



# The state of social care in England 2006-07 Executive summary

January 2008

**The Commission for Social Care Inspection (CSCI)** was created in 2004 by combining the Social Services Inspectorate, the National Care Standards Commission and the Joint Review function of the Social Services Inspectorate and the Audit Commission.

The Commission (CSCI) has a statutory duty to report annually on the state of social care services in England. In this, the Commission's third report to Parliament, we use the findings from our inspections and assessment activity and two specially commissioned studies to describe the state of social care in England. Informed throughout by the views of people who use services, the report looks at what is working well and what needs to improve.

# The state of social care in England 2006-07

**This third report from the Commission for Social Care Inspection:**

- **Describes trends in the range, quality and availability of social care services in 2006-07 across public, voluntary and private sectors.**
- **Reports on what is happening to people seeking support who are not eligible for council-arranged care or who fund their own care.**

## The context

Over 2 million people of all ages, including children, and from every community, used social care services arranged by local councils during 2006-07. Councils spent £14.2 billion on social care for all adults. It is estimated that £5.9 billion was spent by private individuals on personal social care for older people alone.

People looking for support have emphasised the importance of services that fit with their daily lives, recognise their individuality and respect their culture. People want to know what they are entitled to and, if they have to pay for themselves, assurance they will get a fair deal.

During 2006-07 there have been many calls to clarify state and individual responsibilities, as highlighted in last year's *The state of social care* report, 2005-06. There have also

been calls for a new public sector financial settlement for social care.

There have been increasing concerns, too, that people's human rights are not being respected following a number of reports of serious shortfalls in health and care services and examples of abuse and neglect.

A report by Dame Denise Platt reviewing the status of social care was presented to Government in 2007, who responded with a five-point action plan designed to rebuild confidence within the sector and with the public.

## Government policy

Government sees personalised care and systems that put people in control as the cornerstone of policies for transforming social care. The promotion of health and well-being is also a priority and councils are charged with ensuring their local areas are the sorts of places that people of all ages want to live and work in.

In the Comprehensive Spending Review 2007, Government announced a 1% real-terms increase to the revenue support grant for local government; and an increase in Department of Health direct funding for adult social care of £190 million by 2010-11. An additional £250 million was also announced to help ensure that all children at school are ready to learn and benefit from personalised services and support. Over the next four years, £300 million is to be spent on securing a better start in life for children in care.



Government has also announced a Social Care Reform Grant, worth £520 million over the next three years, to take forward its agenda of personalised and responsive care services.

It is in this context that we consider whether people are getting personalised care, where individuals can shape services to their needs and preferences.

# Part One

## Council expenditure

Gross expenditure by councils in 2005-06 on social care for **adults** amounted to £14.2 billion; a rise of 4.5% in real terms from 2004-05.

Of this expenditure, 61% was on services for older people and 21% on adults aged 18 to 64 with learning disabilities. There was an increase in expenditure of nearly 14% in real terms between 2003-04 and 2005-06 on adults with learning disabilities and physical and sensory impairments.

In total around 1.75 million adults received one or more social care services from councils during 2005-06; and councils responded to over 2 million new referrals from local people, an increase of 4% over 2004-05.

The shift of expenditure from residential care to community services over the last five years, 2001 to 2006, appears marginal. For older people there has been a 1% increase in expenditure on services to people living at home, whilst for other adult groups there has been a decrease. This apparent lack of change is more complex than at first glance and reflects a variety of factors, including rising costs in care homes to support people with increasingly complex needs.

In 2005-06 councils spent £238 million net on supported accommodation and £455 million of Supporting People funds. Together this accounted for 26% and 33% of net council expenditure on community services for adults with

learning disabilities and mental health needs respectively and represents a significant investment in 'ordinary' housing with care.

Direct Payments accounted for nearly 6% of net expenditure on community services, amounting to £267m in 2005-06. As a percentage of *total* gross costs of adult social care, £2 in every £100 was spent on Direct Payments. This compares with £1 in every £100 in 2004-05. As at 31 March 2007, 40,600 adults and older people used Direct Payments, compared with 32,000 at the same point the year before.

