Submission to CSCI review of eligibility criteria
Joint ADASS and LGA Response

Background

The Association of Directors of Adult Social Services (ADASS) represents Directors of Adult Social Services in Local Authorities in England. As well as having statutory responsibilities for the commissioning and provision of social care, ADASS members often also share a number of responsibilities for the commissioning and provision of housing, leisure, library, culture, arts and community services within their Councils.

ADASS members are jointly responsible through the activities of their departments for the well-being, protection and care of thousands of vulnerable people and for the promotion of that well-being and protection through the use of direct services as well as the co-ordination of and liaison with the NHS, voluntary agencies, private companies and other public authorities. ADASS members have leadership responsibilities in Local Authorities to promote local access to services and to drive partnership working to deliver better outcomes for local populations. They participate in the planning of the full range of council services and influence Health Service planning through formal and informal Local Strategic Partnership arrangements.

The Local Government Association (LGA) promotes better local government. It works with and for member authorities to realize a shared vision of local government that enables local people to shape a distinctive and better future for their locality and its communities. The LGA aims to put councils at the heart of the drive to improve public services and to work with government to ensure that the policy, legislative and financial context in which they operate, supports that objective.

1. Is the current FACS system appropriate in principle? What principles should underpin eligibility for publicly funded care?

Questions of principle are always difficult. As a nation we have established a principle that everyone is eligible for publicly funded healthcare but a different line has been taken on social care – or support deemed not to be healthcare.

The established principles have affected the way in which different services have been funded which means that, unless there are some very fundamental changes, the eligibility for publicly funded social care cannot be universal and so who can access it must be defined in some way.

- The first and most obvious principle is that should underpin decisions about eligibility is fairness – though this in itself is clearly open to interpretation, particularly when it comes to whether it is fair to apply a means test as well as some sort of measure of need.

- The second principle must be that those who need help most can access it – again there is an issue here of whether help in terms of publicly funded care is needed most because of level of needs or because of financial circumstances.

The other question here is to what the criteria should be applied to – what is it we need to manage access to? Clearly there are some services that everyone should be able to access to e.g. information and advice; some that we might want particular people access to e.g. falls prevention services; and some services that might contribute to preventing social exclusion e.g. lunch clubs – access to which should not be constrained by formal eligibility criteria.

The current FACS system as written is a reasonable attempt to find a fair way to determine who should be able to access care within finite resources. It was intended to provide a consistent national, legal framework to tackle the unfairness of having widely varying criteria between areas and between care groups. Removal of the framework would result in a return to this ‘post code lottery’ - there is a need for some means of determining who should receive support.

Inevitably there is subjectivity involved in applying criteria and this has led to differences in application between local authority areas and even between different staff in the same area.

We need to be clear about what FACS is trying to achieve. The system attempts to ensure we give more to those who need it most (in terms of level of need) - but in terms of accessing publicly funded services a double test applies as we then means test for eligibility for funding. However, this is not how we present it: we

talk about contributing to the cost of care but essentially we are testing people's eligibility for funding.

The system does not help us deal with the needs of people below the eligibility threshold. Yet this is preventative services territory and a key part of *Putting People Firs*t. Many authorities, some with NHS partners, are investing in preventive services and people who do not reach a threshold are getting the support they need in some places.

2. Does the FACS system work in practice? If not, why not?

The FACS system works in that it enables authorities to select those with the greatest needs and focus support on them.

At present what FACS does is pick out those people with needs above a certain threshold. In the majority of authorities the threshold is "substantial". In these authorities the criteria are really being used to pick out those people whose needs are such that they need a more personalised care or support plan, rather than just access to lower level services available more widely in the community.

This works as long as the lower level, less targeted, more universal services are available through direct access. This needs sufficient investment in these local services and good information and signposting so people can find them. Clearly this is not always the case at present but where it is we have a version of "progressive universalism" i.e. something for everyone but more for those who need it most. (However, there may be problems with consistency as this will be very much down to local prioritisation.)

