

Making a difference to people's lives: policy principles and the role of health and social care regulation

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Abstract

Society is experiencing significant demographic changes and this, coupled with the consequences of the 2008-2010 economic recession, has put enormous pressures on health and social care services. The first two parts of the paper are background and contextual and provide an overview of these changes and pressures, and the priorities of the new coalition government. The regulatory framework for health and social care is also discussed. The substantive part of the paper examines the following key policy issues and challenges: putting people at the centre of their care; joining-up care; promoting independent living; providing safe and effective care; safeguarding people in vulnerable circumstances; reducing inequalities; and securing fair access to care. The paper reviews evidence, largely drawn from regulatory work, which demonstrates that more needs to be done to improve outcomes for people using services. In conclusion, services need to be commissioned and provided in ways that maximise their value for money and put people first.

Keywords: Social care, health care, regulation, policy

Introduction

Health and social care is all about people. Health and social care can enrich people's lives and excellent care is about providing what matters most to people, as much as it is about providing a service. All needs are individual, distinctive and personal. There is not a 'one size fits all'.

Health and social care services touch everyone's lives at some point – a health check by a nurse, a visit to a hospital, a family member who needs domiciliary care or someone moving into a care home. The quality of services has a profound impact on people using services, as well as those around them.

There are a number of pressing social, demographic and economic challenges facing the health and social care systems in England. How government and policy makers respond to these challenges shapes people's experiences and their outcomes.

Regulation has a key role to play in ensuring better care and services that put people first. The focus of this paper reflects these issues.

First – by way of background and context, the paper begins by outlining some of the key issues facing health and social care, including growing demands and expectations for services; managing the consequences of the economic downturn; and responding to the priorities of the new coalition government.

Second – the paper goes on to describe the regulatory backdrop of health and social care in England. This section of the paper briefly outlines the remit, role and vision of the Care Quality Commission (CQC) in England.

Third – from putting people at the centre of decisions about their own care to the effective management of resources – the substantive section of the paper provides an overview of key issues and challenges

shaping high quality care. It draws on recent evidence, including reviews and studies by CQC, to highlight some of the challenges facing health and social care services. These case examples are by no means an attempt at systematic representation, nor are they mutually exclusive, but they do afford the opportunity for policy analysis across the broad spectrum of health and social care provision.

The paper strives to maintain a people oriented focus. It seeks to identify where people's experiences of services and outcomes can be improved. To these ends, and drawing on work from CQC, we highlight people's views and experiences of services where appropriate. These views and experiences have been obtained via CQC's ongoing programme of user, public and stakeholder involvement (CQC, 2009a). CQC's methods of involvement are not set up as research interviews or subject to the rigours of research and detailed analyses as might be found in academic work. Notwithstanding, the views captured from these involvement activities help to illustrate the issues discussed from the perspective of people who use services, providers and commissioners.

For the purposes of this paper we use the term 'people who use services' in its broadest sense. This therefore includes carers, families, friends and the public as well as patients in health services and people who use social care services.

Background and context

There are two key issues that have been shaping health and social care in recent years. First, managing growing demand for services, especially in the light of rising expectations for services to be personalised. Second, and more recently, managing the effects of the economic downturn and reducing the deficit. By way of policy context, it is also important to recognise the emerging ideology and priorities of the

conservative-liberal coalition which came to power in May 2010.

Demographic pressures: growing demands and rising expectations

Society is experiencing significant demographic changes, largely arising from an ageing population, increasing life expectancy of many disabled people and a growing number of people with long-term conditions. Over 15 million people in England currently live with conditions such as diabetes, chronic lung disease, heart disease, cancer and dementia. A significant proportion of these are older people (Department of Health, 2009a).

Demands on services are growing. By 2026, we expect to see 1.7 million more adults who need social care and support. In the next 20 years, the number of people over 65 will increase by just under half, those over 85 in England will double, and the number over 100 will quadruple. These positive trends in people living longer also mean that they have greater needs and will reflect a growing number of people with chronic and complex needs. Alongside this people will, rightly, expect more choice and control over services (HM Government, 2010a).

