PSSRU

Personal Social Services Research Unit

An assessment of the impact of the Care Act 2014 eligibility regulations

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3.1 Background

National minimum eligibility criteria for social care were introduced in April 2015 as part of the reforms set out in the Care Act 2014. In contrast to the previous Fair Access to Care Services (FACS) guidelines, whereby minimum eligibility thresholds for support were determined by local authorities, the national criteria introduce minimum levels of eligibility across all councils in England.

The Personal Social Services Research Unit (PSSRU) at the London School of Economics and Political Science (LSE) was commissioned by the Department of Health to evaluate the impact of the national minimum eligibility regulations on client eligibility and their associated effects on service use and expenditure. The aims of this study were to examine:

- The impact of the new regulations on the eligibility of people with different social care needs;
- The impact of the new regulations on the support provided by local authorities;
- The views of professionals about the impact of the new regulations.

3.2 Survey and focus group methods

All English Councils with Social Services Responsibilities (CSSRs) were invited to take part in the study, which involved two main components:

- **A care manager questionnaire** (completed by care managers from 32 English local authorities). In each participating authority, 12 care managers were each asked to provide details about ten cases assessed since the introduction of the new eligibility criteria. Cases included in the survey covered a wide range of care needs. The survey collected information about age, gender, dimensions and levels of need, living arrangements and informal care receipt. Care managers were asked to specify whether each client was likely to receive support under the new regulations – and if so, the types and costs of support provided - as well as to indicate what the outcome of the assessment would have been under the preceding FACS guidelines.

- **A series of focus groups** in five local authorities. Focus groups involved between two and seven care managers (or other staff involved in needs assessments) and team managers. Participants were asked to provide feedback on the implementation of the new criteria and on their impact on management, workflow and eligibility for different service users.

3.3 Results

Although the new regulations differ in important ways from FACS guidelines in the way they consider needs to determine eligibility – in particular, taking a more outcomes-focused approach – the new minimum eligibility threshold was intended to be consistent at the national level with the number of service users and expenditure associated with a 'substantial' needs threshold under FACS.

Across adult client groups, the results suggest that nearly all clients with 'critical' or 'substantial' needs would be eligible for support under both the FACS and the national eligibility regulations. Among clients with moderate or low needs under FACS, the evidence collected suggests a very small increase in eligibility under the national minimum criteria. The degree of change was found to vary according to client group.

When compared to clients already likely to have been eligible under FACS, those that were newly eligible under the national regulations were predominantly found to have difficulties performing 'household' tasks such as housework and shopping, as well as physically-demanding personal care activities such as bathing. Their average care package costs were substantially lower than those of individuals that would have been eligible under FACS regulations.

Regression modelling identified factors such as disability (as measured by Activities of Daily Living - ADLs), living arrangements (whether the person lives alone) and the receipt of informal care to be strong predictors of eligibility and care package levels.

Predicted eligibility and cost levels were combined with estimates of underlying client and population characteristics to get estimates of the overall impact of the new eligibility regulations on client numbers and social care expenditure (Table 1 and Table 2).

Client numbers are estimated to increase by approximately 1.6% across the four main adult client groups (an additional 14,600 clients). Under the assumption that changes to care package costs apply to new cases, but not to existing ones, gross current expenditure is expected to increase by 0.6% (£88 milion), and net expenditure by 0.6% (£72 million).

Table 1 Estimated changes in client numbers by client group

Client group	Existing clients	Change in client numbers	Change in clients (%)
Older people	562,600	+8,900	+1.6%
Adults aged under 65 with a physical disability or sensory impairment	110,100	+3,100	+2.8%
Adults aged under 65 with learning disabilities	131,000	-1,100	-0.9%
Adults aged under 65 with mental health needs	92,000	+3,700	+4.0%
Total	895,600	+14,600	+1.6%

Table 2 Estimated changes in gross current expenditure by client group, assuming changes in unit costs only for additional community clients

Client group	Existing gross current expenditure (£m)	Change in gross current expenditure (£m)	Change in gross current expenditure (%)
Older people	7,611	54	+0.7%
Adults aged under 65 with a physical disability or sensory impairment	1,319	35	+2.6%
Adults aged under 65 with learning disabilities	4,004	-36	-0.9%
Adults aged under 65 with mental health needs	1,016	35	+3.4%
Total	13,950	88	+0.6%

Table 3 Estimated changes in net current expenditure by client group, assuming changes in unit costs only for additional community clients

Client group	Existing net current expenditure (£m)	Change in net current expenditure (£m)	Change in net current expenditure (%)
Older people	5,467	41	+0.7%
Adults aged under 65 with a physical disability or sensory impairment	1,204	32	+2.7%
Adults aged under 65 with learning disabilities	3,773	-34	-0.9%
Adults aged under 65 with mental health needs	971	33	+3.3%
Total	11,415	72	+0.6%

3.4 Study limitations

It is important to note some study limitations:

- The evaluation was carried out very soon after the Care Act was implemented, whilst some of the local implementation processes were still being developed.
- Even though the study includes a wide range of authority types, it cannot claim to have a representative sample of authorities.
- The study evidence includes cases for whom assessment information about needs and eligibility was available. It did not observe cases for whom this information was not recorded.
- The numbers of cases in the analysis for some subgroups is limited, which means that the uncertainty surrounding some of the estimates in the analysis is significant.

4 Introduction

National minimum eligibility criteria for determining the eligibility of adults for receipt of funded social care and support were introduced in April 2015 as part of the reforms set out in the Care Act 2014. In contrast to preceding Fair Access to Care Services (FACS) guidelines, whereby minimum eligibility thresholds for support were determined by local authorities, the national criteria introduced minimum levels of eligibility across all councils in England.

This report provides an early assessment of the impact of the national minimum eligibility criteria in the months following their introduction. It builds on a number of previous analyses on the same topic by the research team (Fernández, Snell, & Marczak, 2014; Fernandez & Snell, 2012, 2013, 2014).

In particular, the study aims to examine:

- The impact of the new regulations on the eligibility of people with different social care needs;
- The impact of the new regulations on the support provided by local authorities;
- The views of professionals about the impact of the new regulations.

5 Study data and methods

The present study combines quantitative and qualitative evidence drawn from a bespoke survey and a number of workshops involving professionals in charge of the assessment of social care eligibility and local managers.

5.1 Recruitment of local authorities

Invitations to participate in the study were sent by email to Directors of Adult Social Services in all English Councils with Social Services Responsibilities (CSSRs) on 18th May 2015, approximately 7 weeks following the introduction of the new criteria. Invitations were accompanied by a letter of support from the Department of Health with acknowledgement of support from the Association of Directors of Adult Social Services (ADASS) and ethical approval from the Social Care Research Ethics Committee (SCREC). All English local authorities were invited to take part in the survey, and to indicate whether they had an interest in hosting a focus group discussion. Focus groups were arranged in five local authorities.

In order to maximise the time available for data collection, full survey documentation was sent along with invitation emails for distribution among participating staff members. In order to comply with reporting deadlines for the Department of Health, a deadline of 8th June 2015 was requested for survey responses. Follow-up emails were sent to local authorities that had not confirmed their participation on 27th May and 26th June, with the response deadline extended to 24th July 2015 to maximise response rates.

Participation in the study (both at the local authority and individual staff level) was entirely voluntary. The lack of resources – particularly in light of the pressures associated with the implementation of new eligibility regulations – was commonly cited as a reason for non-participation. It is therefore possible that the sample of authorities (see section 5.4) in the study might over-represent authorities with fewer problems implementing the new regulations at the time of the survey.

The survey-based component of the study involved 32 local authorities in England. Table 4 describes the region, type and FACS threshold of the authorities in the study.

Table 4 Characteristics of participating authorities

By region	
North East	2
North West	2
Yorkshire and the Humber	3
East Midlands	3
West Midlands	3
East	3
London	10
South East	2
South West	4
By type	
Inner London	5
Outer London	5
Metropolitan District	5
Shire County	8
Unitary Authority	9
By FACS threshold (as of 2012)	
Critical	1
Upper substantial	0
Substantial	20
Upper moderate	4
Moderate	7
Total	32

5.2 Survey of needs assessments

5.2.1 Using 'real life' assessments

Earlier analyses of the likely impact of draft national eligibility criteria – conducted during the development of the final regulations – have followed two alternative approaches. In the first (Fernandez and Snell 2014), care managers were provided with a series of vignettes, describing the characteristics of a range of hypothetical cases. Participants were asked to provide an indication of likely eligibility and the allocation of services both under FACS and under draft national eligibility regulations. In the second (Fernandez et al 2015), care managers were asked to summarise the characteristics of a sample of 'real life' assessments that they had recently carried out, and to provide equivalent information about eligibility under alternative regulations.

An advantage to the former (vignette-based) approach is that client characteristics are identical across participating authorities and assessment staff, facilitating in particular the examination of how assessment outcomes vary between respondents. However, case studies have limited capacity to reflect the range and complexity of need-related characteristics relevant to a social care needs assessment. Furthermore, the use of 'real life' assessments provides a more accurate approximation of the characteristics of cases assessed and a broader pool of client characteristics on which to base the evaluation.

The care manager questionnaire in this study focused on real-life assessments. As discussed later in this report, regression-based modelling was therefore used to control for differences in the characteristics of the cases between authorities.

Given that the primary aim of the study was to investigate cases assessed during the relatively short time since the introduction of national eligibility criteria, the reliance on 'real life' assessments constrained somewhat the number of cases available for inclusion in the study. In particular, care managers were often unable to identify large number of cases assessed as having ineligible need; this was most notable in authorities that screened potential clients (e.g. using first contact teams) prior to undergoing a full needs assessment.

The fact that the study focuses on cases with available assessment information means that the observed proportion of eligible cases in the study should not be understood to represent the overall eligibility rate out of all cases approaching local authorities for support, as many of these will be redirected to other services or provided with information and advice without undergoing a full assessment.

5.2.2 Data collection

The survey covered the four main groups of users of social care services (older people aged 65 and above, adults aged 18-64 with a physical disability, adults aged 18-64 with a learning disability and adults aged 18-64 with mental health needs) and their carers. Participating local authorities were each asked to select a sample of 12 care managers (covering all client groups) to respond to a Microsoft Excel-based questionnaire survey. Authorities were allowed to include

fewer participants than requested if enough could not be identified. This means that the number of cases submitted across the LAs in the study varies.

Although the specific logistical arrangements vary locally, most English local authorities use a two-stage process for deciding whether an individual's needs are eligibility for support. In a first stage, individuals usually provide a limited amount of information about their needs. On the basis of this information, a decision is taken as to whether the person should receive a full-assessment or whether he/she is provided with information or sign posted to a different service. The nature of the first contact varies across authorities in its form (e.g. face to face, telephone, professionals involved), content (areas of needs assessed), and in the nature of the decisions taken.

In some areas and for some client groups, eligibility to receive care is established at first contact. In this case, the full assessment concentrates on the design of the care plan. The study included professionals involved in the first point of contact and in carrying out full assessments in order to gain an overall view of the impact of the new regulations on all stages of the eligibility assessment process. Across all participating authorities, 18% of survey respondents identified themselves as members of a first contact team.

Participating assessment staff were allocated to a specific client group according to their usual roster. Each was asked to provide information about 10 cases recently assessed, preferably including the last 5 cases assessed as having eligible needs, the last 4 cases assessed as not eligible, and the most recent carer assessment. For each client, information was collected about:

- The needs-related factors of the individual assessed (e.g. age, gender, disability, living arrangements and informal care support)
- The outcome of the assessment under national regulations (whether eligible, likely support packages and corresponding care package costs)
- The regulation clauses applicable, if eligible
- The likely outcome of the assessment had previous FACS guidelines been in place at the time of assessment (FACS rating, whether eligible, likely support packages and corresponding care package costs)

A summary of the Excel questionnaire is shown in Appendix 3 (a separate client information sheet was included for each case assessed). Responses were imported into STATA 13 software and complemented with local authority-level indicators including historic FACS eligibility thresholds, indices of deprivation and social care expenditure for analysis.

5.3 Focus groups

Five focus groups were carried out in a sub-sample of participating LAs with between two and seven care managers taking part in each. Additionally, one focus group was conducted with five members of the management team (see Appendix 15 for a description of the characteristics of LAs and professionals taking part in the workshops). Participants were asked to provide feedback on the content of the new eligibility regulations and to discuss the implications of new regulations on the

eligibility for adult and social care support for users and carers (see Appendix 16 for the focus group question guide).

Discussions were audio-recorded, transcribed verbatim and material was entered into the qualitative data management software NVivo 10. Thematic analysis was employed to organize systematically the content of the discussions, focusing on identification and reporting of patterns and themes across the dataset and collating passages relevant to each theme. The content of the focus group with management team was analysed separately and is presented in section 10.10.

5.4 Survey respondent characteristics

At the end of July 2015, data corresponding to 1,797 assessments carried out since April 2015 had been collected in the survey, completed by 219 care managers. The majority of respondents were care managers in charge of carrying out needs assessments for individuals with social care needs; the rest were professionals involved in "first contact" teams in the local authority. As mentioned above, the inclusion of professionals fulfilling the two types of assessments was important in order to capture the current eligibility process overall, and to cover as fully as possible the range of clients approaching local authorities.

By its stratified nature, the study sample does not constitute a representative sample of cases in the local authorities in the study. Rather, the aim of the study was to ensure that the full range of clients approaching social care departments for support was included in the study. Table 5 provides a breakdown of the cases in the study in terms of their client group and FACS need classification.

Table 5 Distribution of cases in the survey

By client group	
Older people	1,044
Adults aged 18-64 with a physical disability	238
Adults aged 18-64 with a learning disability	205
Adults aged 18-64 with mental health needs	129
Carer	133
By FACS rating	
Critical	493
Substantial	735
Moderate	235
Low	173
Not sure	12

As Figure 1 shows, the number of cases contributed to the study varied significantly across authorities.

Figure 1 Distribution of cases per participating authority

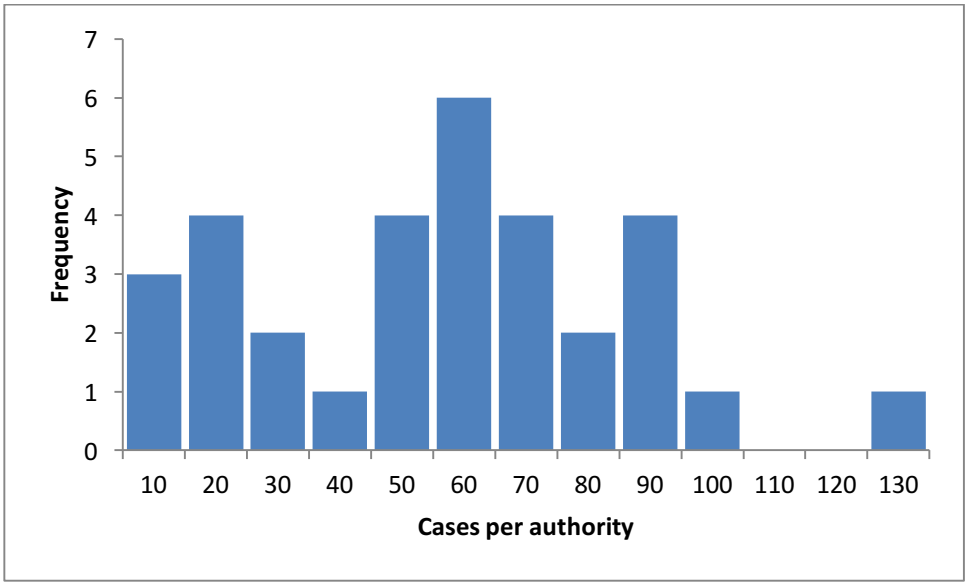


Table 6 presents summary needs-related characteristics of the four adult client groups in the sample.

Table 6 Needs-related characteristics of cases in the survey

By client group	Older people	Young adults (physical disability)	Young adults (learning disability)	Young adults (mental health)
Mean number of ADLs & IADLs always unable to perform without help (0-14)	7.4	6.8	6.2	1.9
Mean number of ADLs & IADLs always or sometimes unable to perform without help (0-14)	8.9	8.7	8.2	4.8
Proportion receiving informal care (co-resident)	37%	54%	42%	31%
Proportion receiving informal care (any)	75%	73%	61%	52%

The following sections provide key findings from the results of the care manager survey. In particular, the next chapters describe the patterns of:

- Eligibility under the national regulations, compared against likely eligibility under previous FACS policies in place prior to April 2015, and broken down by level of need (according to estimated FACS needs levels).

- Likely sources of support for clients under national eligibility regulations, according to likely sources of support and eligibility under FACS.

- Analyses of the characteristics of clients newly or no longer eligible under the national regulations.

It is important to note that clients may undergo a period of enablement (also referred to as *reablement*) for up to six weeks following assessment. During this period, clients may be offered short-term help to regain independence and well-being before a final decision is made as to the appropriate requirement for long-term care services. Hence, there may exist a degree of uncertainty as to the long-term eligibility of clients immediately following assessment. To allow for this, care managers were asked to specify whether clients were 'definitely' or 'probably' eligible or ineligible.

Likely eligibility under FACS was estimated according to the FACS need level applicable to each client (criticial, substantial, moderate or low) and care manager indications of whether such needs would have met FACS eligibility policies in place immediately prior to April 2015.

Care managers were not asked to factor in decisions made on the basis of clients' ability to pay according to a financial means test.

5.5 Study limitations

It is important to note that whereas significant efforts have been made to collect as much robust evidence as possible for the evaluation, the results are the subject of some study limitations. In particular:

- The evaluation was carried out very soon after the Care Act was implemented, and some of the local eligibility and assessment processes were still being developed in some of the authorities.
- The results are based on evidence from approximately one fifth of local authorities in England. Even though the study includes a wide range of authority types, it cannot claim to have a representative sample of authorities. In particular, some authorities stated that they could not take part in the study because they were working through the challenges of implementing the new regulations.
- The use of real assessment data in the study means that the analysis was unable to observe cases approaching local authorities but whose needs meant they were redirected to other support services or provided with information and advice without undergoing a formal assessment.
- The numbers of cases in the analysis for some subgroups is limited, which means that the uncertainty surrounding some of the estimates in the analysis is significant.

6 Eligibility under the new system

6.1 Eligibility by FACS dependency rating

Figure 2 to Figure 6 show, for each client group, descriptive statistics reported likely eligibility under the national criteria and according to FACS policies in place prior to April 2015.

Across all adult client groups, the vast majority of adults assessed as having 'critical' or 'substantial' needs under FACS would be assessed as eligible for support under both the national eligibility criteria and FACS. Among younger adults with mental health needs, there is an apparent small reduction in the proportion of clients with substantial needs considered eligible under the new regulations. Since this contradicts patterns observed among clients with moderate needs, and given the sensitivity of results to anomalous cases given the sample size, this is an issue for further investigation.

A small increase in the proportion of clients with moderate (and to a lesser extent, low) needs that are considered eligible following the introduction of national regulations is evident within all client groups. This increase suggests that the regulations are applied such that the policy is somewhat more generous than the equivalent of a 'substantial' eligibility threshold according to FACS guidelines. Analysis of the characteristics of newly eligible clients is described later in this report (see Section 7).

It should be noted that since authorities retain the autonomy to provide services to clients below the national threshold, changes to eligibility thresholds need not be expected *ceteris paribus* to yield reductions in eligibility levels of clients with low or moderate needs.

Figure 2 Outcome of assessment by estimated FACS rating – older people

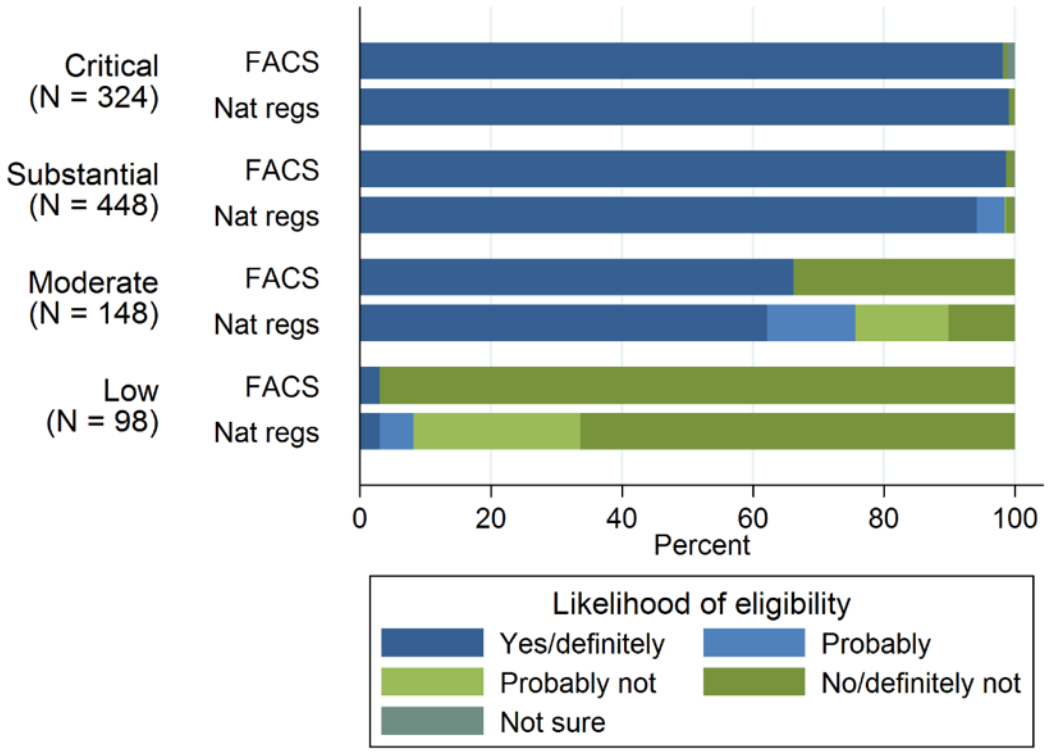


Figure 3 Outcome of assessment by estimated FACS rating – younger adults with a physical disability

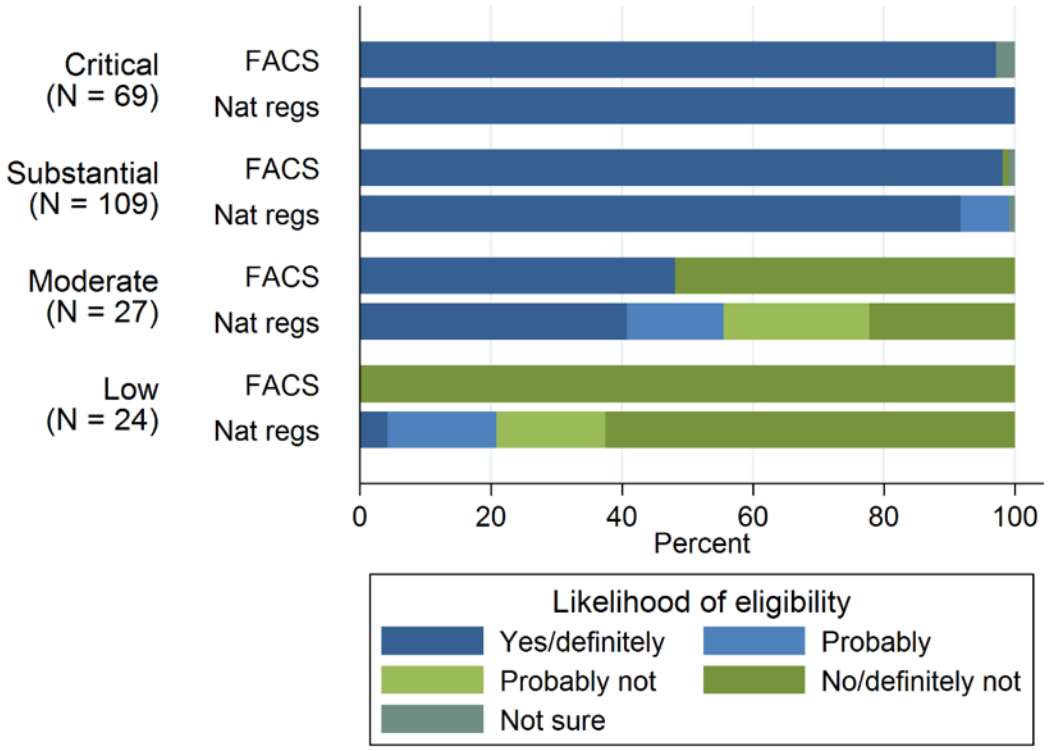


Figure 4 Outcome of assessment by estimated FACS rating – younger adults with a learning disability

