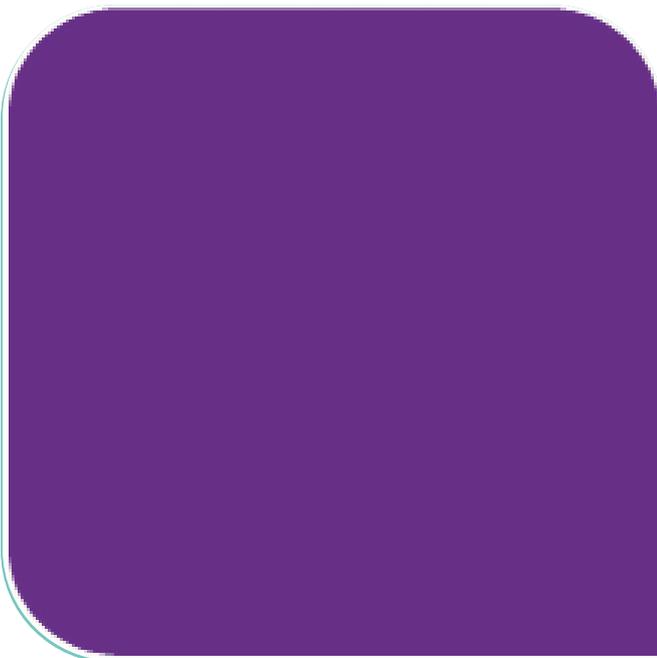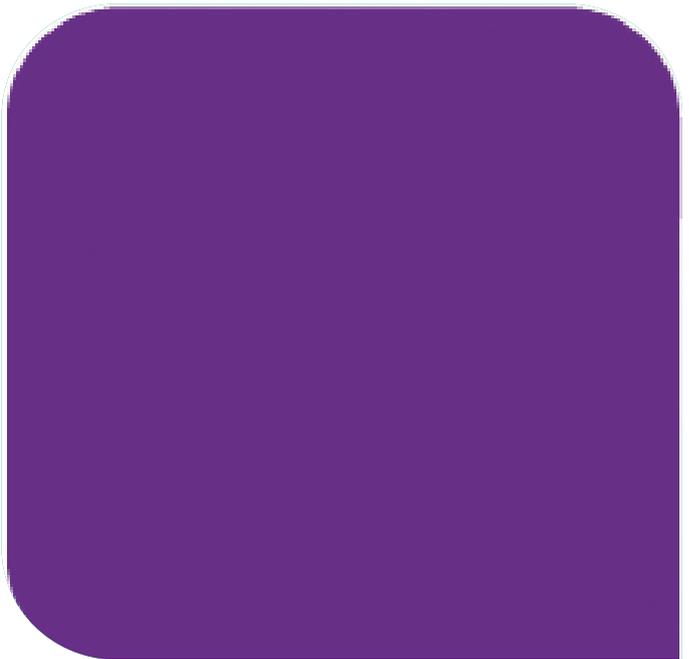scie
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Crossing the threshold:
The implications of the Dilnot Commission and Law Commission reports for eligibility and assessment in care and support

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Crossing the threshold:
The implications of the Dilnot Commission and Law Commission reports for eligibility and assessment in care and support

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Written by Melanie Henwood

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Foreword

This scoping report explores the implications of implementing key Dilnot and Law Commission proposals in respect of assessment and eligibility for publicly funded adult social care. It concludes that this will require a number of complex practical and implementation issues to be addressed. As with other recent programmes of transformation – such as personalisation – history and practice elsewhere suggest that these issues need considerable policy and practice attention if they are to be successful. Drawing from this report, key questions that need to be addressed include the following.

Assessment

- What are the implications of moving away from a model of assessment by care managers/social workers to a 'more objective' system, such as one based on inability to carry out several activities of daily living?

- How should issues such as greater clarity and consistency for individuals be weighed against the consequences of focusing on what people cannot do rather than an asset-based approach focused on achieving life goals?

- How would a personalised approach, including self-assessment, fit with a 'more objective' model of assessment?

- What are the implications for workforce development and training of a new approach to assessment?

Eligibility

- How can a national eligibility threshold and portable assessments be made compatible with a localism agenda and individual council funding decisions?

- What might be learnt from approaches used to determine eligibility for NHS Continuing Care and for some social security benefits, and can greater coherence be achieved across these systems?

- How can eligibility for publicly funded social care be better integrated with a universal 'offer' to all citizens in respect of information, advice and access to community resources?

The 'capped contribution'

- What approach should be taken to integrating assessment of need with the practical operation of the proposed £35,000 care cap and limited liability for people funding their own care?
- What mitigation needs to be put in place to avoid the management of people's spending against their capped contribution becoming highly bureaucratic and complex, and how can the system be transparent and simple but also resistant to gaming or manipulation?

Executive summary

This scoping report was commissioned by the Social Care Institute for Excellence (SCIE) from Melanie Henwood Associates. Drawing on research literature and from a series of semi-structured interviews with key stakeholders, the report explores the Dilnot Commission's recommendations, and those of the Law Commission, for a new model of assessment and a national eligibility threshold for publicly funded adult social care in England. It also discusses the implications for these processes of establishing limited liability for individuals by the proposed capped lifetime contribution of £35,000 for people paying for care. The report is intended to bring critical analysis to these important issues, and concludes that if major change is to be introduced, successful transformation will depend on a number of policy and practice issues being addressed.

The Dilnot Commission's report (2011a) adds to a considerable body of evidence identifying shortcomings with the existing framework for adult social care. At the time of writing (November/December 2011), further work was under way with the Department of Health, consulting with stakeholders to look at fundamental issues for reform in social care. That work will feed into the preparation of a White Paper in spring 2012. This scoping report is also intended to inform the debate leading to the White Paper.

Assessment

The Dilnot Commission (2011a) argued the case for a changed approach to social care assessment through the development of a new assessment measure, and (consistent with the recommendations of the Law Commission) portability of assessments between local authorities. The assessment measure should be 'more objective and more easily understood' (2011a, p 46). However, as we explore, there are considerable challenges with such reform, and there is a long history in social care of endeavour to achieve greater consistency and better integration in assessment. There is no shortage of assessment tools and methodologies already in existence, and any decision to introduce a new model would need to take full account of tools that have previously been validated, and to make the case for developing a further measure. In fact, this study found no appetite for the introduction of a new tool and considerable awareness of the fact that the history of assessment over the last couple of decades is one characterised by the quest for new approaches and tools, with mixed results.

Assessment processes can be bureaucratic and unwieldy, and introducing a new tool risks increasing such transactional costs and creating a system that is costly to operate and ultimately may deliver little to people who are assessed only to be told that they do not qualify for any support.

The emphasis on developing better personalisation in adult social care in recent times means that self-assessment has a particular role to play, and where it is done well the assessment process is much more of a dialogue concerned with identifying goals and outcomes and how these might best be achieved through support. It is essential that if a 'more objective' approach to assessment is adopted, it is developed in a manner that is consistent with the wider objectives of personalisation and compatible with self-assessment. The experience in many other countries is that assessment tools are often

functional and focus on measuring people's capacity to undertake activities of daily living, but are less successful in capturing people's preferences, aspirations and aspects of psychosocial wellbeing. This approach tends to be concerned with things that a person is *unable* to do, rather than with supporting people to maximise their independence. It would be a backward step if the search for greater objectivity and clarity in social care assessment led to a tool that was similarly 'deficit' focused, rather than addressing assets, outcomes and aspirations.

There are considerable variations not only in models of assessment, but also in practitioner interpretation, behaviour and understanding. The particular values and beliefs held by individual social workers, for example, can make a significant difference in practice to their approach to assessment and the outcomes achieved for individuals. There is considerable research evidence on people trying to 'do their best' for clients by ensuring that they assess their needs in a way that will 'get them over the eligibility threshold'; other practitioners may be concerned to protect budgets wherever possible and may interpret eligibility more restrictively. Any change of assessment tools and methodology would therefore bring major training and workforce development implications, and the introduction of standardised tools and thresholds would not *in itself* be sufficient to ensure consistent outcomes.

Whether and how assessment and eligibility and resource allocation decisions should be separated is a matter that is attracting increasing debate. The gatekeeping role is frequently caught up with support planning and outcome evaluation, often with potential conflicts of interest.

In looking at assessment issues, the Dilnot Commission recommended that the Government should consider how best to align relevant social security benefits with the social care funding system. Many commentators believe that there is a major opportunity to address social care and social security reform comprehensively. The operation of a parallel system of benefits that also contributes to 'cash for care' creates significant challenges. There are different advantages and disadvantages in the operation of national and local systems, of universal and means-tested entitlement, and of conditionality (where money can only be used for a particular purpose) and non-conditionality (where money is a contribution to extra costs and can be used freely), but the current system has elements of all of these, which do not relate to each other, are not easily understood or transparent and do not consistently address outcomes.

At the very least it should be possible to achieve greater coherence between the systems, including around information sharing, reducing the need for repeat assessments, and passporting entitlement.

Eligibility

Problems with the operation of local eligibility thresholds for access to publicly funded social care have been increasingly recognised in recent analysis. The Dilnot Commission highlighted several issues with the current approach to assessment and eligibility that are enshrined in the Fair Access to Care Services (FACS) framework, many of which have been previously well evidenced. The variability in eligibility across the country, and the absence of portability between councils, were judged to be

unacceptable in their impact. In establishing a clearer and more objective eligibility framework with portable assessments (largely in line with the recommendations of the Law Commission), the Commission also argued that the threshold for eligibility should be set nationally.

Previous analysis of these matters has highlighted the extent to which eligibility thresholds operate as a rationing device to control access to publicly funded social care and thereby limit the demands on local council budgets. We explore the evidence on the impact of different eligibility thresholds and the implications for prevention and early intervention if a threshold is set at a high level.

A national eligibility threshold as proposed by the Dilnot Commission (2011a, p 45) would offer a 'clearer, fairer and more coherent system for the public'. However, as we explore, the question of eligibility is not simply a technical matter, and actual implementation would reflect the interplay of multiple policy and practice variables. In practice, most councils are already operating on the basis of 'substantial' needs being the threshold for eligibility for publicly funded support.

The issue of eligibility cannot, however, be considered in isolation. Paying disproportionate attention to the threshold issue can overlook the importance of the wider context within which eligibility operates. The level of the threshold is not the only factor – in different councils people are able to access different preventative and community services without needing to satisfy eligibility criteria. Thus, in addition to support that is targeted on a particular part of the population (that is, the eligible population), social care needs to be located within a wider whole system approach to prevention, reablement and universal services (including information and advice). This is the focus of 'place shaping' and community-based commissioning strategies, which take a wider view of community assets and resources. Where this strategy is fully developed alongside targeted support, the 'cliff edge' between eligible and ineligible groups is considerably softened. How eligibility for publicly funded social care can best be integrated with a universal offer to all citizens around information, advice and wider community support is of particular importance. However, just as eligibility criteria vary between councils, so too does the availability of open access services, and a national eligibility threshold for social care would not of itself ensure equitable access to support.

Nonetheless, the inequity that *can* result from diverse eligibility thresholds is likely to mean that achieving greater consistency across the country would be welcomed by the public, and there is an obvious appeal to reducing or removing the 'postcode lottery'. At the same time, however, as we explore, there are considerable tensions between such objectives on the one hand, and those of localism, local democracy and council decision making on the other.

There are some parallels between the debate about national eligibility now taking place in social care and the approach that has evolved to determine eligibility for NHS continuing healthcare, which has moved in recent times from a local to a national model. Certainly, this has reduced substantially (but not entirely removed) variation across the country (from an 18-fold to eight-fold difference in the levels of provision of NHS continuing healthcare). The process for assessing continuing healthcare need is complex and often bureaucratic and may not offer a particularly helpful model for social care. It is not clear how a new national eligibility framework for social care would work

alongside that for continuing healthcare, and resolving the interface between these two systems was not within the remit of the Dilnot Commission or the Law Commission, although both highlighted the problematic nature of the health and care boundary and argued the need for government to establish greater clarity.

Limited liability and the capped contribution

The central recommendation of the Dilnot Commission (2001a) was to protect people from catastrophic care costs by capping the lifetime contribution that people might be required to make to the costs of their care at a proposed £35,000. It was assumed that establishing this limited liability would increase both the demand for and supply of financial products from the private sector. Such assumptions are untested and unprecedented elsewhere in the world, but are beyond the scope of the present analysis.

Of more direct relevance to the concerns of this report is the interface of the capped cost model with assessment and eligibility issues. The limited liability model would require people who are paying for their own care to have their needs assessed and for a notional spend to be calculated that *would* be required for their support if they met the national eligibility threshold of needs *and* if they were eligible for publicly funded support. This notional allocation would then be aggregated until it triggered the cap of £35,000 (or wherever the cap was set). This process would bring significant numbers of people paying for their own care into the assessment system who are currently outside it, and how this would be integrated with managing the capped contribution would be crucial if bureaucracy and process are to be controlled. There are multiple practical considerations that arise with this model, including: the variability of local sophistication in unit costing; the capacity of councils to manage assessment and reassessment of need for notional packages; uncertainty over what would count as legitimate spending; the implications of how to address the role and support provided by informal carers; and incentives for people to manipulate or 'game' the system. There could, however, be opportunities to ensure that when people who are self-funding have their needs assessed for the purpose of monitoring their capped contribution, they are also given adequate information and advice about care and support services, and help in meeting their needs. The relative marginalisation of self-funders from much social care debate has been increasingly recognised, and the universal offer that councils need to make to all their citizens might be realised better if more people paying for their own care had contact with council assessment services.

It is probable that many people would continue to spend considerable sums on care and support needs judged to be below the eligibility threshold and so without their expenditure being counted towards their capped contribution. Others could also spend considerably more than the £35,000 figure if they were unable to find care and support available at the level and price they are judged to require by the assessment and notional budget calculation. If this were to happen on a significant scale, there could be a credibility problem with the offer of a capped cost guarantee.

Although the recommendations of the Dilnot and Law Commissions' reports have been widely welcomed in principle, and given that they are the only real option currently on offer, it is apparent that they raise many policy and practice issues and challenges that

need to be addressed if transformational change is to be achieved. It is also apparent that any changes in the model of assessment, and in redefining eligibility and changing the respective liability between individuals and the state, can have multiple unintended consequences that need to be fully appreciated. Above all, finding the 'right' assessment methodologies and eligibility thresholds have to be seen not as ends in themselves, but as means to address individual needs and to achieve the best outcomes for people. Focusing on process issues alone can lead to a counsel of perfection that ultimately fails to deliver. Successful implementation and smooth transition would require attention to all of these matters in a systematic and comprehensive transformation programme. As a White Paper on the reform of adult social care is in preparation, it is vital that such issues are explored and are the focus of informed public debate.

1. Introduction and background

1.1. The Dilnot Commission on the funding of care and support was established by the Coalition Government in July 2010, with a remit to report within a year. The terms of reference tasked the Commission with making:

'… recommendations on how to achieve an affordable and sustainable funding system or systems for care and support, for all adults in England, both in the home and other settings.' (Dilnot Commission, 2011a, p 9)

1.2. The requirement was for a system that would be consistent with the government's deficit reduction plan. Furthermore, the work of the Commission:

'… should support reform of the whole system, ensuring that the right care is available at the right time and in the right place, for individuals and their families. It must also be compatible with the Government's vision for care and support – supporting personalisation, prevention and partnership and offering protection for people.' (Dilnot Commission, 2011b, p 13)

1.3. The Commission reported on 4 July 2011, setting out a new model for the funding of adult social care and support (Dilnot Commission, 2011a). The Commission concluded that the current funding system 'is not fit for purpose and needs urgent and lasting reform' (2011a, p 5). The central recommendations are to protect people from 'extreme care costs' and cap the lifetime contribution that people can be required to make to long-term care (with £35,000 proposed as 'an appropriate and fair figure' (2011a, p 5), and to raise the asset threshold for means-testing from £23,250 to £100,000.

1.4. In addition to proposing a new funding model, the Commission also offered a critique of other aspects of the current adult social care system in these terms:

'The current system is confusing, unfair and unsustainable. People are unable to plan ahead to meet their future care needs. Assessment processes are complex and opaque. Eligibility varies depending on where you live and there is no portability if you move between local authorities. Provision of information and advice is poor, and services often fail to join up. All this means that in many cases people do not have good experiences.' (2011a, p 5)

1.5. The Commission concluded that this needs to change and that 'there should be a clearer, more objective eligibility framework and portable assessments' (2011a, p 45). It was also argued that eligibility should be set at a national level rather than subject to thresholds determined by local councils:

'A single eligibility threshold and more consistent eligibility criteria would make for a clearer, fairer and more coherent system for the public.' (2011a, p 45)

1.6. The immediate response to the Commission was overwhelmingly positive. The Association of Directors of Adult Social Services (ADASS), for example, welcomed the report 'without reservation', and especially supported 'the call to

simplify social care, to improve public understanding and to develop greater consistency in funding care across the country' (ADASS, 2011). SCIE (2011a) also welcomed the report and remarked that its publication 'marked a really important day for long-term social care in England'. In written evidence to the Health Select Committee, SCIE also supported the principle that 'a new system should be based on a single national eligibility threshold for social care, with a fully transparent approach to assessment' (SCIE, 2011b, P.4).