These trends will lever greater pressures on the use and uptake of services and will ultimately put pressures on the public purse. Recent estimates put the cost of dementia, for example, at £27,647 per year per person living with the condition. These figures are set to increase as the numbers with dementia rise and are expected to double in the next 30 years (Alzheimer's Research Trust, 2010). Overall, the King's Fund (2009) estimates that the demographic pressures facing the UK require additional NHS spending of between £1 billion and £1.4 billion each year.

Consequences of the economic downturn

The NHS has experienced considerable growth in recent times. Growth in funding has averaged nearly 7% in England up to 2010/11 (King's Fund, 2009). Following the recession, however, significant budget reductions are set. During the previous administration the Chief Executive of the NHS for England, David Nicholson, gave early warning and advised the sector to plan efficiency savings of between £15 billion and £20 billion over 3 years (Office of the NHS Chief Executive for England, 2009). It soon became apparent that a much more significant amount of savings across services would be required. The then Government's operating framework confirmed the need for savings, adding that the health budget would contribute some £2.3 billion to Government's announced £5 billion efficiency savings required for 2010/11 (Department of Health, 2009b).

During 2009, the leadership across health and social care published a number of reports outlining the key pressures across the sector (Department of Health 2009c; NHS Confederation, 2009; Royal College of Psychiatrists *et al.*, 2009). The recession was described by one group as "the greatest ever leadership challenge for the NHS" (NHS Confederation, 2009).

Money aside, it is important not to forget the social consequences of the economic downturn and the effect stringent economic times can have on people:

- Work for the Cabinet Office highlights how certain social groups, including people with lower levels of education, those on lower incomes, young people and people living in deprived areas, tend to be the worst affected (Barnes *et al.*, 2009). People's feelings of insecurity are greater in recession, older people and those close to retirement are more likely to lose their jobs and the effects of job loss on

longer-term depression were found to be statistically significant.

- Carers UK (2009) highlighted the struggle that many of the UK's 3 million carers face, combining paid employment with their caring responsibilities. Eighty six per cent of carers report to Carers UK that their financial position is worse than 12 months ago.
- The downturn in the housing market has made it difficult to buy or sell property. For people who fund their own social care and are not eligible for public funding, the downturn in the housing market is making it difficult to sell property which would normally be used to meet care costs. Councils are required to offer deferred payment schemes, essentially interest-free loans, which are recoverable on the sale of the property. However, concerns have been raised that councils are restricting access to these schemes owing to increasing demands (Samuel, 2009).

Priorities for the coalition

Following the 2010 general election and the formation of the Conservative-Liberal coalition, a new programme for government was announced (HM Government, 2010b). Government's aim is to seek to distribute power to "build the free, fair and responsible society we want to see" (HM Government, 2010b). Building on these values a new programme of work is underway to reform health and social care, all brought together in the White Paper, *Equity and Excellence* (Department of Health, 2010b). The reforms set out huge changes for health, as well as its partner agencies including social care.

In health:

- Considerable power will be devolved to general practitioners (GPs) to enable them to commission care on

behalf of their local community. Particular emphasis is placed on meeting the needs of disadvantaged groups.

- People can be registered with a GP of their choice, without restriction of where they live.
- Similarly, people will be able to choose any healthcare provider that meets NHS standards, within NHS prices, including independent and voluntary run nursing providers.
- Community care is a cheaper and more cost effective means of managing the care needs of older people. People will be encouraged to live at home for longer and the use of solutions such as home adaptations and domiciliary care will be encouraged.

Across social care and welfare:

- Reform of the social care system is urgently required. The current system is unsustainable in the face of changing demographics and growing demand. It is over a decade since the Royal Commission on Long Term Care (1999) reviewed this issue and reported to government.
- An independent Commission on Long Term Care will be established “tasked with delivering a sustainable settlement, which is a fair partnership between the state and the individual”.
- Personal budgets provide an allocation of funding sufficient to meet people’s assessed social care needs. Individuals can choose to take their personal budget as a direct payment or, whilst directing their own support, leave councils to commission services. Alternatively, people may choose a combination of approaches. Government’s commitment is to “extend the greater roll-out of personal budgets to give people and their carers more control and purchasing power”

- Dignity and respect will be embedded into the provision of services, including support for older people, people with long-term conditions and people with social care needs (HM Government, 2010b).