In 2005-06, £2.24 billion net was spent on home care and accounted for 49% of all community services expenditure. This percentage increased from 47% in 2001-02.



From 2001-02 to 2005-06 the percentage of (gross) expenditure on care services with private and voluntary providers grew from 59% to 72%, amounting, with overheads, to £9.3 billion.

Grants (not including contracts for services) made by social services to over 5,000 voluntary organisations providing services for adults amounted to £252 million. A further £43 million was provided to fund carer organisations and £11 million for other 'client groups'.

The NHS contributed almost £650 million to joint arrangements and pooled budgets with councils (4.7% of gross spend on adult care) with the majority being for learning disability services, £412 million, and a further £117 million for services for older people (principally intermediate care).

Councils recovered over £2 billion in fees and charges for social services in 2005-06 (14% of total gross adult care expenditure).

Councils' adult social care departments reported over £269 million efficiency savings in 2006-07. However, there is no systematic data to show the impact of those savings on the quality of services.

## Council activity

Just over a million adults were supported at home with community services as at March 2006. A further 240,000 adults provided with services by councils were permanent residents in care homes.

In the four years from March 2003, there has been a fall of 24,400 (9%) permanent residents supported by councils in care homes. The reduction has occurred in all groups of people who use services, other than those aged under 65 with learning disabilities, where it was 6%.

The pattern and delivery of community services for adults under 65 per 10,000 population has changed in the four years to March 2006, with an increase in Direct Payments and home care; an increase in day services for those with mental health needs and a decline for disabled people; a marked increase in professional support services for those with a mental health problem; and a growth in numbers (per 1,000 population) provided with equipment and adaptations.

In contrast, from March 2003 to March 2006, there was a significant reduction for older people in the rate per 1,000 of the older population in receipt of home care, meals and day care services. However there have been increases in Direct Payments, equipment provision and short-term respite care. But the number of older people using services has dropped overall from 867,000 people in 2003 to 840,000 in 2006; and this at a time when the population aged 75 and over increased by nearly 3%.

Assessments and reviews were undertaken for 383,000 carers in 2005-06; 142,000 carers received a service following an assessment. Some 7,700 carers used a Direct Payment as at March 2007. Breaks for carers, reported by councils, increased by 15% from 2004-05 to an average of 20,520 per council in 2006-07.



## Trends in services

As at 31 March 2007, there were 18,577 registered care homes for adults of all ages, with 441,958 places. This represents a continuing trend of falling numbers of care homes (down 141 over the last year), but with an increase in the number of places (up 623 places from 2006 to 2007).

There has been a reduction in the number of care home places in largely urban areas of metropolitan councils and inner London councils and an increase in rural shire counties.

Over the last year there has been an increase of 4,175 places in privately run care homes, and a fall in the number

of places in council (1,599 fewer) and voluntary sector run homes (2,340 fewer).

There is little change in the average size of care homes: from 23.6 places in 2006 to 23.8 in 2007. Nursing homes tend to be larger with an average of 44 places compared to 18 in residential homes.

On average, homes tend to be smaller in the South of England than in the North.

The average size of care home for older people is 34 places compared to 9 for younger adults.

On 31 March 2007, 4,735 home care agencies were registered with the Commission, an increase of 112 over the previous year. The primary growth has been in the private sector (194 agencies) with a fall in the number of home care agencies run by councils and the voluntary sector.

The home care market appears to be most developed in London and the North East.

## **Outcomes for people using social care**

The data and evidence about the extent to which registered care services meet national minimum standards (NMS) and the performance of councils is presented according to the seven outcomes as in *Our health, our care, our say*.

It is important to highlight that the NMS were put in place five years ago and whilst some look at outcomes, there is a disproportionate emphasis on inputs and processes

in others. Thus some NMS may be met, but may simply indicate there are policies and processes in place, and not whether these are actually applied in practice. New inspection processes that focus on outcomes are being introduced under the CSCI Inspecting for Better Lives programme.

## Overall performance of services and councils

The average percentage of NMS met by care services has improved for the fourth consecutive year but the rate of improvement has stalled. For example, care homes for older people meet on average 80% of the standards; a 21% improvement since 2003 and a 1% improvement over the last year.

