

Prevention, personalisation and prioritisation in social Care: Squaring the circle?

A report commissioned by CSCI for the review of
eligibility criteria

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1 Introduction

- 1.1 This paper arises from, and builds upon, the review of Fair Access to Care Services (FACS) undertaken by the authors for the Commission for Social Care Inspection (CSCI) in 2008,¹ and which informed Chapter 8 of CSCI's The state of social care in England 2006-07 report.² The report expressed concern about the tightening of the FACS eligibility criteria and the impact upon the lives of people excluded from support, including those who fund their own care. In response to the report, Care Services Minister Ivan Lewis MP asked CSCI to undertake a review, to be completed by 15 September 2008, which will look at national definitions of need and their application at a local level. This paper is being prepared as background to the review of eligibility criteria (which has a number of components).
- 1.2 Eligibility for and access to social care are controlled in a number of ways. The current framework of FACS provides a system of prioritisation between low, moderate, substantial and critical level needs. Any framework for allocating scarce resources must, however, be consistent with dominant policy objectives. The purpose of this background paper is to examine the relationship between policy imperatives and eligibility criteria. The assumption we make is that eligibility criteria should constitute a 'second order' decision contingent upon 'first order' policy objectives; in other words, the key policy imperatives for social care should determine primary eligibility for support. To assign an independent status to eligibility risks such a framework pulling in a different direction to desired policy outcomes.
- 1.3 The FACS framework has been in place since 2002 and was developed to be consistent with the policy objectives of the 1990s, in particular to focus attention upon people with the greatest assessed needs. However, adult social care is on the cusp of major transformation, with a Green Paper expected later in 2008. A wide ranging consultation will explore options for the long-term funding of the care and support system "to ensure that it is fair, sustainable and unambiguous about the respective responsibilities of the state, family and individual".³
- 1.4 In advance of this debate – and almost regardless of its outcome – a parallel process of reform is to start from April 2008 to transform the purpose of the adult care system. While the Green Paper reforms might be seen as concerned largely with questions of how to organise and pay for social care, the immediate policy reforms are addressing what it is that social care should deliver. The concordat (Putting People First), published by the Government in December 2007, set out the vision which will place personalisation at the heart of a community-based support system "focused on the health and wellbeing of the local population". The values which underpin the transformation agenda are those of seeking to support independent living and maximising quality of life:

"The time has now come to build on best practice and replace paternalistic, reactive care of variable quality with a mainstream system focused on prevention, early intervention, enablement and high quality personally tailored services. In the future, we want people to have maximum choice, control and power over the support services they receive."

- 1.5 It is vital to consider the issue of eligibility in the light of the changing policy agenda, and it is for this reason that we precede our examination of eligibility frameworks with a brief review of the two key issues central to the concordat – prevention and personalisation.

2 Prevention in social care

- 2.1 What is meant by 'prevention and early intervention' in social care? Typically the term is used very loosely, but it can – and does – refer to different things in different circumstances. In exploring the literature as background to the Wanless social care review,⁴ Curry highlighted the difficulty of conceptualising prevention in social care because of the continuum that it embraces – from intermediate care services at the top end of the spectrum to 'low-level' interventions and community services supporting social inclusion at the other.⁵ While in health care it is conventional to distinguish between models of primary prevention (focused on specific risks to prevent illness or injury), secondary prevention (identifying and treating illness at an early stage), and tertiary prevention (aimed at reducing disabilities such as through rehabilitation), this model does not easily transfer across to social care. Godfrey observes that:

*"The meaning attached to prevention is fraught with ambiguity, presenting enormous difficulties in evaluating the effectiveness of services/interventions."*⁶

- 2.2 It is important to explore some of these aspects of prevention in order to understand and clarify the focus of current and emerging policy, and the relevance to any focus on eligibility criteria. Godfrey argues that recent policy has seen a shift in home care first of all, from the poorly targeted old style 'home help' service to more intensive 'home care' targeted on people assessed as having high and complex levels of need:

"Preventive services in this context were those aimed at keeping out of institutional care those people on its threshold."

- 2.3 This change has been well documented and was a central component of the community care reforms of the early 1990s. By the late 1990s policy was still emphasising this aspect of prevention, but was simultaneously focusing on avoiding dependency through targeted rehabilitation and recuperation. The 1998 White Paper, *Modernising social services*,⁷ set out the "guiding principle" for adult social services that "they provide the support needed by someone to make most use of their own capacity and potential". This new direction of policy was reinforced with special grants for partnership and prevention development. While focusing primarily on rehabilitation and help for people to improve social functioning, the prevention grant also sought to stimulate preventive strategies and effective risk assessment "so as to target some low level support for people most at risk of losing their independence".

- 2.4 As Godfrey observes, this "broader conception" of prevention is concerned with wider issues than simply avoiding or delaying permanent residential care, but this also introduces "considerable ambiguity" within different policy documents, and a frequent conflation of services intended to prevent or delay loss of independence, with those concerned with improving quality of life:

"It is evident that the concept of prevention within policy discourse has multiple layers of meaning with no consensus on definition."

- 2.5 This is an important conclusion since the current focus on prevention within the framework of Putting People First makes no attempt to define its terms beyond a very general nod towards 'early intervention'. This is not simply an academic or semantic debate; without clarity over objectives there can be no consensus around appropriate outcomes, and no judgement therefore of the extent to which interventions are effective. By the same token it will be difficult to develop an eligibility framework that is consistent with clear policy objectives.

Intermediate care

- 2.6 Intermediate care is a particular variant of prevention focused on promoting independence and thereby preventing admission to, and supporting discharge from, hospital. The major focus of intermediate care has been on services which target frail older people. The national evaluation of costs and outcomes of intermediate care for older people⁸ dates the formal policy to the *NHS Plan* of 2000⁹ (although it is also clear that local initiatives had been under way since the early 1990s), and subsequent amplification in the *National service framework for older people*¹⁰ of the following year which defined the policy in these terms:

*"Older people will have access to a new range of intermediate care services at home or in designated care settings, to promote their independence by providing enhanced services from the NHS and councils to prevent unnecessary hospital admission and effective rehabilitation services to enable early discharge from hospital and prevent premature or unnecessary admission to long-term residential care."*¹¹

- 2.7 The national service framework (NSF) described the need for services that would *"bridge the gap between acute hospital and primary and community care"*. The need for such services had been highlighted, in particular, by the Audit Commission, which identified the problems caused by lack of alternative preventive and rehabilitation services, and the need to break the 'vicious circle' of growing admission to hospital, increased pressures on beds, earlier discharge and more people being admitted to long-term care.¹²

- 2.8 The *NHS Plan* introduced additional investment to support the development of *"new intermediate care and related services to promote independence and improve quality of life for older people"*. Working together (and where appropriate making use of arrangements under the Health Act flexibilities), health authorities, primary care trusts and local councils were expected to develop a range of intermediate care services. Guidance issued in 2001 identified both the criteria for services to be classed as 'intermediate care' and the various models that might be included (see the box below). This can be seen as a response to the diversity of schemes that were being described as 'intermediate care' (and the consequent confusion), but it was also a clear attempt to drive further development in a particular direction.

Intermediate care

Service models in intermediate care

- **Rapid response** – services designed to prevent avoidable acute admissions by providing rapid assessment and – if necessary – rapid access to short-term support at home.
- **Hospital at home** – intensive support in the patient's own home above that normally provided in primary care in order to avoid acute admission or to facilitate earlier discharge from hospital.
- **Residential rehabilitation** – short-term therapy and enablement in a residential setting. This may be 'step-down' from an acute hospital stay, or 'step-up' from home to avoid admission to hospital or residential care.
- **Supported discharge** – a short-term period of nursing and/or therapeutic support in a patient's own home.
- **Day rehabilitation** – a short-term programme of therapeutic support at a day hospital or day centre.

In order for services to be classified as 'intermediate care' they must be:

- Targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute in-patient care, long-term residential care or continuing NHS patient care.
- Provided on the basis of comprehensive assessment, resulting in a structured care plan that involves active therapy, treatment or opportunity for recovery.
- Have a planned outcome of maximising independence and typically enabling people to resume living at home.
- Are time-limited, normally lasting no more than six weeks and frequently as little as two weeks.
- Involve cross-professional working, with a single assessment framework, single professional records and shared protocols.

HSC 2001/001 : LAC (2001)1 *Intermediate Care*, Department of Health, 19 January 2001.

- 2.9 Intermediate care is clearly a policy designed to prioritise health and social care service interventions for categories of people deemed to be at high risk of admission to hospital or permanent residential care, or of remaining in hospital too long following admission. While the major drivers for the policy were, as the Audit Commission analysis made clear, concerns over the resource impact on acute hospitals unable to maintain patient 'throughput', the policy also has the potential to deliver considerably improved outcomes for older people. Has it, in fact, done so? As a 2002 guide from the King's Fund for health and social care professionals on

developing intermediate care made clear, there are (at least) four key areas that need to be monitored in any evaluation. These are:

- client experience/satisfaction
- care outcome
- process
- cost-effectiveness.¹³

2.10 While the King's Fund advocated a 'balanced scorecard' model for evaluation (which takes account of all these dimensions across the same timeframe), it is also apparent that these elements may not always be compatible.

2.11 The national evaluation by Barton *et al* highlighted the difficulties of definition and the fact that the label of 'intermediate care' is applied to extremely diverse services. Similar observations were made by the House of Commons Health Committee in the report of its inquiry into delayed discharges, which highlighted the apparent 're-badging' of existing NHS services as intermediate care.¹⁴ As the authors of the national evaluation remarked, the diversity of provision becomes even more problematic when trying to evaluate services, and *"it may be more useful to talk about different types of intermediate care (residential vs non-residential, admission avoidance vs delayed discharge) rather than about 'intermediate care' generally"*.¹⁵

2.12 In considering whether it is more cost-effective to focus resources on admission avoidance or supported discharge models of intermediate care, the evaluation found *"strong support"* for the former. However, this is in contrast to the actual shape of intermediate care development, which has tended to be concerned more with services to support discharge from hospital. The preoccupation with delayed discharges was also driven by other policies – most obviously the Community Care (Delayed Discharges) Act of 2003 which introduced 'reimbursement' arrangements to financially penalise local councils for each day that a person remained in hospital after they were judged fit for discharge. The provision of the Delayed Discharges Grant was intended to support a whole-systems approach to investment across health and social care economies. Research into the early implementation of the policy and the impact it was having on people and services was undertaken by the Commission for Social Care Inspection. This found that while delayed discharges were falling, there was worrying evidence that emergency admissions of older people to hospital were continuing to rise. It appeared that the focus on speeding up hospital discharge was leading – in some places – to reduced attention on the need to develop community capacity to avoid hospital admissions.¹⁶ As the Commission observed:

*"The best localities are using reimbursement monies to advance plans to extend community-based rapid response services and round-the-clock crisis support. Localities with less well-developed community provision know this is where investment is needed but are pulled towards securing quick fixes to support discharge."*¹⁷

2.13 The tension between services concerned with delayed discharges and those seeking to prevent admissions remains a key characteristic of intermediate care services. As the Commission pointed out, the pressures to find quick fixes to support discharge

were *“at the expense of a wider focus on securing better outcomes for older people”*,¹⁸ and indeed were often associated with a rise in permanent admissions from hospitals to care homes.

