LSE PSSRU

SURVEY OF FAIR ACCESS TO CARE SERVICES (FACS) ASSESSMENT CRITERIA AMONG LOCAL AUTHORITIES IN ENGLAND

FINAL REPORT

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OVERVIEW

Fair Access to Care Services (FACS) guidelines were introduced by the Government in 2003 as a means of providing local authorities with a common framework for determining individuals' eligibility for social care services and address inconsistencies in outcomes across the country. According to these guidelines, the needs of assessed individuals are split into one of four categories (critical, severe, moderate or low) according to their level of risk and potential loss of independence (see BOX 1). Eligibility varies across local authorities in terms of which of these groups are entitled to public support.

BOX 1: THE FOUR BANDS OF THE FACS ELIGIBILITY FRAMEWORK

Critical - when

- life is, or will be, threatened; and/or
- significant health problems have developed or will develop; and/or
- there is, or will be, little or no choice and control over vital aspects of the immediate environment; and/or
- serious abuse or neglect has occurred or will occur; and/or
- there is, or will be, an inability to carry out vital personal care or domestic routines; and/or
- vital involvement in work, education or learning cannot or will not be
- sustained; and/or
- vital social support systems and relationships cannot or will not be
- sustained; and/or
- vital family and other social roles and responsibilities cannot or will not be undertaken.

Substantial – when

- there is, or will be, only partial choice and control over the immediate environment; and/or
- abuse or neglect has occurred or will occur; and/or
- there is, or will be, an inability to carry out the majority of personal care or domestic routines; and/or
- involvement in many aspects of work, education or learning cannot or will not be sustained; and/or
- the majority of social support systems and relationships cannot or will not be sustained; and/or
- the majority of family and other social roles and responsibilities cannot or will not be undertaken.

Moderate – when

- there is, or will be, an inability to carry out several personal care or domestic routines; and/or
- involvement in several aspects of work, education or learning cannot or will not be sustained; and/or
- several social support systems and relationships cannot or will not be sustained; and/or
- several family and other social roles and responsibilities cannot or will not be undertaken.

Low - when

- there is, or will be, an inability to carry out one or two personal care or domestic routines; and/or
- involvement in one or two aspects of work, education or learning cannot or will not be sustained; and/or
- one or two social support systems and relationships cannot or will not sustained; and/or
- one or two family and other social roles and responsibilities cannot or will not be undertaken.

Source: Department of Health (2010)

In 2008, the Commission for Social Care Inspection (CSCI) carried out a review of eligibility criteria (CSCI 2008) which identified a number of shortcomings in the way FACS guidelines were implemented. The complexity of the FACS was cited as central to problems with clarity, a lack of fairness and an apparent incompatibility with personalisation. FACS guidance was updated in 2010 (Department of Health 2010) to incorporate a more outcomes-based approach and to allow a better integration with prevention, early intervention and enablement strategies. The national eligibility bandings remained unchanged from 2003, however, and local authorities continued to have autonomy in deciding how services are allocated across the FACS spectrum according to their individual resources.

While FACS guidance and broad local authority eligibility policies are publicly available, there is very little evidence about how these bandings are applied and the number and characteristics of recipients in each FACS group. The Personal Social Services Research Unit (PSSRU) at the London School of Economics were asked by the Department of Health to conduct a survey of local authorities in England to understand the way in which local authorities in England assess eligibility for services in terms of the processes used for assessing and classifying need for services, the relationship between combinations of need-characteristics and FACS groups and the targeting of resources across need groups. In particular, the survey aimed to shed light on the following questions:

- the targeting of resources across FACS need groups;
- the processes used for assessing, classifying and storing information on need for services; and
- the relationship between combinations of need-characteristics and FACS groups.

The PSSRU survey was split into two parts. The purpose of the first part of the survey was to obtain information about the distribution of resources across FACS groups, and to understand the processes used to determine eligibility according to current guidelines. This part of the survey was typically completed by a commissioning manager, performance manager or other member of staff within the local authority with access to key figures. Local authorities were also asked to provide copies of local materials used for assessing needs eligibility criteria, as well as documentation explaining the charging rules applied locally (e.g. policies on the calculation of disability-related expenditures).

The second part of the FACS survey presented a series of vignettes, each of which described the characteristics of an individual with social care needs. Participating authorities were asked to nominate up to 12 care managers (3 managers per user group) to provide responses to this section of the survey. The primary purpose was to build a picture of the types of people that are allocated to each FACS group, and of the characteristics that distinguish those that do receive services from those that do not. From an analysis perspective, this information helps us model the probability of service receipt among different groups of people with a

greater degree of accuracy than on the basis of current assumptions. By extension, understanding how the current FACS guidelines apply to people with different characteristics at present also helps us to understand how changes in the population or changes to eligibility policies will impact on both individuals and local authorities in the future.

Data and feedback collected in the second part of the survey also provide an indication of how rigidly FACS guidelines are applied to individuals – whether or not individuals with the same needs and living circumstances are likely to be banded in the same way across and within local authorities. While the vignettes only convey a portion of the information that would be obtained in a real-life assessment and as such are likely to generate greater variability in the responses than would be observed in real life, the evidence collected and feedback from respondents provide a strong indicator of the drivers of eligibility and highlight some of the challenges faced by professionals in assigning individuals to FACS groups and thus in determining eligibility for care receipt in a consistent manner.

SURVEY METHOD

The PSSRU survey was initially piloted with three local authorities, and informal discussions were held with commissioning and performance managers and care managers to ensure that the content of the survey and accompanying documentation was as clear and relevant as possible. Following the pilot phase, an invitation to participate in the survey was sent to Directors of Adult Social Services departments in 149 Councils with Adult Social Services Responsibilities (CASSRs) in England. Directors of participating authorities were asked to nominate a member of staff, typically a commissioning or performance manager, to coordinate the survey response as well as to arrange for care manager responses to the second part of the survey.

Prior to approaching local authorities to invite participation, the research team obtained support from the Association of Directors of Adult Social Services (ADASS) and ethical approval from the Social Care Research Ethics Committee (SCREC). Local authority research governance leads were also contacted to ensure that any additional guidelines at the local level were adhered to. The survey was conducted on a confidential basis: the identity of participating authorities and individual respondents was collected for administrative purposes and to match up responses to both parts of the survey, but was kept confidential and has not been included in the outputs of the study.

LOCAL AUTHORITY QUESTIONNAIRE

The first part of the survey was collected using a Microsoft Excel spreadsheet in order to facilitate completion by multiple members of staff within participating authorities. Authorities involved in the pilot phase suggested that the range of

data collected by the survey would require most councils to consult a number of departments and staff members, which would be difficult to orchestrate using a web-based survey. A printable copy of the Excel questionnaire is available as an appendix at the end of this document.

Since reporting mechanisms vary widely between local authorities (as was found to be the case during the pilot study), the local authority survey was designed to be as flexible as possible in the way it collected data. Where client and expenditure levels were requested, an option was included to provide sample-based estimates where complete population figures could not be sourced. Notes fields were also included adjacent to all questions to allow for additional clarification or comments where necessary.

CARE MANAGER QUESTIONNAIRE

The care manager questionnaire presented a range of vignettes, clustered by user group (older people aged 65 and above, younger adults aged 64 and below with a physical disability, younger adults with a learning disability and younger adults with mental health needs), via an online survey using the Survey Monkey website (http://www.surveymonkey.com). Participating authorities were asked to arrange for responses to be provided by three care managers for each user group, in order to standardise responses within each authority. Care managers were asked to respond only to the sections of the survey that related to user groups they usually carry out assessments for.

The vignettes described a basic level of information about individuals' physical and mental health needs, social participation, living arrangements and receipt of informal care. While such information is limited in its ability to covey the volume or detail of information collected in a full assessment process, it is broadly in keeping with the type of information available from household survey data commonly used to populate projection models for estimating future levels of demand for care services.

For each vignette, respondents were asked to specify which of the four FACS bands they felt most closely applied to the individual described, and whether they would be eligible to receive an ongoing care package (excluding equipment and adaptations) according to their council's existing eligibility policy. If there was not enough information to pick an answer, respondents were asked to select a 'not sure' option and to describe which answers were most likely, and what further information would have been required in order to be able to provide an answer.

At the end of the survey, respondents were invited to add any additional comments about the survey, their responses or the application of FACS criteria in

general. Participants were also asked to specify whether they were happy for their (anonymised) responses to be shared with their local authority.

RESPONSE RATE

Invitations to participate in the survey were sent to Directors of 149 CSSRs in England. In total, 85 local authorities (57% of those invited to participate) took part in one or both parts of the survey. Where cited, the reason for non-response was generally linked to a lack of resources and to constraints in terms of the availability of the relevant data. Authorities were encouraged to participate in as much of the survey as their resources and reporting mechanisms would allow. There is likely to be an under-representation of local authorities with more restrictive reporting systems to whom the survey would have presented a greater challenge, although characteristics such as authority size and level of social care provision used as weighting dimensions will help to account for such bias.

Response rates have been analysed according to a range of local authority characteristics including local authority type, geographical region, deprivation and population-weighted provision of social care. Survey findings have been weighted in order to account for differences in response rates according to these factors.

As TABLE 1 shows, response rates were highest among metropolitan districts and shire counties, with a notable under-representation of inner London authorities. The lower participation rate among London authorities might be linked to their smaller size and more limited resources available for taking part in the survey.

TABLE 1: RESPONSE RATE BY TYPE OF LOCAL AUTHORITY

Authority type	Invited to participate	Participated (N)	Participated (%)
Shire County	29	19	66%
Metropolitan District	36	23	64%
Outer London	19	11	58%
Unitary Authority	52	26	50%
Inner London	13	6	46%
Total	149	85	57%

Geographically, responses were reasonably well distributed with at least 50% of authorities represented in all regions except for the East Midlands (44%) (see

TABLE **2**).

TABLE 2: RESPONSE RATE BY GEOGRAPHICAL AREA

Region	Invited to participate	Participated (N)	Participated (%)
West Midlands	14	10	71%
South East	18	11	61%
Yorkshire and the Humber	15	9	60%
North East	12	7	58%
North West	23	13	57%
East	11	6	55%
South West	15	8	53%
London	32	17	53%
East Midlands	9	4	44%
Total	149	85	57%

The 2010 Index of Multiple Deprivation (Department for Communities and Local Government 2010) provides a range of summary measures of deprivation at the local authority level. Quintiles based on the population weighted average of the combined ranks for all Lower Super Output Areas (LSOAs) in each authority have been applied to the 149 authorities that were invited to participate in the survey. Response rates were highest within the least deprived 30 authorities (63% response rate), and decreased with each quintile group to a 48% rate of response within the most deprived group of authorities (**TABLE 3**).

TABLE 3: RESPONSE RATE BY DEPRIVATION QUINTILE

Deprivation quintile	Invited to participate	Participated (N)	Participated (%)
1 (least deprived)	30	19	63%
2	30	19	63%
3	30	16	53%
4	30	17	57%
5 (most deprived)	29	14	48%
Total	149	85	57%

According to total population size, response rates were highest among the largest authorities (**TABLE 4**). Analysis by decile (rather than quintile) group shows this

to be largely driven by the largest 10% of authorities, more than 85% of which responded to the survey.

TABLE 4: RESPONSE RATE BY LOCAL AUTHORITY POPULATION QUINTILE

Total population quintile	Invited to participate	Participated (N)	Participated (%)
1 (smallest)	30	15	50%
2	30	14	47%
3	30	20	67%
4	30	15	50%
5 (largest)	29	21	72%
Total	149	85	57%

As shown in **TABLE 5**, Authorities with the lowest level of expenditure on social care per head of population were more likely to respond to the survey. This measure is based on 2010 total gross annual expenditure on home care, day care and residential and nursing care per head of population (all ages).

TABLE 5: RESPONSE RATE BY TOTAL GROSS SOCIAL CARE EXPENDITURE PER CAPITA QUINTILE

Expenditure per capita quintile	Invited to participate	Participated (N)	Participated (%)
1 (lowest)	30	19	63%
2	30	17	57%
3	30	17	57%
4	30	16	53%
5 (highest)	29	16	55%
Total	149	85	57%

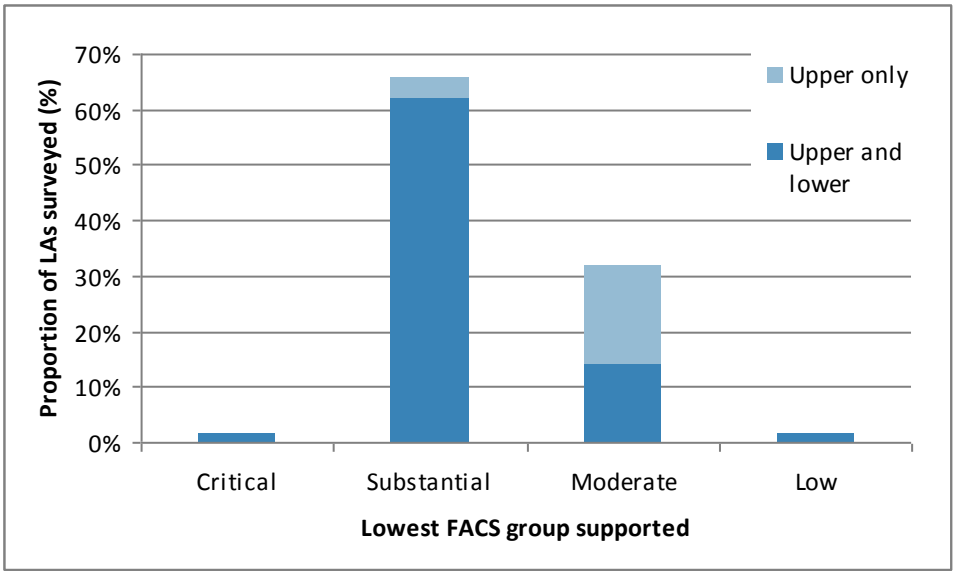
SURVEY FINDINGS – PART 1: RESULTS FROM THE LOCAL AUTHORITY AGGREGATE SURVEY

ELIGIBILITY POLICIES

While government guidelines provide a basic framework for FACS assessment, eligibility policies are set individually by local authorities. These are not always defined purely in terms of the four FACS bands – 22% of participating authorities use other criteria to create additional categories of need (usually in terms of upper and lower 'substantial' or 'moderate' categories).

Authorities were asked to specify whether individuals in each of the four FACS groups are 'always', 'sometimes' or 'never' eligible for publicly-funded care packages according to their current policy (notwithstanding factors such as financial eligibility and availability of informal care). Two thirds of those surveyed (67%) have set their eligibility policy to cover clients in the top two FACS groups (critical and substantial) only (see FIGURE 1). Nearly all of the remainder (32% of all participating authorities) provide services to clients with critical, substantial and moderate needs. Within this group, however, fewer than half provide care packages to *all* clients within the moderate FACS group eligible for services: most had introduced 'higher' and 'lower' moderate categories in order to set an eligibility threshold that dissects the moderate need group. These authorities are represented by the lighter shaded areas in FIGURE 1, which illustrates the distribution of local authorities according to the lowest FACS group to which they provide services.

FIGURE 1: LOWEST NEED FACS GROUPS SUPPORTED BY LOCAL AUTHORITIES



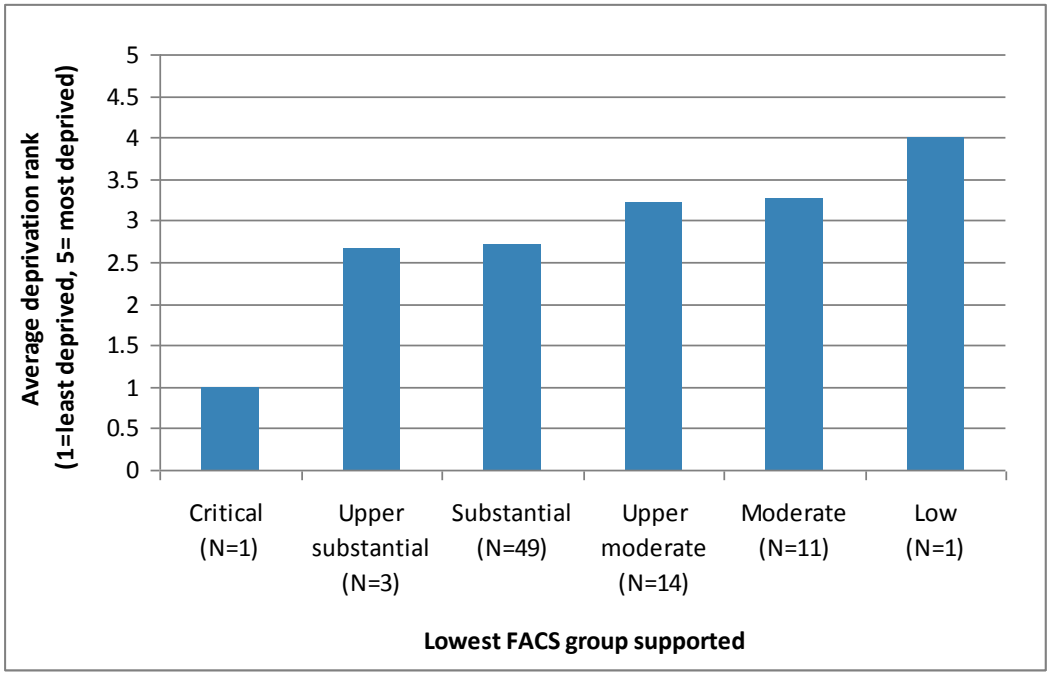
While the authorities categorised as 'critical' and 'substantial' in **FIGURE 2** are generally consistent with the policies stated on local authority websites, three quarters of the participating authorities that indicated users with moderate needs were 'sometimes' considered eligible for services had policies that included only critical and substantial needs according to their web sites. Based on the client volumes reported, however, the numbers of supported individuals within the 'moderate' category are relatively modest in these cases. Eleven authorities noted that they would use their discretion from time to time to provide services to individuals below the existing eligibility threshold where exceptional circumstances arose, although the client distributions and care manager responses suggest this to be more widespread (findings from the second part of the survey provide further insight into the way individual eligibility is determined).

Local eligibility policies are under constant review and the figures provided in this report only provide a snapshot of the national picture. Approximately 4 out 5 authorities (both respondents and non-respondents) had set their eligibility threshold at substantial or above on their websites at the time of the survey, and 2% supported clients with critical needs only. This represents a notable tightening in thresholds since the 2008 CSCI report *Cutting the Cake Fairly*, which noted that 70% of councils had set their minimum eligibility threshold at substantial and 2% at critical in 2007/8. In the previous financial year, the proportion of authorities supporting only substantial or greater needs had increased from 53% to 62% (CSCI 2008). Four local authorities that participated in the survey commented that their eligibility policy has changed over the past 12 months – in all cases the authority has moved to a more restrictive policy (since this information was not explicitly sought by the survey, it is likely that additional authorities have recently undergone a change in eligibility policy over this time period).

While ineligible to receive an ongoing care package, clients that do not meet local authorities' eligibility criteria are usually signposted to third-sector agencies or other sources of support, advice or guidance. Clients with lower levels of need may also receive one-off or short-term care where there is considered to be a risk of deterioration of the needs of the person. In identifying the FACS groups supported, 22 authorities added a comment to emphasise that they also invested in preventative and early-intervention services for some low- and moderate-need clients, delivered primarily through the voluntary sector.

As illustrated in FIGURE 2, Local authorities with the most inclusive eligibility policies have on average a higher deprivation ranked score (generally associated with a higher prevalence of disability within their population) than those with more restrictive eligibility thresholds. The survey results do not suggest a correlation between eligibility policies and population size, region or authority type.

FIGURE 2: AVERAGE DEPRIVATION RANK BY LOWEST FACS GROUPS SUPPORTED



LEVELS OF PROVISION AND EXPENDITURE

Whereas levels of provision and expenditure by user group are routinely reported by local authorities, there is little available evidence about how services are currently distributed across FACS groups.

Participating authorities were asked to provide a breakdown of the number of individuals and the corresponding levels of expenditure within each FACS group. These figures were provided broken down by user group (older people aged 65 and over, younger adults with a physical disability, younger adults with a learning disability, younger adults with mental health needs, and those in the other/asylum category). Where possible, we asked for clients to be assigned to a single FACS category according to their highest assessed level of need, with all expenditure counted against that category. Where exact figures could not be produced, local authorities were asked for a sample-based estimate to be provided.

Just over 20% of responding local authorities reported that they are unable to provide a breakdown of clients by FACS group, mostly due to the nature of the recording systems used (methods of recording assessment information are covered later in this report). One authority also commented that the FACS group associated with individual clients are not generally seen as important beyond

determining whether or not they were eligible for receipt. As such, reporting by FACS group is not often seen as a priority for adult social care departments.

Of those authorities that did provide a distribution of clients, nearly two thirds (62%) indicated that their figures were derived from a sample or other estimate. Availability of expenditure data was significantly more limited: a little over half of the participating authorities (55%) were able to disaggregate expenditure by FACS group. Furthermore, some local authorities that were able to apportion expenditure to FACS groups were only able to do so at the *need* level rather than the individual *level* (such that expenditure relating to one individual may be split across multiple FACS groups). This presents an important caveat when approximating expenditure per client for each group, since client and expenditure figures are not strictly comparable in all cases.