Social care services for adults, *where councils have arranged their care*, have improved for the fifth successive year. In 2007, the performance ratings improved for 24 councils (16%) and deteriorated for 15 councils (10%).

Overall, 20 councils (13%) were judged as delivering 'excellent' outcomes for people who use social care, 102 (68%) were judged as 'good', and 28 (19%) were judged as 'adequate'.

***Exercising choice and control:*** Care services perform best against NMS relating to introductory visits, day-to-day life and choice, and least well around standards on information, safety policies and risk assessment.

Care homes and adult placement schemes meet on average 86% of standards in the area of choice and control.

Even though there has been improvement in recent years, the information standard remains one of the least frequently met standards; not met by nearly a quarter of care homes and home care agencies.

Twenty-four councils (16%) were judged to be 'excellent' at increasing choice and control for people using social care, but 42 councils (28%) delivered only 'adequate' outcomes in this area.

Increased use of Direct Payments, Individual Budgets and a greater range of supported housing options are examples of developments to improve people's choice and control.

**Health and emotional well-being:** Care services perform best in relation to NMS for needs assessment and least well in relation to care plans and, with the exception of nursing agencies, medication. Nursing agencies meet on average 89% of standards in this domain while home care agencies meet only 69%.

Overall, four-fifths of councils (83%) are delivering 'good' or 'excellent' health and emotional well-being outcomes for people using social care. Increased numbers of people receiving intermediate care at home, Partnerships for Older People Projects and other preventative developments are promoting people's health and well-being.

**Personal dignity and respect:** Care services perform best against standards relating to privacy and dignity, rights and confidentiality and least well in standards relating to policies on protection. Care homes meet on average 88% of

these standards, while adult placement schemes meet on average 69%.

Overall, most councils performed relatively well in this outcome with 63% of councils providing 'good' outcomes and 11% providing 'excellent' outcomes. However, 35 councils are classed as 'adequate' and three councils are classed as 'poor', the highest number for any outcome.

**Quality of life:** Care services perform best against standards relating to the provision of meals (88% of care homes meet the NMS) and in assisting people to live their daily lives with autonomy and independence (93% of care homes for younger adults). Care homes for older people are performing least well in the area of safe working practices (61% meet the standard). This standard covers health and safety issues such as fire procedures, first aid and infection control. Nursing agencies perform better in this area (86%).

Twenty-two councils (15%) were judged to be 'excellent' at improving the quality of life for people using social care but nearly a third of councils (30%) delivered only 'adequate' outcomes in this area.

Whilst the number of breaks for carers increased along with the numbers of carers receiving a service in their own right, approximately a half of councils have yet to address carers' needs effectively.

**Freedom from discrimination:** All services are performing well in relation to standards concerning complaints procedures – 87% of care services perform well – and,

with the exception of nursing agencies, less well on recruitment processes: 29% are not performing well. This standard measures the extent to which care services operate a thorough recruitment procedure based on equal opportunities and which protects the interests of people receiving care.

Only 11 three-star and 2 two-star councils delivered 'excellent' outcomes relating to freedom from discrimination and harassment. Two-thirds of councils (99) were judged to be delivering 'good' outcomes and a quarter of councils (38) were 'adequate'.

More help is needed to secure work opportunities for disabled people; and people using mental health services need better access to advocacy.

***Making a positive contribution:*** An average of 95% of care homes (for older and younger people) met NMS relating to social inclusion and community links. These standards include simply providing information about local community activities and visiting arrangements.

Overall, councils performed relatively well on this outcome with 59% of councils providing 'good' outcomes and 24% providing 'excellent' outcomes. 16% of councils are 'adequate' and one council was judged to be 'poor'.

***Economic well-being:*** Care services perform best against the standards relating to procedures for supporting people with their finances (91% of care homes for older people meet the standard); education and occupation (92% of care homes for younger adults).

Overall, councils performed relatively well on this outcome measure, with 69% of councils providing 'good' outcomes and 15% providing 'excellent' outcomes. Twenty-three councils are 'adequate'.