- 2.14 Another major evaluation of intermediate care for older people¹⁹ also found considerable diversity in the interpretation and implementation of intermediate care, and:

“...underlined the importance of intermediate care being seen as a set of bridges at key points of transition in the person’s journey from hospital to home (and vice versa) and from illness/injury to recovery.”

- 2.15 Unlike the national evaluation cited above, this study concluded that it was unhelpful to distinguish between different models of intermediate care on the basis of *“whether they are preventive, diversionary or rehabilitative”*, but *did* suggest that a main question for further investigation should be to *“identify what particular services and combinations work best for users with particular needs and in particular circumstances”*.²⁰

- 2.16 Intermediate care is intended (as the circular quoted above made clear) to be targeted on the people most in need of it, and most at risk of deterioration without intervention. Godfrey *et al* found that services were used primarily by older people, with the majority of people in all types of intermediate care being aged over 75, and in most services people aged over 85 made up nearly half of all admissions. What was also striking was that more than half the people who used intermediate care services *had not been using formal services prior to their intermediate care episode*. The fragility of informal support arrangements was typically broken by a crisis which then necessitated intervention at a critical point *“on the cusp of the shift from independence to dependence.”*²¹ The obvious question that this raises is whether support needs to be provided at a much earlier stage for people who are otherwise outside of the system, or below eligibility thresholds for support (such as we have documented in previous work for the Commission examining the impact of FACS²²).

- 2.17 Evaluating the cost-effectiveness of intermediate care interventions (in terms of duration of service, cost per episode, and effectiveness in diverting people from hospital or long-term care) indicates nearly two thirds of people able to return home on discharge from intermediate care.²³ In addition to these dimensions of costs and outcomes are the important aspects of qualitative evaluation and quality of life criteria. Godfrey *et al* found intermediate care making *“a significant difference”* to people’s lives, with the service being viewed positively – particularly in the user-centred focus which contributed to maximising people’s abilities and building their confidence. Barton *et al* similarly found patients associated the experience of intermediate care with *“patient-centredness, flexibility and opportunities for independence”*. The aspect of care that received the lowest satisfaction scores was the timing of discharge, with patients often finding the six-week cut-off point came too soon and with no ongoing support with their needs.

- 2.18 Intermediate care is clearly about much more than functional rehabilitation and enabling people to return to a level of independence. As McLeod *et al* point out, there is also a potential contribution in facilitating re-engagement in social networks, and having regard for people’s psychological well-being alongside their physical health.²⁴

Moreover, such dimensions are integral to the definitions that people (including frail older people) attach to good health, which extend beyond 'not being ill' to *"enjoying and negotiating the benefits for psychological and physical well-being of multiple dimensions of social networks"*.²⁵ The importance of defining prevention and rehabilitation in comprehensive terms which address 'high-level' or intensive support alongside 'high-coverage' simple services has been emphasised by others, including work by CSCI tracking the experience of people discharged from hospital.²⁶

- 2.19 McLeod *et al* studied five Age Concern pilot aftercare social rehabilitation projects (following discharge from hospital). Social rehabilitation was defined as time-limited interventions to help restore confidence and skills lost through injury, bereavement or other trauma or loss, and focusing on motivation and restoring valued social roles and networks. In addition to underlining the importance of access to social networks in people's recovery, the study emphasised the connections between such support and 'low-level' social care interventions which facilitated recovery and social engagement.
- 2.20 Intermediate care clearly forms an important part of services concerned with 'prevention'. Because of the variety of schemes and models of support that are included under the general banner of intermediate care, it is important that there is clarity about the specific objectives of and outcomes from any given scheme. The Wanless review also emphasised the need for clarity on the desired outcomes, and concluded:
- "If these are immediate improvements to quality of life and/or functional status, then the most recent evidence suggests targeting patients with the greatest clinical need whose intermediate care services will be relatively expensive. If immediate cost savings are the main aim, then admission avoidance schemes should receive more emphasis, although this does not take long-term care costs into account. A balance is needed between the two approaches."*²⁷
- 2.21 Interventions which focus on admission avoidance occupy a continuum. At one end are those which address the high risks which often precipitate an emergency admission (such as falls), while at the other are the 'low-level' interventions which may support people in living their lives independently for longer. Curry's review of evidence on falls prevention cites estimates that accidental falls represent an annual cost to health and social services of £1 billion, with some 41% of this falling on social services. In addition to the potential savings that could arise from preventing falls and injuries (particularly hip fracture), there are wider potential benefits in reducing the likelihood of a fall that typically marks the onset of a downward spiral of increasing dependency.
- 2.22 There are obvious problems with identifying cause and effect in falls prevention programmes, and the range of approaches in different studies, together with different measures and outcome data, make it *"impossible form this information to make generalisations about the cost effectiveness of falls prevention services"*.²⁸ Interventions which concentrate on improving physical functioning (through muscle strengthening and balance exercises) may not prove cost-effective in terms of overall impact on health costs, but as Curry points out, wider benefits may accrue. A study in New Zealand, for example, found that participants in a prevention programme had

better physical functioning that was not counted within the cost-effectiveness judgement:

*"...such preventive interventions may yield benefits for an individual's independence which may not be represented in cost-effectiveness calculations, or which may prove cost effective in the long term. Whatever the ultimate cost effectiveness, the programme was relatively low cost and was shown to improve physical functioning. Related to this is the issue of the importance of cost effectiveness versus cost savings or cost minimisation and just how appropriate and desirable it is to put a price on a person's independence or happiness."*²⁹

'Low-level' interventions and quality of life

2.23 A model of intervention concerned with promoting health and well-being is that of 'healthy living centres' established in 1999 with support from the New Opportunities Fund. One of these (the Upstream Healthy Living Centre in mid-Devon) has been the focus of independent evaluation.³⁰ Upstream is a community-based intervention *"operating on an outreach basis with mentors working closely with socially isolated people over the age of 50 to re-kindle their passion and interest in life by engaging in self-determined programmes of activities."*³¹ Qualitative interviews found most participants reporting an increased sense of well-being and optimism and increased social activity:

*"The evidence suggested that the intervention might be particularly successful in ameliorating depression/loneliness and improving quality of life in general. Increased cognitive alertness was also cited as a psychological benefit."*³²

2.24 However, as with many such interventions, the absence of a control group makes it difficult to attribute cause and effect. The authors acknowledge that the cost-effectiveness of the intervention cannot be demonstrated without further explanatory research, but conclude that *"on balance, the idea that Upstream is responsible for at least some of the changes identified seems the most likely explanation at this stage."*³³

2.25 The emphasis in the transformation agenda on maximising choice and control underlines the importance of quality of life dimensions. As the Wanless review, and other commentators, have observed, 'low-level' services can be of central importance. However, while qualitative evaluations (including the Upstream initiative) consistently find that 'low-level' support (such as help with housework and gardening, and befriending opportunities) can improve self-esteem and improve the sense of control and independence, the impact is on dimensions of quality of life and *"the extent to which it delays deterioration or reduces service utilisation is unclear on the evidence available."*³⁴

2.26 It may be the case that quality of life objectives should be conceptualised outside of a preventive framework. Improving people's physical and psychological well-being and quality of life are entirely legitimate objectives, but to assume that they will necessarily 'prevent' longer-term deterioration may impose inappropriate evaluation criteria. We will address such dimensions more fully when we explore personalisation, but 'low-level' services can be conceptualised particularly in terms of

user-defined outcomes. Qureshi *et al* have distinguished between outcomes concerned with change, maintenance and process. Maintenance outcomes are those which principally address well-being and quality of life (meeting basic physical needs; ensuring personal safety and security; living in a clean and tidy environment; keeping alert and active; having access to social contact and company, and having control over everyday life).³⁵

- 2.27 Retaining independence and autonomy have a universal resonance, as Harding has pointed out:

*"...these aspirations are common to all older people, not just those who are relatively active and healthy...the evidence from older people themselves is that inclusion and quality of life are just as important to those whose health or mobility are impaired as it is to more active older people."*³⁶

- 2.28 If the area of intermediate care is beset with problems of definition, this is no less true in the case of 'low-level' prevention services. As Curry has pointed out, no standard definition appears to exist, however:

*"low-level or low-intensity interventions are those services or initiatives that require minimal resource input in terms of working hours and do not necessarily require the input of specialist professionals. Examples of services that might be classed as low-level include help with those tasks that people find difficult as they get older, such as gardening, laundry, cleaning and shopping."*³⁷

- 2.29 However, this apparently straightforward definition is muddled by the fact that other definitions of 'low-level' interventions sometimes include home adaptations and home repair schemes, as well as wider interventions concerned with social inclusion and well-being. A 1999 review by Godfrey, undertaken for the Anchor Trust and the Joseph Rowntree Foundation, found the research knowledge was insufficiently robust to provide definitive answers about the impact of 'low-level' social care interventions, but that this *does not in itself mean that preventive interventions are not effective*.³⁸

- 2.30 Curry also found little quantified evidence on the outcomes of 'low-level' interventions, but noted the considerable volume of *qualitative evidence* which typically points to the high value attached to such interventions.^{39 40} Not only are 'low-level' interventions of intrinsic value to the people who use them, but typically they also offer benefits in terms of people being able to maintain control, dignity and independence (objectives that, as we have noted earlier, are central to the current transformation agenda in adult social care).

- 2.31 The value of 'low-level' interventions is not really in doubt; but this is not necessarily the same as demonstrating that 'low-level' support has a direct and quantifiable benefit in preventing deterioration or the need for long-term care. This is not to say that 'low-level' support is not cost-effective, but to be very clear about the objectives that need to be established for these interventions, and the appropriate measures that need to be developed for their evaluation. Improving the psychological and mental health of older (and other) people, enabling them to maintain social networks, and to live in an appropriate environment over which they have some control, are important outcomes *in their own right*. As Qureshi and Henwood conclude:

“Effective services from the perspective of older people are those which: directly maintain, or remove barriers to achieving, quality of life (keeping clean and comfortable, living in a clean and orderly environment, being safe, having access to social contact and company, being able to keep active and alert, and having control over one’s life) and which do so in a way which ensures that people are treated as fellow citizens with respect for their individual priorities and circumstances.”⁴¹

2.32 Moreover, these quality of life dimensions are not unique to older people, but might more usefully be conceived as dimensions of citizenship.