Across all user groups and authorities, clients with critical needs accounted for 35% of all supported clients on the basis of the available data. As TABLE 6 and FIGURE 3 show, there is some variation between user groups, with a larger concentration of critical clients within the learning disabilities category (42% of care recipients) than the other user groups.

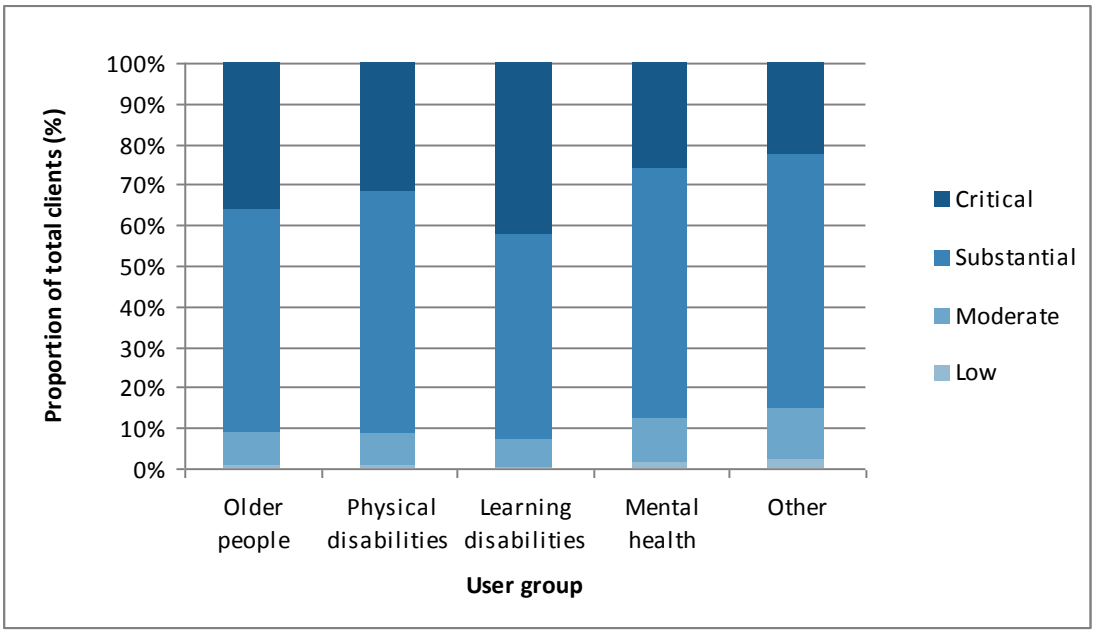
The focus of this part of the survey was on the allocation of ongoing care packages, excluding one-off or short-term care or assistance such as equipment, adaptations and re-ablement. The distributions shown in TABLE 6 and FIGURE 3 should therefore not be used to draw inferences about the provision of preventative and low-level services within the FACS system.

TABLE 6: DISTRIBUTION OF CLIENTS BY FACS GROUP

	Older People	Physical disabilities	Learning disabilities	Mental health	Other
Critical	36%	32%	42%	26%	23%
Substantial	55%	60%	51%	61%	62%
Moderate	8%	8%	7%	11%	13%
Low	1%	1%	1%	1%	2%

The column totals do not always add to 100% due to rounding error.

FIGURE 3: DISTRIBUTION OF CLIENTS BY USER AND FACS GROUP



Not surprisingly given the higher intensity of the support they receive, the proportion of total expenditure accounted for by critical needs group for all user groups exceeds the proportion of cases with critical needs (see TABLE 7 and FIGURE 4). Across all participating local authorities, older people assessed as having moderate or low needs account for over 9% of all older people in receipt of services but only 5% of total expenditure within the same age group.

TABLE 7: DISTRUBUTION OF EXPENDITURE BY FACS GROUP

	Older People	Physical disabilities	Learning disabilities	Mental health	Other
Critical	49%	45%	47%	36%	39%
Substantial	46%	50%	48%	51%	52%
Moderate	4%	4%	5%	12%	7%
Low	1%	1%	1%	1%	1%

The column totals do not always add to 100% due to rounding error.

FIGURE 4: DISTRUBUTION OF TOTAL GROSS EXPENDITURE BY FACS GROUP

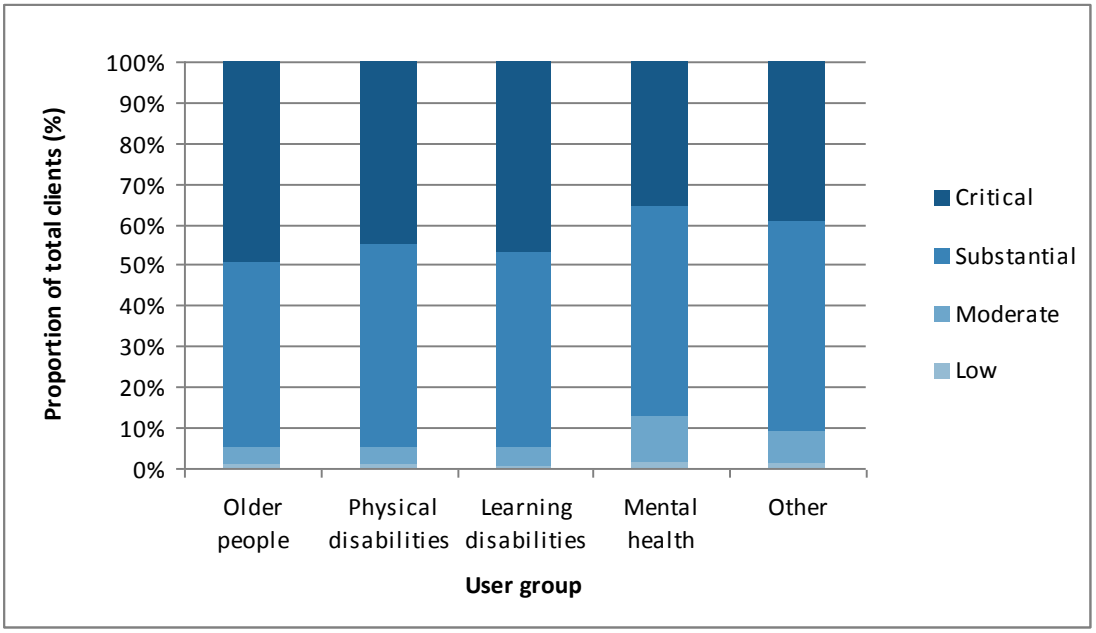


TABLE 8 provides an approximation of expenditure per client on the basis of reported client and expenditure numbers. It should be noted that this provides only an approximation of average expenditure per client: some authorities were only able to report expenditure at the *need* level rather than the *client* level. Consequently, some of the expenditure reported against lower FACS groups might in fact have been incurred by users with higher levels of need.

Since not all authorities support clients in all four FACS groups, it should also be noted that not all figures are based on the same sample when comparing across FACS groups. Where cell counts are particularly low (most notably within the low FACS groups and the *other* user group), the mean estimate of expenditure per user is particularly susceptible to outliers. Median values (also shown in Figure 8) provide a less volatile picture of the relationship between FACS group and expenditure based on median values, although these show somewhat lower average values than expenditure expressed as a mean figure[1].

[1] Mean values are more sensitive than median values to the costs presented by outliers. Small numbers of clients requiring very intensive care services often have a highly level of impact on total expenditure within an authority.

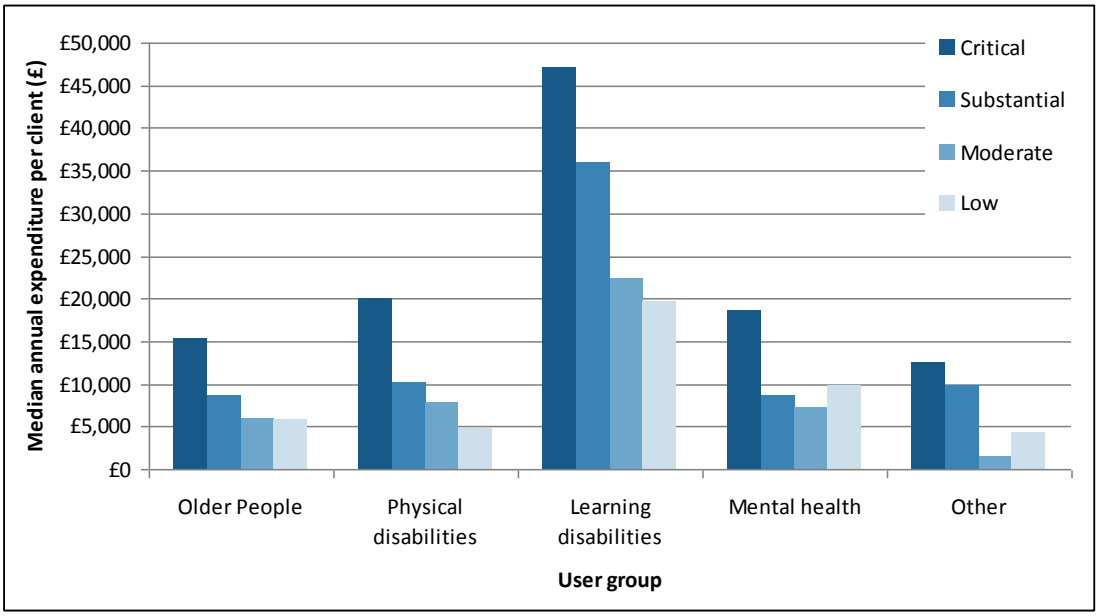
TABLE 8: MEAN AND MEDIAN ANNUAL GROSS LOCAL AUTHORITY EXPENDITURE PER CLIENT BY USER AND FACS GROUP

	Older People	(N)	Physical disabilities	(N)	Learning disabilities	(N)	Mental health	(N)	Other	(N)
					Mean annual expenditure per client (£)					
Critical	£18,144	40	£19,308	40	£48,662	39	£65,232	37	£24,989	29
Substantial	£11,268	39	£11,406	39	£33,215	39	£30,064	36	£36,774	30
Moderate	£9,940	29	£10,647	28	£30,694	25	£26,969	27	£18,910	16
Low	£11,881	20	£5,804	12	£32,666	13	£22,486	14	£15,412	9
					Median annual expenditure per client (£)					
Critical	£15,483	40	£20,163	40	£47,860	39	£19,829	37	£12,669	29
Substantial	£9,052	39	£9,738	39	£34,640	39	£9,839	36	£8,883	30
Moderate	£6,298	29	£7,699	28	£23,518	25	£7,619	27	£1,790	16
Low	£6,483	20	£3,722	12	£13,564	13	£9,818	14	£4,333	9

Note: results exclude one outlier

Within the older people, physical disabilities and mental health user groups, median expenditure per eligible client with critical needs is around twice that of the substantial user group, with the differential in expenditure per client being less pronounced further down the FACS scale. Within the learning disabilities and other user groups, a more significant drop in median care package expenditure is evident between the substantial and moderate eligibility categories.

FIGURE 5: MEDIAN ANNUAL EXPENDITURE PER CLIENT BY USER AND FACS GROUP



Authorities with the most inclusive eligibility policies generally supported a larger number of clients per capita, although there were exceptions to this rule. The ability to infer disparities in coverage according to eligibility policy is significantly constrained by the convergence of authorities towards a 'substantial or higher'

threshold, not least as support for clients with moderate needs, where offered, is often low.

In the absence of longitudinal data, it is difficult to determine the impact of shifts in eligibility policy in terms of client numbers and expenditure at the local authority level. Some authorities noted that policy changes are generally only applied to new clients, whereas clients already on the books often continue to receive services regardless of their standing against current eligibility thresholds. It is reasonable to assume, therefore, that the full impact of changes to eligibility thresholds at the local level is unlikely to be visible in the short term. The volume of clients below eligibility thresholds that are supported by councils on a discretionary basis are also likely to be highest within authorities with more restrictive eligibility criteria, since they will have a greater volume of clients at high risk of escalating needs.

ASSESSMENT OF ELIGIBILE NEEDS

Participating local authorities were asked a series of questions about the assessment tools and processes used alongside FACS guidelines to determine eligibility and the means by which this information was recorded.

Nearly all participating authorities responded that eligibility is determined on a discretionary basis following general FACS guidance, rather than on the basis of a rigid points-based system. Only a handful of authorities employ algorithms to determine eligibility, either on the basis of risk and impact matrices or dependency scores weighted by informal care availability. In addition to the immediate needs identified, authorities emphasised a focus on addressing the risk to independence and of deterioration of need if care services are withheld.

Eighty-eight per cent of authorities reported that they use a standard assessment process across the authority, with 65% using the same assessment form for all user groups. The majority (62%) reported that toolkits are used to assess eligible needs. Most of these were developed or adapted in-house, although nearly half (48%) of all authorities that make use of toolkits reported using FACE assessment toolkits for assessing at least some user groups.

Most authorities reported that information on dependency, informal support, mental health and risk is collected in a standardised format during the assessment process for all user groups (figures vary - see FIGURE 6 AND FIGURE 7). Levels of standardisation are highest for older people and younger adults with physical disabilities, with information more commonly recorded in a non-standardised way in assessments of adults with mental health needs and those in the ‘other/asylum’ category. Of the dimensions of need listed in the questionnaire, risk of deterioration is the least commonly recorded area. The

level of detail recorded often varies according to the types of need identified during assessment and the complexities of individual cases.

FIGURE 6: COLLECTION OF STANDARDISED INFORMATION ON PHYSICAL AND HOUSEHOLD TASKS AND INFORMAL CARE RECEIPT, BY USER GROUP

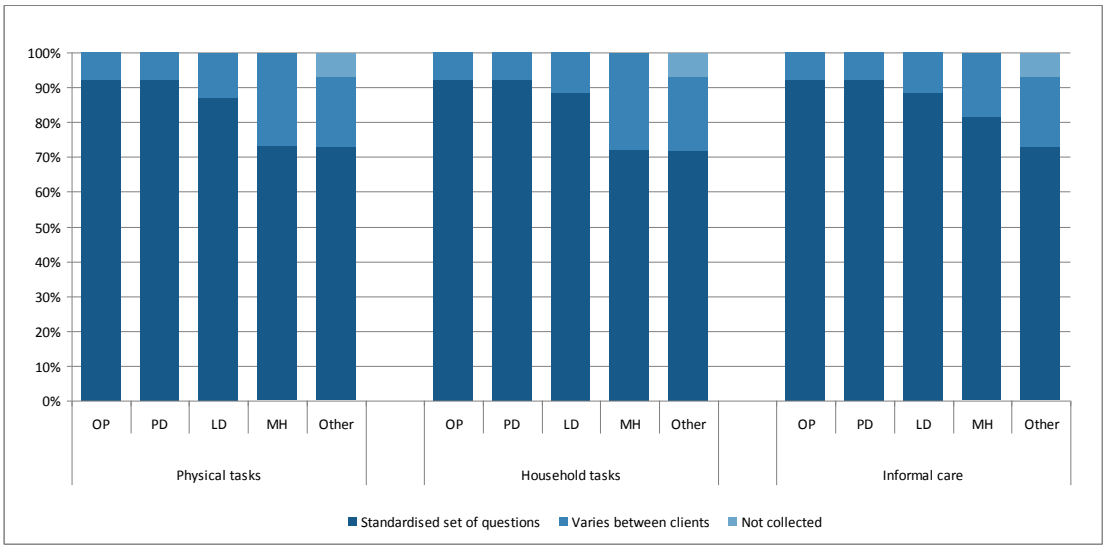
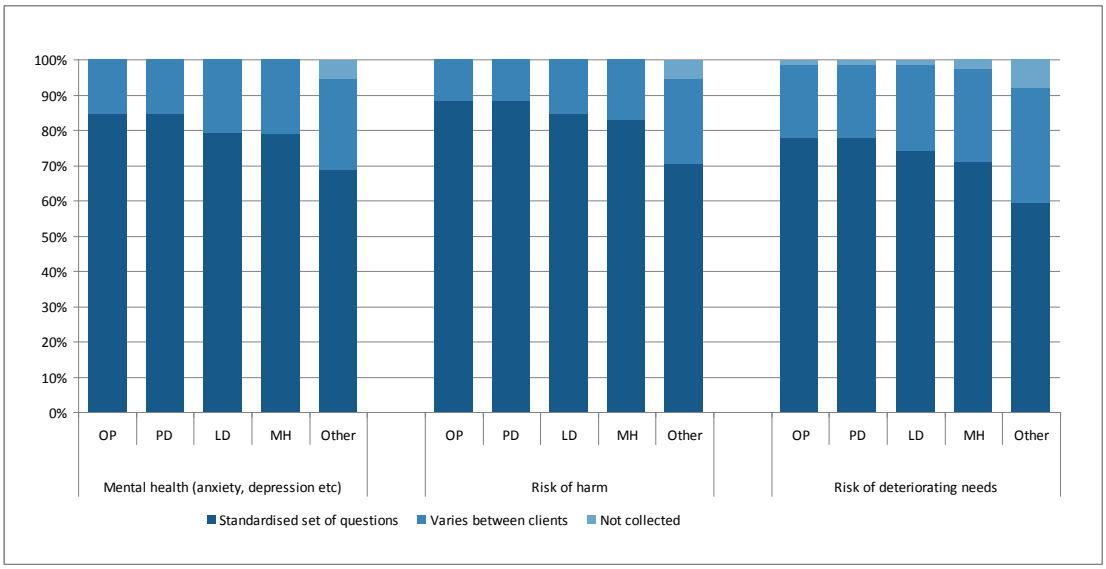


FIGURE 7: COLLECTION OF STANDARDISED INFORMATION ON MENTAL HEALTH AND RISK OF HARM OR DETERIORATING NEEDS, BY USER GROUP



Nearly all authorities indicated that the size and nature of client care packages are determined according to the Resource Allocation System (RAS) independently of clients' FACS banding, although the latter is inherently indicative of the level of support required.

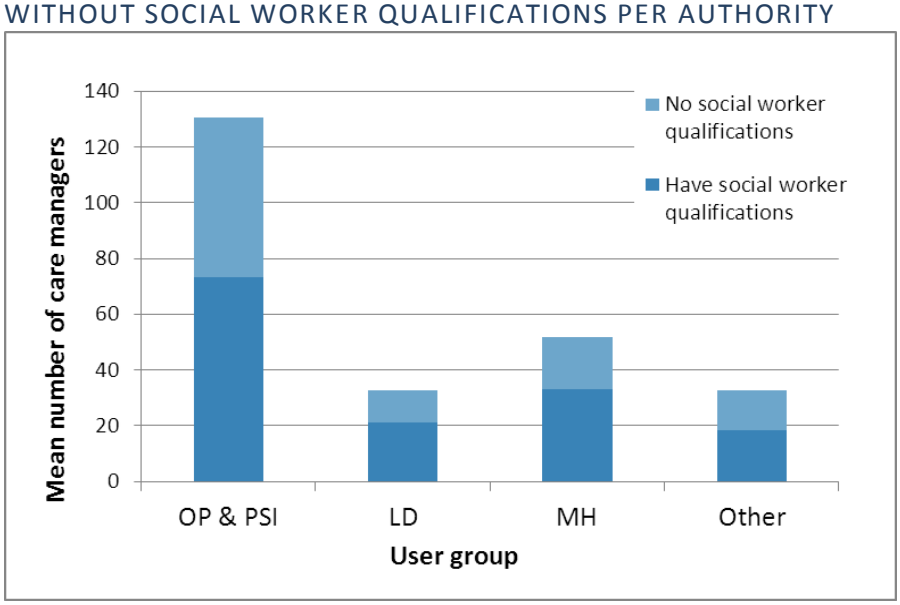
Mechanisms employed by authorities to record assessment information vary largely, which goes some way to explaining the difficulties encountered in collecting consistent information about clients and expenditure. While little over

a third of authorities (36%) specified that they store assessment information using a standardised database (such as Microsoft Access), all but 5% of the remainder noted that information is stored electronically on a bespoke records system (in total, 95% indicated that information is recorded on either a standardised dataset or other electronic recording system; the remainder rely on paper and word processed documents). A number of client management packages are used, by far the most common being CareFirst and SWIFT. Five authorities added that information corresponding to users with mental health needs is stored on a separate system to allow for greater accessibility between health and social care teams.

The link between care managers and different client groups varies between authorities. Generally, assessments for older people and adults with physical or sensory impairments are conducted by a common group of care managers. In some authorities the same assessment team also provided assessments for people with learning disabilities. The definition of client groups used for determining the professionals in charge of assessing a client's needs does not always overlap with the classification of client groups used by local authorities when reporting data. For instance, clients with particular needs such as learning disabilities will generally be assessed by a specialist learning disability assessor regardless of age group.

As FIGURE 8 illustrates, just over half of care managers providing assessments of clients in each category are reported to be qualified social workers. Some respondents pointed out that assessment teams frequently encompassed a range of job titles beyond that of "care manager", including community care workers, occupational therapists, social workers and social worker/care manager. Many of these staff roles do not require GSCC registration.

FIGURE 8: AVERAGE NUMBERS OF CARE MANAGERS WITH AND WITHOUT SOCIAL WORKER QUALIFICATIONS PER AUTHORITY



Whereas assessments for older people and adults with physical or sensory impairments are usually carried out in-house, assessments for other groups (in particular clients with mental health needs) are often provided by specialist teams outside the authority.