These reforms and commitments are surrounded heavily by caveats that deficit reductions take absolute precedence. This was made clear in the revisions to the operating framework for the NHS which called for a “relentless focus on achieving the £15 billion efficiency savings” (Department of Health, 2010a). The 2010 ‘emergency’ budget announced further reductions in public spending – an additional £17 billion to what had previously been projected by 2014-15.

Health spending is, however, ring fenced. Government has committed to increase spending on health in real terms each year (Department of Health, 2010b). However, such measures require cuts in other areas of welfare and tax rises (King’s Fund, 2009), measures we saw implemented in the June budget and comprehensive spending review.

Modern regulation

CQC was established to bring together the regulation of health (including mental health) and social care. Following the Health and Social Care Act 2008, CQC came into operation on 1 April 2009, combining the functions of the Healthcare Commission, Commission for Social Care Inspection (CSCI) and the Mental Health Act Commission. The remit of CQC is to inspect all health and adult social care services. This includes services provided by the NHS, local councils, private companies and voluntary organisations. The interests of people whose rights are restricted (via detention) under the Mental Health Act are also monitored.

CQC has a number of powers and duties, including:

- Registering providers of health care and social care to ensure they meet the essential standards.
- Monitoring how providers comply with standards.
- Using enforcement powers, such as fines and public warnings if services drop below the essential standards. Where necessary, taking more stringent enforcement actions.
- Acting to protect the rights of people who are restricted under the Mental Health Act.
- Promoting improvement in services by conducting regular reviews of how well those who arrange and provide services are performing.
- Carrying out special reviews and studies of particular types of services and pathways of care, and undertaking investigations on areas where we have concerns about quality.
- Supporting public accountability by assessing performance of how well people are being served by their local public services.
- Seeking the views of people who use services and involving them in our work.
- Telling people about the quality of their local care service.

The government programme recently strengthened CQC's role as a quality inspectorate (HM Government, 2010b). The White Paper also confirmed CQC's continued role as the quality regulator for health and adult social care. Under the proposals, the current risk-based regulatory regime will remain largely unchanged. However, the White Paper does set out a number of important changes for CQC:

- HealthWatch England will be established as a new independent consumer champion within CQC;
- Providers will have a joint license overseen by both Monitor and CQC;

- The NHS Board will take over assessment of commissioning (Department of Health, 2010b).

CQC does not regulate most social care services for children as these are regulated by the Office for Standards in Education, Children's Services and Skills (www.ofsted.gov.uk). CQC's remit is for England only. The following are regulators for health and social care in Wales, Scotland and Northern Ireland:

- The Healthcare Inspectorate Wales (www.hiw.org.uk) and Commission for Social Services Inspection in Wales (www.csiw.wales.gov.uk);
- NHS Quality Improvement Scotland (www.nhshealthquality.org) and Care Commission (www.carecommission.com); and
- In Northern Ireland, the Regulation and Quality Improvement Authority (www.rqia.org.uk).

Regulation remains under the jurisdiction of separate health and social care agencies in Wales and Scotland. In Northern Ireland an integrated approach is adopted, which mirrors the integrated approach to health and social care provision (Heenan & Birrell, 2006).

Regulatory principles and vision

Regulation and inspection costs, both in time and money for the organisations involved and to the public purse. Over 3 million inspections occur each year in the UK across public, private and voluntary organisations. The challenge is for the regulator to prove their worth and deliver better outcomes for people. In 2004, a review of regulation was initiated and the subsequent Hampton (2005) report set out an ambitious programme to reduce the burdens created by regulatory systems and a number of key principles for regulators to follow:

- Regulators, and the regulatory system as a whole, should use comprehensive risk assessment to concentrate resources on the areas that need them most;
- Regulators should be accountable for the efficiency and effectiveness of their activities, while remaining independent in the decisions they take;
- All regulations should be written so that they are easily understood, easily implemented, and easily enforced, and all interested parties should be consulted when they are being drafted;
- No inspection should take place without a reason;
- Businesses should not have to give unnecessary information, nor give the same piece of information twice;
- The few businesses that persistently break regulations should be identified quickly, and face proportionate and meaningful sanctions;
- Regulators should provide authoritative, accessible advice easily and cheaply;
- When new policies are being developed, explicit consideration should be given to how they can be enforced using existing systems and data to minimise the administrative burden imposed;
- Regulators should be of the right size and scope, and no new regulator should be created where an existing one can do the work;
- Regulators should recognise that a key element of their activity will be to allow, or even encourage, economic progress and only to intervene when there is a clear case for protection (Hampton, 2005).