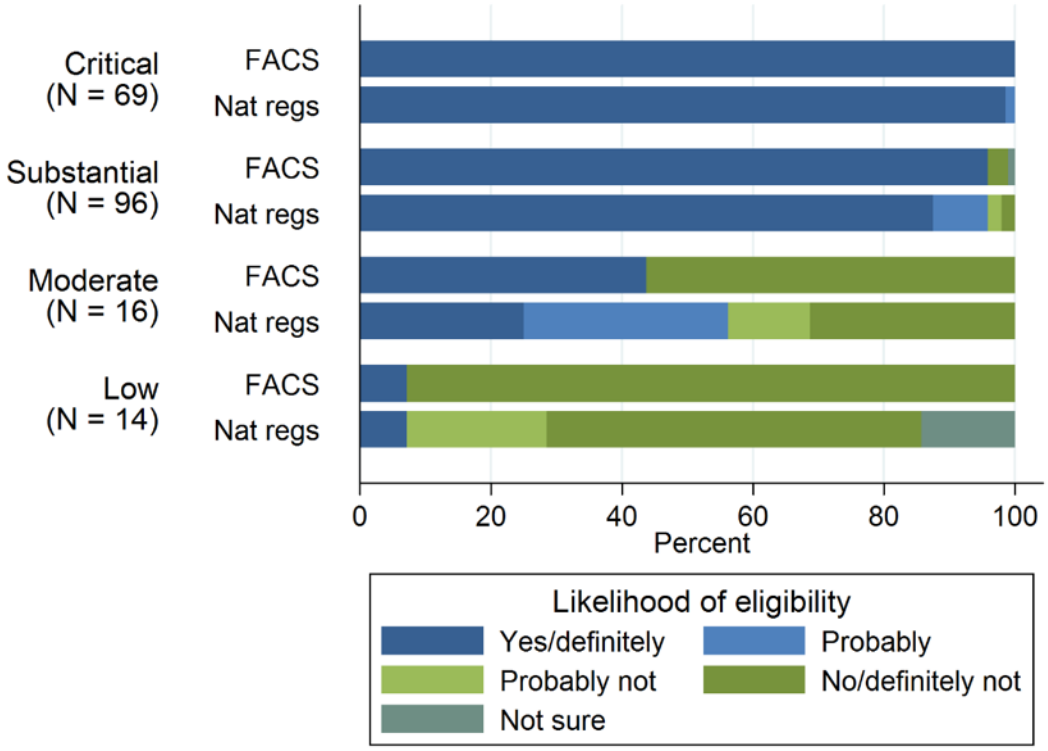
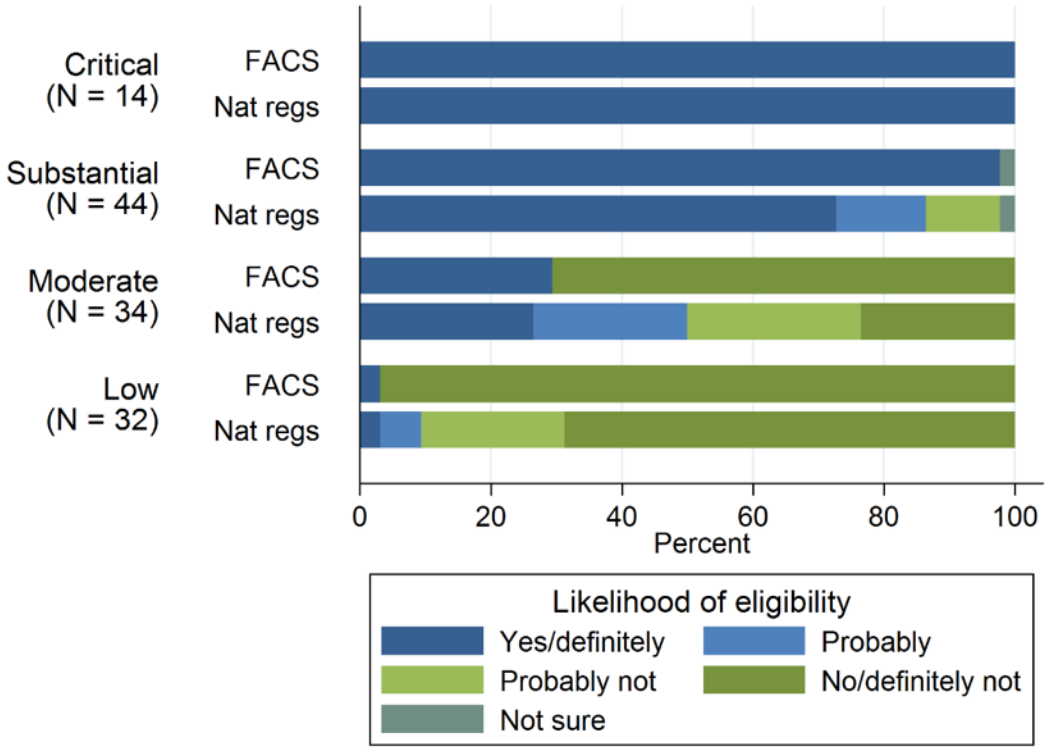


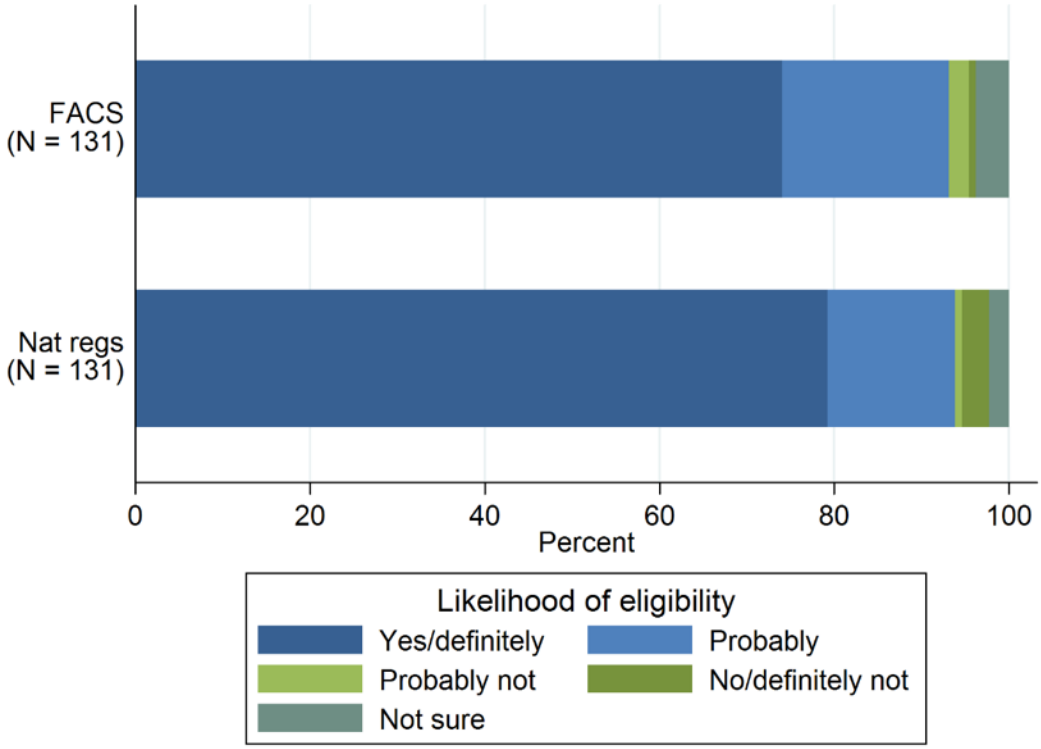
Figure 5 Outcome of assessment by estimated FACS rating – younger adults with mental health needs



According to regulations specified under the Care Act, local authorities have additional responsibilities to provide adult carer assessments where apparent needs exist. This contrasts with previous legislation, according to which carer assessments were largely carried out on a discretionary basis.

As Figure 6 illustrates, however, the vast majority of carers assessed since April 2015 would have been eligible to help and support prior to the introduction of the new regulations, with only a small increase (particularly when disregarding responses marked as 'not sure') under the new criteria. Comments from survey respondents provide some insight: in certain cases, assessment staff suggested that the regulations did not affect the type or volume of services provided, but whether those services were attributed to carers themselves or the recipients of their care.

Figure 6 Outcome of assessment – carers



6.2 Eligibility by ADL count

Under the national regulations, eligibility decisions are largely contingent on individuals' capacity to achieve certain outcomes – such as maintaining nutrition, maintaining hygiene, managing toilet needs or accessing necessary community facilities – without assistance, pain or distress, significant risk or impediment.

Below, eligibility decisions under FACS and national eligibility are shown according to the number of Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) that adults are unable to perform without help. ADL/IADL scores are grouped from 0 to 5+, on the basis of 14 distinct activities:

- Get up and down stairs
- Get out of doors and walk down the road
- Get around (except stairs)
- Get in and out of a bed or chair
- Use the WC/toilet
- Wash hands and face
- Bath, shower or wash all over
- Get dressed and undressed
- Groom (e.g. washing hair)
- Feed themselves
- Cook or prepare food

- Carry out housework (laundry, cleaning etc)
- Go shopping for groceries
- Manage finances or paperwork

Figure 7 Outcome of assessment by ADL count – older people

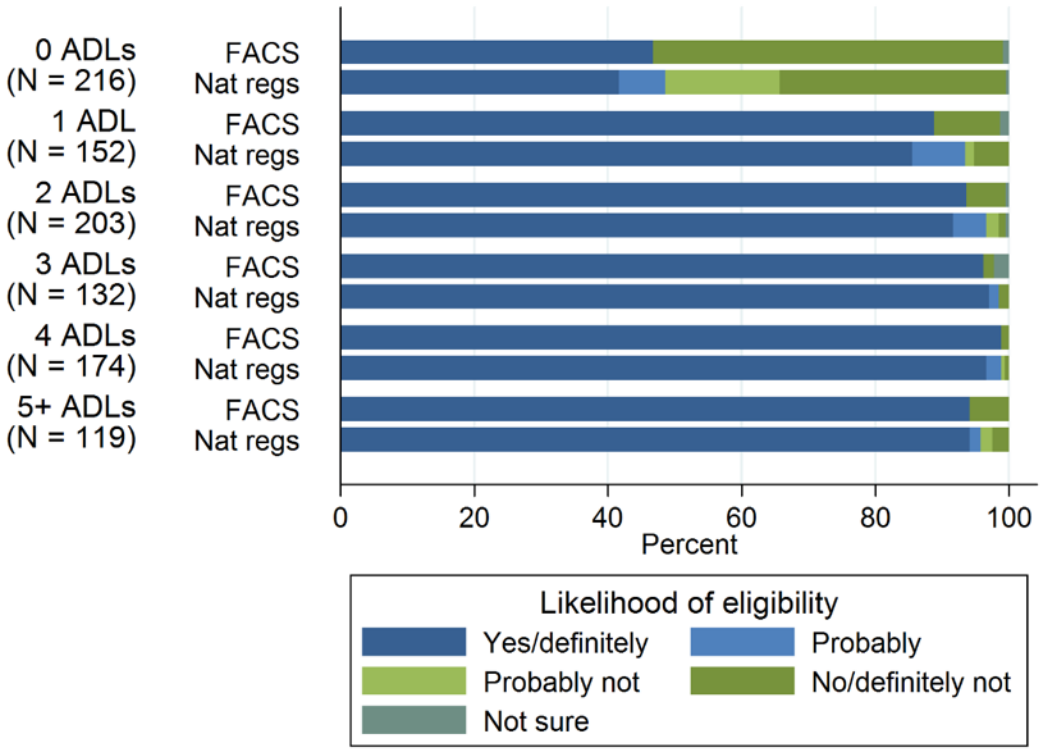


Figure 8 Outcome of assessment by ADL count – younger adults with a physical disability

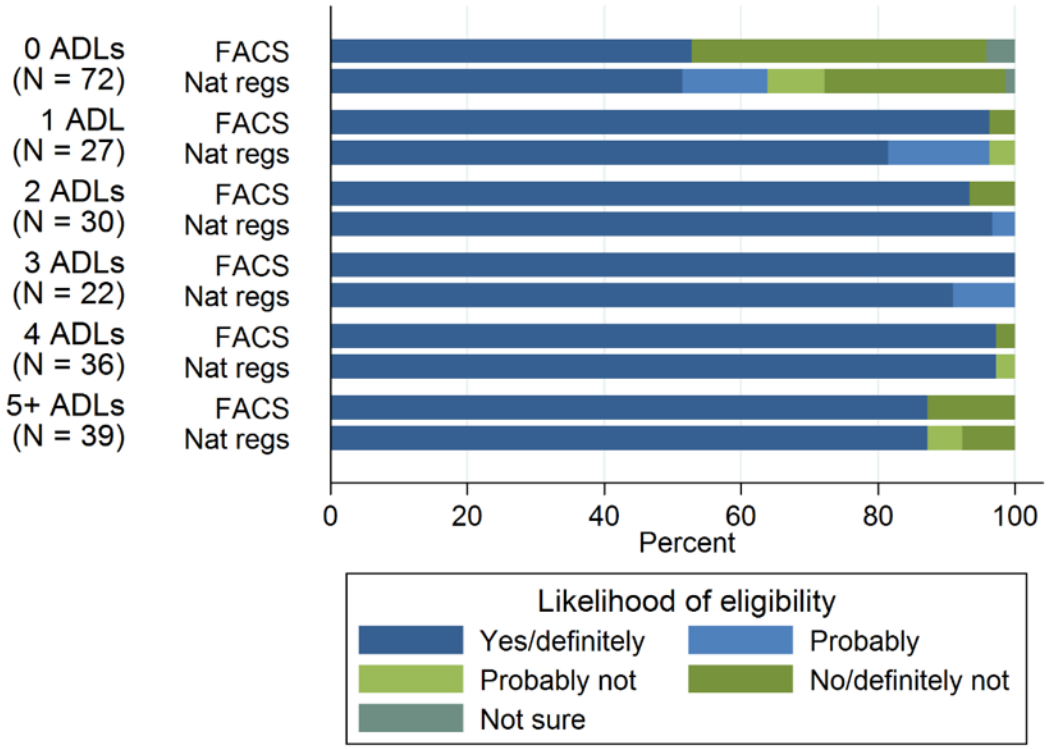


Figure 9 Outcome of assessment ADL count – younger adults with a learning disability

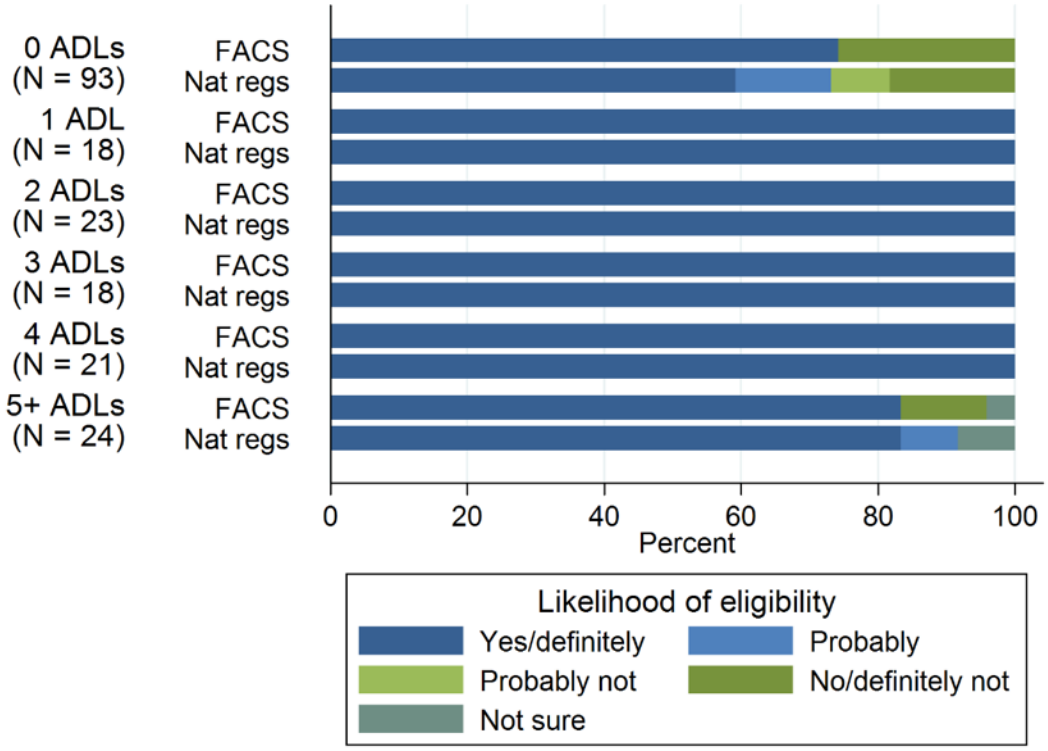


Figure 10 Outcome of assessment by ADL count – younger adults with mental health needs

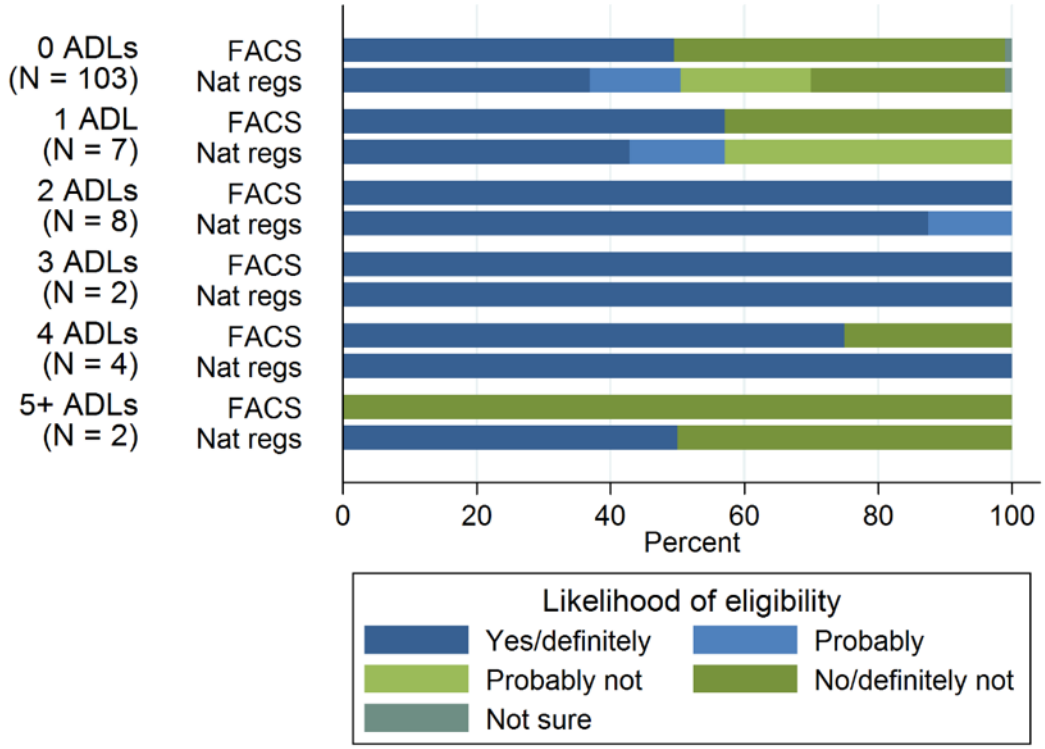
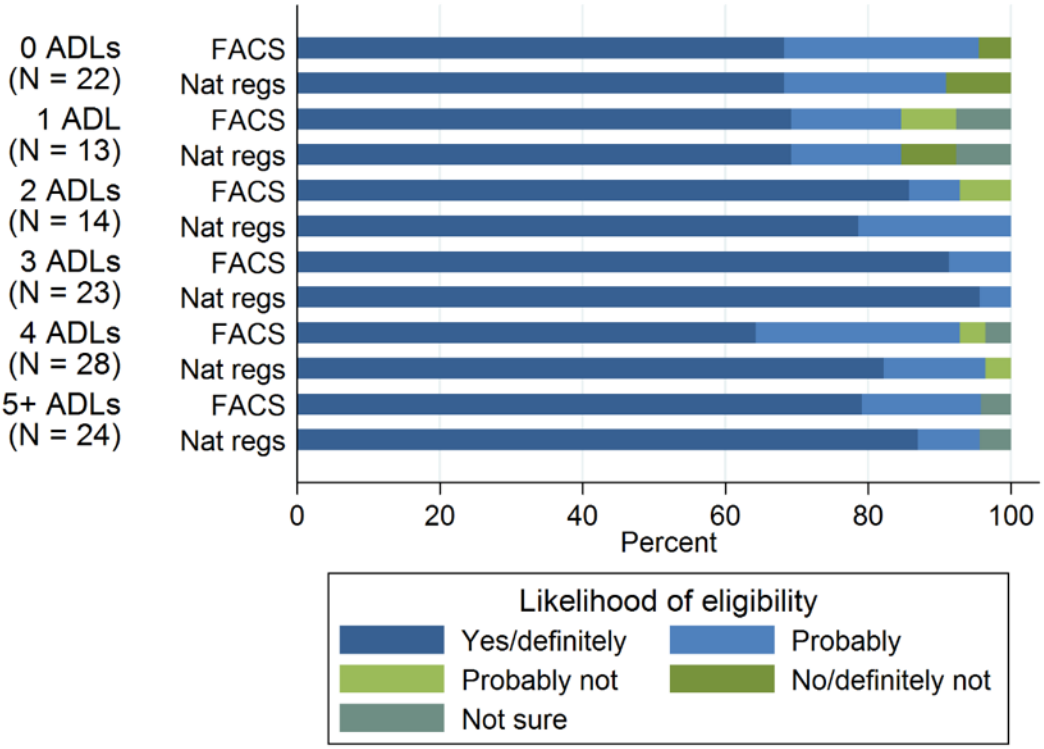


Figure 11 Outcome of assessment by recipient ADL count – carers



7 Factors associated with increased eligibility

This section explores which factors are associated with an increased probability of eligibility under the new regulations. It does so by focusing mostly on those cases assessed as not having eligible needs under the FACS system. Figures presented in this section are largely descriptive, and aim to provide an overview of the characteristics of clients according to eligibility under the new regulations and preceding FACS guidelines. A more detailed investigation of predictors of eligibility using regression-based methods is described in section 11.

7.1 ADL dependency

For each client, care managers were presented with a list of 14 'Activities of Daily Living' (ADLs) – including bathing, dressing and going to the toilet and 'Instrumental Activities of Daily Living' (IADLs) – including shopping, carrying out housework and dealing with finances. Staff were asked to identify whether clients needed help, occasional help or no help with each task.

Focusing on clients ineligible under FACS, Figure 13 shows that those clients that are newly eligible under the national criteria have particularly high levels of need in terms of IADL factors (such as house-work and grocery shopping) as well as physically demanding activities such as bathing, relative to those who remain ineligible for support. It should be noted that the figures below do not account for the availability of informal care.

