

The failure of the National Eligibility Criteria – what next?

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Abstract

Social care has traditionally managed the tension between demand and supply through strategies rooted on the demand side. The concept of 'eligible need' is used to limit spending so it matches budget. The strategy has been very successful in its primary objective. However, it has had seriously undesirable side effects. Fair Access to Care (FACS), the form given to the strategy from 2002, was held responsible by Government for persistent inequity. FACS was replaced with a single national set of criteria in 2015. The new strategy was built on the same core principles as FACS. Recent evidence, including new data generated through use of the Freedom of Information Act involving 30 councils, shows the inevitable failure of the national criteria. Persisting inequity is not the only price being paid. The eligibility process has been shown to be responsible for disempowerment and depersonalisation for service users and carers, waste of resources and concealment of information about the cost of meeting needs for wellbeing. The strategy of personal budgets through upfront allocations to nullify these ills is now shown to have failed and cannot succeed. The eligibility process remains dominant for all but a very small minority able to escape the mainstream system. Whilst many believe the most pressing issue is to adequately fund social care, it is hard to sustain this argument in the absence of credible information about what would actually be adequate. It will not be until social care switches from a demand side to a supply side approach to control spending, replicating the way demand and supply is managed in health, that it will be possible for social care to commence a journey toward a service that is both personalised and financially sustainable. Parliament, through the Care Act, has made the required change possible by replacing eligibility of need with affordability of need as the means to control spending. Government, through national policy, is ensuring the relevant provisions of the Care Act lie dormant.

Keywords: Eligibility criteria, personalisation, Care Act, resource allocation, equity

Context

Perhaps the most vexing and longstanding challenge confronting the delivery of social care is how to reconcile demand with supply. Demand is in the form of needs for care and support. They arise from the complex interplay of a range of factors – the nature and severity of each person's impairment, how long they have lived with it, the attitudes and personal resources they bring to bear, the attitudes and personal resources of those around them, the attitudes and resources of the wider community and of society as a whole, the person's physical living environment. Each factor is highly variable, making the combinations almost infinite and unique to each individual. Consequently, demand takes the form of units that are highly variable in nature and in the cost of meeting them. Supply comes in the form of a budget, determined by political priorities both centrally and locally.

The challenge has long been addressed through application of eligibility policies. These set out the range of needs that will be met using criteria designed to result in spend matching budget. Prior to 2002, each council set their own formal criteria. Concern this was leading to inequity between councils led to creation of a national policy – Fair Access to Care Services (FACS). FACS set out descriptions of four bands of 'needs'. Councils then decided how many of the four they believed they could afford to meet with all needs in those bands to be deemed 'eligible' (Department of Health, 2002). However, the problem of inequity persisted. The Audit Commission (Audit Commission, 2008) had drawn attention to major inequity between councils in 2008. A Commission set up by Government to review the funding of social care observed that people who moved between councils experienced very different levels of provision, concluding there was a 'postcode lottery' (Dilnot, 2011, p.12).

Government held the choice councils had about how many of the FACS bands they would treat as eligible responsible for the inequity. The solution was to require all councils to work to the same criteria. The Regulations to the Care Act (Department of Health, 2014a) required all councils to work to the same single set of criteria. The new National Eligibility Criteria would set a single threshold to provide 'more transparency on what level of need is eligible' (Department of Health, 2017). Need in one part of the country would be seen the same in any other, making assessments of need consistent and transportable.

Delivery of the National Eligibility Criteria

Early doubts the strategy would work were raised when the University of Kent, in a study for Government (Personal Social Services Research Unit, 2015) found that councils were assessing for eligibility in much the same way they always had, merely changing the terminology. Hopes suffered a further and even more severe blow following a study published in 2017 (Institute for Fiscal Studies, 2017). It found large variation in spending per head of population persisting in 2015/16. The highest spending 10% averaged £445 net spend per 1,000 adult population and lowest spending 10% £325 (p.17). The finding of inequity resonated with other researchers. The King's Fund and Nuffield Trust (King's Fund, 2016) found more than 'a six-fold variation between councils in their rates of people supported in care homes, and an eight-fold variation in their provision of home care' (p.16).