CQC's principles and vision are grounded in these Hampton (2005) principles of better regulation and recommendations set out in associated reports (National Audit Office, 2008). CQC's (2010a) 5 year corporate

priorities aim to drive improvement in the quality of care experienced by people by:

- Making sure care is centred on people's needs and protects their rights;
- Championing joined-up care;
- Helping to eliminate poor quality care;
- Promoting high quality care; and
- Regulating effectively and in partnership.

More information on how these priorities are being delivered is set out in CQC's annual reports and accounts (CQC, 2010b).

Politics, policy and practice: key issues and challenges

I had to ask too many different people for advice. It was too disjointed. (carer for husband with long term condition, CQC consultation event)

Recovering from his coma in hospital, 'Paul' asked for physiotherapy, which he felt he needed after 60 days in bed, but was told: "This is a neurological ward. We don't do physiotherapy on this ward". (person using services, CQC consultation)

How do you exercise your rights when you are being faced by a group of professionals who are talking over your head and about you at the same time? (person using services, CQC consultation)

People who use services, and their carers, raise a number of common concerns about the provision of health and social care services. These issues and concerns have influenced and shaped this section of the paper. They include:

- Putting people at the centre of their care;
- Joining-up care;
- Promoting independent living;

- Providing safe and effective care;
- Safeguarding people in vulnerable circumstances;
- Reducing inequalities; and
- Securing fair access to care.

It is important to recognise that these topics are not mutually exclusive, nor the sole preserve of people who use services, but are also issues shared by providers and commissioners of care:

Trust is an issue, for example, not accepting assessments from each other's organisations. This is not helped by charging; [generally] social care charge for services and health don't. (commissioner of social care services, CQC consultation event)

If we, inside the system, don't understand how the system works, what chance do the public have of navigating through? (provider of health care services, CQC consultation event)

Putting people at the centre of their care

Personalisation means putting people at the centre of the design and delivery of services, acting to respect their rights and choices, and providing care, treatment and support that respects their wishes. In policy terms, the concept of personalisation is coupled with a shift towards early intervention and prevention. Successive governments have sought to embed the principles and practices of consumer voice and power into their health and social care policies, and in public policy more broadly. However, it requires a significant transformation of services to put people first (Social Care Institute for Excellence, 2010). This vision was reflected in a multi-agency concordat (HM Government, 2007), which was recently revised by the coalition into a sector-wide agreement to move personalisation and community-based support forward (HM Government, 2010d). Government's vision for social care is expected to be published

following the report from the Commission on Long Term Care.

The end of life care strategy seeks to involve people in identifying their preferences and emphasises that people should have a choice of where they die; whether that be in hospital, care home, palliative care setting or home (Department of Health, 2008a). Most people express a preference to die at home but, at present, about 60% of people die in hospitals. There are differences according to people's illness, and slightly more deaths due to cancer occur in the home. Deaths at home, having been subject to decline, are now starting to rise. These trends are recognised as a welcome move in the right direction (Department of Health, 2009d).

CQC's (2009b) annual performance assessment of councils found evidence that partnerships were being used to develop and deliver effective end of life strategies. A co-ordinated multi-agency approach with health and social care services has been beneficial in offering a range of support and palliative care to people in their own homes, with increased opportunities for individuals to die at home. Better access to services and support has helped people to make more informed and positive choices about end of life care, as well as helping to retain personal dignity:

People who receive end of life care are supported to live as independently as they choose, and have well timed, well co-ordinated treatment and support through increased services to support them in their own homes, such as the 24/7 Macmillan and district nursing services. (CQC annual performance assessment report, 2009b,)

Dedicated specialist teams and services and trained staff were identified as key strengths in councils performing well in the provision of end of life care. However, there is clearly scope for improvement, with a fifth of

councils still requiring further development and implementation of end of life strategies. The White Paper signalled government's commitment to introduce national choice to support people's preferences about how to have a good death (Department of Health, 2010b).