Figure 12 Count of problems with ADLs by eligibility under the new regulations

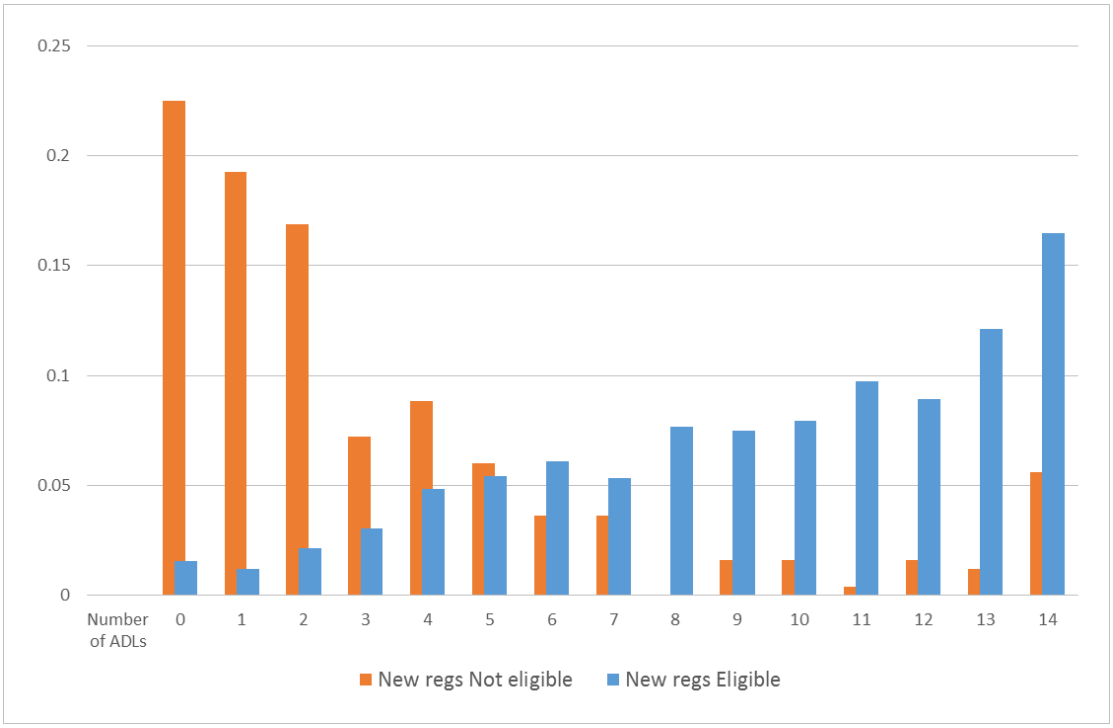


Figure 13 Prevalence of needs amongst cases not eligible under FACS by whether eligible under new regulations: all clients

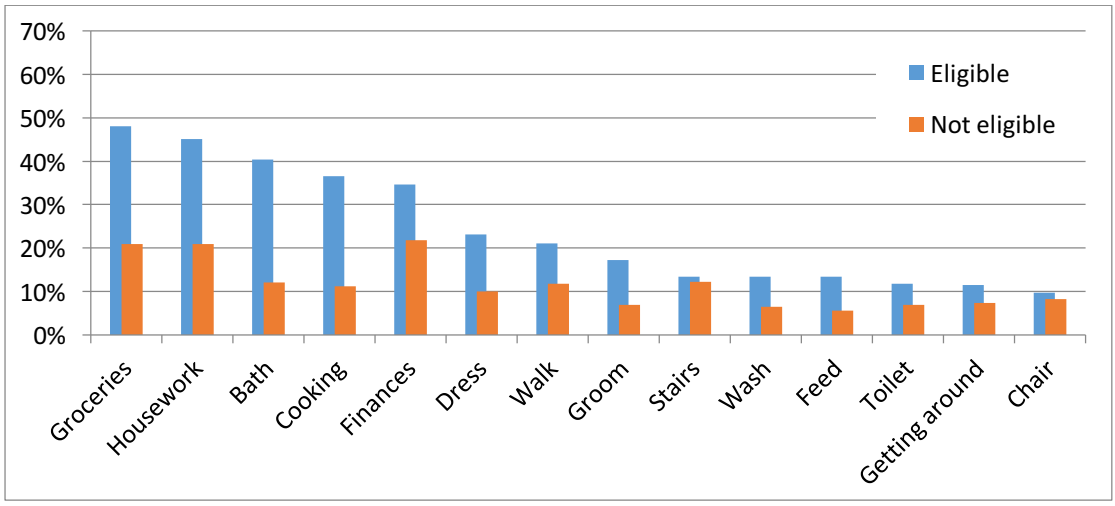


Figure 14 Prevalence of needs amongst cases not eligible under FACS by whether eligible under new regulations: older people

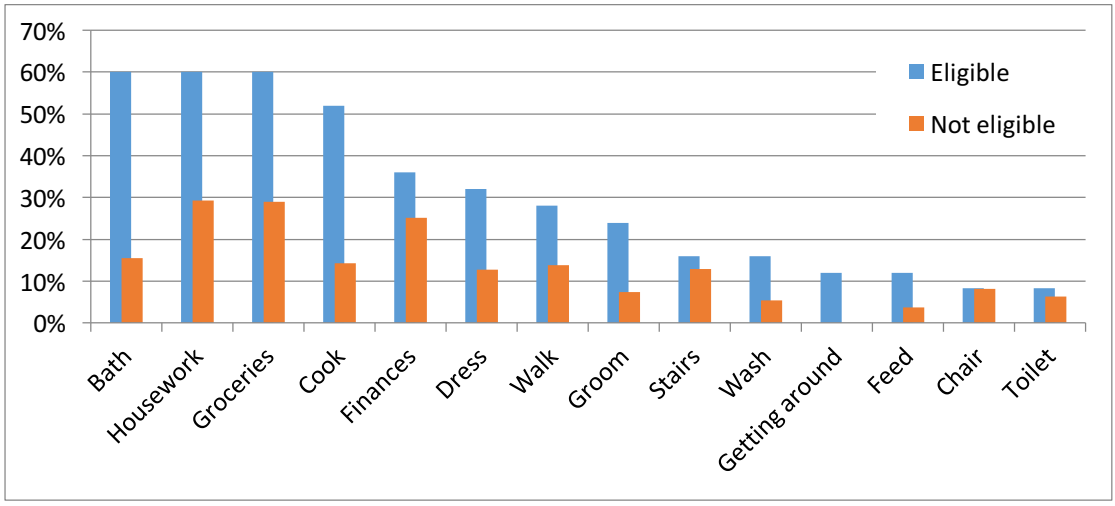
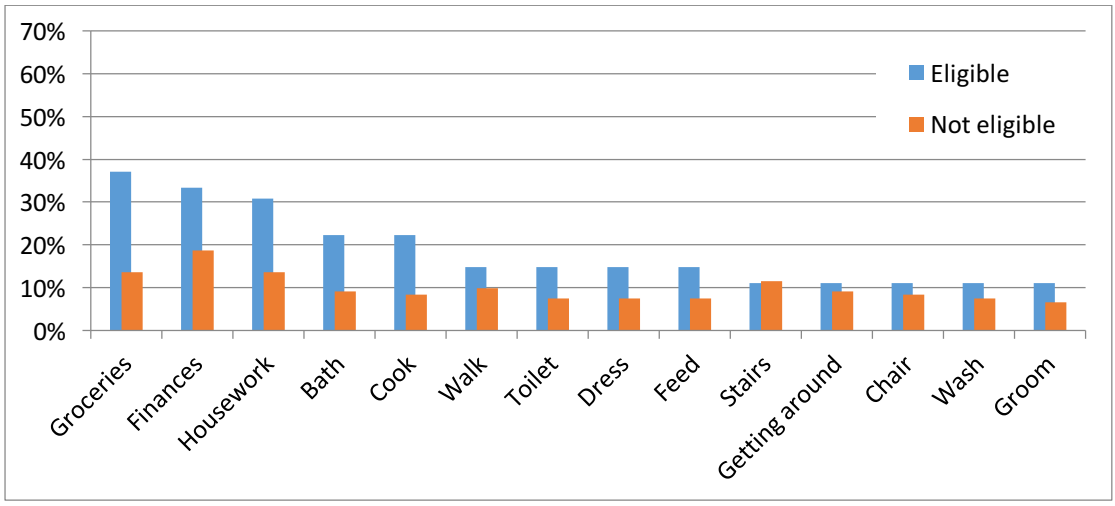


Figure 15 Prevalence of needs amongst cases not eligible under FACS by whether eligible under new regulations: younger adults



7.2 Outcome dimensions

To further understand the factors influencing changes in eligibility decisions, care managers were asked to identify the criteria of the national eligibility regulations according to which clients were eligible for support. Specifically, they were asked to specify which of the following outcomes (based on section 2:2 of the regulations) clients were unable to achieve:

- Managing and maintaining nutrition
- Maintaining personal hygiene
- Managing toilet needs
- Being appropriately clothed
- Being able to make use of the home safely
- Maintaining a habitable home environment
- Developing and maintaining family or other personal relationships
- Accessing and engaging in work, training, education or volunteering
- Making use of necessary facilities or services in the local community including public transport, and recreational facilities or services
- Carrying out any caring responsibilities the adult has for a child

On average across all adult user groups, clients that were newly eligible were unable to achieve approximately 3 of the 10 outcomes specified by the regulations. By comparison, those who would also have been eligible under FACS were unable to achieve just over 6 of the outcomes on average.

Figure 16 Distribution of problems with outcome dimensions amongst eligible / not eligible cases under new regulations

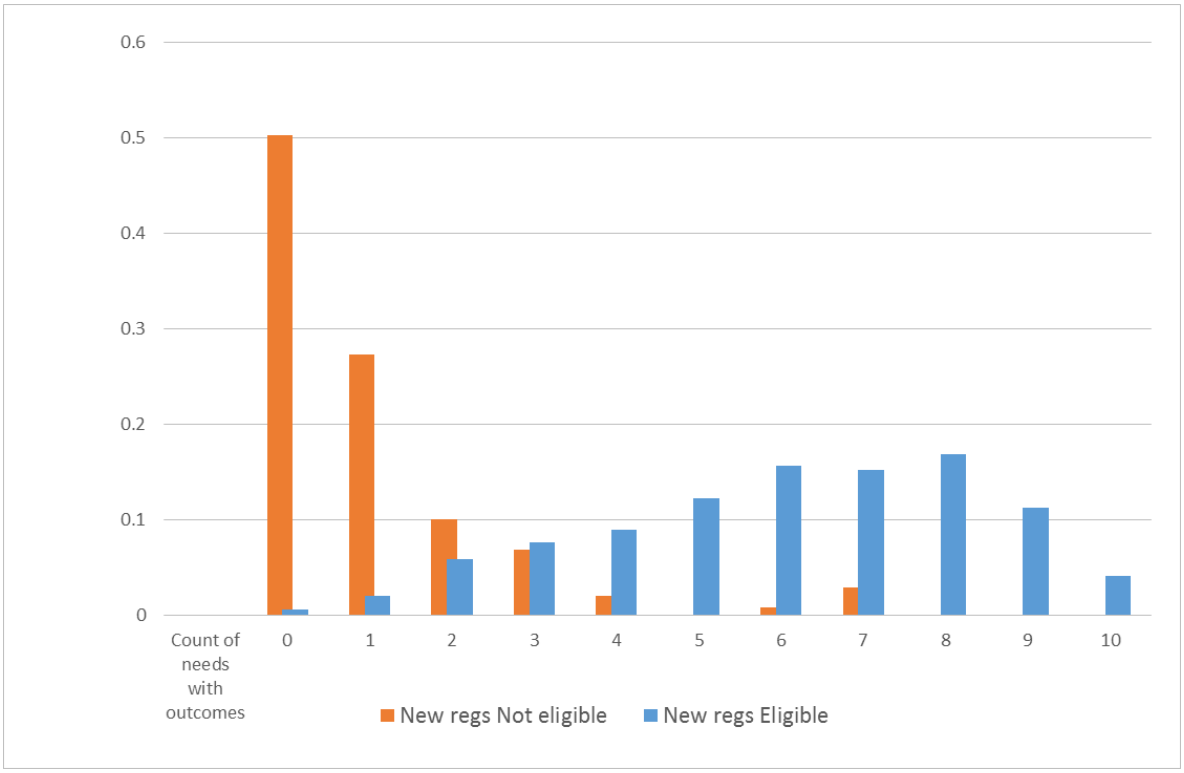
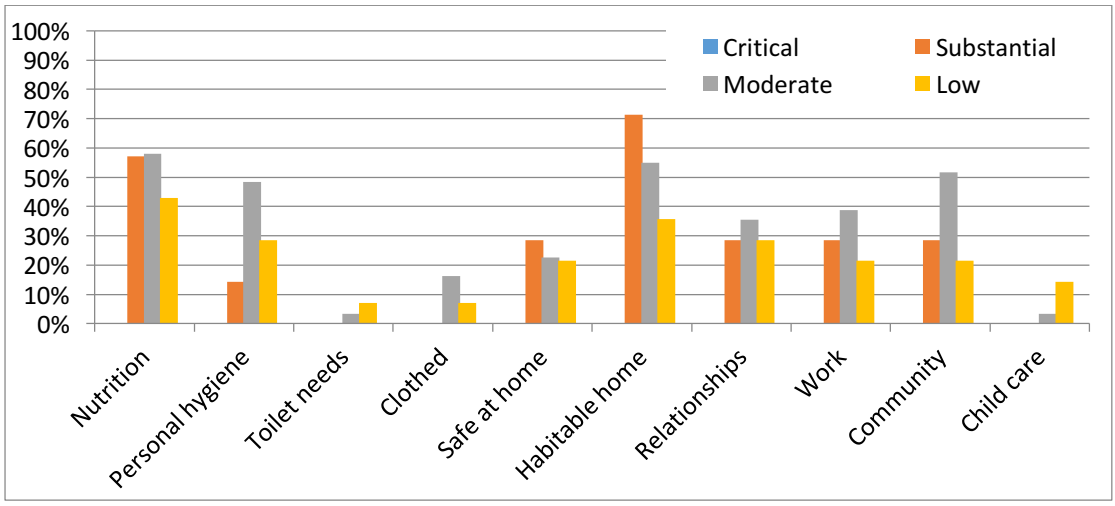


Figure 16 shows the proportion of cases across all client groups for whom each of the above clauses were considered applicable. Given that the regulations were designed to be broadly aligned with a FACS 'substantial' rating (as adopted by the majority of authorities prior to April 2015), stratifying by client group is of particular use in understanding why the criteria may increase eligibility for moderate- and low-need clients. In particular, each of the following clauses were considered applicable to more than 50% of those moderate clients that would be eligible under national regulations but not under FACS:

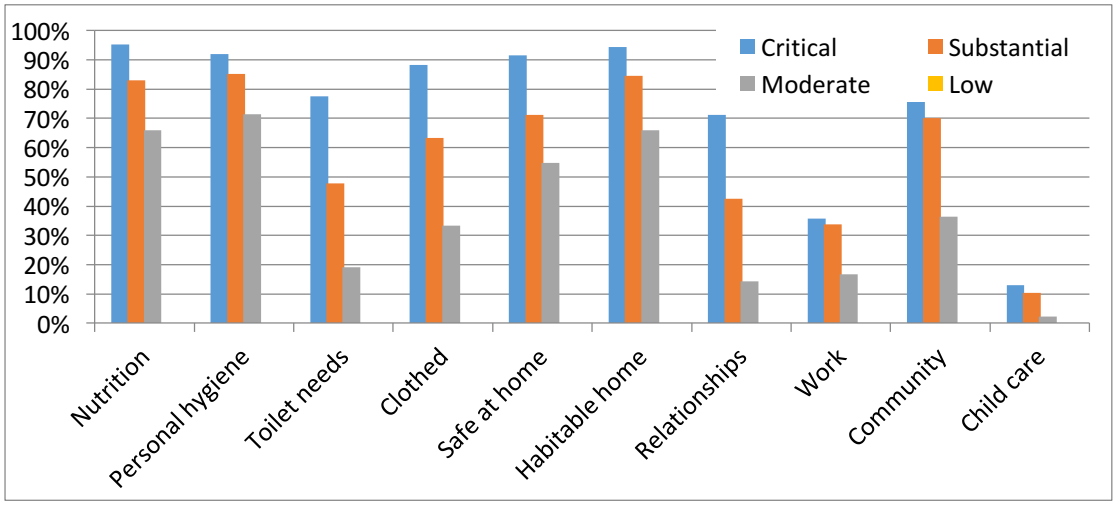
- Maintaining a habitable home environment
- Managing and maintaining nutrition
- Making use of necessary facilities or services in the local community including public transport, and recreational facilities or services

Figure 17 Prevalence of outcome clauses applicable amongst newly eligible cases, by FACS level - all client groups



For comparison, equivalent levels among adults considered eligible both under the national criteria and FACS are shown in Figure 18.

Figure 18 Prevalence of outcome clauses applicable amongst already eligible cases, by FACS level - all client groups



7.3 Equivalence of ADL and outcome measures

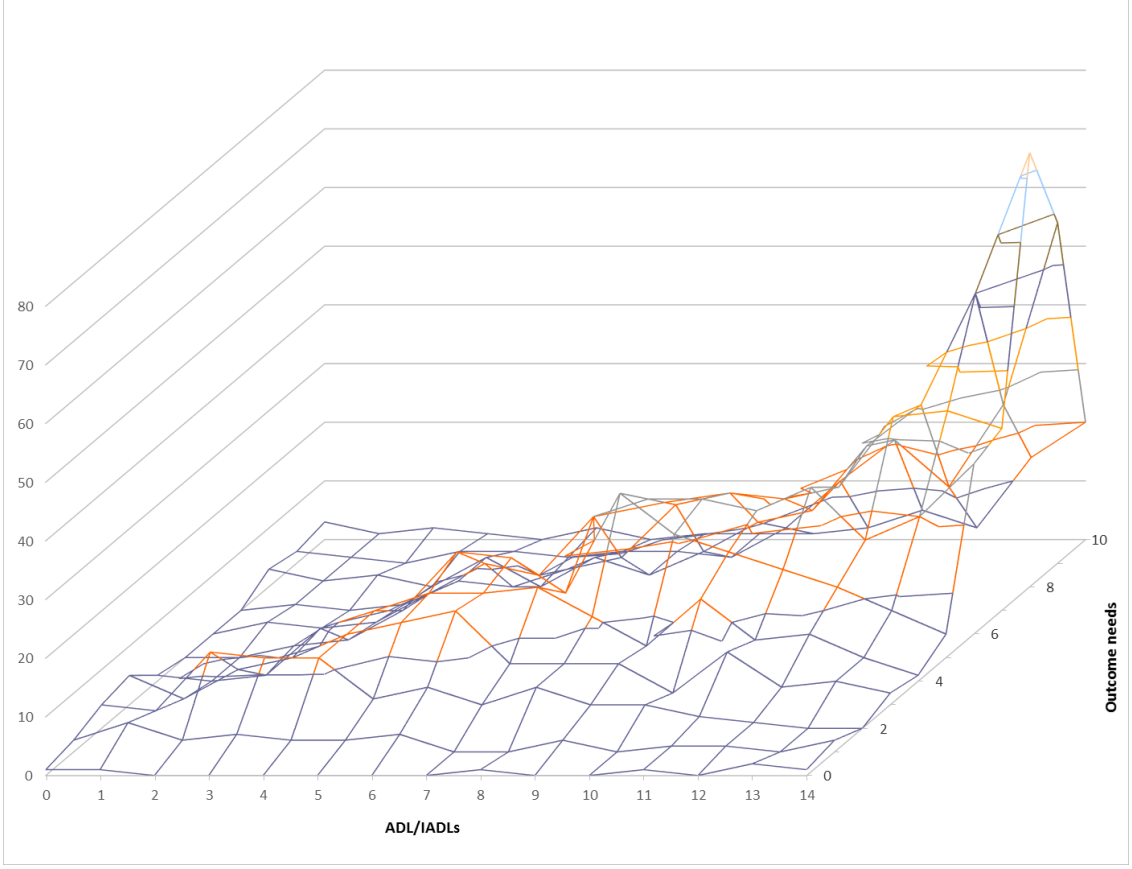
Overall, more than 97% of the cases in the survey that were considered eligible under the new regulations had difficulty performing at least 2 ADL or IADL activities, compared to 58% of those not eligible under the new regulations. By comparison, 97% of those eligible under FACS had at least 2 ADL/IADL difficulties, as did 63% of those ineligible under FACS.

It appears, however, that the number of I/ADL problems is not perfectly correlated with the number of outcome dimensions identified by care managers as significant to the case. For instance, 76% of the cases that were eligible under the new regulations with 0 or 1 ADLs were associated with problems in at least 2 outcome dimensions (see Table 7 and Figure 19). In such cases, it would appear that care managers are not "counting" numbers of ADLs in determining eligibility, but either ADLs and/or outcome dimensions.

Table 7 ADL/IADLs and outcome needs of eligible cases

		ADLs															
		0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	Total
Outcome dimensions	0	1	1	0	0	0	0	0	0	1	0	0	1	0	2	1	7
	1	2	5	2	3	2	2	3	0	0	2	0	1	1	0	2	25
	2	4	3	13	12	12	5	7	4	7	4	4	2	1	0	0	78
	3	5	1	6	8	12	14	16	7	7	7	2	9	3	4	2	103
	4	1	0	1	9	12	15	15	16	11	6	14	7	8	4	1	120
	5	0	0	2	3	8	18	17	11	28	21	18	15	12	8	4	165
	6	0	2	1	2	7	12	10	20	23	23	21	25	16	20	29	211
	7	0	1	0	1	5	4	7	9	18	20	19	21	33	34	31	203
	8	3	1	2	0	5	0	5	2	6	11	13	24	31	50	74	227
	9	2	1	0	2	2	1	2	2	1	6	14	21	13	27	58	152
	10	3	1	2	1	0	2	0	1	1	1	2	5	2	14	20	55
	Total	21	16	29	41	65	73	82	72	103	101	107	131	120	163	222	1,346

Figure 19 Outcome needs and ADL/IADLs for eligible cases in the survey



Also, there are perhaps some surprising relationships between *individual* ADLs and outcome dimensions, in that the presence of an ADL does not necessarily lead to the care manager mentioning the related outcome dimension as an issue, or vice versa (for instance, maintaining nutrition is often identified even if the individual can feed themselves, as illustrated in Table 8).

Table 8 Relationship between ADL and outcome dimensions

ADL	Outcome: managing and maintaining nutrition No/not specified	Yes
Needs help to feed self		
Yes	8%	92%
Sometimes	9%	91%
No	36%	64%
Not sure	43%	57%
Total	27%	73%
Needs help to cook/prepare food		
Yes	10%	90%
Sometimes	41%	59%
No	68%	32%
Not sure	100%	0%
Total	27%	73%
ADL	Outcome: maintaining personal hygiene No/not specified	Yes
Needs help to wash hands and face		
Yes	8%	92%
Sometimes	11%	89%
No	44%	56%
Total	28%	72%
Needs help to bath		
Yes	6%	94%
Sometimes	39%	61%
No	76%	24%
Total	28%	72%
ADL	Outcome: managing toilet needs No/not specified	Yes
Needs help to use WC/toilet		
Yes	14%	86%
Sometimes	37%	63%
No	90%	10%
Total	54%	46%

8 Services and other forms of support following assessment

The following section summarises the likely outcome of the assessment under FACS and the national regulations in terms of eligibility, the allocation of an ongoing care package, and the allocation of other forms of support (one-off support, information and advice, referral to another service, or informal care support).

Figure 20 to Figure 24 categorise adults and carers according to the highest level of support likely to have been available under FACS (y-axis), whereby an 'ongoing care package' refers to ongoing residential- or community-based care and 'other support/informal care' refers to one-off services, one-off payments (in the case of carers), referrals, information or informal care. Within each category, the horizontal distributions reflect the support likely to be received under the national criteria, according to the highest level of support.

The results suggest that:

- Most individuals that would have received an ongoing care package under the FACS system continue to do so under national eligibility.
- A small minority of cases who would have been assessed as eligible under FACS but receive "other forms of support" would be assessed as requiring an ongoing care package under the new regulations.
- A small proportion of cases that would not have been eligible under FACS would receive an ongoing care package under the national regulations.