Variation in spend is, of course, not an issue of concern if the differences can be explained by variations of levels of need and therefore demand in the communities served. The Institute for Fiscal Studies (IFS) tested the spending variations against the range of factors usually expected to impact on need, such as the percentage of the population who are older, the Index of Multiple Deprivation, percentage of the population who are benefit recipients, percentage of the population who rent their homes. However, they found the relationships to be either non-existent or, at best, weak.

Freedom of Information request

There is, however, one factor that could account for the variations without compromising the integrity of the National Eligibility Criteria. The Care Act allows councils to choose to provide, if they so wished, a greater level of need whatever the prevailing national eligibility criteria requires them to meet.

To test whether councils are using this provision in a way that would account for the variations, 30 councils were asked the following questions under the Freedom of Information Act:

1. Does your council's policy in relation to resource allocation to individuals explicitly provide or allow for any assessed needs that require council funding, but not deemed eligible under the Care Act, to be met?
2. If the answer to question one is yes, do you monitor how much assessed need deemed not eligible need is met, and if so, is it measured in terms of volume of need or the amount of money required or both?

The councils were chosen to reflect a mix of rural and urban and different types of council with a sample size sufficient to be considered reasonably representative; 28 councils responded. All but two of those answered 'no' to question one. This made question two not applicable in their cases. The two councils who said their resource allocation policies did allow for meeting needs above the eligibility criteria did not, however, monitor the volume of needs or spend under this provision. This raises questions as to whether these two councils are merely regurgitating the formal legal position in their policies, but in practice not actually behaving differently to the other councils. Nonetheless, they were excluded from the following analysis. Not one of the 30 councils, therefore, monitored demand beyond needs they deemed to fall within the National Eligibility Criteria.

Diagram 1. Net spend (£) per 1000 adult population in 2015/16.

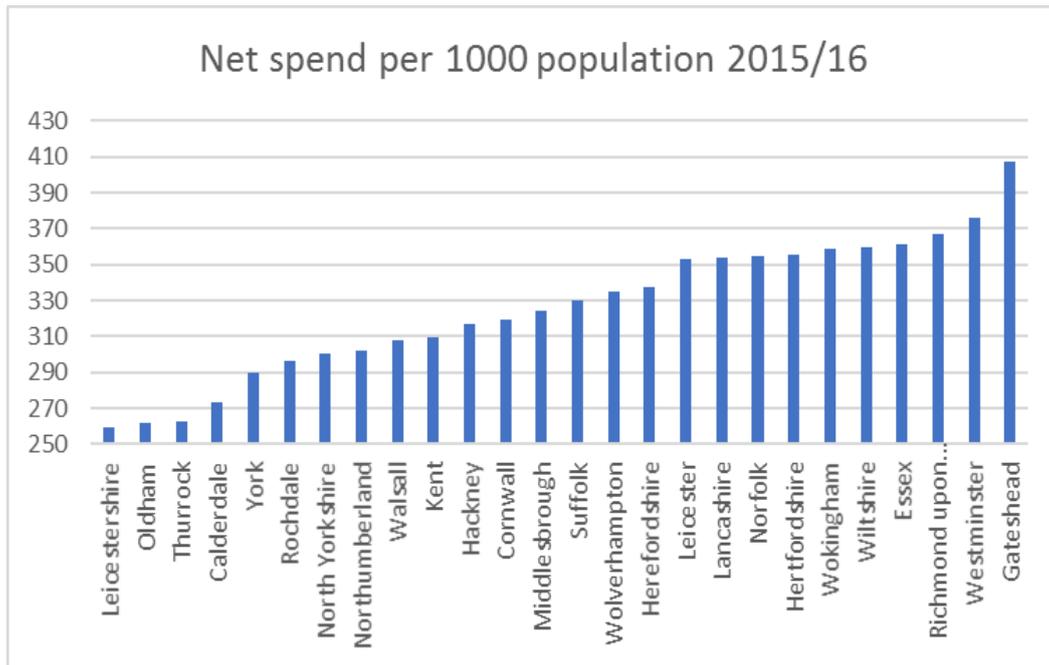


Diagram 1 shows the spend in 2015/16 in relation to the 26 councils that acknowledged they only met 'eligible' needs (NASCIS, financial return and JSNA populations). The councils are named given that the source data is publicly available and gives greater transparency. The range of values broadly reflects the range IFS found for all councils. This confirms the sample to be reasonably representative.