Partnerships for Older People Projects

- 2.33 Much of the above discussion around prevention in social care has explored approaches to prioritising support for people who are identified through a largely professionally determined agenda. As we have noted, a major focus of prevention – particularly the development of intermediate care – has been on reducing delayed patient discharges from hospital. In March 2005 the Department of Health announced funding of £60m for councils to develop “innovative ways to help older people avoid emergency hospital visits and to live independently longer” through services “which enhance the independence, health, and well-being of older people living at home.”⁴² Rather than providing support at the point of crisis (at a major transition between independence and dependence), the Partnerships for Older People Projects (POPP) programme is intended to provide early intervention.
- 2.34 The POPPs grant provided ring-fenced funding (£20m in 2006/07 and £40m in 2007/08) for councils to establish local projects in partnership with older people, primary care trusts and the voluntary, community and independent sector (in total supporting 245 projects in 29 pilot sites). The wider focus on health and well-being has been an increasingly prominent objective of policy set out in the 2005 Green Paper, *Independence, well-being and choice*⁴³, and reinforced in the subsequent White Paper, *Our health, our care, our say*, in January 2006.⁴⁴
- 2.35 The POPPs initiative is subject to independent evaluation and the final report is not due until October 2008. Interim findings have highlighted the following:
- Compared with non-POPP sites, the POPP pilots are having a significant effect on reducing hospital emergency bed-day use (with estimates that for every £1 spent on POPP, £1 will be saved on hospital bed-days).
 - Pilot sites are reporting improved access for excluded groups through proactive case finding, greater publicity and links with the voluntary sector.
 - Partnerships between statutory organisations and the community and voluntary sectors have improved compared with the situation prior to POPP.
 - Pilot sites are reporting improved engagement of older people within steering groups, and in commissioning, recruitment, provision and evaluation processes.
 - Older people’s health and well-being needs are becoming better integrated within the wider strategic agenda.⁴⁵
- 2.36 The pilots are providing a diverse range of interventions to promote independence for local older people. Importantly, the projects include many which are concentrating on

targeting support for older people whose needs are below or borderline for eligibility for FACS-defined social care. Some of these projects take the form of 'signposting' to other services. As we found in our study on the impacts of FACS, signposting can be active or passive, but for it to be more than simply providing information, there needs to be support to help people navigate their way through the system. There are signs that POPPs schemes are addressing these requirements by:

- ensuring that referrals are made between services
- ensuring that fast-tracking is possible for people who need immediate help
- establishing outreach through services to find people who might not otherwise contact services
- follow-up and review of individual cases.⁴⁶

2.37 The findings of the independent evaluation are awaited. It will be important that this reflects the breadth and depth of POPPs initiatives, particularly in capturing the evidence on quality of life. While data are being collected across the projects, in-depth analysis is taking place in only six of the 29 sites, and it would be a missed opportunity if this was not able to provide analysis of the value of 'low-level' and similar early interventions beyond measures concerned with hospital bed utilisation.

Housing adaptations, improvements and equipment

2.38 The role of housing in contributing to people's capacity to remain independent is crucial. Clearly this is not a responsibility of social services, but it *does* underline the importance of adopting a strategic approach to supporting independence and well-being which engages the wider community. Work by the Office for Disability Issues (commissioned as part of the Independent Living Review) has explored the research evidence and, while acknowledging the difficulties of disaggregating the impact of complex interventions, has concluded that the provision of housing adaptations and equipment for disabled people can produce savings to health and social care budgets in four major ways:

- reducing or completely removing an existing cost (specifically around residential care and intensive home care)
- preventing an outlay that would otherwise be incurred (notably prevention of accidents such as hip fractures), and prevention of admission to residential care
- preventing waste
- better outcomes for the same expenditure.

As the authors comment:

"Not all adaptations save money. But when they are an alternative to residential care, or prevent hip fractures or speed hospital discharge; where they relieve the burden of carers or improve the mental health of a whole household, they will save money, sometimes on a massive scale."⁴⁷

2.39 Cause and effect is not easy to demonstrate, and isolating the single factor of a housing intervention among a complex interplay of other factors is extremely problematic. However, the key message that investment in housing adaptations and

repairs can have a central role as part of a wider prevention strategy has been taken up in the Government's strategy for lifetime homes.⁴⁸ The strategy addresses the importance of 'preventative housing services' including advice and information, and adaptations and repairs *"which prevent health and care crises for individuals"*. However, in seeking to improve effectiveness by identifying people most at risk, a new approach to early intervention and prevention is to be piloted using predictive risk modelling developed by the King's Fund *"to accurately identify which people will have a health or care crisis, such as a hospital or care home admission a year before it happens"*.⁴⁹

- 2.40 This is extremely ambitious and such a model *could* have significant application in identifying individuals for preventative services, as well as predicting future population needs. However, the range of possible models discussed by the King's Fund⁵⁰ are relatively blunt instruments in their understanding of social care data. One model, for example, suggests using data on people identified at 'FACS critical' as a key predictor of risk, while others focus on people at risk of nursing home admission, or simply use high-cost data as a proxy for need. Given that there are well-documented difficulties with the FACS framework – both in terms of the inconsistencies within and between councils, and in the lack of coherence between FACS and the emerging personalisation agenda⁵¹ – it is arguably inappropriate to use FACS as any objective indicator of need or as the basis for preventive intervention. These 'high-end' predictive models would not appear to offer anything to the lower end of prevention and are concerned with stopping people who already have significant social care needs needing more costly interventions. The scope for using this model (or any of its variants) remains to be seen, but there are obvious risks in focusing 'prevention' strategies only at the highest level of need, and not also addressing prevention more holistically and further upstream.

Overview of prevention

- 2.41 The foregoing analysis has explored the meaning of prevention in the social care research literature. It is evident that the concept is highly complex and multi-dimensional. Any judgement about the preventive value of any intervention has to be made in terms of the specific objectives it is trying to achieve, which in turn determine the relevant outcome criteria and cost-effectiveness indicators.
- 2.42 Much of the debate about prevention has been a professionally dominated one. The factors which have focused interest in the value of prevention have primarily been those concerned with establishing that particular investment can generate longer-term savings for public expenditure. These objectives may coincide with improved outcomes for people needing social care, but this is not axiomatic. Experience in the area of intermediate care has highlighted the tensions which can exist between professional- and managerial-led agendas (maximising hospital throughput) and those concerned with the best interests of people who use services.
- 2.43 Because of the complexity of interplay between various potential outcomes and of multi-factorial variables, it has been notoriously difficult to attribute cause and effect to preventive interventions, and to demonstrate cost-effectiveness. The discussion on 'low-level' interventions has also underlined the central importance of quality of life

dimensions, which often fail to be adequately acknowledged in evaluations and which can be overlooked if the prime concern is with savings within the health and care system. It is against this background that the emerging policy emphasis of personalisation must be located. What distinguishes this development from much of the professional-decision models of prioritisation is the central focus on outcomes and user-defined objectives. We turn now to explore the characteristics of personalisation and the origins of the self-directed support framework which provides its philosophical underpinning.

3 Personalisation

The underlying principles

3.1 The terminology of 'personalisation' and 'Individual Budgets' has rapidly entered the lexicon of social care. Although these concepts are of relatively recent origin, they build on a much longer established discourse around the social model of disability and the emerging ideology of independent living. In place of traditional, 'medical model' understandings of disability, the social model has challenged interpretations and offered instead a socio-political understanding which emphasises the right to self-determination and citizenship. The 2005 report *Improving the life chances of disabled people*,⁵² published by the Prime Minister's Strategy Unit, defined disability as:

"Disadvantage experienced by an individual resulting from barriers to independent living or educational, employment or other opportunities that impact on people with impairments and/or ill health."

3.2 Attitudinal, policy and physical barriers can all combine to marginalise disabled people from the mainstream of society and the economy. Removal of these barriers is therefore the key to empowering disabled people, and the Government set out a 20-year vision for improving life chances such that:

"By 2025, disabled people in Britain should have full opportunities and choices to improve their quality of life, and will be respected and included as equal members of society."

3.3 While the historical focus of policy on disabled people as dependent has led to a concern with 'care' which can reinforce dependency, the new approach is characterised by a focus on promoting independent living. The *Life chances* report emphasised that while disabled people may need support with daily living, this does not mean they have to be 'dependent'; rather, *"independence comes from having choice and being empowered regarding the assistance needed"*. Furthermore, the report acknowledged that disabled people are *"best placed"* to take the lead in identifying their own needs and in identifying the most appropriate means of meeting them.

3.4 The future strategy for disabled people addressed four key areas:

- helping disabled people to achieve independent living
- improving support for families with disabled children.
- facilitating a smooth transition to adulthood.
- improving support and incentives for getting and remaining in employment.

3.5 It was recognised that new ways were required to support people to achieve independent living, including the use of Individual Budgets. The 2005 social care Green Paper, *Independence, well-being and choice*,⁵³ similarly outlined a vision for a system in which *"adults are able to take greater control of their lives"*, and accepted the recommendations of the Strategy Unit report that Individual Budgets should be

piloted as a means of offering greater choice, empowerment and freedom. This new system will require a debate about risk management and the balance between protecting people and *“enabling them to manage their own risks”*, while also putting people *“at the centre of assessing their own needs and how those needs can best be met”*.

- 3.6 Thirteen Individual Budget pilot schemes were subsequently established in 2006. Unlike Direct Payments these pilots were able to integrate other funding streams. In addition to social services expenditure on adult social care, potential funding was also available through Supporting People, the Independent Living Fund, the Disabled Facilities Grant, the Integrated Community Equipment Service, and Access to Work. Not all funding streams were being integrated in all 13 sites, and not all sites were covering all adult care groups. At the time of writing (March 2008) the report of the independent evaluation of the Individual Budget pilots is imminent. However, in advance of those findings becoming public, the Government has already committed itself to extending personal budgets. Since the pilots were established it appears that there has been a shift in the commitment to the underlying principles of personalisation, and the value of the evaluation will lie primarily in how it can inform further development by demonstrating which models work best for which groups of people using social care support.
- 3.7 The White Paper of 2006 (*Our health, our care, our say*) confirmed the objectives of the Green Paper of providing high-quality support to meet people’s aspirations for independence and greater control over their lives, and to shift services into a more personalised model to fit around people’s needs.
- 3.8 *Improving the life chances of disabled people* was followed in 2006 by the establishment of the Independent Living Review to develop a strategy for delivering the objectives of independent living. The report of the review in 2008 addressed personalisation, choice and control in the following broad terms:
- “We will support the transformation of social care to deliver a system which will focus on timely, preventative and high quality personally tailored services. We want everyone – whether they receive state-funded support or fund support themselves – to have maximum control and power over the support services they receive and we will work with local authorities and key partners to help them deliver this.”⁵⁴*
- 3.9 Increased personalisation will be promoted through personal budgets and Direct Payments. There is a specific commitment to extending the scope of Direct Payments to people who are currently excluded (people without capacity), and this has been addressed in the Health and Social Care Act 2008.