Figure 20 Comparison of the outcome of assessment between FACS and national regulations: older people

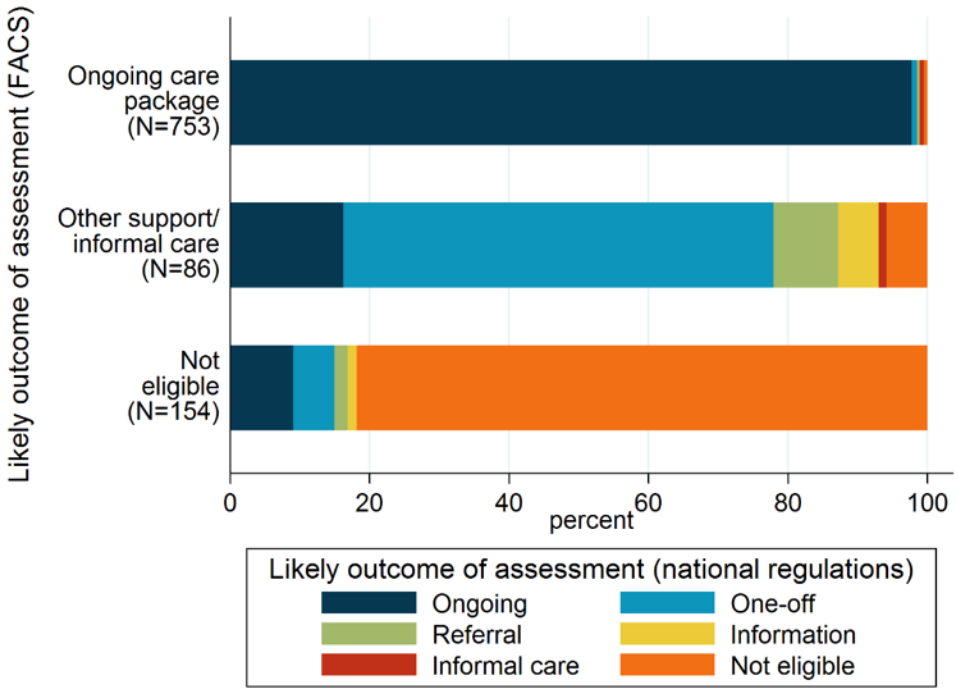


Figure 21 Comparison of the outcome of assessment between FACS and national regulations: younger adults with a physical disability

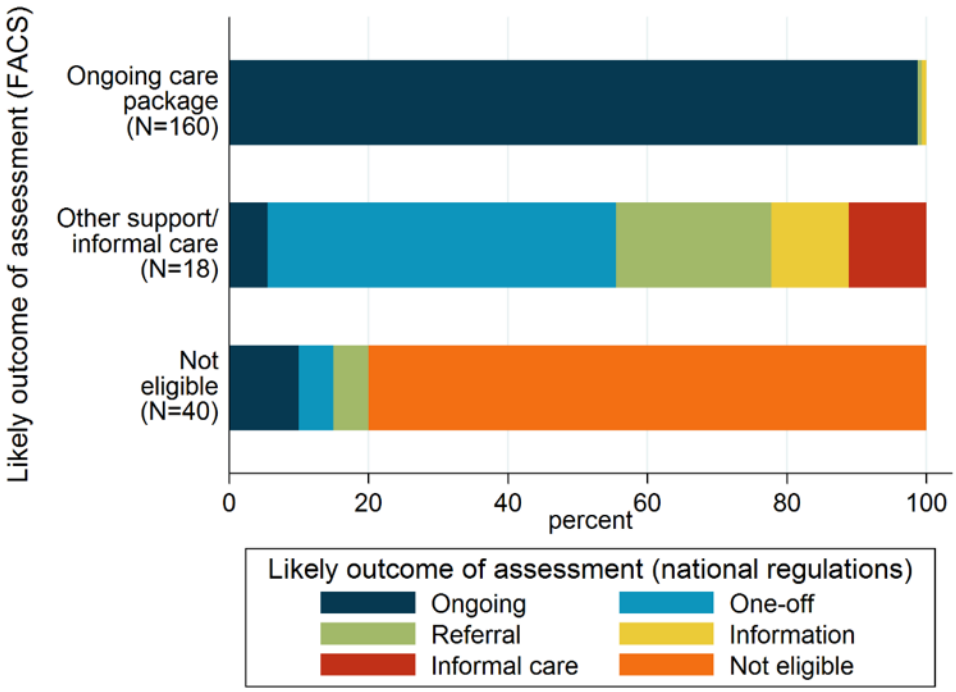


Figure 22 Comparison of the outcome of assessment between FACS and national regulations: younger adults with a learning disability

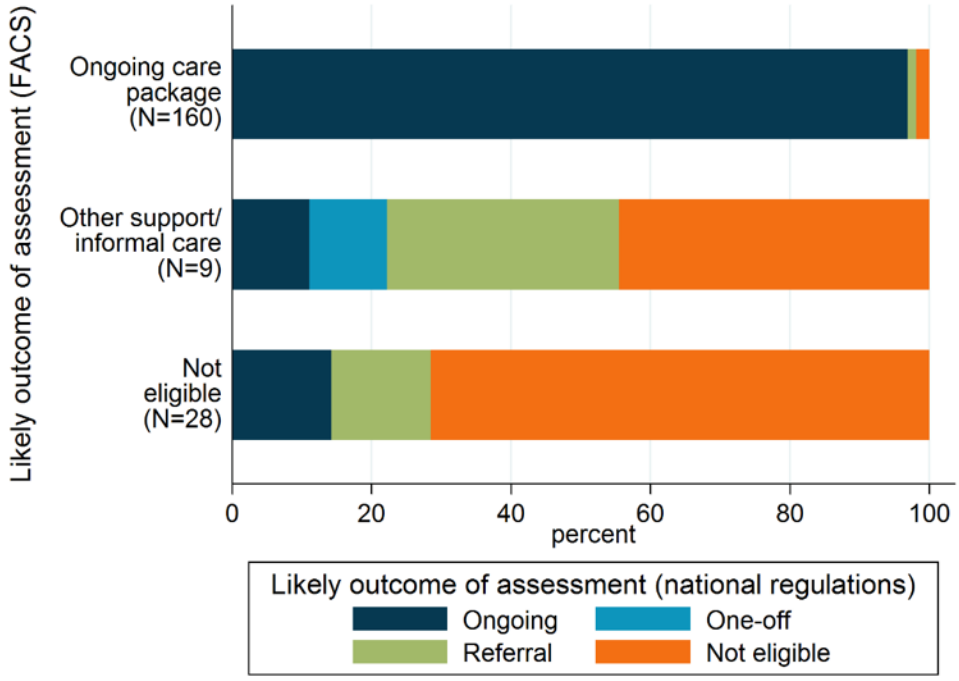


Figure 23 Comparison of the outcome of assessment between FACS and national regulations: younger adults with mental health needs

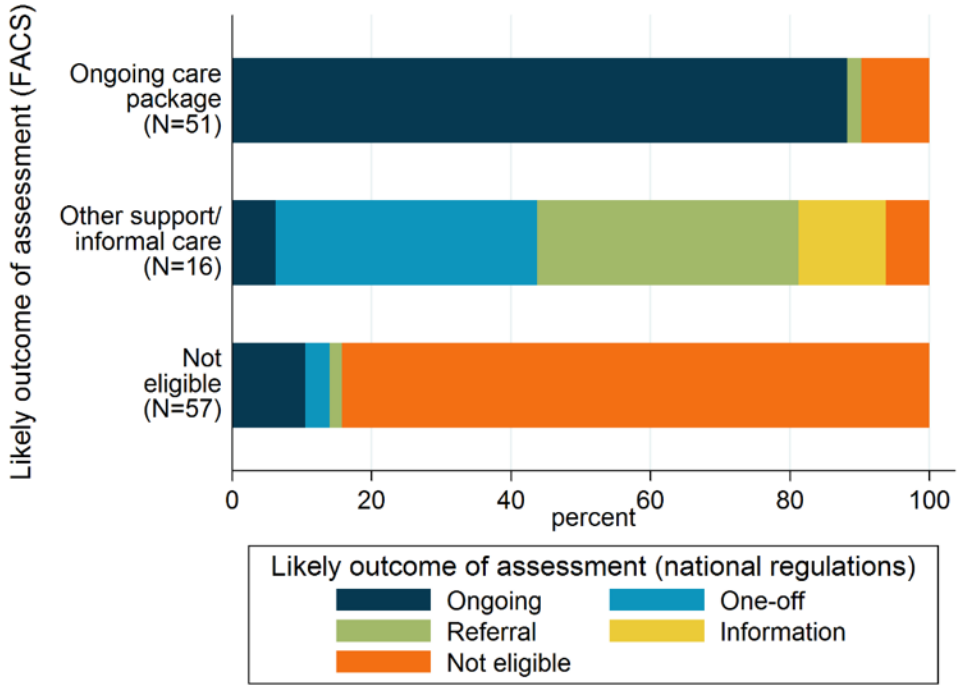
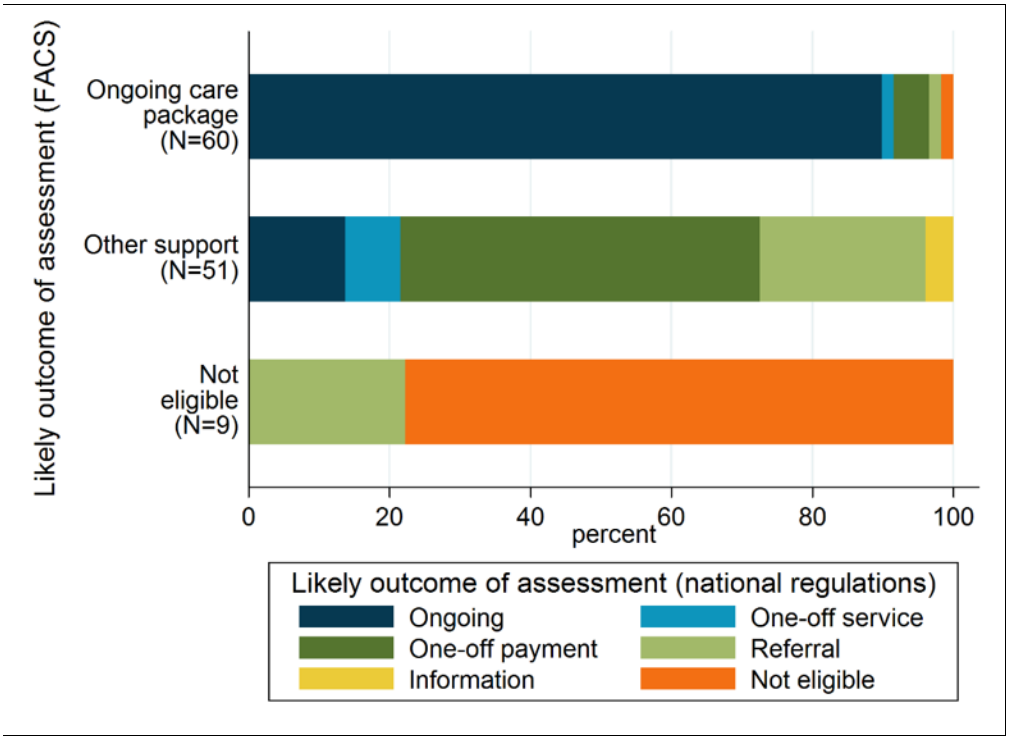


Figure 24 Comparison of the outcome of assessment between FACS and national regulations: carers



9 Care package costs

Table 9 shows the mean and median costs of care packages for cases where service costs were estimated under both FACS and the national regulations. As the figures show, mean and median costs for existing clients remain largely unchanged under the new regulations.

The estimated costs of services for newly eligible cases under the national regulations were substantially smaller than for existing clients. This difference reflects the fact that newly eligible clients are predominantly those with moderate and low levels of need, whereas a large proportion of existing clients will have critical and substantial needs – and hence higher average care packages. Estimates of the costs associated with the replacement of FACS with national eligibility regulations, covered later in this report, provide a breakdown of care package costs by client FACS rating.

Table 9 Mean and median care package costs - older people

	FACS (Mean)	FACS (Median)	Valid (N)	Nat regs (Mean)	Nat regs (Median)	Valid (N)
Existing service users						
Ongoing community care (per week)	£228	£170	369	£230	£173	369
One-off services	£530	£250	29	£530	£250	29
Newly eligible clients						
Ongoing community care (per week)	-	-	-	£81	£79	8
One-off services	-	-	-	£300	£300	1
All clients						
Ongoing community care (per week)	£227	£170	386	£220	£161	412
One-off services	£521	£208	36	£509	£405	44

Table 10 Mean and median care package costs – younger adults

	FACS (Mean)	FACS (Median)	Valid (N)	Nat regs (Mean)	Nat regs (Median)	Valid (N)
Existing service users						
Ongoing community care (per week)	£472	£255	272	£462	£263	272
One-off services	£1,583	£1,735	13	£1,583	£1,735	13
Newly eligible clients						
Ongoing community care (per week)	-	-	-	£70	£50	11
One-off services	-	-	-	£300	£300	2
All clients						
Ongoing community care (per week)	£470	£254	286	£443	£250	307
One-off services	£1,346	£885	16	£1,484	£885	18

In keeping with results for adult service users, Table 11 shows care package costs under the national regulations to be very similar to the estimated care package costs under FACS regulations for eligible carers.

Table 11 Mean and median care package costs – carers

	FACS (Mean)	FACS (Median)	Valid (N)	Nat regs (Mean)	Nat regs (Median)	Valid (N)
Existing service users						
Ongoing community care (per week)	£197	£60	42	£197	£60	42
One-off services	-	-	-	-	-	-
One-off payment	£443	£288	16	£463	£350	16
Newly eligible clients						
Ongoing community care (per week)	-	-	-	-	-	-
One-off services	-	-	-	-	-	-
One-off payment	-	-	-	-	-	-
All clients						
Ongoing community care (per week)	£190	£66	48	£178	£61	52
One-off services	£910	£150	3	£319	£350	3
One-off payment	£374	£250	27	£433	£300	23

10 Implementing the new eligibility regulations: evidence from care manager workshops

10.1 Adaptation of the new regulations

Care managers participating in the focus groups reported that the Councils and practitioners were still adapting to the new criteria and to applying them in everyday practice. The systems to implement the new regulations were reported by some LAs to be in place, in others the assessment forms and processes were under review (see section 10.8 for more details). The interpretations of the new regulations have also been changing:

> Interviewee [I] 3: … I think we have got the infrastructure in across the organisation, but obviously it's applying knowledge to that, I think will take time…
>
> I5: I think filling the actual questionnaires in…I think we're filling them in wrong actually at the moment…
>
> I6: I think the important thing is that you keep reviewing it…and you're looking at it and any new information that comes your way is adjusting to how you work…? [LA 2]

I3:... and you're talking about educating the whole workforce, you're talking about changing all the paperwork, it's no wonder that what we've put in place isn't, you know, working as good as it would have done and that's why they're still mopping it up now. [LA 4]

10.2 New regulations versus FACS: a major change?

On the one hand the introduction of new regulations was perceived as just 'rebranding' of what was in place before April 2015. Some respondents highlighted that although new regulations introduced some changes, these were not significant – and most informants perceived these changes as positive relative to FACS (see also section 10.3). For example, it was articulated that the major difference between FACS and the new regulations was that the latter put more emphasis on wellbeing, personalisation and they were more comprehensive than FACS. However it was also noted by some LAs that the personalisation agenda and the focus on outcomes and wellbeing had been in place prior to April 2015. It was reported that since the new eligibility regulations underpin these principles, the new criteria help to bring about culture change among practitioners to work in a more person-focused way. The emphasis on outcomes in new regulations was also seen as a positive change, although some care managers pointed out that it was a minor change relative to FACS - a change which sometimes barely required different language to describe the same needs.

I1: I think it makes you think about the language that you use [new eligibility regulations]. Because you may say the same thing but you have to say it in a different way…

I2:… looking at outcomes is a shift in thinking but I think there's been that sense of…needing to look at outcomes for a long time, but like you say, it's how you then record that, you have to think about that a little bit more.[LA2]

I5: I see that [new regulations] as just rebranding, because we're doing the same thing and it's more like you're having a ten-page question, previously and now you have about twenty…I'll say the Care Act it's more, you know, a comprehensive form that covers everything. [LA 1]

I1:… the way I actually assess people I don't feel has changed, I don't think the criteria are that different than they were under FACS that you feel you have to work in a different way… [LA 5]

In one LA it was reported that although the Care Act emphasises the need to consider non-statutory services such as community support or preventative services in designing care packages, such services have not always been commissioned, which gives care managers no option but to rely solely on statutory care services.

10.3 Clarity of language, easiness of interpreting and applying new regulations

Overall, the new regulations were reported to be clearer and easier to understand relative to FACS by care managers and by professionals working in initial screening teams.

> I5: They're [new regulations] easier to understand that the old FACS criteria, more simple language. [LA 2]

> I3: I think it's [new regulations] easier to understand because you're looking at each outcome and if they can't make two of them then you're looking at how that's impacting on their wellbeing.... So, I think that it's set out better than FACS was, easier to follow and easier to fit into the boxes. [LA 3]

There was nonetheless a degree of ambiguity in the perceptions of respondents regarding clarity of wording. Although care managers mentioned that the new regulations are clear, easy to understand and apply, respondents on occasions also articulated that the phrase 'significant impact on wellbeing' was vague and subjective. For example, deciding what constitutes a significant impact on wellbeing was labelled as 'a guesswork' by one care manager [LA 2]. The judgement was reported to be particularly difficult in such areas as recreation:

> I1: I think the hardest one around significant well-being for me, is the recreational, the social leisure…I've been out to see people that tell me they need to go out every day for three hours because that would have a significant impact on their well-being, whereas I'm thinking "Actually, I don't think you do…' but I think that's the hardest one to justify perhaps... [LA 5]

Nonetheless, interviewees who pointed out to the difficulty with interpreting the phrase also highlighted that its interpretation will become easier with practice. Conversely, the inclusion of words such as 'significant' and/or 'wellbeing' was reported by some respondents to allow for more professional judgement and a more personalised assessment (see also section 10.10):

> I2: And I think that whole well-being concept is quite relative and that means something different to somebody else, which is quite nice…So, I think, yeah, that open to interpretation and kind of personalisation works quite well. [LA 3]

Language of the new regulations and people with social care needs/carers

Although respondents noted that the new regulations used language that was not always user- and carer- friendly, most also pointed out that FACS were similar and that when explaining new regulations to people with social care needs and their carers they adapted the language to make themselves comprehensible. Nonetheless, the language in new regulations was reported to be more challenging to explain to service users and carers when self-assessment forms were used (see also section 10.10). It was also articulated that it would be beneficial to have a version of the regulations adapted for people with learning disabilities to ensure that the new law can be understood by different groups of citizens. Moreover, in one LA it was pointed out that the phrase 'physical or mental impairment' is offensive to some individuals:

> I4: I can speak for Asians…when you say to them there is a mental impairment or mental illness…they will always say "No, no, there is no mental...

> I1: Well, you said anything about mental they [clients] just say "I'm not mad"…you're not going to get anything out of them after that.
>
> I3:… previously it was "vulnerable"…and now we've gone to physical and mental impairment... like if a person's having problems with…washing and dressing, I know that some clients would not describe themselves as having a physical impairment…And it's culturally and for some older people groups, I think it can be quite offensive… [LA 4]

One LA reported that the new assessment process creates confusion for some clients as the actual support users receive may be (and often is) much lower than the indicative budget specified on the assessment form. In other LAs care managers were not sharing the information about the indicative budget with users, partly not to raise their hopes.

10.4 Identifying needs: FACS and new regulations

It was reported that the new regulations, unlike FACS, do not address the need related to medication, which is important for specific user groups such as older people or individuals with mental health needs:

> I3…often times, with some people…successful management of medication can be all that it takes to actually keep somebody in their own home, keep somebody maintained without needing additional support…it is very difficult to, you know, to be creative and to find ways of incorporating it into care packages. [LA 2]

Conversely, the assessment form in one of the sampled LAs had a question about the ability of individuals to self-medicate; their form was reported to have been updated several times to include, among other things, medication and social history information.

Notwithstanding these challenges, overall care managers reported that if a particular need is not explicitly addressed in the new regulations they usually find related outcomes to assign the need to. The medication need, for example, was reported to be categorized under outcome related to 'being able to make use of the adult's home safely' [LA 3] and under 'maintaining a habitable home environment' [LA 2] as, it was argued, failure to take medication could put individuals at risk of not achieving these two outcomes. Similarly, it was acknowledged that although social isolation is not explicitly included in new regulations, it can be addressed by outcomes related to 'developing and maintaining family or other personal relationships' and 'accessing and engaging in work, training, education or volunteering' [LA 3].

Overall, it was reported that the new regulations are less well suited and/or less relevant for:

- People with mental health needs for whom many of the outcomes in new regulations do not apply. Still the situation was reported to be similar when FACS were used.
- For assessing needs of people with challenging behaviour. FACS regulations were perceived to be slightly better for such assessments. Conversely others reported that new regulations are better suited for assessing needs of people with challenging behaviour relative to FACS.

On the other hand, new regulations were believed to be better relative to FACS for:

- People with dementia due to the focus on outcomes rather than tasks as although people with dementia often have the ability to perform tasks they still may have difficulties achieving an outcome.
- The inclusion of outcomes related to recreation, work, training and volunteering in the new regulations was reported to be vital for assessing needs of younger individuals (see also section 10.10).

10.5 Carers

Overall, care managers were satisfied with the explicit inclusion of carers in the regulations and highlighted the importance of acknowledging carers' roles and the eligibility criteria for carers were thought of as appropriate and addressing carers' needs and circumstances well. In one LA care managers expressed concerns that there are no additional financial resources in the system to address carers' needs, although they still emphasised the importance of supporting carers in their roles. In other LAs care managers expressed that resources were in place to support carers:

> I6: …because of these new assessments we have sent them [carers] to complete [self-assessment], but that issue is because there's no funding element on the system, so we have been struggling with that… [LA1]

> R: I just wanted to ask you about the carers' criteria, do you have any comments on that?
>
> I1: I think the difference is there's actually a resource though attached to the end of it, so people can go on to a support plan to meet their own needs... because you're actually looking at what can you provide for them [carers] … [LA 2]

However, it was also highlighted that some outcomes in the carers' section are irrelevant, for example, the outcome related to maintaining nutrition. Moreover, while forms in some LAs asked a general question about the impact of needs on 'wellbeing', the assessment forms in other LAs had several dimensions of wellbeing specified[1]. For example in one LA the form asked about the impact of carers' needs on their personal dignity (as one dimension of wellbeing) and 'personal dignity', as defined in that form, included washing, dressing and using the toilet. Asking such questions was reported as irrelevant for carers' assessment:

> I1: … why would we be assessing a carer whether they can go to the toilet or not? ... Some of the things that they're asking carers, you know, "How do you manage your nutrition?" Well, if you can't manage your own nutrition how are you being a carer for somebody else? ... [LA4].

These concerns however stem from the interpretation of specific phrases by LAs and the design of assessment forms, which were still under review at the time of research.

[1] For example in one sampled LA the dimensions of wellbeing specified included: 'Economic and social wellbeing'; 'Personal dignity and being treated with respect'; 'protection from abuse and neglect'; 'physical, mental health and emotional wellbeing'; 'control over day to day life'; 'domestic and family relationships'; 'suitability of living accommodation'; 'contribution to society'; and 'participation in work, training, education or recreation'.

10.6 Impact of new regulations on volumes of assessments and on clients assessed as eligible

In one LA it was reported that people with social care needs and their carers were widely aware of the new regulations partly due to media campaigns. Media, it was articulated, have increased individuals' expectations and encouraged unrealistic hopes regarding the level of support they may be eligible for. Such increased expectations, it was believed, led to disappointments following the assessment process, which in turn led to an increased level of complaints and legal challenges.

The widespread awareness of new regulations was also reported to be linked to the increased numbers of individuals requesting assessments, especially, but not exclusively carers:

> I1: There's a definite increase in adults in referrals coming through and assessments being asked for. There's an increase in complaints as well, because this feeds into the whole issue around what people's expectations are…
>
> I4: … there's an increase of complaints, there's an increase... there's just an increase of
>
> I3: Of everything, workload, assessments... [LA 1]

Several other LAs reported that the volume of assessments and eligible individuals increased, and although it was perceived as beneficial for service users, it was also highlighted that the actual support individuals receive is still constrained by limited funding:

> I4: … there is an increase...I mean this is all well and truly very good. But I'm just concerned about the money, who's going to pay...
>
> I3: But from a client's point of view, it's great, because then they're able to qualify and we're able to help more people.
>
> I1: …it doesn't matter whether they qualify, it's what they're going to get…
>
> I3: that money thing, isn't it? [LA 4]

Anxieties over new regulations leading to an increase in the volume of assessments and eligible individuals were related to concerns over the lack of financial resources to address the rise. In LAs where no budgetary concerns were expressed, even when some increase in the volumes of assessments and eligible individuals was noted, care managers expressed more positive views about the new regulations. For example, in one LA care managers noted that the increase in the volumes of assessments and in the eligible individuals was not as high as they expected or would like to be. The small increase was attributed mainly to the lack of awareness among people with social care needs and their carers regarding new regulations and the view was that the LA could do more to increase public awareness about new eligibility criteria:

> I1…I don't think we've had the uptake on carers assessments that I thought we may have and I think that's down to the fact that carers still don't understand themselves that there's a resource there for them …
>
> I4: Looking at it from a different perspective. If we had more information and advice, and we had it more visible…which is part of the remit of the Care Act isn't it, to provide people with as much information and advice as we can… and maybe it shows that there's a lot of potential for us to use that more so that people can access that information. [LA 2]

> I5: …and I think it's [new regulations] easier than FACS, in some respects because I think it's broadened up access for people, people that we would have normally assessed as having low to moderate needs, that wouldn't have met FACS in this area before, are more likely to be able to access a service now... [LA 3]

Some LAs were however proactive in raising public awareness about the new regulations by distributing information through different channels (e.g. voluntary agencies, care agencies, leaflets delivered to residents' households). It was also highlighted in surveyed LAs that there may be an increase in eligible individuals with time as people become more aware of the new regulations which may lead to more legal challenges for LAs.