SURVEY FINDINGS – PART 2: RESULTS FROM THE CARE MANAGER SURVEY

Responses to all of the client vignettes in terms of the associated FACS need group were spread across more than one of the four FACS band, although in most cases there was an overall consensus as to the applicable band, or a split between two adjacent FACS bands. From a data modelling perspective, this allows us to refine current assumptions about how individuals with different characteristics are likely to be assessed under current guidelines.

It is important to note certain caveats when considering the responses to the vignettes. The results are likely to overstate the level of variation that would be observed in a real life situation and on the basis of full assessments as usually carried out by care managers. Whereas the vignettes included in the study were refined following the pilot phase of the survey to include as many pertinent details as possible, it is an inherent limitation of this form of study that it cannot realistically replicate all the elements of a real-life holistic assessment of needs:

> *'These (vignettes) are based on very limited information and not a full assessment - it is the full assessment that may take place over several visits and in different places that helps set the FACs criteria - the impact of the difficulties is hard to assess from the statements as is the motivation and individual resources to be able to effect change.'*
>
> *'It is always difficult to make accurate judgements on limited information and without seeing the person/people concerned in their home environments.'*
>
> *'It is difficult to establish eligibility without carrying out a proper criteria assessment. This needs time and face to face contact in their own environment to get a clearer picture of the issues.'*
>
> [Care manager feedback]

There are also limitations in that we can only look at the characteristics at a given point in time. Following assessment it will often be appropriate to prescribe lower-level forms of support (such as equipment or adaptations) before re-assessing to ascertain whether this has been sufficient to meet an individual's needs:

> *'Before final decisions are taken about longer-term needs for support, and whether those needs are eligible for local authority support, councils should always consider whether a period of re-ablement or intermediate care should be made available, in order to maximise what people can do for themselves before further assessment of needs is undertaken.'*
>
> *'The evaluation of a person's needs should take full account of how needs and risks might change over time and the likely outcome if help were not to be provided. This should include consideration of the impact upon the person of changes in the circumstances of any carer(s). Assessment is often most effective when conducted as an iterative and ongoing process rather than a one-off event.'*
>
> [Department of Health, 2010]

This is important to take into account when considering how responses to the survey are formulated, and in comparing the FACS band assigned to each vignette with the judgement over eligibility for long-term care. While an individual may have a high level of presenting needs (which may deem them eligible for care *prima facie* according to local guidelines), a care manager may consider them to be ineligible for an *ongoing care package* if their needs are likely to be met through other forms of support such as informal care, equipment and adaptations or signposting to other services:

> *'Most of the cases would come under FACS Substantial at the time of referral. However, following the provision of a short term enablement and equipment/adaptations including Telecare, those service users would probably be re-assessed as FACS Moderate, as the risks would have decreased and the needs met.'*
>
> [Care manager feedback]

These caveats aside, it is clear that applying FACS criteria to individuals following assessment is widely seen as a subjective process and that there is often seen to be a lack of certainty as to how those presenting needs should be categorised:

> *'Application of FACS continues to be quite subjective depending on the assessor's interpretation of the information gathered/given. This continues to be an issue among professionals, it would be helpful to think of some ways to standardise this.'*
>
> *'Eligibility criteria are not clear and it often feels like a lottery as to whether somebody is accepted for a care package or not.'*
>
> *'FACS is a valuable guideline for identifying the needs & risks involved and as a way for Social Services to provide a consistent approach to customers. However there are always exceptions and every case does not necessarily fit easily within categories. Professional judgement & discretion is also*

essential to ensure that criteria are not followed rigidly to the detriment of customers.'

'Interpretation of the criteria can often be difficult and subjective.'

'There is not a formalised way of assessing FACS eligibility and very much depends on individual practitioners viewpoint - application of the criteria is therefore not consistent and there are likely to be lots of people not receiving social care that I would consider eligible, and people in receipt of social care that I would not consider eligible. Like most health and social care assessments it is highly subjective.'

'The eligibility criteria [are] at times not applied consistently as there are many services users who have historically received a service, but are not eligible. This creates a difficulty when thorough assessments are completed and an individual is deemed ineligible, however because of historical agreements, continue to receive a service. It is also very difficult to change the mindset of workers who think that people should receive a service 'just because' which makes it difficult when social workers deem someone ineligible.'

[Care manager feedback]

Much of this feedback is of a similar nature to the views described in reports by Henwood and Hudson (2008) and CSCI (2008), which cited problems with the consistent interpretation and application of FACS criteria across teams and user groups.

At the national level, the results show a greater degree of variation in terms of prescribing eligibility to receive services than they do in terms of assigning individuals to FACS groups. This is expected, since in practice FACS banding should be universal across authorities, whereas eligibility policies are set at the local level:

'Local discretion means that there may be variation in the response of different councils to individuals with similar levels of need. However, if councils base their approach to needs on achieving outcomes rather than providing specific services, then people with similar needs within the same local authority area should expect to receive a similar quality of outcome, according to their individual circumstances and the aspirations of each individual.'

[Department of Health, 2010]

Responses to the vignettes showed an apparent correlation between the eligibility policies set by local authorities and the level at which their care managers banded individuals. In many of the case studies, care managers in

authorities with tighter eligibility policies were more likely to assign case studies a higher FACS banding than care managers from authorities with more inclusive policies. Although this effect was most visible in vignettes where responses were split more or less equally between two categories (such as substantial and moderate), it is also apparent when all responses are aggregated across all vignettes by user group.

FIGURE 9 to FIGURE 12 show the distribution of grouped responses to all vignettes in each of the four user groups by eligibility policy, which span a range of combinations of need-related circumstances for each client group. As mentioned above, the probability of vignettes being categorised as substantial or above within each user group summarised in FIGURE 9 to FIGURE 12 are highest within authorities with the most restrictive eligibility policies. In practice, this could indicate a propensity to up-rate client needs ratings among care managers from authorities with more stringent eligibility policies.

FIGURE 9: DISTRIBUTION OF RESPONSES TO ALL 'OLDER PEOPLE' VIGNETTES*

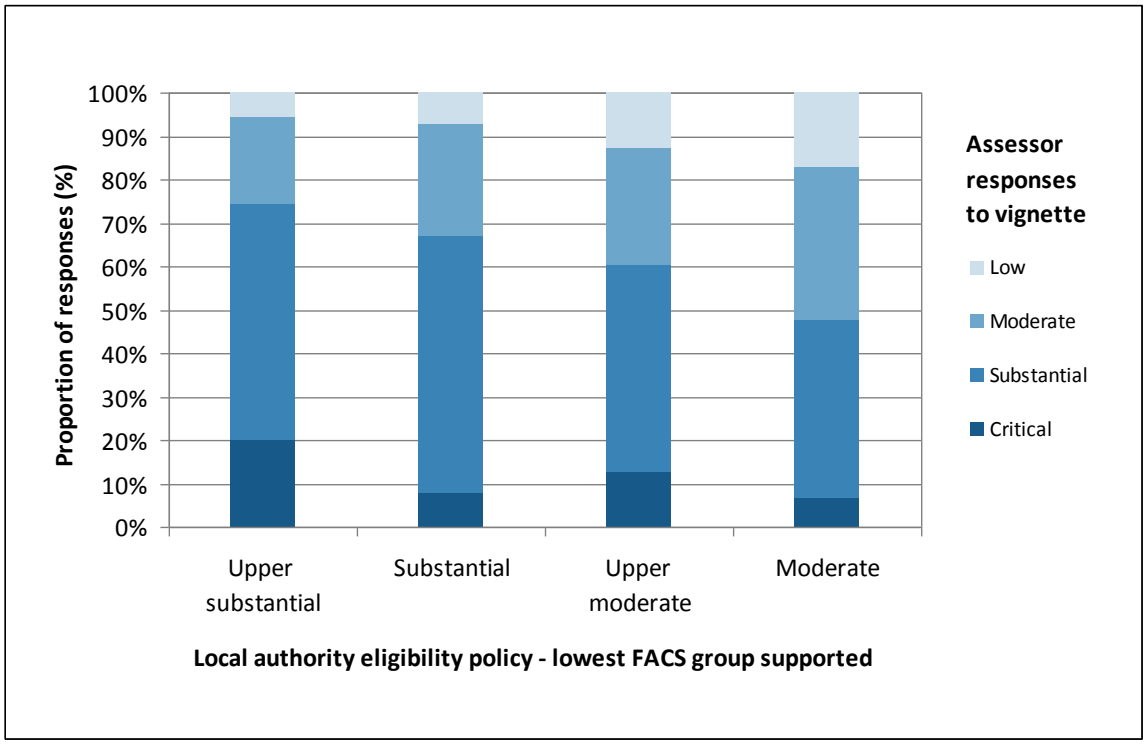


*Chart excludes 'not sure' responses

FIGURE 10: DISTRIBUTION OF RESPONSES TO ALL 'ADULTS WITH A PHYSICAL DISABILITY' VIGNETTES*

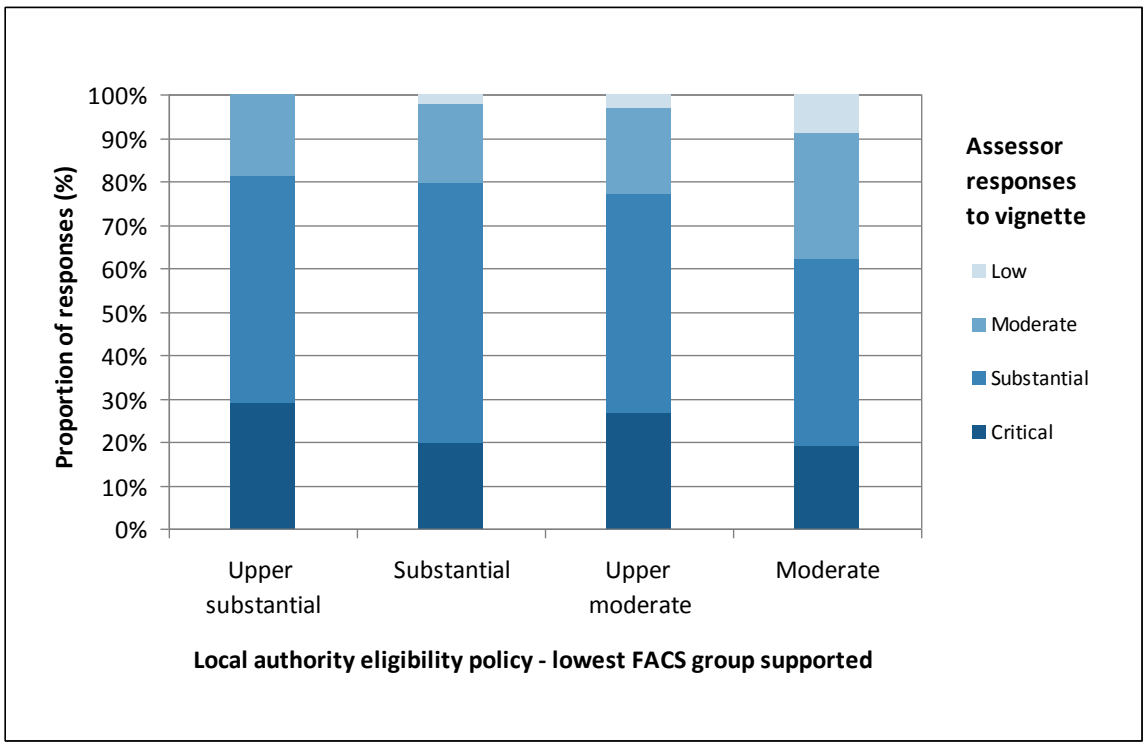


*Chart excludes 'not sure' responses

FIGURE 11: DISTRIBUTION OF RESPONSES TO ALL 'ADULTS WITH A LEARNING DISABILITY' VIGNETTES*

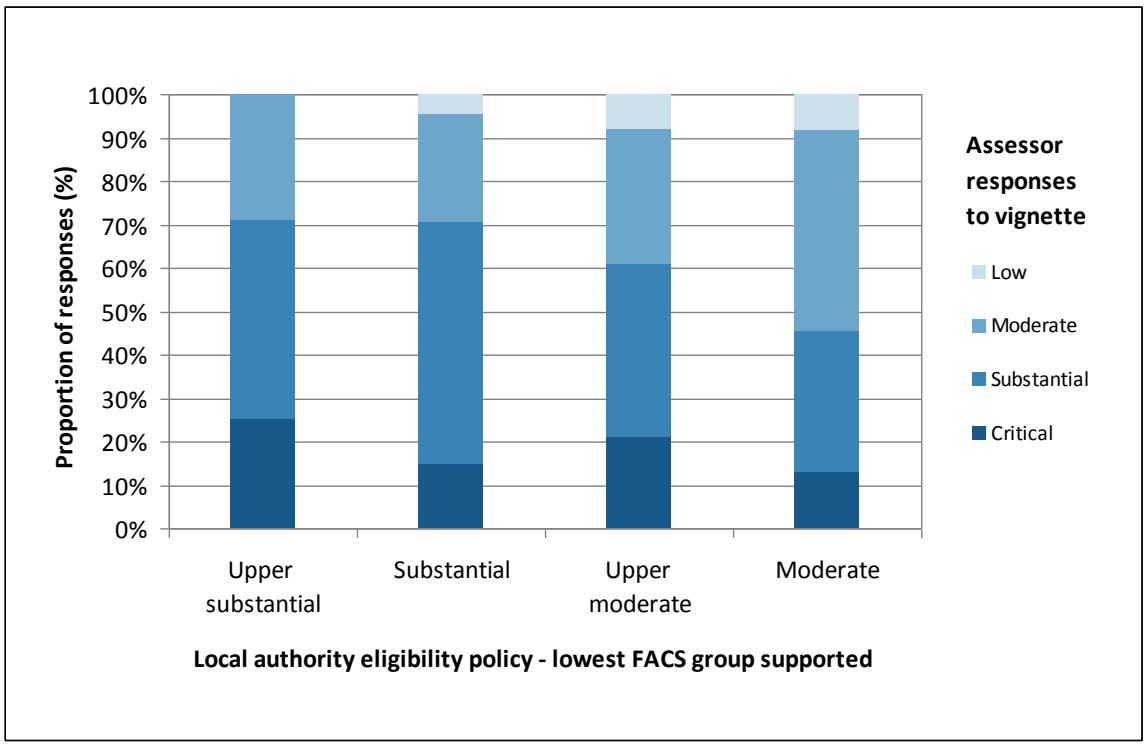


*Chart excludes 'not sure' responses

FIGURE 12: DISTRIBUTION OF RESPONSES TO ALL 'ADULTS WITH MENTAL HEALTH NEEDS' VIGNETTES*

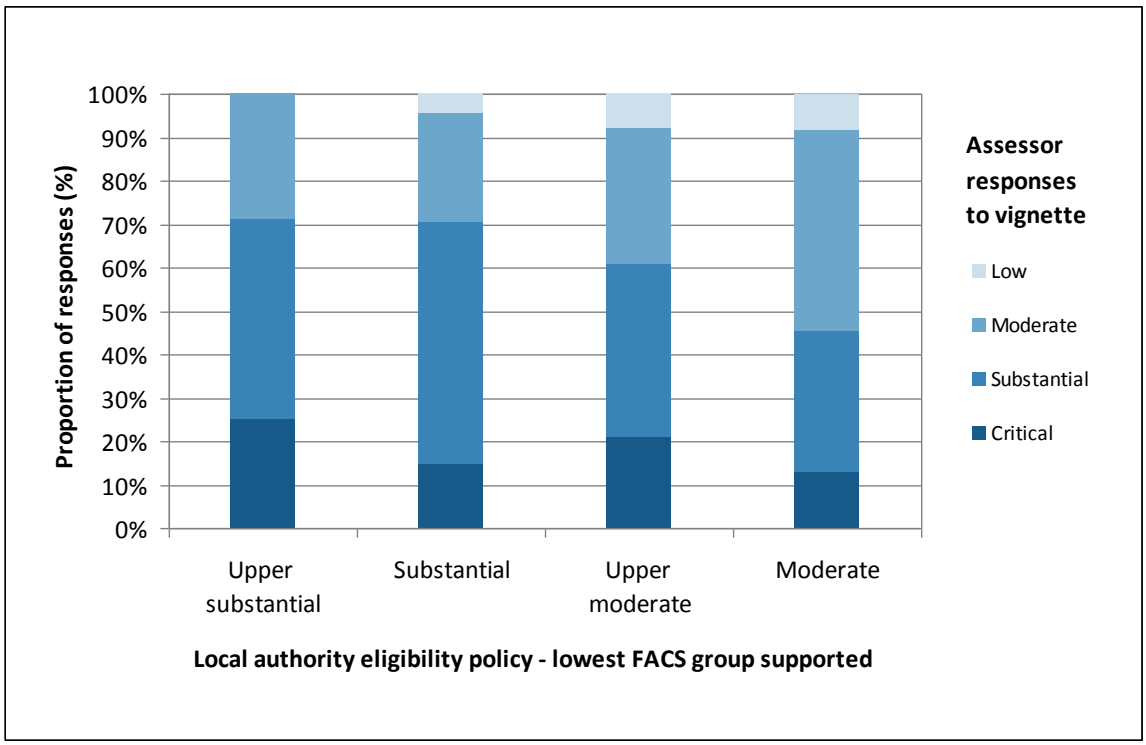


*Chart excludes 'not sure' responses

In their 2008 report *Cutting the Cake Fairly*, CSCI reported that 'respondents [to an online survey] also acknowledged that staff 'bent the rules' to ensure people got the help they need' (CSCI 2008). Whereas the patterns in FIGURE 9 to FIGURE 12 do not suggest necessarily the "bending" of rules by care managers, they suggest systematic differences in the perception of FACS group membership between care managers of authorities with varying eligibility thresholds.

Results were also heterogeneous *within* local authorities, although further investigation is needed to establish the extent to which this is indicative of within care manager heterogeneity or just reflect information limitations associated with the use of vignettes.

CARE MANAGER VIGNETTES

The following section provides the full description of each vignette included in the care manager survey followed by a visual summary of responses.

The "doughnut" charts that follow the case study descriptions illustrate the distribution of answers given by care managers to the questions of the most

appropriate FACS band and the likelihood of eligibility for services according to the policy currently in place within the care manager's authority.

The bar charts provide a breakdown of FACS group responses (excluding 'not sure') by the eligibility policy in place within authorities. The valid ('N') numbers correspond to the number of care managers that provided a response.

The correlation between the eligibility policy at the local level and the grading of individuals by care managers is most evident in the vignettes to which responses are most diverse. Responses to the first vignette in the 'older people' user group are predominantly split between 'substantial' and 'moderate', care managers in authorities with more restrictive policies in place being clearly more likely to attribute a higher FACS rating than those offering more generous policies. In cases such as the third 'older people' vignette, where there is more agreement on the appropriate FACS rating, no clear pattern emerges.

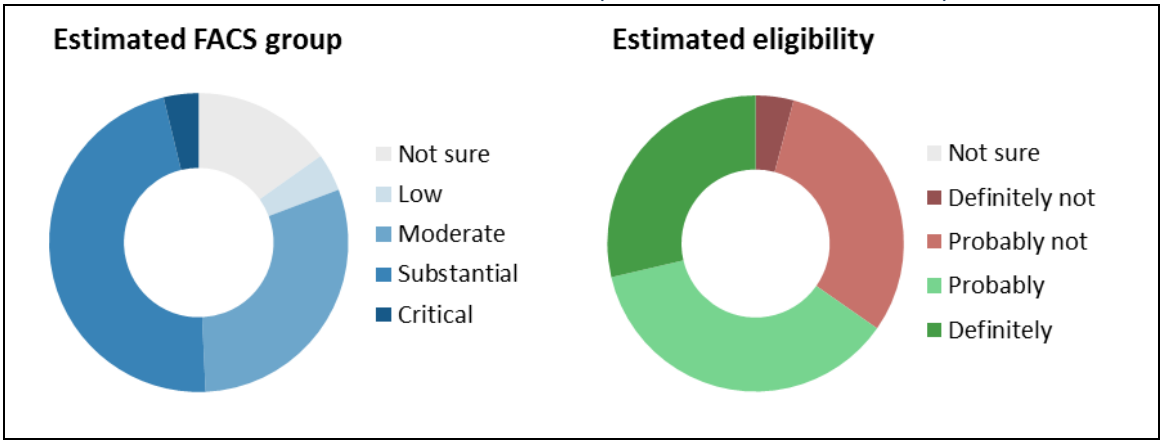
As noted, the level of detail included in the case descriptions provided in the survey is far removed from that which is accumulated in a face-to-face assessment, and as such a substantial degree of uncertainty is expected in the results. It is nonetheless surprising that responses to nearly *all* of the vignettes cover the entire range of FACS bands, suggesting significant disparities in how individual cases are graded.

OLDER PEOPLE – VIGNETTE 1

Mrs A, aged 94, lives alone and has recently been discharged from hospital after suffering a fall in the garden. She has a perching stool installed in her bathroom but can no longer bathe without help, and says that she finds it hard getting in and out of bed and going to the toilet although she currently receives no help to do so.

