people and carers.
- a literature review and background paper describing an analytic framework for eligibility[10]
- a review of international experience by SCIE[11]
- consultations within CSCI and with external reference groups, including people using services and carers
- meetings with different stakeholders, including ADASS, LGA, the Partnerships for Older People Projects network, councils, Carer Support Network, Association of Chief Executives of Voluntary Organisations
- a workshop with people involved in developing individual budget schemes
- a study for this review by the Audit Commission on the relationship between expenditure by councils and their eligibility thresholds.

1.4 An advisory 'sounding' board involving key stakeholders has met throughout the review process to hear and discuss the evidence and offer different perspectives on the issues raised. (Appendix 2 provides a list of members.)

1.5 There has been considerable interest from both the public and the social care sector in this review. Much of this interest has been on the adequacy of funding for social care – the size of the overall 'cake' and how the long-term care and support system should be funded.

1.6 There have also been concerns about how to share out the 'slices' of the cake 'fairly' and it is the different understandings of what is 'fair' that have surfaced throughout the discussions about eligibility criteria. Is it fair to focus on people's care needs or their ability to pay? Is it fair to expect families and partners to provide care and if so, how much? Is it fair to have different levels of resources allocated for younger and older people? Is it fair that people looking for support get a different response depending upon where they live and who they see?

1.7 The part played by other services in encouraging people's well-being, including the support offered by local communities as well as people's own contribution to their

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[10] Henwood M and Hudson B (2008) *Prevention, personalisation and prioritisation in social care: a review of the literature and development of an analytic framework.* London: CSCI

[11] Robbins D (2008)*Criteria for care: assessing eligibility for long-term care services in Europe.* London: CSCI and SCIE

community, have also featured strongly in the discussions. Social care is seen as only one part of a much wider system for supporting people and there is increasing recognition that it is the universal services, such as health services, housing, employment and transport, as well as people's own networks and families, that are fundamental to the quality of people's lives.

1.8 There are some high expectations for this review of FACS but clearly changing eligibility criteria alone cannot solve all the problems related to the social care system. However, the findings and proposals in this report about who gets support and how best to cut the 'cake' fairly do get to the heart of the rationale and functioning of our social care system. The recommendations of this review seek to support the ambitions of *Putting People First*[12] and ensure people are supported to live independently, exercise control over their life and have the best possible quality of life, irrespective of age, illness, impairment or disability.

Structure of this report

1.9 This report begins by looking at the reasons for introducing a national framework for eligibility criteria and the legal and policy background to FACS. The main findings of the review are then summarised which include people's experiences of seeking support and eligibility decisions as well as their views about FACS and what needs to change. Different approaches to allocating resources and experience from other countries are considered before the report concludes with a series of recommendations.

1.10 Six background papers are included with this report and together provide further details on the evidence as well as findings of relevance to the Green Paper consultations :

(i) Hudson B and Henwood M, *Prevention, personalisation and prioritisation in social care: squaring the circle? A review of the literature and development of an analytical framework for eligibility*

(ii) *'Have Your Say' about Fair Access to Care Services* – report by OPM of a CSCI consultation event held on 1 April 2008 for the review of eligibility criteria

(iii) Henwood M and Hudson B, *Lost to the system? The impact of Fair Access to Care – a report commissioned by CSCI for the production of the State of social care in England 2006-07*

(iv) Robbins D, *Criteria for care: assessing eligibility for long-term care services in Europe* London:SCIE

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[12] LGA, ADASS, NHS et al (2007) *Putting People First: a shared vision and commitment to the transformation of adult social care.* London: HM Government

(v) Hudson B and Henwood M, *Analysis of evidence submitted to the CSCI review of eligibility criteria. A report for the Commission for Social Care Inspection*

(vi) Audit Commission The effects of *Fair Access to Care Services bands on expenditure and service provision*

1.11 To set the scene for this review of eligibility criteria, the following chapter considers why national criteria were introduced, how they were framed, the legal position and the current policy context.

Chapter 2

Background: the introduction of a national framework for eligibility

2.1 The conceptual roots of the current social care system are very longstanding. Some have traced its origins to the Elizabethan Poor Law distinction between the 'deserving' and the 'undeserving' poor. It is certainly the case that – in stark contrast with the NHS which started in the same year – the 1948 National Assistance Act did not herald the arrival of universal social care services accessible by all and free at the point of delivery. Instead the legislation made it plain that councils were only obliged to provide care and support to people in circumstances where it was not 'otherwise available to them'. Publicly funded social care was thus seen as a 'safety net' rather than a universal entitlement.

2.2 Importantly, whilst residential care has long been subject to a nationally-determined means test, the 1983 Health and Social Services and Social Security Adjudications Act enabled councils to levy charges for home care and other community services. As a result, the total 'cake' of resources available to councils for adult social care comprises central government grants, a proportion of council tax receipts and income from fees and charges. In this context the relationship of charging and eligibility criteria is crucial and both can act – independently – as rationing mechanisms.

2.3 The transfer of some key funding responsibilities from the social security system to local councils, under the NHS and Community Care Act 1990, introduced the requirement for an assessment of needs before public support could be offered to individuals. But it did not alter the essential architecture of social care – that support was dependent on an assessment of needs as well as a test of means. Following the introduction of the 1990 Act, judgements in significant court cases in the area of community care permitted councils to consider their *own* resources in determining provision. This is the system which this report addresses.

2.4 There are a number of ways in which eligibility for access to social care can be controlled. The line between those people who are, and are not, eligible may be drawn according to people's needs and financial resources, based on needs alone, or solely on means testing, by reference to outcomes judged to be important, limited to people with certain conditions, and so on. In this country, the national framework for assessing who is eligible prioritises between risks arising from low, moderate, substantial and critical needs. People who are deemed eligible according to a locally determined threshold are then financially assessed to determine how much they have to contribute to their care. FACS is thus a trigger for intervention by public services, even where some people may end up paying for the full cost of their care.

2.5 Any framework for allocating finite resources needs to be consistent with current policy objectives so that rationing decisions are not pulling in the opposite direction to policy. Thus the relationship between policy imperatives and eligibility criteria is critical to this review. How far does the Fair Access to Care Services (FACS) framework introduced five years ago fit with the current policy agenda of personalisation and prevention?

Background to introducing the FACS framework

2.6 Prior to the implementation of FACS in 2003, councils had (and continue to have) a number of responsibilities under a variety of pieces of legislation, including:

- National Assistance Act 1948
- Chronically Sick and Disabled Persons Act 1970
- Local Authority Social Services Act 1970
- NHS and Community Care Act 1990.

Councils have a duty to assess the needs of people for community care services, a duty to accommodate people needing 'care and attention', and separate responsibilities with regards to disabled people.

2.7 Following the NHS and Community Care Act 1990, which transferred funding from the benefits system to councils, councils were obliged to manage a cash-limited system. In order to balance their budgets, they had to ration social care spending using eligibility criteria. But there was no national approach as to when, or if, responsibilities towards individuals began. Indeed the Audit Commission in 1993 acknowledged that it was 'no mean feat' to define a need for a service, allow for flexibility and adjustment to tailor services, meet the greatest needs and stay within budget.[13] Councils interpreted their responsibilities in very different ways which resulted in a number of legal challenges.

2.8 The landmark case of R v Gloucestershire County Council ex parte Barry (1997) went to the House of Lords. The court held that councils are entitled to take into account their available resources when assessing an individual's needs and in making any necessary arrangements to meet those needs. The court also stated that access to assistance should be determined via eligibility criteria, contending that when establishing any criteria the council must take into account current standards of living, the nature and extent of the disability, the extent to which the quality of life would be improved by the provision of a service, and the relative cost of the service balanced against the relative benefit and the relative need for that benefit.

2.9 Subsequently the Government committed to developing guidance on Fair Access to Care in its 1998 White Paper *Modernising Social Services*, recognising "*decisions about who gets services and who does not are often unclear, and vary from place to place. Eligibility criteria are getting ever tighter and are excluding more and more people who would benefit from help.*" Guidance was promised that would set out the principles councils should follow when devising and applying eligibility criteria, as well as compatibility with NHS continuing care criteria. In essence the FACS framework was designed to increase national consistency in a heavily locally determined system.

2.10 The FACS guidance issued in May 2002 (for implementation in 2003) provided a national framework for eligibility criteria for adult social care. The Department of Health had acknowledged that the use of different local criteria "*leads to considerable variation in access to adult social care, which in turn leads to unfairness*".[14] The guidance issued under section 7 (1) of the Local Authority Social Services Act 1970 was mandatory and designed to be consistent with the policy objectives of the 1990s to focus upon people with the greatest assessed needs.

2.11 However, legislation concerning social care remains fragmented and the Law Commission is now scoping a review of adult social care law in England and Wales. This covers the law under which residential care, community care, adult protection and support for carers is provided. The ultimate aim is to provide a coherent legal structure, preferably in the form of a single statute, for these services.

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[13] Audit Commission (1993) *Taking Care – progress with care in the community.* London: HMSO

[14] Department of Health (2002) *Local Authority Circular LAC(2002)13 Fair Access to Care Services Guidance on Eligibility Criteria for Adult Social Care.* London: Department of Health

FACS framework

2.12 The FACS framework was based on risks arising from needs associated with various forms of disability, impairment and difficulty in order to *"help councils to promote the independence of those seeking their help"*. However the guidance also claimed to support 'a *preventative* approach to adult social care' as the risks relate to both the immediate and the longer term.[15]

2.13 The FACS framework did not seek to achieve a position where individuals with similar needs receive similar services across the country as it was acknowledged that councils would take account of their local resources. It did aim for *"people with similar needs to be assured of* ***similar outcomes****, if they are eligible for help, irrespective of the services that are provided to meet eligible needs"*.[16] This separation between 'needs' and 'services' was fundamental to the framework and supported earlier attempts to change practice away from slotting people into the services available towards tailoring services to meet their needs. Assessment of needs, not *for services,* was the cornerstone of good care management.[17]

2.14 A distinction is made in the guidance between *presenting* and *eligible* needs. Presenting needs are the issues identified when people first contact social services and eligible needs are those that fall within the council's eligibility criteria. Councils are asked to support those people who have needs that are not eligible for help *"through the provision of information or advice, referral on to other agencies, or by providing alternative services as part of community development, Supporting People, health promotion or other wider initiatives"*. FACS guidance also makes it clear that councils should *"avoid screening individuals out of the assessment process before sufficient information is known about them".*

2.15 The FACS guidance is also clear about the importance of monitoring both those whose needs are 'presenting' but may not receive public support and those whose needs are deemed eligible, particularly to inform service delivery, planning and commissioning.

2.16 The guidance also highlighted the importance of equality and human rights and that councils should have regard to the relevant legislation, including the Human Rights Act 1998 and the Disability Discrimination Act 1995.

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[15] Department of Health (2002) *Fair Access to Care Services: guidance on eligibility criteria for adult social care.* London: Department of Health

[16] Ibid

[17] Department of Health (1991) *Care management and assessment manager's guide.* London: HMSO

2.17 Carers' needs are included, with a reminder in the FACS guidance that carers need to be involved in assessments of the individual being supported and that their own needs may be assessed within the framework of the guidance for the Carers and Disabled Children Act 2000.

2.18 There are thus some important principles established in the FACS guidance, which still stand but have been lost sight of in their implementation. These are about:

- trying to ensure a needs-led not a service-led approach
- people with similar needs having similar outcomes
- taking a non-discriminatory and human rights approach
- ensuring carers' needs are taken into account
- the role of councils in supporting people who are not eligible with information, advice and alternative services
- adopting a preventative approach

2.19 Importantly, the framework was not simply a guide and councils were not permitted to vary the wording in its use locally. However, councils may add additional risk factors within a band, and they may create 'sub-bands' such as 'moderate-greater' and 'moderate-lesser'. The guidance also pointed out that "in determining eligibility for individuals, councils should prioritise needs that have immediate and longer-term critical consequences …ahead of needs with substantial consequences" and so on down the bands. This prioritisation of the bands depending on local resources has often resulted in reductions in support for those at the lower levels of need (and, erroneously, in cuts to simple services as well) (See box 1 for a detailed description of the four bands.)

Box 1: The current eligibility framework: four bands

The eligibility framework is graded into four bands, which describe the seriousness of the risk to independence or other consequences 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 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 of 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.

Department of Health (2002) *Fair Access to Care Services – guidance on eligibility criteria for adult social care London*: Department of Health

Resource pressures and recent legal challenges

2.20 Since the introduction of FACS, there have been well-documented increasing demands on social care budgets.[18] There are more older people, living longer and often with more complex needs, and there are also increasing numbers of younger adults with severe physical and learning disabilities. Although councils have been reconfiguring and modernising services, nevertheless the vast majority of councils have taken steps to restrict the numbers of people accessing funded social care. For example, from 1997 to 2006, the numbers of households receiving supported home care fell from 479,000 to 358,000; and compared to 2003, fewer older people per 1000 population were receiving council-arranged care services in the community in 2006.

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[18] Commission for Social Care Inspection (2006) *The State of social care in England 2005-06.* London: CSCI
Commission for Social Care Inspection (2008) *The State of social care in England 2006-07.* London: CSCI
Wanless D (2006) *Wanless Social Care Review: securing good care for older people.* London: King's Fund

2.21 In 2006-07, the proportion of councils who set their eligibility at 'substantial' or 'critical' level of risk increased from 53% to 62%. In 2007-08, 72% of councils were operating at 'substantial' or 'critical' level. (70% of councils set the threshold at 'substantial' and 2% at 'critical'.)[19] Formally this means most people with 'moderate' or 'low' needs are not eligible for publicly funded support, although in practice some may access universal or 'open access' services that provide help.

2.22 Increasing concerns about the tightening of eligibility criteria have led to some recent legal challenges. In December 2007, the High Court considered whether it was lawful for a council to restrict eligibility only to people with a 'critical' need as defined by FACS.[20] The court held that, in principle, it was lawful but in the particular case under consideration the council's decision to restrict eligibility was unlawful because it had failed, in taking that decision, to discharge its obligations under the Disability Discrimination Act 1995. In summary this case underlined that as long as the consultation process is properly followed by a council and changes to eligibility criteria are genuinely due to resource constraints, increases to thresholds are unlikely to be successfully challenged.

FACS and continuing health care

2.23 The FACS guidance applies to adult social care services that have been agreed as the responsibilities of councils under local continuing care arrangements. However there have been longstanding difficulties in defining the boundary between NHS-funded continuing health care (which is free at the point of need) and means-tested social care. Disputes over financial responsibilities have particularly affected those people with a complex mix of health and care needs, ie those most likely to be deemed as 'critical' or even 'substantial' according to FACS criteria. In response to major variations between PCTs in defining who is eligible for NHS continuing care and repeated legal challenges around whether specific cases should be deemed as health or social care responsibilities, the Government introduced a new national framework for continuing health care (October 2007) that replaces criteria determined at local or regional level. The reforms are expected to increase the numbers of people supported by the NHS by about 7,000 each year, up to a total of 31,000. However the definitions for eligibility for NHS continuing care and those within the FACS framework do not flow seamlessly and how the new national framework for NHS continuing care is implemented across the country will have an impact on decisions about access to social care funding.