Next steps?

1.7. In responding to the Dilnot Commission, the Secretary of State for Health (2011) made a statement to the House of Commons in which he welcomed the report and undertook to consider the recommendations as a priority. To take matters forward, work would be undertaken with stakeholders in the autumn, which would 'look at the fundamental issues for reform in social care'. The Dilnot report (Dilnot Commission, 2011a, p 77) had recommended that three working groups be established in order to:

- develop a more objective, portable, national eligibility and assessment framework, and how this might align with disability benefits
- look at how to support the development of new financial products
- design a new national and local framework for information and advice for those who need care and for carers.

1.8. On 15 September 2011, the Government launched *Caring for our future: Shared ambitions for care and support* (DH, 2011a) as an initiative to engage stakeholders in examining priorities for improving care and support. A response to both the Law Commission (2011) review of adult social care and the Dilnot report (Dilnot Commission, 2011a), will be published in the spring of 2012, comprising 'full proposals for the reform of adult social care in a White Paper and a progress report on funding reform' (Secretary of State for Health, 2011, column 1234). Six areas were identified 'where we believe there is the biggest potential to make improvements to the care and support system' (DH, 2011a, p 5). The remit is wide-ranging; it is recognised that making changes to the funding system 'would impact on all aspects of the care and support system' (DH, 2011a, p 5). The six themes are not the same as those suggested by Dilnot but address:

- priorities for promoting improved quality and developing the future workforce
- priorities for promoting increased personalisation and choice
- ensuring that health and social care services are better integrated around needs
- priorities for supporting greater prevention and early intervention
- priorities for creating a more diverse and responsive care market

- the role of the financial services market in supporting users, carers and their families.

1.9. There is not a separate topic addressing eligibility and assessment, but these issues are likely to cut across almost all of the themes. The headline findings from the six themes have been shared through a series of workshops, and reference is made to this material in the course of the present report.

1.10. This scoping report has been commissioned by SCIE from Melanie Henwood Associates. It offers a critical analysis to inform the wider debate around the forthcoming White Paper, and specifically to explore matters of assessment and eligibility for adult social care, and the policy and practice implications of developing an alternative model, building on recommendations of the reports from both the Dilnot Commission and the Law Commission. We examine the considerable likely challenges, and particularly those surrounding implementation where multiple variables impact on the reality of assessment and eligibility determination, and which will not be overcome simply by a change of definition or by the adoption of a new tool.

Methodology

1.11. This scoping report draws on a range of literature that was identified through online searches using key words including assessment, eligibility criteria, continuing healthcare, long-term care insurance and personal budgets. It was not a systematic literature review (which was not possible within the parameters of the study); rather it drew on the findings from a range of recent research and analysis to highlight key findings that illuminate the current debate.

1.12. In addition, a series of semi-structured interviews took place with 11 key stakeholders and commentators, which included:

- policy analysts, commentators and researchers
- service users
- director (and former director) of adult social care
- the voluntary sector
- the financial services sector.

1.13. The interviews explored stakeholders' perceptions of and responses to the key proposals for changing the approach to assessment and eligibility for adult social care in England. All interviews were confidential and none of the material used in the report is attributed to identified individuals.

2. Assessment and eligibility: the key issues

2.1 Before any new model can be proposed, it is essential to understand the shortcomings and challenges that characterise the existing approach to social care assessment and eligibility determination.

2.2 The Dilnot Commission highlighted a number of problems with the current approach to assessment and eligibility enshrined in the Fair Access to Care Services (FACS) framework. As we have already noted, the variability in eligibility across the country and the absence of portability of assessments between councils were identified as 'unacceptable'.

'The result of such local variability is that people in very similar circumstances, with similar levels of need and financial resources, can be treated very differently and experience vastly different outcomes. Access to social care is often labelled a "postcode lottery" and is seen as unfair. The level of variability adds complexity and leads many to be confused about how the system works.' (Dilnot Commission, 2011a, p 45)

2.3 The Commission (2011a, p 45) recommended 'a clearer, more objective eligibility framework and portable assessments' (broadly in line with the recommendations of the Law Commission). Furthermore, it was argued that 'eligibility for social care should be set nationally' (2011a, p 45) with a single eligibility threshold, such that everyone – wherever they live in England – should 'expect to start receiving state support when their care and support needs reach the same point' (2011a, p 46). The Commission (2011a, p 46) further recommended that 'until the current assessment system is replaced, the threshold should, at minimum, be set at substantial'.

2.4 The Commission (2011a, p 46) argued that, alongside this standardised eligibility threshold, a new assessment measure should be developed that is 'more objective and more easily understood, and people should be able to self-assess against the scale'. A new scale should be transparent, so that people are able 'to work out where, approximately, they may fit on the scale and whether they are eligible for state support' (2011a, p 46).

2.5 The thinking behind the current eligibility framework of FACS has been in existence for more than a decade. The 1998 White Paper *Modernising social services* (DH, 1998) recommended that councils should have clear rules about who can get help in order that 'everyone in the area gets treated fairly'. Guidance on developing eligibility criteria for adult social care was issued in 2002 with the intention of setting a national framework for eligibility criteria based on people's assessed needs and the risks to independence (DH, 2002). Four bands of eligibility were identified: critical, substantial, moderate and low.

2.6   Determining eligibility for social care has a dual purpose. First, it is about assessing the needs of an individual and ensuring that these are met appropriately, but second, it is also about controlling access to resources and limiting the demands on council budgets. It is this duality of functions that is arguably at the heart of many of the problems with FACS.

2.7   Despite the apparent simplicity of the objectives of eligibility assessment, there are actually additional layers of objectives that FACS is supposed to take account of and address. The 2002 guidance stated that individual councils should:

'make only one eligibility decision for all adults seeking social care support – namely, should people be helped or not?' (DH, 2002, p 2)

2.8   The FACS guidance accordingly distinguished between 'presenting needs' identified by people seeking support, and 'eligible needs', which fell within a council's eligibility criteria. The concept of 'unmet need' refers to the difference between these two. The guidance observed that 'councils will find this distinction useful in monitoring which presenting needs are met and which are not' (DH, 2002, p 3). It is also arguable that the separation of eligible and ineligible needs was not intended to be as stark as it has become in practice, and the guidance asked councils 'to be prepared to support' (2002, p 4) people falling outwith the eligibility threshold:

'… 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.' (DH, 2002, p 4)

2.9   The assessment of needs and the determination of eligibility actually emerge as complex and multi-layered. There are tensions and indeed potential areas of incompatibility between these various requirements. A considerable amount of analysis has previously been undertaken in this area – particularly by the former social care regulator, the Commission for Social Care Inspection (CSCI) – and it is important to understand the findings and conclusions that this work generated and to use it as a foundation for further analysis rather than starting entirely afresh when examining the implications of the Dilnot recommendations.

FACS: critique and response

2.10   The 2006–07 annual report from CSCI *The state of social care in England* (CSCI, 2008a), drew particular attention to the impact of FACS and of rising eligibility thresholds across councils. Some key conclusions identified a number of trends and challenges, including the following (2008a, p 154):

- Tightening eligibility criteria does not control the demand for support.

- An eligibility-based framework increases the likelihood of frontline staff assessing for bands and services rather than assessing people's situations in terms of needs and risks to independence.

- People who are ineligible for council support are often signposted to other services but councils do not generally follow up what happens subsequently or collate information about these unmet needs.

- The trend towards tightly circumscribed social care support sits poorly with the personalisation agenda and with wider conceptions of health and wellbeing.

2.11   The situation of people who were described as 'lost to the system' because they failed to meet eligibility criteria was seen to underline 'an increasingly sharp divide between those who are and those who are not supported by the system' (2008a, p.xiii). In response to the findings of *The state of social care in England*, the government asked CSCI to undertake a comprehensive review of eligibility criteria. The report of the review was published in October 2008 (CSCI, 2008b) and was also accompanied by a number of supplementary research reports and additional evidence.

2.12   As described above, the FACS system was introduced to try to improve extreme variation in eligibility between councils and to establish some underlying principles that would 'increase national consistency in a heavily locally determined system' (CSCI, 2008b, para 2.9). The FACS framework was based on risks arising from needs associated with disability and impairment and was intended both to promote the independence of people seeking help and to support a preventive approach. As CSCI (2008b, para 2.18) points out, some important principles were therefore established in the FACS guidance, 'which still stand but have been lost sight of in their implementation'. These include:

- tying 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 that 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.

2.13   The fact that many of these issues have been lost in implementation points to the consequences of councils determining priorities according to local resources, and also to the impact of removing support entirely at lower levels.

2.14   The CSCI review found acknowledgement of the inevitability of rationing and the necessity of having some system to decide 'who gets what'. Similarly, it was recognised that FACS also marked an improvement on the situation that had existed prior to 2003. However, the majority of the evidence gathered in the review underlined multiple shortcomings and unintended consequences, including: lack of clarity and transparency; unfairness; service-led rather than needs-led approaches; neglect of prevention and inclusion; and tensions with the personalisation agenda (CSCI, 2008b, para 3.4).

2.15 The review also found evidence of people failing to be assessed when seeking help from social care, and often in such circumstances this appeared to be because people were 'asked about their financial resources and savings prior to any assessment of their needs for support' (CSCI, 2008b, para 3.48). This was also consistent with the findings of a special study (Henwood and Hudson, 2008) undertaken for *The state of social care in England 2006–07* (CSCI, 2008a).

2.16 People who were unable to get access to social care, or who did not get the support they needed, typically 'managed' the best they could without any other help, and often 'at great cost in financial, emotional, personal and physical terms' (CSCI, 2008b, para 3.52).

2.17 CSCI made a number of recommendations for reform that would require 'a broader-based approach to social care' (2008b, para 5.32). In particular, this suggested shifting thinking away 'from the current narrow focus on FACS criteria' (2008b, para 5.3) and locating support within a wider context of strengthening communities, assisting individual choices (through improved information and advice) and changing the approach to prioritising funding for individual needs:

*'... 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.'* (CSCI, 2008b, para 5.8, emphasis in original)

2.18 A human rights approach was proposed that would be concerned not solely with meeting physical needs, but also with addressing 'meaningful human contact, dignity and respect' (2008b, para 5.9). At the same time, the approach to supporting carers and assessing their needs was also underlined as the evidence indicated confusion and poor practice.

2.19 In place of the four FACS bands to determine eligibility, CSCI proposed three 'priorities for intervention' (2008b, para 5.17). These were intended to be easier than FACS and less mechanistic, with interventions rated according to the urgency of the response needed:

Immediate intervention: required when without immediate support a person's wellbeing would be seriously threatened.

Early intervention: where problems are likely to develop and threaten a person's independence within six months if support is not provided.

Longer-term intervention: where people's independence would be threatened within the year without intervention.

2.20 Addressing 'barriers to dignity and quality of life' was intended to address all aspects of life, and other than in life-threatening situations, there should be no hierarchy of needs. For this approach to work, CSCI emphasised that councils would need to invest some resource at all levels, although they would need to manage within available resources. However, any assessment of the 'priority for intervention' would arguably need to develop and use different tools and methodologies, including predictive risk analysis.

2.21 The timing of the CSCI review was one of uncertainty. A Green Paper was in preparation, and when it emerged in 2009 (HM Government, 2009) it outlined ideas for a 'National Care Service' that would be 'fair, simple and affordable', and based around six features:

- prevention services
- national assessment
- a joined-up service
- information and advice
- personalised care and support
- fair funding.

2.22 The 'Big Care Debate' was launched by the Green Paper, and the White Paper that followed was published in March 2010 (HM Government, 2010), pledging the creation of the National Care Service. This also envisaged national eligibility criteria, portable assessment and assessment processes joined up across care and support (including between social care and Attendance Allowance). Because of the change of government that followed in May 2010, such plans failed to materialise, and the Dilnot Commission was established to look at these issues once again.

2.23 The CSCI recommendations to change the approach to eligibility criteria and replace it with a framework of priorities for intervention were not taken up by the government, but revised guidance on FACS *was* issued in February 2010 in an attempt to support fairer, more transparent and consistent implementation of eligibility criteria (DH, 2010a). The guidance placed greater emphasis on prevention, early intervention and enablement, and also located eligibility within a wider context that included the importance of strengthening communities and ensuring the adequacy of universal services. The guidance restated that the purpose of assessment is to 'identify and evaluate an individual's presenting needs and how these needs impose barriers to that person's independence and/or well-being' (DH, 2010a, para 78). A detailed guide was issued by SCIE (2010) to support implementation of the 2010 FACS framework.

2.24 Both the Department of Health guidance and the SCIE guide emphasised key principles that should characterise FACS assessment. These include, *inter alia*:

- Eligibility assessment must always precede financial assessment.
- Assessment and support planning should focus on achieving outcomes, rather than on needs or impairments.
- Prevention, early intervention and so on can prevent or delay needs from escalating.
- Signposting, information and advice should provide choice for people whether or not they are eligible for publicly funded support.

2.25 The implementation milestones developed by ADASS, the Local Government Association and the Department of Health to support the transformation agenda of *Putting People First* reflected similar priorities, particularly around matters of prevention, 'suitable assessment' and access to information and advice. The importance of adopting a whole system approach, particularly in the context of reducing resources, has also been highlighted by ADASS. Six key areas have been identified (prevention, recovery, continued support, efficient process, partnership and contributions), with the first three addressing what should be offered to people and the latter three addressing how it is delivered (ADASS, 2010).

2.26 In November 2010, the Coalition Government published its *Vision for adult social care* (DH, 2010b). The document did not address matters of eligibility for social care beyond reiterating that information and advice should be a universal service, that assessments should not entail 'unnecessary processes' and that they should be portable.

2.27 It is clear that despite the best intentions of revised guidance and continuing attempts to improve practice, the experience and consequences of assessment and eligibility determination are often unsatisfactory. The evidence gathered by the Dilnot Commission underlined the same problems with eligibility that had been previously identified by CSCI and other analyses.

2.28 In the following sections we explore in greater detail the recommendations of the Dilnot Commission and Law Commission around eligibility and assessment, and the prospects for them offering a solution to the problems that have been repeatedly identified. Box 1 summarises the key requirements of a new approach to assessment and eligibility determination for adult social care that have been identified.

Box 1: Key requirements of a new approach to social care assessment and eligibility

A number of features can be identified that should be requirements of any new approach to eligibility and assessment. The following are of particular importance:

- There should be a national eligibility threshold for social care.

- The approach to assessment should be transparent.

- Assessment should be person-centred and might include self-assessment or assessment by user-led and community organisations.

- Application of the assessment should be consistent and criteria therefore need to be clear.

- There should be portability of completed assessments.

- Assessments should join up, or be consistent and compatible with, assessment in related areas, including NHS continuing healthcare, disability benefits and so on.

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3. Assessment

3.1   The Dilnot recommendations on establishing transparent, portable assessments, and developing methodologies that allow consistent approaches to be followed, build on a long history of endeavour to achieve greater uniformity in the approach to social care assessment. The quest for better-integrated assessment is far from new. The 2010 FACS guidance (DH, 2010a) reiterated that:

'Assessment should be coordinated and integrated across local agencies relevant to the individual concerned. Agencies should work together to ensure that information from assessment and related activities is shared among professionals, with due regard to data protection, in such a way that duplication of assessment is minimised for service users, carers and professionals alike. In coordinating assessment, agencies should maintain an emphasis on outcomes rather than functions or services.' (DH, 2010a, para 86)

3.2   The Coalition Government's *Vision for adult social care* (DH, 2010b, para 7.17) acknowledged that 'high quality assessment and care management services are central to providing a person-centred social care service'. However, while the document reminded councils that they should remove 'unnecessary processes' and management costs, and that consideration would be given to 'whether the law could allow some assessments to be undertaken by people themselves, including user led and community organisations, rather than councils' (2010b, para 7.17), the *Vision* did not address the nature or methodology of assessment.

3.3   There are two elements to consider: first there are issues about streamlining assessments between agencies so that there is minimal overlap and people do not have to provide the same core information time and time again; second, there are issues about the nature and content of the assessment process itself. Both are important.

Previous approaches to assessment

3.4   As several interviewees observed wryly, 'we've been here before', which begs the question of why assessment continues to be problematic and whether it is sensible to frame the problem largely as an administrative or technical one, as this interviewee remarked:

'[We've already had] the Single Assessment Process, and the Common Assessment Framework; so I think we have to ask ourselves why we have not achieved this before.' (policy commentator)

3.5   This observation makes an important point and underlines the complexity of variables that are involved in assessment. At least part of the answer to why common assessment objectives have not been fully realised lies in the fact that this is not simply about finding the right mechanism or technical approach.

3.6   In 2009, the Department of Health consulted on developing a Common Assessment Framework (CAF) for adults aimed at promoting person-centred

assessment and sharing of information (and building on a model already established in children's services). A number of CAF demonstrator sites were established and the findings are expected in 2012. The CAF is intended to: avoid unnecessary duplication; promote an efficient and transparent system of information sharing; and ensure that service users receive appropriate care and support (PSSRU, 2010).