Joining-up care

People who use health and social care services rarely require just health or social care services. Rather, to meet people's cross-cutting and often complex or long-term needs requires dedicated multi-agency and 'whole system' responses. This can be particularly important for people with learning disabilities, mental health needs and older people with complex conditions such as dementia.

The importance of providing joined up care is reinforced by the need to provide a person-centred approach that maximises outcomes for people. Joined-up care is about those working in health and social care and the relationships that are forged both within individual services as well as between services and across sectors. By working together, improvements can be made to the ways in which people access and experience services as well as overall levels of service satisfaction and quality. Sharing investment and planning between services can also improve their efficiency and effectiveness and, in the longer term, may reduce the demands placed on health and social care services, thereby maximising opportunities to deliver services that offer good value for money (Ham, 2009, 2010).

Inter-agency working and coordination between adults' and children's services are highlighted as key to ensuring that services adopt a 'think family' approach (HM Government, 2010b). A study by one of CQC's predecessor bodies, the CSCI (2009) examined how far council policies, services and practices were providing appropriate support to disabled parents and their

families and children. A survey of 50 councils and in-depth study workshops with disabled parents and their families, providers and commissioners found:

- Disabled parents and their families continue to face difficulties in accessing services which support family life. This includes universal services such as education and health, as well as social care services.
- 66% of councils reported their policies focused separately on adults and children.
- 34% of councils systematically collected data to show, for example, how many disabled parents live in their area, the services used and their needs, so few are planning and commissioning on a basis of knowledge.
- 30% of councils had joint working protocols on supporting disabled parents which means that roles and responsibilities between agencies are not clearly set out.
- Health and social care services and their partners should make extra efforts to ensure that there is not a disjointed approach to family life.

Promoting independent living

When people are supported to live as independently as possible, it not only improves the quality of their daily lives but also minimises permanent admissions to care homes and the need for emergency hospital care. Both represent very high costs to the NHS and social care. Trends from CQC's (2010c) state of care report illustrate positive signs that people are being better supported to live independently:

- Numbers of people receiving council funded non-residential intermediate care to prevent hospital admissions have nearly doubled in the last 5 years;

- Rates of council-funded permanent admissions to residential and nursing care are falling.

However, across England there are considerable variations, up to three-fold, in the use of council-funded nursing and residential care. There is higher use of long-term care in England compared with many other countries in the Organization for Economic Co-operation and Development (2005), and, whilst 8% of areas have reduced repeated emergency admissions, 15% of areas have seen a rise.

If local areas reduced their rates of emergency admissions and the associated occupied bed days, this could have a significant impact overall. Analysis for CQC (2010c) suggests that, if every local area could reduce emergency stays in hospital for people over the age of 75 years to the levels seen in the best performing parts of England, this would result in 8 million fewer days in hospital for people, and a saving of about £2 billion a year for NHS hospitals.

Providing safe and effective care

Discussions of safe and effective care have, traditionally, been the preserve of health care policy and guidance. It was highlighted as one of the 6 dimensions in the *NHS Next Stage Review* of the last administration (Department of Health 2008b). The topic was also given renewed impetus when the House of Commons Health Committee (2009) published its report *Patient Safety*. The provision of safe and effective care has been one of the central elements of the coalition's healthcare reforms. The vision for the NHS includes a refusal to tolerate unsafe and substandard care (Department of Health, 2010b). Safe and effective care reads across, of course, to social care. For example, the management of medicines, recognising and acting upon the signs of deterioration, minimising falls, ensuring good nutrition and hydration and managing

the spread of healthcare-associated infections across organisations.

Healthcare-associated infection can be a major problem for people living in care homes. Because individuals tend to have regular contact with health care services, it can lead to a 'revolving door': people bring infections they have picked up in hospital into the care home and are then readmitted to hospital because the care home feels unable to manage the infection. A study examined the arrangements for infection prevention and control between hospital and care homes (CQC, 2009c). The work mapped how care homes interact with healthcare and other social care providers and surveyed over 1000 care homes in England. The study found that care homes and hospitals were not providing information on infections to each other in a co-ordinated way. In the survey, 17% of care homes had received no information about individuals' infections when discharged from hospital:

The local hospital does not always inform us of the presence of infection and we have, in the past, found out by the medication the person is on. This stage of communication could be improved but sometimes data protection and confidentiality are quoted as the reason.
(care home manager)

The lack of information sharing on infections – which effectively brings together the issue of joined-up care with safe and effective care – can mean that people may not receive the best service possible. People's recoveries may be hindered, or even curtailed, and there is risk of infection to others living in the home.