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[19] SAS evidence 2007-08 to be published

[20] The High Court in R (on the application of Chavda and others) v Harrow London Borough Council (2007) EWHC 3064 (Admin), (2007) All ER (D) 337 (Dec)

Current policy: prevention and personalisation

2.24 At the same time as many councils have been seeking to manage their resources by tightening their eligibility criteria, Government policy has placed increasing emphasis on prevention and personalisation. The concordat, *Putting People First,* agreed by the Government in 2007 with social care provider and professional bodies and regulators (see box 2), focuses on prevention and early intervention alongside enablement and high quality personally tailored services. *"In the future we want people to have maximum choice, control and power over the support services they receive*." Prevention and personalisation are thus key policy objectives that any revised or new eligibility framework needs to support.

Box 2: Putting People First: a shared vision and commitment to the transformation of adult social care

This Ministerial Concordat, signed by six Cabinet Ministers and published on 10 December 2007, sets out a joint approach between central and local government, the sector's professional leadership, providers and the regulator to transform adult social care.

Across Government, the shared ambition is to put people first through a radical reform of public services, enabling people to live their own lives as they wish, confident that services are of high quality, are safe and promote their individual needs and preferences for independence, well-being and dignity.

The concordat aims for high quality support that is universal and available to every community. *"Every locality should seek to have a single community based support system focused on the health and wellbeing of the local population."*

People who use social care services and their families will increasingly shape and commission their own services. Personal budgets will ensure people receiving public funding use available resources to choose their own support services.

The concordat includes objectives for a universal information, advice and advocacy service; and a common assessment with greater emphasis on self-assessment.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081118

2.25 However, as one of our background paper explores,[21] the concept of 'prevention' is highly complex and multi-dimensional. It encompasses notions of avoiding dependency, targeted rehabilitation and recuperation as well as broader approaches to improving the quality of life. This can mean there is a lack of clarity over objectives that not only makes it difficult to evaluate the effectiveness of preventative services, but also presents challenges in developing an eligibility framework that is consistent with policy aims.

2.26 Much of the debate about prevention has been a professionally dominated one where interest has focused on the potential longer-term savings from any particular investment and avoiding high cost solutions. This can mean that important quality of life dimensions which can be particularly relevant to simple, low cost interventions may not be adequately acknowledged in evaluations.

2.27 In contrast the personalisation agenda is centred on outcomes for people. A long-established discourse around the social model of disability and independent living underpins key elements of personalisation, notably self-directed support and personal budgets. Important to this review is that the model of self-directed support is based on the identification of a personal budget so that people know up front what funding they are entitled to. Often, the 'up-front' funding is people's own financial resources.

2.28 The Resource Allocation System (RAS) which has been developed by *In Control* continues to evolve. Significantly, the *In Control* scheme has tended to assume that people with learning difficulties are already in receipt of social care services. In adopting these models locally, in some councils care managers lead the assessment process in consultation with people who use services, whereas in others approaches are almost entirely dependent on individuals completing self-assessment questionnaires.

2.29 Under FACS, resources are allocated towards the end of the assessment process, whilst in self-directed support schemes, resources are allocated at the beginning of the process. In outline the RAS uses a self-assessment questionnaire to gather information about the person's needs and then identify the level of funding to match them. Most places developing a RAS:

- Select a self-assessment questionnaire with domains or broad areas of life such as personal care needs, relationships, staying safe from harm, and grade ability within each domain. Each field is scored and the greater the need the higher the points allocated. This is essentially a deficit model of assessment.

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[21] Hudson B, Henwood M (2008) *Prevention, personalisation and prioritisation in social care: a review of the literature and development of an analytic framework.* London: CSCI

- Select a test group of 100 people which is broadly representative and cost the care packages they are currently receiving; and complete the questionnaires to give a total score.
- Calculate the average cost per point by dividing the total cost of all packages by total points scored; the product of a person's total score and the average cost per point adjusted by a multiplier then gives the indicative funding allocation for that person.

However, developing individual budgets based on past choices might under- or over-provide when people with individual budgets may prefer to make very different choices.

2.30 Currently local versions of the RAS are being developed across the country and sometimes several local versions exist for different groups of people. In some places assessment for eligibility and assessment for RAS are being combined in one process. In others there is a distinct step between being deemed eligible for publicly-funded social care and the resource allocation process.

2.31 CSCI noted in the State of Social Care in England report that there are tensions between the self-directed support model and the FACS framework. "The standardisation and explicit decision making that goes with targeting services sit uneasily in practice alongside the personalisation agenda that is about self-assessment, individual direction and arm's-length accountability for expenditure decisions".[22] However there is a distinction; whilst the self-directed support model is concerned with maximising the choice and control available to people who use social care, it cannot of itself determine how the eligibility of those people is defined.

2.32 The following chapter looks in more detail at these tensions from people's experiences of seeking support, how FACS is being implemented and what people feel should change.

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22 Commission for Social Care Inspection (2008) *The state of social care in England 2006-07*. London: CSCI

Chapter 3

What the review found about the current FACS system

(i) Views on the current eligibility system

3.1 CSCI sought and received both a substantial volume and a wide spread of opinion from people using (or seeking) services, carers, people employed in council social services and other sectors of social care, national and local lobbying and provider organisations, groups of people who use services, professional and other interested stakeholders. This chapter summarises the key points of an analysis of responses from the online survey and written evidence,[23] feedback from the consultation event[24] and other meetings held during the review.

Acknowledgement of the inevitability of rationing

3.2 With very few exceptions, there is a strong underlying acceptance that some means of limiting access to publicly funded support has to be in place.

> ‘*It is recognised that resources in social care are limited and that there will always have to be some system of deciding who should get what.*’
> (Multiple Sclerosis Society)

> ‘*It is accepted that in a system where there are limited resources, there has to be a tool used to decide who does and doesn’t receive support.*’ (Help the Aged)

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[23] Hudson B and Henwood M (2008) *Analysis of evidence submitted to the CSCI review of eligibility criteria.* London: CSCI

[24] OPM (2008) *‘Have Your Say’ about Fair Access to Care Services: report by OPM of a CSCI consultation event held on 1 April 2008 for the review of eligibility criteria.* London: CSCI

Support for FACS

3.3 Whilst there is substantial criticism of FACS, there is some support for the current system in that it offers:

- an improvement on the pre-FACS situation

'*Some people recalled the situation before the national framework of FACS was introduced, and problems where judgements were too subjective and there was no one way in which people using services could hold a worker to account.*' (consultation event)

- a national system of accountability and consistency, where FACS is

'*…a useful benchmark to compare practice within and between councils…a useful tool with which to challenge councils to scrutinise their practice more closely.*' (consultation event)

- transparency and a means of crystallising local debates on priorities

'*The FACS guidance has worked very well to make the tightening of social care budgets transparent.*' (Sense)

'*[FACS has] 'provided a powerful means for raising interest in social care at a local level and arguing the case for increased resources*' (ADASS)

- a 'whole person' approach to people's needs

'*The current FACS guidance covering health, personal care, education, work, social and family life, is a positive 'whole person approach.*' (The Resolution Foundation)

- if properly put into practice, an adequate framework in the short term

'*In the short term the question has to be – how likely is it that anything different we put into place would be better than what we have at present, and is it worth making a change prior to the Green Paper recommendations?*' (ADASS)

Criticisms about FACS

3.4 However, the majority of the evidence is critical of FACS at the level of both principle and practice and concerns:

a) lack of clarity and transparency

b) lack of fairness

c) service-led rather than needs-led approaches

d) limitations of a risk/needs-based model

e) insularity and fragmentation
f) neglect of the prevention and inclusion agendas
g) inadequate diversion and signposting
h) dominance of budgetary considerations
i) tensions with the personalisation agenda.

a) Lack of clarity and transparency

3.5 Whilst in theory FACS should offer clarity about who is eligible for social care and consistent and standardised responses, in practice respondents felt this was not the way it was working. In addition to a lack of available information about the criteria, one carer observed:

> ‘*The general public have little or no understanding of social services eligibility criteria. ‘Fair Access to Care’ means nothing to the person in the street.*’

3.6 It was apparent from survey respondents that there is considerable confusion about the meaning of ‘eligibility’ and some thought it referred to a determination of people’s savings and assets, rather than an assessment of their needs. Indeed this can be people’s experiences when seeking support – to which we return later.

3.7 A frequently raised issue related to the sheer complexity of the FACS framework, such that neither professionals nor people using services and their carers were confident of their understanding. This can culminate in a system that is too complex for staff to operate and too confusing for people to understand or confidently challenge assessment decisions.

> ‘*Most people have absolutely no idea whether their council is acting fairly and in accordance with best practice or other councils’ practice. All people want is a fair deal.*’ (survey respondent)

> ‘*We don’t know what help we are entitled to…what we can expect if we need help…where to get help or who to contact*’ (person seeking services)

b) Lack of fairness

3.8 A lack of fairness in the way criteria are being applied and resources allocated was perceived to be due, firstly, to variations in professional judgement, and secondly, to differences between councils – the ‘postcode lottery’.

3.9 Professional judgement is necessary because needs cannot be automatically determined from the descriptions of the FACS bands. The evidence from this review confirmed the findings of earlier research commissioned by CSCI[25] that showed considerable variation in professional judgement and practice in applying the FACS criteria. As some councils acknowledged in their written submissions to the review: "*FACS is subject to wide and varied interpretation, with different custom and practice in different teams and specialisms".*

3.10 Respondents also acknowledged that staff 'bent the rules' to ensure people got the help they need, and whilst this could work in people's favour, inconsistent application and interpretation are unreliable and run the risk that 'who shouts loudest' is listened to while others are overlooked. This is likely to have particular impact on some groups of people, including those from black and minority ethnic communities. Those on the receiving end of eligibility decisions are not happy with this variability. As one voluntary organisation commented: *"The four bands are open to massive interpretation...they lay claim to an objectivity that is not present".*

3.11 A very common criticism was the perception that individuals with apparently similar needs receive very different levels of support. There was little or no enthusiasm for the notion that these variations constitute an acceptable consequence of local democratic autonomy and decision making.

> ‘***The postcode lottery generates confusion and dissatisfaction among service users and carers, who do not understand how a system called 'fair' can result in the same level of need being met by provision of social care in one local authority and not another.***’

In addition the local variations made it harder for people to have portable packages of care. Scope highlighted that:

> ‘***Despite guidance, local authorities and Primary Care Trusts use disputes over the person's place of ordinary residence as a means to delay or avoid paying the costs of care. In some cases, people are unable to move until an assessment has been made, but are unable to receive an assessment until they have moved. Large sums of money are wasted in administrative and legal costs in seeking to resolve such disputes and in some cases people are prevented from moving into independent life-styles.***’

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[25] Henwood M and Hudson B (2008) *Lost to the system? The impact of Fair Access to Care: a report commissioned by CSCI for the production of 'The state of social care in England 2006-07'.* London: CSCI

c) Service-led rather than needs-led approaches

3.12 FACS was an attempt to move away from a service–led approach to support, ie where people are fitted into available services, but evidence submitted to this review confirms earlier findings of the continuing influence of such a model. In some councils there has been a basic misunderstanding that 'low-level needs' equate with 'low-level services' and complex or critical needs always require complex services in response. This has resulted in 'low-level' services being cut in some councils.

> ‘*social workers still tell people what they can have rather than base the services on the needs of the person.*’

> ‘***The inherent ambition within the FACS guidance is particularly limited when authorities (such as our own) firmly and definitively link eligibility for help to tasks and equipment to be provided in given circumstances.***’

3.13 The position of carers was felt to be at particular risk in these situations where models "*lean towards the funding of services rather than needs*" and hence the refusal to offer support for shopping, gardening, pension collection and similar can have a perverse effect. Families are often prepared to provide high level personal care but need support with other tasks, deemed as 'low level'. Without such support from simple services there are dangers that family care breaks down, the individual is unsupported and publicly funded services have to step in at crisis point at greater overall cost.

d) Limitations to a risk/needs-based model

3.14 There are two main strands of criticism about unintended consequences seen to emerge from the current 'risk to independence' model. Firstly, that it has encouraged inadequate and unduly standardised assessments and, secondly, has led to the neglect of some groups of people using services.

3.15 There is considerable discontent in general with the nature of the assessment process, for example:

> ‘***Members agreed that the assessment process itself is personal, intrusive and, if it results in a refusal of eligibility for services, very negative…there is concern that substantial numbers of vulnerable people self-select out of the system as they believe that they have low or medium levels of risk.***’
> (Newcastle Health and Community Care Forum)

A community organisation (Mushkil Aasaan) gave evidence to the review about assessments that failed to take into account cultural issues of importance to the individual and made incorrect assumptions about black and minority ethnic communities.[26]

3.16 In addition there are particular concerns that:

(i) assessments are more concerned with using standardised procedures to screen people out of support than to assess their needs

(ii) the FACS framework encourages a focus on what cannot be done by individuals (a deficit model) rather than on what they could do with support and what outcomes people want to achieve.

3.17 Regarding standardised assessments, the consultation event reported that "*assessments were seen as a tick box exercise with staff acting primarily as gatekeepers to accessing services*". Respondents to the online survey identified similar concerns:

> ‘***The current system feels as though its main purpose is to ration inadequate resources, rather than assess need and ensure that appropriate help is provided.***’

3.18 Concerns about the negative focus on deficits encouraged by the FACS framework suggested this often results in the undue primacy of personal care issues above any other preferred outcomes:

> ‘***FACS is judgemental about the level of risk associated with different situations and therefore leads to discrimination – an inability to carry out certain personal tasks makes a person more likely to be eligible for services than someone facing complete social isolation.***’ (NCIL)

> ‘***The framework appears to over-emphasise risk and protectionism instead of asking how it can help people have an 'ordinary life'...the way FACS focuses on different areas of risk does not necessarily accord with the way people who use services see their lives.***’ (Consultation event)

3.19 There has been considerable evidence submitted to this review about certain groups of people currently felt to be marginalised by the FACS system, often to the extent that they are described as 'hidden'.

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[26] See also Commission for Social Care Inspection (2008) *Putting people first: Equality and diversity matters 2 –providing appropriate services for black and minority ethnic people.* London: CSCI

> ***There are many people with ‘hidden’ disabilities whose needs may become increasingly ignored as social care criteria are reviewed and directed towards those with more obvious or immediate needs.*** (The Disabilities Trust)

3.20 The groups particularly highlighted in the written submissions and in comments through the online survey include:

(i) **People with long-term conditions** – where it is argued that the criteria do not include sufficient requirement to take account of the long-term impact of a condition.