3.7   The CAF in turn built on the earlier Single Assessment Process (SAP) introduced in 2004 as a person-centred approach for assessing the health and care needs of older people. A person-centred approach to assessment can also be traced back in policy terms to the community care reforms following the 1989 White Paper *Caring for people* (DH, 1989). A review of the literature on the SAP highlights the tensions between different stakeholder perspectives on assessment, particularly between professional and user viewpoints:

'Much of the literature ... draws a sharp distinction between assessment seen from a professional viewpoint, where the assessor is deemed as an expert in identifying users' needs, and that from the user's viewpoint, where the older person's preferences and wishes become paramount. Several studies have suggested that despite an expressed commitment to listening to and taking account of the perspective of the service user, professionals were unable to do this when these perspectives differed from their own.' (Abendstern et al, 2008, p 18)

3.8   As Abendstern et al (2008, p 23) comment, there are considerable complexities 'in delivering a "joined up", standardised and participatory assessment process'. Implementation of the SAP would inevitably be challenging, they concluded, not least because it attempts 'to change professionals' *behaviour* rather than merely the pattern of resource allocation and distribution' (2008, p 24, emphasis in original). This observation is highly pertinent to bear in mind when considering any further change towards standardising assessment approaches.

3.9   The policy ambitions for professional collaboration in assessment that were expressed in the early 1990s largely failed to become established for a variety of reasons, including the structural divide between health and care systems, but also because of the different cultures and mutual mistrust between professions, which have tended to mean that assessments are not accepted by other professional groups and duplication is inevitable (Abendstern et al, 2008, p 20).

3.10   Reviewing the literature, Abendstern et al observe that rather than multiple agencies contributing to an assessment process coordinated by a social services care manager,

'instead, separate assessments, often with little sharing of information, have taken place. Breakdown in communication between professionals and agencies was found to be particularly pronounced at points of transition from one care situation to another, such as hospital discharge. This resulted in the repetition of the assessment process performed in hospital, once an older person returned home. The lack of successful structures to enable information exchange was closely linked to and frustrated by inter-professional mistrust.' (PSSRU, 2005, p.2)

3.11   The SAP was intended to address matters of both integration and standardisation. In terms of the latter, the Department of Health established an accreditation process in 2003 for 'off-the-shelf assessment tools' for use in the overview assessment of older people's needs. Six such tools were accredited as being compliant with Department of Health guidance: CAT (Cambridgeshire Assessment Tool); EASYcare; FACE (Functional Assessment of the Care Environment for Older People); MDS (Minimum Data Set) Home Care; NOAT (Northamptonshire Overview Assessment Tool); and STEP (Standardised Assessment of Elderly People in Primary Care in Europe). However, the advice on the use of such approaches was somewhat equivocal and it is not surprising that assessment approaches have proliferated as a consequence:

'Localities are reminded that other approaches to SAP overview assessments are legitimate. For example, they may wish to develop their own assessment tools for local use, using the January 2002 guidance as a framework. Alternatively, localities may favour a 'checklist' approach whereby professionals ensure that the domains of the SAP guidance are covered during an overview assessment.' (DH, 2004, p.1)

3.12   The SAP also addressed different levels of assessment:

- contact assessment
- overview assessment
- specialist assessment
- comprehensive assessment.

Arguably, this differentiated approach was intended to provide for a proportionate response, with 'comprehensive assessment' reserved for people judged to have complex needs. However, in practice there was evidence of people being screened out of the process at too early a stage and deemed ineligible before their needs were properly addressed (including at the stage of contact assessment).

3.13   By the time the revised FACS guidance was issued in 2010 (DH, 2010a), any mention of assessment tools appeared to have been replaced by a broader emphasis on assessment 'as a collaborative process' within the context of self-directed support:

'The assessment process should be person-centred throughout and also consider the wider family context. Councils should recognise that individuals are the experts on their own situation and encourage a partnership approach, based on a person's aspirations and the outcomes they wish to achieve, rather than what they are unable to do.' (DH, 2010a, para 83)

3.14   The central policy emphasis on self-directed support and personalisation, which was introduced by the Putting People First concordat in 2007, continues to characterise policy on adult social care with the vision for personalisation, and the Think Local, Act Personal Partnership agreement, which succeeds Putting People First. The twin 'building blocks' of the reform agenda are personalisation and community; building community capacity should:

'... help local communities and groups to provide networks of support, to help people improve their health and well-being, and to reduce their need for more acute health and care services.' (Putting People First Consortium, 2011a, p 2)

3.15   Enabling people to stay healthy and actively involved in their communities should delay or avoid 'the need for targeted services' (2011a, p 2). Those people who *do* need such help 'should have maximum control over this, with the information, means (financial and practical) and confidence to make it a reality' (2011a, p 2). Local leaders are advised in the partnership agreement that they will need to ensure that universal approaches to promote health and wellbeing, and targeted support for particular groups, are both addressed, but the *mechanism* for targeting support is not specified.

3.16   The eligibility framework of FACS remains rooted in the policy objectives of the 1990s and the requirement to focus attention on people with the greatest assessed needs. The shift towards personalisation, supporting independent living and maximising choice and control, does not fit easily within this framework. In a report prepared as background to the CSCI (2008b) review of eligibility criteria, Hudson and Henwood (2008, p 44) concluded:

'FACS was well suited to a system in which professional judgement determined levels of need and risk. However, it is not fit for purpose in the very different policy regime arising from Putting People First. The challenge now is to devise fresh eligibility criteria that better reflect the new policy world, and ... this means criteria that are consistent with the "partnership" and "user-led" models.'

3.17   As Hudson and Henwood also argued, there is an inescapability to rationing: decisions will always need to be made about who gets access to publicly funded social care services and in what circumstances. However, an eligibility framework needs to be consistent with the principles and values of policy, thus 'reconciling prevention, personalisation and prioritisation' (2008, p 45).

The Law Commission's view of assessment

3.18   The review of adult social care by the Law Commission (2011) also explored assessment and identified three concerns about the current focus (para 5.54):

- The service-led model continues to influence practice 'despite the intention of guidance to focus on needs alone'.

- An assessment on needs alone can be problematic 'as it focuses on a person's problems and difficulties, and can thereby be disabling for the person concerned and fail to support independence'.

- Focusing on needs alone may give insufficient consideration 'to the outcomes the person wants to achieve'.

3.19   Response to the consultation by the Law Commission showed strong support for the assessment duty focusing on both needs and outcomes:

'As well as preventing a service-led approach to assessments, consultees argued that the proposal would ensure that assessments are not focused on a person's perceived deficits and weaknesses, but rather towards their abilities, aspirations and preferences.' (Law Commission, 2011, para 5.55)

3.20   The current duty is for councils to carry out an assessment of a person's needs for community care services. This seems now to be a narrow and outmoded conceptualisation, which reflects the origins of the duty in the NHS and Community Care Act 1990. The Law Commission recognised that a duty to assess, and to consider outcomes, does not determine the decisions subsequently made by councils since 'local authorities do not have a duty to meet all the public's presenting wants, wishes and preferred outcomes' (para 5.58). The Law Commission (2011, para 5.58) recommended that:

'The focus of the assessment duty should be an assessment of a person's care and support needs and the outcomes they wish to achieve.'

3.21   The Law Commission also considered whether the assessment process should be prescribed in regulations. The present position is that the process for undertaking an assessment is set out in directions and 'a multitude of guidance' (para 5.60) as well as in some statutory requirements. It was acknowledged that 'this approach can allow for flexibility and innovation' (para 5.60), but this will only be the case if the process itself is clear and accessible. This, however, is not the case.

3.22   Response to consultation highlighted the problems of complexity arising from multiple guidance documents. There was a preference for putting the detail in regulations, but many consultees were nonetheless concerned that such regulations 'must not be overly prescriptive or constrain local authorities in adopting a proportionate and flexible approach to assessments' (para 5.63). The Law Commission concluded that the existing legal framework around assessment causes confusion and inconsistent practice, and recommended therefore 'that the key elements of how an assessment is carried out should be clarified in legislation' (para 5.65). Regulations, rather than statute, are seen as the most appropriate vehicle that would allow amendment as necessary with changing practice.

3.23   Regulations might address a number of areas, and the Law Commission considered the following:

- who is to be consulted in an assessment
- the way an assessment is carried out
- who can carry out an assessment
- timescales
- considerations to which the local authority must have regard
- self-assessment and delegation of assessment
- links with other assessments
- different types of assessment.

3.24 The Law Commission made several recommendations on addressing these matters within regulations. The White Paper that is expected in 2012 is intended to address the recommendations of both the Dilnot Commission and the Law Commission. It is vital that these are addressed in an integrated way; if changes are to be made in the approach to assessment and eligibility for social care it will be essential for these to be specified in appropriate regulations rather than adding another layer of guidance to an already complex and multi-tiered area of policy and practice.

International evidence

3.25 Discussion about long-term care and assessing people's needs for care and support is evident in many countries. Typically, assessment of need in many systems is based around ability to undertake activities of daily living (ADLs), and levels of care dependency are allocated, which in turn carry entitlement to given levels of services (or hours of care), or specified financial support. A 2008 review of approaches to eligibility assessment in Europe observed:

'Virtually all countries in the European Union assess eligibility for long-term care services by reference to internationally validated scales involving ADLs and IADLs [instrumental activities of daily living], related – in many cases – to the Katz scale.' (Robbins, 2008, p 14)

3.26 The Katz ADL index has been in existence for more than four decades and despite various modifications it is a limited tool based on functional status and within a medical (deficit) model. As Robbins (2008, p 14) also remarked, it is often not the scale itself 'but how it is located in the political system and used which determines its effects'. That is, an assessment tool can examine needs along given dimensions, but the determination of eligibility of those assessed needs is a political judgement.

3.27 Reflections on determining eligibility for long-term care (LTC) in Germany highlight similar issues to those being explored in England:

'One of the key questions in any long-term care system is the definition of eligibility for LTC benefits and services. It is one of the most important aspects for steering LTC systems in terms of regulating the number of beneficiaries.' (Büscher et al, 2011, p 2)

3.28 Eligibility criteria provide a mechanism for containing costs by defining 'which individual circumstances related to health, ill-health or disability are considered to be serious enough to be covered' (Büscher et al, 2011, p 2). The German long-term care insurance system introduced in 1995 assessed eligibility against ability to undertake ADL, with dependency classified into three levels. Each level corresponded to an estimated duration of time required for selected care activities to be undertaken each day. However, people who are eligible can choose between receiving services in kind or cash benefits (or a combination of the two) (Pavolini and Ranci, 2008, p 246). Cash can be used to purchase services or to pay informal carers and is seen as an important element in

strengthening family support (on which the system is heavily reliant) (Rothgang and Igl, 2007). Rothgang and Igl (2007, p 80) observe that cash allowances have an important role in stabilising family care and 'although the data clearly reveal a trend towards formal care, there can hardly be any doubt that cash allowances moderated this trend'.

3.29   The definition of long- term care in Germany was narrower than in many comparable countries and eligible individuals had to require help with at least two ADLs for more than 90 minutes a day over a six-month period (Comas-Herrera et al, 2006). Assessment of need – determining whether people meet the eligibility criteria for long-term care insurance LTCI – was carried out by the MDK (a medical review board), and restricted to the needs covered by LTC benefits (that is, activities of daily living). The narrowness of criteria, and their definition in terms of time needed, were criticised from the outset, and reform was approached through analysis of international systems of LTC, eligibility criteria and assessment tools. Some 40 tools were examined but it was decided that a new one needed to be developed for the German LTCI system. Eight 'modules' or domains were developed: mobility; cognitive and communication abilities; behaviour and psychological problems; self-care; ability to deal with illness/therapy-related demands and burden; managing everyday life and social contacts; activities outside the house; and household maintenance. Scores are allocated and weighted by an algorithm with five different levels and threshold values identified. The new tool (NBA) was recommended for implementation in the German LTC system.

3.30   The improvements in the tool, particularly in expanding the domains, will have significant implications as they will increase the numbers of people potentially eligible for support. The previous model had fixed ceilings within each category of assessed dependency level, rather than being determined by individual need (Glendinning and Moran, 2009, p 7).

3.31   Glendinning and Moran's (2009) analysis of lessons from other countries in reforming LTC identifies a trade-off between universal coverage for all people meeting a support threshold, against adjustment in the range of support that is funded:

'... it is the range of publicly-funded provision that has been adjusted, with practical domestic help being most likely to be removed from otherwise universal long-term care coverage.' (Glendinning and Moran, 2009, p 40)

3.32   A European Union (EU) review of LTC in member states highlights the similar challenges that are being addressed, particularly around 'improving access, enhancing quality and ensuring sustainability'; such matters are inherent in all systems. The review argues that universal or near-universal 'rights' giving access to care are to be found in all member states; however:

'... universal rights do not necessarily translate into universal access and there remain significant sources of inequalities in access that demand further attention.' (European Commission, 2008, p 17)

3.33 It is difficult to make direct comparisons between England and the rest of the EU because systems differ, particularly with other countries using models of insurance or including different services within a definition of LTC long-term care. Nonetheless, the overall conclusion about access within the EU *does* have some clear parallels with England:

'... barriers to access still persist, unevenly distributed across the population. These include lack of insurance coverage, lack of coverage/provision of certain types of care, high individual financial costs of care and geographical disparities of supply. They also include lengthy waiting times for certain treatments, lack of knowledge or information and complex administrative procedures.' (European Commission, 2008, p 17)

3.34 As Robbins (2008, p 15) has observed, most models of care:

'… use combinations of scales of needs and risks, multi-disciplinary teams and local care management to establish the service user's allocation of time, money or services.'

Furthermore:

'Access thresholds, expressed as needs/risks or time entitlements, have been explicitly linked to cost containment.' (p 15)

3.35 The issue with the English care system is not about removing all controls on access to care, but about establishing mechanisms that are equitable in their consequences and which do not set eligibility at a level that excludes many areas of need. While the debate about how best to fund LTC, and whether care is provided by services in kind or by cash transfers, is one that is increasingly evident in many comparable European countries, there has been less debate elsewhere around the specific questions of assessing need and determining eligibility such as we have explored above. Perhaps because models elsewhere in Europe (particularly in Germany) tend to be insurance based, there has been an acceptance of ADL approaches to determining eligibility that is not shared in England. The recent developments with eligibility and assessment in Germany indicate an attempt to move away from a narrow definition and towards a model that is closer to the type of assessment that has been evident in the SAP, the CAF and other models of person-centred assessment in common use in England.

Tools and methodologies

3.36 Wherever an eligibility threshold is established, some assessment process will be required to determine whether people's needs meet eligibility criteria. There is a danger of seeing the assessment issue solely in terms of the need for a new and better tool or the development of a 'new assessment measure'. The study undertaken for this scoping report found little support for such an approach, and considerable caution that the development of another measure or tool would generate further bureaucracy and be a costly process, or that it would divert attention from the real issues, as this interviewee remarked:

'I worry that, you know, "let's have a new tool" becomes an excuse for not doing anything to make the system work better. And it's somehow this "wonder pill" that's going to change everything.' (policy commentator)

3.37 Many interviewees highlighted concerns over the ways in which assessment processes and transactional costs have apparently multiplied in recent years, and had no wish to see yet another layer introduced. The following comments were typical of many:

'I'm not aware of anybody who's managed to do a RAS-based system[1] in a way that doesn't add another layer of assessment and bureaucracy. Some people seem to do that better than others.' (voluntary sector, chief executive)

'I've never been through so much assessment!' (service user)

'… the bureaucracy was created; we tried to unravel the bureaucracy a little bit in recent times but it's very hard to do once you've set all the systems up, and people don't trust unravelling all of it.' (policy commentator)

3.38 Others were similarly critical of the costs of the gatekeeping process that is encapsulated in assessment:

'And it's been beautifully subverted into gatekeeping hasn't it?' (service user)

And:

'I think that means let's revisit the basic business model, which is spending £2 billion a year on assessing and managing a sort of dwindling number of people who are entitled to help and often the product of that assessment is saying "no".' (policy commentator)

3.39 People also highlighted the training implications of introducing any new tool, and the risks of not doing so:

'... tools are only as good as the operators. And I think the biggest deficit in my mind is on workforce training and development, and support.' (voluntary sector, chief executive)

3.40 As another interviewee remarked, the difficulty with assessment is often in reducing it to a tick-box process, when in reality:

'It's a skill; it's a dialogue.' (service user)

3.41 However, it *was* acknowledged that there are considerable inconsistencies in the way that tools and processes are currently employed. Despite the lack of appetite for another assessment tool, it is nonetheless clear that a more consistent approach *would* be welcome:

'And actually I don't really care what the tool is if people are consistent in using it and understand how best to do it ... the big challenge ... is about workforce attitude, training and experience.' (voluntary sector, chief executive)

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[1] The 'RAS' refers to the Resource Allocation System developed by In Control whereby responses to an assessment questionnaire generate a score, which is linked to the allocation of a personal budget.