In areas where the threshold is lower, it is like that more people will have a formal assessment of their needs but the services offered are quite likely to be from the same kind of "menu" as those available to those not meeting eligibility criteria elsewhere.

However, there are some current problems with the application of the current system:

- It does not encourage investment in preventive services, though some authorities invest in these in an attempt to reduce demands for higher level services in the longer term. This does not necessarily sit easily with wellbeing and the Government's stated ambition to focus on early intervention and prevention.

- Interpretation of guidance in different ways and inappropriate use of criteria to prescribe only certain services for particular levels of need, as well as to manage budgets, has meant that we criteria are not currently consistently

applied in the way intended and set out in the FACS guidance. Some authorities would argue that the inadequacy of funding levels makes this inevitable as authorities struggle to meet their statutory responsibilities in the face of rising demand and levels of need.

- Use of the current FACS criteria in relation to carers is inconsistent and requirements to support carers are not universally well understood.

- FACS currently acts adversely on people with fluctuating conditions – an interim way round this may be to ensure that a persons needs are looked at over a given period of time rather than at a point in time.

As we move to a system of self-directed support and individual budgets, what eligibility criteria will do is essentially determine eligibility for an individual budget i.e. some additional personal investment from public funds (though we will continue to apply a means test in addition so needs alone are not enough). The needs assessment questionnaire and the scorings and funding associated with this will determine eligibility for funding (subject to means test). In order to manage within current budgets, authorities will need to ensure that people only begin to attract needs points (and funding) when they cross the existing FACS eligibility threshold.

There could be an alternative which offered some funding to people with lower levels of need. Money to fund this would need to be freed up from current agreements and contracts for lower level and preventative services, with an expectation that the organisations providing such services now would only receive funding to the extent that people chose to spend their individual budgets on services. The problem with this approach is that it could lead to the dismantling of voluntary sector and preventative services infrastructure, meaning that if and when people did want to access services, they could be no longer there.

3. What changes would you put in place?

In the short term the question has to be – how likely is it that anything different we put in place would be better than what we have at present and is it worth making a change prior to any Green Paper recommendations? However, it would be worth revisiting the FACS guidance and ensuring that the principles that are encapsulated in this are re-emphasised, for example, offering clarification about the use of FACS in assessing the needs of carers.

It would also be helpful to consider how eligibility fits with the development of resource allocation systems. One model could be that the RAS determines eligibility for an individual budget. However, the difficulty in producing something new purely based on this is that in the short term, local authorities are at different

stages of development and some may be developing models which deliver different outcomes than the application of FACS.

Given the publication of *Putting People First* it would also be helpful to clarify, alongside eligibility criteria, what everyone should be able to access regardless of whether they cross an eligibility threshold e.g. information and advice.

In the longer term, if the Green Paper does deliver a fundamentally different model for funding social care and associated services, then there will be a need to see whether an eligibility framework is needed and the nature of the model will influence how that any eligibility framework needs to be shaped.

What we know of the likely Green Paper outcome is that it will a) be predicated around putting people first and personalisation, and b) that it will propose a version of progressive universalism: i.e. something for everybody and more for those who need it most. The issue of course will be what is the universal offering. In this context we may be looking to eligibility criteria review to define what everyone will get, at the minimum (i.e. advice, support, safeguarding access to some universal services, mainly those which currently exist but are not subject to formal access criteria). The question then is, how is access to support for more complex needs arranged? Given that people will have the advice and support, will this be simply on the basis of finance? It will need to be linked to the RAS for Individual Budgets but will the RAS come before or after the financial assessment? Will the RAS (which could well be mostly done on a self-assessment basis) be part of the universal entitlement? These issues of process are fundamental.

Whatever the decisions about a future system, principles of fairness, certainty of meeting high need, safeguarding, promoting of enabling and prevention and personalisation would all need to be accommodated in any new model.

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May 2008