Since Mrs A finds it difficult to walk long distances, a close neighbour has started to help with shopping and comes in every day to check on her, but otherwise she doesn't really get any visitors. She says that she often feels lonely, but has lived in her home since her 40s and doesn't want to move away.

ESTIMATED FACS GROUP AND ELIGIBILITY (ALL LOCAL AUTHORITIES)



ESTIMATED FACS GROUP BY LOCAL AUTHORITY ELIGIBILITY POLICY*

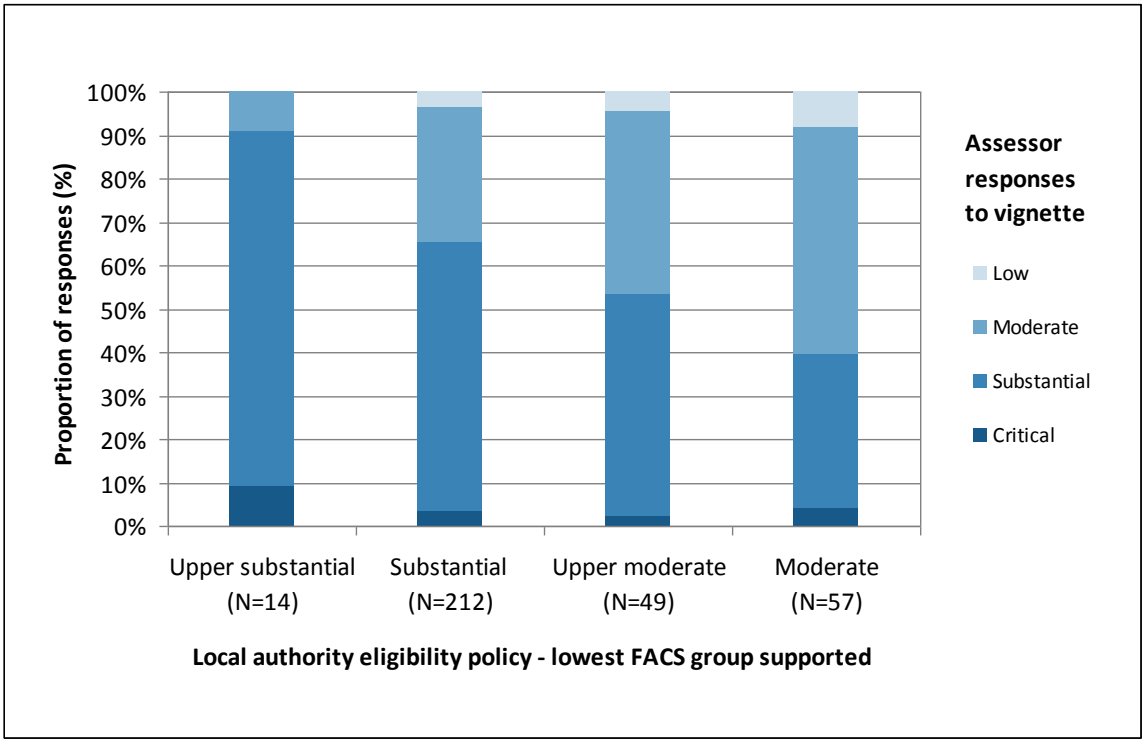
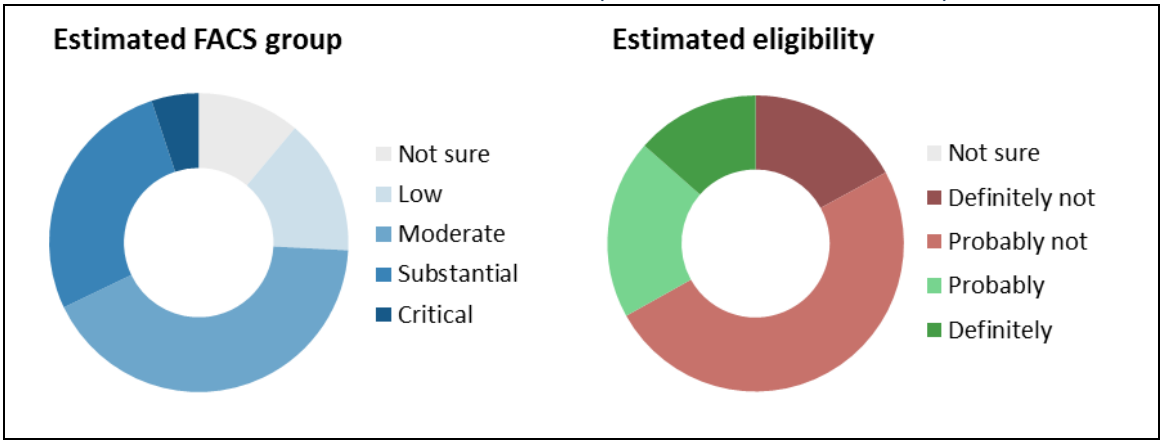


*Chart excludes 'not sure' responses

OLDER PEOPLE – VIGNETTE 2

Mr B, 86, is a widower of four years and suffers from the early stages of dementia. He has no real difficulties performing physical tasks, however his children (one of whom lives a mile away) are becoming increasingly worried about his condition. Mr B's daughter says that she bought him a bath alarm after he left the bath running on one occasion, but is now very anxious since he recently left the house with the oven on, prompting the fire brigade to turn up after neighbours were alerted to his smoke alarm. Mr B enjoys an active social life and likes to catch up with friends in his local pub; his children describe him as fiercely independent and say that he would hate any disruption to his routine.

ESTIMATED FACS GROUP AND ELIGIBILITY (ALL LOCAL AUTHORITIES)



ESTIMATED FACS GROUP BY LOCAL AUTHORITY ELIGIBILITY POLICY*

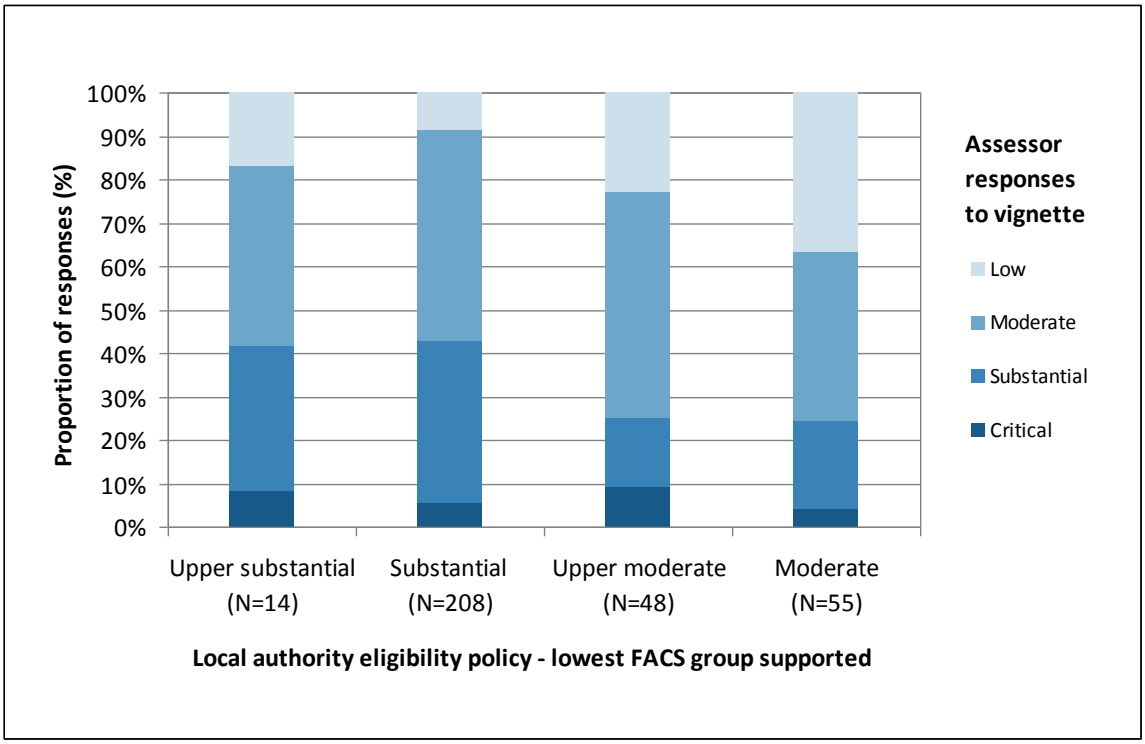


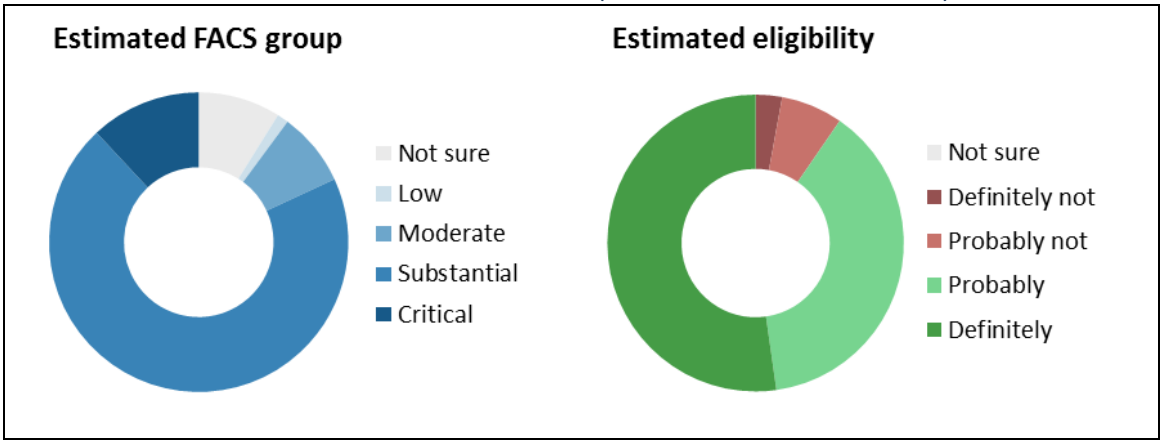
*Chart excludes 'not sure' responses

OLDER PEOPLE – VIGNETTE 3

Mr C, 66, was left blind and with mobility problems after suffering a stroke. He lives with his wife and the youngest of his children who is at secondary school. Mr C was referred by the hospital for home discharge planning.

Due to his disabilities he is unable to return to work, and needs help at home with personal care and daily living tasks. His family currently provide support with domestic and personal care. At present, his wife spends the equivalent of two days per week working in a local library.

ESTIMATED FACS GROUP AND ELIGIBILITY (ALL LOCAL AUTHORITIES)



ESTIMATED FACS GROUP BY LOCAL AUTHORITY ELIGIBILITY POLICY*

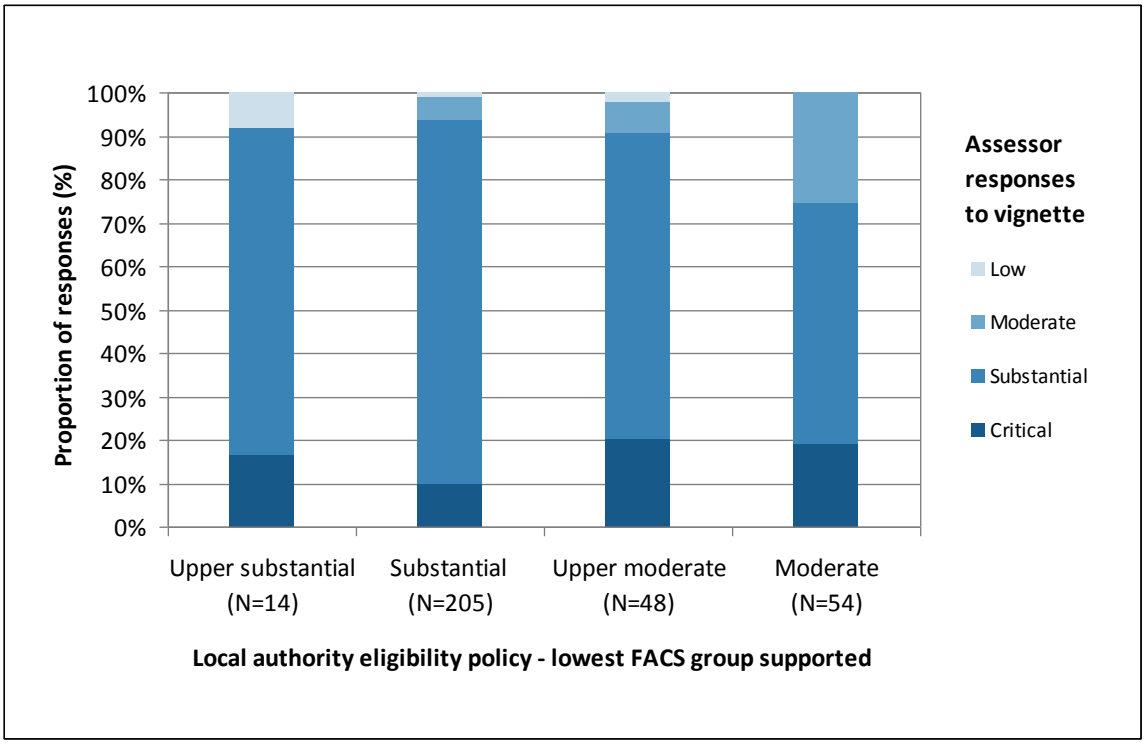


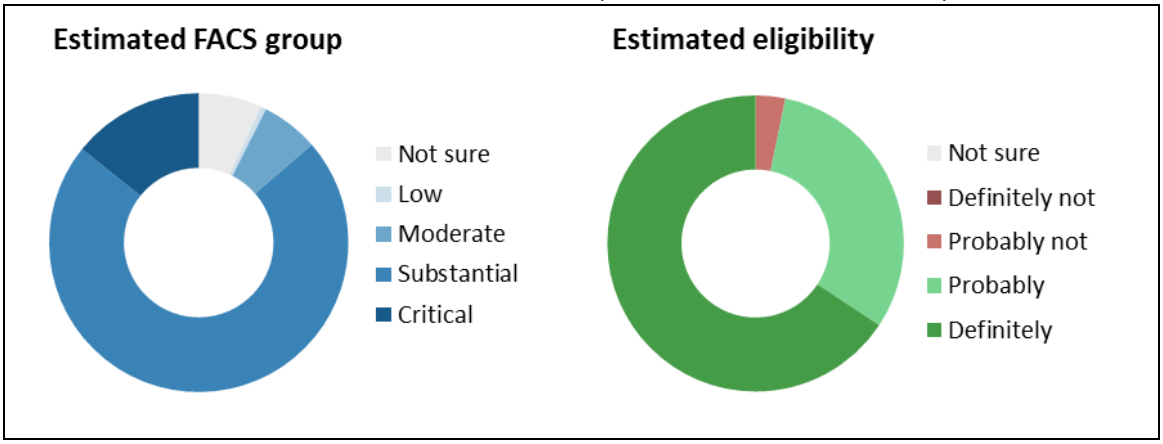
*Chart excludes 'not sure' responses

OLDER PEOPLE – VIGNETTE 4

Mrs D, 90, was admitted to hospital after a fall at church, in which she suffered bruised ribs and a fractured neck of femur. She is being discharged from hospital following successful rehabilitation.

Mrs D needs personal care assistance, and is showing signs of early stages of dementia. Her husband, with whom she lives, has been in contact as he feels he cannot cope with all of her physical needs as already struggling to carry out much of the work that she used to do around the house.

ESTIMATED FACS GROUP AND ELIGIBILITY (ALL LOCAL AUTHORITIES)



ESTIMATED FACS GROUP BY LOCAL AUTHORITY ELIGIBILITY POLICY*

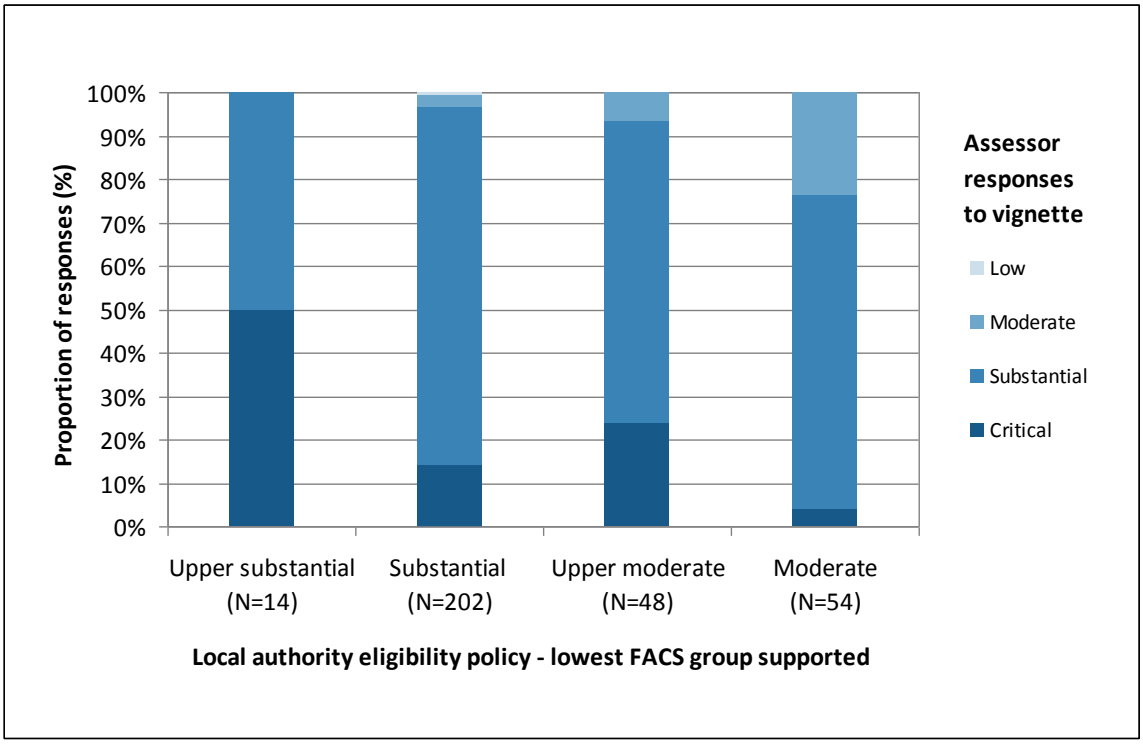


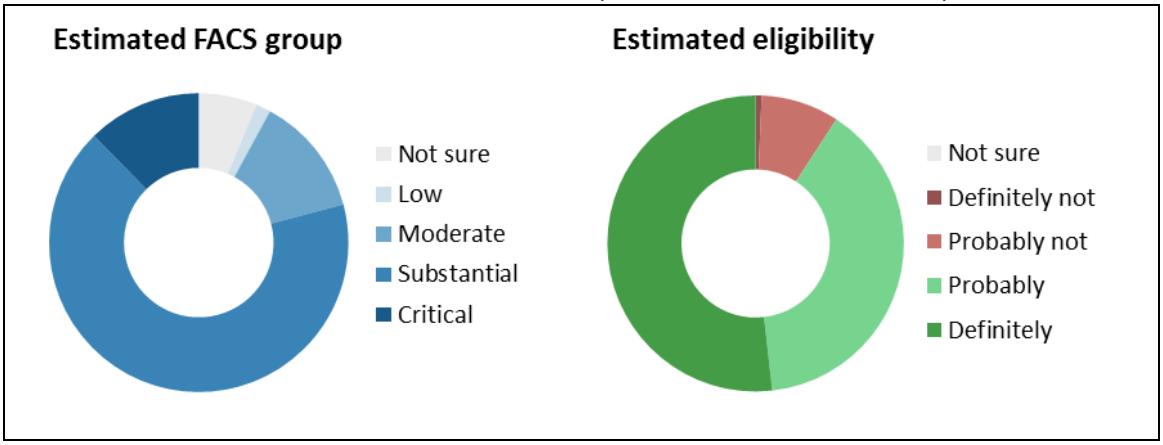
*Chart excludes 'not sure' responses

OLDER PEOPLE – VIGNETTE 5

Mrs E, aged 91, lives alone and has had two hip replacements and experiences ongoing mobility problems. She can move around her bungalow using a frame, but cannot bathe herself properly and struggles to get in and out of bed and to go to the toilet, which has been fitted with a seat raiser.

Mrs E suffers from pruritus (itchy skin) which has worsened since she has been unable to wash properly. A friend provides help with shopping and the odd bit of housework, but otherwise she doesn't really get any visitors. She does not describe herself as depressed, but often feels lonely.