(ii) **People with fluctuating conditions** whose needs over time are not properly taken into account.

(iii) **Blind and partially sighted people** who are disadvantaged by assessors who are unaware of the impact of loss of vision, leaving many outside the top two eligibility bands.

(iv) **Young adults who move from children’s services** where they may have been well supported *“into the adult’s world where they may find availability is restricted”* (consultation event).

(v) **People with Asperger’s syndrome/autism** whose support needs are often not properly understood.

(vi) **Carers** – who are those most frequently referred to as a ‘hidden’ group.

Carers and FACS

3.21 The local implementation of FACS has been seen to underplay the role of carers. There is uncertainty whether, and how far, assessors should take into account the support available to people from carers and other networks.

> ***Some councils take the availability of a carer into account in assessing eligibility for FACS, others do not. On the one hand it is argued that the availability of the carer is a fact of life and should therefore be taken into account. Others argue that taking carers’ support for granted leads to an underestimation of the amount of support the person requesting social care requires, and does nothing to share the caring responsibilities taken on by carers.*** (Consultation event)

3.22 Our findings indicate considerable misunderstanding around the position of carers in relation to FACS and there are reports that:

- some councils appear to believe that FACS only relates to people using services, while others do not seem to understand that it is policy guidance and therefore mandatory

- some councils are failing to collect adequate information about carers at the contact, assessment and screening stage
- there is a duty to address carers' eligible needs but discretion about whether to meet these through carers services or community care services – however, some practitioners appear to think the discretion is about whether to help carers at all
- inappropriate assumptions are made about the willingness of carers to provide support, leading to too low an assessment of their level of need and risk
- too few carers receive an assessment, and follow-up analysis on the family's support needs as a whole is not taking place.

e) Insularity and Fragmentation

3.23 The consultation event reported the view that FACS was "*not holistic*" in the sense that it does not include consideration of important areas such as health, housing and leisure. This in turn had, in the view of some people, resulted in social care becoming an isolated and stigmatising service:

> ‘***People who use services said they find the FACS process of having to prove their eligibility stigmatising. Some also commented that they were reluctant to approach a voluntary organisation because of the stigma of having to rely on charity.***’ (Consultation Event)

3.24 This insularity is exacerbated by the fragmentation between FACS and some important parallel processes that are likely to involve the same people. The most frequently mentioned of these were continuing health care, the care programme approach (CPA) and learning disability services.

Continuing health care

3.25 The ways in which FACS interacts with continuing health care (CHC) are far from straightforward and are likely to affect people assessed as being in the critical and substantial FACS bands. Written evidence to the review confirmed the existence of problems at the interface between FACS and CHC. A number of respondents were attracted to the principle of having a national framework for social care eligibility similar to that for CHC, ie with detailed and prescriptive lists of eligible conditions. Arguably this is precisely what FACS currently has become in some places, with an emphasis on deteriorating physical conditions, but unlike continuing healthcare there is currently more discretion for local councils to determine levels of entry.

Care programme approach

3.26 The care programme approach (CPA) describes the framework for supporting people with severe mental health needs in secondary mental health services. Currently two levels of support are distinguished:

- *standard* for those people receiving care from one agency, who are able to self-manage their mental health problems and maintain contact with services
- *enhanced* for those people with multiple care needs using support from a range of services.

3.27 From October 2008 CPA will no longer apply to people needing 'standard' support and this new CPA is to be targeted upon people with the greatest need as defined in the new best practice guidance. The new guidance is cognisant of the changing policy scene in several important respects. Firstly, it is clear that support through the CPA approach should not be service-led: *"New CPA should not be used as a gateway to social services or as a badge of entitlement to receive any other services or benefits*". Secondly, it is emphasised that since CPA is a process (rather than a measure of eligibility) then it should not be equated with FACS eligibility levels. And finally, it is said that support via CPA should not stop people from taking advantage of individual budgets.

3.28 The written evidence suggests that current practice falls some way short of this, and indeed that the pending changes may further complicate access to social care support.

> ‘***FACS does not fit easily with the CPA, and it has added an unnecessary level of complexity to decision-making in some areas.***’ (Council respondent)

3.29 Others highlighted for those potentially eligible for social care support, the problematic consequences of community mental health services which are informed primarily by clinical priorities and led by NHS budgeting priorities:

> ‘***Because the health service is usually the first port of call for those needing mental health care, many potential service users are wrongly screened out before they can be assessed for social care because their clinical needs are not acute enough to engage with the health service. Because the route to social care is concentrated within the community mental health service, many people who are treated solely in primary care are never assessed for social care needs.***’ (MIND)

3.30 Further, according to MIND, 'many' councils are complicit in this situation by operating a threshold for service provision based on mental distress that is severe enough to justify CPA-based care. This threshold, it is said, is frequently used as a basis for deciding whether to provide an initial assessment, and "*as a result service users are unlawfully denied an initial social care assessment".* This situation could be exacerbated by the new guidance outlined above with the CPA threshold itself about to rise even higher.

Learning disability services

3.31 In a similar vein to mental health services, the consultation event for this review reported "*There is a view that FACS has no direct relevance to learning difficulty services since it is effectively the referral criteria imposed by community learning difficulty teams which determines who will receive a service – not the application of FACS, which is a paper exercise having no direct impact on the level of service delivered".*

3.32 Other evidence submitted reveals the widespread use of IQ measurements to determine eligibility for support from adult learning disability teams. This includes:

- A cut-off point of an IQ of 70 is commonly used that can exclude parents who (although they score above 70 when tested) do have cognitive impairments that impact upon their parenting abilities, and who would benefit from specialist social care support.
- When someone is assessed as not needing the specialist input from an adult learning disability team (because they do not meet the IQ criterion) they may still meet FACS criteria but tend not to be referred to another social care team for assessment. The common situation is that if a person is deemed ineligible for adult learning disability services, they then have no further contact with social services.
- The practice of using IQ tests as an initial gateway to a FACS assessment is unlikely to be lawful as councils have a general duty not to 'fetter their discretion' and must consider each individual's circumstances.
- Another Catch 22 can arise for parents with learning disabilities – too high an IQ to be eligible for adult social care support, yet judged by children's services to have too low an IQ to be competent parents.

3.33 The situation of people with Autistic Spectrum Disorder (ASD) was also highlighted in the evidence submitted:

> *IQ should not be used as a criterion (my Mum was told that it shouldn't be; but my LA still uses it). My abilities are very patchy – I am highly literate, but extremely vulnerable and socially challenged. Government guidance has not clarified the situation for people with ASD – too often we are pushed between learning disability and mental health, each saying we are the other's responsibility.*

f) Neglect of the prevention and inclusion agendas

3.34 Whilst the need for preventative support is acknowledged in the FACS guidance, the evidence suggested this is often not observed in practice and that it is marginalised in the FACS framework, as Age Concern argued "*requirements for a preventative strategy are tagged onto, rather than integrated with, the guidance*".

3.35 Many respondents to the online survey identified concerns that prevention was being overlooked and that a focus only on higher level needs was simply storing up problems for the future.

> *A little support for people in a moderate state could prevent severe and critical situations requiring heavier input.*

3.36 Other issues confirmed the evidence in our earlier research:

- The impact of raising eligibility thresholds where a lack of preventative services means there is a short term dip in the number of people eligible for social care soon followed by a longer-term rise.
- A narrow interpretation of prevention where "*in some cases local authorities are limiting consideration of risks to those that are likely to arise in weeks or even days…a substantial departure from the national guidance*" (Age Concern).
- The apparent incompatibility of FACS and prevention: "*The system does not help us deal with the needs of people below the eligibility threshold, yet this is preventative services territory and a key part of Putting People First*" (ADASS).

3.37 The prevention agenda is not simply about trying to avoid needs intensifying at a later stage, it is also about addressing wider social inclusion objectives giving people a reasonable quality of life. Respondents to the online survey highlighted concerns that such objectives were being marginalised by FACS.

> *It should be enabling not disabling, by supporting people to live in the community and have greater inclusion in society and help to access their rights and choices.*

3.38 Others have highlighted the problems of accessing advocacy in relation to safeguarding people from abuse and how this is only possible once people are in the publicly funded system. In some places it is reported people have to be eligible for services before they get access to any sort of advocacy.

g) Inadequate diversion and signposting

3.39 Our findings indicate three key problems with the practice of signposting to other support those people who do not meet the eligibility threshold:

(i) At their initial contact with the council, people's needs and circumstances are insufficiently explored.

(ii) Inadequate help is given to people who are signposted in this way.

(iii) Councils do not monitor what happens to people signposted to other support, so unmet need is not being recorded nor are those people's outcomes known.

3.40 Submissions to the review and evidence from CSCI inspectors raised concerns about the quality of the response to people's first contact with some councils. There are concerns that often the least experienced staff are making judgements and that people do not understand that the initial conversation or phone call is often the 'assessment' and are thus unprepared.

> ‘***We are concerned that local authorities are relying more and more on telephone assessments to make a judgement about eligibility…We are worried that applicants' needs can easily be taken at face value when downplayed by an individual (as is often the case with older people who find it hard to ask for help) and therefore can go unrecognised.***’ (Local Age Concern)

> ‘***We meet service users on a regular basis who appear to have been screened out because a brief initial phone call elicited the 'wrong' responses in social services' eyes. The needs that a person mentions at the beginning of a phone call may not be their primary needs.***’ (Local Centre for Independent Living)

3.41 The online survey specifically addressed the question of signposting and the consequences for people who did not meet council eligibility criteria for social care:

- More than 60% of respondents stated that they were not given any information about other help that might be available.
- Around one third (29% people who could benefit from social care and 34% carers) indicated that they *had* been given information but this *did not lead to them getting any help.*

- Only 5% of all those responding said that they had both been given information *and* that it had positive outcomes in leading to them getting help.

> ‘*Social services did not tell me why I did not qualify; nor did they suggest any alternative ways of getting help (…)That was the end of the story! I think I was expected to be able to manage for myself because I don’t fit the stereotype of someone who needs help. Because I am articulate, they made assumptions about my background and expected me to be able to look after myself.*’

h) Dominance of budgetary considerations

3.42 The repercussions of the pressure on budgets has been a dominant feature of much of the written evidence, online survey comments and discussions with stakeholders. Our earlier research noted that the need to set priorities and control expenditure was paramount in all the study sites and typically served as a catalyst on councils to review FACS thresholds. For many respondents the pressures in the system were simply a reflection of inadequately funded social care rather than any inherent fault with the eligibility framework.

> ‘*…the fundamental reason for the tightening of eligibility criteria is shortage of funding which has not kept pace with demographic, social and economic trends.’*’
> (Learning Disability Coalition)

> ‘*…much of the current feeling that FACS is not fair is because funding is so tight.*’
> (Sense)

3.43 The experiences which many people using services reported of having their eligibility changed from one assessment to another, without any apparent objective change in their needs, underlined the sense that dominant budgetary concerns lead to a continual ‘shifting of the goal posts’ and a considerable sense of insecurity for people who fear losing their support. Five per cent of survey respondents received help for a while but then lost it on review. Others feared losing their package of services when moving to another geographical area.

3.44 For some respondents the solution lay in the abolition of local discretion to set eligibility thresholds (ie the current system) and its replacement with a national approach. Others recognised that this would fail to address the underlying issue of inadequate resources to meet all presenting social care needs.

i) Tensions with the Personalisation Agenda

3.45 The tension between FACS and personalisation was a recurring theme of the written evidence:

> ‘*The structure is incompatible with the personalisation agenda and increasing choice and control in that it is wholly based on the notion of professionally led assessment, care planning and service provision.*’ (Council)

> ‘*The principle of fair allocation of funding based on equivalent levels of need is partly at odds with the philosophy of personalisation, which allows for variations in responses tailored to people’s individual circumstances.*’ (SCIE)

3.46 Some people believed that the adoption of a Resource Allocation System (RAS), as has been used by *In Control* and in the Individual Budget pilots, *“could remove the need for FACS altogether by wholeheartedly embracing the RAS and using that system to allocate resources. This could remove the role of assessors as rationers of the service or the ability of local authorities to raise eligibility levels to reduce the numbers accessing the services”* (person employed in council social services). This is discussed later in this report, in both the recommendations and the commentary on longer-term options.

(ii) The consequences of restricted access to social care on people’s lives

3.47 It is important to highlight the findings from the online survey for this review which indicated that most people who had an assessment had largely positive experiences of the process, and of those responding to the survey around three quarters met the eligibility criteria for help.

3.48 However, almost one in five people identifying themselves as carers, and one in eight of those who said they could benefit from social care, reported that they had failed to have an assessment of their needs when they asked for help from social services. One third of these respondents understood this was because they did not meet financial eligibility criteria for help. In other words, they were asked about their financial resources and savings prior to any assessment of their needs for support. Significant numbers of people who had resources of their own were diverted from the system at this stage. This reflects the findings in the special study for the report on the State of Social Care in England, 2006-07, and contravenes current policy.

3.49 Only 30% of people who met eligibility criteria reported that they subsequently received all the help they needed, while around half got *some* of the help they required.

3.50 People with support needs who failed to meet their council's eligibility criteria (and those who may not have approached their council for help because they did not expect to meet the criteria) were asked what they did. Of people responding, 35% said that they managed without help; a similar proportion (32%) had help from family members; almost one quarter (23%) made private arrangements and just 10% had assistance through a voluntary organisation.

Survey findings

Experience of assessment

82% people asked for help from social services and most of these people (84%) went on to have an assessment of their needs.

One third of the people who failed to get an assessment reported they were told they did not meet the council's financial criteria.

38% of people who had an assessment felt their wishes were not listened to; 22% felt unable to express their views; 27% felt their lifestyle and culture were not respected.

Eligibility and support needs

76% of people met their council's eligibility criteria; of these people, 30% received all the help they needed; 16% reported they did not.

35% of people who did not meet the eligibility criteria (and those who may not have approached their council for help but still felt they needed social care support) reported they struggled to manage without help.

23% of all respondents paid privately for help and 10% had help from a voluntary organisation.

62% of all respondents said they were not given any information about other help; only 5% of people reported they were given information and that it led them to getting help.

3.51 A few of the many comments made by people who were asked to describe the impact on their lives of not having help are reproduced below.

‘I feel unsupported and unimportant. Sometimes I have been made to feel that my son’s needs are a mix of either not severe enough, too severe or a burden on services. I feel that unless a family is at crisis point then help is not available.’

‘House became very dirty. Relied on availability of friends for shopping. Eating nutritious and attractively presented food was a rarity. Overall, extremely undignified and stressful.’

‘Isolation and having to live with inadequate food and the frustration of not being able to keep the house clean and tidy for Mum – this is important as she doesn’t see anything else. For us it’s about struggling to manage 50-60 hour working weeks and travelling and other time. I’ve thought about giving up work but try not to dwell on it. It doesn’t make sense either for someone paying 40% tax to exchange that for a carer’s allowance.’