Eligibility criteria and spending levels

So what can explain the fact that the same range of 'eligible' needs in Gateshead results in 60% more spending than it does in Leicestershire, with all stops in between? Whether Leicestershire or Gateshead are doing the better job of meeting actual need is another matter. They are both meeting needs they claim to be the same.

The Government view that the postcode lottery under FACS was due to councils choosing how many of the four bands to meet was simply never credible. Evidence available to Government before the change in policy made this much clear.

- The 2008 Audit Commission report was clear that the differences in spending between councils were not explained by differences in the number of FACS bands councils had declared to be eligible. Nor could they discern any other factors at play.
- In 2014, the Government's own impact assessment in preparation for the Care Act concluded that *'there is little relationship between a local authority's stated local threshold and how that authority is meeting needs'*.

(Department of Health, 2014b, p.46)

- The impact assessment also noted that the *'vast majority of councils'* operated the same number of FACS bands – the top two called 'critical' and 'substantial' respectively – thus undermining the view that differences in the number of bands deemed eligible could account for a 'postcode lottery'.

By the time of the changeover from FACS to the National Eligibility Criteria, there were just three councils who operated at just the top band of 'critical'. These councils sought additional funding to get them up to the levels of all other councils so they could meet the higher levels of demand expected under the new national criteria. Government had stated the expectation was that the new national criteria would replicate the 'critical' and 'substantial' FACS bands.

The impact assessment had already addressed the situation of the three councils who were 'critical' only. They said that 'whilst it might be expected that those local authorities would provide fewer services and spend less per head than other authorities' it actually found 'spending is either close to or above the median of their statistical neighbours, and in some cases, the proportion of services provided to over 65s is significantly above the median'.

Government duly refused the request of these councils for more funding. When the councils threatened judicial action, all parties agreed to a detailed study to determine the impact of the change from FACS to the national criteria following application of the new criteria. A separate Freedom of Information request to the councils concerned to discover the outcome resulted in a response in June 2017. The Department of Health letter to the councils said 'the case for a new burden on the councils has not been established' and accordingly 'no additional funding should be awarded' (Slasberg, 2017a). Thus not only did a restricted threshold under FACS result in spending any different from the rest of the country, but application of the National Eligibility Criteria had not led to increased spending levels.

Evidence since implementation of the National Eligibility Criteria merely confirms what was known prior to its implementation. Formal eligibility criteria do not determine the level of needs met or spend by councils.

What does account for variations in spending levels?

If eligibility criteria do not determine spending levels, what does? Both logic and evidence point to a very simple answer. Each council's budget – howsoever it is set – determines if a need will be deemed eligible and therefore funded. Under a policy of only meeting needs that it is legally bound to meet, councils have no choice other than to create a circular definition of need. A need that requires public resources can only be acknowledged if there is resource to meet it. Wide variations in budget between councils, along with year-on-year fluctuations of budget within councils, means delivery of this process must be highly localised. The process is led by budget holding managers with the skills and seniority required to control the flow of demand through the assessment process. The eligibility decision is subsequently presented using the terminology of the formal eligibility criteria of the day. This serves to create the impression of consistency and delivery of policy. It is a wholly misleading impression.

Henwood & Hudson first drew attention to eligibility decisions being made by 'street level bureaucracies' (Henwood & Hudson, 2008, p.122) rather than application of whatever the prevailing formal criteria happen to be. Henwood & Hudson believed individual practitioners were the 'street level bureaucrats' who therefore effectively determined eligibility. However, this view does not square with the systemic pattern of the variations between councils as a whole and between user groups across the country. If individual practitioners were driving the decisions, a more random pattern would be expected. Direct evidence that the 'street level bureaucrats' were indeed not practitioners, but managers delivering councils' policy came from a study for the Department of Health into the way FACS operated (Personal Social Services Research Unit, 2012). Testing practitioners from different councils using a series of case vignettes, the study found large variations in how practitioners assigned cases to the different FACS bands. However, they also found a 'correlation between the eligibility policies set by local authorities and the level at which their care managers banded individuals'. At best, individual practitioners have been able to push the boundaries set by managers in order to maximise the level of support to individual service users, but their impact is very limited.