ESTIMATED FACS GROUP AND ELIGIBILITY (ALL LOCAL AUTHORITIES)



ESTIMATED FACS GROUP BY LOCAL AUTHORITY ELIGIBILITY POLICY*

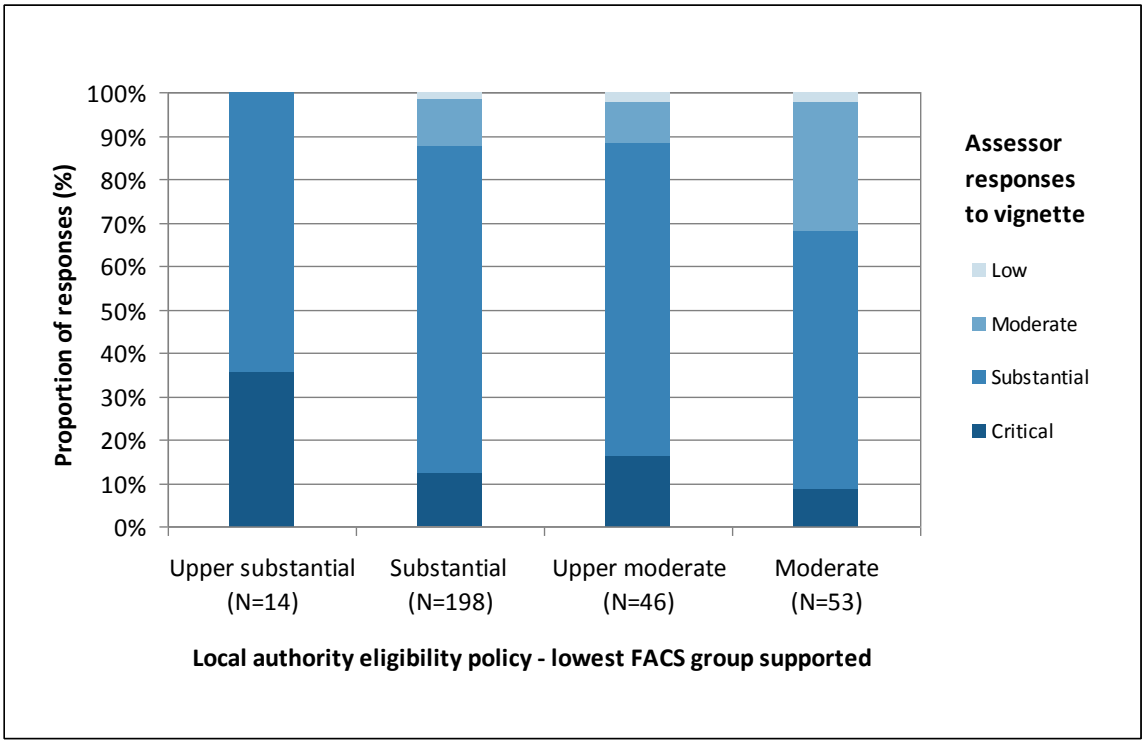


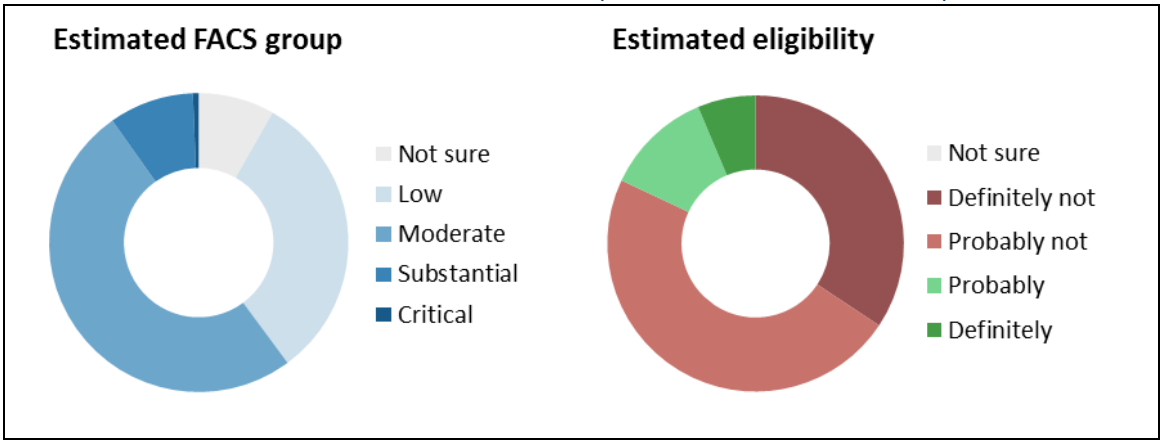
*Chart excludes 'not sure' responses

OLDER PEOPLE – VIGNETTE 6

Mrs F, aged 89, lives alone and has recently been discharged from hospital after suffering a fall at home. She manages to perform personal care tasks independently, albeit with some difficulty, and still manages to perform most basic household tasks.

Since Mrs F finds it difficult to walk long distances, she will no longer be able to travel further than her local shop which only stocks very basic provisions. The area in which Mrs F lives has no public transport links within easy access. She has no children and few surviving friends in the local area.

ESTIMATED FACS GROUP AND ELIGIBILITY (ALL LOCAL AUTHORITIES)



ESTIMATED FACS GROUP BY LOCAL AUTHORITY ELIGIBILITY POLICY*

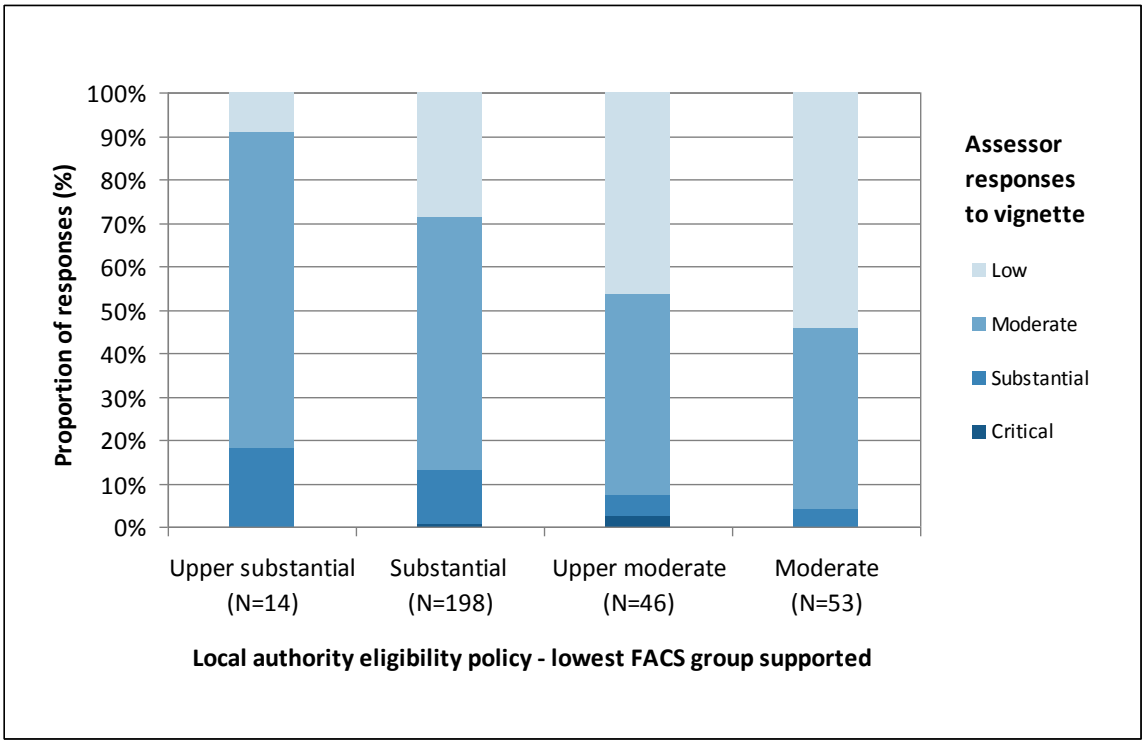


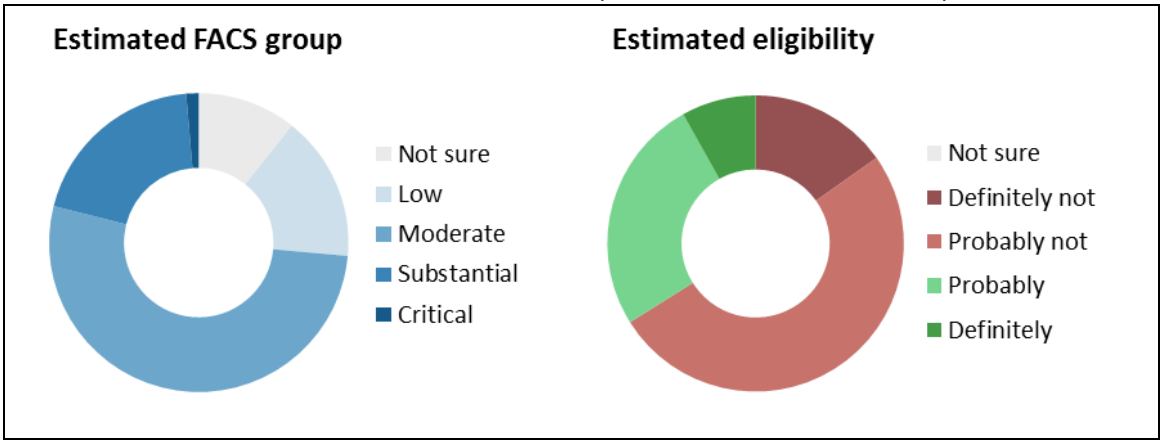
*Chart excludes 'not sure' responses

YOUNGER ADULTS WITH A PHYSICAL DISABILITY – VIGNETTE 1

Mr A, 24, been severely visually impaired since birth from congenital varicella syndrome. He recently moved away from his parents to a self-contained flat as he wants to live as independently as possible.

Mr A manages to carry out personal care tasks on his own with little difficulty, although he suffers from moderate incontinence and says that he needs some help with cleaning around the home, as well as assistance with finances and other paperwork.

ESTIMATED FACS GROUP AND ELIGIBILITY (ALL LOCAL AUTHORITIES)



ESTIMATED FACS GROUP BY LOCAL AUTHORITY ELIGIBILITY POLICY*

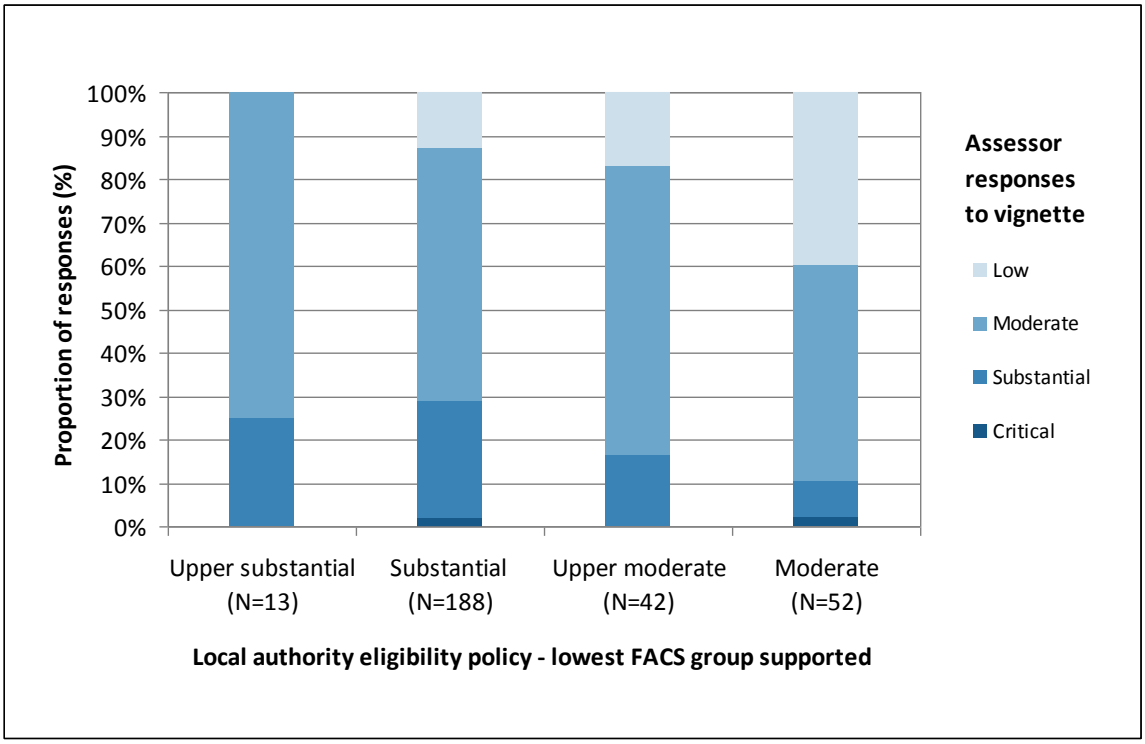
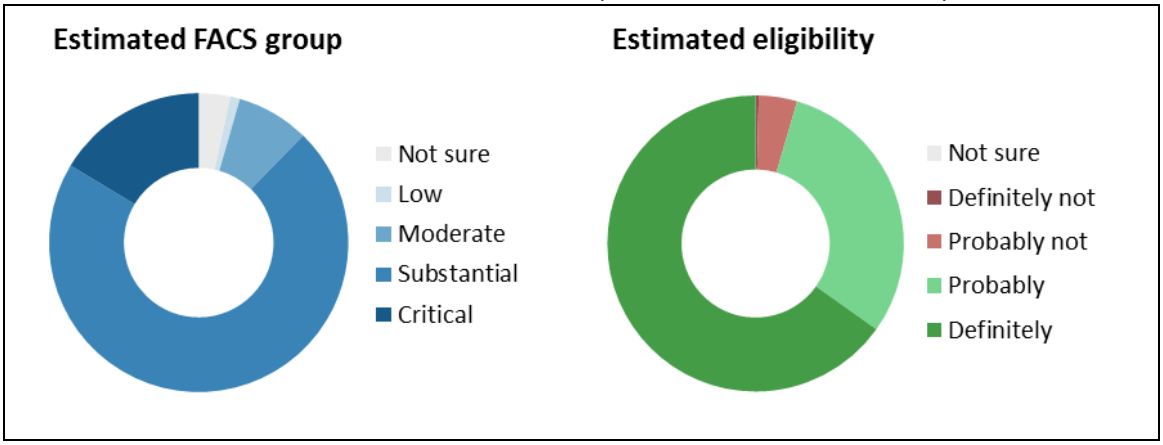


*Chart excludes 'not sure' responses

YOUNGER ADULTS WITH A PHYSICAL DISABILITY – VIGNETTE 2

Mrs B is aged 57 and lives alone. She is having increasing problems with mobility due to chronic arthritis. Currently she manages most personal care tasks with the help of her daughter, who lives at home. The daughter, however, is about to go to university and will only be able to visit once or twice a week. Without her, Mrs B probably will have great difficulty dressing, and will not be able to bathe properly. She needs help to do heavy housework, and is unable to do the weekly shopping alone. If Mrs B lacks help, she could well develop more serious health problems, and her ability to live independently at home will be severely compromised.

ESTIMATED FACS GROUP AND ELIGIBILITY (ALL LOCAL AUTHORITIES)



ESTIMATED FACS GROUP BY LOCAL AUTHORITY ELIGIBILITY POLICY*

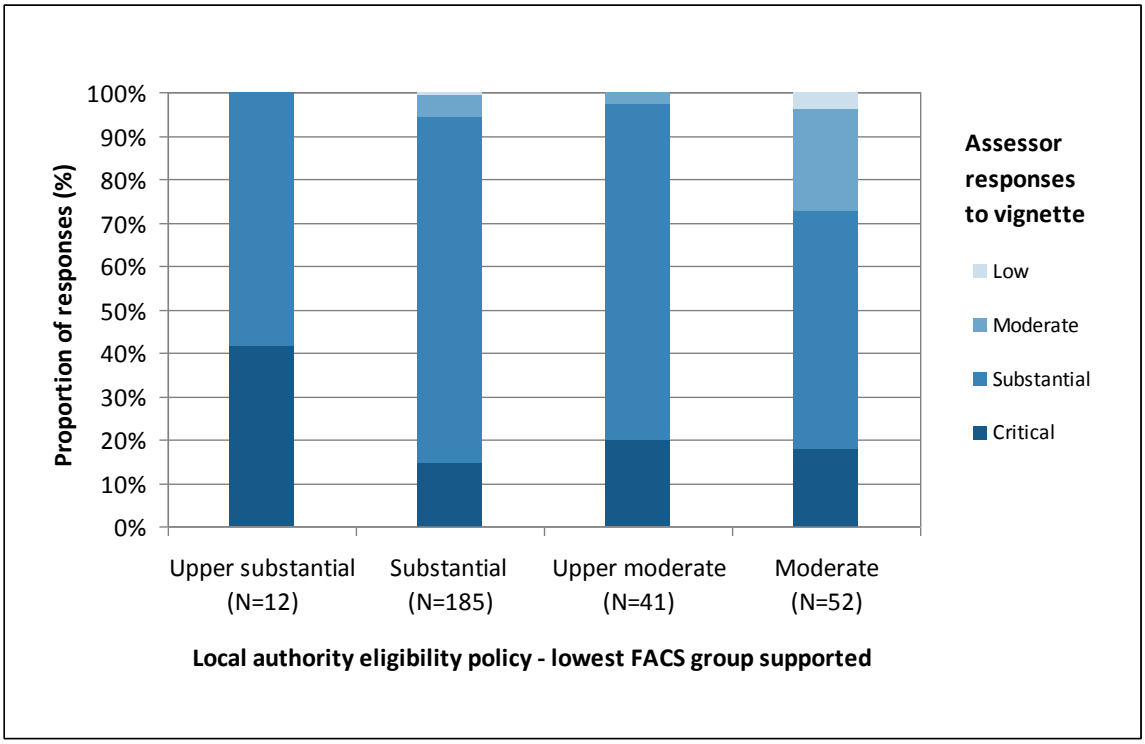


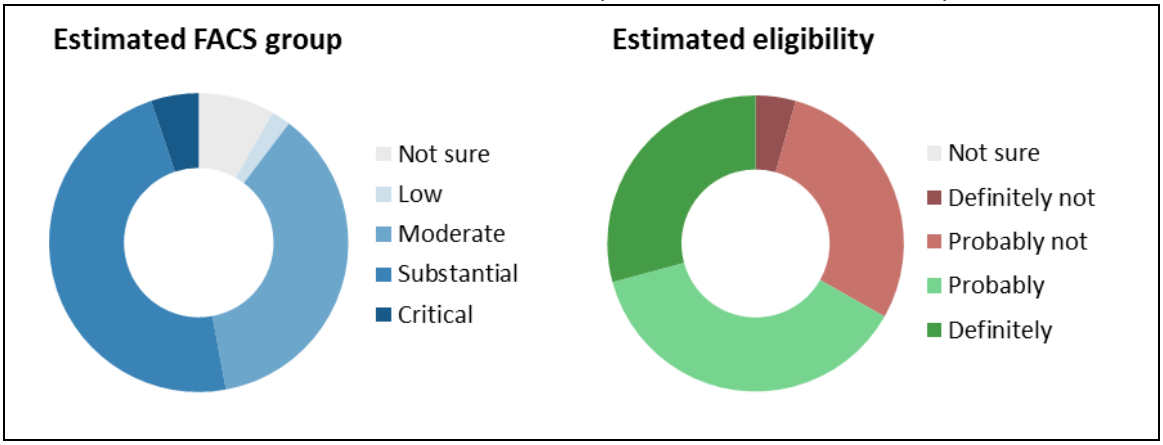
*Chart excludes 'not sure' responses

YOUNGER ADULTS WITH A PHYSICAL DISABILITY – VIGNETTE 3

Mr C, 55, was diagnosed with multiple sclerosis in his early forties. Due to the progression of his illness, he is unable to work and as he has very little energy, is reliant on help from his daughter, with whom he lives, with most household tasks including cleaning, cooking and shopping. As she is still at school, however, he wants some help around the home to take the pressure off his daughter.

Mr C currently manages personal care tasks fairly independently. He is sometimes depressed due to his lack of independence, and says that he feels guilty about the level of reliance on his daughter.