## Children's services

In 2005-06, councils spent £4.75 billion gross on children's services, a 5% increase from 2004-05 after allowing for inflation.

Nearly half of the expenditure was spent on children in care. As at 31 March 2007, 60,000 children were in care. Of these, 60% were placed in foster homes; 11% were fostered by relatives or friends; and 9% were placed at home with their parents. Just under 15% were in residential care. In 2006-07, 3,300 children in care were adopted.

There has been an increase of 73% in the expenditure on Direct Payments, from £11 million to £19 million between 2004-05 and 2005-06. At March 2006 there were 600 disabled children aged 16 or 17 and 4,200 carers of disabled children using Direct Payments, compared to 492 and 2,265 in March 2005.

In 2006-07, 545,000 referrals about children and families were made to councils; 56% received an initial assessment.

Nearly 28,000 children were on councils' child protection registers as at 31 March 2007. The rate per 10,000 aged under 18 on registers at 31 March was up from 23.9 in 2006 to 25.2 in 2007.

Of council expenditure on children's services, 40% was spent on support to children in need and their families, primarily on family centres, support for children under 8 and youth justice services.

On 31 March 2007, immediately prior to the transfer of responsibilities to Ofsted, the Commission regulated 3,566 children's social care services; 55% of these were children's homes, of which 61% were run by the private sector.

Performance of children's services against the NMS has greatly improved since 2002, but the rate of improvement has slowed since 2005-06.

On average, children's homes are meeting 83% of NMS; fostering services 82%; and adoption services 61%.

Progress has been made in implementing *Every child matters* but high eligibility criteria in response to resource



pressures are limiting the range of services to assist families of children in need, restricting support for young people transferring to adult services and sometimes failing to recognise that the need to protect children should trigger service provision to parents with complex problems.

There continues to be a gap in opportunities and outcomes between those for the majority of children and young people and those available to children who use social care services.

## Part Two

Part Two focuses on people who seek social care support and are deemed ineligible for council-arranged services and those people who fund their own social care. Full reports of the specially commissioned studies are available on the CSCI website ([www.csci.org.uk](http://www.csci.org.uk)).

### People who fund their care and people ineligible for council care: a national analysis

This analysis focuses on older people only.

**Private spend on social care:** Around half of the expenditure on personal social care for older people comes from private contributions, either from charges and top-ups for those receiving care with council financial



support, or from spending on privately purchased care. It is estimated to be nearly £5.9 billion. This does not include the substantial contribution of resources from private individuals in the form of caring by families and friends.

**Numbers of 'self-funders':** As at 31 March 2006, it is estimated that, of the people who were ineligible for council-supported care in the community, just fewer than 150,000 older people purchased care privately. In addition 118,000 older people paid for places in care homes privately.

**Impact on services of tightening eligibility criteria:** The tightening of eligibility thresholds has had an effect on the level of non-residential services provided by councils, particularly home care. Since 1997, the numbers of households receiving supported home care has fallen from 479,000 to 358,000 in 2006, though the number of total hours has increased (because the average number of hours that each eligible person receives has increased).

It is estimated that, were all councils to set their eligibility thresholds at 'substantial' and 'critical', the average provision of council-supported home care would fall by just under 20%.

**Shortfalls in care:** A shortfall in care can occur when people choose not to use services or when they cannot afford to pay for care. It is difficult to establish levels of such shortfalls at any given time, although the data clearly identify their existence. Shortfalls in care are particularly high in the population with moderate or low care needs.

It is **estimated** that:

- The total number of older people who receive no services and have no informal care, despite having high support needs, is around 6,000 older people; and 275,000 older people with less intensive needs.
- In the current system, 1.5 million older people (60% of the total number of older people with any disability or impairment) have some shortfall in their care if it is assumed they do not have any informal care; this goes down to 450,000 people if we assume the support of family carers.
- If we focus only on older people with high needs, and who receive family carer support, 50,000 people out of 850,000 have some shortfall in their care.