'... a national assessment tool would potentially iron out some of the variations of professional judgement I think.' (policy commentator)

'Each social worker is measuring it differently.' (service user)

'I think part of the problem is, if you put, you know, 20 care needs assessors in a room, or in 20 rooms, and you sent in the poor person, you'd get 20 different assessments!' (financial services sector)

3.42   People may also enter the assessment process when they do not need to do so. If what people are looking for is information about services they can access, for example, it should be possible for them to navigate to this without having to undergo assessment:

'... if you don't want to be assessed by us, you can go directly to get your service ... anyone can be assessed that wants to be, but a lot of people don't want to be, and actually don't need to be if only they knew how to get the thing that they wanted.' (director of adult social services)

3.43   The importance of differentiating between councils' responsibilities to the whole local community, and those targeted at the eligible population, and the need for proportionality of approach are the focus of new advice from the Think Local, Act Personal (TLAP) partnership (Think Local, Act Personal, 2011a). 'Leaner' approaches to operating systems are required to 'reduce unnecessary and expensive process while extending the authenticity of personal budgets (2011e, p2).'

3.44   As discussed above, there have been various attempts to introduce assessment tools, but the development of personalisation and self-directed support has also seen increasing emphasis on the role of self-assessment, support planning and self-management.

3.45   Whatever approach to assessment is employed, there will be an element of subjectivity or professional judgement. In fact, professionals continue to occupy a pivotal role in determining access to services. Lipsky (1980) described the theory of 'street-level bureaucracy' to analyse the discretion and power of professionals determining eligibility for limited resources. This power can work for or against the best interests of people seeking support from social care. Charles and Manthorpe's (2007) exploration of the impact of FACS on assessment practice for older visually impaired people, for example, found:

'The practitioners were unanimous that FACS had not made much, if any, difference to their assessment practice. They said that they carried out their assessments in the same way that they always have done.' (Charles and Manthorpe, 2007, p149)

3.46   Practitioners in the study had apparently undertaken little training in FACS, but it was also evident that an 'informal consensus' had been established within this particular team 'that FACS would make no different to assessment practice' (2007, p150). There was a belief that existing practices were consistent with FACS and an assumption that anyone referred for a social care assessment by

an ophthalmologist 'would automatically qualify as eligible for services' (2007, p150). Furthermore,

'Their view was also that wherever the local authority set the bar above which those being assessed would be eligible for services, they would report their assessment such that the person being assessed would fit those criteria.' (Charles and Manthorpe, 2007, p151)

3.47 The exercise of discretion in this way reflects a belief that the professionals are experts in making judgements, but also reveals practitioners determined to get the best 'deal' for their clients (what Le Grand, 2007, has characterised as practitioners acting as 'knights' rather than 'knaves' or 'pawns'). Charles and Manthorpe (2007, p 153) observe that:

'... practitioners might see this as a rational solution to the ambiguity at the heart of FACS. This ambiguity is the problem of delivering clear, consistent and identifiable outcomes for FACS when resources are limited and there are pressures to both undertake preventive work and to respond to high levels of need.'

3.48 Henwood and Hudson's (2008) analysis of the impact of FACS for CSCI also explored this 'rationing by discretion', and the extent to which it could reinforce or undermine 'rationing by directive' (particularly in the setting of FACS eligibility thresholds). It is not only social workers who may undertake assessments for social care: in Henwood and Hudson's study, some of those people working in care management came from a home service provider background and had National Vocational Qualifications rather than professional qualifications. Assessments undertaken by these staff tended 'to be very service-led'. The study highlighted a continuum of professional compliance and resistance. What these findings underline is that establishing a national approach to eligibility and using national assessment models would not – of themselves – be sufficient to ensure consistency of outcomes.

3.49 Manthorpe et al (2008) examined the experiences and expectations of older people in relation to social workers' roles and activities, and highlighted unevenness of experience and disappointment in social workers not 'being on the side' of the older person:

'Much depended on the personal qualities of the social worker….' (2008, p 1144)

The authors commented on the tensions between the need to undertake assessments quickly and to target resources on those most in need,

'with their other obligations to advocate on behalf of services users or to promote empowerment.' (Manthorpe et al, 2008, p 1144)

3.50 Furthermore, the development of a relationship between social workers and the people they are supporting 'is often sacrificed under the pressure to undertake assessment and care planning more speedily', despite the fact that the skills and sensitivity involved in building a relationship might be seen as 'a prerequisite to undertaking effective assessments' (2008, p 1145).

3.51 Ellis (2007) similarly explored the scope of frontline discretion in determining people's access to direct payments and highlighted a tension for social workers:

'… between their ethical obligation to value self-determination and empowerment – a tension heightened by the rooting of eligibility criteria in functional and financial definitions of independence rather than on autonomy and full participation.' (Ellis, 2007, p 409)

3.52 Interviewees who took part in the present study also recognised the significance of social worker behaviour interacting with assessment processes and eligibility thresholds, for example:

'What I know about what social workers do, and what I know about eligibility, is that sympathetic social workers, if they think people are "deserving", will find ways of getting them in.' (policy commentator)

3.53 Ellis's (2007) research was undertaken in just one English authority, so the findings may not be 'generalisable', but are nonetheless of interest. Social workers apparently justified rationing access to direct payments because these were seen to be about meeting 'wants' rather than 'needs'. Others highlighted concerns about risk as 'a justificatory discourse', but the dominant concern appeared to be how to limit demands on resources, and this included not telling people about the option of direct payments. There was also widespread ignorance or misunderstanding about the role and function of direct payments, with a tendency also highlighted in other studies for them to be viewed 'as an adjunct to existing patterns of service delivery rather than as a mainstream option routinely offered to people seeking assistance' (2007, p414). Ellis concluded that social workers were 'behaving as street-level bureaucrats' by attributing characteristics to people that avoided needing to offer direct payments, and which made it easier 'for them to 'routinise' responses in a context of conflicting demands on their time and other resources' (2007, p418).

3.54 Moreover, such conduct was a way not only of managing resources, but also of professionals maintaining power and control rather than handing it to people who use services. Ellis (2007, p 419) concluded:

'Unless entitlement to individual budgets is strengthened by far more extensive advocacy and support services, the conditions which allow, even encourage, front line social workers to behave as "street-level bureaucrats" are unlikely to disappear.'

3.55 The implications of personalisation for the role of social work also received attention in the national evaluation of the individual budget pilots (Manthorpe et al, 2009). The evaluation found limited investment in training for skill development or the practicalities of implementing individual budgets. Furthermore, this seems to be a common feature of social care, and 'limited training for front line staff about innovations, such as person-centred planning, has been consistently observed' (Manthorpe et al, 2009, p1299). The challenge of changing the culture of social work and care management practice is significant; Manthorpe et al (2009, p 1300) suggested that in-service training has a particular role:

'... to work with practitioners around developing practice in, for example, situations where the choices of people using services may be at odds with professionals' expectations and expertise or in conflict with their training or beliefs. These are therefore not simply matters of addressing knowledge or skill deficits.'

Self-assessment

3.56 The current assessment process is seen by many to have become unnecessarily complex and to pay little regard to principles of co-production or to give scope for self-assessment, as this interviewee commented:

'The ideal is to start with a plain sheet of paper and say "just tell me, write down before I come, what are your basic needs. We can't do all the frills; tell us what your basic needs are".... We shouldn't spend any money on new tools; what we should spend money on is listening to what the person actually wants. And it would be a lot cheaper because what people often need is not something terribly expensive.' (service user)

3.57 Where assessment follows a collaborative process, it *can* be highly successful, as this interviewee described:

'The way that I was assessed was pretty much okay ... we looked at what I needed, we looked at the definition and the intention as to why they were providing social care, and we looked at what the council's policy was on, you know, developing independent living for disabled people.... That's my view on the way that one should develop an assessment process; it should be clearly co-produced.' (service user)

3.58 'Self-assessment' can refer to a range of approaches and practices. The Law Commission (2011) distinguished between self-assessments that are co-produced with the local authority, in which the person may be encouraged to self-assess at a certain stage of the process, and self-assessments that are 'pure', with the entire assessment process being undertaken by the individual and without any involvement by the local authority (although the latter would be unlawful within the current legal framework). The Law Commission decided against recommending that self-assessment should be put on a statutory footing, but supported guidance within a code of practice on how self-assessment should be integrated in the assessment process.

3.59 Self-assessment has been encouraged for a few years, and the drive towards personalisation and self-directed support has increased this focus. Many councils operate some model of self-assessment (including online tools) that enable people seeking help, or those acting on their behalf, to identify their needs and get some idea of whether they are eligible for support.

3.60 Supported self-assessment is at the heart of the self-directed support process developed by In Control. Self-assessment questionnaires ask people both about their needs and about available support (such as from friends and family). The principles underlying self-assessment recognise that people are experts on their

own situation. The evaluation of the individual budget pilots by the Individual Budgets Evaluation Network (IBSEN) found a positive response to self-assessment:

'Previous experience of assessments, in which professionals decided what they needed, were reported to focus on what they could not do; but IB [individual budget] self-assessment and support planning were felt to be more about what they could and wanted to do. The processes were also felt to be holistic and encouraged people to think creatively about what they wanted to achieve.' (Rabiee et al, 2009, p 924)

3.61   The involvement of other people (including family, friends, social workers and so on) in completing the self-assessment could be important:

'Several people felt that without this support potential IB holders risked under-estimating their support needs because they wanted to minimise their impairment; did not think certain things were important; or in the case of fluctuating conditions, did not want to acknowledge that their condition could sometimes get worse.' (Rabiee et al, 2009, p 925)

3.62   A review of self-assessment by older people in health and social care commissioned by the NHS Service Delivery and Organisation Research and Development Programme (Griffiths et al, 2005) highlighted the variety of meanings attached to 'self-assessment'. At the time the study was undertaken, the majority of examples of self-assessment were 'focused health-related assessments' (2005, p 7), which were largely professionally initiated and interpreted. Few examples were identified in the social care domain, but where they did exist they 'were more likely to be user-initiated and interpreted and to aid decision-making on behalf of the user' (2005, p 3). The definition of self-assessment adopted by the study, and the elements of self-assessment identified as essential, are open to debate. For example:

'Simply put, the term "self-assessment" refers to "an assessment that is completed by the subject of the assessment without the immediate involvement of professionals, or a professionally-employed layperson".' (NCCSDO, 2007, p 2)

3.63   Such a definition would exclude much self-assessment in social care that is undertaken with the support of professional and lay individuals, including advocates and social workers. Equally, the emphasis on 'self-completion', requiring that this be undertaken by the individual concerned rather than by a professional, layperson or family member, would exclude many models of self-assessment that are well established within person-centred support.

3.64   An evaluation of self-assessment pilot projects (Challis et al, 2008) also pointed to the difference between health and social care models; thus, in health settings, self-assessment can be a precursor to assessment and often refers to screening for further enquiry. By contrast, in social care, typically self-assessment is *part of* the assessment process. The study concluded:

'Overall, self-assessment appears to have greatest utility when it complements existing processes rather than attempts to substitute for them. In this way it can contribute to the assessment and care planning processes, thereby linking with

the personalisation agenda since it facilitates the user's involvement in the assessment. In contrast, requiring the user to complete the assessments process alone could be conceived of as disempowering. The findings from the evaluation indicate that self-assessment has greatest utility when there is a facilitator (mediator) and/or a "professional" person (not necessarily qualified) to translate the assessment into an appropriate response.' (Challis et al, 2008, p 19)

3.65   Interestingly, the study also explored the use of information technology within self-assessment and found it 'not as successful or important' (2008, p 20) as it was anticipated it would be.

'Generally speaking, information technology was not a driver for change in encouraging users to self-assess. Nevertheless, there were examples of authorities linking self-assessment to other local electronic initiatives. Furthermore, there was some evidence that self assessment by electronic means was incompatible with a personalised response. In fact, people accessing on-line assessment were significantly less satisfied, except where there was a personal mediator involved interpreting the findings of the assessment into appropriate service provision or identifying the need for a professional assessment.' (Challis et al, 2008, p 20)

3.66   The IBSEN evaluation referred to 'mediated or supported self-assessment' and observed:

'Most IB [individual budgets] lead officers felt that some degree of professional assessment was necessary in addition to self-assessment. Having both views was believed to produce a more accurate assessment of needs and offered an opportunity for useful dialogue between the service user.

In addition to the benefits that self-assessment may offer in enabling people to take greater control over their lives, it is also often assumed that it will offer 'back office' savings. Challis et al (p 19) identified savings primarily in staff costs:

'suggesting that less qualified staff undertook work in relation to self-assessment enabling more qualified staff to focus on service users with complex needs. In the majority of projects there was a trade off between costs and efficacy.'

3.67   However, practice continues to evolve. Recent work commissioned by SCIE (2011c) explored these issues in greater depth in a sample of local authorities and found variable help provided for people with mental health problems in completing self-assessment questionnaires:

'While some said self-completion had boosted their confidence, most would have liked more help.' (2011c, p 5)

3.68   Many of the older people in the study could not recall the detail of assessment and few mentioned self-assessment. However, both these older people and people with mental health problems identified many similar ideas for improving assessment, including:

- Level of support and forms should be tailored to individual needs, without making prior assumptions about what different groups could do in terms of self-assessment.

- A consistent contact person should be involved throughout the assessment process.

- Fewer people should be involved in the assessment process overall (but with opportunities to involve other people if required).

- Assessments should be focused on outcomes and address aspirations as well as needs. (SCIE, 2011c, p 6)

Assessment and the Resource Allocation System

3.69   Self-assessment (or supported assessment) is a central element of the development of personalisation. This is not simply because the process enables a focus on individual needs and aspirations, but also because it has been closely linked with the development of a new model of budget determination – the Resource Allocation System. The RAS concept was developed by In Control and uses a scored assessment questionnaire (SAQ) to allocate points linked to locally defined funding levels. In Control describes the purpose thus:

'This enables people who need support and the local authority to quickly and easily determine both the amount of money any individual needing support can reasonably expect in their personal budget and what outcomes their support plan must address.' [2]

3.70   Creating a mechanism for determining the financial allocation is also argued by In Control to address the tensions in the roles of social workers:

'By providing an allocation of resources and a set of key outcomes, the RAS provides a way of setting out the deal upfront using a simple and transparent set of rules. This frees the social worker from tensions inherent in a gate-keeping role.' [3]

3.71   The idea that the RAS offers an objective and consistent approach to budget allocation is not something that commands total consensus. The apparently scientific methodology of awarding points to assessment responses, and then attaching values to points and converting them to a budget, has been criticised by several commentators. Social care legal expert Luke Clements (2011, p 4) comments:

'The form produces a total score for the person ... the local authority then has to decide what a point is actually worth.... The point score is then multiplied by the value assigned to a point. It is at this stage that any science in the process is

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[2] www.in-control.org.uk/related-pages/support/support-for-organisations/ras/ras5.aspx
[3] www.in-control.org.uk/related-pages/support/support-for-organisations/ras/ras-resource-list/using-ras-to-create-a-fair-deal.aspx

jettisoned in favour of witchcraft. The resultant sum is then reduced ... known as an "indicative amount".'

3.72 In practice, Clements argued, the indicative amount quickly becomes seen as 'the maximum amount' and an absolute (and unlawful) limit. Criticisms have also addressed the ongoing problems of the assessment process (even using self-assessment) within this model. For example:

'You have to prove how vulnerable and helpless you are before you get anything. You may actually have to wait until your health or wellbeing deteriorates before you become eligible for expensive state support, when a much cheaper preventative intervention could have avoided that need if it had been available at an early stage.' [4]

3.73 Other criticisms of the RAS have focused on the *additional* stages of assessment and planning that it has necessitated (translating needs into an estimated cash amount and then into a final cash value), and because this is operating as 'an add-on to the existing social care system, rather than a replacement for it', thereby adding to bureaucracy and costs. In part this is an indication of the in-built inertia of systems, and the caution of some councils and practitioners around transferring power to people using services. There is nothing inherent in the RAS model that should lead to additional bureaucracy or process and indeed the emphasis of its architects from the outset was on simplicity. However, recent evidence of increasing bureaucracy and complex assessment questionnaires has been cited as a threat that is 'derailing personalisation' (Dunning, 2011, p 22). The following problems have been highlighted:

- too many assessment forms
- forms that are overly complicated
- information technology systems used by different organisations that are not compatible and necessitate repeat data inputting
- funding panels that are overly bureaucratic
- increased use of standardised assessment forms that do not allow for creative packages (Dunning, 2011, p 22).

3.74 Some people have argued that 'one side of A4 is the ideal length for an assessment questionnaire – but those used by some authorities run to 40 pages' (Dunning, 2011, p 22). What this suggests is that a lot of the discussion about assessment is about a second level – that is, care planning – rather than initial assessment to determine eligibility.