ESTIMATED FACS GROUP AND ELIGIBILITY (ALL LOCAL AUTHORITIES)



ESTIMATED FACS GROUP BY LOCAL AUTHORITY ELIGIBILITY POLICY*

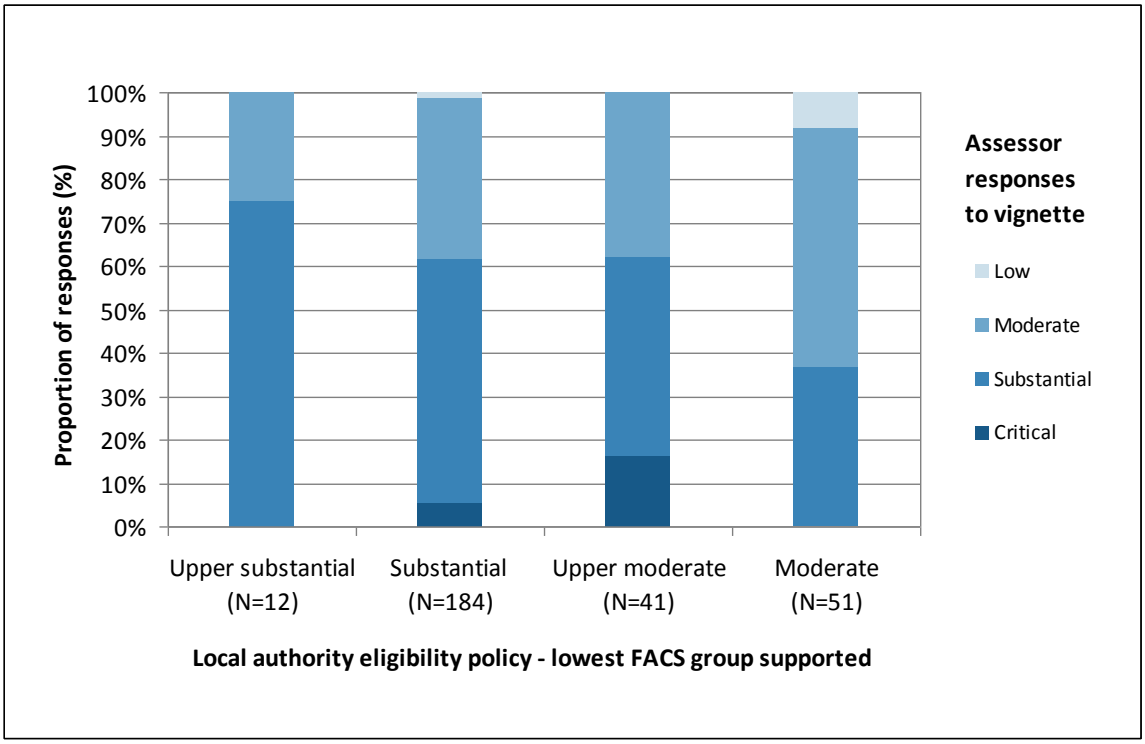
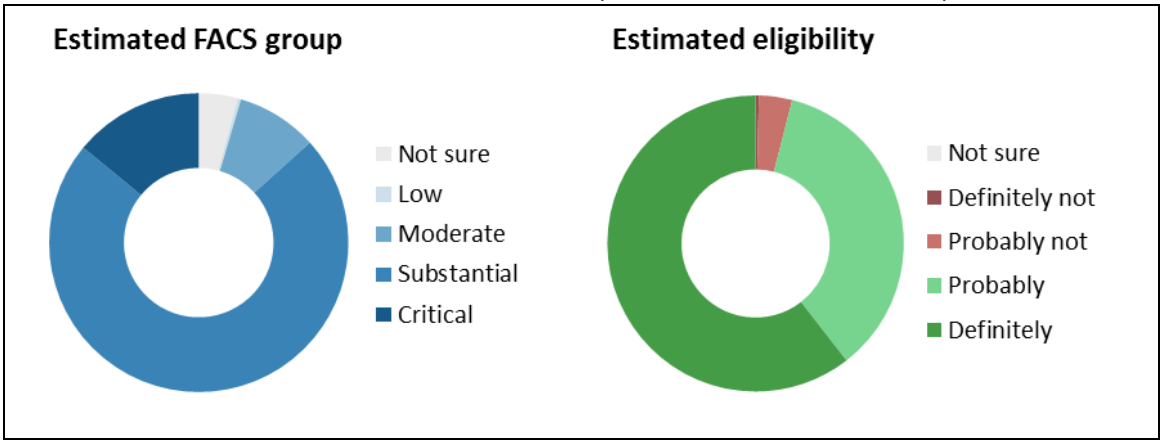


*Chart excludes 'not sure' responses

YOUNGER ADULTS WITH A PHYSICAL DISABILITY – VIGNETTE 4

Ms D, 47, has had rheumatoid arthritis from a young age and has always relied on support from her parents with personal care tasks. She has had a number of adaptations fitted at home to help with bathing and getting up and down the stairs, but finds it very difficult getting in and out of bed and dressing without any help. Her father died four years ago, and her mother now struggles to help with physical tasks since she now has worsening mobility problems due to arthritis.

ESTIMATED FACS GROUP AND ELIGIBILITY (ALL LOCAL AUTHORITIES)



ESTIMATED FACS GROUP BY LOCAL AUTHORITY ELIGIBILITY POLICY*

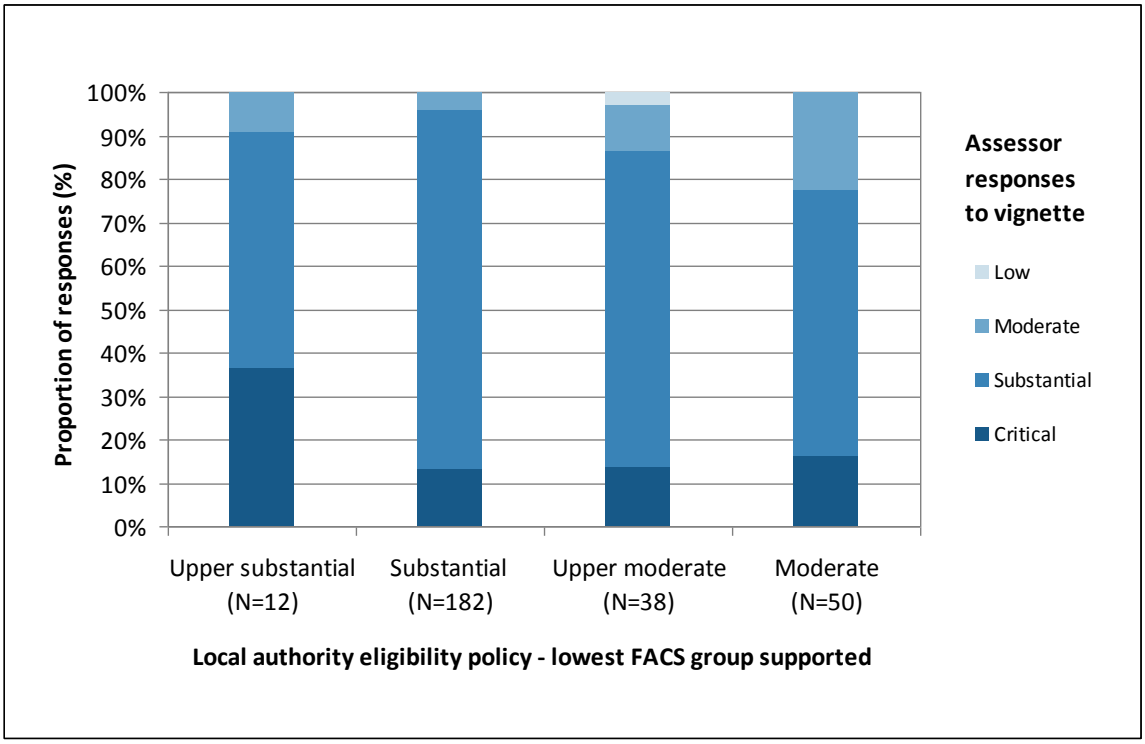


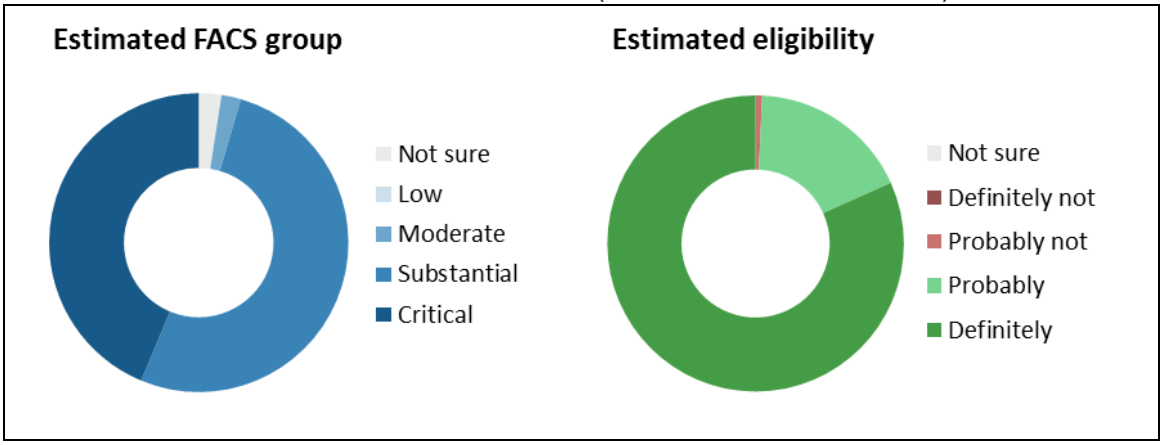
*Chart excludes 'not sure' responses

YOUNGER ADULTS WITH A PHYSICAL DISABILITY – VIGNETTE 5

Mr E, 57, suffers from motor neurone disease and is increasingly reliant upon his wife, with whom he lives, for both personal and household support as his condition progresses. While his wife has managed to provide assistance so far, she is now struggling to provide the level of help that he needs, as she struggles to lift him easily and therefore has difficulty helping him to get in and out of bed, use the toilet and wash effectively.

The couple has a tight network of friends and family nearby, but no one else that is able to provide regular ongoing help with personal care.

ESTIMATED FACS GROUP AND ELIGIBILITY (ALL LOCAL AUTHORITIES)



ESTIMATED FACS GROUP BY LOCAL AUTHORITY ELIGIBILITY POLICY*

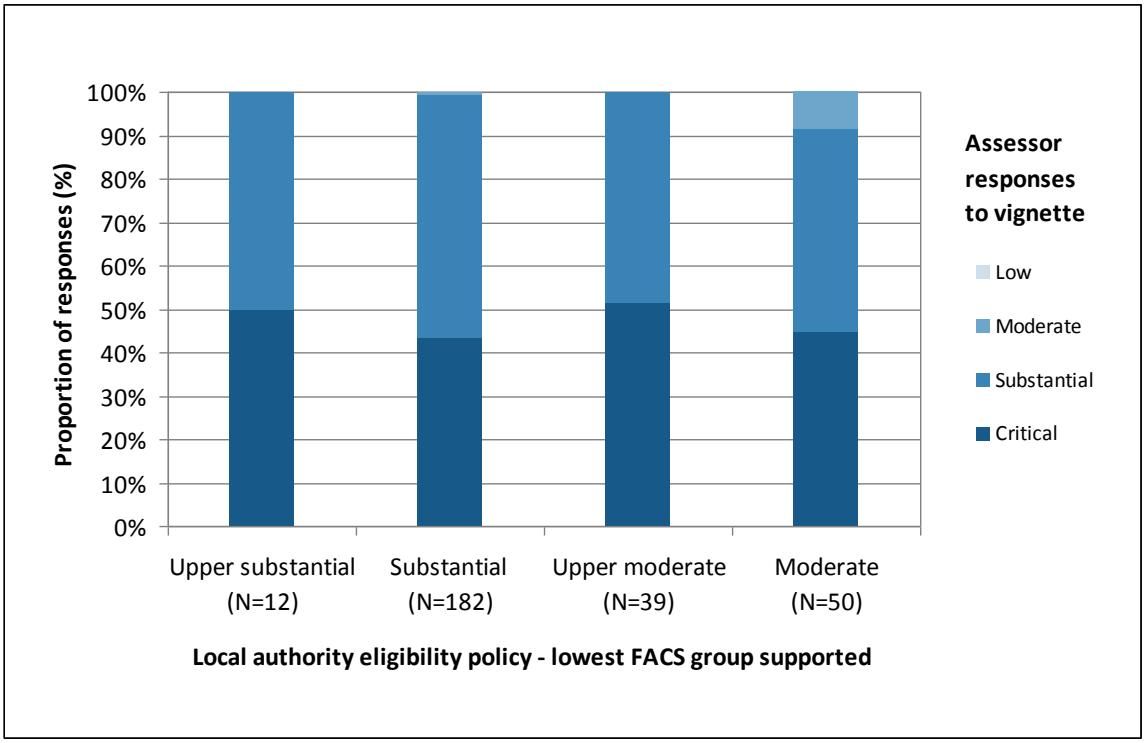
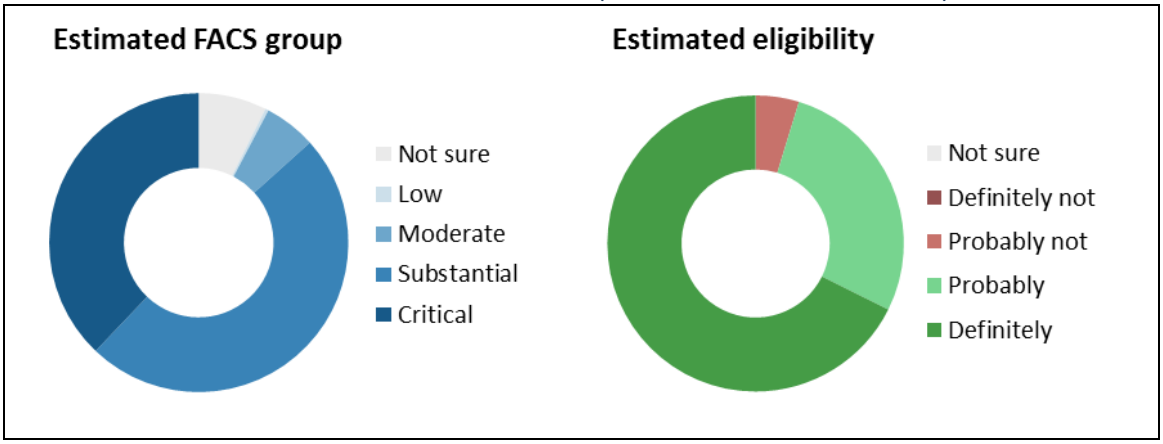


*Chart excludes 'not sure' responses

YOUNGER ADULTS WITH A PHYSICAL DISABILITY – VIGNETTE 6

Mrs F, 40, was diagnosed with Huntington's disease in her late 30s and was forced to quit work due to increasing impairments in his psychomotor functions. Mrs F is divorced and lives with her 15 year old daughter, who is still at school. So far she has got by with help from her daughter in performing household tasks such as cleaning, shopping and preparing meals. Due to worsening short-term memory problems as well as increasing self-care requirements, however, Mrs F feels that she needs extra help, particularly at mealtimes during the school week as she has difficulty chewing and swallowing. Mrs F has a supportive network of friends but none that can be around during the day.

ESTIMATED FACS GROUP AND ELIGIBILITY (ALL LOCAL AUTHORITIES)



ESTIMATED FACS GROUP BY LOCAL AUTHORITY ELIGIBILITY POLICY*

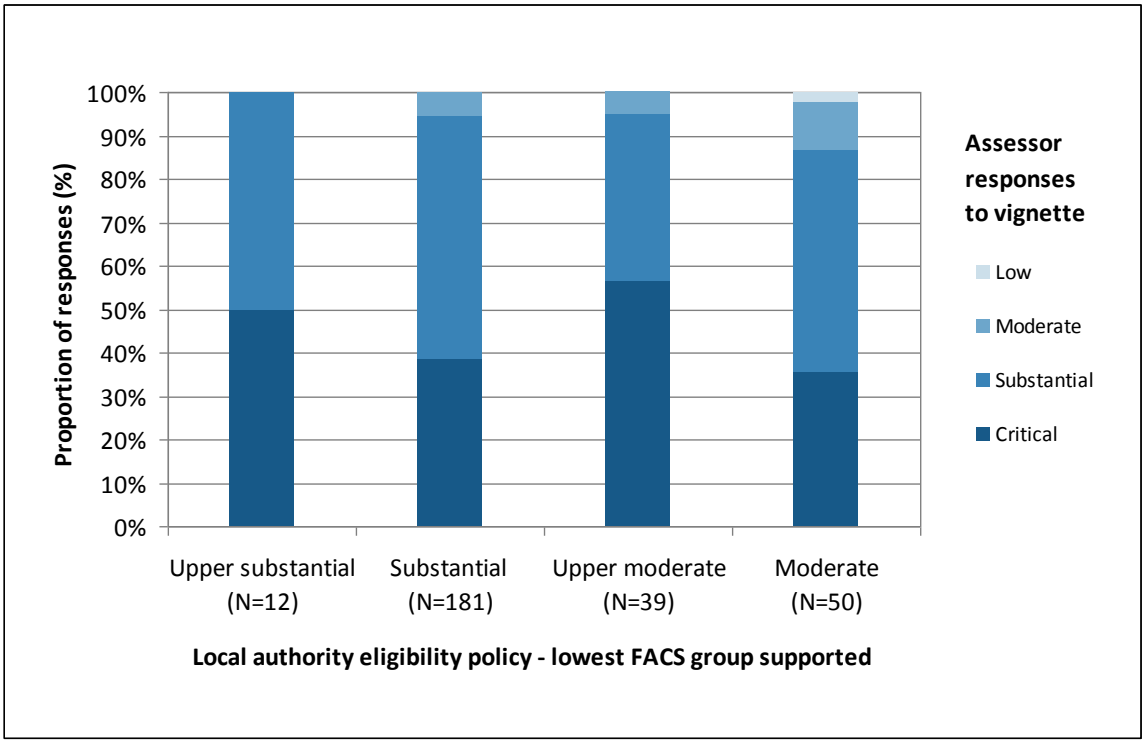


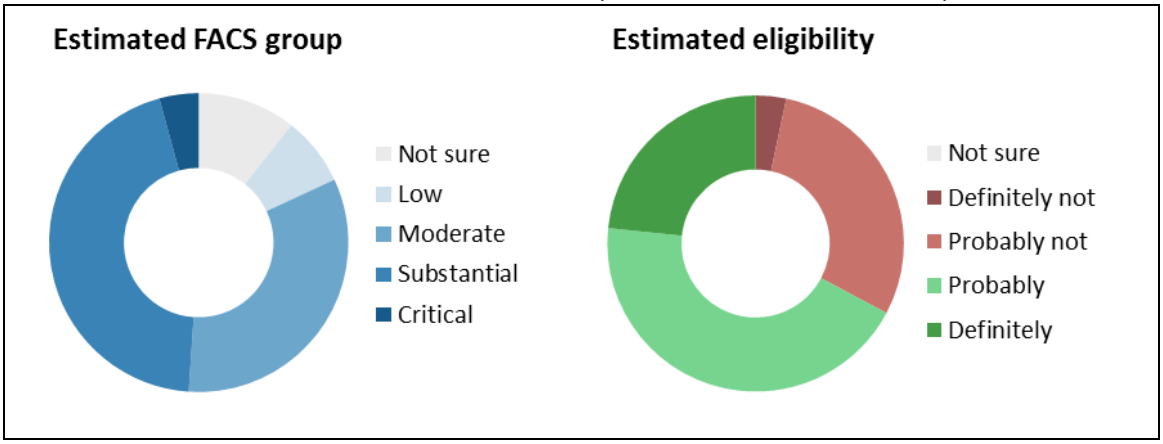
*Chart excludes 'not sure' responses

YOUNGER ADULTS WITH A LEARNING DISABILITY – VIGNETTE 1

Ms A, 54, has learning disabilities and has lived at home with her mother for most of her life. She has been reliant on their help with tasks such as managing her finances and shopping. Her mother now suffers from the early stages of dementia, and can no longer help with more complex tasks.

Ms A helps her mother around the house, and is keen that they should both remain living at home. She says that she doesn't need help very often, but is getting very distressed about having to deal with bills on her own. She says that she has a number of friends living nearby, but most are a lot older and can't always help.