**Variations between councils:** There are large variations between councils in rates of council-supported care, especially for community-based services. Some variation is legitimate due to unavoidable local needs and cost characteristics but analysis supports the anecdotal evidence that councils are operating with different financial as well as needs eligibility arrangements.

**Data:** The data available to make assessments of the current situation are very limited and a range of assumptions have had to be made based on data of variable quality. Much better data on people who fund their own care needs to be collected to ensure a rigorous analysis to inform policy.



## People 'lost to the system'

In-depth fieldwork was carried out in six councils to gather evidence about what happens to people who use their own resources to obtain care and those deemed ineligible for council-arranged care. This study included younger disabled people as well as older people.

The study identified the raising of eligibility thresholds as essentially a rationing device. The concept of rationing is often used pejoratively but there is nothing inherently wrong with allocating resources according to need. The issue is how this is translated into practice. A conceptual framework based on rationing was used to understand what is happening and three interrelated dimensions of rationing were identified.

### ***'Rationing by directive'***

In all the councils, the need to set priorities and control expenditure was paramount and typically the catalyst for reviewing eligibility (FACS) policies. (*Fair access to care services* provides a national framework within which councils must set their eligibility criteria for adult social care based upon individual needs and the associated risks to their independence. There are four eligibility bands: critical, substantial, moderate and low.)

Adult social care was not necessarily a high political priority, and there were different political reactions when changes in eligibility criteria were being considered.

Demand was often managed by tightening procedural guidelines to reduce scope for interpretation by front-line workers.

There was some evidence that tightening of FACS bands was neither appropriate nor effective: it failed to meet legitimate needs *and* failed to save money in the longer term. However, while closing an eligibility band was relatively straightforward, re-opening it was more complex.

Only one of the councils had any policy specifically to support people who funded their own care (and this has yet to be implemented). Most conceded little more than the right to an assessment if requested; some felt that 'self-funders' were not the responsibility of the council.

### *'Rationing by discretion'*

Finding an appropriate balance between the goals of an organisation and the judgements of professionals in relation to individuals could be highly problematic.

A frequently made claim was that social work was becoming 'de-professionalised'; the need to meet performance indicators particularly on speed of response was cited as an obstacle to reflective practice.

A service-led approach to assessment appeared to be entrenched in some councils. This was felt to be a particular risk where staff who did not have a professional social work background were involved in assessment.

A continuum of professional compliance and resistance towards FACS guidance was identified among care managers (with people often exhibiting elements of both).

Guidelines on eligibility criteria were sometimes seen by professionals as an aide to decision making, but also supported defensive practice where the response to complaints could be couched in terms of compliance with rules rather than of personal responsibility for professional decisions.

Not all staff were happy with the tightening of procedural guidelines and felt this broader rationing agenda was incompatible with professional judgement. In practice professionals had considerable power to interpret eligibility criteria flexibly.

Whilst balancing resources and needs at the same time as personalising care is not necessarily contradictory, in practice there are tensions between assessing people's eligibility for services and promoting individualised, self-directed support.

The existence of FACS criteria and associated guidelines, matrices and scoring systems was not always adequate to ensure professional compliance. Other techniques to reduce discretion were evident in training programmes, peer review, supervision and management, and cultural change.

### ***'Rationing by diversion'***

Signposting was in widespread use in the councils to advise – and sometimes support – people by directing them to alternative sources of help.

For councils operating less than all four FACS bands, signposting effectively provides an exit strategy. The one council which had retained all four bands claimed that even those people signposted to other services remained under the council 'umbrella'.

The nature and quality of signposting appeared to depend upon the skills and personal commitment of individual workers – some did no more than provide lists of addresses and telephone numbers; others attempted to support individuals in making contact and arranging appropriate services.

In parallel with the growth of signposting as a strategy, councils have also developed mechanisms for filtering people in or out of the system at the point of referral.

It was striking that in the councils in this study, the gate-keeping role was increasingly undertaken by people without a professional social work background. There need to be adequate safeguards that people with eligible needs are not excluded at an early stage from any further consideration or assessment of those needs.

In all the councils in the study, signposting was associated with a greater reliance on the contribution of the third sector. Little was known about the effectiveness of signposting to these voluntary and community services.