The origins of self-directed support

- 3.10 In order to understand the current policy direction and the emphasis on personalisation, it is important to locate this within the wider development of self-directed support and the promotion of independent living. The concept of personalisation which is at the heart of Direct Payments and Individual Budgets has

also been developed through other initiatives, both in the UK and internationally.⁵⁵ Lord and Hutchison observed in 2003 that:

“A worldwide paradigm shift is occurring in the disability field. Regardless of whether the focus is in physical disabilities, learning disabilities or mental health service users, the paradigm shift reflects a move away from institutional services and professional control towards an emphasis on self-determination and community involvement.”⁵⁶

- 3.11 At the heart of some of this development, in addition to a core emphasis on person-centred planning and individualised response, has been a parallel focus on the idea of individualised funding, or money provided directly to the person. In reviewing ten such initiatives in Canada, the US and Australia, Lord and Hutchison found that all shared explicit underlying values and principles – typically a commitment to self-determination and community participation and inclusion. The review highlighted the importance of recognising that the budget is only one element of individualisation, and that too much concern with the funding mechanisms without sufficient attention to other elements such as network building and person-centred planning *“could create a false impression that having money alone would solve serious disability issues”*. However, individualised support and funding *together with* a focus on building community capacity and network building *“can be seen as critical elements of the new paradigm of disability and community”*.⁵⁷
- 3.12 Direct Payments have existed in the UK since April 1997. The Community Care (Direct Payments) Act of 1996 gave councils powers to make cash payments, or to provide a combination of services and cash, instead of local authority commissioned services for disabled people who were willing and able to take responsibility for their own support arrangements. Initially Direct Payments were available only to eligible people aged between 18 and 65, but further extension made them available to people aged over 65 from February 2000, and to carers, parents of disabled children and to young people in transition (16- and 17-year-olds) from April 2001.
- 3.13 Take-up of Direct Payments remains relatively low, although it is of growing significance. The latest data indicate that 12,000 more people used Direct Payments in March 2007 compared with the situation a year before (40,600 compared with 32,000). Even so, Direct Payments account for only £2 in every £100 of total gross spending on social care (and 6% of net spending). However, if spending on community services for adults with a physical or sensory disability is considered, direct payments account for more than one fifth of expenditure.⁵⁸ Take-up also varies significantly between different councils, and in ways which cannot be explained by differences in socio-demographic factors.
- 3.14 It is also evident that not everyone who uses social care (or might do so) has equal access to Direct Payments. The latest information comes from a major national survey which found that direct payments were most often provided for people with a physical disability or sensory impairment, compared to other groups, and least commonly to people with a mental health problem.⁵⁹ However, as the authors point out, considerable variation between councils underlines the significance of some embracing user-centred care through direct payments, while others continue to lag behind. Despite improvements in take-up of direct payments, the continuing variation between councils, between different parts of the UK, and between service

user groups, *“raises questions about the impact of devolved governance on equity and social justice for people supported by social care services and their carers across the UK”*.⁶⁰

- 3.15 The national survey also pointed to a *“shift in the dynamics of implementation”*. The initial development of Direct Payments was strongly associated with user-led support organisations, particularly for people with physical disabilities. Although Direct Payments have been extended to other groups of people, there remains a legacy from the early development such that there is greater take-up in councils and areas that were particularly associated with early implementation. Strikingly, these same areas which pioneered take-up for people with physical disabilities *“had some of the lowest levels of direct payments uptake among people with learning disabilities”*.⁶¹ Other evidence about differential client take-up comes from a joint review by the Healthcare Commission and CSCI of adult community mental health services, highlighting the fact that *“take up by people who use mental health services lags behind other groups”* and accounts for just 0.3% of expenditure.⁶² Brewis argues that the reasons for this poor take up reflect the impact of misunderstandings, myths and concerns about the appropriateness of self-directed support and Direct Payments being offered to people with mental health problems.⁶³
- 3.16 In the same way that care managers can be highly influential in ‘gatekeeping’ access to social care and judging whether or not people satisfy eligibility criteria, the survey found that care managers also *“impose selective criteria in decision making – for example, generally only offering Direct Payments to clients who are able to express their needs and clarify the types of support arrangements they wanted”*.⁶⁴
- 3.17 The extension of Direct Payments and the promotion of personal budgets both have the potential to extend personalisation in social care, but not necessarily *of themselves* to challenge the eligibility criteria or determinants of who has access to social care. At the present time the 13 Individual Budget pilot sites have required people to meet FACS eligibility thresholds before they can be offered the option of an Individual Budget. The Individual Budget is about the process and nature of support, *not* about the threshold for access. However, there is anecdotal evidence that more, and different groups of, people are making use of Individual Budgets than would be the case with conventional social care. This is not about the threshold for eligibility changing so much as people making their own decisions about whether they want to access social care. People who might be unaware of social services, or who do not believe what is on offer is appropriate for their needs (for example, people from Black and minority ethnic communities) might be more inclined to seek help if they know they can have greater control over the support they can access and how they use social care resources.
- 3.18 The increasing demand for support which can accompany new models of personalisation has also been documented in comparable schemes within Europe,⁶⁵ and in the Western Australian development of local area coordination.⁶⁶ In the case of the latter, access to the ‘full programme’ has been restricted to people who meet eligibility defined in terms of levels of disability, while people who ‘self-identify’ as having a disability are entitled to a lower level of support in terms of information and advocacy. There are obvious parallels in this approach with the ‘universal offer’ aspect of Putting People First.

In Control

- 3.19 Until the findings from the Individual Budget evaluation become public the major evaluation of personalisation and self-directed support is that of the first and second phases of *In Control*. *In Control* came into being in 2003, under the joint sponsorship of Mencap and the Valuing People Support Team. The initial objectives were to respond to the requirements of the White Paper *Valuing people*, and a new model was developed based around principles of self-directed support. Work took place initially in six sites to test and develop the concept of personalised budgets and support plans for people with learning disabilities. Since 2005, a second phase of activity has turned to examine the development and adaptation of the model of self-directed support such that it is appropriate for *all* people who use social care. At the heart of the approach is a model of service brokerage providing advice, and administrative support through local (and typically user-led) organisations. As the research briefing from the Social Care Institute for Excellence has highlighted, service brokerage – operating independently of funding – is a defining feature of many consumer-directed schemes. The values of brokerage are not simply about accessing services but are linked “to a vision of full citizenship and quality of life to which recipients are entitled”.⁶⁷ Commitment to this ideology characterises developments through *In Control*; it is this which attracts praise from admirers, but it is also the ‘evangelical zeal’ of the commitment which has encouraged detractors.
- 3.20 The scale of *In Control* development is impressive; moving from the initial six sites to having 60 councils as signed up members by 2005, and 107 by the end of 2007. The conceptual understanding of the principles of self-directed support has been extensively developed by *In Control*. The essential core of the model is that “*self-directed support is about disabled people exercising their rights to determine their own lives with the clear goal of achieving independent living*”.⁶⁸ The model of self-directed support is based around the identification of an individual or personal budget, so that people know up front what funding they are entitled to. Unlike direct payments, the model has also reduced restrictions on how the money can be spent “so that people can plan the creative use of their budget, meet their support needs in a way that makes sense to them and exercise their rights as citizens”.⁶⁹ It is this model which has informed the subsequent development of the Individual Budget pilots.
- 3.21 The second phase evaluation presents findings from a sample of 196 people in 17 councils using personal budgets through *In Control*. It is important to emphasise (as indeed the authors acknowledge) that this is not a full-scale, comprehensive evaluation of self-directed support, but draws on low-impact and low-cost monitoring. The sample of people is not a complete or necessarily representative sample; people were drawn from a small number of councils, and people with learning disabilities were over-represented in the sample. Despite these caveats, data from nearly 200 people using self-directed support indicate improvements in key domains including spending time with people they liked, quality of life, taking part in and contributing to the local community, choice and control over their lives, and personal dignity. These are areas in which self-directed support would aim to have an impact. Most people reported no change in terms of general health and well-being, safety and security at home and economic well-being, which are described as

“areas of life where self-directed support would not aim to have a direct impact in the short term”. Where people had been using the system for more than a year, however, they were more likely to report improved health and well-being and economic well-being, *“suggesting that self-directed support may require a longer period for improvements in these areas to be apparent”*.

- 3.22 For some outcome dimensions, people with learning disabilities and people with physical disabilities were more likely to report improvements than were older people. At present it is not clear what this may indicate as the numbers involved in the study are small, but the authors suggest it is possible that it is because older people were less likely to have been using social care support prior to the introduction of self-directed support, and they had also been using self-directed support for a shorter time. The longer-term impact of self-directed support, and the impact on the lives of different groups of people, will need careful evaluation before definitive conclusions can be drawn.

Overview of personalisation

- 3.23 The policy commitment to developing personalisation in social care (and potentially in a wider range of public services) has been outlined. The evolution of the concept of self-directed support which has taken place in the UK over the last decade and a half can be traced to various influences, not least the growth of campaigning user-led organisations which have lobbied for the right to exercise choice and control over the nature of the support they want. It is also evident that this development is part of a wider international shift and the identification of a new paradigm.
- 3.24 The coexistence of the newly emergent model of self-directed support *alongside* the pre-existing framework of Fair Access to Care Services creates some obvious tensions. While the new model is concerned with maximising the choice and control available to people who need to use social care, it cannot *of itself* determine how eligibility of those groups is defined. Without a significant change to bring a model of prioritisation more in line with that of personalisation, there will remain significant – and inappropriate – restrictions on the scope for self-directed support to achieve the ambitious objectives which are being set.
- 3.25 Moreover, not only does personalisation not solve the dilemmas of people with needs for support who are currently deemed ineligible for social care, but it is also possible that the model of self-directed support introduces *some additional risks* that certain groups of people may be marginalised. This need not be intrinsic to the nature of self-directed support, but it *is* an area where it is likely that specific attention will be required in order to ensure greater equity. As we have described above, both direct Payments and personal budgets to date have not been equally available to all adults who use social care. Even within a legal framework that creates the preconditions for wider availability, the assumptions made by some care managers and others about the capacity of people to benefit from self-directed support has limited its reach, particularly for older people and people with mental health needs.

4 Prioritisation

Introduction

- 4.1 The third 'P' in this review is 'prioritisation'. Principles and policies can determine the direction of public services reform, but at some point a decision has to be taken on precisely how scarce resources are to be allocated to individuals in need of support. We can conceptualise this decision as the point at which some sort of understanding – either implicit or explicit – is used as the rationale for meeting some claims and not others. Logically this understanding (or, as we will term it, 'eligibility framework') should be a second order issue that reflects higher order principles and policies, and it should be based upon a clear rationale. In other words there should be consistency of approach across principles, policies and prioritisation, for if the last is out of step, then it could pull the others in unintended directions with perverse consequences for individuals.
- 4.2 There are several types of eligibility framework being used in social care, each resting upon different organising concepts and each having potentially very different consequences for individual claims. Perhaps surprisingly there seems to have been very little examination of these various options and the extent to which they are consistent with proclaimed principles and changing policies. In this part of the report the intention is to examine some wider issues about eligibility for social care in order to place the current FACS model in a wider context, both nationally and internationally. The review begins by looking at some general underlying issues about prioritisation in resource allocation, then goes on to identify a range of approaches, each with different underpinning assumptions.