ESTIMATED FACS GROUP AND ELIGIBILITY (ALL LOCAL AUTHORITIES)



ESTIMATED FACS GROUP BY LOCAL AUTHORITY ELIGIBILITY POLICY*

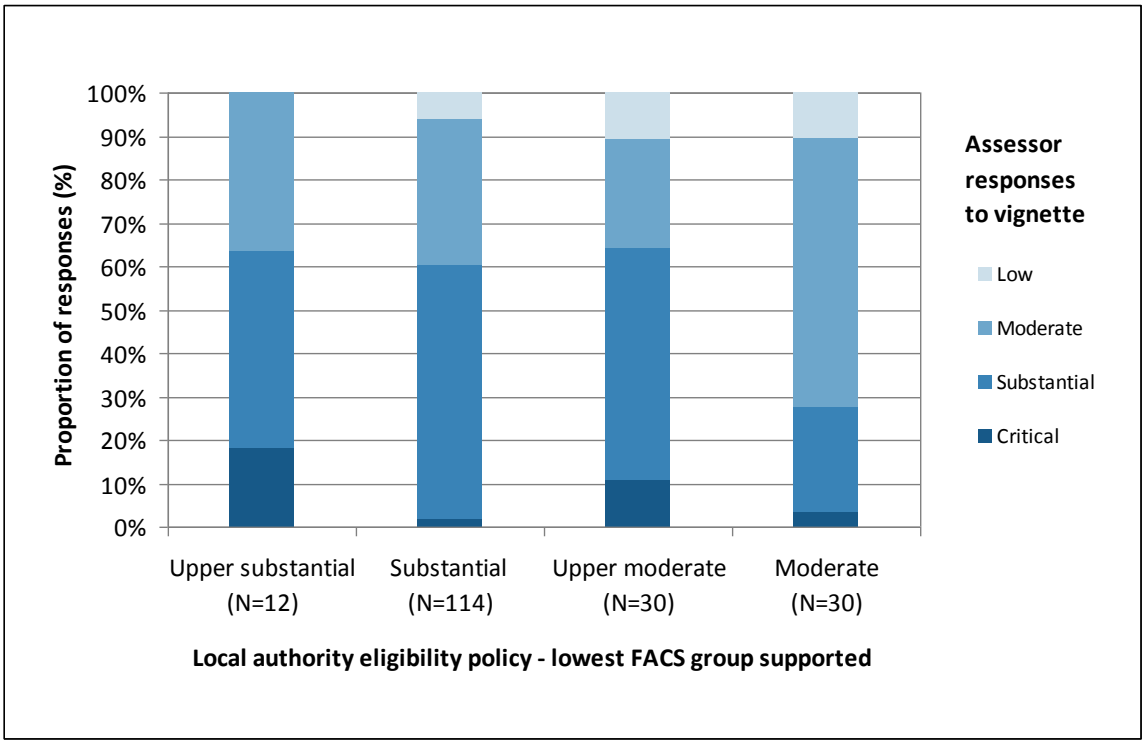
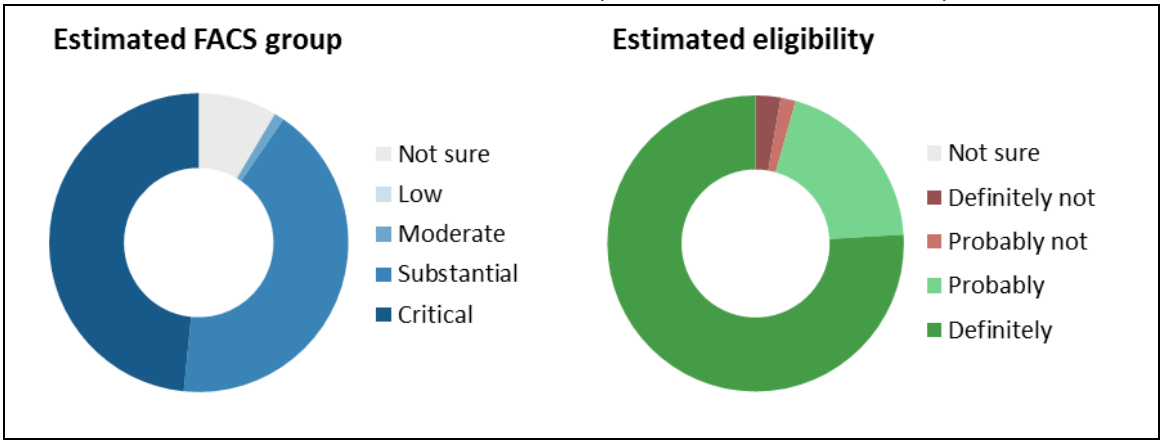


*Chart excludes 'not sure' responses

YOUNGER ADULTS WITH A LEARNING DISABILITY – VIGNETTE 2

Mr B, 21, was involved in a serious road accident six years ago and has severe short-term memory problems as well as being confined to a wheelchair. He is entirely reliant on his parents for help washing, buying and preparing food and dealing with all of his paperwork. Both have been providing informal care for the past two years, but feel unable to cope in the long term without assistance as he requires support 24 hours per day.

ESTIMATED FACS GROUP AND ELIGIBILITY (ALL LOCAL AUTHORITIES)



ESTIMATED FACS GROUP BY LOCAL AUTHORITY ELIGIBILITY POLICY*

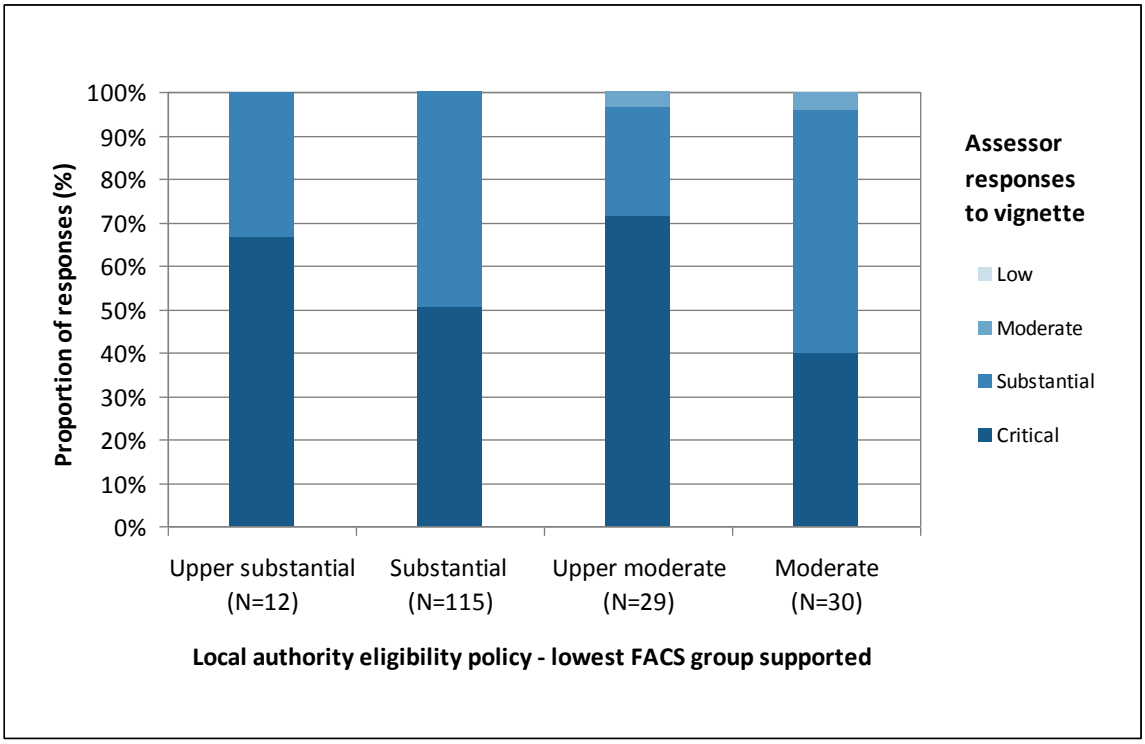


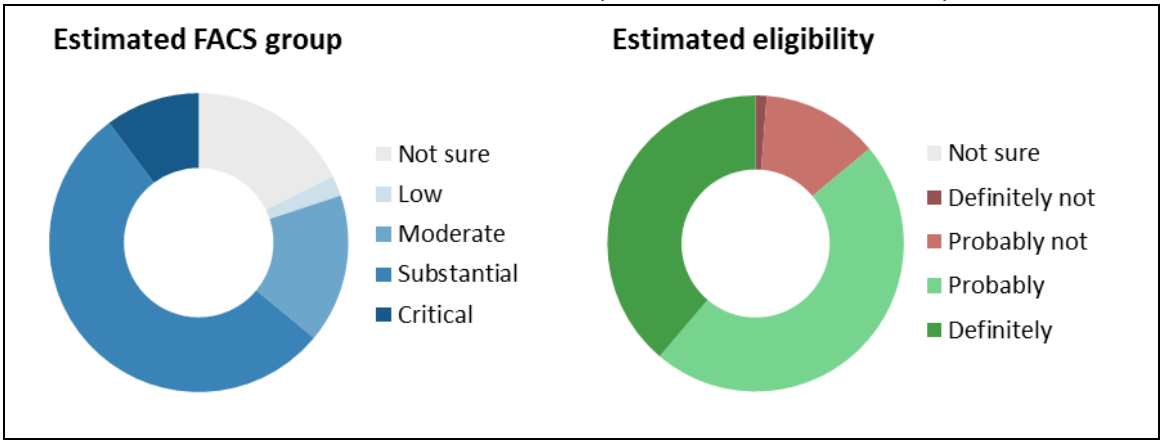
*Chart excludes 'not sure' responses

YOUNGER ADULTS WITH A LEARNING DISABILITY – VIGNETTE 3

Mr C, 19, has fragile x syndrome and suffers from numerous problems with communication and has short term memory problems. His parents both act as carers, but have been in contact since they are struggling to cope after having to spend more time at work.

Mr C doesn't go out without his parents and his parents are worried about him getting increasingly lonely as they are struggling to get out with him during the week.

ESTIMATED FACS GROUP AND ELIGIBILITY (ALL LOCAL AUTHORITIES)



ESTIMATED FACS GROUP BY LOCAL AUTHORITY ELIGIBILITY POLICY*

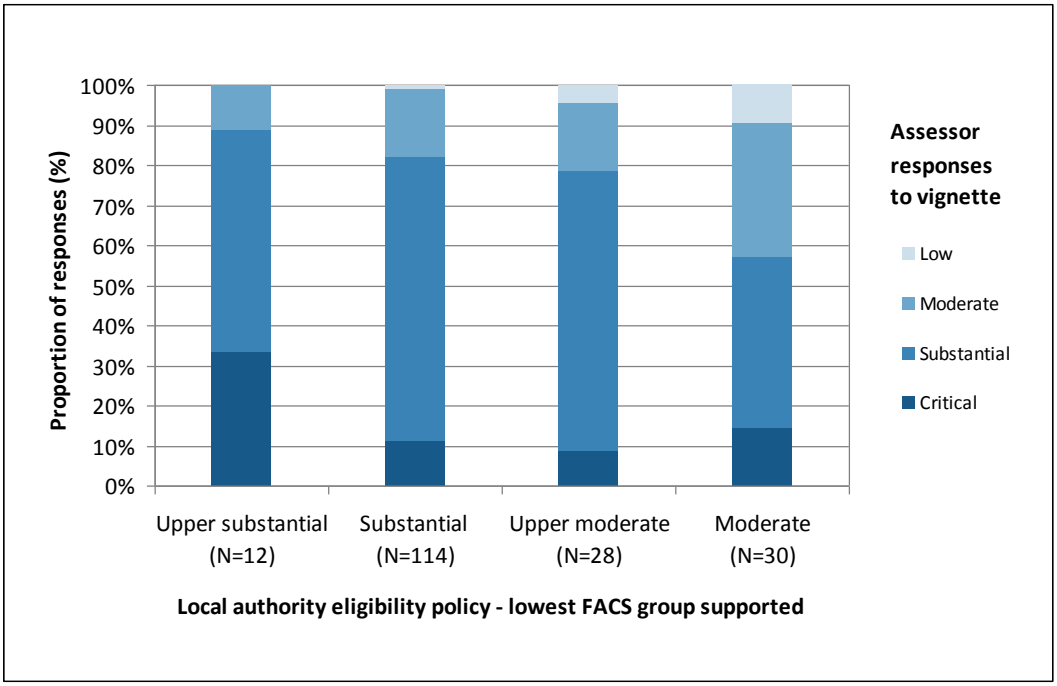
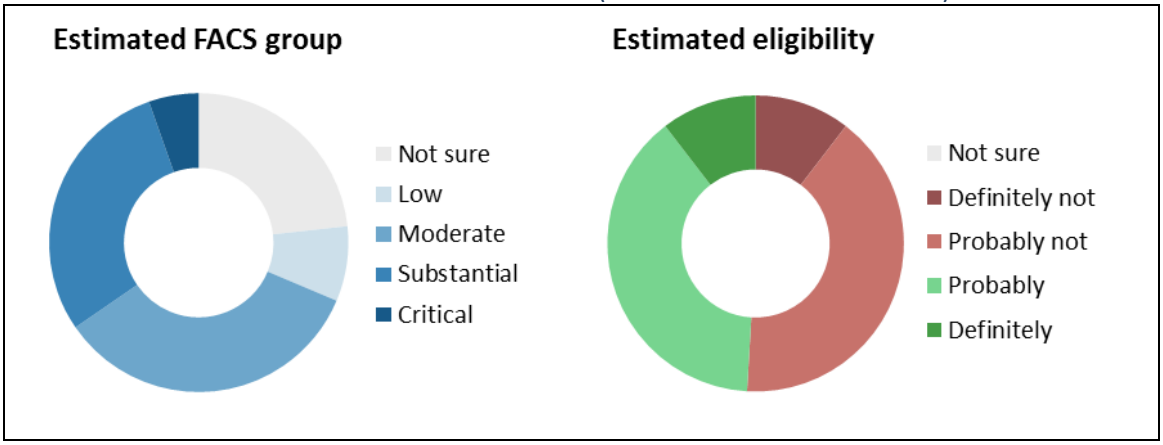


*Chart excludes 'not sure' responses

YOUNGER ADULTS WITH A LEARNING DISABILITY – VIGNETTE 4

Mr D, 26, has moderate learning disabilities and has been homeless on and off for the last four years. He has a history of alcohol and drug abuse and depression, and has been in contact to request help. He says that he is desperate to get work but doesn't know where to start.

ESTIMATED FACS GROUP AND ELIGIBILITY (ALL LOCAL AUTHORITIES)



ESTIMATED FACS GROUP BY LOCAL AUTHORITY ELIGIBILITY POLICY*

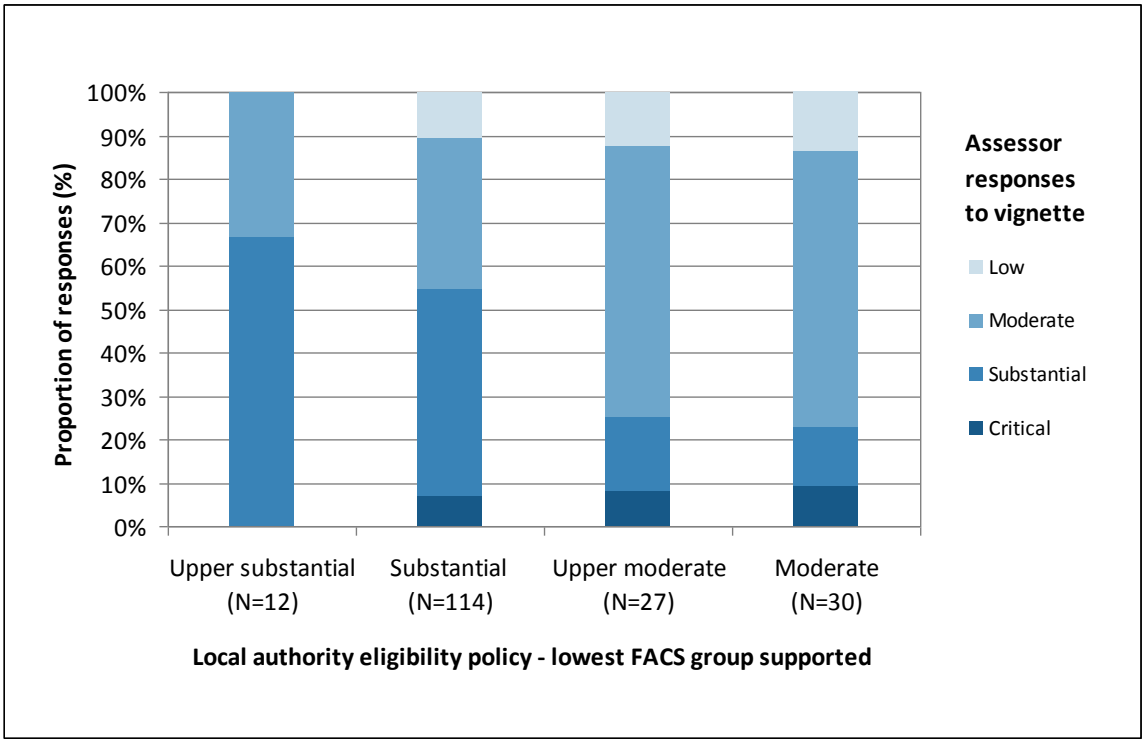


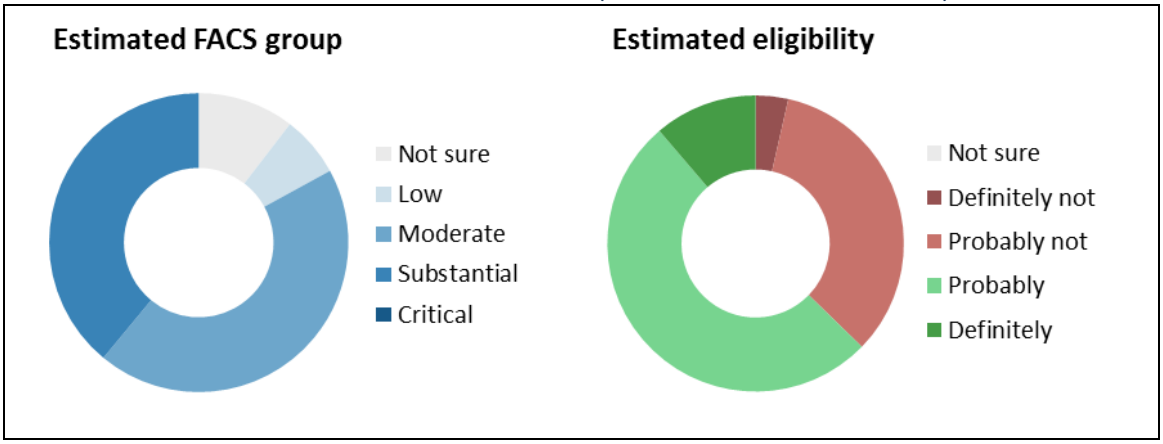
*Chart excludes 'not sure' responses

YOUNGER ADULTS WITH A LEARNING DISABILITY – VIGNETTE 5

Ms E, 28, has had post-natal learning disabilities since a young age, and has always lived with her parents, who are both in their mid-sixties. She is generally able to carry out personal care tasks with little assistance but has never worked, and has very little contact with anyone outside the family.

Her parents are concerned about her well-being as she is often depressed but that making friends has been difficult as she feels uncomfortable around new people and has difficulty communicating.

ESTIMATED FACS GROUP AND ELIGIBILITY (ALL LOCAL AUTHORITIES)



ESTIMATED FACS GROUP BY LOCAL AUTHORITY ELIGIBILITY POLICY*

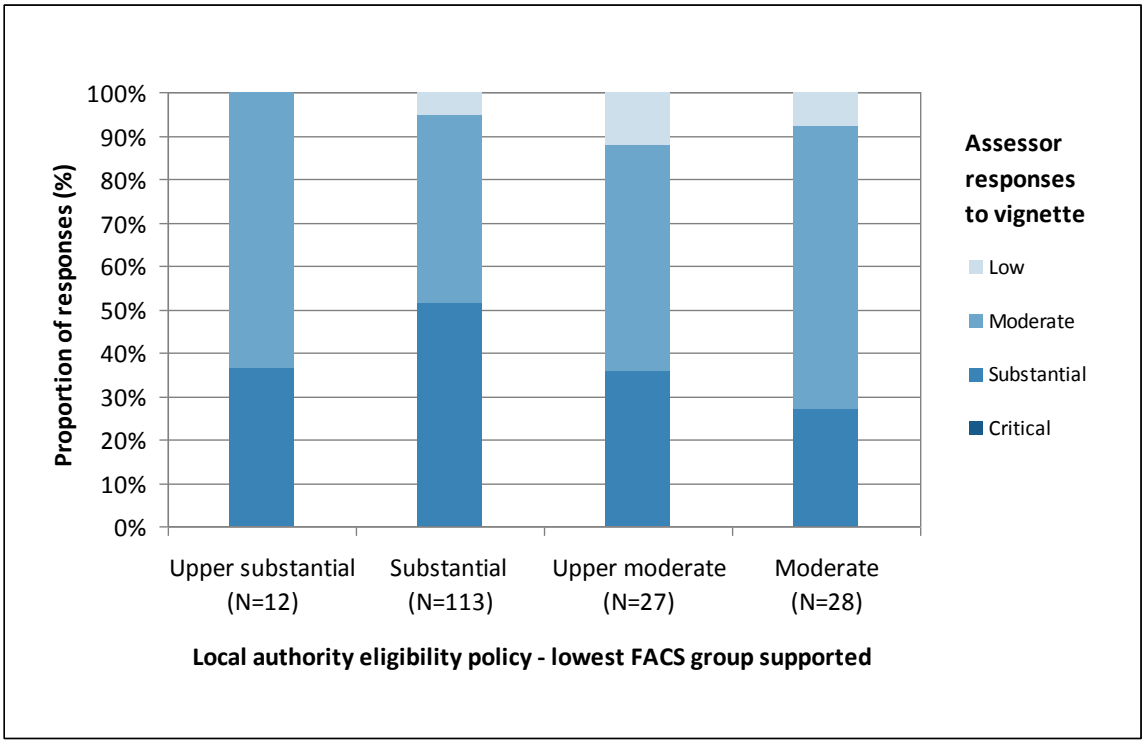


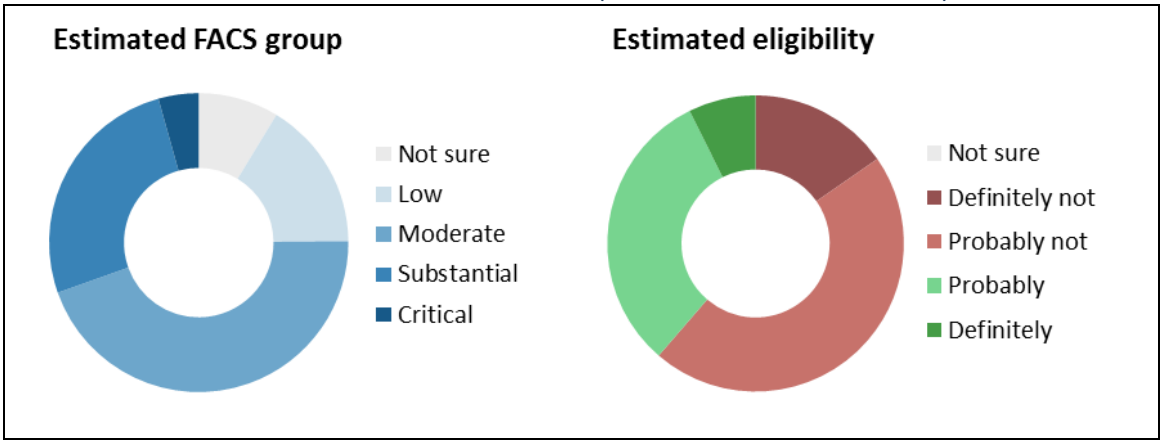
*Chart excludes 'not sure' responses

YOUNGER ADULTS WITH A MENTAL HEALTH CONDITION – VIGNETTE 1

Mr A, 30, has struggled with depression since the death of his father when he was 27. Heavy drinking caused Mr A to lose his job a year ago, and he has been hospitalised twice with acute alcohol problems.