Safeguarding people in vulnerable circumstances

Protecting children and adults from abuse is everyone's responsibility. However, there are a number of high-profile instances

where the performance of care services in safeguarding people in vulnerable circumstances is not consistently high. Compared with the general population, people living in vulnerable circumstances – including older people, individuals living with a dementia, people with learning disabilities, physical disabilities or long-term conditions – tend to experience worse outcomes (CSCI, 2008a).

Safeguarding arrangements have improved across health and social care, but more needs to be done to ensure a stronger, more consistent focus on keeping people safe. A small but significant number of services are particularly weak (CQC, 2010c).

One of the starkest safeguarding cases is the circumstances leading up to the death of Peter Connelly ('Baby P'). A review found that communication was very poor, both between the health professionals and between the NHS, social services and the police. This badly affected the assessment of Peter's needs and the professionals' ability to protect him (CQC, 2009d). Since then, CQC has closely monitored progress which shows improvements, but further work is still required (CQC, 2010d).

CQC also conducted a national review of arrangements for safeguarding children (CQC 2009e). The review found that most trusts have the right arrangements in place. Ninety-five per cent of trusts said that they had protocols for sharing information on children and their families, both within their own organisation and with other key agencies. However, there are still some concerns:

- 36% of acute trusts did not have a policy for joint working between maternity services and social services; and
- 81% of mental health trusts had joint protocols in place between their services and children's services.

Reducing inequalities

There are still wide inequalities in England. A recent report from government found:

- 5.3 million people in the UK suffer from multiple disadvantage;
- Families with children with some or all of the following characteristics; lone parents, those living in social housing or rented accommodation, those living in large families, those who have a young mother, those who have a black mother, and those who live in urban and the most deprived areas, are most at risk of persistent multiple disadvantage;
- Income inequality in the UK is now at its highest level since comparable statistics began in 1961;
- People living in the poorest neighbourhoods in England will, on average, die 7 years earlier than people living in the richest neighbourhoods;
- Health inequalities, as proxied by life expectancy at birth, are higher now than they were in the 1970s;
- Disabled people are more likely to live in poverty, to be workless and to have lower skills than non-disabled people – among disabled people, 32% report difficulties in accessing goods and services, and 22% do not have frequent choice and control over their lives (HM Government, 2010c).

A CQC (2009f) study contributed to existing efforts to reduce inequalities in people's health. It focused on the prescription of statins (drugs that lower cholesterol) and stop smoking services as part of wider prevention programmes to reduce inequalities in cardiovascular disease, the largest contributor to health inequalities. The study found that the financial incentives offered by the quality and outcomes framework have greatly improved health outcomes for people using services and reduced inequalities in

secondary prevention of cardiovascular disease. However, the study also surfaced a number of concerns, including an inverse care process in place - whereby people who are most in need of services are least likely to obtain access and receive them. Notably, people living in deprived areas were less likely to be prescribed nicotine replacement therapy by their GPs, be referred to NHS stop smoking services or to quit smoking with NHS services.

Tackling inequalities is not the sole responsibility of healthcare organisations, but rather a joint challenge for health and social care:

The focus of the local area agreement is on tackling the underlying deprivation and inequalities in the borough, including the need to improve health inequalities, and there is good progress on some targets. Partnership working with health has led to significant investment in preventive health services in targeted areas. (CQC annual performance assessment report, 2009b)

Of those councils that were delivering improved health and emotional well-being for people using social care in 2009, 91% were performing well or excellently. The 29% of councils that were assessed as excellent were reducing local health inequalities and providing a wider range of advice services. These councils use a variety of approaches to promote healthier lifestyles: information prescriptions, DVDs for people with learning disabilities, community magazines and health checks (CQC, 2009b).

Securing fair access to care

Across the country, people receive different levels of care because of the ways in which services are organised locally (a 'postcode lottery'). In social care, the Fair Access to Care Services (FACS) framework was introduced in 2003 to address

inconsistencies across England about who receives publicly-funded social care. The aim was to provide a fairer and more transparent system for the allocation of services. FACS sets out 4 levels of need: low, moderate, substantial and critical. Councils decide at which level they will fund care. People whose needs fall below these levels receive no publicly-funded care and have to arrange and pay for their own care and support (Department of Health, 2002).