10.7 Flexibility, transparency and risk of legal challenge

Overall, care managers thought that the new regulations provide sufficient flexibility to exercise professional judgment. In one LA it was reported that the low eligibility threshold and increased subjectivity of new regulations relative to FACS have increased numbers of complaints and have made practitioners and the LA subject to more legal challenges.

> I5: … So, because the threshold has come down, then a lot of challenges…because it would open to a lot of legal challenges, it will be open to how people interpret it…
>
> I3: … they [outcomes] are very open to further interpretation, but also by us, not just by the family…So, there's a lot of subjectivity from professionals as much as families in kind of the terminology of the outcomes I think. [LA 1]

On the contrary, in some LAs new regulations were reported to be more objective relative to FACS:

> I4: What I've found with the new criteria is, because it's quite specified in the outcomes it's... whereas as FACS before used to be a little bit more open to interpretation. The new criteria kind of have an objective element to it, which is your specified outcomes. [LA 3]

In most surveyed LAs it was reported that relationships with individuals with social care needs have not changed following the implementation of new regulations, however it was pointed out that it is still early for any conclusions. Relationships with carers were reported to be better in two LAs because, according to care managers, carers felt more valued following implementation of the new regulations:

I3: I think the carers feel better because their assessment is more in-depth now…there's more space for them to get how they're feeling out and what's happening in regard to the carers. So, I do think they feel more valued, yeah. [LA3]

Beliefs regarding transparency of new regulations were aligned with concerns over budgetary pressures and the fiscal implications of the new regulations. Where LAs were reported to be in good financial situations, the care managers expressed more positive views about transparency of the new regulations.

10.8 The management of assessments, in-house processes and systems

In some LAs assessment processes were reported to take longer following the implementations of new regulations and the introduction of new assessment forms. This led to some concerns regarding permanent increase in care managers' workload.

I4: I think yeah, it's probably like being new makes it [the assessment process] a little bit longer, but it's still a longer process, you know, even once you are used to it.

I1: Even before…you assess somebody's needs, you were having to like be more succinct, so you were like addressing three needs in one box, where now it's very much divided out, like the outcomes isn't it? The needs. [LA 3]

I1: The paperwork is atrocious.

[several agree]

I2: .... it's just more work for us…for me as a social worker, I'm staying longer, doing more work for the same kind of end result, like I would do before. [LA 4]

Some LAs reported that prior to April 2015 the assessment and support plan were conducted during one visit; following the introduction of new regulations the process required two separate visits. Simultaneously the longer process was believed by some care managers to benefit clients as it allowed for a more comprehensive and accurate assessment. In contrast, in other LAs it was believed that the workload and the time required to carry out assessments is similar to the situation when FACS were in place.

Three LAs were in the process of developing and promoting online self-assessment forms. Promoting self-assessments was considered as a solution to increased workload and also as a way to improve the accuracy of the first screening as in one LA care managers reported that following the implementation of new regulations the first contact team was referring increasing numbers of ineligible individuals for full assessment.

Overall, LAs developed new assessment forms compliant with the Care Act, one LA reported to be in contact with other LAs in the process of developing the form. All surveyed LAs reported to be looking at updating the assessment forms taking into consideration feedback received from professionals and from service users and carers:

> I1:… because it [new assessment form] was brought in so quick, I will say quick, we didn't have opportunity to actually think... we were making sure it [the form] was Care Act compliant but it we weren't looking at how that was user friendly for the clients or for the staff [LA3]
>
> I3: ... it's because of the short timeframe, something had to go in by the 1st April because everybody's got to be compliant,…and now, we're kind of backtracking yourself, to say "Right, okay, what we've put in, is it, now we need to make it, it's compliant, but now we need make it user-friendly." [LA4]

10.9 Training

Care managers, individuals from initial contact teams as well as team managers in all but one sampled LAs reported receiving a considerable amount of training prior to the implementations of the new regulations. It was nonetheless highlighted by some that the training received was very generic. Moreover, implementing the regulations in everyday practice brings unforeseen challenges and questions:

> I2:… So the training was sort of general and obviously in terms of the eligibility criteria it was about what the new criteria is, what the new sort of the three conditions for both customers and carers were to meet eligibility…as we know, having training and then actually implementing it, there is a difference with that. [LA 2]

Care managers in one LA reported that the opportunity to practice assessments using case vignettes was most useful part of training. Also in LAs were more general training was provided care managers sometimes articulated that it would have been more useful to have the opportunity to practice assessments using case vignettes.

There was nonetheless an ongoing support available to staff in all sampled LAs. For example, one LA had an Eligibility Panel which met once a week where team managers discussed questions that were raised by care managers and feedback was provided to the practitioners. There were drop-in sessions in place in another LA which allowed care managers to ask questions regarding new regulations and two LAs had Care Act/Eligibility Criteria Champions in place who were responsible for gaining in-depth knowledge about certain aspects of the criteria and organising workshops for practitioners. There were also plans for practitioners to present and discuss case studies as a reflective practice to enhance their knowledge base around how to deliver services within the new legislation. One LA was also planning to develop eLearning tools around the Care Act to allow practitioners revise their knowledge when needed. Most respondents also highlighted that they need an ongoing training and support as only with time and practice they are becoming more aware of specific training needs that they may have. Some care managers yet reported that they did not require any further training and that practice and an ongoing consultations with other practitioners and managers was sufficient.

10.10 Views of the management team

According to the management team their LA was still in flux regarding new regulations, they were finalising their paperwork and they were in the process of understanding the implications of the new regulations:

> 1:…the assessment forms that we have, we've tweaked to make sure they're Care Act compliant, but they're not where we're trying to get to. …So, our current assessment is being tweaked, but we're taking the Care Act and we're pushing it right to the front door now and starting there and then starting to change all our paperwork all the way through.
>
> I2: …it's still a bit of a journey…we're still working our way through it and understanding some of the implications as we go along because I think it's the mind-set that has had to change and so some things that we might have thought early on we're now having to rethink, you know, what does "well-being" actually mean and what is "significant" and all of those sorts of things, yes.

It was also mentioned that the first contact teams were finding it challenging to apply new regulations and focus on outcomes in their work whereas FACS were easier to work with due to being 'very pointed, very functional'.

Informants expressed that new regulations necessitate culture change among practitioners and users towards strengths-based, holistic assessment which requires time even though the LA had been promoting personalisation and independence prior to April 2015 and the principles underlying the new eligibility regulations were not entirely new. It was also articulated that new regulations make it easier for the team managers to ensure that social workers conduct assessments in a person-centred way rather than as a 'tick-box exercise' (I4). Simultaneously, it was believed that the subjectivity of new regulations necessitated that care managers were trained to be able to articulate the rationale behind their decisions better relative to when FACS were in place. This however was believed to have led to better practices since people with social care needs were given more comprehensive justifications for eligibility decisions. Conversely, it was highlighted that the more holistic approach that is required by the new regulations makes the new assessment process more difficult to understand by health partners which makes collaboration between social and health care professionals more challenging.

The management team expressed that understanding and interpreting such terms as 'well-being' and 'significant' was challenging due to subjectivity of these terms and the Council was waiting for a lawyer's letter which would clarify the term 'well-being'. Moreover, as the LA was in the process of developing and promoting self-assessments these phrases were reported to be particularly difficult to explain on the self-assessment forms:

> I1: … when you start putting them ['significant' 'wellbeing'] on a self-assessment form and… because we asked somebody about well-being and you said, "Well, would they understand what well-being means?"
>
> I2: Yeah, 89-year-old woman being asked about her well-being... I mean what does well-being... we all, you know, what we think it is...
>
> I3: Well, we'll have six different views.

The outcomes in new regulations were believed to cover a broader set of needs relevant for a variety of clients in different circumstances relative to FACS. For example, the inclusion of the outcome related to 'engaging in work, training, education or volunteering' as well as 'carrying out any caring responsibilities the adult has for a child' was reported to be very important in assessing needs of younger clients. New regulations were also believed to be better for assisting individuals with mental health needs and with challenging behaviour relative to FACS.

Although the Council noticed some increase in the volumes of client assessments the increase was reported to begin prior to the implementation of new regulations. The LA also sent a 'Care Act' leaflet to the residents; however it was believed that individuals were not interested in the changes to social care eligibility regulations unless they were already recipients of the services. Overall, it was reported that the public, including carers, were not aware of the new eligibility regulations and likewise no change in the volumes of complaints or legal challenges was noticed following the implementation of new criteria. It was nonetheless articulated that the new regulations represent an opportunity to help more individuals with social care needs who were not eligible under FACS and that the LA was making an effort to identify people with care needs and their carers who are not in the system currently but who may benefit from social care assistance.

No changes in the budgetary expenditure were reported since April 2015, although it was highlighted that it was too early to make a judgement about long-term financial implications of new regulations. It was also voiced that the new regulations provide an opportunity to reduce both costs and workload long-term:

> I5: … if we honestly give really robust holistic or whole system type assessments then I think that in fact the amount of running around I think will be reduced…
>
> I3: Well, it's always cheaper to get things right the first time, do a good job of it and right the first time.
>
> I2: … if we're identifying what people can do for themselves and encouraging that and working on that shift in the culture amongst assessors…When we achieve that we might have quite a different picture…
>
> I5: I think that's true. I think we've got the potential for a reduction in workload if we work it properly.

The opportunity provided by new regulations to deliver services in a more person-centred way, to identify a wider set of needs and to provide services to individuals which may have been assessed as ineligible under FACS was believed to have a potential for long-term cost-savings either in the social care system or elsewhere in the public sector (e.g. to the benefit system, criminal justice). However, it was also pointed out that the challenges to the LA may come from providers, rather than service users, as providers may be requesting more financial resources in the future to meet the outcomes:

> I2: I'm just waiting for those calls which are saying "We need, you know... to deliver the outcomes for this person we need more care, you know, we need more time" … I can see it being used in unintended ways to start to give some push-back towards us which may, maybe fair and not unreasonable to challenge, but again, creates more work actually, even if we don't change anything we've got to justify all of the time why we are not going to change the support plan for an individual.

Similarly to other LAs the informants reported that there was face-to-face as well as online training related to the Care Act available in their LA for management teams and for social workers. An ongoing training was planned in the LA as it was believed that only with practice it becomes more clear what further training is required. An ongoing support was reported to be available to social workers, and practitioners were given opportunities to discuss any issues related to the new regulations with their managers on a regular basis.

11 Estimated impact on client numbers and expenditure

The survey provides strong evidence about changes in the assessment of eligibility of needs and about changes in the intensity of the care packages provided. These changes can impact upon overall expenditure in three ways:

- By affecting the number and need-characteristics of individuals undergoing a needs assessment. This could be either because of changes in the rates of referral (self-referral and referral from other services) or because of changes in the outcome at first point of contact with services.

- By affecting the likely outcome of needs assessments, and whether care needs are assessed as being eligibility.

- By impacting on the care package provided as a result of the assessment.

Regression models were specified in order to understand the association between client characteristics and changes in eligibility, and to standardise for those effects in estimating the overall impact of the regulations at the national level. The use of regression methods also helps us deal with problems of potential instability in estimates owing to limited numbers of cases.

Within each client group, two models were constructed: the first – a random-effects logistic regression - was used to explore the predictors of likely eligibility; the second – a GEE population-averaged model – explored predictors of care package costs (where received). Multiple imputation techniques were applied in order to minimise the numbers of cases excluded on the basis of incomplete data.

In the models we control for age, gender, sensory impairment, disability (ADL/IADLs), household composition (living alone) and availability of informal care. Although data do not exhaustively cover all factors likely to influence receipt (in particular dementia and mental health problems such as dementia), they provide a strong indicator of individuals' dependency and need for additional support. Controlling for these factors, we estimated the effect of the new regulations in general and (through interactions) for individuals with particular combinations of characteristics.

Survey results are extrapolated to the national level by using other sources of evidence describing the levels and patterns of take-up of social care services and levels of expenditure in England.

These sources include PSS EX1, RAP, ASC-CAR and the Adult Social Care Survey, and PSSRU macro and micro-simulation models.

Within each client group, adults were stratified according to definitions common across data sources (for example, levels of ADL dependency according to activities recorded both within the survey and in PSSRU microsimulation models). Doing so allowed us to "reweight" the results to reflect the broad characteristics of social care users in England when aggregating effects.

The level of stratification varied across user groups, according to the availability of information about existing clients and in order to achieve stable results not driven by cases at the extremes of the client distribution. Consequently, older people were aggregated into 4 categories according to ADL dependency and informal care receipt, while younger adults with mental health needs were treated as a single group. In all client group models, however, estimates of likely eligibility of costs reflected the characteristics of the adults assessed. In other words, variability across factors such as age, gender, ADL dependency, informal care receipt and household composition was taken into account regardless of the unit of stratification applied.

The survey does not provide direct evidence about changes in the volume of cases coming forward for assessment. However, the analysis of the characteristics of cases reaching the needs assessment stage (regardless of the outcome of the assessment) does not suggest significant changes in the characteristics of individuals being assessed by local authorities for social care support when compared previous analyses involving assessments under FACS (Fernandez, Snell and Marczak 2014).

In the analysis, we assume that changes to care packages apply to new cases, but not to existing ones, and in particular not to residential care users. An alternative scenario, illustrating changes to gross and net current expenditure when applying unit cost effects to all (existing and newly-eligible) clients in community and residential settings is shown separately in Appendix 2 (section 14). Client numbers are estimated to increase by approximately 1.6% across the four main adult client groups (an additional 14,600 clients). Under the central cost scenario, corresponding gross current expenditure is expected to increase by 0.6% (£88 milion), although the size and direction of cost effects varies substantially across user groups.

Table 12 Summary of estimated change in client numbers by client group

Client group	Existing clients	Change in client numbers	Change in clients (%)
Older people	562,600	+8,900	+1.6%
Adults aged under 65 with a physical disability or sensory impairment	110,100	+3,100	+2.8%
Adults aged under 65 with learning disabilities	131,000	-1,100	-0.9%
Adults aged under 65 with mental health needs	92,000	+3,700	+4.%
Total	895,600	+14,600	+1.6%

Table 13 Estimated changes in gross current expenditure by client group, assuming changes in unit costs only for additional community clients

Client group	Existing gross current expenditure (£m)	Change in gross current expenditure (£m)	Change in gross current expenditure (%)
Older people	£7,611	+£54	+0.7%
Adults aged under 65 with a physical disability or sensory impairment	£1,319	+£35	+2.6%
Adults aged under 65 with learning disabilities	£4,004	-£36	-0.9%
Adults aged under 65 with mental health needs	£1,016	+£35	+3.4%
Total	£13,950	+£88	+0.6%

Table 14 Estimated changes in gross current expenditure by client group, assuming changes in unit costs only for additional community clients

Client group	Existing net current expenditure (£m)	Change in net current expenditure (£m)	Change in net current expenditure (%)
Older people	£5,467	+£41	+0.7%
Adults aged under 65 with a physical disability or sensory impairment	£1,204	+£32	+2.7%
Adults aged under 65 with learning disabilities	£3,773	-£34	-0.9%
Adults aged under 65 with mental health needs	£971	+£33	+3.3%
Total	£11,415	+£72	+0.6%

Sections 11.1 to 11.5 introduce the results by client group, with corresponding regression output summarised as an appendix in section 13.

At face value, the results suggest that carer blindness is not taking place at the point of assessment, in that a significant correlation between the presence of informal care and the likelihood of eligibility, even after controlling for other factors. It is feasible, however, that informal care is picking up other effects; indeed, informal care is itself an indication of the presence of need. This might be a particular issue among adults with learning disabilities or mental health needs, since ADL and IADL measures may be less well suited to capturing relevant dimensions of needs. Furthermore, it is important to note that the types of support that eligible clients are likely to receive are shown to differ according to regulation type.

11.1 Older people

Table 15 summarises the results of the modelling for care recipients aged 65 and above.

Table 15 Summary of results: older people

	Number of recipients (2013/14)	Gross current expenditure (2013/14) (£m)	Change in likely eligibility	Change in recipients	% change in care package	Change in gross current expenditure (£m)
Community						
0-3 ADLs, IC	104,200	£565	+4%	+4,200	-7%	+£21
4-12 ADLs, IC	241,600	£1,932	+0%	+600	-3%	+£4
0-3 ADLs, no IC	29,800	£159	+13%	+3,900	-5%	+£20
4-12 ADLs, no IC	21,000	£237	+0%	+0	-4%	+£0
Residential care						
4-12 ADLs, no IC	166,000	£4,718	+0%	+300	+0%	+£8
Total	**562,600**	**£7,611**	**-**	**+8,900**	**-**	**+£54 (+£41 net)**

The results in Table 15 suggest an increase in gross current expenditure amongst the older people user group of £54M gross (£41M net). Figures 1 to 4 provide further details about the nature of the effects identified.

Figure 25 Likely eligibility by informal care (IC), ADL/IADL score and regulation: older people

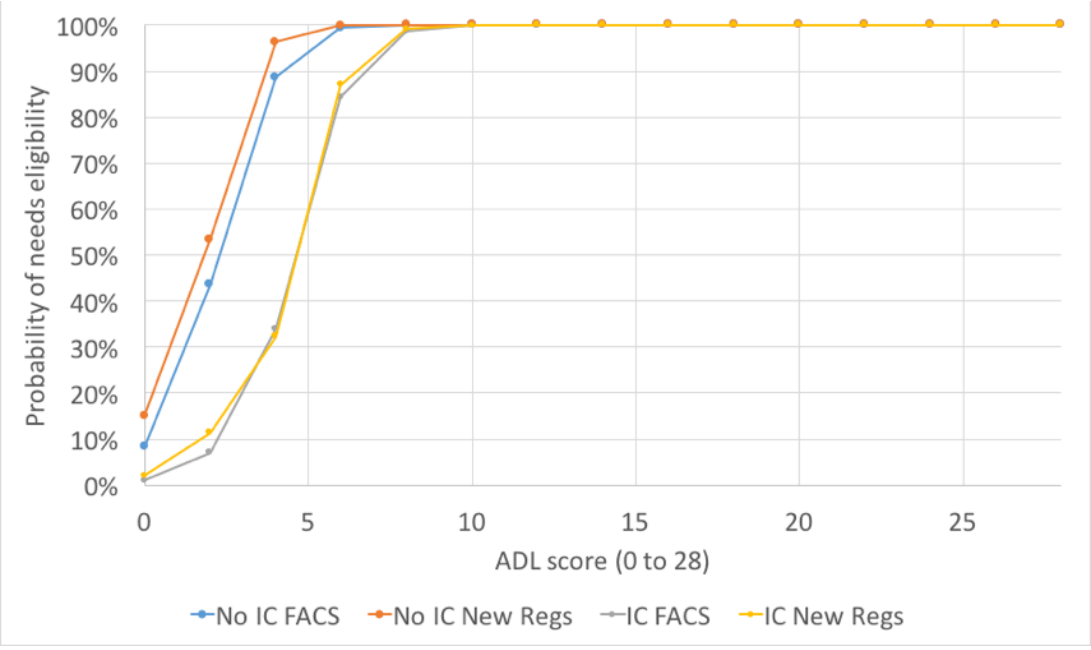


Figure 26 Expected average community care package cost for key modelling groups: older people

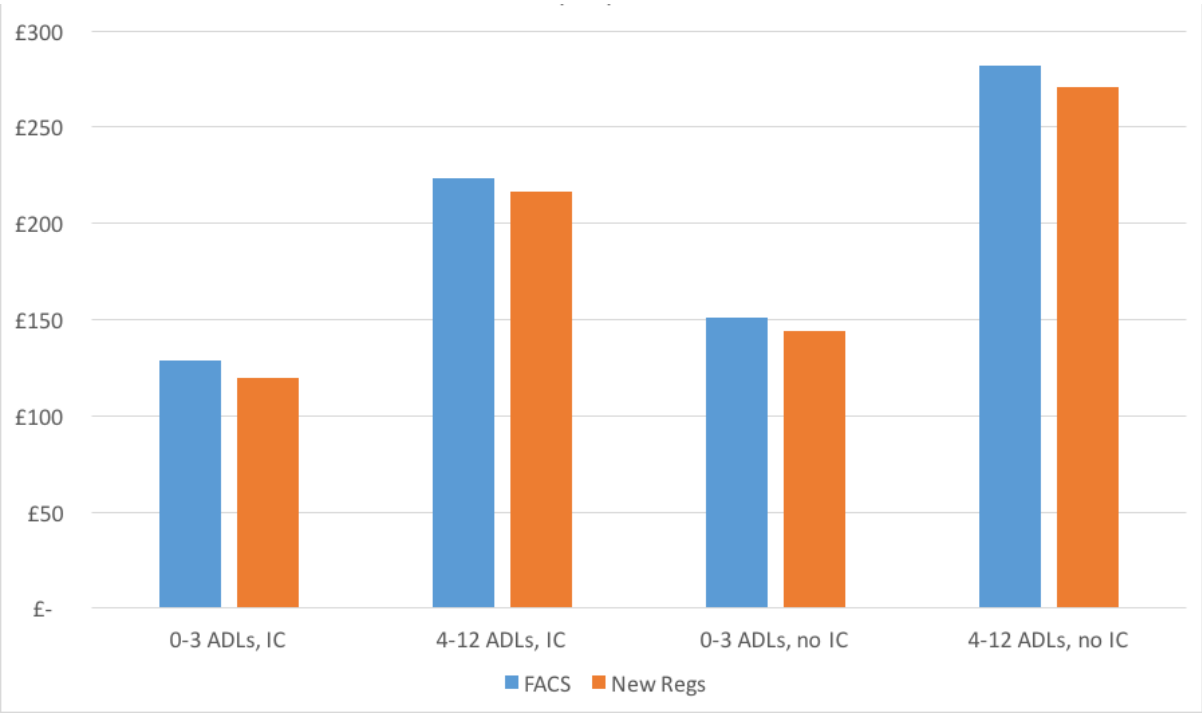


Figure 27 Expected care package cost by ADL/IADLs, informal care and regulation: older people