The success of the eligibility process in its primary objective is shown by the annual budget survey by Directors of Adult Social Services. This showed that overspending in 2015/16 was less than 2% of gross budget (ADASS, 2017, p.10). This was the case despite not only coming during a period of austerity, but during a period of extraordinarily high levels of budget volatility. The IFS found that between 2009/10 and 2015/16, the 10% of councils who cut spending the deepest did so on average by an astonishingly high 31%. At the other end of the scale, 10% of councils actually increased spending by an average of 7% (p.28).

This evidences how the circular, resource-led definition of 'need' at the heart of the eligibility process ensures spending follows budget.

The Government's role

Government policy, knowingly or otherwise, covertly invites this process. It does so through two devices. Firstly, the Statutory Guidance to the Care Act (Department of Health, 2017) is silent on the critical question of how councils should address the challenge of managing affordability, thus leaving councils to their own devices to meet the key imperative of matching spend to budget. The Guidance merely advises councils to be cost effective in their choice of services to meet the needs they have deemed eligible. However, cost effectiveness does not deliver affordability. It is improbable in the extreme that the aggregate cost of meeting all assessed needs for wellbeing that require council resources, even in the most cost effective ways, will match whatever the council's budget happens to be. It will in all likelihood exceed it.

Secondly, the National Eligibility Criteria are constructed in a way that makes them capable of an almost limitless range of interpretations. Under the National Eligibility Criteria, the key judgement is whether a need will have a 'significant impact on wellbeing' (Department of

Health, 2014a). FACS achieved the same effect by using descriptions of the bands that were highly convoluted. The Commission for Social Care Inspections noted that for councils 'FACS is subject to wide and varied interpretation, with different custom and practice in different teams and specialisms' (p.32) and to the public 'Fair Access to Care' means nothing to the person in the street' (2008, p.31).

National criteria – whether under FACS or the National Eligibility Criteria – are, in reality, not criteria at all.

Does it matter that needs are assessed and resources allocated in this way?

Whether or not it matters depends upon the perspectives of the key interests within the system.

- To political and sector leaders whose sole concern is to keep spending under control, then it clearly does not matter. It's a system that works. If they are also motivated to keep spending on social care at the lowest possible level, they will have the bonus of a system that always denies there is any funding gap. They are able to take the view that all councils are meeting all needs that have a 'significant impact on wellbeing'.
- For political and sector leaders whose perspective includes a desire for fairness, the system will be of real and obvious concern.
- For service users and carers the disempowering and depersonalising nature of this system matters greatly. In 2008, the link was made between the eligibility process and assessments being based on '*deficits*', being '*standardised*' and '*service led*' (Commission for Social Care Inspections, 2008, p.4). Government acknowledged the findings but saw no need to make any fundamental changes to FACS. That was because it believed a programme of '*significant transformation*' was in place that would promote '*personalised support through the ability to exercise choice and control*' (Department of Health, 2010, p.5). The key device to achieve the transformation would be the allocation of resources 'upfront' to create a personal budget. It was expected there would be '*a seamless approach between personalisation programmes and the determination of eligibility*' (p.6). However, the Care Act 2014 did not define personal budgets in this way, but as merely the financial value of the services the council had decided to offer to meet the needs it had decided to meet (HM Government, 2014, para 26). This amounted to no change from the previous legislation. It is now evident that the personal budget strategy will not deliver the transformation expected in 2010 (Slasberg, 2017b). Other than for a very small minority with the skills, energy and time to escape the mainstream system (Slasberg & Beresford, 2016) the eligibility process remains dominant along with its ill effects.
- For those whose priority is to secure the best value for money from the resources made available, the current system is a matter of great concern. There is currently a widely held view within the sector that the system creates dependency leading to calls for '*strengths-based practice*' to become the new norm (Think Local Act Personal, 2017). The basic premise is that practitioners should cease to practice in ways that promote dependence and instead practice in ways that promote independence. However, what is not explained is why practitioners should have chosen, *en masse* and over several decades, to practice in ways that are not already based on strengths and promotion of wellbeing. Not only is practice that promotes dependency against the best interests of service users but, in the case of social workers, is in contravention of their Code of Ethics (BASW, 2017).