Claims, rights and rationing

- 4.3 All governments are concerned to hold down public spending and all societies limit access to social care in some way, and although the concept of rationing is often described pejoratively, there is nothing inherently wrong with allocating resources according to a set of priorities. In setting up such arrangements, eligibility frameworks are a key mechanism, serving to regulate service provision in line with available resources and identified priorities. Where resources become tighter, these criteria can be adjusted in order to narrow access to support, but greater exposure may give rise to controversy over the extent to which such criteria are equitable in principle and consistently applied in practice. It is precisely this dilemma that is bedevilling the current arrangements, Fair Access to Care Services.
- 4.4 Conceptually there are two distinct processes at work here – *priority setting*, which denotes the allocation of resources to particular services or programmes, and *rationing*, which refers to the distribution of resources to individuals at the point of service delivery. This review focuses upon rationing rather than priority setting – the latter will be examined in due course in the Green Paper on social care funding expected later this year. The distinction is important. Although there is clearly a funding issue to be addressed in respect of social care, extra funding would not

necessarily alter the way the care system works. This will only happen when there is a different conceptualisation of social care which is underpinned by a clear rationale for the allocation of resources. It is an exploration of the rationale for different approaches, and their respective relationship to emerging policy, that lies at the heart of this review.

- 4.5 The view that rationing is inescapable is based upon the economists' assumption of scarcity: there is never enough of anything and therefore rationing is ubiquitous. The basic model assumes not only that all resources are scarce, but that people are never satisfied – the principle of 'non-satiation'.⁷⁰ In the case of social care, the sources of demand are well established, with the ageing population in particular creating a triple impact: thus there are more older people, older people are living longer, and they are living longer with more complex needs. The last point also applies to adults below pensionable age with physical and learning disabilities. In addition, rising unit costs alongside limits to the future supply of unpaid informal care will cause the total cost of care to rise significantly, even without improvements in quality to meet any 'non-satiation' and rising expectations.⁷¹
- 4.6 The standard microeconomic model assumes that people deal with scarcity by having preferences, and by trying to maximise their preferences in rank order of priority. This also allows for the calculation of 'opportunity costs' which are the value of the alternatives that might have been chosen. The complicating factor here is those rationing decisions that are taken *not* by individuals, but by the state acting on their behalf – the typical situation in respect of social care. In their sociological examination of the issues, Light and Hughes⁷² reframe such rationing as "*a form of collective planning that suppresses individual choice*". They go on to say that this sort of rationing happens "*when people are denied scarce resources which they would have chosen if given the opportunity, and which would have been of benefit to them*". Given the Government's agenda on choice and personalisation – outlined earlier in this review – it could be argued that the prime purpose of eligibility criteria should be to seek maximum reconciliation between scarcity and user/carer preferences.
- 4.7 This is no easy task, raising dilemmas that moral philosophers have not yet been able to solve. In the case of social care there is no automatic right or entitlement, rather there are 'claims'. Having a claim to 'X' is not necessarily the same as having a right to 'X', but constitutes a case of at least minimal plausibility that one has a right to 'X'. A claim establishes a right to consideration, and claims will differ in degree with some being stronger than others. By contrast a 'moral right' is held to exist prior to, or independently of, any legal or institutional rules, and might be best summed up by the concept of 'respect for persons'. Harris⁷³ defines this in the following way:

"The ultimate aim of the whole social way of life is the fullest possible development of the capacities of the individuals who make up the society concerned, giving the fullest possible satisfaction of the complete personality...The most important values can be enjoyed by any person only if, and to the extent that, they are enjoyed by all."

- 4.8 Whilst the notion of 'respect for persons' might be a useful summary of the basis of social work values, for a moral right to be absolute it would have to threaten no conflict with other moral rights. It is difficult to think of many such entitlements in respect of social care beyond a negative right not to be treated inhumanely or a right not to be subjected to exploitation or degradation. Beyond this there can be only claims rather than rights, and it is down to legislators (national and local) to rank claims in respect of importance – in other words to determine the basis for eligibility.

Priorities and rationing in social care

- 4.9 Rationing has always been a dilemma in social care, just as in other public services. The 1989 White Paper, *Caring for people*,⁷⁴ for example, envisaged a future of user-centred, needs-led assessment and care management, but this had to be squared with financial probity:

"The aim of assessment should be to arrive at a decision on whether services should be provided and in what form. Assessments will therefore have to be made against a background of stated objectives and priorities determined by the local authority. Decisions on service provision will have to take account of what is available and affordable. Priority must be given to those whose needs are greatest."

- 4.10 Early reports of implementation found most authorities spreading their resources thinly across many cases, and this led to calls for a clearer definition of eligibility on the part of local councils to ensure that the greatest needs were met first. Writing shortly before the introduction of FACS, Arksey⁷⁵ and Tanner⁷⁶ noted that the slim evidence available was suggesting that:
- local authorities were tightening eligibility criteria to determine who qualified for an assessment
 - initial screening processes (often undertaken by reception staff) were being used to establish the level and type of assessment required, and the urgency of the need
 - subsequent service provision was being delayed, reduced or withdrawn, leaving people to manage with inadequate levels of care, or even no care at all
 - people in seemingly similar circumstances were receiving different levels and types of service provision
 - decisions about care were driven by what was available rather than being tailored to individual needs.
- 4.11 It was in order to address this inconsistency of approach on the part of councils that FACS was introduced in 2003, yet the evidence of our 2008 report for CSCI⁷⁷ suggested that the dilemmas described by Arksey and Tanner remain in place. We concluded that:
- The decision to restrict eligibility for social care to certain FACS categories is not one that any council makes lightly. Councils are obliged to find ways of rationing resources because of wider issues about comprehensive under-funding by central government.

- It is clear that reducing eligibility *does not* eliminate demands for support and people with ostensibly eligible needs are rejected by councils.
- Councils are increasingly focusing on narrowly defined areas of core business of adult social care. This is in fundamental tension with the objectives of personalised support which are being encouraged by models of direct Payments and the adoption of Individual Budgets.
- In many cases the absence of help results in deleterious outcomes for the people concerned, but also more widely for the social care system.
- At central level there is a powerful case for greater priority for social care expenditure. At local level more sophisticated and flexible approaches to rationing are required which do not rule out support for entire types of need or classes of applicants.
- An outcome-focused framework for the delivery of social care demands a different operational model from the FACS determination of rationing and ineligibility.

4.12 Allen *et al*⁷⁸ have noted that allocative decisions are made at a number of levels:

- at the *macro* level, politicians have to decide on the level of welfare funding and how this should be distributed between areas
- at the *meso* level, intermediate bodies like local councils make decisions about the resources allocated to different services
- at the *micro* level, the conflicts and dilemmas created by these decisions have to be managed by professionals and other service providers.

4.13 We drew upon this distinction in constructing our '3D' framework to analyse the ways in which rationing takes place under the current system:

- *Rationing by directive* refers to the elaboration of rules and procedures to determine who gets what in terms of services and support – in effect the various formal attempts by agencies to locally implement FACS. The key characteristics of rationing by directive are that it is (or should be) explicit and rule-based, resulting in clear, consistent and standardised responses to all of those who fall within the remit of the 'directive'. It is a model rooted in the top-down view of policy implementation.
- *Rationing by discretion* refers to the exercise of professional judgement in the rationing process. This bottom-up perspective provides a contrast to the top-down approach of rationing by directive. Whereas top-down models put their main emphasis on the ability of decision-makers to produce unequivocal policy objectives, and on controlling the implementation stage, bottom-up critiques view local 'street-level bureaucrats' (in this case, social workers or care managers) as a key influence upon policy delivery. The important issue here is the extent to which the exercise of professional discretion can, in practice, reformulate policy and thereby make or break the paradigm of rationing by directive. The key characteristics of rationing by discretion are that it will be informal and individually focused, with judgements potentially varying on a case-by-case basis.

- *Rationing by diversion* refers to the attempt to limit demand upon one part of the system by either diverting it to other parts, or by simply returning responsibility to the applicant. The greater the system demands, the tighter any eligibility criteria will be drawn, and the greater the likelihood that diversionary rationing will be instituted. The key issue here will be the extent to which such diversion is reasonably meeting the needs of applicants, rather than simply diminishing the budgetary problems of the diverting agency. Rationing by diversion may encompass characteristics of both of the other modes of rationing – it may be explicit and rule-based, but it may also be heavily contingent upon discretionary judgement.

Priorities and rationing in social care: a comparative perspective

- 4.14 Britain is not alone in grappling with the dilemma of resource allocation and rationing in social care – all European countries share major challenges. One recent study for the European Commission,⁷⁹ for example, studied long-term care in a sample of eight countries – the Czech Republic, France, Germany, Italy, the Netherlands, Poland, Sweden and the UK – and confirmed that: :

“Concerns about the impact of demographic trends, financial constraints, quality of services and the need for better adapting them to users’ needs, are at the top of social policy agendas for long-term care services.”

- 4.15 However, despite facing common problems, EU member states differ widely in the ways that long-term care is organised, accessed and funded, and this is the case for all core aspects of long-term care: access to services and their financing, the role of families and informal care, and the quality of care. Whereas in Britain the trend has been towards establishing a national framework for eligibility (FACS) in an attempt to address the ‘postcode lottery’ phenomenon, the trend in much of the EU has been to devolve responsibility for the determination of access to care down to local level.

- 4.16 There are also continuing differences in the anticipated roles and contributions of family members, with caring for frail dependant persons still viewed as primarily a family responsibility in countries such as Spain, Italy and Ireland. Even in these countries, however, there has been a recent need to reassess policy, in some cases because of the controversy over the use of immigrant labour to care for elderly people living at home. Similar issues exist in countries with an ideological resistance to collective provision. In a review of the position of chronically ill and disabled people in the USA who are living at home, for example, Buhler-Wilkinson⁸⁰ concludes:

“Despite almost two centuries of experimentation...no agreement has been reached concerning the proper balance between governmental resources and the private resources of family, friends and insurance...In the absence of the requisite public will, our stance appears to be one of waiting for a complete breakdown of long-term care before definitive action will be taken.”

4.17 Some of the eligibility schemes operating in these countries will be briefly examined later in the report, but all of them are attempting to address the fundamental questions raised by Buhler-Wilkinson:

- who should get care?
- for how long should it be provided?
- under what circumstances should public funds pay for care?

5 A typology of eligibility frameworks

- 5.1 The CSCI review of eligibility criteria raises the prospect that these long-standing dilemmas can be revisited with a fresh approach that is consistent with a modernised social care system. If this is to be the case there needs to be a much clearer underpinning rationale to explain the basis of resource allocation. Not all such rationales are appropriate for social care. In the case of allocating scarce and popular school places, for example, some councils are explicitly (and controversially) using a lottery model to allocate places randomly – such an approach would not be acceptable ethically or politically in the case of social care.
- 5.2 It is possible to identify five different approaches to resource allocation that are currently being used in social care, each with a different underpinning rationale:
- professional decision
 - service-led criteria
 - needs and risks criteria
 - outcome-based criteria
 - user/carer decision.