‘The six months when my dad was not taken on as eligible for care were very difficult because he could not manage his medication and was misdosing himself and making himself ill.’

‘My father now is doubly incontinent, can only get out of bed with a physiotherapist, cannot drink enough, cannot remember his name and is being discharged from hospital. All social services provide for self-payers is a fax of the phone numbers of care agencies after being challenged on why he was not being looked after by his family. None of the care agencies except the most expensive had any carers available.’

‘My flat’s a tip and I often spend days without washing or dressing as I’m not able to do it myself. I’m limited in when and where I can go out, and what I can eat as I struggle to prepare a meal, and often burn myself when using the oven.’

‘I cannot leave the room I sit in throughout the day.’

‘I do not go out socially at all. I have neurological problems, wheelchair user part time, also care for husband who has cancer, cognitive problems, heart condition. I cannot expect him to push my wheelchair. I stay in do internet food shop, housework doesn’t get done most of time, garden’s a mess. We both have a boring monotonous existence which is stressful. Social services placed us on a list for months and after six months of not getting an assessment I told them not to bother!’’

‘Feel as if I am putting an extra burden on my already busy family especially as they do not live nearby.’

3.52 The frustration and despair which many respondents felt was evident in their comments through the survey. For those people who failed to get access to social care, or who did not get the support they needed, there was often no alternative plan. Without support people still had needs (and often, it appeared, significant needs that were simply overlooked) and they managed as best they could, but often at great cost in financial, emotional, personal and physical terms. These experiences mirror those of people taking part in the special study for the state of social care whom we described as 'lost to the system'.

> ***'A person taking part in the review[27] who has used a wheelchair since 1997 described how he was originally assessed as 'critical' and then re-assessed in November 2007 but was still waiting (in June 2008) for a care plan. Since November 2007 he has spent a total of 64 nights unable to go to bed and without receiving any care, and 19 consecutive nights without food or assistance.'***

3.53 Other recent studies have also highlighted the difficulties for younger disabled people who have not been eligible for council-funded support. Over half (52%) of disabled people in a recent study for Leonard Cheshire Disability said the shortfall in social care services had led to more accidents, serious illness, suicide attempts and/or more visits to the doctor and hospital. 14% were very concerned that it had also led to illness, accidents and stress in their carers.[28]

3.54 The Voluntary Organisations Disability Group has highlighted the difficulties for young disabled people and their families as a young person reaches adulthood and moves from children's services to adult services with different entitlement criteria.[29] An earlier CSCI study, *Growing up matters,*[30] also highlighted the poor outcomes for those young people losing out on their independence and opportunities to meet their aspirations. Half of the councils in the study said that young people's care packages change at, or after, transition and this generally represented a significant reduction in services.

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[27] Notes from a meeting between CSCI and Leonard Cheshire Disability on 27 June 2008

[28] Foster J et al (2008) *Your Money or Your Life. Disabled people's experiences of the loss of social care services in England* Leonard Cheshire Disability

[29] Voluntary Organisations Disability Group (2008) *Shadow lands: application and impact of eligibility criteria on young people with disabilities.* Oxford: Institute of Public Care, Oxford Brookes University, for VODG

[30] Commission for Social Care Inspection (2007) *Growing up matters: better transition planning for young people with complex needs.* London: CSCI

(iii) Council investment in prevention and social inclusion

3.55 These findings contrast with other evidence presented to this review about the Department of Health's £60 million Partnerships for Older People Projects and other pilot initiatives seeking to support people deemed to be ineligible under local criteria. The positive feedback from people taking part and evaluation of a range of prevention and early intervention schemes provide some pointers to successful approaches which we consider later in this report.

3.56 Councils are investing in a range of preventative services and those promoting social inclusion, some with the NHS and other partners. Many of these are services that every local citizen can directly access. A survey for LGA and ADASS on adult social services expenditure in 2007-08 estimated that each council is spending, on average, £1.63 million on adult social care that people can access without a formal assessment, or without meeting eligibility criteria.[31] Councils also contributed £1,879 million to pooled budgets with health partners for adults and older people, an average of £12.52 million per council.[32] This needs to be put in the context of an average spend per council of £100 million on formal adult social care.[33]

3.57 A recent Audit Commission report provides examples of good practice by some councils in ensuring older people can live independently and actively, with a good quality of life for as long as possible. This includes specific targeted services such as developing resource centres as community hubs; help with essential repairs and small jobs; working with other frontline services to delay dependency – for example by preventing falls – and making use of technology, such as basic and enhanced telecare, to support independence. However the study found only a third of councils are well prepared for an ageing population, though a further third are making progress.[34]

3.58 Councils provide grants and other funding to a range of voluntary organisations and other initiatives that provide support to people who may not be eligible for council-funded social care. In 2006-07 grants – not including contracts for services – were made by councils to nearly 6,000 organisations (providing for

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[31] York Consulting (2008) *Local Government Association/Association of Directors of Adult Social Services Report on Adults Social Services Expenditure 2007-08.* Leeds: York Consulting

[32] Ibid

[33] Gross expenditure on adult social care for 2006-07 was £15 billion. Source: Information Centre (2008) *Personal social services expenditure and unit costs, England 2006-07, section 5*

[34] Audit Commission (2008) *Don't stop me now: preparing for an ageing population.* London: Audit Commission

adults) amounting to £278 million. A further £44 million was provided to fund carer organisations.[35]

3.59 For this review, the Audit Commission undertook an analysis of the FACS bandings and their relationship with actual expenditure.[36] This analysis does not indicate whether the total expenditure is sufficient to meet overall needs. An analysis of the provision of social care for older people by councils applying different FACS criteria indicates that there are real differences. In total gross expenditure terms and using 2006-07 data, those councils which used a relatively generous 'moderate' threshold spent £62 more, about 5%, (using total gross expenditure) per older person than those with the more restrictive 'substantial' threshold.

3.60 The difference in spend between councils applying different FACS bands seems primarily due to greater expenditure on non-intensive home care services where councils with a 'moderate' threshold supply services to a greater proportion of their populations than councils with 'substantial' and above eligibility bands (45.4 clients per 1000 older people compared to 39.6). The financial effect of this greater provision by 'moderate' councils is muted to some extent by their home care costs per client per week being somewhat lower (£128 as opposed to £142), equivalent to an hour less of homecare per week.

3.61 These differences in average expenditure according to FACS band persist over a number of years but they are small when compared to the variations between individual councils – a difference of 100% in expenditure per older person is not uncommon. The diagram below (Fig. 1) shows that many higher spending councils spend two times or more per head than lower spending ones; the more generous and more restrictive groups are distributed reasonably consistently across the expenditure spectrum; and there is a strong correlation of expenditure with deprivation. FACS policy therefore seems to have only a modest effect on expenditure. This may reflect the findings of this review that in practice there are large differences of interpretation in the bandings.

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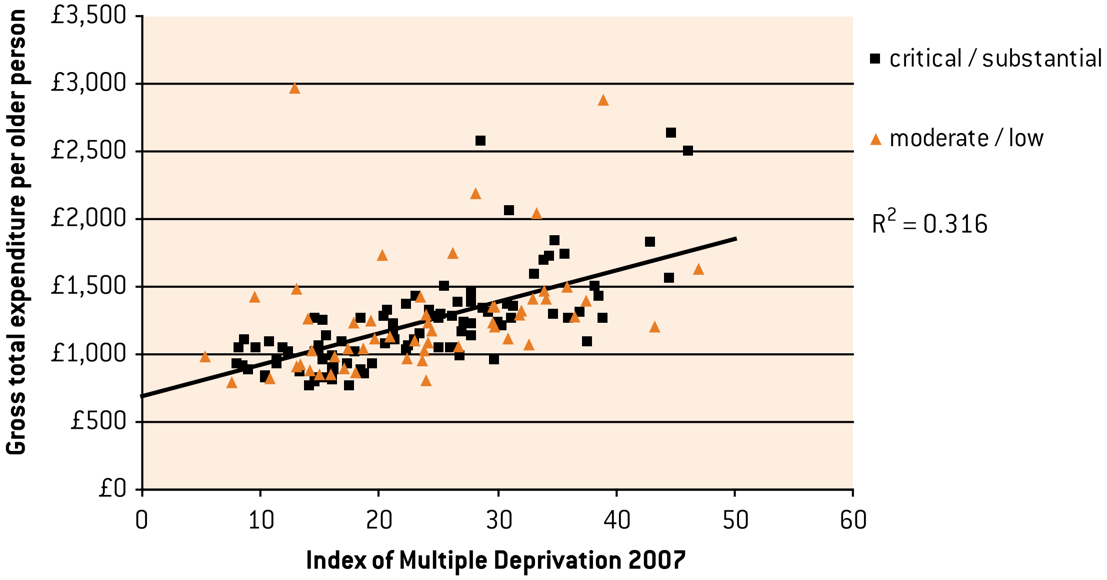
[35] Information Centre (2008) *Personal social services expenditure and unit costs, England 2006-07.* Note: 20% of councils failed to report any grant expenditure and the estimates reflect some grossing up to allow for non-response

[36] Audit Commission (2008) *The effects of Fair Access to Care Services bands on expenditure and service provision.* London: CSCI and Audit Commission

Figure 1: Gross total expenditure per older person and deprivation



(iv) What people said needed to change about FACS

3.62 If FACS is to be retained, six broad proposals for improving it have been identified from the evidence submitted:

(i) More consistent implementation.

(ii) Improved support for people funding their own care.

(iii) More robust diversionary strategies. These should incorporate more effective monitoring and review systems, better evidence trails for decision-making and systematic follow-up of ineligible people who are signposted elsewhere.

(iv) Better information. This includes information about services available, what people will be charged for and by how much, signposting to services and support, and a clear point of contact for every person, detailing who will be responsible for ensuring that information is provided.

(v) More sensitive assessment, to include ensuring timescales are flexible and time is allowed for relationship building. When undertaking assessments, assumptions should not be made about the capacity of families and carers. Re-assessments need to be undertaken and caution exercised when closing a case down.

> ‘*Assessments should start with a dream bubble. Some people take things for granted and don’t understand what it is like to live without these things.’ (Experts by Experience Standing Reference Group)*’

(vi) Modification of FACS criteria. Some people supported the idea of amalgamating the existing bands in order to simplify and streamline access to support. Proposals included merging the moderate and low bands into a separate 'prevention' band, with the distinction between the critical and substantial bands then determined by the speed of response required. Another proposal is that of distinguishing (and separately responding to) people with multiple and complex needs from those with less complex needs.

3.63 Although some of the submitted evidence was supportive of the current FACS framework, there was also a very strong view that nothing less than fundamental change would suffice.

3.64 The key themes for longer-term change were proposals for:

(i) An outcomes-based framework for eligibility criteria, using the outcomes identified in *Our health, our care, our say.*;

(ii) Re-framing eligibility criteria so that it better supports – rather than works against – the personalisation agenda and adopting a formula for linking sums of money with levels of need, with greater amounts going to people in need of greater support.

(iii) Transparency of entitlement. Calls for a clearer, entitlement-based system (allied to frustration with the current tightening of eligibility) led to some respondents calling for a much more serious approach to human rights legislation.

(iv) Prevention and partnership – adopting a new vision of social care that goes beyond the narrow model that currently predominates. Typically this related to the need for a stronger focus upon prevention and inclusion so that councils and their partners know much more about people who currently fall outside of the system. This implies a move towards a more universal model of support. It also suggests that this is no longer the sole preserve of adult social services and is about partnerships between agencies and between different parts of the council.

(v) Reappraising the balance of national and local responsibilities. Given that so much of the dissatisfaction with FACS arises from the variable and inconsistent application of the guidance by professionals and councils, it was inevitable that the evidence would include calls for a reappraisal of the locus of decision-making in respect of eligibility. The call for greater national consistency in the determination of eligibility for, and access to, social care support was widespread in the written evidence. Typically this involved calls for a national minimum guarantee of support.

(v) Conclusions on the findings

3.65 The evidence submitted to this review has come from a wide variety of quarters, sometimes reflecting very different interests, experiences and perceptions. With very few exceptions, the submitted evidence accepts that some form of social care rationing is inevitable, and whilst there is some support for the view that FACS could be made fit for purpose (even if only in the short term), the bulk of opinion calls for a radical reappraisal of arrangements. This is partly because of the multiple problems that have arisen in the wake of FACS implementation, but – importantly – because of the positive desire to move towards an alternative framework which is better suited to the emerging policy agenda.

3.66 The key dimensions of this new framework command near universal support, and comprise:

- an outcomes-based approach
- compatibility with the personalisation agenda
- a stronger focus on prevention and inclusion
- fairness and clarity of access
- guaranteed basic national minimum support.

Chapter 4

Different approaches to individual resource allocation and rationing

4.1 Different approaches to rationing are explored in this chapter, drawing upon experience from abroad and in the UK, as analysed by SCIE for this review[37] and by Melanie Henwood and Bob Hudson in the literature review commissioned by CSCI.[38] These inform our recommendations in the next two chapters.

(i) Rationing in other countries

4.2 All countries share the challenges of resource allocation and rationing in social care but in the EU, member states differ widely in the ways that long-term care is organised, accessed and funded. Whereas in Britain the trend has been towards a national framework for eligibility (albeit implemented by local councils with significant local discretion) the trend in much of the EU has been to devolve responsibility for the determination of access to care down to local level.

4.3 Definitions of levels of dependency, sometimes described as combinations of risks and needs, is frequently the key that unlocks services. In many systems, access to services is controlled by formal assessments which allocate a specific level of need to the applicant, expressed either in terms of inability to carry out unaided certain activities of daily living, or in terms of hours of care needed. In many countries, the formal assessment is followed by the development of a care plan to meet the needs identified by, or sometimes with, a local care or case manager.

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[37] Robbins D (2008) *Criteria for care: assessing eligibility for long-term care services in Europe.* London: CSCI and SCIE

[38] Hudson B and Henwood M (2008) *Prevention, personalisation and prioritisation in social care: a review of the literature and development of an analytic framework.* London: CSCI

4.4 Whilst most European countries assess eligibility for long-term care services by using activities of daily living (ADL) scales (to assess, for example, personal care, mobility and other needs) 'in most countries it is not the scale itself but how it is located in the political system and used which determines its effects.'[39] For example, in Italy many scales are available, but ultimately decisions tend to be determined by what services are available. In relation to homecare services, no explicit criteria are used and allocation is left to the social worker's discretion. This may appear to resemble the situation in Sweden where the social worker works with the applicant and discusses loss of autonomy, with reference to scales 'if necessary'. But this is in the context of citizens' rights and relative plenty of services, funding and experience in running a service embedded in Swedish 'welfare state' traditions.

4.5 Where service allocation is tightly linked to centrally determined eligibility criteria, for example in France, there is confidence about equity and transparency. But there are complaints of rationing by bureaucracy, delay and waiting lists. Locally determined criteria raise criticisms of postcode differences. There is a call in Sweden for national guidelines and standards.