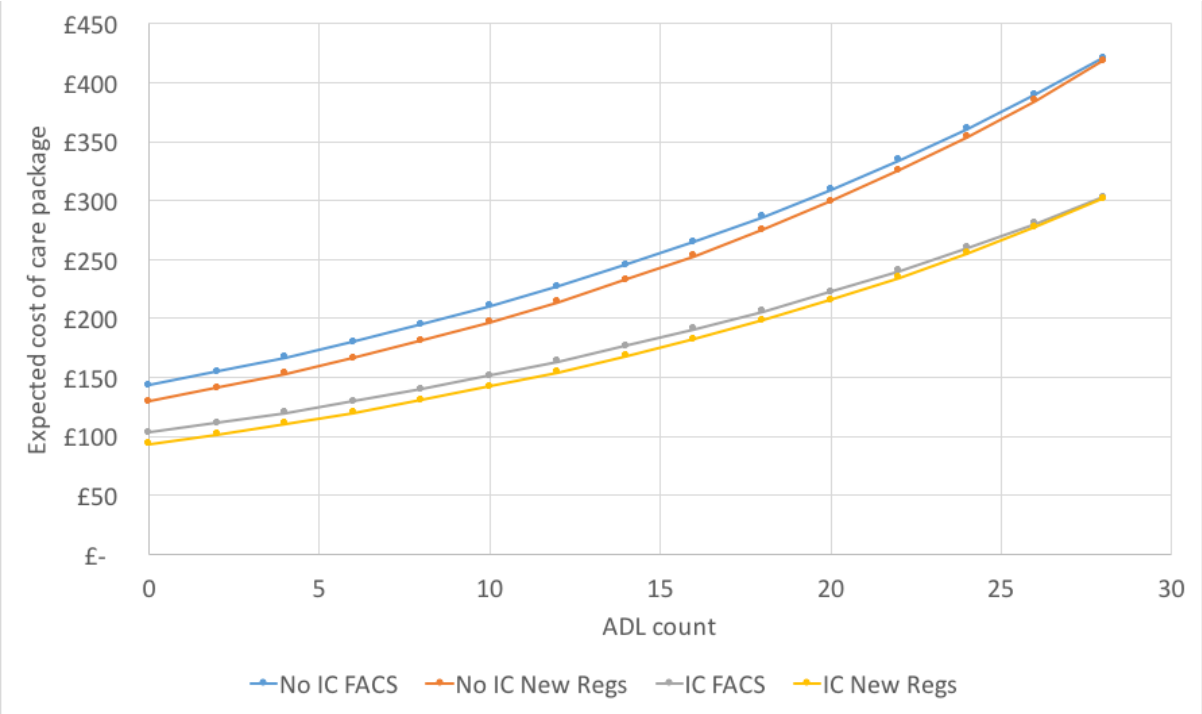
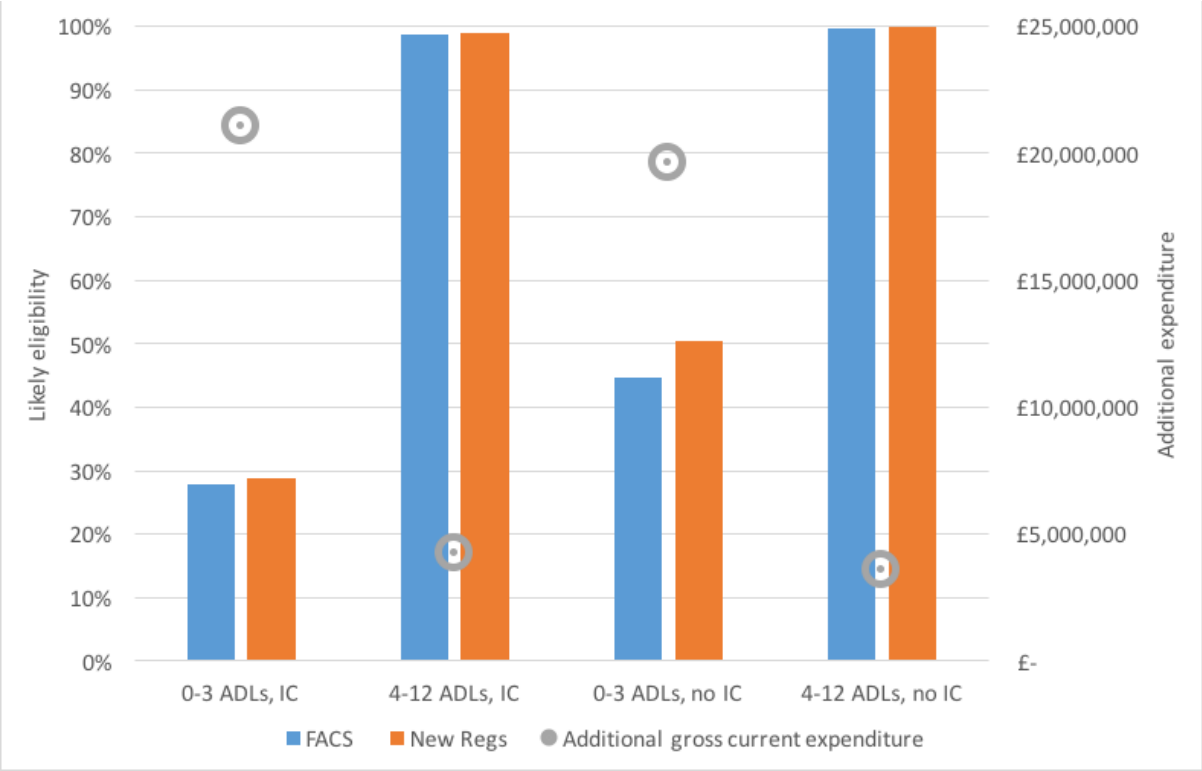


Figure 28 Changes in needs eligibility for key modelling groups (informal care and count of ADL problems: older people



11.2 Adults aged under 65 with a physical disability or sensory impairment

For adults aged under 65 with a physical disability or sensory impairment, the results suggest an increase in current expenditure of £35M gross (£32M net).

Table 16 Summary table: adults aged under 65 with a physical disability or sensory impairment

	Number of recipients (2013/14)	Gross current expenditure (2013/14) (£m)	Change in likely eligibility	Change in recipients	% change in care package	Change in gross current expenditure (£m)
Community						
0 ADLs	19,900	£189	+5%	+900	+1%	+£9
1+ ADLs	81,500	£775	+2%	+1,900	-5%	+£17
Residential care						
1+ ADLs	8,700	£355	+2%	+200	+0%	+£8
Total	**110,100**	**£1,319**	**-**	**+3,100**	**-**	**+£35 (+£32 net)**

Figure 29 Likely eligibility by informal care (IC), ADL/IADL score and regulation: adults aged under 65 with a physical disability or sensory impairment

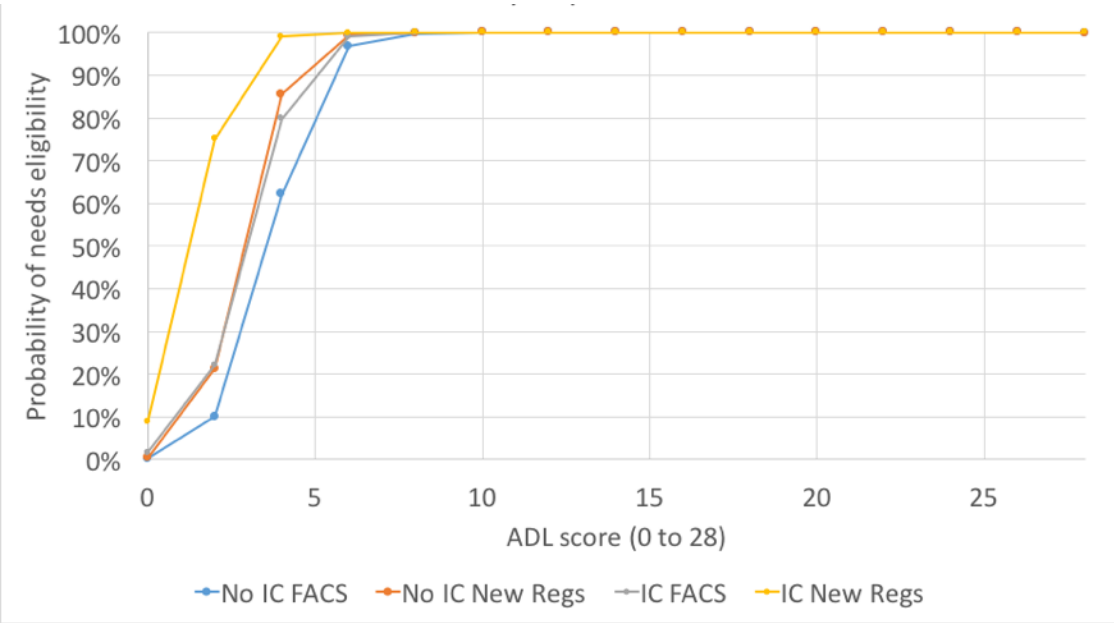


Figure 30 Changes in needs eligibility for key modelling groups (count of ADL problems): adults aged under 65 with a physical disability or sensory impairment

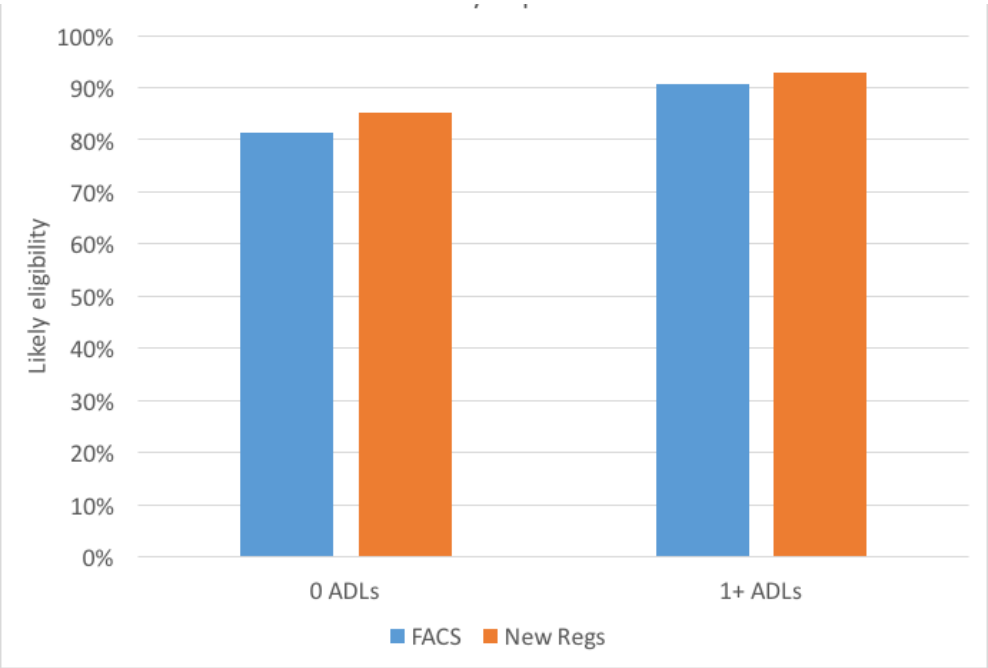


Figure 31 Expected care package cost by ADL/IADLs, informal care and regulation: adults aged under 65 with a physical disability or sensory impairment

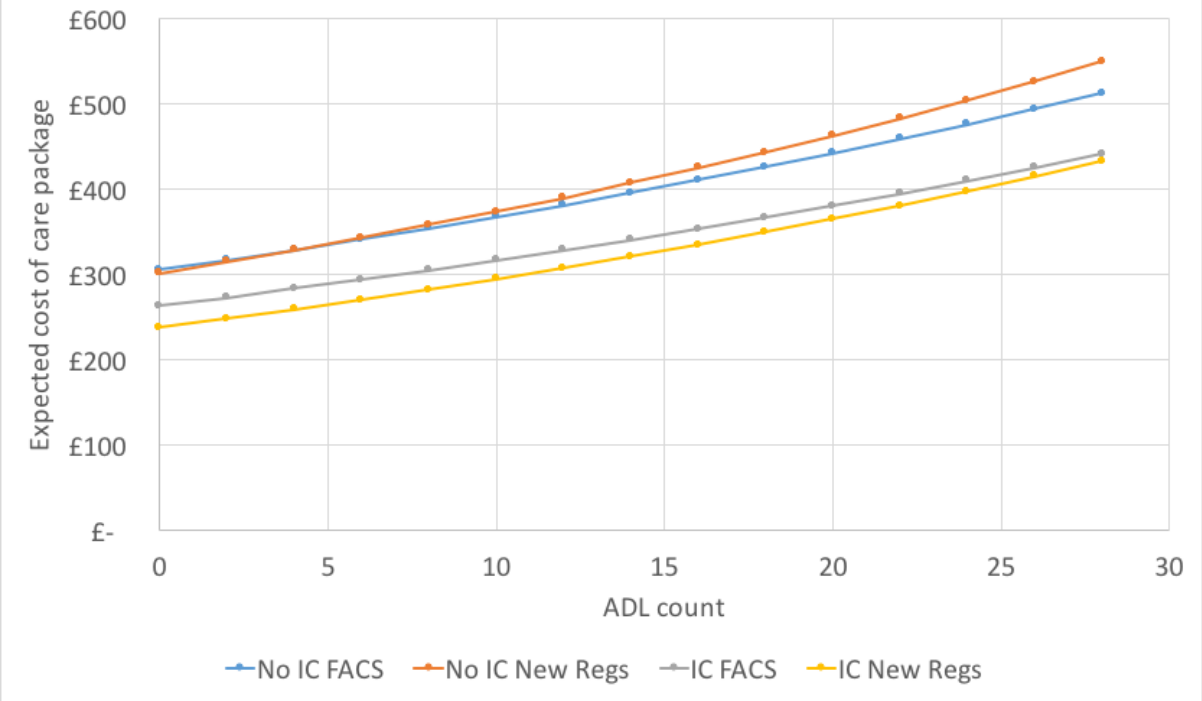
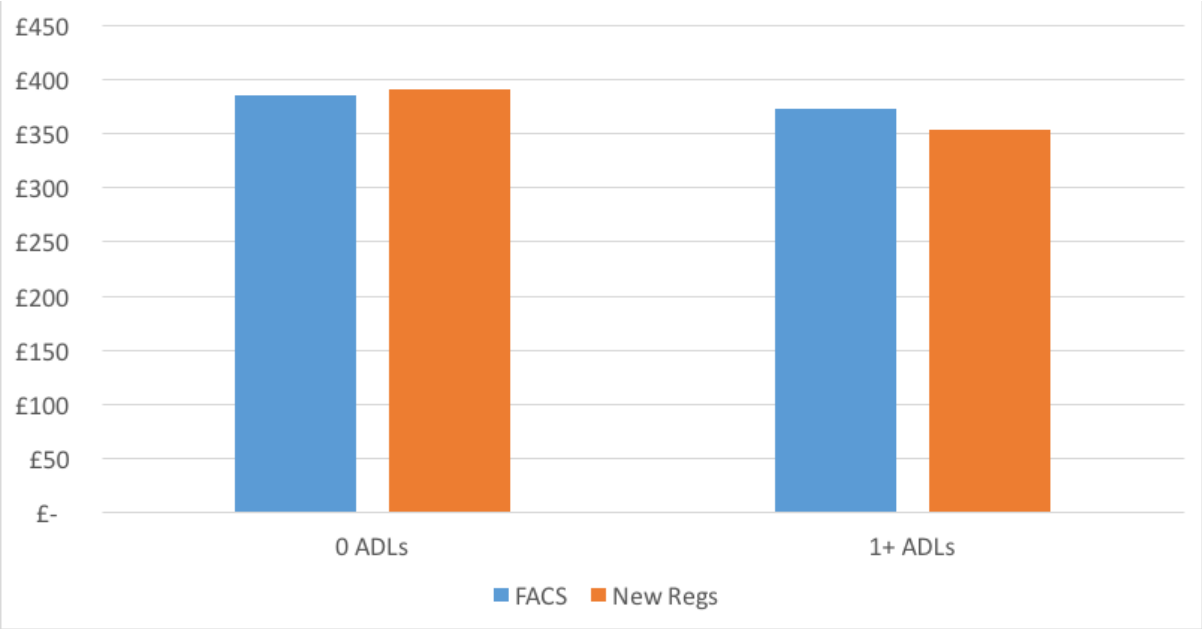


Figure 32 Expected average community care package cost for key modelling groups: adults aged under 65 with a physical disability or sensory impairment



11.3 Adults aged under 65 with learning disabilities

For people aged under 65 with learning disabilities, the results suggest reductions in both the likely eligibility and care package costs. As a result, the implementation of the reforms is associated with savings worth £36M gross (£34M net).

Table 17 Summary table: adults aged under 65 with a learning disability

	Number of recipients (2013/14)	Gross current expenditure (2013/14) (£m)	Change in likely eligibility	Change in recipients	% change in care package	Change in gross current expenditure (£m)
Community						
0 ADLs	57,000	£1,123	-1%	-500	-13%	-£11
1+ ADLs	41,600	£819	-1%	-300	+1%	-£6
Residential care						
0 ADLs	14,200	£904	-1%	-100	+0%	-£8
1+ ADLs	18,200	£1,158	-1%	-200	+0%	-£11
Total	**131,000**	**£4,004**	**-**	**-1,100**	**-**	**-£36 (-£34 net)**

Figure 33 Likely eligibility by informal care (IC), ADL/IADL score and regulation: adults aged under 65 with a learning disability

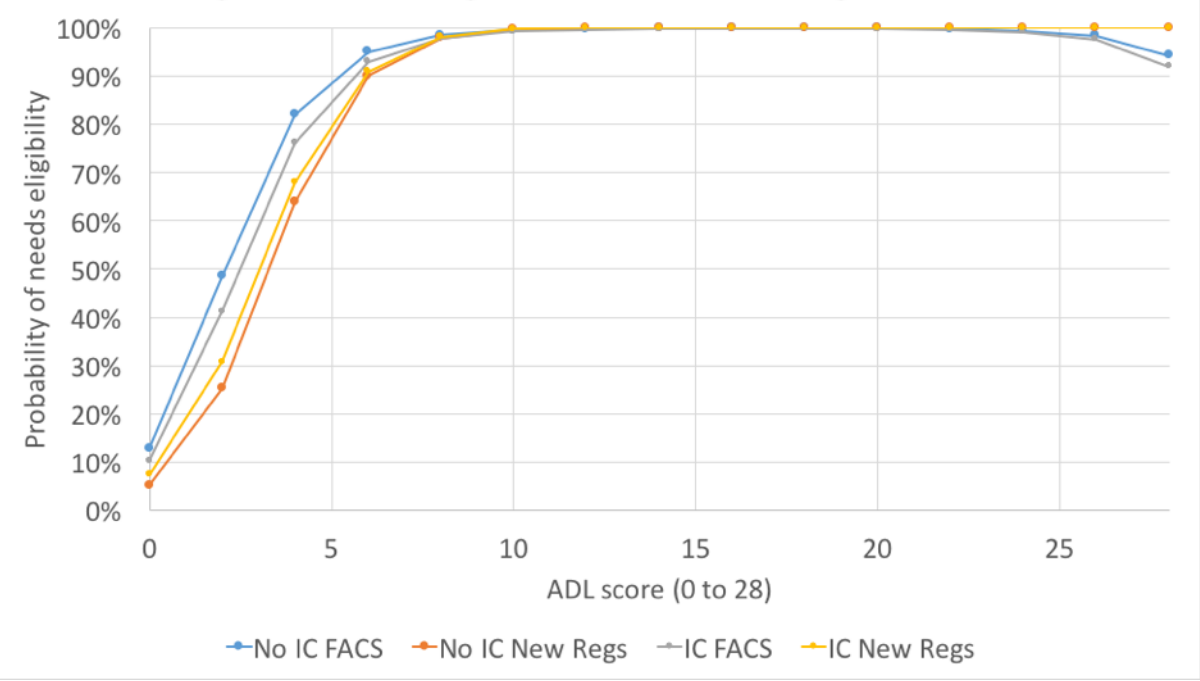


Figure 34 Changes in needs eligibility for key modelling groups (count of ADL problems): adults aged under 65 with a learning disability

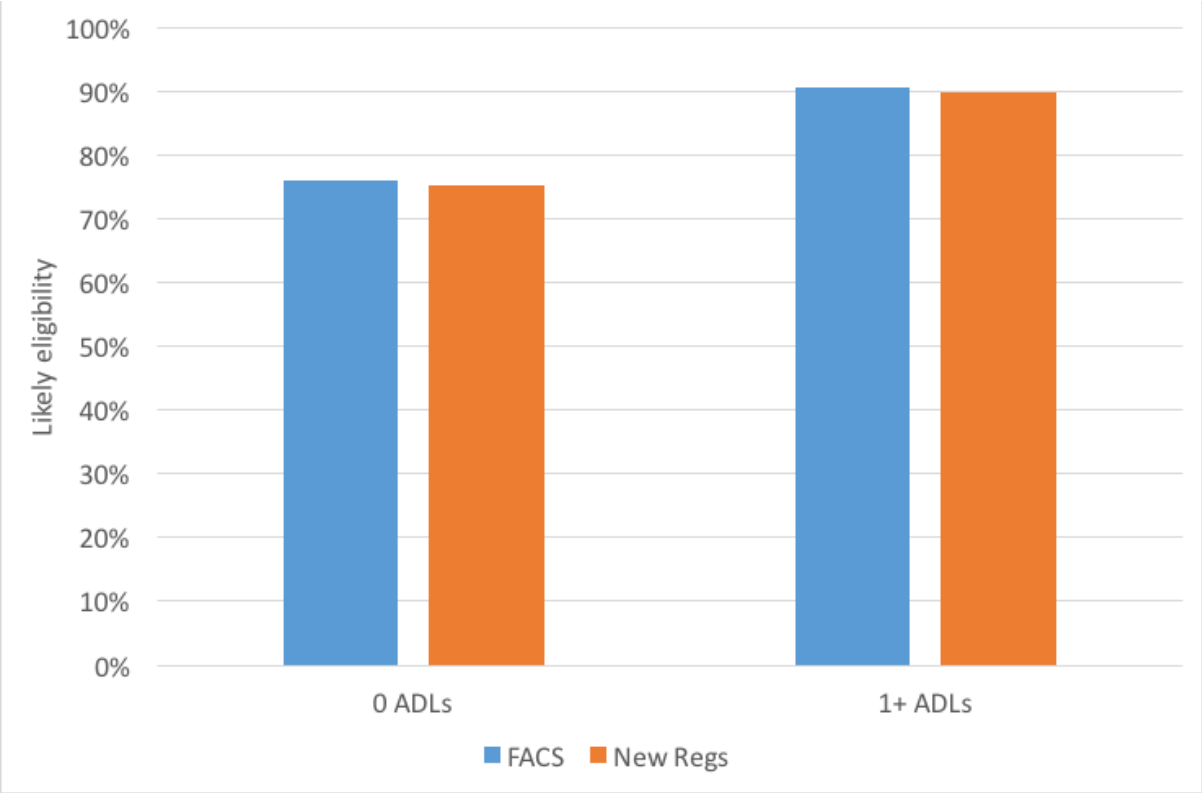


Figure 35 Expected care package cost by ADL/IADLs, informal care and regulation: adults aged under 65 with a learning disability

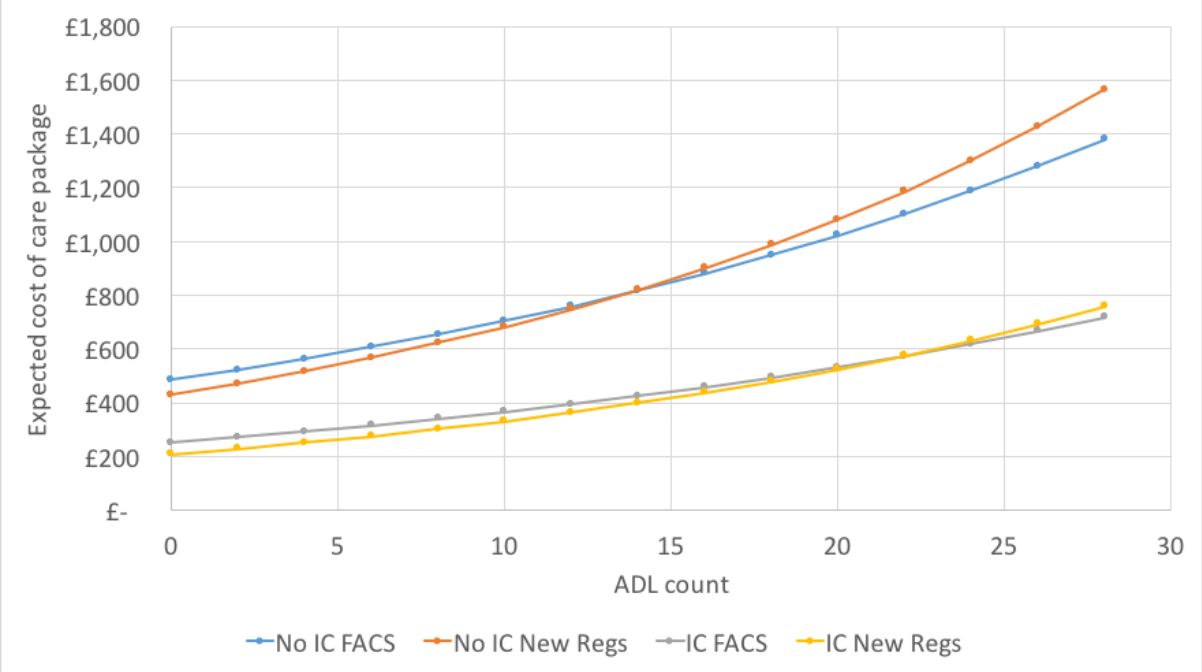
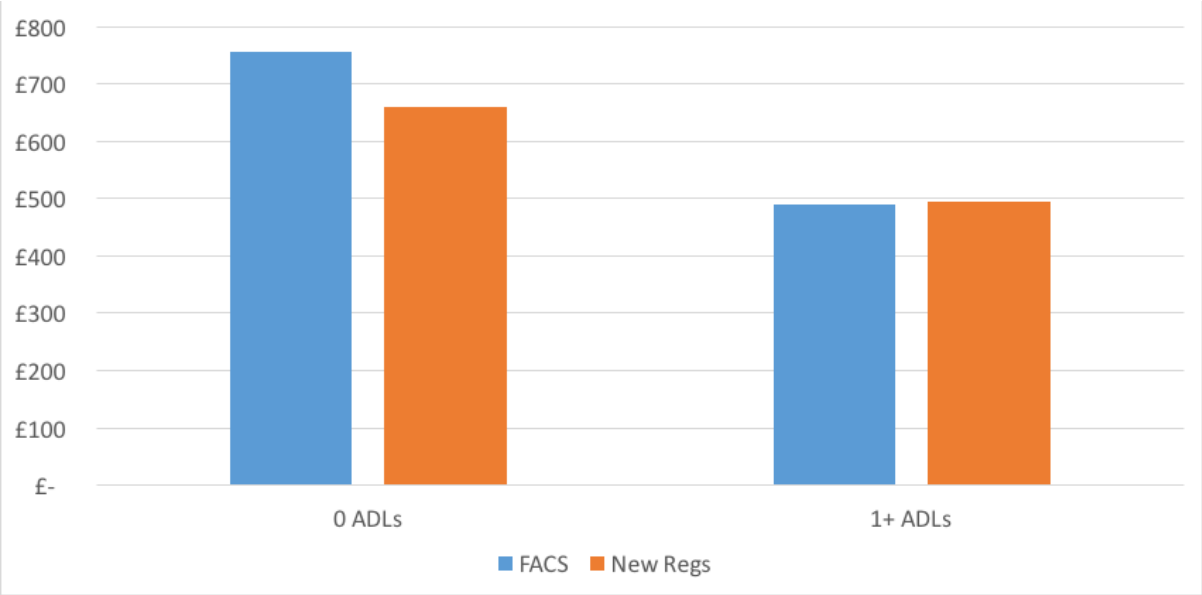