Professional decision

- 5.3 In some systems there has been a preference for implicit rationing by professionals (rather than explicit rationing on the basis of published eligibility criteria) on the ground that professionals have a better understanding of the needs of individuals and are best placed to exercise informed judgement. The case for professional rationing at the point of service has been made strongly by a number of commentators, especially in the case of health care. David Mechanic,⁸¹ for example, argues that despite its limitations, it is more sensitive to the complexity of medical decisions and the needs and personal and cultural preferences of patients.
- 5.4 In this scenario, explicit guidelines are seen as inadequate for addressing the complexity of people's circumstances, and in any case are likely to be so detailed as to be impracticable. The alternative of explicit rationing is also seen as inherently unstable because of the ability of small groups to evoke public sympathy by contesting decision-making, whereas implicit rationing is thought to be underpinned by the trust that patients have for doctors and kindred professionals. Indeed, as Mechanic remarks, "*trust...is a substitute for a cumbersome regulatory bureaucracy*". More questionably, it is argued that to explicitly confront individuals with the fact that they will not receive the support they need because of scarce resources will make them more unhappy than if they believe that there is no real option.⁸²
- 5.5 The issue of whether rationing should be implicit or explicit has been a topical debate in health care circles for many years, but in both health and social care this approach has increasingly been under attack as arbitrary and inequitable. In the case of medicine it is argued that knowledgeable, sophisticated, articulate and even aggressive patients are more able to have their needs heard and satisfied in an

implicitly based system, and that discretion may be exercised by doctors who are acting on personal preferences or ignorance of medical advances. For critics of implicit rationing this is an unacceptable situation – Doyal⁸³ describes it as “*clinicians making decisions on the basis of varied and conflicting criteria dressed in the guise of clinical necessity*”.

- 5.6 In the case of health care, there is now a presumption that the basis for decision-making should be more explicit than in the past, for example through NICE reviews, care pathways and national service frameworks. Social care decision-making has been even more explicitly circumscribed by the introduction of national eligibility criteria in the form of FACS, supplemented by local accountability for criteria-based decision-making. However, our earlier report for CSCI confirmed other studies in suggesting that front-line professionals can still act relatively autonomously and variably in the way they interpret such criteria. This suggests that whatever model of eligibility criteria is adopted, there can be no assumptions made about professional consensus and compliance in respect of implementation.

Service-led criteria

- 5.7 The tendency in the recent past – and to a large extent still – is to think of rationing in terms of access to specific services. Service-led criteria have been influential in social care and represented the first real attempt to be more explicit about resource allocation. Typically each service, such as day centres, domiciliary care, and so forth, would have its own complex criteria, and applicants would have to meet these ‘service-driven’ conditions in order to access specified types of support. Whilst this approach had advantages over implicit rationing, it also had the effect of defining people by a service they might be given rather than by their individual needs or aspirations.
- 5.8 The 1989 *Caring for people* White Paper was perhaps the first attempt to explicitly confront the service-driven model and argue for a much sharper focus on needs as the gateway to eligibility but, as we have already noted, this did not always translate smoothly into practice. The Government now seems to acknowledge the shortcomings of the situation. The recent Putting People First concordat,⁸⁴ for example, is clear that:
- “While acknowledging the Community Care legislation of the 1990s was well-intentioned, it has led to a system which can be over complex and too often fails to respond to people’s needs and expectations.”*
- 5.9 The introduction of FACS can, in part, be understood as a further attempt to move practitioners away from a service-led approach to support, but in our report we identified the continuing influence of service-led approaches. We noted that in some localities we visited, managers and operational staff conflated FACS bands with the allocation of ‘band-specific’ services, with the accompanying danger that support could be highly standardised and potentially inappropriate. In more than one of the localities in the study, the FACS directive had explicitly linked bands to services, with front-line staff making decisions in a very inflexible manner. The fact that this is not

the intention expressed in FACS national guidance is an illustration of the weakness of top-down directives which are then interpreted at local level.

- 5.10 This evidence is consistent with the findings from our study of the implementation of self-directed support, which we undertook last year for the Department of Health,⁸⁵ in which we noted the continuing influence amongst social care practitioners of the 'giving and doing' tradition. The essence of this position is that social workers are accustomed to doing things for people and giving them services, and that the extent to which they can do this is often perceived (by themselves and their peers) as a measure of their professional prowess. In one of the authorities we visited this attitude was seen as one of the main reasons why the council was in severe financial deficit, with operational staff said to have been ignoring FACS criteria in order to 'give' people as many services as they considered desirable.
- 5.11 However, it is important not to assume that all social care services and support comes from local councils. Of particular significance for this review is the position of the Independent Living Fund (ILF) which has an annual budget of over £250m to support people with severe disabilities to live independently in their own homes. The ILF was subject to an independent review (by the authors of this report) in 2007⁸⁶ and the Minister for Disabled People accepted the main recommendation that there should be a smooth transition towards full integration of the ILF within a system of personal budgets.
- 5.12 In a written ministerial statement, the Minister said that the recommendations would be taken forward as part of the Government's overall programme to support independent living for disabled people. The detail on this programme has now been published⁸⁷ and does not refer to the ILF review. In the review we were critical of the service-led nature of ILF eligibility criteria, and the restrictions on what funding could be used for – effectively support is limited to tightly defined notions of 'personal care and domestic assistance.' We noted that this limited the flexibility that people required and effectively constrained the choices they were able to make, and we reported that this was one of the most consistent complaints to emerge across all of our streams of evidence. Similar findings have been reported from the Individual Budget pilot sites.
- 5.13 The dilemma here is that although a service-led approach to eligibility is now regarded as old-fashioned and paternalistic, it still holds sway in some formal criteria (notably those of the ILF) and in the mindsets of some managers and front-line practitioners. It is hard to see how there can be a transition to other, more progressive models without addressing these matters.

Needs and risks criteria

- 5.14 A needs and risks model constitutes the basis of the current FACS regime, with an assumption that a hierarchy of needs can be identified to justify resource allocation – those whose needs have immediate and longer-term 'critical' consequences for their independence and safety should be supported ahead of those with needs that have 'substantial' consequences, and so on. Policy guidance⁸⁸ requires the evaluation of an individual's 'presenting' needs and related circumstances against the risks to his or

her autonomy, health and safety, ability to manage daily routines, and involvement in family and wider community life. It is by comparing risks to independence against the council's eligibility criteria that those needs which are eligible for support are identified.

- 5.15 In our earlier review we referred to this model as 'rationing by directive', and concluded that in practice it was subject to a number of difficulties:
- common use as a budgetary tool, with councils removing FACS bands as a crude means of cutting costs
 - highly variable interpretation of the criteria between and within councils – one team manager used the description '*pin the donkey*' to describe some practitioner judgements
 - a tendency to reduce council social care responsibilities to a locally identified minimum 'core business'
 - a tendency, especially in the case of older people, to reinterpret needs and risks in terms of service eligibility, with access to specific FACS bands linked to access to specific services
 - an acknowledgement by councils that tightening FACS bands brought only short-term financial relief.
- 5.16 These difficulties have contributed to a growing critique of the ways in which FACS has been put into effect, with some describing it as a 'triple lottery' based upon where someone lives, how their council applies the eligibility criteria, and the local charging policy.⁸⁹ FACS has also become a contentious legal issue, with several applicants taking legal action against the decision of the London Borough of Harrow to restrict support to 'critical needs only' cases. In a ruling in the High Court in December 2007,⁹⁰ it was decided that although there was nothing inherently unlawful in having a policy which restricted services to those with critical needs, Harrow Council had not properly considered its proactive duty to promote equality for disabled people, now included in section 49A of the Disability Discrimination Act 1995.
- 5.17 Although these difficulties are fuelling calls for a reappraisal of the basis of eligibility for social care in England, the needs/risks model is still the dominant paradigm in other services and countries. The most obvious parallel in England is with children's services where there are some duties that arise out of statutory requirements (notably the Children Act 1989) rather than from a general assessment of need, and these have to be met alongside priorities identified through the application of eligibility criteria. Unlike adult services, however, children's social care services do not have any national equivalent of FACS, and indeed some councils do not even have any local eligibility criteria in place. In this case it can only be presumed that the operating model is largely based upon the professional decision-making model described earlier.
- 5.18 Where criteria *are* in place, then typically they have bands of need and risk somewhat similar to the FACS model. A typical model distinguishes between four levels of need and prevention – universal services, vulnerable children, children with complex needs, and those with acute needs. The cut-off point for specialist social care support is likely to be the border between vulnerability and complexity. As with

FACS, it is normal practice to consider the potential impact of *not* providing a service, but identical issues around tightening the threshold for eligibility are being experienced, albeit with much a lower profile than is the case with adult social care.

5.19 An interesting issue here is the limited extent to which the outcomes-driven policy arising from the *Every child matters*⁹¹ reforms seems to be shaping local eligibility criteria – rather than judging the need for support against the five outcomes, local councils tend to be sticking with traditional hierarchies of professionally defined need and risk. The respective similarities and differences between adult and children’s services are shown below.

ADULT SERVICES	CHILDREN’S SERVICES
Needs/Risks Based	Needs/Risks Based
National Determination of Eligibility	Local Determination of Eligibility
Implicit Professional Judgement	Explicit Professional Judgement
Local Implementation	Local Implementation

5.20 Another example of the reliance upon the professionally driven needs/risks model is that of the care programme approach (CPA) that has been used since 1990 to describe the framework for supporting people with severe mental health problems in secondary mental health services. Currently two levels of support are distinguished:

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

5.21 From October 2008. CPA will no longer apply to people needing ‘standard’ support and this ‘new CPA’ is to be targeted upon people with the greatest need as defined in the new best practice guidance.⁹² The guidance explicitly seeks to combine the professional discretion and needs/risks models. It is said of the factors associated with enhanced need that:

“The list is not exhaustive...but it should provide the basis of a reliable and useful tool. However, it is also critical to stress that clinical and professional experience, training and judgement should be used in using this list to evaluate which service users will need the support of [new] CPA.”

5.22 However, the new guidance is cognisant of the changing and complex policy scene in three important respects. Firstly, it is clear that support through the CPA approach should not be service-led: *“New CPA should not be used as a ‘gateway’ to social services or as a ‘badge’ of entitlement to receive any other services or benefits.”* Secondly, it is emphasised that since CPA is a process (rather than a measure of eligibility), then it should not be equated with FACS eligibility levels. And finally, it is said that support via CPA should not stop people from taking advantage of individual budgets.