3.75 The experience of some authorities that have moved forward successfully with personalisation highlights that bureaucracy is not inevitable, but it *is* a significant risk. Although personal budgets are now 'mainstream business' in the delivery of adult social care, the Think Local, Act Personal (TLAP) partnership acknowledges that:

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[4] http://alexfoxblog.wordpress.com//2011/07/05/time-to-ditch-the-ras/

'Excessive bureaucracy has impeded overall delivery of personal budgets, and specifically the take-up of direct payments when unnecessary and restrictive "custom and practice" has been introduced.' (Think Local, Act Personal, 2011b, p 1)

3.76 Furthermore, 'process creep' appears to have become a significant problem affecting the delivery of personal budgets and limiting the ability of users and carers to exercise choice and control. Other explanations for the apparent complexity and increased layers of process that are commonplace reflect, once again, the contradictory pressures on assessment processes, which are about determining needs but also controlling resource demands. As Tyson observes:

'Personalisation needs to be kept simple but the opposite is happening in practice. In our understandable desire to control budgets, we have added in particular to 'front-end' assessment protocols and introduced more complex audit systems for direct payments users.' [5]

Separating assessment, support planning and resource allocation

3.77 The question of who should be involved in assessments and – in particular – what role professionals should play, is also significant. Much of the discussion has focused on the role of social workers, both in having the right skills to support assessment, but also in acting as gatekeepers to service, and we have noted the tensions and contradictions between these roles. The objectives of personalisation with the emphasis on self-assessment and on greater choice and control would suggest the increasing separation of assessment and eligibility determination. The Think Local, Act Personal partnership has addressed these issues in rethinking support planning, and observes:

'It is clear that current practices can often be very bureaucratic, as well as offering little in the way of choice and control to individuals.' (Think Local, Act Personal, 2011c, p 2)

3.78 The objective is 'to make support planning available to those who require it while keeping the process lean' (2011c, p 2). In examining existing processes, the TLAP partnership identified the need to 'de-couple' support planning from what is required to allocate a personal budget. Importantly, the process of support planning is identified as part of the core 'universal offer' from social services (of equal value to people who are self-funding). The financial pressures on local authorities make the 'need for a sustainable model of support planning' (2011c, p 9) particularly pressing. Removing layers of bureaucracy from assessment and care management is part of the solution, but the other dimension in making the system fit for purpose, it is argued, lies in 'empowering people to take greater control of the planning process and a strong commitment to continue to nurture the freedoms and flexibilities which make Personalisation meaningful' (2011c, p

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[5] www.communitycare.co.uk/Articles/01/09/2011/117376/how-councils-can-implement-personalisation-without-bureaucracy.htm

9). Any new model of assessment will need to ensure that it meets these requirements.

3.79 The idea of new roles such as 'care navigators' emerging as part of this separation has featured in policy for a few years. However, the TLAP partnership cautions that it is important to resist 'a tendency to professionalise and layer on processes' (2011c, p 4), and support should start from the person and building what makes sense to support them and keep them at the centre of the process 'rather than starting with the default being support from a care manager or other paid professional' (2011c, p 5). Developing appropriate support to enable people to assume greater control has particular implications for the role of user-led organisations, peer support and charities with specialist knowledge and expertise.

3.80 Another development that supports this direction of travel is that of 'social work practice' (SWP) pilots. These have previously been piloted for looked-after children where the focus has been on providing greater continuity and stability. The SWP model is intended to be small enough for social workers in the practice to feel a 'sense of ownership'.

3.81 In November 2010, the government launched a call for expressions of interest in developing the model for adult social care. The SWP pilots have been described as supporting the 'Big Society' and devolving responsibility away from government. SWPs are led by social workers but are independent (or at arm's length) of the local authority:

'They should give more discretion to social work professionals to work closely with the people who use services. They will discharge statutory duties and responsibilities of the local authority in relation to these people. SWPs will be funded by local authorities using resources currently spent on those adults that will be transferred to the SWP.' (DH, 2010c, p 1)

3.82 It is anticipated that frontline social workers in SWPs will enjoy more autonomy; there should be less bureaucracy in checking decisions, and the aspiration is that allowing social workers more control over their work should lead to greater innovation.

3.83 Six SWP pilot areas were announced in April 2011: Birmingham, London Borough of Lambeth, North East Lincolnshire, Shropshire, Suffolk and Surrey. Clearly, these are very early days for the pilots, but the objectives of the schemes emphasise a number of potential benefits, including:

- improving experiences and outcomes for people using services
- empowering social workers and reducing bureaucracy
- enabling staff to exercise discretion
- bring decision-making closer to service users
- improved integration of services (for example between SWPs and GP practices/consortia).

3.84   The pilots are adopting a range of approaches and focusing on different client groups; they also offer the scope to work with a wider range of needs. For example, the SWP in Lambeth is focusing on early intervention for people with lower-level needs who would not generally meet the eligibility criteria for statutory social care.

3.85   There is also scope for social workers within the practices to work in a more enabling way. Birmingham City Council, for example, describes social workers in its pilot being 'catalysts within local communities, creating new opportunities for disabled people to be independent and encouraging people to become active citizens'.[6] This has also been a feature of some of Skills for Care's New Types of Worker Programme, with a focus on:

'... brokering community involvement by providing signposting to activities that were already going on.' (Skills for Care, 2011, p 12)

3.86   Approaches to building social capital in the New Types of Worker Programme also featured various 'community enabler' and 'community connector' roles aimed at increasing the amount of community support and widening people's natural networks.

3.87   The separation of assessment, eligibility determination, resource allocation and outcome evaluation were recurrent issues identified by interviewees in the present study. These disparate functions are often all the responsibility of local councils, with consequent potential conflicts of interest, as these interviewees described:

'You've got inherent tensions in the social work role as it's morphed into care management. You've got "am I the ally and the champion of the family I'm supporting, or am I the gatekeeper of the public purse"?' (research consultant)

'I'm keen that the decision to allocate resource is removed from the subsequent process of how to use the resource and whether it's being used properly ... it causes contradictions and complications when you're asking somebody to think out the best situation for somebody but also to allocate them money, because one influences the other.' (policy commentator)

'The gatekeeping role should be straightforward, skilled but quick. The more important role is then helping people how to use their money; helping them not controlling how they use it.' (policy commentator)

3.88   Who should be responsible for these different components could vary, but it is not necessarily the case that they should be undertaken by social workers. Some councils are already moving to separate these different elements, including assessment and care management roles. With the increasing use of web-based portals to access customer service centres, such separation becomes easier to design, and from the point of view of a person trying to navigate the system, the experience should be smoother.

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[6] http://birminghamnewsroom.com/2011/09/birmingham-to-pilot-adult-social-work-scheme/

3.89 Some of the anxiety about 'letting go' of assessment and care management processes is obviously around concerns about losing the capacity to directly control expenditure. In commissioning such services from local community groups or user-led organisations, there has to be a sense of the wider community, rather than just focusing on (and advocating for) individual interests, as this interviewee described:

'If you were to let go of the assessment function as well, you could have different accountability there that would connect to the average level of allocation ... you need to take responsibility for the overall kind of serving this community and this area ... you can't just be the person who's shouting for the individual in front of you; you need to have a bigger picture here.' (research consultant)

4. Eligibility: analysis and comment

4.1 As the foregoing analysis has highlighted, there is considerable evidence on the problematic nature of eligibility criteria for adult social care. The key issue is how reform can best be approached and what challenges need to be addressed around implementation. We turn now to explore these issues, drawing both on research literature and on the qualitative interviews undertaken for this piece of work. As we highlight below, changing the eligibility threshold cannot be viewed in isolation, nor approached as a technical matter that can be resolved merely by revising systems and processes.

4.2 It is worth noting that the report of the Dilnot Commission (2011a) seems to use the terms 'eligibility' and 'assessment' almost interchangeably, when they refer to different things. 'Eligibility' refers only to the point at which local authorities recognise that they have responsibilities to meet people's needs, while 'assessment' is about the process for determining the needs that a person may have (whether or not the local authority has any responsibility in meeting them). It is probably not helpful for the discussion of both these matters to merge together.

4.3 As the Dilnot Commission (2011a, p 45) observes, under the present system 'each local authority can decide the level at which people are entitled to state support'. This leads to widely documented variability (the so-called 'postcode lottery') and to consequent inequity. There has also been increasing challenge to the approaches of councils in raising eligibility thresholds, and there have been recent High Court judgments against the process followed by councils operating 'critical only' eligibility (Birmingham and Isle of Wight). The situation is generally seen as both unfair and confusing – people have little understanding or awareness of whether they are likely to 'qualify' for social care support and on what grounds.

National eligibility threshold

4.4 The Dilnot Commission set out the basis for a 'clear, national offer' with eligibility for social care to be set nationally. A single eligibility threshold would operate everywhere. This more consistent approach, it was argued, 'would make for a clearer, fairer and more coherent system for the public' (2011a, p 45). Within the context of the current model of FACS, it was suggested that the threshold should, at minimum, be set at 'substantial'.

4.5 Wherever a threshold for eligibility is established, there will be people who fall on the 'wrong' side of it: people who apparently have needs for support but are told they do not meet eligibility criteria. As stakeholders interviewed for this study repeatedly emphasised, this is a complex issue and it cannot be approached as if it can be resolved simply as a technical matter. People's eligibility is determined by where their needs are seen to lie in relation to a given threshold, but making that assessment involves the interplay of multiple variables around structure, process and resources.

4.6 There is some debate about whether eligibility is the right place to start this discussion. The notion that setting a national eligibility threshold will offer a complete solution is seen widely as too simplistic and ignores the complexities of policy and practice. The pursuit of the goal of a national eligibility threshold *in itself* will not achieve anything, as this interviewee remarked:

'What I have a problem with is people think there's this magic solution where we can have a nice objective set of criteria ... but there isn't. Because actually you have to have a way of deciding.' (director of adult social services)

4.7 While a cut-off point of 'substantial' needs might be seen broadly as reasonable, and largely consistent with the approach being taken by most councils in any event, setting this threshold might make relatively little difference in practice, as this director of adult social services observed:

'You can see why people do [raise eligibility thresholds]; it's one of the few levers there are ... but it's quite a blunt instrument.'

'I imagine ... that what you get for a given level of need is probably quite similar regardless of your eligibility threshold.'

4.8 The danger of focusing on the threshold issue is that it tends to address *only* the point at which people qualify for state-subsidised support (subject to an assessment of financial means). In fact, as already indicated above, eligibility is only part of the story, as the same interviewee commented:

'And actually where your eligibility is set is not the key determinant of how well people are supported in your area. Because places that have got "low" or "medium" [thresholds] are providing post-assessment things you can access [elsewhere] without an assessment ... so it's more apparent than real, and actually it's putting you through an unnecessary process.'

4.9 Many commentators argue therefore that a much broader perspective is needed that addresses the wider context within which social care is located, and this builds on the whole system approach encouraged by ADASS, and the engagement of active and supportive communities (Think Local, Act Personal, 2011d). For some this is seen primarily in terms of prevention. As this interviewee explained, if a preventive approach to eligibility was to be followed, the threshold would need to be lowered, but in the expectation of avoiding greater needs further down the road:

'You would bring thousands of people into eligibility that don't currently have eligibility ... but they would have entitlements to services at a level at which it was predicted that ... they're not going to be eligible in the future. Almost everybody would be eligible for something ... but some of what they would be eligible for would be supporting them to think through how they might better help themselves.' (voluntary sector, chief executive)

4.10 This discussion opens the related areas of prevention, reablement, and universal services (including access to information and advice). As another interviewee remarked, if eligibility is not linked to this wider context, the risk is that it becomes purely crisis driven:

'And because the only point of intervention and the only point of funding coming into play is when you get to crisis point, you're spending more money less well to achieve poorer outcomes. So it makes perfect sense to actually try and turn that back and say how can we actually get some funding and support within a personalised system that enables people to have more control earlier to better manage their condition?' (voluntary sector, chief executive)

And:

'It seems to make sense that people disinvest in prevention in a time of budget cuts – people have rights and councils have duties when it comes to high needs and nobody has an individual right to a preventative service. If you took the logic of choice, control, personalisation – shouldn't I have a choice to choose a preventative service now and thus stay in control of my life, rather than waiting until my life is out of control?' (voluntary sector, chief executive)

Prevention and early intervention

4.11   The need to address prevention and early intervention in social care is frequently identified, although often with little clarity about what this might mean. Most recently, the *Vision for adult social care* (DH, 2010b) published by the Coalition Government in November 2010 identified prevention as the first of its seven principles, and defined it in these terms:

'Empowered people and strong communities will work together to maintain independence. Where the state is needed, it supports communities and helps people to retain and regain independence.' (DH, 2010b, p 8)

4.12   This view of independence and prevention is strongly rooted in the vision for empowering communities and neighbourhoods, consistent with the aspirations for the 'Big Society':

'We also know that prevention is best achieved through community action, working alongside statutory services. We need to inspire neighbourhoods to come together to look out for those who need support. In other words, we need a Big Society approach to social care – one that gives people the power to support each other and meet the challenges they face. This not only leads to better and more creative solutions, it also makes our communities stronger and people less isolated and vulnerable.' (DH, 2010b, p 9)

4.13   The 'first priority' for people with care and support needs is seen in the *Vision* document as being 'to restore an individual's independence and autonomy' (2010b, p 12), and it is further argued that 'there is no reason for councils to restrict support to those with the most intensive needs' (2010b, p 12), which offers a poor service to local people and represents a false economy. While the *Vision* acknowledged the implications for supporting carers as part of a prevention strategy and also highlighted the potential contribution of new technology and telecare to support people in their own homes, and of reablement in getting people back on their feet, there is much less clarity on the actual strategy for prevention.

4.14 The maxim that preventing people's needs from escalating will help to reduce the costs of intensive care packages is one that few would argue with. This can have implications for a number of interventions, including:

- reablement and intermediate care services following a crisis and hospitalisation
- crisis or rapid response services
- telecare services.

4.15 In addition to these interventions, which are generally concerned with avoidance of admissions (or readmissions) to hospital or permanent residential care, are a range of 'low-level' interventions, which may be particularly concerned with improved quality of life. The 2006 Wanless review of social care examined the evidence base on low-level services; and highlighted studies which indicate that these services are highly valued, improve quality of life and enhance people's sense of control (Wanless, 2006, p 170).

4.16 More recently, the national evaluation of Partnerships for Older People Projects (POPPs) (PSSRU, 2009) examined pilot projects in 29 sites designed to promote the health, wellbeing and independence of older people, and to prevent or delay the need for higher-intensity or institutional care. Across the sites, 146 local projects were developed, two-thirds of which were concerned mainly with reducing social isolation and exclusion or promoting healthy living. The remaining third were concerned primarily with avoiding hospital admission or facilitating discharge from hospital or residential care. The evaluation found that the POPPs were cost-effective as well as producing evidence of improved quality of life. Thus, 'an additional investment of £1 in POPP services would produce greater than £1 savings on emergency bed days' (2009, p xi). Considering the POPPs as a whole, there was a very high probability (86%) that the programme 'was cost-effective, compared with usual care' (2009, p xii). Furthermore, those projects focused on improving wellbeing (practical help, small repairs, gardening, limited assistive technology or shopping) found even stronger evidence:

'For an extra spend of £5,000 per person – £96.15 per week – there is a 98 per cent probability that such projects are cost-effective compared with "usual care". Commissioners putting in place such projects could be reasonably confident that only around 0.2 projects in ten would not be cost-effective.' (PSSRU, 2009, p 7)

4.17 The Wanless (2006) review argued that, as with any intervention, the greatest benefits are likely to result from targeting preventative support at people who are likely to deteriorate or who have a high predicted risk of costly future needs. Identifying people who may be at risk of developing particular conditions or needs is a concept that is longer established in healthcare than in social care and support. The assumption behind such attempts is usually two-fold: first, by identifying the individuals or populations at risk, prevention can be put in place to remove or reduce the risk, and second – and related to the first –such actions and interventions can save money by avoiding the need for high-cost care? It is a model that has therefore attracted particular attention from health insurers and other funders in systems based on private insurance models.

4.18   The 'Caring for our future' stakeholder engagement group on prevention and early intervention similarly highlighted the need for 'trigger points' to be identified for prevention, and the importance of robust tools to measure risks and outcomes (Caring for our future, 2011). The Adult Social Care Outcome Tool (ASCOT) was highlighted as one of the best such tools currently available (measuring social care-related quality of life).[7] The group also observed that the business case for prevention has not yet been made effectively, and 'commissioning for prevention can be fluffy and divorced from outcomes' (Caring for our future, 2011, p6). Interventions for prevention typically need to include a range of services that go beyond social care and include health, housing and community development. However, the lack of sufficient integration across such service boundaries, and the absence of incentives, frequently impede attempts to address prevention and early intervention.

4.19   FACS had also tried to focus attention on matters of prevention, and to encourage councils to develop methods of risk assessment 'to help them identify those individuals where risks to independence appear relatively low, but are likely to become more serious over time' (Department of Health, 2002, p.5). In commissioning services, councils were also cautioned that they should not 'have blanket policies not to provide specific services' (2002, p.6).