4.6 Eligibility criteria can and are used to contain costs and depress demand. Insurance-based systems appear equitable and may 'cover' most of the population but the extent to which they cover the needs of an ageing population is more problematic, and depends on the thresholds set by each system's eligibility criteria. The German threshold was set relatively high from the start of their national long-term care insurance system, by contrast with Japan. But rapidly escalating costs led the Japanese to adapt their framework introduced in 2000. As cost pressures increase, the trend is towards targeting help on those most in need. In some countries, for example the Netherlands, Sweden and Japan, this runs alongside a programme of preventative services.

4.7 Most frameworks use combinations of scales of needs and risks, employed by multi-disciplinary teams and local care management to establish an individual's allocation of time, money or services. These allocations are seen as rights in insurance-based systems and in Nordic welfare states.

4.8 Where responsibility for assessment is fully devolved to local authorities, it is very difficult to obtain a clear, national picture of access to social services. The trend towards greater standardisation is beginning in Sweden and is further advanced in Denmark. Notions of 'user sovereignty' are beginning to influence thinking in some countries where they have traditionally used rather paternalistic frameworks driven

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[39] Robbins D (2008) *Criteria for care: assessing eligibility for long-term care services in Europe.* London: CSCI and SCIE

primarily by medical opinion. In Nordic countries, the person using services does appear to occupy a central place in decisions about resource allocation, as a citizen with a clear claim on the local community's assistance.

Examples of approaches taken by different countries

France

A national system targeting the care of older people was set up in 2001 which provides for the allocation of a personal allowance. Assessment of the degree of needs and risks is made by a professional. A national scale allocates applicants to one of six groups, from the highest level of dependency to the lowest. The allowance is made in relation to a specific package of support services and depending on local supply. The tight conditions governing the allocation of the allowance (that is managed and largely financed by 100 French Departements) and central planning for the Departements are designed to prevent the growth of a 'grey market' in care services, and ensure equity across the country. Nonetheless, debates continue about postcode lotteries and whether a long-term care insurance scheme would be preferable as demand increases. The elaborate, centralised system for determining needs and risks, and the associated waiting lists, are seen by some as a means of deterring applications.

Sweden

Sweden operates a relatively generous welfare system with 97% of services publicly funded from compulsory insurance and high taxation, and seen as a right by citizens. Health and social care are formally seen as separate systems but have worked together for more than 25 years in care planning teams to ensure appropriate care for the individual.

Long-term care services are the responsibility of each of the 286 municipalities based on the principle (well supported by the public) that it should be the community, not the family, who cares for people needing support. Municipalities organise assessments for services along lines recommended by the Ministry for Health and Social Affairs but have a high level of autonomy to define and raise taxes for their own systems. There has been a downward trend in home help services and variation in provision between municipalities. However recent research shows that levels of unmet need remain low despite shrinking service levels.

Personal allowances for those under 65 who are severely and permanently disabled are provided through the social security system.

Debate about equity and service quality continue and there are proposals for the development of national standards and closer collaboration between municipalities and the National Board of Health and Welfare.

Germany

Germany has a comprehensive, national long-term care insurance system which was reformed substantially in 1995 where public insurance covers most people and mandatory private insurance covers most of the rest (97% in all). The scheme is primarily to provide assistance in the home, and relatives can be employed with the allocation.

A standard assessment uses a national scale of risks and needs, including activities of daily living (ADLs). Benefits are either a care package or cash, or a mixture of the two. The social services element of the package are assessed by a local case manager making use of the completed medical assessment. Cash benefits have been particularly popular and because they have been set at levels less than the cost of services have helped to control the costs of the scheme. But this has given rise to debates about the impact on women's employment and carers' rights; about the adequacy of the smaller cash sum; and about the impact on the development of a market for high quality professional services.

The Netherlands

The Netherlands has a statutory insurance scheme to cover the risks of long-term care, where the insurance is compulsory for everyone paying payroll tax and benefits are thus seen as a right. Policy supports the principle that the family is the carer of first resort.

Benefits are offered as a package of services or (except for treatment or residential care) in cash as a personal budget. There are seven broad categories of support – domestic help, personal care, nursing, supportive guidance, activating guidance, treatment and accommodation. A national, independent assessment agency is responsible for assessing eligibility for each kind of support, with local offices to carry out home visits or hold multi-disciplinary meetings. Assessments use a checklist of more than 100 items based on the World Health Organisation International Classification of functioning, disability and health. 'Indications' of eligibility are issued to successful applicants with a determination of hours and type of care which can be taken by the applicant to any local provider.

Responsibility for funding, developing and allocating homecare was decentralised to the municipalities in 2007. People have less legal certainty about their entitlements and expenditure has gone down but, despite fears from some groups, there is no evidence as yet that services are fewer or worse.

The Dutch system is transparent – citizens are readily able to find out how the system works and the lobby representing people using services is fully involved in its operation and debate about thresholds.

Japan

Since 2000, Japan has had a compulsory insurance-based long-term care system which mainly targets people aged over 65. Applicants are assessed by a doctor according to a national format which covers physical and mental health. According to the assessment the applicant is allocated to one of seven categories (or none) ranging from 'in need of support' to 'in needs of nursing care assistance'. Neither the availability of informal help nor income is taken into account in the determination.

The eligibility framework was revised in 2006 because of spiralling costs and a new package of preventative services was introduced. Questions remain about the financial viability of the scheme.

4.9 This brief overview shows that other countries are grappling with the problem of maximising outcomes for people whilst keeping within allocated resources. Countries have adopted different systems which are largely culturally determined, each of which has its own merits and disadvantages.

(ii) Different approaches to rationing in social care

4.10 Five different approaches to resource allocation can be identified that are currently being used in social care in the UK:[40]

- Professional decision
- Service-led criteria
- Needs and risks criteria
- Outcome-based criteria
- Decision by person using services or carer

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[40] Hudson B, Henwood M (2008) *Prevention, personalisation and prioritisation in social care: a review of the literature and development of an analytic framework.* London: CSCI

(i) Professional decision

4.11 The case for professional rationing at the point of service has been made strongly in the case of health care where it has been argued that, despite its limitations, it is more sensitive to the complexity of medical decisions and the needs and preferences of patients.

4.12 Whilst decision making in social care has been circumscribed by national eligibility criteria, in practice front-line professionals can still act relatively autonomously and variably in the way they interpret these criteria.[41] This suggests that whatever model of eligibility criteria is adopted, no assumptions can be made about professional consensus and compliance in implementing them.

(ii) Service-led criteria

4.13 FACS attempted to move practitioners away from a service-led approach but in some councils FACS bands are explicitly linked to services. Although a service-led approach is regarded as paternalistic and out-dated it is still evident in the approaches taken by some managers and front-line staff.

4.14 Indeed earlier attempts to change practice to be needs-led through the introduction of care management faltered when care managers were given the potentially conflicting roles of gatekeeper to resources and advocate for the individual.[42] There remains the challenge as to how best to separate these roles.

(iii) Needs and risks framework

4.15 FACS is based on a needs and risks model, as in many comparable countries. In this country, although there is no national equivalent of FACS for children's social care services, where local criteria have been established they typically have bands of need and risk. A typical model distinguishes between four levels of need and prevention: universal services, vulnerable children, children with complex needs, and those with acute needs. The dividing line for specialist social care support tends to be at the border between vulnerability and complexity.

4.16 There is some tension between a needs/risks model and approaches that focus on positive well-being associated with feeling in control. The creation of a culture

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[41] Henwood M, Hudson B (2008) *Lost to the system? The Impact of Fair Access to Care: a report commissioned by CSCI for the production of 'The state of social care in England 2006-07'.* London: CSCI

[42] Beardshaw V and Towell D (1990) *Assessment and care management: implications for the implementation of caring for people.* London: Kings Fund

that prioritises risks above other issues is perceived as working against a broader approach to well-being, as identifying risk factors does not automatically lead to an improved quality of life and may even restrain people from a decent quality of life. Thus professional notions and interpretations of risk, which are often risk-averse in practice, are being challenged.

(iv) Outcome-based criteria

4.17 A number of children's services are pioneering an approach to resource allocation for individual budgets based upon *Every Child Matters* outcomes. A direct link is made between identified support need and money drawing upon a *judgement* as to the amount of support needed to realise one or more of the five outcomes in the life of a child or young person. It is important to note that once again a professional opinion or judgement is involved in this model. Moreover, there can be difficulties at the point of transition for children into adult services if their previous and future care packages are based on very different eligibility criteria.

4.18 In Scotland, there has been some piloting of an outcomes dimension in assessment and eligibility using the User Defined Service Evaluation Toolkit (UDSET).

4.19 The seven dimensions of social exclusion – one of the products of the English Longitudinal Study of Ageing project – is another potential framework for underpinning assessment and eligibility arrangements. These dimensions fit well with notions of citizenship and well-being:

- social relationships: contact with family and friends
- cultural and leisure activities
- civic activities
- basic services such as health services and shops
- neighbourhood, including safety and friendliness of local people
- financial products such as a bank account
- material goods such as consumer durables and central heating.

4.20 An important finding from research is that it is individuals' assessments of their circumstances which appear to have the greatest influences on reported well-being, as opposed to their actual circumstances. So if individual well-being is the policy goal, and if this is to an important extent shaped by the subjective perceptions of individuals, then it suggests these individuals should be influential in determining their own priorities.

(v) Decision by people using services and carers

4.21 This model is where people who use services and their carers make their own judgements about how best to meet their needs and how to achieve their own priorities. This is clearly more closely aligned to notions of 'self-directed support'.

4.22 As mentioned earlier, under FACS, resources are allocated to individuals towards the end of the assessment process and depend on resource availability; under self-directed support they are allocated at the beginning using a formulaic methodology. The new Resource Allocation Systems use a self-assessment questionnaire to gather information about the person's needs, and then identify the appropriate level of funding to match them. As has been mentioned, these latter approaches tend to assume that people are or will be eligible for publicly-funded support, which may not be the case once options such as intermediate care are taken up.

4.23 These five conceptual models for determining eligibility suggest a range of operating models, from professional discretion, through organisational directive, towards partnership models and models led by people using services (see following table). In the new policy world, eligibility criteria need to be consistent with the two latter models – partnership and led by people using services. This is the underpinning philosophy of the next chapter.

Table: Analytic framework for eligibility

Operating model	Organising concepts	Examples
Professional discretion	Professional judgement Accountability to professional ethics Paternalistic and reactive Flexibility and variation Risk-averse Service/needs driven	Pre-1990 social care Some current practice
Organisational directive	Clear and explicit rules on eligibility Standardisation Professional accountability to the organisational mission Risk averse Service-led Needs and risk led	Post-1990 social care FACS Independent Living Fund Children's services Care programme approach
Partnership models	Professionals, managers, people using services and carers in dialogue Shared accountability Risk sharing Outcomes focused	Direct payments Some variations of personal budgets UDSET Scotland
Led by people using services	Individual self-determination Outcomes defined by person using services Prevention and personalisation Flexibility and variation Risk defined by individual Independence from control by professionals	In Control Individual/personal budgets Total transformation councils Disability benefits

Chapter 5

Recommendations

5.1 In the light of the preceding findings and analysis we recommend:

- setting 'eligibility criteria' for access to publicly-funded support in a broader context that is more consistent with *Putting People First* and offers some level of assistance and advice to everyone seeking care and support;
- given the inescapable need to ration public resources, replacing the FACS criteria with a revised system and reinforcing the point that decisions about ongoing needs for support should not be made too early in the assessment process.
- making a clear distinction between the assessment of individual needs and the allocation of public resources.
- introducing a range of measures to support the implementation of the new arrangements, including ways of improving the initial response from councils to people seeking support and developing a national resource allocation formula in the context of personal and individual budgets.

5.2 Taken together, these recommendations provide an opportunity to de-stigmatise social care and to reinforce current moves away from narrow and paternalistic notions of social care as a system primarily designed for the 'poor and needy'. The recommended arrangements aim (see the table in paragraph 5.28) to reflect the principles that people have said should underpin any eligibility system:[43]

- person-centred with a focus on the whole person
- outcome based –promoting choice and independence
- transparent
- equitable and fair
- wide scope and linkage
- efficient and flexible

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[43] OPM (2008) *'Have Your Say' about Fair Access to Care Services: report of a CSCI consultation event held on 1 April 2008*

- easy to implement and understand.

Recommendation 1: Better arrangements that offer universal support

5.3 Eligibility criteria for access to public funding for social care services should be explicitly placed within a much broader context of reform policies – for public services in general and social care services in particular – which seek to give individuals more personal choice and control. The new arrangements should also properly recognise the significant, and growing, proportion of people who fund their own care. It is therefore suggested that the improved arrangements should comprise three key elements, which would move thinking away from the current narrow focus on FACS criteria. Underlying this is the notion of progressive universalism where all citizens can expect some level of support and those with the greatest needs can access further help. These three elements are:

(i) Strengthening communities

(ii) Assisting individual choices

(iii) Prioritising funding for individual needs

(i) Strengthening communities

5.4 Any new guidance (which is for Government to draw up and issue) should re-affirm more clearly the role of the whole council working with NHS and other partners, and any legal obligations in:

- **'Place-shaping'** to ensure people feel supported, included and able to take part in the community in which they live. There would be an emphasis on the responsibilities of the Director of Adult Social Services to encourage the whole community to participate and contribute to society and to develop well-being. This would also link with the proposed NHS Constitution and its principle that "*the NHS works across organisational boundaries and in partnership with other organisations in the interests of patients, local communities and the wider population*".[44]
- **Service/market development:** working with service providers, health partners, voluntary and community organisations to stimulate the development and provision of sufficient types of services and support – of the appropriate quality – that people both want to use and to purchase themselves, using their own resources or a personal budget. These will relate to their whole quality of life, not just personal care needs. The focus is thus on developing a supply of services for all individuals living locally, moving away from councils solely concentrating on

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[44] Department of Health (2008) *Consultation on the NHS Constitution.* London: DH

those people they expect to fund and providers focusing on what councils will buy.

- **Prevention and well-being strategies:** implementing, with partner agencies, a comprehensive approach to prevention and to well-being; including targeted prevention work based on evidence of what works and access to good general information about all local services and community networks.
- **addressing equality issues and human rights:** fully meeting their legal duties on equality and human rights for their community as a whole.