- 5.23 The needs/risks model is also predominant in other countries, usually with determination of need firmly in the gift of assessing professionals.⁹³ In *France*, long-term care policy is based on a specific scheme (the APA) which is a benefit delivered to old people both at home and in institutions according to their level of dependency. A national assessment grid distinguishes between six levels of dependency, with APA being allocated up to the fourth level. In order to guarantee access to the same services across the country, care packages are defined according to the level of dependency. The APA is paid to finance a specific care package which is determined by a team of professionals according to their assessment of the needs of the recipient – there is no flexibility to use the money for any other purpose. The French model is therefore a mixture of service-led and needs/risk based approaches.
- 5.24 The position in *Austria* is somewhat different. There is a care allowance benefit which is paid to those in need of long-term care at seven different levels – Level 1, for example, represents care needs amounting to more than 50 hours per month, whereas Level 7 requires needs for at least 180 hours' care per month. Entitlement is based upon a medical report which includes the need for personal services and assistance. Once accessed, the benefit is not means-tested, and (unlike in France) recipients are free to decide how to use it, including paying family members. The Austrian model, then, is based upon an assessment of needs/risks, but is not tied in to service-led assumptions about how these needs and risks should be addressed.
- 5.25 *Italy* has an approach that resembles Austria's. There is a national cash allowance which is delivered to all disabled people (regardless of age and means) in constant need of help with everyday activities whether at home or in an institution. Applicants must be assessed as totally unable to work as well as in need of constant care in order to carry out everyday activities. Local commissions are in charge of the assessment process and are endowed with considerable discretionary power, but once deemed eligible, beneficiaries are free to use the benefit as they wish.
- 5.26 In *Spain*, eligibility criteria for support at home are very strict.⁹⁴ Only people with severe disabilities, low incomes and no direct family caregivers may receive domestic support, and this tends to confine help to poor older women who live alone. Nearer home, *Scotland* has its well-known policy of providing free personal and nursing care (FPNC), but as has been recently pointed out by Audit Scotland,⁹⁵ councils are using a variety of approaches to manage demand. The report notes that:
- there are differences in the use of waiting lists and eligibility criteria which mean that older people may receive different levels of service depending on where they live
 - there is ambiguity as to whether current FPNC is a universal entitlement based on an assessment, or whether locally available budgets and resources can be taken into account
 - there is a need for a national eligibility framework (much like FACS) which defines risks and priority levels to ensure transparency in access to support – currently 25 (of the 32) councils have developed local eligibility criteria, and these operate with very different eligibility thresholds.
- 5.27 The needs/risk based model is in some tension with alternative approaches that focus on the feelings of positive well-being that can arise from feeling 'in control' –

the creation of a 'risk culture' can be seen as an impingement on well-being. The identification of risk factors (and their attempted eradication) does not automatically lead to an improved quality of life, and indeed may end up restraining people from a quality of life that is open to them. The Green Paper *Independence, well-being and choice* encouraged a debate about risk and consulted on the right balance between protecting individuals and enabling them to make decisions about their lives, including the scope for managing risk.

- 5.28 Subsequently, the White Paper *Our health, our care, our say* gave a commitment to develop a national approach to risk management in social care, and this promise has been fulfilled with the publication of new guidelines from the Department of Health on best practice in supported decision-making.⁹⁶ In his foreword to the new guidance, the Care Services Minister states that the avoidance of risk is inconsistent with the current emphasis upon choice. He concedes that decision-making "*can be a complicated job, especially if people have a different understanding or perception of risk*" and that the new publication is therefore intended "*to encourage practitioners and their organisations to adopt the common approach set out in this guidance as the basis for working practice*".
- 5.29 The *governing principle* behind the guidance is said to be that "*people have the right to live their lives to the full as long as that doesn't stop others from doing the same*". To put this principle into practice, it is said that those supporting users of services have to:
- help people to have choice and control over their lives
 - recognise that making a choice can involve some risk
 - respect people's rights and those of their family carers
 - help people understand their responsibilities and the implications of their choices, including any risks
 - acknowledge that there will always be some risk, and that trying to remove it altogether can outweigh the quality of life benefits for the person.
- 5.30 All of this adds up to a substantial challenge to the professionally led needs/risks framework of eligibility, and has fuelled the search for alternatives. It is these alternatives – outcome-based and personalised-based – that constitute the new discourse.

Outcome-based criteria

5.31 Outcome-oriented policy is now driving developments in children’s services (the *Every child matters* changes) and adult social care (the outcomes articulated in *Our health, our care, our say*). The table below compares the identified outcomes for the two services.

Children’s services outcomes	Adult services outcomes
<ul style="list-style-type: none"> • being healthy • staying safe • enjoying and achieving • making a positive contribution • economic well-being 	<ul style="list-style-type: none"> • improved health • improved quality of life • making a positive contribution • exercise of choice and control • freedom from discrimination or harassment • economic well-being • personal dignity

5.32 In principle there is no reason why eligibility criteria should not be related to these outcomes, rather than focusing upon needs, risks and services, but there seems to be little evidence that this is yet happening in England. In the case of adults, one of the reasons for this will be the current national legal framework with which councils have to comply, meaning that any alternative framework will still have to be FACS compliant. Although children’s services are not similarly constrained there is (as has been demonstrated) little apparent use of the five outcomes as the framework for determination of eligibility. However, the recent review of the second phase of *In Control*⁷⁷ reports that a number of children’s services are pioneering an approach to resource allocation (for Individual Budgets) based upon the *Every child matters* outcomes. In this model a direct link between identified support need and money is drawn by making a judgement about the amount of support needed to realise one or more of the five outcomes in the life of a child or young person.

5.33 In *Scotland*, where there is also no national framework, there has been movement in some localities towards incorporating an outcomes dimension into assessment and eligibility using the *User defined service evaluation toolkit* (UDSET).⁹⁸ A key driver for change here has been the development of a new outcomes-focused joint performance framework, the *National outcomes framework for community care*. This framework centres around four high-level outcomes:

- improved health
- improved well-being
- improved social inclusion
- improved independence and responsibility.

5.34 At the heart of UDSET are two outcomes frameworks on the matters that are important to service users and their carers respectively. Like the outcomes articulated in *Our health, our care, our say*, these frameworks have been adapted from a ten-year programme of research on service user and carer outcomes developed at the University of York. UDSET aims to improve practice through the application of user/carer-defined outcomes tools, and to enable health and social

care partnerships to gather data to determine whether they are delivering good outcomes to service users and carers. This data can be used to include user and carer experiences in performance management, planning, commissioning and service improvement.

- 5.35 Initial piloting has been conducted with three health and social care partnerships (Orkney, Fife and East Renfrew) and Bob Hudson is involved in some ongoing monitoring of the initiative. The inclusion of outcome measures relating to the experience of users and carers in the performance management framework has been widely endorsed by policy-makers, practitioners and users and carers across Scotland. This does, however, pose a challenge for partnerships that do not currently systematically gather the data required to report on these outcomes – it is recognised that gathering ‘tick-box’ data on these aspects of user and carer experience will not drive service improvements. Further roll-out of UDSET to other parts of Scotland is anticipated during the course of 2008.
- 5.36 One of the Scottish national outcomes relates to *social inclusion*, and some see this as a potential framework for underpinning assessment and eligibility arrangements. This is, for example, the position taken in a recent report from Age Concern⁹⁹ which itself is based upon research undertaken earlier for the then ODPM – the *English longitudinal study of ageing* (ELSA) project.¹⁰⁰ ‘Social exclusion’ is commonly used to refer to the process that leads to a breakdown of the relationship between society and the individual, and which prevents access to different elements of the social, economic, political or cultural components of everyday life. Although traditionally concerned with issues of economic disadvantage, social exclusion has grown to incorporate barriers to the attainment of civil, social and political rights, as well as to accessing support to attain personal and social fulfilment.
- 5.37 All of this fits well with current concerns with ‘citizenship’, but if the concept of ‘exclusion’ is to be useful in the determination of access, assessment and eligibility, then it needs closer definition and measurement. This has been one of the products of the ELSA project, which is a large-scale survey of people aged 50 and over living in England. Seven dimensions of social exclusion have been constructed from the ELSA data:
- social relationships: contact with family and friends
 - cultural and leisure activities such as going to the cinema or theatre
 - civic activities such as membership of a local interest group, voluntary work or voting
 - basic services such as health services and shops
 - neighbourhood, including safety and the friendliness of local people
 - financial products such a bank account
 - material goods such as consumer durables and central heating.
- 5.38 The ELSA researchers use the concept of ‘multiple exclusion’ to refer to people who are excluded on three or more of these dimensions, and reported that 7% of respondents were experiencing multiple exclusion. It is possible to envisage the construction of a range of eligibility criteria based upon social exclusion (rather than

upon services, needs and risks) and people suffering from multiple exclusion could be expected to have a higher priority.

- 5.39 Such a development could fit well with the concept of an outcomes-based framework of eligibility and with the current focus on *well-being*. Improving well-being is increasingly seen as an important political goal, and this is true across the political spectrum.¹⁰¹ In her wide-ranging review of the concept, Searle (2008)¹⁰² notes that the evidence suggests that it is “*a multi-faceted entity arising from complex relationships involving both the individual and their environment*”. Well-being emerges through a combination of circumstances, experiences, subjective evaluations and social conditions. In all of this there is a contextual element (an individual’s social and physical environment) but also a subjective dimension (the feelings of the individual about levels of satisfaction). An important element in achieving positive subjective well-being is therefore an ability to manage one’s life in respect of the surrounding world, to understand events and to feel ‘in control’ of the damage that might be created.
- 5.40 The complex character of well-being is reflected in the debate on how best to measure it. *The Oxford happiness questionnaire*.¹⁰³ for example, not only taps into people’s emotional state, but also addresses issues related to psychological well-being such as ability to make decisions, feeling satisfied, being healthy, showing an interest in other people, having a sense of life achievement and being in control. Similarly, in the USA, Campbell and colleagues¹⁰⁴ asked respondents to rate their life as a whole across a range of bipolar extremes (such as ‘miserable v enjoyable’ and ‘useless v worthwhile’) and combined the results to produce an ‘index of subjective well-being’. A similar exercise across ten domains at the personal and national level has been conducted in Australia by Cummins *et al.*¹⁰⁵
- 5.41 No attempt seems to have been made to consider the usefulness of these sorts of measurement scales for determining eligibility for support. However, an important finding from the research is that it is individuals’ assessments of their circumstances which appear to have the greatest influences on reported well-being, as opposed to their actual circumstances. This has important implications for the policy shift towards well-being (as opposed to risk or need) and for a compliant eligibility framework. Put simply, it raises the issue that if individual well-being is the policy goal, and if this is to an important extent shaped by the subjective perceptions of individuals, then it may be that these individuals – people who use services and their carers – should be influential in determining their own priorities.