Figure 36 Expected average community care package cost for key modelling groups: adults aged under 65 with a learning disability



11.4 Adults aged under 65 with mental health needs

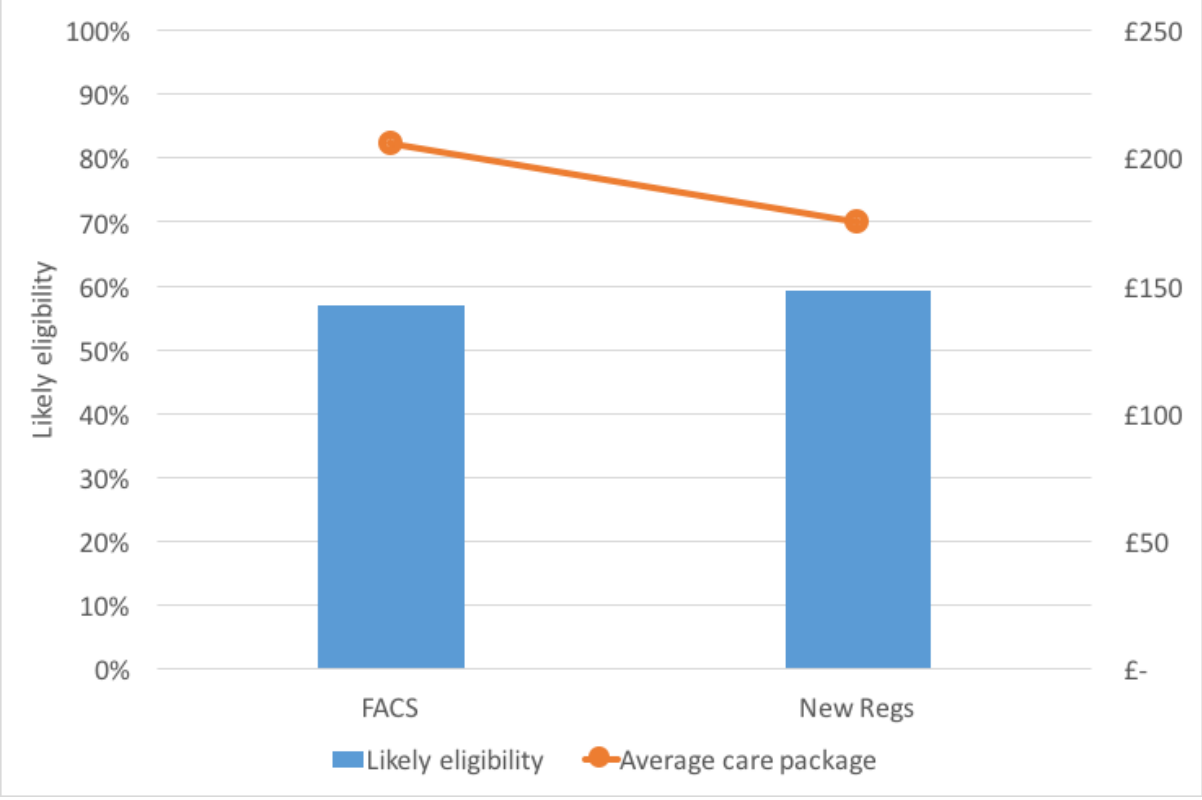
Due to the lack of evidence about the patterns of service use by different needs amongst adults under 65 with mental health needs, we apply the estimated changes in the probability of eligibility and changes in care package to the total expenditure for the client group as reported in PSS EX1 for 2013/14.

Table 18 Summary table: adults aged under 65 with mental health needs

	Number of recipients (2013/14)	Gross current expenditure (2013/14) (£m)	Change in likely eligibility	Change in recipients	% change in care package	Change in gross current expenditure (£m)
Total	**91,960**	**£1,016**	**+4%**	**+3,700**	**-15%**	**+£35 (+£33 net)**

The results suggest an increase of 4% in the likelihood of eligibility overall, but with a reduction of 15% in the cost of care packages. Assuming the reduction in care packages only applies to new cases, the changes for the group would result in increases in gross current expenditure of £35M (£33M net current expenditure).

Figure 37 Changes in needs eligibility for key modelling groups (count of ADL problems):



11.5 Carers

The ability to quantify the impact of national regulations on the number of carers receiving support and corresponding expenditure is constrained by limited information about levels of support under previous regulations. Furthermore, care manager feedback suggests that in cases, the regulations would give rise to a shift in the recording of care packages from person to carer, but would not affect the nature or volume of support provided.

Figure 39 illustrates an 11% increase in the reported costs of community care packages under the new regulations. Costs above £397 per week were excluded from analysis in order to reduce the risk of costing a residential care package specifically for the user.

Figure 38 Expected care package cost by recipient ADL/IADLs and regulation: carers

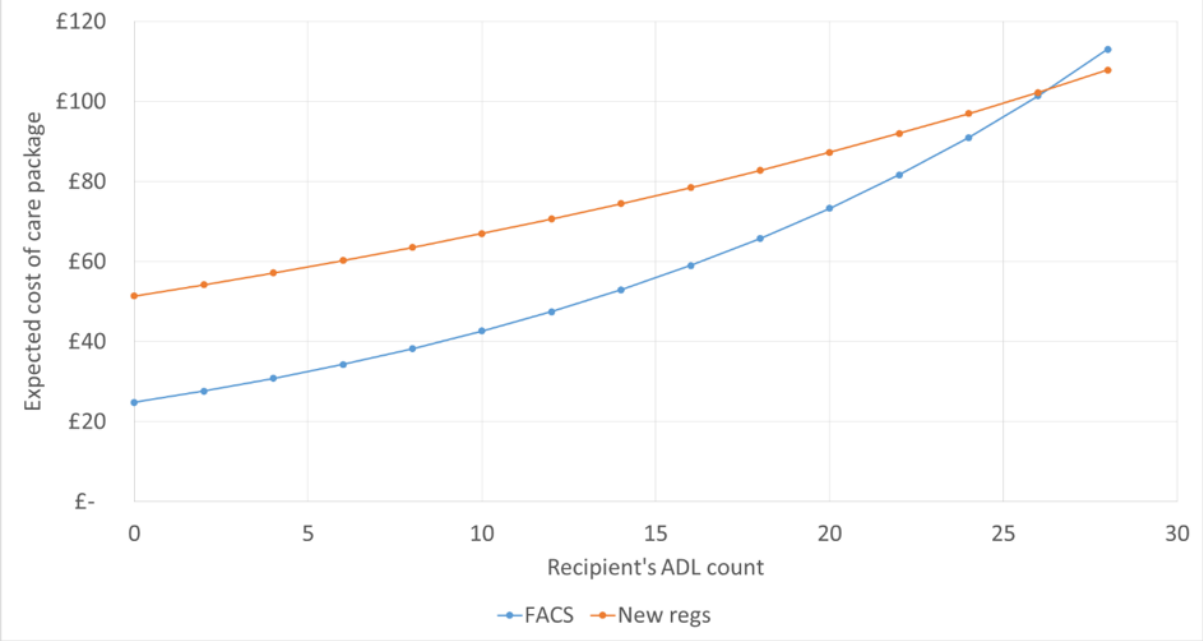
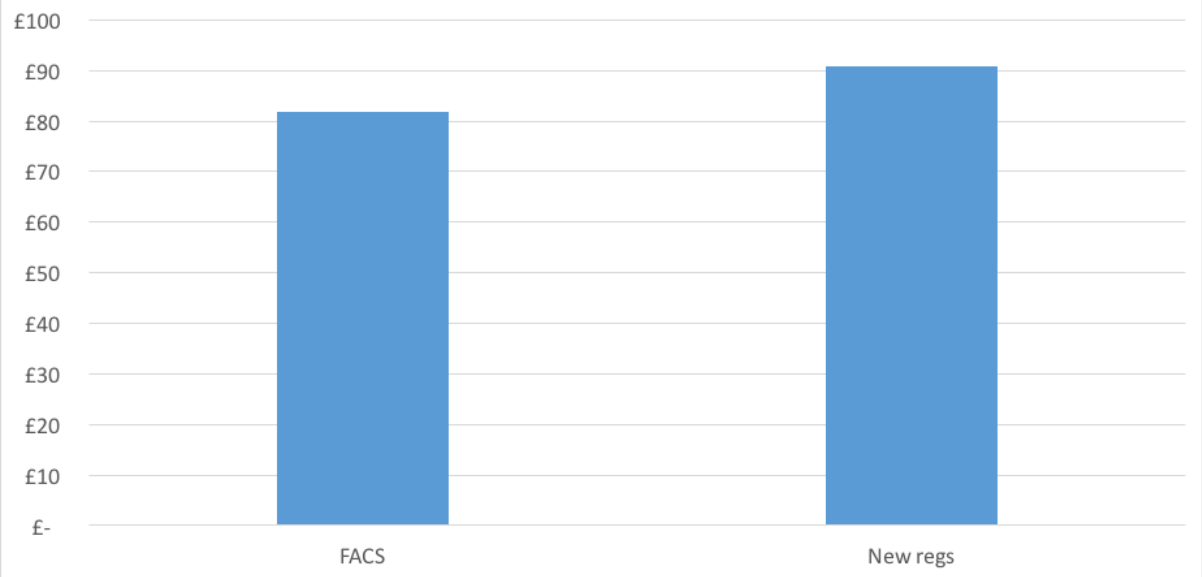


Figure 39 Expected average community care package cost by regulation: carers



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13 Appendix 1: Regression model output

13.1.1 Regression models: older people

13.1.1.1 Likely eligibility: older people

Multiple-imputation estimates		Imputations	20
Random-effects logistic regression		Number of obs	1946
Group variable: id		Number of groups	983
Random effects u_i ~ Gaussian		Obs per group: min	1
		avg	2
Integration points = 12		max	2
		Average RVI	0.7467
		Largest FMI	0.8765
DF adjustment: Large sample		DF: min	25.27
		avg	992117
		max	21400000
Model F test: Equal FMI		F(20, 2909.5)	10
Within VCE type: OIM		Prob > F	0

	Coef.	Std. Err.	t	P>|t|	[95% Conf.	Interval]
Age	-0.0101	0.0556	-0.180	0.855	-0.1194	0.0991
Male	-1.0370	0.9649	-1.070	0.283	-2.9284	0.8543
ALD count	2.2477	0.4047	5.550	0.000	1.4438	3.0516
ADL count ^2	-0.0455	0.0104	-4.390	0.000	-0.0658	-0.0251
New regulations	-0.1114	0.9655	-0.120	0.908	-2.0038	1.7809
New regulations * ADL count	0.4871	0.2113	2.300	0.021	0.0726	0.9015
New regulations * ADL count^2	-0.0152	0.0075	-2.040	0.041	-0.0298	-0.0006
Visual impairment	1.1160	1.3508	0.830	0.409	-1.5320	3.7639
Hearing impairment	2.3738	2.2342	1.060	0.288	-2.0053	6.7528
Dual impairment	7.4912	3.9107	1.920	0.056	-0.1782	15.1605
Visual impairment * new regulations	-1.2433	1.1359	-1.090	0.274	-3.4698	0.9832
Hearing impairment * new regulations	4.0877	2.3369	1.750	0.080	-0.4944	8.6698
Dual impairment * new regulations	3.2149	3.4926	0.920	0.357	-3.6306	10.0604
Lives alone	-3.3838	1.3988	-2.420	0.016	-6.1293	-0.6383
Informal care (from in household)	-5.1526	2.1081	-2.440	0.015	-9.2865	-1.0186
Informal care (from outside household)	-4.0703	1.4894	-2.730	0.006	-6.9917	-1.1488
Informal care (from in and outside household)	-6.3025	2.5926	-2.430	0.015	-11.3865	-1.2185
Informal care (from in household) * new regulations	-2.2590	1.2609	-1.790	0.073	-4.7305	0.2125
Informal care (from outside household) * new regulations	-1.0748	1.1186	-0.960	0.337	-3.2672	1.1176
Informal care (from in and outside household) * new regulations	-3.4791	2.0180	-1.720	0.085	-7.4348	0.4766
Constant	-2.5549	4.5503	-0.560	0.575	-11.4924	6.3826
/lnsig2u	4.3949	0.4111			3.5487	5.2411
sigma_u	9.0022	1.8504			5.8965	13.7436
rho	0.9610	0.0154			0.9136	0.9829

13.1.2 Care package costs: older people

Multiple-imputation estimates				Imputations		20
GEE population-averaged model				Number of obs		837
				Number of groups		450
Group variable: id				Obs per group: min		1
Link: log				avg		1.9
Family: gamma				max		2
Correlation: independent				Average RVI		0.0223
Scale parameter: x2				Largest FMI		0.2464
				DF: min		324.97
DF adjustment: Large sample				avg		3.12E+09
				max		2.71E+10
Model F test: Equal FMI				F(18,648458.8)		8.13
Within VCE type: Conventional				Prob > F		0
	Coef.	Std. Err.	t	P>|t|	[95% Conf.	Interval]
Age	-0.0090	0.0034	-2.650	0.008	-0.0156	-0.0023
Male	-0.1449	0.0565	-2.560	0.010	-0.2557	-0.0342
ALD count	0.0385	0.0060	6.380	0.000	0.0267	0.0504
New regulations	-0.0926	0.1950	-0.480	0.635	-0.4747	0.2895
New regulations * ADL count	0.0033	0.0084	0.400	0.690	-0.0131	0.0198
Visual impairment	0.0035	0.1001	0.030	0.972	-0.1926	0.1996
Hearing impairment	-0.1762	0.1184	-1.490	0.137	-0.4082	0.0559
Dual impairment	-0.0485	0.1336	-0.360	0.717	-0.3103	0.2133
Visual impairment * new regulations	-0.0707	0.1364	-0.520	0.604	-0.3380	0.1965
Hearing impairment * new regulations	0.0528	0.1646	0.320	0.748	-0.2699	0.3755
Dual impairment * new regulations	-0.0365	0.1852	-0.200	0.844	-0.3995	0.3266
Lives alone	-0.2862	0.0783	-3.660	0.000	-0.4395	-0.1328
Informal care (from in household)	-0.4653	0.1279	-3.640	0.000	-0.7159	-0.2146
Informal care (from outside household)	-0.3183	0.1123	-2.830	0.005	-0.5385	-0.0982
Informal care (from in and outside household)	-0.4033	0.1461	-2.760	0.006	-0.6897	-0.1169
Informal care (from in household) * new regulations	0.0099	0.1631	0.060	0.952	-0.3098	0.3296
Informal care (from outside household) * new regulations	0.0154	0.1547	0.100	0.921	-0.2878	0.3185
Informal care (from in and outside household) * new regulations	-0.0240	0.1967	-0.120	0.903	-0.4094	0.3615
Constant	5.9410	0.2916	20.370	0.000	5.3683	6.5137

13.2 Regression models: adults aged under 65 with a physical disability or sensory impairment

13.2.1 Likely eligibility: adults aged under 65 with a physical disability or sensory impairment

Multiple-imputation estimates				Imputations		20
Random-effects logistic regression				Number of obs		463
Group variable: id				Number of groups		237
Random effects u_i ~ Gaussian				Obs per group: min		1
				avg		2
Integration points = 12				max		2
				Average RVI		0.1626
				Largest FMI		0.597
DF adjustment: Large sample				DF: min		55.93
				avg		1.16E+06
				max		1.13E+07
Model F test: Equal FMI				F(12,15039.7)		3.03
Within VCE type: OIM				Prob > F		0.0003
	Coef.	Std. Err.	t	P>|t|	[95% Conf.	Interval]
Age	0.0201	0.0655	0.310	0.759	-0.1085	0.1487
Male	2.2467	1.9153	1.170	0.241	-1.5077	6.0011
ALD count	2.6224	0.7254	3.620	0.000	1.1856	4.0593
ADL count ^2	-0.0697	-0.0215	3.240	0.001	-0.1121	-0.0273
New regulations	2.0178	2.1956	0.920	0.358	-2.2861	6.3218
New regulations * ADL count	-0.0155	-0.3860	0.040	0.968	-0.7720	0.7410
New regulations * ADL count^2	-0.0038	-0.0131	0.290	0.774	-0.0295	0.0220
Visual impairment	4.5729	4.2777	1.070	0.285	-3.8125	12.9582
Visual impairment * new regulations	-2.6516	-3.1814	0.830	0.405	-8.8873	3.5840
Lives alone	-1.6014	-2.1665	0.740	0.460	-5.8479	2.6451
Informal care (any source)	1.3077	2.6398	0.500	0.620	-3.8672	6.4825
Informal care (any source) * new regulations	2.1410	1.9402	1.100	0.270	-1.6620	5.9440
Constant	-10.4857	-4.9226	2.130	0.034	-20.1765	-0.7949
/lnsig2u	4.2296	0.4789			3.2702	5.1890
sigma_u	8.2880	1.9845			5.1301	13.3898
rho	0.9543	0.0209			0.8889	0.9820

13.2.2 Weekly community care costs: adults aged under 65 with a physical disability or sensory impairment

Multiple-imputation estimates	Imputations	20	
GEE population-averaged model	Number of obs	275	
	Number of groups	147	
	Obs per group:		
Group variable: id	min	1	
Link: log	avg	1.9	
Family: gamma	max	2	
Correlation: independent	Average RVI	0.0017	
Scale parameter: x2	Largest FMI	0.0269	
	DF:		
	min	26484.85	
DF adjustment: Large sample	avg	5.78E+10	
	max	8.91E+11	
Model F test: Equal FMI	F(18, 1.0e+08)	1.87	
	Prob >		
Within VCE type: Conventional	F	0.0142	

	Coef.	Std. Err.	t	P>|t|	[95% Conf.	Interval]
Age	-0.0057	0.0042	-1.350	0.176	-0.0140	0.0026
Male	0.1162	0.1192	0.970	0.330	-0.1175	0.3499
ALD count	0.0185	0.0105	1.770	0.077	-0.0020	0.0390
New regulations	0.0039	0.3465	0.010	0.991	-0.6752	0.6830
New regulations * ADL count	0.0030	0.0145	0.200	0.839	-0.0255	0.0315
Visual impairment	-0.6516	0.4465	-1.460	0.145	-1.5268	0.2236
Hearing impairment	0.0991	0.2011	0.490	0.622	-0.2950	0.4932
Dual impairment	-0.1787	0.6797	-0.260	0.793	-1.5110	1.1535
Visual impairment * new regulations	-0.1007	0.6017	-0.170	0.867	-1.2801	1.0787
Hearing impairment * new regulations	-0.0825	0.2847	-0.290	0.772	-0.6406	0.4756
Dual impairment * new regulations	0.4138	1.1743	0.350	0.725	-1.8877	2.7153
Lives alone	-0.3501	0.2125	-1.650	0.099	-0.7665	0.0664
Informal care (from in household)	-0.3377	0.2739	-1.230	0.217	-0.8745	0.1990
Informal care (from outside household)	0.0710	0.2589	0.270	0.784	-0.4363	0.5784
Informal care (from in and outside household)	-0.7129	0.3238	-2.200	0.028	-1.3475	-0.0782
Informal care (from in household) * new regulations	-0.1066	0.3116	-0.340	0.732	-0.7174	0.5042
Informal care (from outside household) * new regulations	-0.0335	0.3655	-0.090	0.927	-0.7498	0.6829
Informal care (from in and outside household) * new regulations	-0.1109	0.3808	-0.290	0.771	-0.8572	0.6354
Constant	6.1778	0.3464	17.830	0.000	5.4989	6.8568

13.3 Regression models: adults aged under 65 with a learning disability

13.3.1 Likely eligibility: adults aged under 65 with a learning disability

Multiple-imputation estimates					Imputations	20
Random-effects logistic regression					Number of obs	389
Group variable: id					Number of groups	197
					Obs per group:	
Random effects u_i ~ Gaussian					min	1
					avg	2
Integration points = 12					max	2
					Average RVI	0.0158
					Largest FMI	0.1306
					DF:	
DF adjustment: Large sample					min	1140.87
					avg	3.10E+08
					max	3.93E+09
Model F test: Equal FMI					F(12,731481.8)	1.2
					Prob >	
Within VCE type: OIM					F	0.2774
	Coef.	Std. Err.	t	P>|t|	[95% Conf.	Interval]
Age	0.0433	0.0345	1.260	0.209	-0.0244	0.1110
Male	-1.3835	0.8630	-1.600	0.109	-3.0750	0.3081
ALD count	1.1365	0.3436	3.310	0.001	0.4631	1.8099
ADL count ^2	-0.0336	0.0106	-3.170	0.002	-0.0544	-0.0128
New regulations	-0.9590	1.3447	-0.710	0.476	-3.5945	1.6765
New regulations * ADL count	-0.1369	0.5677	-0.240	0.809	-1.2495	0.9757
New regulations * ADL count^2	0.0371	0.0613	0.610	0.544	-0.0829	0.1572
Visual impairment	-0.9379	1.7121	-0.550	0.584	-4.2936	2.4178
Visual impairment * new regulations	-2.3518	2.9754	-0.790	0.429	-8.1835	3.4798
Lives alone	-1.2684	0.8996	-1.410	0.159	-3.0315	0.4948
Informal care (any source)	-0.1744	0.9121	-0.190	0.848	-1.9622	1.6133
Informal care (any source) * new regulations	0.6333	1.2456	0.510	0.611	-1.8080	3.0745
Constant	-2.6863	1.8402	-1.460	0.144	-6.2941	0.9216
/lnsig2u	1.4834	0.8934			-0.2676	3.2345
sigma_u	2.0995	0.9379			0.8748	5.0391
rho	0.5726	0.2186			0.1887	0.8853