(ii) Assisting individual choices

5.5 This aspect of the arrangements would set out what is available to *all* people seeking more specific types of support. This would seek to address the 'no help here' syndrome referred to by Ministers and illustrated by people responding to our survey. These 'universal rights' will need to be defined. CSCI proposes this means that everyone, *including carers,* would have a right, in line with current policy and legislation, to:

- Access good information and advice and, where appropriate, advocacy and brokerage in order to assess care options and make informed choices. These different services would need to be tailored to each individual's requirements, ie not everyone would need all of these services. The information would need to cover all aspects of care and support, both specialist and more generic, that a person would need to make decisions.
- Be offered an assessment of their care and support needs (which may or may not be carried out by the council), whatever their financial circumstances. Any such assessment – already a legal entitlement but often honoured in the breach – would start with a self-assessment of people's own aspirations in order to focus support on what they want to achieve.
- Access re-ablement services (which seek to maximise what people can do for themselves, often following an unexpected incident such as a fall or stroke).
- A systematic follow-up to their first contact with social services, thereby encouraging councils to check whether people have actually been helped by signposting and diversion.
- Expect a supply of services of good quality, to treat people with dignity and respect, and which people feel safe to use.
- Have access, if things go wrong, to a robust complaints process, regardless of the care service used and who was funding their care; and access to effective

multi-agency procedures in their locality designed to safeguard people from abuse and which take their concerns seriously.

5.6 Within the context of a policy of progressive universalism, services beyond social care might be appropriately available to all, such as health services, home safety checks, winter fuel payments etc., but this is beyond the scope of this review, which is focused on access to care and support services.

(iii) Prioritising funding for individual needs

5.7 There needs to be clarity that decisions as to who gets publicly funded support should be made after an assessment that is centred on the person's aspirations and support needs, whether carried out by the person themselves, the council or an independent organisation. One of the innovative – and controversial – new models being piloted in the children's services context involves the creation of independent social work practices, partly to break the current link between assessment of need and rationing of resources. As CSCI said in its response to the DCSF consultation on this issue, such a model may well also be applicable, if not more so, in relation to adult social care services.

5.8 Whilst many people think the overall FACS focus on 'risks to independence' is reasonable, we suggest that decisions about eligibility should primarily be based on ***barriers to people's dignity and quality of life***. This is not about functional risk, nor eligibility for *services*.

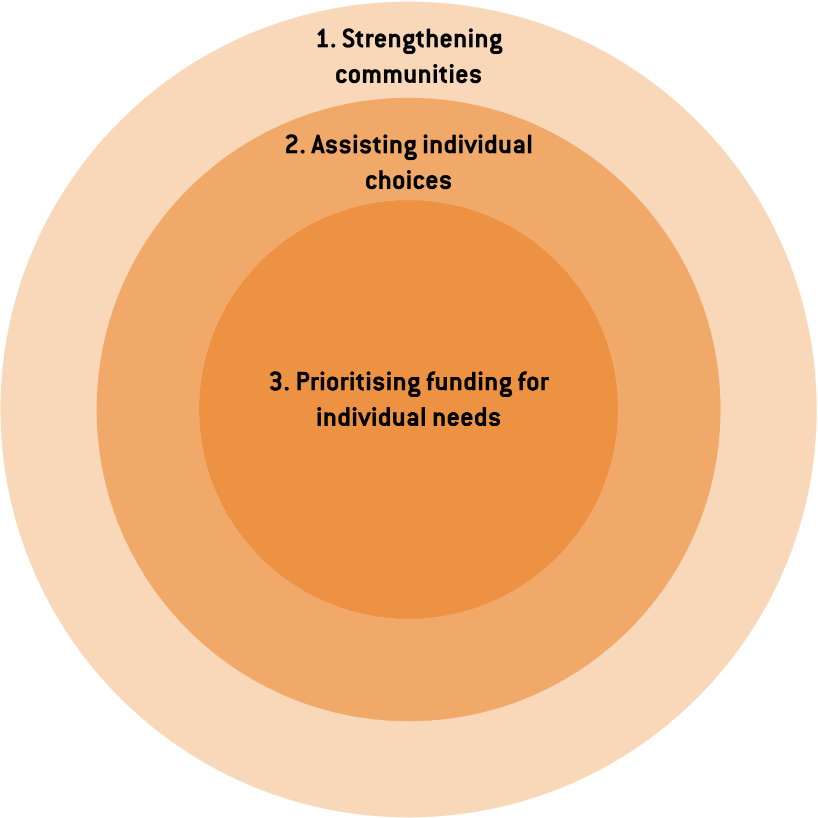
5.9 The emphasis should also be on a ***human rights approach*** so it is not solely about physical needs being met but about meaningful human contact, dignity and respect. The guidance should provide clear examples of a human rights based approach.

5.10 Policy towards ***carers*** should also be re-stated as there has been confusion and a lack of adherence to legislation and guidance on supporting carers and assessing *their* needs (see box 4). The principles of choice and control should also be applied to carers.

Box 4: Reaffirm carers' rights to:

- **Community care assessments** (section 47 (1) NHS and Community Care Act)
- **Having assessed needs met** (case law)
- **Carers' assessments** (Carers Recognition and Services Act 1995; Carers and Disabled Children Act 2000; Carers Equal Opportunities Act 2004)
- **Right for carer to be consulted in user's assessment** (Community Care Directions 2004)
- **Information** (Community Care Directions 2004; Carers Equal Opportunities Act 2004)
- **Risk to carers to be addressed when making eligibility decisions** (FACS)
- **Support to young carers –** support for disabled parents must be provided when it is necessary to ensure that young carers are not left with unreasonable caring responsibilities

5.11 The proposed approach set out above with three key elements of support could be presented diagrammatically as follows. The diminishing size of the circles indicate a narrowing of the focus and of potential beneficiaries:



Recommendation 2: Improving the response to people needing assistance

5.12 Initial contact: The quality of response at first contact with the council is crucial to the outcomes experienced by people seeking support and, given the findings of this review, CSCI recommends that particular attention is given to supporting and developing the skills of staff undertaking this work. There needs to be systematic monitoring of the response at the first point of contact and of outcomes for people.

5.13 Other approaches, such as referral on to special community workers (such as Neighbourhood Access and Prevention Officers in Oldham, and Gateway Workers in Kirklees) may be valuable for those people needing community and other support.

5.14 Steps should be taken to ensure that people, such as those with mental health needs and learning disabilities, who are supported by specialist health and social care teams are also able to access mainstream health and social care services so all their needs are properly addressed.

Assessment of needs, including self-assessment

5.15 Whilst this has been a longstanding issue, it will be important to reaffirm the importance of properly understanding people's needs and aspirations at the stage when they seek more specific support. Guidance would need to emphasise that:

- The first step in the process for people seeking support should be an assessment, usually a self-assessment, based on people's aspirations and the outcomes they want to achieve. Assessment should be a dynamic process rather than a one-off event and include, where appropriate, a full discussion between the person seeking support, the carer, other members of the family as necessary, and the care manager. The option of family assessments or family group conferences should always be available, in addition to an individual assessment of need.
- Before any final decisions are taken about ongoing needs for support, and whether those needs are eligible for public funding, people should be offered a short period of re-ablement or intermediate care to maximise what they can do for themselves. Such services may be funded by the NHS or jointly with councils. This should minimise the risks of premature decisions about people's long-term needs.
- Any assessment of a person's financial situation must not be made until after a proper assessment of needs.
- Assessors, or those supporting self-assessments, should be skilled in understanding people with a range of needs so that specific groups of people (as highlighted in our findings) are not marginalised. Some people may prefer to discuss their situation with a specialist advisor/advocate/peer. In reviewing the

ways in which people contact them and their means of conducting assessments councils should pay particular attention to the values set out in the General Social Care Council's Codes of Practice for both employers and employees.

- Lessons from recent pilots to streamline assessments so as to employ one process for both Attendance Allowance and the provision of health and social care services (under the Single Assessment Process), should be used in order to reduce the number of potential assessments and any duplication for people using services. However, it will be important to ensure these are outcome-based assessments, not function- or service-based.

Recommendation 3: Criteria for allocating public funds to individuals

5.16 Decisions about eligibility could continue to be based on the current four bands (see box 1). Some people have argued that people are familiar with these and there is little point in a major upheaval until decisions are made about the long-term funding of the care and support system. However, more attention would need to be paid to ensuring good practice in implementing the criteria.

5.17 Notwithstanding this, and given the clear difficulties in interpreting and implementing the current FACS criteria, including the confusion between assessment of needs and assessment of means, CSCI proposes a different approach which adopts three 'priorities for intervention'. These would replace the present four FACS bands. They are designed to be easier to use in practice and less mechanistic than the "totting up" risk factors. The interventions are rated according to the urgency of the response needed. They are not equated with specific services and would vary with each individual.

(i) *immediate intervention* – without immediate support to remove 'barriers to people's dignity and quality of life' a person's well-being would be seriously threatened. An example might be where a person living alone has suffered a stroke and been in hospital, has had limited benefit from re-ablement and is no longer able to care for him or herself without assistance.

(ii) *early intervention* – where problems are likely to develop and threaten a person's independence within six months if support is not provided. An example might be a situation where a carer providing substantial personal care is unlikely to be able to continue unless some support is provided either for the carer or the person being cared for.

(iii) *longer-term intervention* – where people's independence would be threatened within the year without evidence-based targeted interventions. This might include situations of growing social isolation where the person's mental health might deteriorate.

5.18 The 'barriers to dignity and quality of life' should be defined as those which may prevent the achievement of the outcomes set out in the White Paper *Our health, our care, our say* : exercising choice and control, health and emotional well-being, personal dignity and respect, quality of life, freedom from discrimination, making a positive contribution, economic well-being.

5.19 It is essential that the following issues are clarified:

- A person's needs should be considered over a period of time, rather than at a single point in time, so the needs of people who have fluctuating and/or long-term conditions are properly taken into account. Many of these people are likely to come within the 'early intervention' group.
- 'Health and well-being' includes mental and emotional as well as physical health and well-being.
- The guidance needs clearly to emphasise that 'barriers to dignity and quality of life' relate to all aspects of life, and with the exception of life-threatening circumstances, there is no hierarchy of needs. For example, a disabled person who is facing significant obstacles in taking up education and training that is fundamental to their independence and well-being should be given equal weight to an older person who is unable to perform vital personal care tasks – and vice versa.

5.20 To get the full benefits from this approach, councils would need to invest some resources at all levels. Given the present local government funding arrangements, including councils' need to manage within their available resources, CSCI accepts that the appropriate resourcing of these categories will need to remain a decision to be taken at local level. Given this conclusion, it is important that councils spell out these decisions clearly to their local population. This is particularly important given that the new approach based on 'priorities for intervention' might alter who is deemed eligible for publicly funded support in future.

Recommendation 4: A national resource allocation formula

5.21 Some people suggest that the RAS approach (see Chapter 3) makes the system of eligibility criteria redundant. We do not agree, since the underlying system remains one where councils decide who receives publicly-funded care and support. However, in the current situation where different Resource Allocation formulae are being developed in different ways across the country, councils need a fair and transparent means of prioritising their resource allocations to individuals.

5.22 The roll-out of individual budgets using RAS-type approaches is already under way. We therefore recommend that the Department of Health should urgently consider developing – with the relevant stakeholders – a single, national, Resource Allocation formula in order to:

- increase clarity and transparency, as well as equity between different council areas;
- reduce variations likely to emerge locally; and
- improve the "portability" of assessments between council areas by having a standard "score" for relevant individuals.

Such an approach would also be more cost-effective to develop. The attribution of financial values to the points generated by a national RAS could remain a matter for local decision, given wide variations in the costs of services in different parts of the country. Particular attention should be paid to the RAS process to ensure it focusses on the outcomes sought by individuals and the support required to achieve them rather than on those activities which they cannot perform.

Charging and means testing

5.23 Concerns have been raised that charges are operating as a disincentive to some people to access services and so, in practice, constitute a further form of rationing on top of eligibility criteria. A recent survey conducted by the Coalition on Charging found 80% of the people who no longer used care services said charges played a part in their decision.[45] The current work of the Department of Health on the issue of charging should address the impact on individuals and their families of high charges in some parts of the country. As discussed in the following chapter, some of the different models of funding social care in the longer-term would require fundamental changes to the current charging regime. And in the shorter-term, the interaction between the charging and means testing of individuals, which assess and take account of the contribution required from them, and the setting of personal budgets is an issue yet to be fully addressed.

Equalities

5.24 There has been considerable feedback about the different levels of funding awarded to older people as against some younger disabled people, particularly those with learning disabilities. These differences are particularly exposed in the development of new resource allocation systems in relation to individual budgets.

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[45] Coalition on Charging (2008) *Charging into poverty? Charges for care services at home and the national debate on adult social care reform in England.* London: Coalition on Charging

5.25 This is a complex and emotive issue. Amongst many important issues to be taken into account, is the fact that younger disabled people may need support throughout their life and may not be in a position to build up savings or assets. In contrast older people may seek support in the latter stages of their life and may have their own home and other assets accumulated over their lifetime.

5.26 Some organisations have suggested that any new framework for eligibility criteria should be subject to a full Equality Impact Assessment before being implemented. CSCI would endorse such an approach.

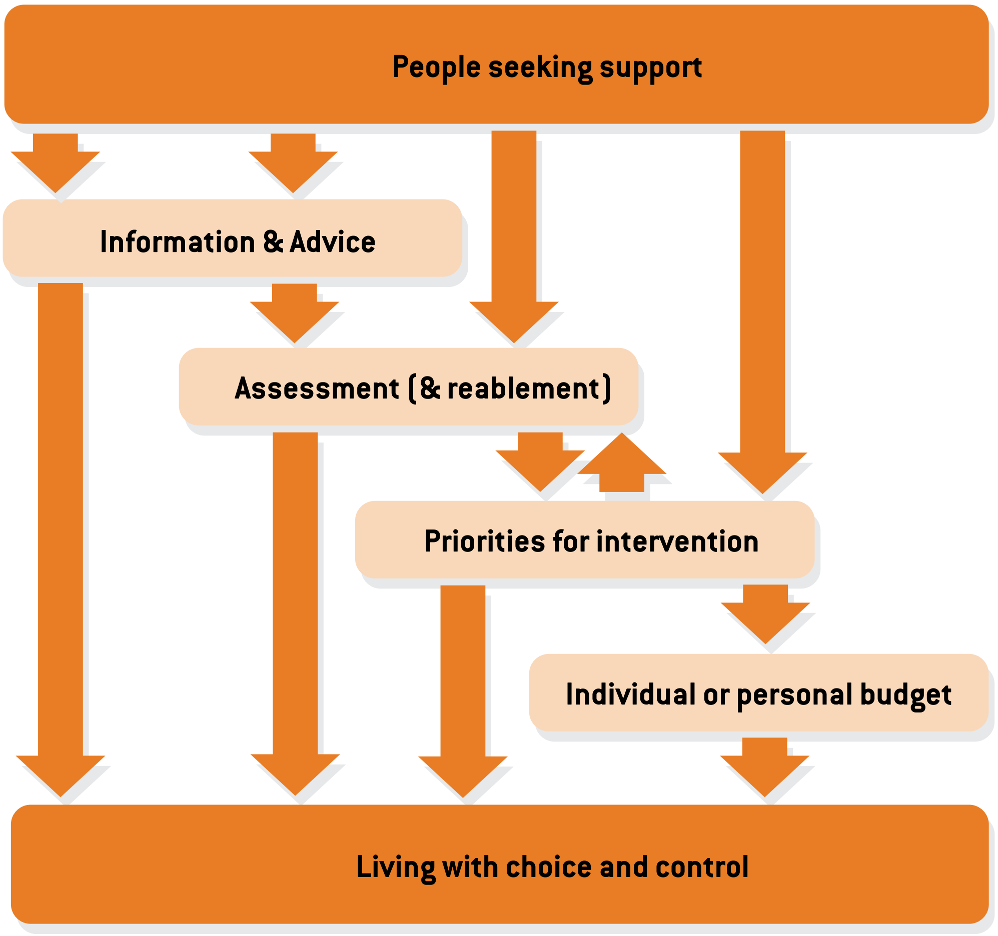
The process in summary

5.27 In summary (as the following diagram illustrates) the key steps for people seeking support in the future would be:

1. to obtain information and advice and, where appropriate, advocacy and brokerage from a range of contact points and organisations in their local community, including those provided by the council
2. to access support services to purchase privately, if someone has received independent advice, advocacy and/or brokerage
3. to have a proportionate assessment, which should usually start with a self-assessment (taking great care that people with seemingly simple requests are not diverted elsewhere before exploring their concerns)
4. this could trigger a range of responses, such as signposting to other services, 'case coordination' or other means to ensure people are successfully helped; *or*
5. where appropriate, to have a short period of support to maximise what people can do for themselves before any final eligibility decision is made; then to
6. to have any ongoing needs identified as a priority for intervention
7. if needs are eligible for publicly-funded support, to have points awarded according to the support needed and a notional budget awarded (including other funding streams as necessary); finally
8. drawing in the person's own resources after a financial assessment to determine their contribution.