User/carer decision

- 5.42 The final model is one in which the underpinning rationale is that of people who use services and their carers making their own judgements about how best to meet their own needs and how to accomplish their own priorities or outcomes. Whilst this approach is diametrically opposed to the first model outlined in this review (that of professional decision), it is close to those models rooted in an outcomes-based framework and self-directed support. As we have described previously, the notion of self-determination has reached its policy apotheosis with the emerging paradigm of self-directed support (SDS), which has been repeatedly identified by ministers as the

mainstream operating process of the future for social care. The expectations arising from the Putting People First concordat¹⁰⁶ and the subsequent circular¹⁰⁷ have now reached the point where most commentators assume it to be simply a matter of time before SDS becomes the standard operating system. For this to happen there will need to be many changes to current arrangements, not least of which will be to the existing framework for eligibility.

- 5.43 Putting People First is both critical of current practice and impatient for change. In what might be seen as a criticism of the current framework for eligibility it is said that:

“The right to self-determination will be at the heart of a reformed system, only constrained by the realities of finite resources and levels of protection which should be responsible but not risk averse.”

The key policy lever designed to bring this change about is personal budgets. Putting People First is clear about the goal:

“What it means is that everyone who receives social care support, regardless of their level of need, in any setting, whether from statutory services, the third and community or private sector, or by funding it themselves, will have choice and control over how that support is delivered.”

- 5.44 *Transforming social care* in turn does not shy away from the shift in values implied by this goal:

“This move is from a model of care where an individual receives the care determined by a professional, to one that has person-centred planning at its heart, with the individual firmly at the centre in identifying what is personally important to deliver his or her outcomes.”

- 5.45 In terms of an eligibility framework, the accompanying task is to develop a model that is consistent with this vision. As we noted earlier, the objective is to create eligibility criteria that permit maximum reconciliation between scarcity and user/carer preferences, but in our earlier report for CSCI we highlighted tensions between FACS and a policy model based upon SDS and *In Control* principles. FACS is concerned with categorisation, standardisation, consistency of treatment and explicit decision-making, whereas the personalised budget agenda emphasises self-assessment, self-determination, choice, individual differentiation and some arm’s-length accountability for expenditure decisions.

- 5.46 On one reading, the two approaches could be seen as complementary, with FACS constituting the decision on eligibility for support, and Individual Budget holders then determining their own care needs and how these should best be met. In reality there are two different paradigms at play here with very different underpinning assumptions, values and operating procedures. In the localities that formed our study there was very little evidence that the tensions between the two paradigms had been understood, let alone addressed. We concluded that:

“Overall, there seems to be a danger that the personalisation agenda could end up running on parallel tracks to the FACS agenda, but at some point the two will

nevertheless collide. Any serious attempt to introduce an approach based upon the In Control principles will challenge the values and operating processes currently represented in the FACS model, and councils need to urgently understand and address these inconsistencies."

- 5.47 In SDS, the alternative model to the FACS eligibility framework is the resource allocation system (RAS) which has been developed by *In Control*, and continues to evolve. The experience in the Individual Budget pilot sites is of a variety of arrangements for undertaking the assessment.¹⁰⁸ A more conservative approach involves care managers leading the assessment process in consultation with people who use services, whereas other approaches are almost entirely dependent on self-assessment questionnaires. The latter involves technical complexities and constitutes a radical challenge to established notions of professional determination of need.
- 5.48 Under FACS, resources are allocated towards the *end* of the assessment process and depend on resource availability; under SDS they are allocated at the *beginning*, using a transparent methodology. In outline the RAS uses a self-assessment questionnaire to gather information about the person's needs, and then identify the appropriate level of funding to match them. Most places developing a RAS use one of the variants developed by *In Control* for people with learning disabilities, and normally these cover the following steps:
- Selecting a self-assessment questionnaire consisting of 'domains' – broad areas of life such as personal care needs, relationships, staying safe from harm – and 'fields', which reflect graded ability within each domain. Each field is scored and the greater the need, the higher the points allocated.
 - Selecting a test group of 100 people that is broadly representative and costing the packages they are currently receiving; completing the questionnaires to give a total score.
 - Calculating the average cost per point by dividing the total cost of all packages by the total points scored; the product of a person's total score and the average cost per point adjusted by a multiplier then gives the indicative funding allocation for that person.
- 5.49 Early findings from the Individual Budget pilots¹⁰⁹ found that in most sites different RASs were being implemented for different client groups, each with different 'pounds per point', but the Department of Health has requested that over time a single RAS be developed covering all groups. Under the traditional approach, when budgets become tight, individuals receive less – the very problem that is bedeviling FACS – but under a transparent RAS, this option is less easy to manage. Authorities must set their RAS with considerable care, creating enough headroom to allow for extra demand if they are to avoid overspending their budgets at the end of the financial year. A user-led model with funding calculated via the RAS will not, of course, solve the problem of scarcity in relation to demand.
- 5.50 Currently pilot areas are developing their own local versions of the RAS – indeed, often several local versions for different client groups. However, Duffy¹¹⁰ suggests that localities are aware that they cannot sensibly define such a framework in isolation from each other or from central government. He accordingly argues that *"it is vital that central government takes a lead role in shaping the RAS, even if finally a*

high level of discretion is to be left with the local authorities". This would result in a RAS that resembles the position of FACS in terms of the balance between national requirement and local implementation. Already authorities are talking of pooling their experiences and effort, developing resource allocation systems together, and ultimately there may be a move towards one common approach across the country. This review could form part of such a consideration.

6 Conclusion: a framework of options

6.1 We have identified and delineated five frameworks for determining eligibility, each with a distinct underpinning rationale. We are not suggesting that these can be found anywhere in their pure form; rather they are conceptual tools designed to aid our understanding of the real world. The likelihood is that more than one (conceivably all of them) could be found in any one locality, some co-existing relatively comfortably, others pulling in competing directions. It may be helpful to conceive of these frameworks in terms of a continuum of governance imperatives ranging from professional discretion, through organisational directive, towards partnership models and ultimately to user-led models. Each of these imperatives is associated with some key organising concepts, and each is represented by past and current practice. The box below depicts the analysis.

Governance imperative	Organising concepts	Examples
Professional discretion	<ul style="list-style-type: none"> Professional judgement Accountability to professional ethics Paternalistic and reactive Flexibility and variation Risk-averse practice Service/needs-driven 	<ul style="list-style-type: none"> Pre-1990 social care Some current practice
Organisational directive	<ul style="list-style-type: none"> Clear and explicit rules on eligibility Standardisation Professional accountability to the organisational mission Risk-averse practice Service-led Needs/risks-led 	<ul style="list-style-type: none"> Post 1990 social care FACS Independent Living Fund Children's services CPA
Partnership models	<ul style="list-style-type: none"> Professionals, managers, users and carers in dialogue Shared accountability Risk sharing Outcomes-focused 	<ul style="list-style-type: none"> Direct payments Some variations of personal budgets UDSET Scotland
User-led	<ul style="list-style-type: none"> User/carer self-determination User-defined outcomes Prevention and personalisation Flexibility and variation User-defined risk Independence from control by professionals 	<ul style="list-style-type: none"> In Control Individual/personal budgets Total transformation councils Disability benefits

- 6.2 It is not the purpose of this literature review to propose one system or another – views will emerge from the wider process of evidence gathering. However, it *is* pertinent to highlight the values that the Government itself has identified as central to the Putting People First concordat and to suggest that future decisions on eligibility need to be consistent with these values. As we have already noted, the main such features of the concordat are:
- to replace paternalistic, reactive care of variable quality with a mainstream system focused on prevention, early intervention and enablement
 - high-quality personally tailored services
 - enabling people to have maximum choice, control and power over the support services they receive
 - the right to self-determination, constrained only by the realities of finite resources
 - levels of protection which should be responsible but not risk averse.
- 6.3 Given these objectives, it is hard to avoid the conclusion that the current system (FACS) appears to be designed for the policy imperatives of a previous era. This is not surprising, since the construction of eligibility criteria (in this case of a belated national framework) logically follows the direction set by values, principles and policy. FACS was well suited to a system in which professional judgement determined levels of need and risk, followed by a care plan based around available services. 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 in terms of our classification this means criteria that are consistent with the ‘partnership’ and ‘user-led’ models.
- 6.4 We have set this analysis within a ‘3P’ framework – the imperatives of prevention, personalisation and prioritisation. However, if change at all levels is to be effective, there is an important fourth ‘P’ – that of ‘partnership’, and the wider the conceptualisation of the nature of the problem, the more complex will be the necessary partnering. This review has traced a broadening in the way in which problems are conceived – from an initial focus upon individual ‘deficits’ through to single services and multi-agency services, then on to outcomes and ideas around citizenship and self-determination.
- 6.5 Such a shift has some important policy implications for our future understanding of the nature of social care and its relationship with other forms and sources of support. In general terms a shift from a narrow perception of eligibility (social care) to a wider conceptualisation (health and well-being) raises the need for much more sophisticated and joined-up approaches to understanding, assessing and supporting vulnerable people. In going down this path, social care would need to change from being a relatively stigmatised and narrow service based upon Poor Law principles to be part of a more inclusive and universal response to the need for support.
- 6.6 The ELSA study outlined earlier highlighted the link between a range of variables – for example between exclusion and poor health, and between exclusion and living alone. The clear implication is that without an integrated strategy covering social care, the NHS, housing agencies and many others, approaches to tackling exclusion will be ineffective. Arbitrary divisions between different kinds of care can be

unhelpful, and a focus solely on 'personal care' can lead to the neglect of other areas.¹¹¹ Broadly the model of the future is one in which the emphasis switches from deficit, decline, disability and dependency, to one couched in terms of well-being, activity and inter-dependence.¹¹²

- 6.7 The further policy question, then, is whether it is appropriate to have separate eligibility criteria for social care, or whether a more ambitious inter-agency programme based upon wider health and well-being criteria can be envisaged. Such a development would be consistent with the strong emphasis upon a health and well-being perspective in *Our health, our care, our say*. It would also help to meet one of the key aims of *Putting People First*:

"Ultimately every locality should have a single community based support system focused on the health and wellbeing of the local population. Binding together local government, primary care, community based health provision, public health, social care and the wider issues of housing, employment, benefits advice and education/training. This will not require structural changes, but organisations coming together to re-design local systems around the needs of citizens."

- 6.8 Finally, it is appropriate that such a framework be nationally determined. Our previous CSCI report on the impact of FACS implementation confirmed the evidence of other studies – that FACS is being interpreted locally in a wide variety of ways, both across and even within councils. It would not be appropriate to simply encourage local councils to devise their own criteria, even though the new framework is likely to encourage very different – personalised – outcomes for individuals. This seems to be squarely acknowledged in *Putting People First*, where it is stated:

"We do not seek to prescribe uniform systems and structures in every part of the country. However, access to high quality support should be universal and available in every community."

- 6.9 This review needs to end up where it began – with the inescapability of rationing. Whatever the outcome of the anticipated Green Paper on social care funding, there will always be a need for decisions to be taken on who gets support and in what circumstances. A new eligibility framework will not remove this necessity. But what it *can* do is ensure that such a framework is consistent with the principles and policies that government has determined and articulated. In the case of social care, this means reconciling prevention, personalisation and prioritisation.

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