The evidence suggests that the prevailing practice has not been a matter of professional choice, but the inevitable product of the system within which practice takes place. The 'cliff edge' eligibility test requires people to minimise their strengths and maximise their weaknesses in order to secure resource; the prevalence of depersonalised assessment

practice has been the product of a system that requires practitioners to fit people into pre-determined categories of locally determined 'eligible' needs.

- Finally, those who wish to secure an adequate level of funding for social care are continually thwarted by the absence of information about the real cost of meeting all needs for wellbeing. The system ensures that 'eligible' needs are always met, thus undermining claims of underfunding.

Is there an alternative?

The core problem stems from the simple economics of supply and demand, with demand expected to be greater than supply. Social care's strategy to address the tension is rooted in the demand side. 'Need' is shaped to match supply. In healthcare, the same problem is addressed through a supply side strategy. If we have something wrong with mind or body and there is a health treatment that can do something about it, the system does not require the doctor to deny it. We may have to wait if the resources are not immediately available and the urgency is not great. The resulting length of waiting times provides a measure of the gap between needs and resources, with resulting political pressure.

There is nothing in law or practice to stop social care being managed in the same way. But it would require the Guidance to the Care Act to be changed (Slasberg & Beresford, 2014). The National Eligibility Criteria, which determine when an assessed need is a legal duty to meet, should be set at a level equivalent to the 'blue-light' services in the NHS – life and limb – and expressed in clear and robust terms so they are authentic criteria that can be applied consistently. These are needs it would be unthinkable not to meet as the consequences would be too dire. All other needs – those that determine quality of life – would be met subject to the availability of resources using the power to meet assessed needs under the Care Act. Crucially the existence of these needs would never be denied. Equity would flow from the aggregation of information about how much assessed need is met and how much is unmet. This will make possible informed adjustments of the allocation of resources between councils and between user groups.

At a strategic level, the gap between needs and resources would cease to be solely a matter for epidemiological projections, along with speculative and anecdotal information from interested groups, all of which have very limited impact on the decision making processes that determine public spending levels. Information about the gap between needs and resources would become a matter of real time information as is the case in healthcare. This would place social care on the same footing as health. **Diagram 2** illustrates the proposal.

Councils might well say they already operate at a life and limb only service. But that cannot be true of both the councils that spend the least and the ones that spend the most, or the councils that were able to cut their spending by over 30% and those who increased their spending since 2010. The need to emphasise deficits as the means to secure resources creates a siege mentality that shapes perceptions. If, however, it is genuinely the case that a council is only able to deliver a life and limb service, robustness of the criteria will make it plain to all interests that life and limb is indeed all that council is delivering. Such a council would be palpably failing in its duty under the Care Act to deliver wellbeing. That is something the political system and the council's local community should know, and have the opportunity to put right.

Conclusion

The Care Act has created the framework for an authentically rights based approach to social care, supported by the force of law. This contrasts with claims that social care should be rights based, such as the 'right' for independent living, but which has never existed as a right with legal backing. The right the Care Act has created is to have all needs to enable wellbeing that