5.28 The new framework thus seeks to change the current situation as described in the table below:

Current situation	Aims of new framework
Social care is seen as stigmatising and narrowly focused	Social care is part of a new universal system of care and support
Some people are not getting good advice and information about the options for support	Everyone, including self-funders, has access to good advice and help to make decisions
Mainstream services are not always geared up to improve the quality of life for all local citizens	To achieve a more concerted approach to community well-being and support for all
An inadequate emphasis on human rights and dignity and respect for everyone	An increased emphasis on human rights, by levering in all community resources
Carers' rights are not always recognised or addressed	Carers' rights are highlighted and practice improved
Some people are being assessed as to their eligibility *for services* and/or being financially assessed before their needs are assessed	To clarify that priorities for intervention by social care are based on barriers to people's dignity and quality of life, not on eligibility *for services*, nor – in the first instance – financial means
There is confusion that people with complex needs always need expensive complex support, and that people with 'low-level' needs need 'low-level' services	To ensure certain services are not equated with 'levels' of need. Simple services may meet the needs of a person with complex needs; and a person with 'low-level' needs may need a complex package of services
People seeking services find the current system of eligibility – and the gradations between bands – complex to understand and lacking in transparency between different groups and different council areas.	The new 'priorities for intervention' are less mechanistic, but could still be used to control expenditure, whilst a national resource allocation formula should make eligibility decisions more transparent and 'portable'
FACS is an explicitly hierarchical system which excludes people from services	The new approach seeks to be much more inclusive



Recommendation 5: Measures to support the implementation of the proposed arrangements

5.29 Within the existing localised and discretionary system, the success of the new arrangements in improving people's access to support will depend on a number of measures to assist its implementation. These include:

- A review by councils of their arrangements and quality of decision making at people's first point of contact (particularly as there is evidence that in some places the least experienced staff are making potentially inappropriate first contact decisions).
- Ensuring people supported by specialist services health and social care teams, for example, people with mental health needs or learning disabilities, also have access to **mainstream** health and social care services.
- Introduction of proactive ways of identifying people who could benefit from information and services (case-finding).

- Assistance by regional improvement partnerships and others, such as DH's Care Services Improvement Partnership, the Social Care Institute for Excellence, the Improvement and Development Agency and Regional Government Offices, to support improvements and share good practice, such as approaches piloted in the POPPs programme (eg six-week 'case coordination' for people signposted to other sources of help;[46] Neighbourhood Access and Prevention Officers to help people access general services) and housing-based support, employment schemes and other initiatives.
- Ensuring any revised guidance is communicated clearly to the public as well as to councils, NHS bodies and the voluntary and independent sectors. This would also include clear information about how people can challenge decisions, make complaints and obtain redress, whether council supported or self-funding.
- Systematic monitoring of practice and outcomes for people, including those people signposted to other sources of help. This information should also feed into Joint Strategic Needs Assessments and local commissioning strategies.
- Performance assessment by the regulators, notably the Care Quality Commission and Audit Commission, not least in relation to Comprehensive Area Assessments that consider the broader support provided by councils to local citizens.
- Current work by the Department of Health on charging by councils to address the issue of charging and equity, and the impact of high charges in some parts of the country which can amount to a further form of rationing. In this context the Department should also consider the interaction of charges with processes for determining personal budgets.

Resource implications for councils

5.30 Councils need to live within their means. Many councils are already delivering elements of the overall approach set out here. But our findings suggest that few are delivering all of it to all who might benefit. Much in this report is a restatement of authorities' existing statutory responsibilities, and it also indicates that poor decisions about individuals' needs might cost more in the long run if this results in them needing more care later on. Nevertheless, there are clearly resource implications for at least some councils in implementing these recommendations, for instance if they are not already systematically helping all those seeking advice and guidance.

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[46] Key characteristics of 'case coordination' are: discussion/assessment of a person's whole situation and needs; work with the person over limited period of time to identify mainstream and voluntary sector services to meet their needs; contact at a future date to check whether outcomes are satisfactory.

5.31 However, it is difficult for us to estimate any additional resources which may be required, given the differing circumstances of different councils, as the Audit Commission's analysis for this review indicates. Whilst some councils appear able to offer a wide range of services to a substantial group of their population, others operate a much more tightly focused and restrictive approach. Moreover, additional resources *have* been made available for adult social care over recent spending reviews, including the £520m Transforming Social Care Grant for 2008-11 and in many places councils are seeking to reconfigure services and focus on reablement and prevention. On the other hand, the £520m Grant is itself weighted towards the final year, 2010-11, and in the early years is focused on building capacity and new systems and other infrastructure costs necessary for transforming social care.

5.32 What is clear is that, as indicated by successive CSCI reports on the State of Social Care and evidence from the online survey and written submissions, there are considerable pressures on the social care system. It is therefore reasonable to assume that more funding, from the state and individuals, is needed to support the development of a broader-based approach to social care, as proposed here. Indeed, given the Government's recent acknowledgement of the funding gap in social care by 2024, it seems reasonable to assume that the success of this new approach will depend to a significant degree on the availability of resources as well as how efficiently and effectively they are used. An improved way of rationing public funds can support a broader and more inclusive approach to assisting people but cannot of itself resolve the underlying issues of the underfunding of social care.

Chapter 6

Commentary on long-term options

6.1 This review has been undertaken in parallel with the Government's pre-consultation (the precursor to a planned Green Paper) on a new care and support system in England. Submissions and comments to CSCI from people using services, carers, professionals and others have included widespread calls for an adult social care system which places more emphasis on individual rights and national entitlements. Such entitlements might offer a set amount of funding for those with a particular level or type of need regardless of where they live (akin to a social security benefit) and/or a set of nationally determined eligibility questions. Many people want national entitlements in order to have greater clarity and certainty about what the state may provide, as well as a system that is more 'portable' in allowing people receiving social care funding to move between authorities with at least some minimum guaranteed package of care or funding allocation.

6.2 For many people the 'postcode lottery' is no longer acceptable if it results in those with similar needs for support being treated wholly differently in different parts of the country. And there are several different "postcode lotteries" in social care – for instance, the differing application of FACS resulting in differential access to support and the lack of "portability" of assessments; a big range in the charges levied for non-residential services; wide variations in the support offered to carers and in the provision of open access services and so on. Whilst many acknowledge the differing local histories and service patterns of different council areas, as well as the right of democratically elected councils to determine their own priorities, there seems to be diminishing acceptance of the wide variations in the offers of support, and thus outcomes, which can result.

6.3 Many options being discussed for the longer-term organisation and funding of the care and support system do include a much stronger role for national entitlements than the present arrangements. A cornerstone of current social care policy is the drive to give individuals more power and control over their care and support options through the use of individual or personal budgets. We therefore turn to these next.

(i) Individual and personal budgets

6.4 Individual or personal budgets (the former draw in resources from a number of separate funding streams whereas the latter tend to be confined to social care funding, as are direct payments) offer a potentially transparent system as the level of resources allocated to the individual – and the criteria on which they are awarded – are explicit. Some of the current Individual Budget pilot sites identify needs for support, through assessments which can include a self-assessment, and then allocate a specified number of points in relation to those needs. The 'value' (in monetary terms) attributed to those points is then determined through an exercise derived from the existing adult social care budget of the council concerned. This is to ensure a reasonable degree of cost control. An individual's total points then determine the indicative level of funding they will receive in their budget. As Professor Caroline Glendinning comments[47] ' arguably this transparency could provide the basis for strengthening the notion of entitlement in the allocation of resources for long-term care'. The approach also offers opportunities to reduce – by making them more transparent – current inequalities in resource allocation between older and younger disabled people, described earlier in this report, which cannot always be justified in terms of differential income or lifetime assets.

6.5 There are lessons from the German experience which demonstrates the key role that central government can play in overseeing funding arrangements. Glendinning argues that *"rather than leaving the identification and redistribution of the resources included in 'individual budgets' to each pilot locality, a major opportunity exists for the UK government to take a greater role in both identifying and pooling all the resources available for long-term care and in managing their allocation. Without this leadership variations and potential inequities between countries and local authorities will remain."*[48]

6.6 There is also the potential to increase the total budget for long-term care by pooling a wider range of resources and funding streams than currently, to include NHS Continuing Care monies and relevant social security benefits. These public resources are unlikely to meet all care and support needs so means-tested co-payments would also be needed. But *"this means testing would be built on*

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[47] Glendinning C (2007) 'Improving equity and sustainability in UK funding for long-term care: lessons from Germany' *Social Policy and Society* 6:3, 411-422

[48] Ibid

a platform of equitable, universal arrangements, underpinned by transparent eligibility criteria".[49]

6.7 Indeed others argue that bringing health and social care together and creating a joint pot of resources breaks the current problem of 'free' health care and means-tested social care.[50] A national entitlement system to health and social care would offer an automatic eligibility for a certain level of support and an end to means testing up to that level.

(ii) Social/private insurance and the National Care Fund

6.8 Another funding option is insurance, whether social or private. This review is not the locus for a discussion about the pros and cons of such systems. However, in the context of eligibility criteria, people tend to be clearer about their entitlements in insurance-based schemes, particularly where these are run centrally and such entitlements are properly publicised. The assessment of eligibility for support from insurance funds tends to be related to ability to perform one or more Activities of Daily Living (ADL) – this inevitably focuses on risks and 'deficits' in people's lives rather than their aspirations and desired outcomes. The accompanying SCIE background paper sets this out more fully. But where, for example, a social insurance scheme has been decentralised, as in the Netherlands, people have less certainty about their rights.

6.9 A recent proposal for a National Care Fund (for older people) in this country takes as a key starting point the accumulation of wealth, particularly housing wealth, by many older people as a result of house price inflation over the past 20 years or so. It is argued that this makes both reasonable and more politically acceptable the notion that people entering old age would pay a one-off contribution fee at a level determined by an assessment of means, resulting in entitlement to a standard package of care paid for by the Fund.[51] At the least the Fund would pay for *"the minimum socially acceptable level of long-term care, following an assessment of need"*. The components of that standard package of care would need to be defined, as would the basis of the assessment of need. The poorest older people would have their contribution paid for by the state. It is argued that such a National Care Fund would enable older homeowners to use their property wealth – without having to move house or to totally deplete their equity – to insure themselves against the risk

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[49] Ibid

[50] Ham C and Glasby J (2008) 'Lifelong commitment: the creators of the welfare state didn't have to consider the long-term care needs of older people. Now it is time for a rethink'. *The Guardian* 30 January 2008

[51] Lloyd J (2008) *A national care fund for long-term care.* London: ILC-UK

of needing long-term care and applies the principle of social insurance to facilitate the necessary redistribution to those less well-off.

6.10 Interestingly in the context of this eligibility criteria review, the NCF proposal suggests that assessments of need *"could be undertaken by any number of different agencies…except that a single standardised assessment process would be preferable. In this way, one assessment would entitle an individual to support from a National Care Fund, as well as any private sector long-term care insurance products that they had purchased".* This suggests once again that, under such a social insurance-type model of funding care and support, the assessment of need can (and should) be clearly separated from the financing of any required response in terms of services. As this review has shown, the combination of the functions of assessment and budgetary control, which tends to feature in many council care management processes, can often lead to dominance by the latter to the detriment of the former.

(iii) Partnership scheme (Wanless)

6.11 The partnership scheme proposed by the Wanless Review[52] offers a combination of a universal entitlement (a guaranteed level of state-funded care which is free to individuals at the point of need) with co-payments being possible above this guaranteed level either by individuals or, for those without the means, by the state on their behalf. The matching element potentially offers flexibility so that care and support can be tailored to the individual's requirements/needs.

6.12 The partnership model also alleviates the problems of where the boundary is drawn between health and social care. The 'free' component of the partnership model reduces the gradient of the financial cliff-face between the two systems. It does not solve the underlying cause but in practice would mitigate the problem for many people.

(iv) A national benefit based on a social security system

6.13 In the 1980s and early 1990s, social security payments were available to those without sufficient means who wished to access residential care. There was no assessment of need or consideration of possible alternative care options. As a result spending on this aspect of social security rose exponentially and led to a very substantial increase in the available volume of residential care. The Community Care reforms of 1993 were designed to tackle these issues, to remove 'perverse' incentives to enter residential care inappropriately (and to cap the growth

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[52] Wanless D (2006) *Securing good care for older people: taking a long-term view.* London: King's Fund

in expenditure) by requiring an assessment of need before state funding was made available to support individuals' care needs. A lesson from that experience is likely to be that moves to reinstate a care and support funding model which is based on a clear entitlement to national benefits or allowances would need to be carefully linked to some centrally determined eligibility criteria. As with insurance schemes, these could be based on an assessment of needs and risks associated with activities of daily living. There is some confidence about equity in countries, such as France, who have adopted this type of system, but there are also complaints of rationing service access by bureaucracy, delay and waiting lists.

6.14 Whilst this type of system may be transparent, portable and relatively easy for people to understand, it is likely to be standardised and inflexible. This could lead to challenges about decisions and in turn increased legal and other costs in implementing the system.

A national and local system?