4.20   The assessment process itself was also to be 'rounded and person-centred', with evaluation of the information leading to 'appropriate eligibility decisions and services that promote independence'. The assessment should also look beyond social care, for example:

'In addition to social care problems, where appropriate, assessment should take account of health and other problems such as housing, but at the same time aim to be as simple and timely as possible.' (DH, 2002, para 35)

4.21   In much debate, however, the language of 'prevention' is used loosely to refer to a wide range of support, including all 'low-level' services as well as re-enablement. Because of this, some argue that a sharper distinction needs to be drawn, for example:

'It's a three-stage thing: inform and advise; prevent, recovery and rehabilitation; personalisation, choice and control.' (director of adult social services)

Communities and place shaping

4.22   Addressing the wider context of open access and universal services (and information and advice to enable people to access them) potentially delivers a lot of the support that people might need around 'low-level' support. However, this needs to be done well and located within the wider strategy of targeted support, rather than approached simply as a rationing device whereby people are diverted from assessment (by so-called 'signposting') but are not effectively redirected anywhere else. Much of the wider support is not delivered by councils but

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[7] www.pssru.ac.uk/ascot/

commissioned through the voluntary sector, and user-led organisations. A 'spectrum of support' that addresses a wide range of people's needs but only provides means-tested support above a certain level, describes a different scenario from the sharp divide of eligible or ineligible, which often characterises people's experience of seeking support from social care. The 'markers of progress' published by the TLAP partnership describe scenarios that people 'would expect to find if personalisation is really working well', and the focus is on people's lives 'within their natural communities, rather than inside service and organisational boundaries' (Think Local, Act Personal, 2011d, p 3).

4.23   In addition to specific preventive interventions, this also has implications for inclusive strategies that enable older or disabled people 'to gain access to mainstream life as a citizen and to take active steps to prolong their independence' (ADASS, 2010, p 5). Ensuring access to universal services, and to information and advice, 'enables people to find their own solutions wherever possible' (2010, p 5). This includes access to affordable and reliable practical support, and to some telecare and simple aids to daily living 'made affordable and easily available to people without needing to undergo professional assessment' (2010, p 5). The latter point underlines the importance of councils addressing care and support more widely than is implied by focusing solely on the matter of FACS eligibility.

4.24   Unless the wider context of preventative and community-based services is addressed systematically, the issue *is* solely about the 'cliff edge' where people are either eligible or not, and this can bring further complications, for example:

'The danger there obviously is that you create a perverse incentive for people to present at a higher level of needs than necessarily are there, and that you create a watershed in the system.' (research consultant)

4.25   There is also a range of collective or community-level support and development, which is about building social capital:

'And that may well have a knock-on effect of reducing levels of personal need in the system. But there's probably value in doing that anyway ... thinking about the wider collective needs and wider collective good, and some of the effect of that will have an individual benefit.' (research consultant)

4.26   The idea of 'place shaping' and of 'total place', developed under the previous administration, sought a whole area approach, joining up neighbourhood-level strategies between local authorities and partner agencies. The Coalition Government has continued with this emphasis and the 2010 Comprehensive Spending Review set out plans for 'community budgets' to 'enable partners to redesign public services in their areas, agreeing outcomes and allocating resources across different organisations' (DCLG, 2011, p 6). Sixteen areas, involving 28 local authorities, have been piloting the development of community budgets, and a second phase of work is to see new pilots being established around neighbourhood-level community budgets and whole-place community budgets to explore 'how a transformation in local services could be achieved' (DCLG, 2011, p 7).

4.27 The New Local Government Network has also explored the implications of place shaping for local social care commissioners in learning disability services, and 'ensuring that their commissioning strategies are integrated with plans for housing, economic development and health' (New Local Government Network, 2011, p7). The role of Health and Wellbeing Boards is seen as particularly central to commissioners integrating strategies and the New Local Government Network (2011, p 57) concludes:

'Social care commissioners must take full advantage of the new arrangements to support independent living, employment and access to universal services for those who want it.'

4.28 Some of these issues are being developed in the concept of 'community fund holding' being promoted by In Control, which 'places public money in the hands of a community ... to enable that community to use the money flexibly to achieve a set of agreed outcomes' (Waters, 2011, p 3). This builds on person-centred approaches to care and support, but recognises that the goals of Think Local, Act Personal require partners beyond adult social care in order to make best use of collective resources and 'because the needs and contributions of communities don't fall neatly into service boundaries' (2011, p 2). This is also consistent with the policy emphasis on 'place'-based approaches and localism. The community fund holding model has three fundamental elements: the community fund itself (that is, a ringfenced resource); community planning; and review and evaluation. Both individual and community-wide responses are required; indeed, one of the criticisms that is made of individualised approaches to social care is that they can risk people becoming isolated unless there is corresponding investment in support infrastructure, as this interviewee observed:

'If you give people a direct payment, the argument has been you don't have to spend all the money on the infrastructure, so it's a bit cheaper. But you do still have to create some support structures otherwise you just leave them in the position of self-funders, which is very isolating and unempowering. So you have to create advisory services, support arrangements that take the pressure off people; ways in which people can block and bulk purchase and come together.' (policy commentator)

4.29 Even with a wide spectrum of support available, people with low incomes may be relatively disadvantaged. Focusing exclusively on issues of eligibility around *needs* can overlook other issues of means, for example:

'I think ... it is important for one group probably, which is people with low income or low financial means who have a low level of need; they're the ones who get excluded by the needs test. People with money – in theory it doesn't affect because they are going to be excluded on the financial eligibility anyway so they'll have to buy things and they can buy things ... but people without money and with low needs are the ones that we need to focus on.' (policy commentator)

4.30 As noted above, determining eligibility is not just a technical matter of setting a threshold; it is also about the process of assessment, which judges whether or not people meet that threshold. Such a process will never be wholly objective, as many interviewees acknowledged:

*'It **is** subjective. You can try and make it as objective as you can, but at the end of the day there's a person sat in front of a person, or on the end of the phone, making a judgement.'* (director of adult social services)

Localism, national eligibility and portability

4.31   The principle of a national eligibility threshold in social care is appealing in offering an apparent way forward in tackling the 'postcode lottery'. However, in practice this would be challenging and more complex and there are some fundamental tensions with local authority control of social care budgets, and with the forces of localism, as this interviewee observed:

'The problem I have ... is how you reconcile the idea of a national ceiling or floor, or however you conceptualise it, with the reality of 152 different financial settlements.'

And:

*'It would still be subject to individual interpretation, which has been the problem all the way through really. And it's been a problem **within** organisations, as well as between authorities.'* (policy commentator)

4.32   The tensions between localism and national eligibility are widely acknowledged, as are the difficulties of trying to tackle reform piecemeal without full awareness of the consequences:

'I think we've got to try and get across the message that you can't just tackle one bit of something ... of course, we are working in a local democratic system with 152 authorities, and ... you know, you want localism – you get localism! ... But it's localism versus the postcode lottery, and they're two sides of the same coin.' (director of adult social services)

4.33   As another interviewee observed, there are advantages and disadvantages of different approaches, but integrating them is extremely challenging:

'Are you creating a national system, and how does that fit with all the whole kind of localism stuff? My sense is ... there are benefits to a national system that are around equality and entitlement; there are benefits in terms of local systems around local accountability and local capacity for innovation and resourcing according to circumstance. So the question then becomes, well can you marry the two?' (research consultant)

4.34   There was considerable consensus among interviewees that some sort of compromise would be necessary, and that it would be important for the RAS to be able to reflect local costs variation when setting indicative personal budgets. Nonetheless, there was a strong view that it is national consistency that is the most important element:

'All the feedback I've had ... is that the national standards element of health and social care is important to people.... If you're the daughter of somebody with dementia and you live in Brighton and your father or mother lives in Burnley, you

simply can't understand why you can't get in Burnley what you could get in Brighton.' (voluntary sector, chief executive)

4.35   The principle of portability of assessment endorsed by both the Dilnot Commission (2011a) and the Law Commission (2011) reports is also being promoted by a Private Member's Bill introduced in the House of Lords by Baroness Jane Campbell on 22 June 2011. The Bill aims to secure continuity of care and support for people who move between authorities and to different parts of the country. The duty on the new authority would be to put an equivalent care package in place (in services or a direct payment, or a combination of the two), enabling the person to achieve the same outcomes. As Radar (the disability rights charity supporting the Bill) explains:

'Having the same outcome means that the individual must be able to do the same things in the second authority as they did in the first authority, taking into account that the local economy, environment, and social facilities will be different, as they would be for anyone moving home.' (Radar, 2011, p 8)

4.36   The Dilnot Commission (2011a) recommendation is that people should be able to take their assessment with them if they move, which would allow for the same number of personal budget points and the same amount of money *until a person is reassessed by the receiving authority* ('the receiving local authority should have a duty to meet all eligible care needs in the intervening period'; 2011a, p 47).

'However, this would not mean that the care package itself would be fully portable – the level and type of support that an individual receives under different local authorities could still vary.' (Dilnot Commission, 2011a, p 47)

4.37   In practice, as this interviewee remarked, once someone is reassessed,

'… [then] the local scheme will apply to you. Because you can't sustain a system where you could move from X to Y and in X home care is a lot more expensive than it is in Y, so the RAS in X delivers them more.' (director of adult social services)

4.38   Thus, national assessment, portability and a common threshold would still feature locally determined budgets and different values attached to points in a RAS system. Nonetheless, what portability *would* avoid is people having to 'start from scratch' with an assessment, and being left inadequately supported in the interim.

4.39   Interviewees for the present study recognised the issue of portability, but also saw it as part of a wider question around national consistency in eligibility, for example:

'I think what it is about is fairness. It's "why do I get this in Ealing and that in Hammersmith?" Because some people do move house and there's an issue, but most people don't actually. So portability is not the issue, the issue is, do you get the same?' (director of adult social services)

And:

'If you're living here and you move to there, you need to know that they won't take a completely different approach to you.' (policy commentator)

And as this interviewee remarked, if there was a national threshold for eligibility, the portability issue would be much less of a concern:

'Actually, if you took "substantial" [as the threshold] and dealt with it, then local authorities wouldn't feel so afraid of having portability.' (service user)

National eligibility and continuing healthcare

4.40　There is a parallel system of eligibility that determines access to fully funded NHS continuing healthcare. The recent history of development in this area has gone through a similar process of moving from local to national criteria, and it is worth considering therefore what might be learned from this experience.

4.41　NHS continuing healthcare refers to care:

'provided over an extended period of time, to a person aged 18 or over, to meet physical or mental health needs that have arisen as a result of disability, accident or illness. "NHS continuing healthcare" means a package of continuing care that is arranged and funded solely by the NHS.' (DH, 2009a, para 8)

The definition of NHS continuing healthcare is based around the concept of 'primary health need', where an individual's nursing/healthcare needs in their totality are beyond the lawful power of the local authority to meet (that is, the needs 'are more than incidental or ancillary to the provision of accommodation'; 2009a, para 26).

4.42　A national framework for NHS continuing healthcare, together with prescribed assessment and decision-making processes, were introduced in 2007 with the aim of promoting consistency in eligibility across all primary care trusts; the same level of needs should result in eligibility in any part of the country. Prior to this, eligibility frameworks were the responsibility of the 28 strategic health authorities in England, and prior to 2001 responsibilities rested with individual health authorities. This is an area of policy development that has been substantially shaped and refined by legal judgments and case law, and by the intervention of the Health Service Ombudsman highlighting concern that overly restrictive eligibility criteria for continuing care had resulted in injustice and unequal access for individuals.

4.43　In addition to fully funded NHS continuing healthcare, the NHS is also responsible for providing, or arranging for the provision, of nursing care by a registered nurse. At the same time that the national framework for continuing healthcare was introduced, responsibility for NHS-funded nursing care in nursing homes was simplified (and instead of three possible bands of funding, just one now exists). The assessment of NHS-funded nursing care is now also integrated in the same framework and eligibility determination as NHS continuing healthcare.

4.44 Assessment for NHS continuing healthcare examines a person's needs in terms of their:

- nature
- intensity
- complexity
- unpredictability.

4.45 Assessment uses an initial screening checklist and also makes use of the Decision Support Tool (DST) as 'a way of bringing together and applying evidence in a single practical format' (DH, 2009a, para 71). The tool provides a framework to explore need across 12 domains of need (see Table 1). Completion of the tool should indicate complexity, intensity and/or unpredictability in each domain, by recording levels of need: N (no needs), L (low), M (moderate), H (high), S (severe) and P (priority). The tool *must* be used and other tools cannot be used in its place. A Fast Track Pathway Tool is also available for use where a person requires immediate access to continuing care because of a rapidly deteriorating condition.

4.46 The DST is not an assessment in itself (a multidisciplinary assessment should be carried out first), but is to support the decision about whether there is a primary health need. In making the decision against each domain, the tool requests a written description of the actual needs of the individual and an assessed level of need matched to one of the descriptor statements appropriate to each level of need. A coordinator is identified to oversee and coordinate the assessment and decision-making process, including drawing together the multidisciplinary team to undertake assessment, completing the DST and making a recommendation on eligibility.

4.47 A letter issued to continuing healthcare leads by the Department of Health in July 2011 observes:

'Real progress has been achieved, both in terms of a rise in the number of people in receipt of NHS CHC [continuing healthcare], and in terms of a greater consistency in eligibility levels across England, and it is vital that this continues to improve.' (DH, 2011b, p 2)

4.48 The average number of people receiving NHS continuing healthcare per 10,000 population ranges from 7.3 in South Central Strategic Health Authority to 15.1 in North East Strategic Health Authority. The variation by primary care trust is from 3.3 (Berkshire West) to 29.3 (West Hertfordshire). The latest data (September 2011) show that in the first quarter of the year 2011/12 there were 53,466 people receiving NHS continuing healthcare in England (DH, 2011c). This shows that the national framework has had a significant impact in increasing overall numbers from 27,822 in September 2007, to 50,424 in the fourth quarter of 2009/10.

Table 1: Decision Support Tool for NHS continuing healthcare: care domains

Care domain	P	S	H	M	L	N
Behaviour						
Cognition						
Psychological needs						
Communication						
Mobility						
Nutrition – food and drink						
Continence						
Skin (including tissue viability)						
Breathing						
Drug therapies and medication						
Altered states of consciousness						
Other significant care needs						
Totals						

Source: DH (2009b, p 39)

A transferable model?

4.49   Whether the national framework for continuing healthcare offers a model for social care is highly debateable. The DST looks at levels of need within a medical model and attempts to reach a recommendation based on professional and clinical judgement. The user notes accompanying the DST make it clear that this is not always a straightforward process. For example:

'The fact that an individual has a condition that is described as "severe" does not necessarily mean that they should be placed on the "severe" level of the relevant domain. It is the domain level whose description most closely fits their needs that should be selected (for example, the fact that a person is described as having "severe" learning disabilities does not automatically mean that they should be placed on the "severe" level of the Cognition domain.' (DH, 2009b, para 23)

4.50   The threshold for determining eligibility is also subject to some ambiguity:

'A clear recommendation of eligibility to NHS continuing healthcare would be expected in each of the following cases:

- A level of **priority** needs in any one of the four domains that carry this level.

- A total of two or more incidences of identified **severe** needs across all care domains.

    If there is:

- One domain recorded as severe, together with needs in a number of other domains or

- A number of domains with high and/or moderate needs,

    This may well also indicate a primary health need.' (DH, 2009b, para 32, emphasis in original)

4.51 Clearly, there is a role for interpretation and clinical judgement, both in determining need in any given domain and in evaluating the cumulative weight to be given to results across the domains. This may account – at least in part – for some of the ongoing variation in rates of continuing healthcare eligibility, and the framework arguably still falls short in terms of both objectivity and equity.

4.52 The domains that need to be addressed in assessing needs for social care support are multiple. It is not simply a matter of assessing people's capacity to undertake activities of daily living, but also a matter of considering whether needs present risks to independence and wellbeing. The current guidance on eligibility criteria (DH, 2010a, para 60) highlights that 'councils should consider whether the individual's needs prevent the following outcomes from being achieved:

- exercising choice and control;
- health and wellbeing, including mental and emotional as well as physical health and well-being;
- personal dignity and respect;
- quality of life;
- freedom from discrimination;
- making a positive contribution;
- economic wellbeing;
- freedom from harm, abuse and neglect, taking wider issues of housing and community safety into account.'

4.53 As the guidance also states:

'Councils should make decisions within the context of a human rights approach, considering people's needs not just in terms of physical functionality but in terms of a universal right to dignity and respect.' (DH, 2010a, para 61)

4.54 While the assessment of need for NHS continuing healthcare attempts to identify where needs are the most severe, assessment of social care needs must also have regard to prevention and early intervention, to the needs of people 'on the edge' of needing social care and to people with low or moderate needs who may still need some level of support.

4.55 It is likely to be challenging and complex to develop national eligibility criteria that can address these multiple domains of need within a framework that is also readily accessible, allows greater objectivity, is easily understood and supports self-assessment. However, exploration of an approach based on scenario descriptors and a decision support tool along the lines of continuing healthcare *could* be undertaken. Nonetheless, there are some real difficulties with applying such a model to social care; in particular there would be concerns in developing an assessment tool that effectively requires people to demonstrate dependency in order to gain access to support, rather than supporting people to maintain independence.

4.56   The fact that the NHS and local councils operate within different legal and operational frameworks is also a consideration. While the NHS is supposed to offer a *national* system, and national policies can be rolled out, doing so within a locally administered social care system is more complex. Furthermore, the more comprehensive an assessment methodology is, the more complex it becomes, and the more difficult for it to be transparent, to be readily understood by the public and able to be adapted for use in self-assessment (which have also been identified as objectives of a reformed model). The continuing healthcare eligibility framework has been characterised by the roll-out of extensive training and support, and the development of local lead professionals to coordinate practice. However, implementation has also been characterised by considerable bureaucracy and complexity in the decision-making process, with panels convened to make a final determination, and independent review panel appeal processes often taking up considerable time. Such characteristics are not ones that it would be desirable to replicate in assessing social care needs where the numbers of people potentially being assessed are also considerably higher.