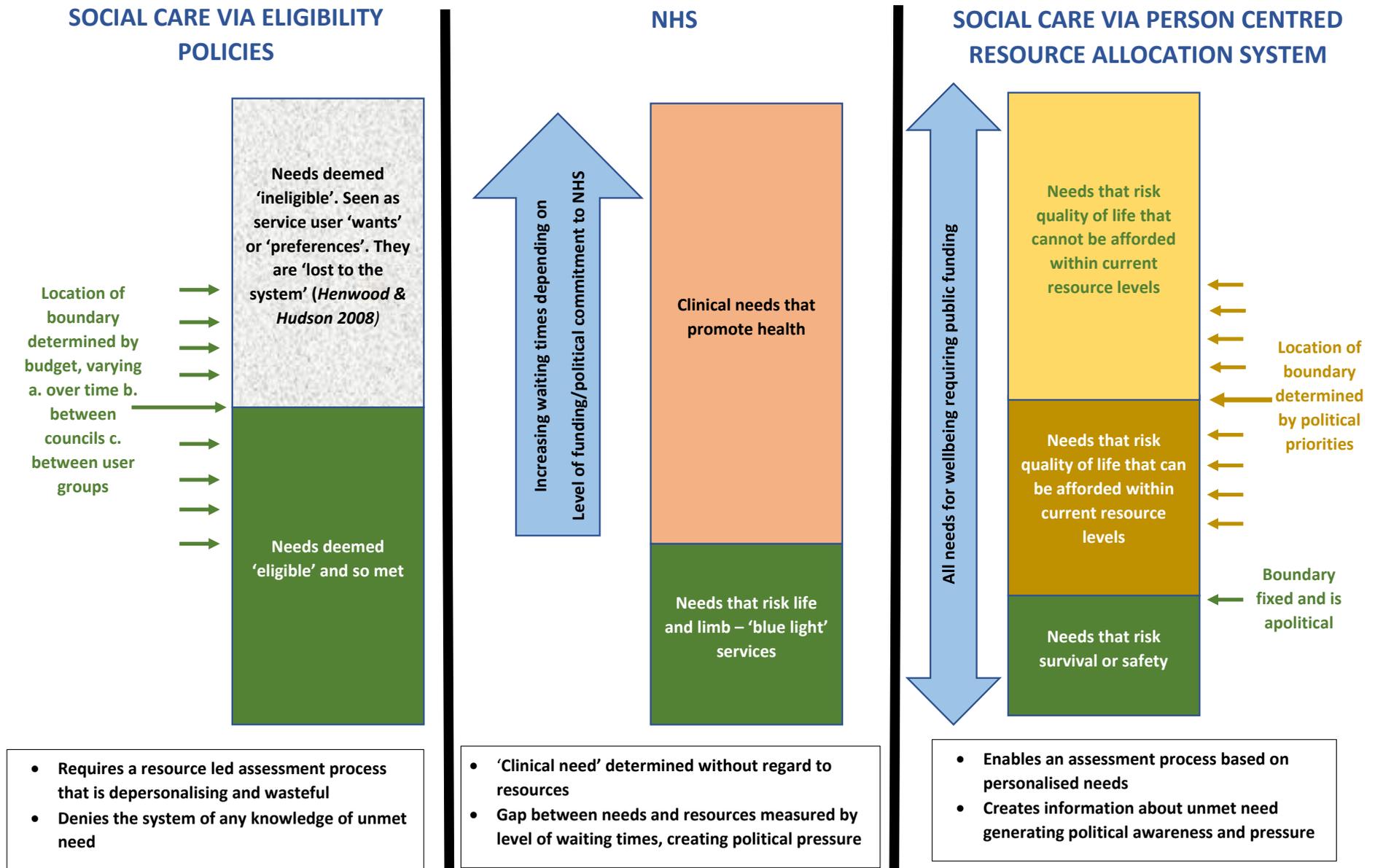
require public funding to be assessed and costed, regardless of whether they can be currently afforded. All such needs will thus be fully acknowledged and in the public arena.

Many would, of course, have preferred the Care Act to go further, and to create a right to all assessed needs to enable wellbeing to be funded. However, the unpredictability of knowing the cost of meeting all needs for wellbeing would mean such a legal right would require an open cheque approach to funding. Not only has Parliament not done this, it is perhaps improbable to expect it might have. It would have given social care an advantage over other public services unlikely to obtain public support.

The delivery of the right to have all needs for wellbeing assessed would be a major advance, arguably the first, and essential, step toward a social care service fit for the modern era. The 'lived experience' of need would replace 'eligible' need as the basis for all assessments, thus personalising the process; the true level of resources required to deliver wellbeing would be known; authentic equity could become a reality; independence and strengths-based practice would replace deficit and dependency inducing practices. Firm movement toward securing the resource to enable all to have an appropriate level of wellbeing cannot realistically begin until we know what the true cost would be.

Perpetuation of a demand side approach to spending control is ensuring this new rights based approach is not being realised. As long as this persists, it is likely social care will remain trapped for the great majority in its inequitable, depersonalised and impoverished state.

Diagram 2. Replacing eligibility policies to control spending and placing social care on a similar footing to health.



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