Councils generally offered little support to people who fund their own care arrangements and 'self-funders' are frequently diverted into the residential sector.

Once people who self-fund are living in care homes, they are unlikely to benefit from reviews or visits by care managers and they may have no one to whom they can turn for advice or support.

All councils were aware of people funding their own care 'bouncing back' to the council system in the event of depleted resources. None had developed a strategy to address this situation.

There is typically no follow-up for people signposted elsewhere and no means to gauge the effectiveness of signposting and other strategies, or to feed this information back to the planning and commissioning processes.

Rationing by diversion results in a system in which people deemed ineligible for council support are – at best – signposted to an alternative system. Once there, it is not generally possible to determine whether people receive any help, or whether any support meets their needs. Monitoring is crude or non-existent and staff are preoccupied with the demands of meeting eligible needs.

## Outcomes for people

A poor quality of life was experienced by the majority of people interviewed for this study. Few described their lives entirely negatively but most expressed a level of resignation and acceptance. People had low expectations and modest desires about what help they might get, but most had been turned down as ineligible for social care, were receiving less support than they felt they needed, or were simply trying to find their own way in the system with little or no help.

While the majority of the stories told by people in this study were of struggling to cope without help, there were also positive examples of targeting help at people needing short-term intensive support and of assistance being provided through Partnerships for Older People Projects.

Contacting social services was often a matter of chance, and the outcome one of disappointment following assessment. Many people were surprised that social services were unable to offer any assistance, particularly where people were just coping but with obvious difficulty.

People judged ineligible for social services support are typically signposted to other services. This often leaves people to take the initiative in following up other leads for themselves, and for some people the signposts lead to a dead end where they remain with no further assistance.

People are resourceful and find ways of getting help from a combination of informal sources alongside privately organised support but these arrangements are fragile and liable to break down at any time.

People funding their own care are also disadvantaged and typically end up in their situation by chance rather than by choice. They risk being fast-tracked into residential care before other options have been properly explored; the decision to move into residential provision is rarely planned and well considered, but often seems to be the only option.

Any contact with social services by people funding their own arrangements is the exception rather than the rule; none of those people interviewed for this study had experienced a social care assessment prior to entering a home.

People paying for their own care in a home are frequently isolated and alone with little access to expert advice and information. They are often fearful about their savings running out and none was well informed about how to obtain support once savings had depleted.

People can and do 'slip through the net' of social services, and some people continue to spend their savings past the threshold at which they should be referred for public

funding. Identifying these people is hit and miss; what happens to people subsequently is a matter of chance.

In the few instances where support was provided for people to participate in the community, it was for younger disabled adults rather than for older people.

The exclusion of lower bands of eligibility means that people have particular difficulty in getting support with practical tasks such as housework, gardening and shopping. People unable to get help elsewhere struggled to continue doing it for themselves with obvious risks.

There was a pervasive view among social services staff that people do not 'need' support with simple tasks and are often trying to 'trick' the council into giving them help they

are not entitled to. Our study shows this is not the case.

It is easier for people to get help in the form of equipment for daily living than to get personalised support. But a task-based and mechanistic approach to people's needs is likely to address basic requirements while





not taking account of people's dignity and emotional well-being.

Groups of people particularly disadvantaged by eligibility criteria include young people in transition between children's and adults' services, and older people who suffer the consequences of institutionalised ageism.

## Conclusion

This study has attempted to provide empirical evidence about the nature and impact on people's lives of the tightening by councils of eligibility criteria. All six councils in the study had to make significant judgements about how they rationed their resources. None of the councils was happy with the situation and those that had gone furthest down the rationing route (such as in limiting eligibility to critical needs only) acknowledged this was an ultimately self-defeating solution which was unsustainable.

A number of common policy and operational threads were discernible across the six sites:

- All councils are developing tighter rules and procedural guidelines about eligibility criteria, regardless of the banding adopted locally.
- Tightening eligibility criteria does not curb demands for support.
- People with ostensibly eligible needs are not gaining access to services.
- Councils are increasingly attempting to narrowly define the 'core business' of adult social care.
- Councils are increasingly using signposting as a way of diverting demand, but rarely know what happens to people signposted out of care-managed support.
- Care managers continue to exercise some discretion in determining eligible needs, but this discretion is being curtailed.