4.57   Whether or not the continuing healthcare model could (or should) be adopted by adult social care, the interface between health and care systems can be particularly sharp around continuing healthcare, underlining the importance of partnership working. People's eligibility for NHS continuing healthcare may not be permanent – reassessment can lead to people no longer being eligible for fully funded continuing healthcare and requiring local authority social care, or jointly funded support from the local authority and the NHS. Because of this level of interconnectedness, the national framework for continuing healthcare eligibility encourages a single assessment to be undertaken by a multidisciplinary team. If a person is found not to be eligible for continuing healthcare, the completed assessment should provide a foundation for care planning to meet needs rather than a separate social care assessment being undertaken from scratch. Any changes to assessment and eligibility for social care will need to take account of implications for the interface with continuing healthcare eligibility.

4.58   Without a partnership 'whole system approach' across the NHS and local authorities, continuing healthcare cannot operate successfully. There is still significant variation in the numbers of people eligible in different primary care trusts, *although this has reduced from an 18-fold variation to an eight-fold in recent years*. There are some concerns that the disappearance of strategic health authorities will in future make it more difficult to collect and analyse regional data and to address matters of variation.

4.59   The implications for continuing healthcare of the Health and Social Care Bill (which will see the disappearance of primary care trusts and strategic health authorities) has therefore attracted some concern, particularly because of the need to avoid a return to high levels of variation in continuing healthcare eligibility, with responsibility transferring to clinical commissioning groups, which will lack the skills and knowledge of continuing care. ADASS has highlighted the potential role for Health and Wellbeing Boards to pick up issues around local continuing healthcare, promote public awareness and work together across a given area in order to collect comparative data and to explore equitable access,

given the importance of these matters to local authority social care as much as to the NHS.

4.60   The transition to new clinical commissioning groups will need to be managed in such a way that the NHS continuing healthcare arrangements are sufficiently resilient to withstand organisational change. Local expertise of key staff will be particularly important at such a time if the understanding of eligibility frameworks and decision-making in both continuing healthcare and NHS-funded nursing care is not to be lost.

4.61   Both the Dilnot Commission (2011a) and Law Commission (2011) reports acknowledged the difficulties that the funding boundary between NHS continuing healthcare and social care can generate. The interface remains contentious and lacks transparency, and responses to the Law Commission suggested:

*'… that a **whole industry** has been established which is dedicated to trying to interpret and implement the dividing line between health and social care, which consequently costs a significant amount of money to administer and police.'* (Law Commission, 2011a, p 149, emphasis in original)

4.62   The Dilnot Commission (2011a, p 58) identified continuing healthcare as 'one of the most acute examples' of the funding boundary, and argued that the 'cliff edge' between eligibility for the two systems would not disappear under its recommendations 'but it does become less threatening because the costs that people face are capped'. The Commission suggested that the government may wish to consider how a new national eligibility framework for social care could work alongside assessment for NHS continuing healthcare since 'clarity in this area could be beneficial to many (2011a, p 58)'. Certainly, this study also found that continuing care eligibility decisions are often perceived to fail to meet the needs of people for whom the major requirements *are* health related, as this interviewee pointed out:

'I think ... you can have a fortune spent on you on the acute side for interventions ... but nothing spent on you for serious illness over the long term ... all the neurological conditions ... haven't been dealt with.' (policy commentator)

4.63   The remaining difficulties over the health and care boundary, and the opaqueness of respective responsibilities, could create particular implementation challenges around the capped contribution. There are many practical questions about whether the limited liability of the capped cost is insurable, but the lack of clarity over the responsibilities of the NHS presents a further area of doubt, which could mean that *if* the industry were to offer long-term care insurance, people could still be left without adequate cover because of the assumptions made about what the NHS would or should offer, as this interviewee observed:

'I think the insurance industry would say we'll offer these long-term care products but we want to know exactly when the NHS is going to come in. Insurers will ask, "what is it that we are liable for?" And they will avoid their liability as strongly as they can.... Which means that you can't go down this route until you're absolutely clear about what the deal is between insurance and the public sector, otherwise people will get very little.' (policy commentator)

5. Social care and social security eligibility

5.1   In addition to assessment of need to determine access to adult social care services, many people needing care and support are assessed through a parallel system, which determines eligibility for disability-related social security benefits. The Dilnot Commission (2011a, p 6) recommends that:

'... the Government consider how better to align benefits with the reformed social care funding system and that Attendance Allowance should be re-branded to clarify its purpose.'

5.2   The Government intends to introduce a new benefit to replace Disability Living Allowance (DLA). The new benefit – Personal Independence Payment (PIP) – is to be introduced for working-age disabled people from 2013/14 (subject to parliamentary approval of the Welfare Reform Bill). The consultation document on DLA reform (DWP, 2010, p 1) described PIP as an:

'... opportunity to improve the support for disabled people and better enable them to lead full, active and independent lives.'

5.3   DLA is a non-means-tested benefit (for people aged under 65) intended to contribute to the extra costs incurred by disabled people. The change from DLA to PIP is supposed to reflect better the needs of disabled people today through a more personalised approach; the benefit is also designed to be 'easier for individuals to understand' while also providing 'clear criteria and consistent awards' (2010, p 1). Might there, therefore, be useful experience to inform the approach to reforming social care eligibility and assessment models?

5.4   The principles underlying the approach to designing the assessment framework for PIP are summarised in Box 2.

> **Box 2: Principles underpinning the Personal Independence Payment**
>
> - **More defined and objective criteria:** designing criteria that are clear to understand and apply and consistent in their outcome.
> - **More holistic:** developing an assessment that takes a more comprehensive approach to disability than the current DLA criteria, fairly reflecting the full range of impairment types.
> - **Less medical:** developing criteria that are not based on the type of impairment individuals have but how these affect their everyday lives.
> - **More active and enabling:** creating a more active and enabling benefit, which considers what individuals can do rather than what they cannot.
> - **Assessing fluctuating conditions more effectively:** accurately capturing the impact of variable and fluctuating conditions and ensuring that an individual's safety is paramount in all cases.
> - **Safeguarding choice and control:** seeking opportunities to ensure that disabled people have the same choices and opportunities as non-disabled people.
>
> *Source:* DWP (2011, para 4.2)

5.5   There is clearly a great deal of similarity and coherence between these principles and those that are stated for social care. The assessment model focuses on five 'activity groups' in terms of ability to: access food and drink, manage a condition, manage personal care, communicate and get around. Eleven 'key activities' were then developed:

Daily living component

1. Planning and buying food and drink.
2. Preparing and cooking food.
3. Taking nutrition.
4. Managing medication and monitoring health conditions.
5. Managing prescribed therapies other than medication.
6. Washing, bathing and grooming.
7. Managing toilet needs or incontinence.
8. Dressing and undressing.
9. Communicating with others.

Mobility component

10. Planning and following a journey.
11. Moving around.

5.6   All of the activities are intended to act as proxies 'to assess the impact of an individual's health condition or impairment on their ability to participate' (DWP, 2011, para 5.3). In an approach that is similar in style to the DST for continuing healthcare, each domain is accompanied by a series of descriptors, which describe different levels of ability to carry out an activity. The descriptor that fits most closely with the individual's circumstances is chosen for each activity, and each descriptor has a corresponding point score:

'... reflecting both the level of ability it represents and the overall importance of the activity. Whether an individual is entitled to the rates and components of Personal Independence Payment will be determined by adding up the points totals from each descriptor that apply to that individual.' (DWP, 2011, para 6.6)

5.7   Despite the underlying principles supporting the development of assessment for PIP, the actual domains are narrow and functional. If this model were to be developed for social care assessment, other domains would need to be added in order to address wider issues of social inclusion and participation, which go beyond an assessment based on ability to undertake activities of daily living and instrumental activities of daily living.

5.8   The Dilnot Commission (2011a, p 47) was reluctant to 'cause further upheaval' in the area of benefit reform but nonetheless suggested that the Department for Work and Pensions (DWP) 'considers how the PIP and the reformed social care funding system can be aligned'. A comparable assessment framework (that is, with descriptors and allocated points) for an expanded range of domains *might* facilitate such alignment but this would fall short of integrated assessment and could still lead to duplication of assessment processes. It is unfortunate that the reform of DLA moved ahead while the work of the Dilnot Commission was under way, as a potential opportunity to look at the interface of the social security and social care systems in greater depth and to address them holistically has been lost.

5.9   A further overlap between the two systems is evident in the operation of Attendance Allowance (AA), which provides a non-means-tested benefit for people aged over 65 who have a disability that requires help with personal care. However, it is described as a benefit to help with the extra costs of disability, and people do not need to be receiving personal care (formal or informal) in order to be eligible. As with DLA, eligibility for AA is largely determined by a paper-based assessment of people's ability to undertake activities of daily living. It is often argued that a particular strength of AA is that it is available to people who would *not* meet social care eligibility criteria, and can provide a benefit for people with lower-level needs. However, as is also true with DLA, it is undoubtedly the case that parallel cash-based systems supporting people with care and support needs are duplicative in their assessment systems, confusing and potentially inefficient. It is not only AA and DLA that might be seen in such terms: the continued existence of the Independent Living Fund (also under the aegis of the DWP, albeit now permanently closed to new applicants, is a further significant anomaly, which we have previously examined and recommended should be resolved

through full integration with the social care system (Henwood and Hudson, 2007).

5.10   Because of the confusion and potential inefficiency of two systems operating with overlapping responsibilities for meeting care needs, the reform of AA as part of the wider reform of social care has been the focus of some debate. The King's Fund, for example, concluded that the argument for including AA 'in the redesign of care funding is compelling' (Humphries et al, 2010, p 32) and proposed an approach that would improve targeting by limiting AA in future to people also in receipt of Pension Credit. The logic of achieving savings from AA would be that this would be 'conditional on these resources being redirected into personal care budgets and not retained as savings' (Humphries et al, 2010, p 38).

5.11   There are some advantages to a support model administered through the social security system. In particular, the system operates nationally and provides for a flat-rate benefit (or higher and lower rates); it therefore offers simplicity. It is also an entitlement system where eligibility criteria cannot be changed to ration resources. However, the assessment process is relatively complex and it does not readily enable people to self-assess or have an idea of their entitlement. A further significant difference between the two models of support is that the social security approach is predicated on demonstrating dependency, while the social care model attempts to support independence. This introduces a significant tension in trying to design assessment processes in health, social care and benefits to 'be more consistent and compatible with each other', as recommended by the Dilnot Commission (2011a, p 47).

5.12   In the 1980s, the availability of funding through the social security system to people who qualified for what was then Supplementary Benefit was widely exploited to pay for residential care. The so-called 'perverse incentives' in the system led to an increase in the numbers of people entering residential care, often without adequate assessment of their needs, and to an uncontrolled growth of expenditure. This was the prime focus of the review undertaken by Sir Roy Griffiths in 1988 (Griffiths, 1988) and of the subsequent reforms to community care in the early 1990s (see DH, 1989). There would clearly be fiscal pressures to avoid a return to an open-ended entitlement-based system, but a model that incorporated an assessment of need could be a different proposition.

Cash for care

5.13   Interviewees in the present study were universally critical of the continuing failure to address the interface between social care and social security systems, but acknowledged the larger political issues that were at stake:

'You probably wouldn't design a system that had a separate welfare and a personal care system, particularly if both of them can generate cash amounts.... But the idea of trying to tackle those two issues probably feels like an ambition too far ..., it makes lots of sense, but the politics....' (voluntary sector, chief executive)

'I can see the attraction of AA and DLA to kind of provide a ... level of additional income that stops people needing to go and have a more sophisticated assessment, but of course it goes to everybody regardless of means, and they're not going to change that, not in the short term.' (director of adult social services)

5.14 If there is not to be more wide-ranging reform, there was support for a change of name around AA that would more accurately describe its function, for example:

'I think if you called it "Care and Support Allowance" that would make it clearer what it was for ... and then people would accept that up to a point that was to deal with their needs, and then after that point you went to seek a bit more help. So it's a care and support allowance for lower-level needs.' (director of adult social services)

5.15 This could also mean that the same needs assessment process (or methodology) was used for social care eligibility and for AA:

'But you would have to change the nature of the questions and award points at a lower level. Because at the moment, if you're clever you only start awarding points where people start crossing the eligibility threshold.... So if you wanted to say this same assessment will determine your entitlement to Attendance Allowance, you would have to have a lower end scale in points.... You could do it ..., but I can't see it happening.' (director of adult social services)

5.16 There *could* be a logic in integrating assessment in this way, but the organisational change required to make it operational would be major, not least in mixing what is currently a nationally determined system with locally determined social care eligibility. However, it could also be turned around so that the shift was in the other direction, as this interviewee observed:

'I would prefer a situation where local authority money for a contribution towards care and support needs was national and not local ... the money will have been ringfenced, it will not be allowed to be used by local government for other needs ... a bit like Housing Benefit.' (policy commentator)

'I would prefer it if it moved towards the benefits philosophy anyway ... please don't move the benefits system towards local government; move local government towards the benefits system!' (policy commentator)

5.17 There are multiple views on these issues. Others argue, for example, that there should be greater clarity over the role of benefits rather than a merging of systems and objectives:

*'The problem is that DLA was never supposed to be about **social care**; it was always for the extra costs of disability.'* (service user)

5.18 Certainly, it could be argued that the transactional costs are considerably lower in the benefits system than within the social care system, which, as this interviewee observed:

'… is so caught up in its process and its bureaucracy.' (policy commentator)

5.19 There is a debate, however, about the extent to which a 'cash for care' model administered through the benefits system should have conditionality attached (that is, whether the money has conditions attached to its use or whether it is simply a cash contribution to be used freely). At present, AA, for example, has none – if people are deemed eligible and are awarded the benefit, they are free to use it as they please (in the same way that Child Benefit exists as a universal payment). The lack of checks and balances is a significant factor in the low administrative costs. However, if social care funding was to be transferred to a benefits model, it is likely that there would be a move towards *some* conditionality, which in turn would have an impact on transactional processes and costs, but these need not be heavy:

'We should be giving you money to achieve these outcomes, which is really what the benefits system does – well actually, doesn't do – but it could do ... if you set outcomes, and we're not going to spend our time checking how you've spent it; we're only interested in whether your outcomes are being met.' (policy commentator)

5.20 There are different advantages and disadvantages in national and local systems, and of conditionality and non-conditionality, but the current system has elements of both, which do not relate to each other, are not easily understood or transparent and which do not consistently address issues of outcome:

'You probably would want and need to have a national framework that was more than just, as we've got with FACS, some broad kinds of areas and eligibility levels, with the ability to put it wherever you like; some sense of a broader national deal around those things. You would also probably want to connect that to much greater clarity around outcome.' (research consultant)

5.21 Those who would advocate such a course of action see the value of money that is not entirely unconditional in terms of how a framework can be structured to improve quality and effectiveness. At the same time, however, it is recognised that there are risks in introducing conditionality, particularly around how this is interpreted and implemented on the ground:

'You have to position that very carefully because the danger is that as soon as you start placing strings on it, you inhibit innovation, you take control away from people ... the judgements are national versus local; completely free versus oversubscribed; and my sense is that the point to aim for is that they're not necessarily mutually exclusive.' (research consultant)

5.22 Determination of eligibility both for NHS continuing healthcare and for disability-related social security benefits is based on assessment of dependency. There is little or no recognition of the importance of supporting independence or of achieving user-defined outcomes. This makes it extremely difficult to develop a consistent or compatible model of assessment that could apply across health, care and disability benefits. However, at minimum it should be possible to achieve better joining up between these systems of assessment. In particular:

- Assessment information should routinely be transferred and shared between systems, reducing or removing the need for repeat assessments.

- Consideration should be given to passporting access to disability-related benefits for people who clearly meet the eligibility criteria when they are assessed for health or social care, and removing the need for them to make a further application. This is a matter of good practice in income maximisation for citizens in many councils, but the process could become more streamlined and automated.

- Similarly, people assessed for AA might automatically be assessed for their social care needs or suitability for support from telecare, for example.

5.23 Given that there are two different spending departments effectively spending money on an overlapping group of people, some improved coherence between assessment and eligibility would make sense. The emphasis on personal budgets and direct payments will increase the significance of 'cash for care' approaches and raises issues about the continued separation and lack of coordination between two systems. The Strategic Society Centre has explored some of the potential for improved coherence:

'What are the implications of this "cash convergence"? First, social care policy and AA are interdependent and must be jointly evaluated. AA can no longer be considered distinct or separate from the development of social care policy. By extension, policymaking in relation to both must be formulated jointly and strategically across the DWP and DH.' (Lloyd, 2011, p 5)

5.24 It is highly unlikely that there is political appetite for fully integrating the disability benefits system with that for social care. The Dilnot Commission (2011a) recommended that benefits should continue, but that there should be better alignment with social care. It was also recommended that AA be 'rebranded' given that there is poor understanding of the existence or purpose of the benefit. Lloyd (2011, pp 7–8) has offered '10 ideas' to improve the way in which AA and social care might work better together, as summarised in Box 3.