The policy set out in FACS is based on sound principles that have validity. For example, the emphasis on a needs rather than service-led approach, people with similar needs achieving similar outcomes, taking a rights based approach and ensuring carers' needs are taken into account. However, a review by CSCI (2008b) found the majority of evidence critical of FACS, some in principle and considerably more in respect of its implementation. Briefly, these concerns relate to:

- A lack of clarity and transparency in practice, particularly related to the complexity of the framework;
- A lack of fairness in the way criteria are applied;
- The continuing influence of service-led, rather than needs-led approaches;
- Limitations of a risk/needs-based model that has led to inadequate and unduly standardised assessments and neglect of some groups of people using services;
- Insularity and fragmentation, where FACS does not include considerations of other important areas such as health, housing and leisure;
- Marginalisation of the prevention and inclusion agendas;
- Inadequate diversion and signposting; and
- Tensions between FACS and personalisation (CSCI, 2008b).

Excellent performance for access to social care is characterised by good support and information for people who fall outside the eligibility criteria, with good signposting to other services. This is particularly important for councils that only fund care for people with substantial and critical needs. However, concerns remain when, in 72% of councils, people's needs have to be substantial or critical before they can get support from social services.

Since CSCI's (2008b) review, the Department of Health (2010c) has consulted on and issued new guidance. It is important to note that the Department's new guidance is framed within the context of improving the current system while longer-term options for the reform of the care and support system as a whole are explored. Government has established an independent Commission on Long Term Care (HM Government 2010b). The Law Commission (2009) is also reviewing the law in this area with a view to proposing a single statute for adult social care.

Conclusion

The health and social care system has a finite amount of public funding. Resources therefore need to be rationed – however individuals and the general public may feel about this. At one time, the message from the centre was for public services to make better use of available resources. In more recent years, there has been recognition of insufficient resource within the system to support growing health and social care needs. As CSCI (2008b) set out with regards to eligibility criteria for social care, “the size of the ‘cake’ is limited, whilst the number of people who want a ‘slice’ is increasing ... [i]n the long term, there is no alternative to radical reform ... the key issue is not simply the criteria used to assess people's eligibility for publicly funded care and support, but the amount of resources currently allocated – the size of the cake itself”.

These concerns prompted the previous administration to examine and set out future proposals for funding social care shortly before the 2010 general election (HM Government, 2010a). The new coalition recognises the need for urgent reform and has established an independent commission. However, in the midst of the aftermath of the longest and deepest recession on record nationally since the Second World War, the economic climate confounds the pressing social and demographic forces further. How these forces will be reconciled represents one of the biggest challenges for the new administration.

There will be challenges. For example, the Audit Commission (2010) recommends that the most effective means for councils to release monies for investment in the future is to reduce the proportion of spend on adult residential care. However, despite some positive trends, councils are still failing to make a shift to spending away from residential care.

Notwithstanding, there are solutions and success stories. The Partnership for Older People Projects (POPP) aimed to develop services to promote health, well-being and independence and to reduce the need for higher intensity or institutional care (Personal Social Services Research Unit, 2010). The evaluation of these projects found that early preventative work could improve both the quality of life for older people as well as yielding improved working relationships between services and financial savings. Most notably a reduction in hospital emergency bed days resulted in considerable savings, to the extent that for every extra £1 spent on the POPP services, there has been approximately a £1.20 additional benefit in savings on emergency bed days. Government has signalled its intention to accelerate efforts to promote joined-up care (HM Government, 2010b; Department of Health, 2010b). For example, hospitals will be responsible for people who have been admitted for 30 days after

discharge – should an individual be readmitted within that time the hospital will not receive any further payment for the additional treatment (Department of Health, 2010a).

Earlier this paper noted that policy issues and challenges are far from mutually exclusive. This was borne out in the evidence presented from the regulator. Taken together the findings suggest that more should be done to improve people's outcomes, whether they are using health, social care or a combination of services. It is more important than ever for services to be commissioned and provided in ways that maximise their value for money and put people's needs first.

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