13.3.2 Weekly cost: adults aged under 65 with a learning disability

Multiple-imputation estimates				Imputations		20
GEE population-averaged model				Number of obs		238
				Number of groups		128
Group variable: id				Obs per group: min		1
Link: log				avg		1.9
Family: gamma				max		2
Correlation: independent				Average RVI		0.0001
Scale parameter: x2				Largest FMI		0.0011
				DF: min		1.47E+07
DF adjustment: Large sample				avg		1.48E+14
				max		2.70E+15
Model F test: Equal FMI				F(18, 1.5e+10)		3.6
Within VCE type: Conventional				Prob > F		0
	Coef.	Std. Err.	t	P>|t|	[95% Conf.	Interval]
Age	-0.0052	0.0056	-0.930	0.351	-0.0163	0.0058
Male	0.1576	0.1433	1.100	0.271	-0.1232	0.4384
ALD count	0.0373	0.0150	2.480	0.013	0.0078	0.0667
New regulations	-0.1354	0.3910	-0.350	0.729	-0.9018	0.6310
New regulations * ADL count	0.0088	0.0207	0.430	0.670	-0.0318	0.0494
Visual impairment	-0.3128	0.3447	-0.910	0.364	-0.9883	0.3627
Hearing impairment	0.1637	0.3287	0.500	0.619	-0.4806	0.8080
Dual impairment	-0.5620	0.5587	-1.010	0.314	-1.6571	0.5330
Visual impairment * new regulations	0.0173	0.4850	0.040	0.972	-0.9332	0.9678
Hearing impairment * new regulations	0.0595	0.4583	0.130	0.897	-0.8388	0.9577
Dual impairment * new regulations	0.1513	0.7493	0.200	0.840	-1.3173	1.6200
Lives alone	-0.1253	0.2143	-0.580	0.559	-0.5453	0.2947
Informal care (from in household)	-1.1682	0.2663	-4.390	0.000	-1.6901	-0.6463
Informal care (from outside household)	0.1116	0.2958	0.380	0.706	-0.4681	0.6912
Informal care (from in and outside household)	-0.7689	0.3558	-2.160	0.031	-1.4662	-0.0716
Informal care (from in household) * new regulations	0.0023	0.3494	0.010	0.995	-0.6825	0.6871
Informal care (from outside household) * new regulations	-0.2259	0.4047	-0.560	0.577	-1.0191	0.5673
Informal care (from in and outside household) * new regulations	-0.0255	0.4686	-0.050	0.957	-0.9438	0.8929
Constant	6.4128	0.3566	17.980	0.000	5.7138	7.1117

13.4 Regression models: adults aged under 65 with mental health needs

13.4.1 Likely eligibility: adults aged under 65 with mental health needs

Multiple-imputation estimates		Imputations	20
Random-effects logistic regression		Number of obs	252
Group variable: id		Number of groups	128
Random effects u_i ~ Gaussian		Obs per group: min	1
		avg	2
Integration points = 12		max	2
		Average RVI	0.0239
		Largest FMI	0.2074
		DF:	
DF adjustment: Large sample		min	456.93
		avg	1.90E+08
		max	1.05E+09
Model F test: Equal FMI		F(12,316608.6)	3.13
		Prob >	
Within VCE type: OIM		F	0.0002

	Coef.	Std. Err.	t	P>|t|	[95% Conf.	Interval]
Age	0.00066	0.05072	0.010	0.990	-0.09901	0.10033
Male	-2.30965	1.44821	-1.590	0.111	-5.14813	0.52882
ALD count	2.11774	0.40252	5.260	0.000	1.32869	2.90679
ADL count ^2	-0.07306	0.01671	-4.370	0.000	-0.10581	-0.04030
New regulations	-0.67555	1.23674	-0.550	0.585	-3.09951	1.74841
New regulations * ADL count	-0.09138	0.30398	-0.300	0.764	-0.68718	0.50442
New regulations * ADL count^2	0.00821	0.01340	0.610	0.540	-0.01805	0.03446
Visual impairment	3.77527	4.20243	0.900	0.369	-4.46134	12.01188
Visual impairment * new regulations	-2.77882	4.24754	-0.650	0.513	-11.10386	5.54621
Lives alone	2.90610	1.49613	1.940	0.052	-0.02627	5.83847
Informal care (any source)	-3.56971	1.73081	-2.060	0.039	-6.96205	-0.17738
Informal care (any source) * new regulations	2.41911	1.36330	1.770	0.076	-0.25291	5.09113
Constant	-5.21131	2.58079	-2.020	0.044	-10.27563	-0.14698
/lnsig2u	3.64860	0.40300			2.85866	4.43854
sigma_u	6.19845	1.24899			4.17590	9.20060
rho	0.92113	0.02928			0.84128	0.96259

13.4.2 Weekly costs: adults aged under 65 with mental health needs

Multiple-imputation estimates				Imputations		20
GEE population-averaged model				Number of obs		86
				Number of groups		49
				Obs per group:		
Group variable: id				min		1
Link: log				avg		1.8
Family: gamma				max		2
Correlation: independent				Average RVI		0.053
Scale parameter: x2				Largest FMI		0.3241
				DF:		
				min		189.07
DF adjustment: Large sample				avg		7.59E+08
				max		1.28E+10
Model F test: Equal FMI				F(16,115531.6)		3.21
				Prob >		
Within VCE type: Conventional				F		0
	Coef.	Std. Err.	t	P>|t|	[95% Conf.	Interval]
Age	-0.0137	0.0081	-1.680	0.094	-0.0297	0.0023
Male	0.7444	0.2207	3.370	0.001	0.3114	1.1774
ALD count	0.0341	0.0282	1.210	0.227	-0.0212	0.0894
New regulations	-0.2005	0.3419	-0.590	0.558	-0.8705	0.4696
New regulations * ADL count	0.0083	0.0349	0.240	0.812	-0.0601	0.0767
Visual impairment	0.3456	0.5304	0.650	0.515	-0.6940	1.3852
Hearing impairment	0.4069	0.5497	0.740	0.459	-0.6706	1.4844
Visual impairment * new regulations	0.1439	0.7111	0.200	0.840	-1.2498	1.5377
Hearing impairment * new regulations	-0.0128	0.7074	-0.020	0.986	-1.3993	1.3737
Lives alone	-0.5892	0.2346	-2.510	0.012	-1.0490	-0.1294
Informal care (from in household)	-0.9608	0.4321	-2.220	0.026	-1.8077	-0.1140
Informal care (from outside household)	-0.4340	0.3654	-1.190	0.235	-1.1502	0.2822
Informal care (from in and outside household)	-0.4759	0.5718	-0.830	0.405	-1.5968	0.6449
Informal care (from in household) * new regulations	-0.1029	0.5200	-0.200	0.843	-1.1220	0.9162
Informal care (from outside household) * new regulations	-0.1061	0.5215	-0.200	0.839	-1.1282	0.9160
Informal care (from in and outside household) * new regulations	-0.0728	0.7073	-0.100	0.918	-1.4592	1.3135
Constant	5.7504	0.4322	13.310	0.000	4.9026	6.5981

13.5 Regression models: carers

13.5.1 Weekly costs: carers

GEE population-averaged model				Number of obs		86
Group variable:	id			Number of grou	ps	50
Link:	log			Obs per group:	min	1
Family:	gamma				avg	1.7
Correlation:	independent				max	2
				Wald chi2(5)		22.82
Scale parameter:	0.557653			Prob > chi2		0.0004
Pearson chi2(86):	47.96			Deviance		56.98
Dispersion (Pearson):	0.557653			Dispersion		0.662567

	Coef.	Std. Err.	z	P>|z|	[95% Conf.	Interval]
Recipient ADL count	0.0542	0.0201	2.690	0.007	0.0147	0.0937
New regulations	0.7296	0.5736	1.270	0.203	-0.3946	1.8538
New regulations * recipient ADL count	-0.0277	0.0261	-1.060	0.288	-0.0789	0.0234
Carer gender	0.3750	0.1717	2.180	0.029	0.0386	0.7115
Carer is spouse	-0.3568	0.1660	-2.150	0.032	-0.6821	-0.0314
Constant	2.7574	0.4945	5.580	0.000	1.7883	3.7265

14 Appendix 2: Cost sensitivity analysis

For sensitivity, this section**Error! Reference source not found.** provides an illustration of changes to gross and net current expenditure when applying unit cost effects to all (existing and newly-eligible) clients in community and residential settings. Given the relative stability of residential care package costs and the likelihood of care packages for existing community clients remaining relatively unchanged in the short term, however, such an assumption**Error! Reference source not found.** is likely to substantially under-estimate cost impact.

Table 19 Summary of estimated change in expenditure by client group, assuming unit cost effects for all community and residential clients (sensitivity analysis)

Client group	Gross (£m)	Net (£m)
Older people	-£59	-£45
Adults aged under 65 with a physical disability or sensory impairment	-£5	-£5
Adults aged under 65 with learning disabilities	-£169	-£161
Adults aged under 65 with mental health needs	-£118	-£113
Total	-£351	-£323

15 Appendix 3: Types of LAs and informants involved in focus groups

No	Type of Local Authority	Focus group participants
LA 1	London Borough (outer)	7 participants: I1: Social worker adults 18-64 with physical disabilities team I2: Social worker adults 18-64 with physical disabilities team I3: Adults team manager I4: Social worker for older people (65+) I5: Social worker for older people (65+) I6: Social worker adults 18-64 with learning disabilities team I7: Social worker/care coordinator adults 19-64 with mental health needs
LA 2	A non-Metropolitan district	6 participants: I1: Social worker learning disabilities team I2: Care manager for physical disability & sensory service team I3: Care manager for mental health team Individual from customer service centre I4: Older people team I5: Operational manager, Care Act implementation learning disabilities team.
LA 3	A Unitary Authority	5 participants: I1: Senior social worker with intermediate care and reablement service I2: Social worker for adult mental health team I3: Service manager for learning disability team I4: Social worker in adults team I5: Social worker with the older people's mental health team
LA 4	London Borough (outer)	4 participants: I1: Social worker learning disability team. I2: Social worker working in hospital for Adult Social Services. I3: Social worker working in a Care Act implementation team, did assessments of different user groups for the survey in the study I4: Social worker from First Contact team
LA5	A non-Metropolitan district	2 participants: I1: SW: generic team (adults over the age of 18: learning disability, physical disability, older people, mental needs). I2: SW: Promoting independence team (adults over the age of 18, but main service user group are stroke and dementia).
LA6	London Borough (outer)	5 participants: I1: Head of Integrated Rehabilitation, Lead for intermediate care I2: Acting Director for Adult Social Care

		I3: Interim Head of Complex Care: Complex Adult Social Work, community commissioning, transition. I4: Service Manager Complex Care team. I5: Head of Complex Care team and community commissioning brokerage team.

16 Appendix 4: Focus Group Question guide

1 Explanation of the process
2 Ethical Issues
3 Introduction to the topic
4 Questions

Q1. The Care Act has brought about important changes, including in terms of the eligibility regulations. Do you feel that you have adapted to the new eligibility regulations by now, or is the council still in flux?

Prompt: do you feel that your interpretation of the regulations is changing significantly as days past?

Q2. How different do you feel the new regulations are from the FACS system?

Q3. Let's continue the discussion by talking about your experiences using the national eligibility criteria.

- How well do you feel the national eligibility criteria work in terms of appropriately identifying needs relative to FACS?
- How easily can the national eligibility regulations be understood?
- How easy are they to explain to service users?
- How easy are the national eligibility criteria to apply?
- To what extent do the national eligibility criteria allow for flexibility of professional judgment?
- Has the relationship with service users/carers changed as a result of the new regulations?
- Are there particular types of client or circumstances to which you feel the regulations are better / less well suited?

Q3. Do you feel that people with social care needs are aware of the new regulations? Has there been a noticeable impact in volumes of client assessments since the introduction of the new criteria? If so, are there particular client groups this has affected more than others?

Q4. Has there been a noticeable impact on the number of clients assessed as eligible since the introduction of the new criteria? If so, are there particular client groups this has affected more than others?

Q5. Have the new criteria led to changes in staffing roles or the management of assessments as a whole? If not, are changes necessary?

Q6. Have any new in-house processes or systems (paperwork, procedural documents, etc) been developed since the introduction of the national criteria? If not, are any needed?

Q7. What training (if any) has been provided to help to understand and apply the new criteria? At what level (members, senior managers, operational managers, practitioners, first point of contact staff, commissioners etc.) has this been provided?

Q8. What training/guidance is still needed/for whom? Who would be best suited to providing this?

Q9. Do you have any other comments on the draft eligibility criteria?

17 Appendix 5: Care manager questionnaire

Thank you for agreeing to participate in this survey.

Please note that the identities of individual authorities and staff completing the survey will be treated as confidential and not published in any reports or other output from the survey We would however be grateful if you could complete this information to help us with linking parts of the survey and in case any responses need to be clarified.

If you have any queries or need help completing the survey please contact a member of the research team by email at pssru.sceligibility@lse.ac.uk or by telephone:

Tom Snell (main point of contact)	Jose-Luis Fernandez	Joanna Marczak
0207 955 7692	0207 955 6160	0207 106 1421

Your contact details

Name

Job Title

Local Authority

Telephone

Email

Please select the client group for which you have been asked to complete this survey by the survey coordinator within your local authority.

This should be completed before you continue with the survey.

In order to help us understand response patterns, we would like to understand which responses are provided by members of first contact teams (involved in the initial screening / triaging of cases at first contact)

Are you a member of a first contact team?

Yes
No

If yes, do you provide first contact support for multiple service areas in your local authority, or adult social care only?

Multiple service areas
Adult social care only
Not applicable

The main purpose of this survey is to understand how eligibility decisions have been affected by the 2015 eligibility regulations relative to Fair Access to Care Services (FACS) regulations.

The first 9 sheets of the survey relate to clients that you have provided assessments for since the beginning of April 2015.

We are interested in understanding the characteristics both of adults that have eligible needs according to the national eligibility regulations and those that do not have eligible needs. If you have provided asessments for adults in both of these categories, then please:

- Include adults that HAVE ELIGIBLE NEEDS under the national eligibility regulations in responses numbered **1 to 5**

- Include adults that DO NOT HAVE ELIGIBLE NEEDS under the national eligibility regulations in responses numbered **6 to 9**

If you do not have a sufficient number of assessments in either category, please use responses **1-9** for adults under either category.

A separate sheet is provided for each case. You will be asked to provide:

- Basic details about the person (age, gender, limitations etc);

- Whether they are eligible to receive services (and if so, which) under the national eligibility regulations;

- Whether would have been eligible to receive services (and if so, which) under FACS guidelines in place in your authority before April 2015.

The final sheet of the survey relates to carers. Please base this upon the most recent assessment that you carried out for a carer (regardless of whether they were eligible) since the beginning of April 2015. You will be asked to provide:

- Basic details about the carer (age, gender, etc);

- Basic details about the person care for (age, gender, limitations etc) and their relationship to the carer;

- Whether the carer is eligible to receive services (and if so, which) under the national eligibility regulations;

- Whether the carer would have been eligible to receive services (and if so, which) when FACS guidelines were in place.

Once the survey has been completed, please return this by email to: pssru.sceligibility@lse.ac.uk

Please also let your local authority survey coordinator know that the questionnaire has been completed or copy them into the email when submitting the completed questionnaire.

The links below allow you to navigate directly to the 10 cases to be covered in the survey. Alternatively, you can use the tabs numbered 1 to 10 at the bottom of the spreadsheet.

Assessment 1	(Ideally, this should be an adult assessed as having eligible needs)
Assessment 2	(Ideally, this should be an adult assessed as having eligible needs)
Assessment 3	(Ideally, this should be an adult assessed as having eligible needs)
Assessment 4	(Ideally, this should be an adult assessed as having eligible needs)
Assessment 5	(Ideally, this should be an adult assessed as having eligible needs)
Assessment 6	(Ideally, this should be an adult assessed as NOT having eligible needs)
Assessment 7	(Ideally, this should be an adult assessed as NOT having eligible needs)
Assessment 8	(Ideally, this should be an adult assessed as NOT having eligible needs)
Assessment 9	(Ideally, this should be an adult assessed as NOT having eligible needs)
Assessment 10 (carer)	(Carer assessment)

Cases 1-9 (If possible, please include an adult whose needs are ELIGIBLE)

Demographic information — **Comments / notes**

Client group - PLEASE SELECT IN 'CLIENT GROUP' SHEET AT START OF SURVEY

Type of assessment

In person

Telephone

Question 1 Age at assessment

Question 2 Gender

Male

Female

Question 3 Ethnic group

Dependency — **Comments / notes**

Question 4	Does this person need help to...	Yes	Sometimes	No	Not sure
(a)	Get up and down stairs or steps	O	O	O	O
(b)	Go out of doors and walk down the road	O	O	O	O
(c)	Get around indoors (except steps)	O	O	O	O
(d)	Get in and out of bed (or chair)	O	O	O	O
(e)	Use WC/toilet	O	O	O	O
(f)	Wash hands and face	O	O	O	O
(g)	Bath, shower or wash all over	O	O	O	O
(h)	Get dressed and undressed	O	O	O	O
(i)	Grooming (i.e. washing own hair)	O	O	O	O
(j)	Feed him/herself	O	O	O	O
(k)	Cooking/food preparation	O	O	O	O
(l)	Carry out housework (laundry, cleaning etc)	O	O	O	O
(m)	Go shopping for groceries	O	O	O	O
(n)	Manage finances and paperwork (bills, etc)	O	O	O	O

Question 5 Does this person have any of the following sensory impairments?

(Tick all that apply)

Hearing impairment

Visual impairment

Dual sensory loss

None of the above

Living arrangements and informal care receipt — **Comments / notes**

Question 6 Does this person receive help from friends or relatives in performing any of the tasks in question 4?

(Tick all that apply)

(a) Yes - receives informal care from someone in the household

(b) Yes - receives informal care from someone outside in the household

(c) Yes - (receives informal care from someone in the household AND someone outside the household)

(d) No - does not receive informal care

Question 7 Which of the following best describes this person's accommodation?

O Private household

O Care home or nursing home

O Hospital

O Sheltered housing

O Other (please specify in comments box)

Question 8 Who else (if anyone) lives with this person?

O Lives alone

O Lives with partner

O Lives with parents

O Lives with others, but none of the above

O Not applicable (e.g. care home)

Eligibility under new national eligibility guidelines | **Comments / notes**

Question 9 **Based on the national eligibility regulations, do you think this person's needs are eligible for support?**

- Definitely
- Probably
- Probably not
- Definitely not
- Not sure (please give details in comments box)

Question 10 **How do you think this person's care needs would be met under the national regulations? Tick all that apply.**

For ongoing or one-off services, please provide an estimate of the cost of the care package they would receive

- **(a)** Ongoing local authority care package (community) costing £ _____ per week
- **(b)** Ongoing local authority care package (care home)
- **(b)** One-off services (e.g. equipment) costing £ _____
- **(c)** Referral to voluntary sector organisations
- **(d)** Information or advice
- **(e)** Unpaid care from family or friends
- **(f)** None of the above

Question 11 **If you felt the person described would be eligible according to the eligibility criteria, which of the following outcomes (based on section 2:2 of the regulations) do you feel the person is unable to achieve?**

- **(a)** managing and maintaining nutrition
- **(b)** maintaining personal hygiene
- **(c)** managing toilet needs
- **(d)** being appropriately clothed
- **(e)** being able to make use of the home safely
- **(f)** maintaining a habitable home environment
- **(g)** developing and maintaining family or other personal relationships
- **(h)** accessing and engaging in work, training, education or volunteering
- **(i)** making use of necessary facilities or services in the local community including public transport, and recreational facilities or services
- **(j)** carrying out any caring responsibilities the adult has for a child

Eligibility under FACS | **Comments / notes**

Question 12 **What rating under the old FACS system would have been most appropriate, according to this person's highest need?**

- Critical
- Substantial
- Moderate
- Low
- Not sure (please give details in comments box)

Question 13 **Would these needs have met the FACS eligibility criteria in place in your local authority immediately prior to April 2015?**

- Yes
- No
- Not sure (please give details in comments box)

Question 14 **How do you think this person's care needs would be met under FACS? Tick all that apply.**

For ongoing or one-off services, please provide an estimate of the cost of the care package they would receive

- **(a)** Ongoing local authority care package (community) costing £ _____ per week
- **(b)** Ongoing local authority care package (care home)
- **(c)** One-off services (e.g. equipment) costing £ _____
- **(d)** Referral to voluntary sector organisations
- **(e)** Information or advice
- **(f)** Unpaid care from family or friends

Case 10 (carer)

	Demographic information about the carer	Comments / notes
	Client group - Carers	
	Type of assessment In person Telephone	
Question 1	Age at assessment	
Question 2	Gender Male Female	
Question 3	Ethnic group	
Question 4	Relationship to the person cared for Parent/step-parent Spouse/partner Son/daughter Son/daughter-in-law (or equivalent) Other relative Neighbour Other (please specify in notes box)	

	Dependency of the carer	Comments / notes
Question 5	Does the carer have a limiting longstanding illness? Yes No Not sure (please give details in notes box)	
Question 6	Does the carer have any of the following sensory impairments? Hearing impairment Visual impairment Dual sensory loss None of the above	

	Demographic information about the person cared for	Comments / notes
Question 7	Age at assessment	
Question 8	Gender Male Female	
Question 9	Ethnic group	

	Dependency of the person cared for					Comments / notes
Question 10	Does the person cared for need help to…	Yes	Sometimes	No	Not sure	
(a)	Get up and down stairs or steps					
(b)	Go out of doors and walk down the road					
(c)	Get around indoors (except steps)					
(d)	Get in and out of bed (or chair)					
(e)	Use WC/toilet					
(f)	Wash hands and face					
(g)	Bath, shower or wash all over					
(h)	Get dressed and undressed					
(i)	Grooming (i.e. washing own hair)					
(j)	Feed him/herself					
(k)	Cooking/food preparation					
(l)	Carry out housework (laundry, cleaning etc)					
(m)	Go shopping for groceries					
(n)	Manage finances and paperwork (bills, etc)					
Question 11	Does the person cared for have any of the following sensory impairments? Hearing impairment Visual impairment Dual sensory loss None of the above					

Living arrangements | **Comments / notes**

Question 12 **Does the carer live with the person cared for?**

(a) Yes

(b) No

Question 13 **Which of the following best describes this accommodation of the person cared for?**

Private household

Care home or nursing home

Hospital

Sheltered housing

Other (please specify in comments box)

Question 14 **Who else (if anyone) lives with the person cared for?**

Lives alone

Lives with partner

Lives with parents

Lives with others, but none of the above

Not applicable (e.g. care home)

Eligibility under previous guidelines | **Comments / notes**

Question 15 **Based on guidelines in place in your local authority before April 2015, would the carer have been entitled to help and support?**

Definitely

Probably

Probably not

Definitely not

Not sure (please give details in comments box)

t

Question 16 **If yes, what services or support (if any) would this person have been likely to receive? Tick all that apply.**

Where applicable, please provide an estimate of the cost of the care package they would have received

(a) Ongoing local authority care package costing £ per week

(c) One-off services (e.g. equipment) costing £

(d) One-off payment costing £

(e) Referral to voluntary sector organisations

(f) Information or advice

Eligibility under new national eligibility guidelines | **Comments / notes**

Question 17 **Based on the national eligibility regulations in place since April 2015, do you think the carer is entitled to help and support?**

Definitely

Probably

Probably not

Definitely not

Not sure (please give details in comments box)

Question 18 **How do you think this person's care needs would be met under the national eligibility regulations? Tick all that apply.**

For ongoing or one-off services, please provide an estimate of the cost of the care package they would receive

(a) Ongoing local authority care package costing £ per week

(b) One-off services (e.g. equipment) costing £

(c) One-off payment costing £

(d) Referral to voluntary sector organisations

(e) Information or advice

Question 19 **If you felt the person described would be eligible according to the national eligibility criteria, Which of the following outcomes (based on section 3:2 of the regulations) do you feel apply to the carer?**

(a) the carer's physical or mental health is, or is at risk of, deteriorating

(b) The carer is unable to achieve the following: carrying out any caring responsibilities the carer has for a child;

(c) The carer is unable to achieve the following: providing care to other persons for whom the carer provides care

(d) The carer is unable to achieve the following: maintaining a habitable home environment in the carer's home (whether or not this is also the home of the adult needing care)

(e) The carer is unable to achieve the following: managing and maintaining nutrition

(f) The carer is unable to achieve the following: developing and maintaining family or other personal relationships

(g) The carer is unable to achieve the following: engaging in work, training, education or volunteering

(h) The carer is unable to achieve the following: making use of necessary facilities or services in the local community including recreational facilities or services

(i) The carer is unable to achieve the following: engaging in recreational activities

Please use this page to record any feedback you have on the national eligibility regulations or your responses to the survey

Thank you very much for your taking time to complete the survey.

Please send completed surveys by email attachment to pssru.sceligibility@lse.ac.uk