5.25 One of the biggest lost opportunities with AA is to treat it in isolation from the social care system. Instead of it simply providing a cash sum in recognition of additional costs of disability, receipt of AA *could* provide a mechanism for identifying people with relatively low-level needs (or potentially un-assessed higher needs) and targeting appropriate support and prevention.

5.26 Lloyd (2011, p 41) concludes that 'ultimately, the picture is one of opportunity', and the principles of both universal and means-tested systems 'can be embodied in a new vision for how the state and society supports older people with care and support needs'. The various options for closer integration or alignment bring different combinations of advantages and disadvantages; any decision would involve a political judgement about the desired direction of travel, but clearly there *are* steps that can be taken that would improve coherence between social care and social security payments, *and* which would improve the overall contribution of both systems to improving independence, choice and control outcomes.

Box 3: Ten ideas to improve coherence of AA and the social care system

- **Signposting:** improved signposting across both systems so that people making contact with either are provided with information about the other system.

- **Data sharing:** full data sharing between the systems so that both can identify people in need of help from either or both systems.

- **Joint assessments:** local authorities incorporate AA assessments into community care assessments in order to passport claims.

- **AA as a social care gateway:** AA claims become the entry point to social care.

- **Soft conditionality:** AA claimants could be contacted by an adviser to tell them what other help could be available.

- **Hard conditionality:** claimants must demonstrate that the money has been spent effectively – so AA effectively becomes a direct payment with some conditions but without means-testing.

- **Opt-out personal budgets:** AA is distributed via personal budgets and direct payments, with individuals choosing to opt out of a local authority-managed personal budget.

- **Single brand:** both AA and social care are rebranded with a single brand covering both, but retaining two separate systems and providing 'a single shop-front but two shopkeepers'.

- **Joint national entitlement framework:** social care adopts a national eligibility framework built around AA as a universal, low-level payment for all individuals with qualifying care and support needs. People can request means-tested community care assessment to access higher levels of support.

- **Resource distribution:** social care interventions and resources are distributed via the AA system.

Source: Lloyd (2011)

6. The implications of the capped contribution

6.1 The central recommendation of the Dilnot Commission (2011a) was to protect people 'from extreme care costs' by introducing a limited liability and capping the lifetime contribution that any person would make at a suggested £35,000, and raising the asset threshold for means-testing of people in residential care from £23,250 to £100,000. Whether or not the capped contribution would stimulate the supply and demand of new financial products, and whether it offers a realistic model, is an important debate, but it is not within the remit of this scoping report. In this final chapter of the report, however, we explore some of the implications for eligibility and assessment processes that would need to be addressed if the capped contribution model was accepted by government.

Assessing need and notional spend

6.2 The capped cost model would work on the basis of notional spend for people prior to reaching the total contribution. The Dilnot Commission (2011a, p 22) describes the process in these terms:

- 'Everyone with a care and support need can ask to be assessed by their local authority.

- If they are assessed as having some care needs above a defined, nationally set threshold, the local authority will work out how much it would cost to meet these needs. This would be based on the cost of a typical local authority package for that level of care, in that local area.'

- Means-tested support would be given. For those not entitled to this support, 'the local authority would use this assessed care package to determine at what point in time the individual would meet the cap. After this point, the individual would be eligible for free care from the state.'

6.3 There would be a number of practical challenges in implementing this model, including the following:

- variability of local authority sophistication in unit costing

- capacity of councils to manage assessment of need for notional packages

- uncertainty over what would count as legitimate spend in terms of the capped contribution

- how the role and support provided by informal carers would be addressed

- how to guard against incentives for people to manipulate or 'game' the system.

6.4 With the move towards personal budgets and the increasing use of both direct payments and managed budgets, councils have had to become more skilled in costing services, but it is still the case that this is work in progress. This interviewee, with considerable experience of local authorities, commented:

'Lots of people still don't understand their costs. If you went to the average local authority and said "tell me the average costs for each person you're supporting", they wouldn't know most of the time. They couldn't break it down for you.' (policy commentator)

'Councils haven't worked out – because it's complicated – how to understand the way they're subsidising things when part of their contracts are in-house.' (policy commentator)

6.5 Another interviewee similarly cautioned against assuming that Resource Allocation Systems are sufficiently well developed (or consistent) to provide a platform for assessing capped cost contributions:

'We know that Resource Allocation Systems vary among different local councils ... some are doing it; some aren't ... councils are still experimenting with the best way to do this.' (policy analyst)

6.6 There would be additional costs and complexity involved in assessing self-funders so that their care costs were counted towards the capped contribution, and it is not clear how this would work in practice, as this interviewee wondered:

'So how would you do it? If you had self-funders coming in for assessment because they wanted to trigger the cap ... then you would assess them the same as anyone else. You would get to the point of calculating their indicative budget ... you would have to think about whether you do or don't want to reflect the input of carers.' (director of adult social services)

And as another remarked:

'I don't think it's worked through enough. The cap thing – there are all sorts of problems and it obviously doesn't deliver the cap as suggested but, anyway – even if it did – you've got this huge problem about where does the clock start?' (policy commentator)

6.7 If people who are self-funding have made arrangements to buy care and support, they will have many questions about when the tariff would be calculated, for example: Would it be retrospective? Who is recording what is spent? How do you notify them of changes? What counts as spend towards the cap? There are concerns, for example, about people spending on care and support but 'without the meter ticking' because their needs are deemed to be below the eligibility threshold. As another interviewee commented, the lack of clarity over what might be included is unhelpful:

'I'm absolutely certain that it doesn't mean you can pay privately, get £35 grand's worth of treatment, wave your receipts at the local authority and then pass all your bills to them! It definitely doesn't mean that. Does it mean cutting the lawn and trimming the hedges? I would doubt that. Does it include aids and adaptations? I mean, I really hope it does because I think that might actually be quite useful. Or might it stretch to, you know, installing a downstairs loo?' (financial services sector)

6.8 While it might be argued that such things could make a significant difference to people's lives and their capacity to remain independent, they would also absorb £35,000 very quickly. If the notional budget actually applies – as this interviewee speculated – only to 'personal care, personally delivered by a care and support worker of some sort', there are further questions about how flexible this will be in enabling people to live their lives and maintain their independence. Indeed, at the very time that the core emphasis of personalisation in social care is gaining ground, and it is being recognised that there should be less attention to means and more to ends and outcomes, it might be seen as a retrograde step for self-funders to be unreasonably constrained in what constitutes spending towards the capped cost.

6.9 The liability of £35,000 is calculated on the basis of residential care costing £550 per week. Clearly, this cost is an average but finding care at this price can be very difficult or impossible in many parts of the country. People may still end up paying substantially more than £35,000 because they are unable to find adequate care (or care that they are satisfied with) at the average cost on which the cap has been calculated.

6.10 In addition to level of need or disability and duration of care, there is also the question of how expenditure that counts towards the cap would be calculated, as this interviewee remarked:

'The £35,000 liability is determined through local authority needs assessments, which obviously means that the amount you [could] receive would vary by location and it's determined by – in a domiciliary setting – by an assessment of informal care availability.' (policy analyst)

6.11   If it is assumed that the financial services sector would play a greater role within a limited liability system, there would also need to be some process to deliver consistency between council assessment and insurance assessment. While the insurance sector would be likely to develop a model around activities of daily living, the thrust of council assessment, as we have discussed earlier, is wider, more collaborative and increasingly based around self-assessment and co-production. As this interviewee concluded, 'this is where it gets very fuzzy' and achieving the fit between two very different systems and approaches would not be straightforward:

'An insurance product would only pay out at a certain threshold of ADLs [activities of daily living] say, whereas, as we know, local authorities, in looking at how best do I get resources, would look at, they would do an assessment of disability clearly, but they would also look at how somebody was coping with the availability of informal care and wider networks and the totality of people's lives.' (policy analyst)

6.12   Assessment for a notional budget would – presumably – be undertaken within the context of other changes proposed by the Dilnot Commission, particularly around a national eligibility threshold. If this were set at 'substantial' and self-funders were assessed against this level, judged to have eligible needs and allocated a notional sum that the council *would* allocate to their care if they satisfied means-testing criteria, should it then be assumed that they do not need to account for how that money is spent but that it would be automatically deducted from their capped contribution? As with people meeting eligibility criteria *and* satisfying means-testing requirements, there would also need to be periodic reassessment. The potential for all of this to generate additional process demands and associated costs is apparent. When many councils are trying to develop support and options for people that can be accessed *without* assessment, and to enable people to undertake self-assessment, the capped cost model could introduce pressures to considerably increase the amount of assessment and reassessment being undertaken, and the costs of this additional process would inevitably impact on local councils' resources available to provide actual support to people meeting both need and financial eligibility.

6.13   A benefit of more people being assessed for their care and support needs could be that people who are self-funding would be better known by councils than is currently the case. The situation of people paying for their own care has attracted increasing attention and there is evidence that many receive little or no help in navigating the system and meeting their needs (Putting People First Consortium, 2011b). At the same time, policy and guidance to local authorities continues to underline their responsibilities to provide information and advice to all citizens, including people paying for their own care. There would be better opportunities to provide such support and to help people in finding their own solutions if they had contact with council assessment services.

6.14   The Dilnot Commission (2011a, p 73) acknowledged that there could be some new burdens created for local authorities and commented:

'We know that more people will need to be assessed. We estimate that our proposals will result in increased spending of around £0.2 billion on assessment and care management costs.'

6.15   It is not clear how this sum has been calculated, but the numbers of people who are currently self-funding is substantial. It has been estimated, for example, that around 45 per cent of registered care home places in England are self-funded (around 170,000 places) – worth an annual estimated £4.9 billion, with almost as many people again topping up local authority-funded places. Similar numbers (168,701) of older people are estimated to be paying for care to help them at home, worth an estimated £652 million (Putting People First Consortium, 2011b, p 4). Clearly, the implications of assessing and reassessing needs, allocating a notional budget and monitoring how this is 'spent' against a capped contribution would be a significant undertaking.

6.16   Even if a national eligibility threshold is to be established, it would still be a matter for local authorities to make decisions about how they respond to people with a given level of need. It is likely that people paying their capped contribution would learn how to get the best out of the system, or effectively to 'game' it in order to maximise the notional allocation, particularly in respect of informal care.

6.17   Furthermore, even with a threshold set at 'substantial' in all councils, there would remain an issue of subjectivity – the fact that as interviewees commented, 'substantial needs mean different things in different places' and 'local authorities use that flexibility as a way of managing their budgets'. We have previously highlighted the role that social workers can play in how they interpret and apply eligibility criteria in individual cases, and the same situation would arise in respect of assessment of need and virtual budgets under the capped contribution. Some social workers would be more generous in how they assessed people's needs, and would advise people on how they could maximise their needs in order to enable them to reach the £35,000 notional threshold more quickly.

7. Conclusions

7.1 In this scoping report we have drawn on a range of research literature, and on qualitative interviews specifically undertaken for this work, in order to consider the implications of the recommendations by the Dilnot Commission and the Law Commission on assessment and eligibility for publicly funded adult social care. It is apparent that, despite considerable consensus around the nature of the problems with the current system of eligibility for adult social care, reform is far from straightforward and there are significant challenges with implementation.

7.2 The quest for better assessment, and the development of shared tools and approaches, have been the focus of much endeavour over the past decade or so. There remain major inconsistencies, however, and problems of ensuring that assessment joins up with related services that typically use different methodologies. The increasing emphasis on the role of self-assessment and co-production within the policy objectives of personalisation also raises questions about the quest for a new tool, and whether this is the best way to proceed.

7.3 It will be important to avoid introducing new systems and processes that increase the burden of bureaucracy and unnecessary paperwork. The recent history of approaches to support planning for personal budgets provides cautionary experience of the dangers of processes becoming overly complex, inappropriately 'professionalised' and time consuming.

7.4 The subjective component of assessment also means that practice will vary between individuals. Some social workers, for example, will always try to do the best for their clients and may interpret this by overstating needs in order to maximise support or resources. The separation of assessment and resource allocation decisions and gatekeeping roles may be seen increasingly as the best way forward.

7.5 The social care system is not the only source of support for adults with social care needs, and a parallel source of 'cash for care' is provided through parts of the social security system. Despite this interface being acknowledged by the Dilnot Commission, it is regrettable that more radical reform was not proposed that would have enabled these separate systems to be addressed comprehensively and consistently.

7.6 At the very least, however, there is scope for improving the way in which the two systems interact and to establish greater coherence between the two systems in the way they operate and in the outcomes they are seeking to achieve for individuals.

7.7 The postcode lottery of eligibility thresholds has been the focus of much criticism and concern in recent years. Despite the existence of a national eligibility framework (in the form of FACS), it continues to be the case that local councils can decide where to set the threshold (although the majority of councils have moved to 'substantial' need as the entry criterion). Establishing a national eligibility threshold would – on face value – be a popular and well-supported step.

However, because the way in which need is assessed will always have a subjective component, in practice there will continue to be some variation in interpretation. There are risks that setting a national eligibility threshold will be seen as offering a panacea to issues on which it will actually have a limited impact.

7.8 Furthermore, while different councils currently operate under different eligibility thresholds, the difference this makes *in practice* may be less significant than is often assumed. A council, for example, that sets its threshold at 'substantial' may nonetheless be enabling open access (that is, without an assessment) to other services and support that in another council would be provided – following assessment – under the eligibility threshold of low or moderate need.

7.9 There has been increasing recognition of the importance of councils providing support and access to some services on a universal/whole community basis (including information and advice) alongside targeted support to people eligible for particular support. This approach seeks to soften the 'cliff edge' between eligible and ineligible populations, as well as to make best use of resources in addressing prevention and maximising independence, and in developing wider community-based solutions that address the resources of 'whole place'. Rather than focusing solely on defining who is eligible for publicly funded support, and effectively rationing access to services, a place-shaping, community-based model adopts a whole system approach to resources and community assets, which potentially creates a very different context within which to locate eligibility. It will be essential that this dual focus is maintained within any reformed system of eligibility, and there are some risks of losing sight of the wider strategic approach if there is too much focus on the point of eligibility for social care and higher-end needs alone.

7.10 There are some considerable tensions between the pursuit of national consistency, portability of entitlement and localism. How these will be resolved in practice is unclear. So long as social care is the responsibility of local councils there will need to be local aspects of eligibility and local interpretation of entitlement. This reflects the reality of councils needing to manage their budgets, and the variability in costs of services between locations.

7.11 Other approaches to establishing national eligibility are evident within the health service, and the experience with continuing healthcare provides an interesting parallel. Certainly, the move from local to national eligibility *has* reduced – but not eliminated – variation, but the assessment process is complex and can be cumbersome, and does not ensure either objectivity or fairness. If such a model of national eligibility and a national assessment tool were to be introduced in social care, there would also be major training implications in making a transition of this nature.

7.12   The recommendations of the Dilnot Commission on eligibility and assessment are, on first sight at least, attractive, and strike a chord with many. However, it is apparent that translating these proposals into practice would be far from straightforward, *and would not in themselves fully resolve major issues of consistency and objectivity.* These are not purely technical problems where the solution lies in finding the 'right' threshold, and using consistent methodologies. The findings from this study cast considerable doubt on such conclusions and point instead to the multiple variables that influence practice, and the risks that focusing on process matters can confuse ends and means and fail to address individual needs and outcomes.

7.13   The main recommendation of the Dilnot Commission concerns the proposals to protect people from catastrophic costs of care, and to do this by establishing limited liability around a capped cost contribution. We have included some discussion of this issue within the current analysis because it also has implications for assessment issues.

7.14   There has been relatively little critical analysis of the limited liability model; this requires further expert scrutiny. However, a related set of issues arises around the process by which people's spending on care and support might be monitored and the £35,000 cap triggered. It would be necessary for people's needs to be assessed and for notional costs for meeting those needs to be assigned. This raises multiple questions about the assessment and reassessment process that will be required; how spend will be monitored; and how it will guard against 'gaming'. It is probable that many people would continue to spend on care and support without triggering the calculation of their contribution (because their needs are not judged to meet the threshold), or they may spend considerably more than £35,000 in meeting their needs because they are unable to find services at the price that is assumed in the notional budget. If this were to happen on a significant scale, there could be a credibility problem with the offer of a capped cost guarantee.

7.15   It is apparent that the Dilnot Commission and Law Commission recommendations for the reform of adult social care – although widely welcomed in principle and presenting the only real option currently on offer – raise many complex issues about practical implementation that need to be explored more fully. It is also clear that changing the nature of eligibility, the assessment of need or the respective liability between individuals and the state, could have unintended consequences. In the period leading up to the publication of a White Paper on the reform of adult social care, it is vital that these issues are examined and are the focus of public debate if successful transformation is to be achieved.

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Crossing the threshold: The implications of the Dilnot Commission and Law Commission reports for eligibility and assessment in care and support

This scoping report explores the implications of implementing key Dilnot and Law Commission proposals in respect of assessment and eligibility for publicly funded adult social care. It concludes that this will require a number of complex practical and implementation issues to be addressed. As with other recent programmes of transformation – such as personalisation – history and practice elsewhere suggest that these issues need considerable policy and practice attention if they are to be successful.