6.15 Whilst there is strong support from stakeholders for some form of national system or national entitlement, as described in the different models above, so that people have greater certainty and portability of care packages or funding, some argue that social care is a very locally determined and differing set of services. But there is no reason for a national entitlement system to rule out local implementation. Indeed this could offer advantages. Local assessments that address individual wishes and services adapted to local circumstances could provide the added flexibility and individualised approaches that people are also seeking alongside a national entitlement to resources.

Assessing people's eligibility for publicly funded support

6.16 There is little discussion alongside most of these funding models about determining eligibility for public funding. Whilst there may be some element of a universal entitlement, for the most part this does not cover all of people's support needs. Some kind of assessment of needs or of daily living activities or assessments for outcomes is necessary, not least to control access to public funds. The challenge is to find the right balance between "***national eligibility criteria*** *that in themselves confer entitlement to long-term care resources (but which may be insufficiently sensitive to some types of care needs and may inhibit cost-effectiveness if they are insufficiently flexible) and* ***individualised needs assessments*** *(which in themselves may produce less horizontal equity)*".[53]

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[53] Glendinning C, Davies B, Pickard L and Comas-Herrera A (2004) *Funding long-term care for older people. Lessons from other countries.* York: Joseph Rowntree Foundation

6.17 There needs to be a debate on the most appropriate process whereby a person's needs are assessed but they then have their own resources taken into account in paying for any required services.

Conclusion – the necessary trade-offs

6.18 Whatever changes to the current funding model emerge as a result of the Green Paper process, it is clear from international experience and work on alternative funding systems that, **in the specific context of assessing eligibility for publicly funded support**, there will need to be debate and discussion on the scope and extent of certain trade-offs, including:

- on the appropriate balance between national entitlements to support or public funds *and* local discretion to assess individual needs
- on how far those responsible for assessing needs for support should also be expected to set and operate eligibility criteria
- on the best way of assessing needs for support – whether by using ADLs, broad criteria based on 'barriers to independence', detailed criteria (as in NHS continuing care) listing specific conditions and their effects, purely on the basis of means and so on;

This chapter is therefore seeking to contribute to that debate rather than suggest definitive answers.

Chapter 7

Conclusions

7.1 This review has illustrated the changes taking place in social care and a range of practices across the country, from innovative approaches – such as individual budgets which seek to put people in control and initiatives to support the well-being and inclusion of local people – to a narrow focus on offering a traditional menu of services only to those deemed eligible for publicly-funded social care. New resource allocation systems for individual budgets are being developed with different approaches as to how eligibility decisions relate to these new systems.

7.2 Many people contributing to the review have perceived the problems of people not getting the support they need as much more related to funding shortfalls than to the eligibility criteria as such. Others have stressed the lack of synergy between FACS and current policy which is thereby working against attempts to shift practice and local systems to respond in better and more effective ways to people seeking support.

7.3 As we have explored, however the criteria are expressed, a system for allocating resources that relies on professional judgement will inevitably have some inconsistencies. The Green Paper deliberations will be important in weighing the advantages and disadvantages of a rights-based, nationally determined system which has been unquestionably the preference of many taking part in this review.

7.4 The timing of this review has presented challenges as the funding system and responsibilities between state and individuals clearly underpin any discussion of rationing. It has therefore been difficult to consider future approaches to eligibility while being uncertain about the longer-term scenario for social care likely to emerge following the anticipated Green Paper. However, it has been useful to review the eligibility criteria five years on from their introduction and in the light of recent policy developments, especially *Putting People First.* The review has highlighted some fundamental problems about how local systems respond to people seeking support. The findings reinforce the importance of ensuring everyone, whether they fund their own care or rely on the public purse, has an early opportunity to discuss their aspirations, choices and options.

7.5 This raises issues about the skills, values, expertise and 'location' of people offering this advice, expertise and support to self-assessment. Some people may prefer to speak with peer advocates, brokers and/or assessors in an independent setting. There has been longstanding debate about the problems of people who are a rationer of resources and an assessor of needs and an advocate for the individual. Separation of these functions may offer a solution.

7.6 Much of what is proposed in this report is a restatement of councils' existing responsibilities, and indicates that poor practices around assessment and eligibility can lead to lower costs initially but higher ones later as people return with greater needs to the social care system. It is therefore difficult for us to assess the funding implications. Moreover, some of the issues raised are about changes in the culture and working practices of councils and health and other partners. Overall, the differential progress of councils towards implementing the approach set out here makes it problematic to quantify any additional resource requirements, not least given the additional resources and grants being made available to support the implementation of *Putting People First.*

7.7 The new arrangements proposed in this report reinforce the direction of policy and place eligibility criteria for social care in a much broader context, recognising the interaction of a whole range of different local services and resources which are crucial to promoting a good quality of life for people. The recommendations aim to offer everyone help to make informed decisions about their support and emphasise the importance of a good response to people seeking assistance. The proposals for priorities for intervention offer a new way for councils to ensure specific resources go to those who need them most. Ultimately though, people's assessment of the transparency and fairness of the system will be heavily influenced by how they are dealt with when seeking help and support and on the adequacy, efficiency and effectiveness of the use of the available resources.

Appendix One: FACS Review Terms of Reference

- In the context of the Government's vision for adult social care, *Putting People First,* to undertake a review of the criteria for Fair Access to Care Services, their application by councils with social services responsibilities and their impact on people.
- To make recommendations to the Care Services Minister on the findings from the review.
- To engage ADASS, LGA and other relevant stakeholders in the process of the review.

7

Acknowledgements

The Commission for Social Care Inspection wishes to thank the many people using (or seeking) services and their carers for contributing throughout this review to meetings, the consultation event (participants listed below), sounding board, online survey and written submissions.

We also thank the large number of organisations and their representatives from across the social care sector who provided evidence and contributed to the discussions at special events and the sounding board meetings (see the list below).

Our thanks also go to Melanie Henwood and Bob Hudson, Diana Robbins and the Social Care Institute for Excellence, and the Audit Commission, who all undertook special research and analysis for the review. Thanks also go to the Office for Public Management who helped to facilitate and report on a consultation event.

Responsibility for this final report and recommendations rests with CSCI.

Members of the Sounding Board

David Walden, Commission for Social Care Inspection (chair)
Penny Banks, Commission for Social Care Inspection
John Bolton, Department of Health (observer)
Sue Buker, Commission for Social Care Inspection
Stephen Burke, Counsel and Care
Ken Cooper, Department for Work and Pensions
Andrew Cozens, Improvement and Development Agency for local government
Melanie Henwood, Independent consultant
Veronica Jackson, Director of Adult and Community Services, Oldham
Jeff Jerome, Director of Adult and Community Services, London Borough of Richmond
Julie Jones, Social Care Institute for Excellence
Anne MacDonald, Local Government Association
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Andy McKeon, Audit Commission

Sarah Pickup, ADASS
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Mike Smith, National Centre for Independent Living
Madeleine Starr, Carers UK
Jane Todorovic, Department for Communities and Local Government
Janet Walden, Department of Health (observer)
Jo Webber, NHS Confederation
Gerry Zarb, Equality and Human Rights Commission

Organisations that submitted written evidence

Age Concern
Age Concern – Exeter
Alexandra Hospital – Integrated Discharge Team
Alzheimer's Society
Asperger's Syndrome Access to Provision
Association of Directors of Adult Social Services
Barking & Dagenham Council
Carers UK
Challenging Behaviour Foundation
Counsel & Care
Crossroads Caring for Carers
Croydon City Council
Croydon Older People's network
Care Services Improvement Partnership
Down's Syndrome Association
Durham County Council
Gateshead Council
Greater Manchester Coalition of Disabled People
Hackney Council
Hampshire County Council
Haringey Forum for Older People
Health Housing and Adult Services, Sunderland City Council

Help The Aged – Dorset
Help the Aged
Hertfordshire County Council Adult Care Services
Hillingdon Carers Support
Hillingdon Elderly Forum
Holme Manor
Islington Housing and Adult Social Services
Learning Disability Coalition
Local Government Association
London Borough of Hackney
Macclesfield Eye Society
Manchester Alliance for Community Care
Mencap – Ealing
Mencap – South West Oxon
Mind
Multiple Sclerosis Society
National Autistic Society
National Centre for Independent Living
National Children's Homes
National Housing Federation
National Pensioners Convention
Newcastle Health & Community Care Forum
Normanton and Altofts Senior Citizens Association
North Somerset Council
North Staffs Pensioners' Convention
Northumberland County Council – Adult Care Directorate
Nottinghamshire County Council
Older & Wiser Merton Seniors Forum
Ophira Limited
Parkinson's Disease Society
Peterborough Community Services
Plymouth City Council – Adult Society Care

Princess Royal Trust for Carers
Resolution Foundation
Royal Association for Disability and Rehabilitation
Royal National Institute of Blind People
Social Care Institute for Excellence
SCOPE
Sense
Somerset County Council
Southampton Centre for Independent Living
Spinal Injuries Association
Staffordshire County Council
Sunderland Carers Centre
Swindon Advocacy Movement
The Children's Society
The Disabilities Trust
UKHCA
United Response
Warrington Borough Council
West Lancs Peer Support Group
Working Together with Parents Network

In addition, 22 individuals lodged written submissions of evidence.

Organisations that attended meetings

ADASS
Alzheimer's Society
Association of Chief Executives of Voluntary Organisations
Audit Commission
Autism Society
Carers Network
Carers UK
Communities and Local Government
Counsel and Care

Department for Work and Pensions
Department of Health
Equality and Human Rights Commission
Essex Coalition of Disabled People
General Social Care Council
Healthcare Commission
Henshaws Society for Blind People
IdeA
Joseph Rowntree Foundation
Leonard Cheshire
Local Government Association
Melanie Henwood Associates
Mental Health Act Commission
Multiple Sclerosis Society
Mushkil Aasaan
National Black Carers & Carer Worker Network
National Centre for Independent Living
National Family Carers Network
National Royal Institute for the Blind
NHS Confederation
Policy Institute on Ageing and Ethnicity
Princess Royal Trust
Relatives and Residents Association
SCOPE
Social Care Institute of Excellence
Southampton Centre for Independent Living
UKHA
University of Manchester
Voluntary Organisations Disability Group

Representatives from the following councils took part in meetings

Barnsley County Council
Bath and North East Somerset Council
Birmingham City Council
Brent Borough Council
Bristol City Council
Bromley Borough Council
Buckinghamshire County Council
Bury Metropolitan Borough Council
Cheshire County Council
City of London
Croydon Borough Council
Cumbria County Council
Devon County Council
East Riding of Yorkshire Council
Essex County Council
Gateshead Council
Gloucester City Council
Hampshire County Council
Hartlepool Borough Council
Hertfordshire County Council
Islington Borough Council
Kent County Council
Kingston Council
Kirklees County Council
Liverpool City Council
Luton Borough Council
Leicester City Council
Lincolnshire County Council
London Borough of Barking and Dagenham Council
London Borough of Richmond
Manchester City Council

Newcastle City Council
North East Lincolnshire Care Trust
North Somerset Council
Nottinghamshire County Council
Oldham Metropolitan Borough Council
Plymouth City Council
Reading Borough Council
Royal Borough of Kensington and Chelsea
Somerset County Council
South Gloucester Council
Swindon Borough Council
Torbay Council

Participants in *the 'Have Your Say' about Fair Access to Care Services event*

John Adams, Voluntary Organisations Disability Group
Jackie Amobi, National Equalities Council
Ian Anderson, Lincolnshire County Council
Simone Aspis, Changing Perspectives
Penny Banks, CSCI
Vincent Bleakley, Manchester City Council
John Bolton, Department of Health
Louise Booth, BSL Interpreter
Mary Bradley, Personal Assistant
Don Brand, SCIE
Jill Buchanan-Huck, Lincolnshire County Council
Sue Buker, CSCI
Stephen Burke, Counsel & Care
Denise Caniffe, Choices and Rights Disability Coalition
Julie Charles, National Equalities Council
Julian Christopher, National Equalities Council
Paul Coleing, CSCI
David Congdon, Mencap

Ken Cooper, DWP
Stephen Corlett, Northumberland Care Trust
Neil Coyle, National Centre of Independent Living
Sarah De Costobadie, BSL Interpreter
Carolyn Denne, CSCI
Rachael Dodgson, CSCI
Pauline Dye, Coventry Carers Centre
Jan Evans, West Berkshire Council
Vicky Farnsworth, National Forum
Annie Ferguson, Speakup Self Advocacy
Debbie Foss, Lincolnshire County Council
Kate Groucutt, Carers UK
John Hannam, LGA – Nottinghamshire County Council
David Hart, Lambeth Community Initiative
Frances Hasler, CSCI
Pat Healy, National Pensioners Convention
Melanie Henwood, Independent consultant
Janet Higgins, London Borough of Lewisham
Steve Holmes, CSCI
Heather Honour, Learning Disability Coalition
Phil Hounsell, Sunderland City Council
George Howard, London Borough of Lewisham
Rhidian Hughes, CSCI
Veronica Jackson, Oldham Metropolitan Borough Council
Barry Jones, RNIB
Julie Jones, SCIE
Arifa Kapasi, Enfield Asian Carers Consortium
John Keep, Disabled Parents Network
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Steve Malyan, CSCI

Anne McDonald, LGA
Steph Moore, Personal Assistant
Ros Munday, Personal Assistant
Cate Oates, Palantypist
Gerald O'Hagan, CSCI
Lina Patel, National Black Carers and Carers Workers Network
Douglas Paulley, Rainbow Ripples
Dorothy Phillips, Oldham Metropolitan Borough Council
Joyce Phillips, CSCI
John Platt, Calderdale Metropolitan Borough Council
Trevor Railton, Northumberland Care Trust
Eve Rank, Who cares for us?
Sarah Reardon, SCOPE
Neil Revely, Sunderland City Council
Suzannah Rosenberg, Portsmouth City Council
Mia Rosenblatt, The National Autistic Society
Moira Rowland, Independent Living Advocacy
Ruth Sheridan, London Borough of Lewisham
Phil Shire, Calderdale Metropolitan Borough Council
John Simmons, OPAG
Paul Snell, CSCI
Kathryn Stansfield, Oldham Metropolitan Borough Council
Debbie Sterry, CSCI
Richard Taunt, HM Treasury
Geraldine Teggart, CSCI
Judith Thomas, CSCI
Michael Thomas-Sam, Kent County Council
Nigel Thompson, CSCI
Pauline Thompson, Age Concern
Jan Turner, United Kingdom's Disabled People's Council
David Walden, CSCI
Janet Walden, Department of Health

Amanda Wells, Shaping our Lives

Peter West, CSCI

Richard West, Expert by Experience

Lucy Wilkinson, CSCI

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John Wiltshire, CSCI

Danny Wright, Liberation Partnership

John Young, Northumberland Care Trust

Notes

Notes

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Get monthly updates on news from CSCI – sign up to our email newsletter
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From April 2009, a new Care Quality Commission will take over the work of CSCI, the Healthcare Commission and the Mental Health Act Commission.

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