- An eligibility-based framework increases the likelihood of front-line staff assessing for bands and services, rather than assessing people's situations in terms of needs and risks.
- People who fund their own care rarely have access to assessment and tend to be left without any form of independent review, advice or support.
- The trend towards tightly circumscribed council help with social care needs does not sit well with the personalisation agenda and with wider conceptions of health and well-being.
- The precise point at which councils establish the threshold for eligibility is not necessarily a predictor of how criteria operate in practice.
- Existing performance measures appear to reveal relatively little about how councils behave towards people who are judged to lie outside their criteria. This underlines the central importance of developing an outcomes-based framework for evaluating councils' performance.

The experiences and voices of people who use services, and of their carers, were sought out in this study. It is here that decisions on priority setting and rationing unravel in people's lives. Sometimes those experiences were positive, particularly where people used models of care that promote, enable or restore people's independence. But too often they were much poorer than they could have been with minor amounts of service input. Situations were uncovered where the absence of any help, or

the provision of inadequate help, resulted in very poor individual experiences. It is possible for FACS to operate in a sensitive and flexible way to match the changing needs of individuals. In reality the risk is that FACS is used as a crude tool to limit demand, leading to overwhelmingly poor-quality life experiences for those who are deemed ineligible.

Important issues for local and central government are raised by this study:

- There is positive feedback from people's experiences of support through the Partnerships for Older People Projects and these successful initiatives need to be built upon. Lessons could also be used for informing partnership developments with younger adults.
- Councils need to review and monitor how their eligibility criteria are set and implemented to ensure more sophisticated and sensitive approaches to allocating resources according to needs and risks.
- Councils should ensure that care assessments are carried out for people who fund their own care, whether they are at home or in hospital.
- Priority should be given to the local provision of expert advice and information about care services, tailored to the individual, whether people fund their own care or not.
- Comprehensive information and support should also be readily available to carers, particularly at the point people take on caring responsibilities. Assessments need to take into account the risk to the carer's health

and well-being, as well as that of the person being supported, should their situation continue unsupported.

- Government policy highlights the role of the third sector in providing advice, advocacy, service brokerage and other support services. Local commissioning and funding of these services need to improve to ensure high quality local provision, stability and continuity in the voluntary sector and good outcomes for people.
- As councils tackle strategic needs assessments for their whole population as the basis for local area agreements and in order to plan and commission services, it will be important they monitor what happens when people are signposted to other support and to collate information about the needs of people funding their own care.
- The positive feedback from successful short-term intermediate and rehabilitative care services indicates strengths in models of care that take an enabling approach. These lessons should inform the design of local services.
- The findings highlight policy tensions and challenges to be tackled by the Government's forthcoming Green Paper. More information is needed, locally and nationally, about the needs of people ineligible for council-arranged care to inform the next Comprehensive Spending Review. A focus is needed on policy towards people who pay for their own care and what they can expect in the way of support and advice from public authorities.

## Summary of the state of social care in England 2006-07

- There is an increasingly sharp divide between those people who benefit from the formal system of social care and those who are outside it.
- People qualifying for services arranged by their council are seeing improvements and, in some areas, early steps towards a redesigned system offering personalised care.
- But the picture can be very different for those people who are not eligible for council-arranged care, and there is little consistency as to who is ineligible both within and between councils.
- People 'lost to the system' because they are not eligible for council-arranged services and cannot purchase their care privately often struggle with fragile informal support arrangements and a poor quality of life.
- People who fund their own care are also disadvantaged, lacking advice and information about their care options and often largely invisible to local councils.
- Care services provided by councils, private and voluntary bodies are meeting more of the NMS but improvement appears to have stalled.
- The Government's proposed Green Paper on long-term care funding offers an important opportunity to establish a fair and sustainable social care system where people, whether they pay for their own care or not, as a minimum get good advice, an assessment of their situation, and access to high quality services.





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