He is physically capable of carrying out all personal care and domestic tasks but has recently had problems managing his money and often goes without eating for long periods.

ESTIMATED FACS GROUP AND ELIGIBILITY (ALL LOCAL AUTHORITIES)



ESTIMATED FACS GROUP BY LOCAL AUTHORITY ELIGIBILITY POLICY*

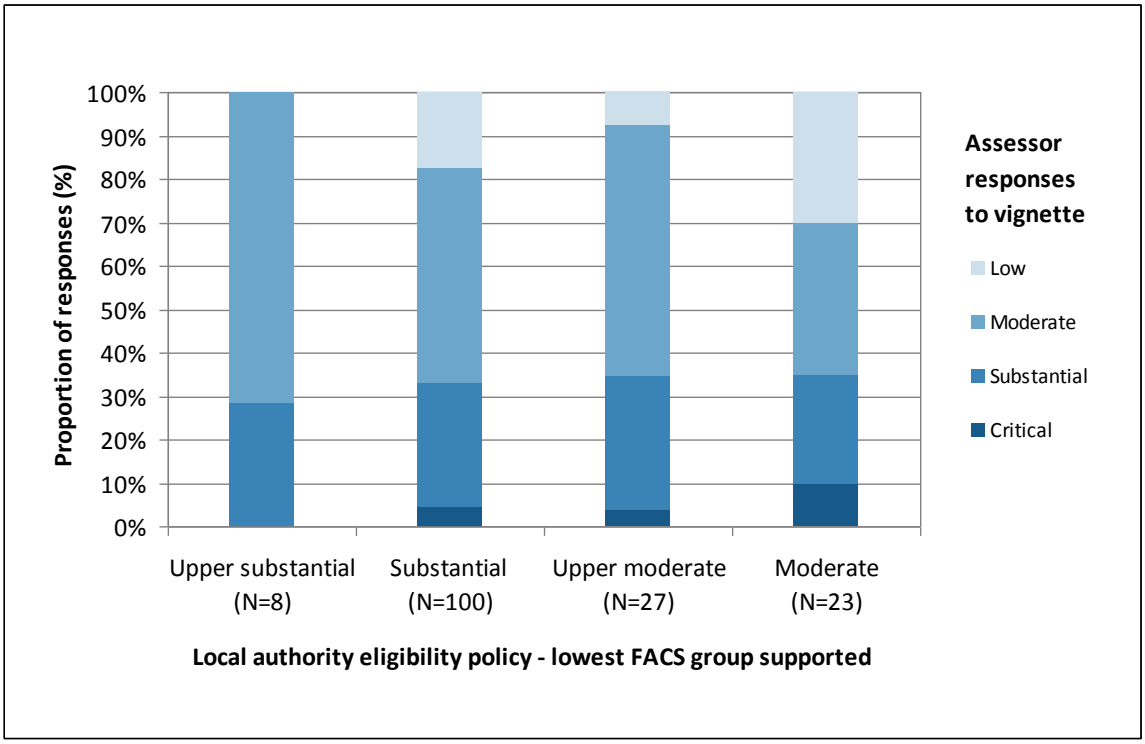
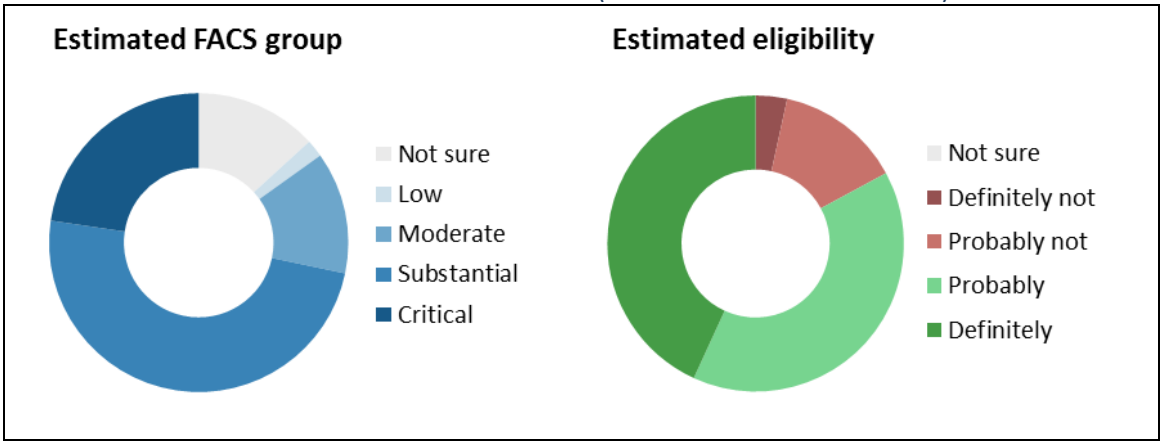


*Chart excludes 'not sure' responses

YOUNGER ADULTS WITH A MENTAL HEALTH CONDITION – VIGNETTE 2

Ms B, 20, has severe autism and struggles with communication, meaning she cannot work and is reliant on help from her parents with shopping and assistance outside the home. Her parents are seeking help as both work part-time. They are also worried about their daughter harming herself as she has started hitting her head violently against the wall during the night.

ESTIMATED FACS GROUP AND ELIGIBILITY (ALL LOCAL AUTHORITIES)



ESTIMATED FACS GROUP BY LOCAL AUTHORITY ELIGIBILITY POLICY*

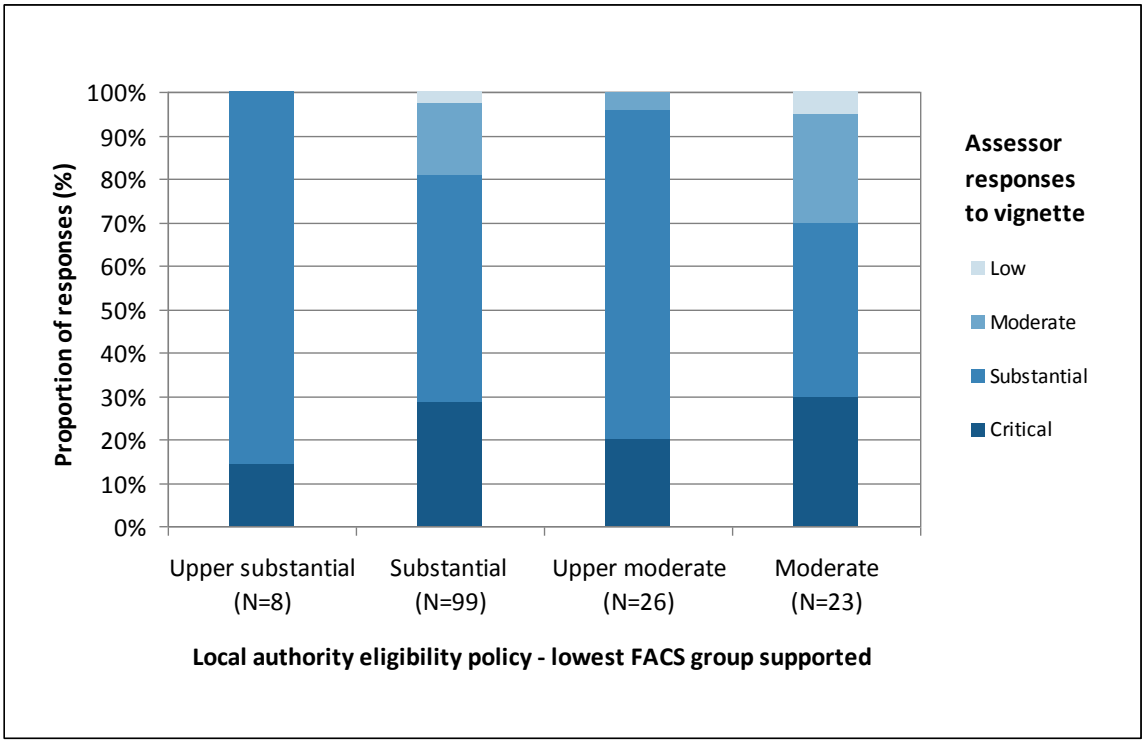


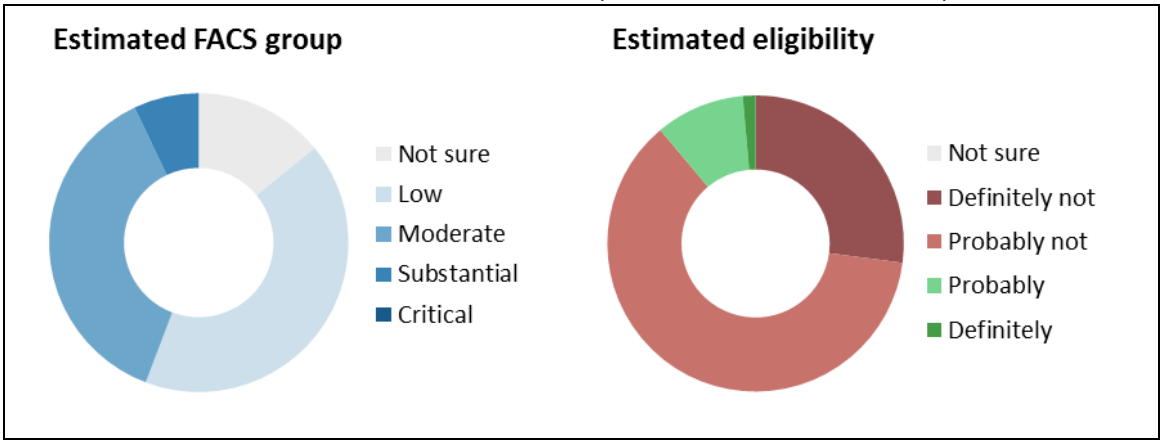
*Chart excludes 'not sure' responses

YOUNGER ADULTS WITH A MENTAL HEALTH CONDITION – VIGNETTE 3

Mrs C has struggled with depression since the breakdown of her marriage and death of her father, and was hospitalised with acute alcohol problems on a number of occasions.

For the past two years, Mrs C has responded well to treatment and has been working part-time which she says has helped her to stay in control. Redundancies being made by her employer mean that she will soon be out of work, however, and already feels unable to cope if she cannot find alternative employment.

ESTIMATED FACS GROUP AND ELIGIBILITY (ALL LOCAL AUTHORITIES)



ESTIMATED FACS GROUP BY LOCAL AUTHORITY ELIGIBILITY POLICY*

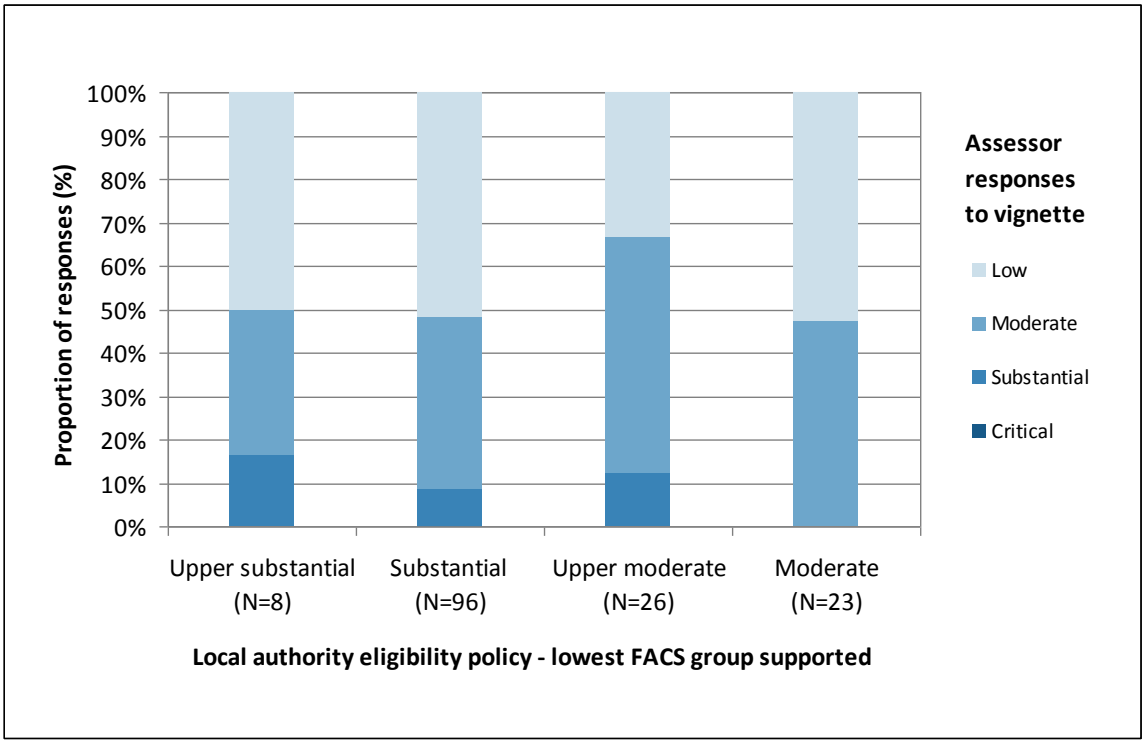


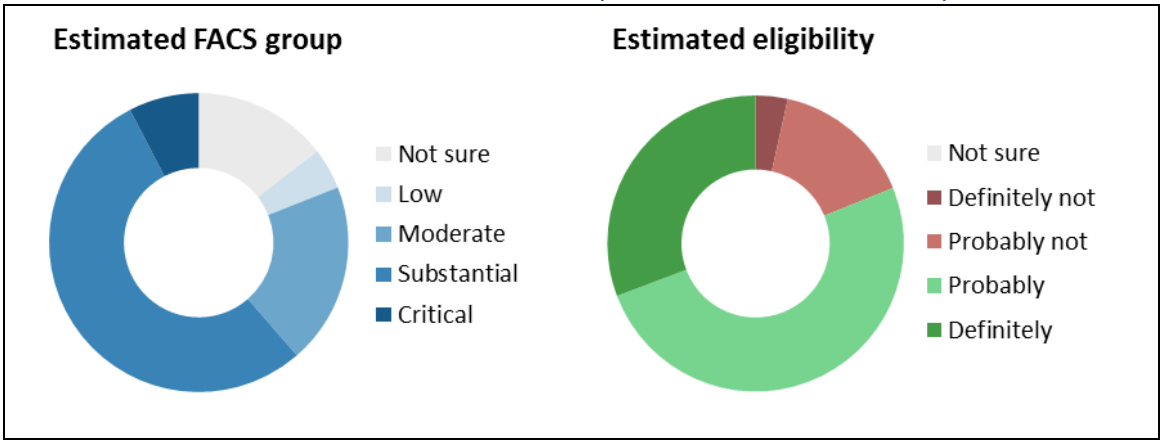
*Chart excludes 'not sure' responses

YOUNGER ADULTS WITH A MENTAL HEALTH CONDITION – VIGNETTE 4

Mr D, 31, has simple schizophrenia. A relative has recently been in contact as they are concerned about the impact of Mr D's poor hygiene and living conditions. Neighbours have also been in contact with the council to complain about the volume of waste left in and around the house.

Mr D, who has been unable to work for the last two years due to his condition, rarely leaves the house and receives no visitors other than immediate family.

ESTIMATED FACS GROUP AND ELIGIBILITY (ALL LOCAL AUTHORITIES)



ESTIMATED FACS GROUP BY LOCAL AUTHORITY ELIGIBILITY POLICY*

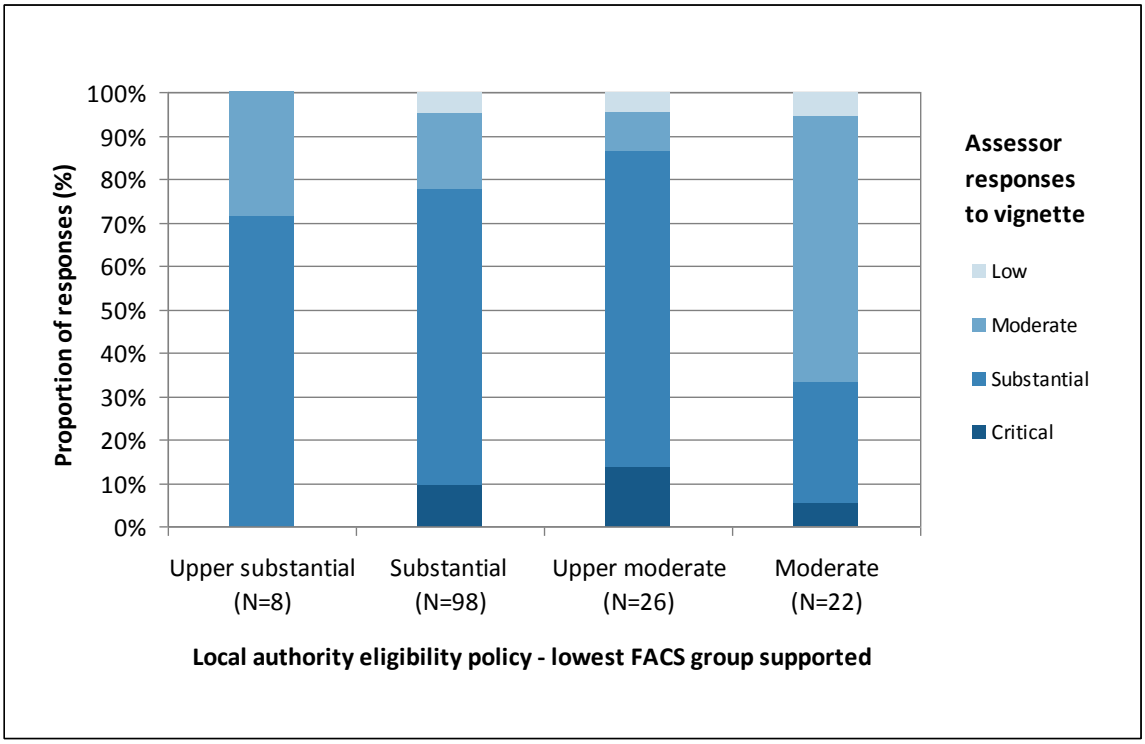


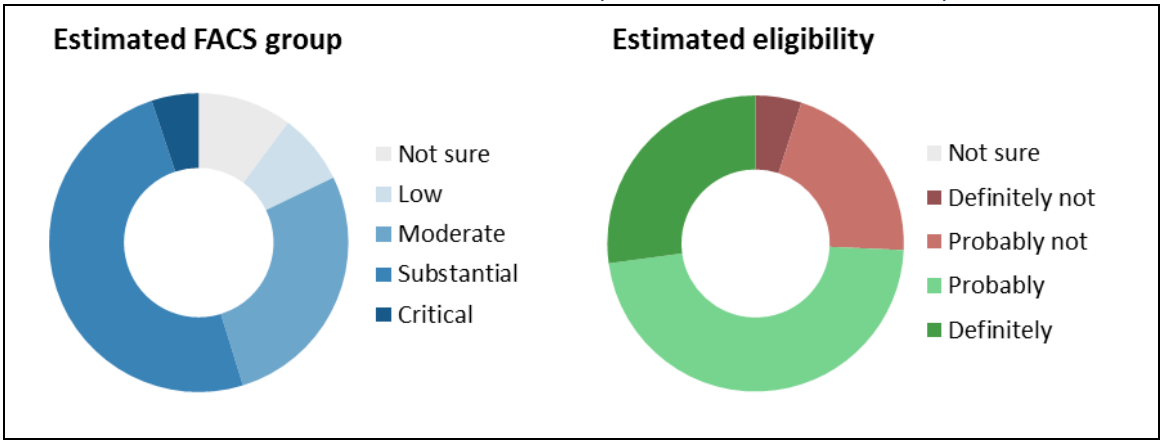
*Chart excludes 'not sure' responses

YOUNGER ADULTS WITH A MENTAL HEALTH CONDITION – VIGNETTE 5

Ms E, 38, lives alone and has recently been diagnosed with bipolar disorder and suffers from episodes of severe depression. Ms F's diagnosis came after she was sectioned during a recent manic episode, and she has since commenced medical treatment.

A community psychiatric nurse is visiting regularly but some help is likely to be required around the home with shopping, managing finances and meals.

ESTIMATED FACS GROUP AND ELIGIBILITY (ALL LOCAL AUTHORITIES)



ESTIMATED FACS GROUP BY LOCAL AUTHORITY ELIGIBILITY POLICY*

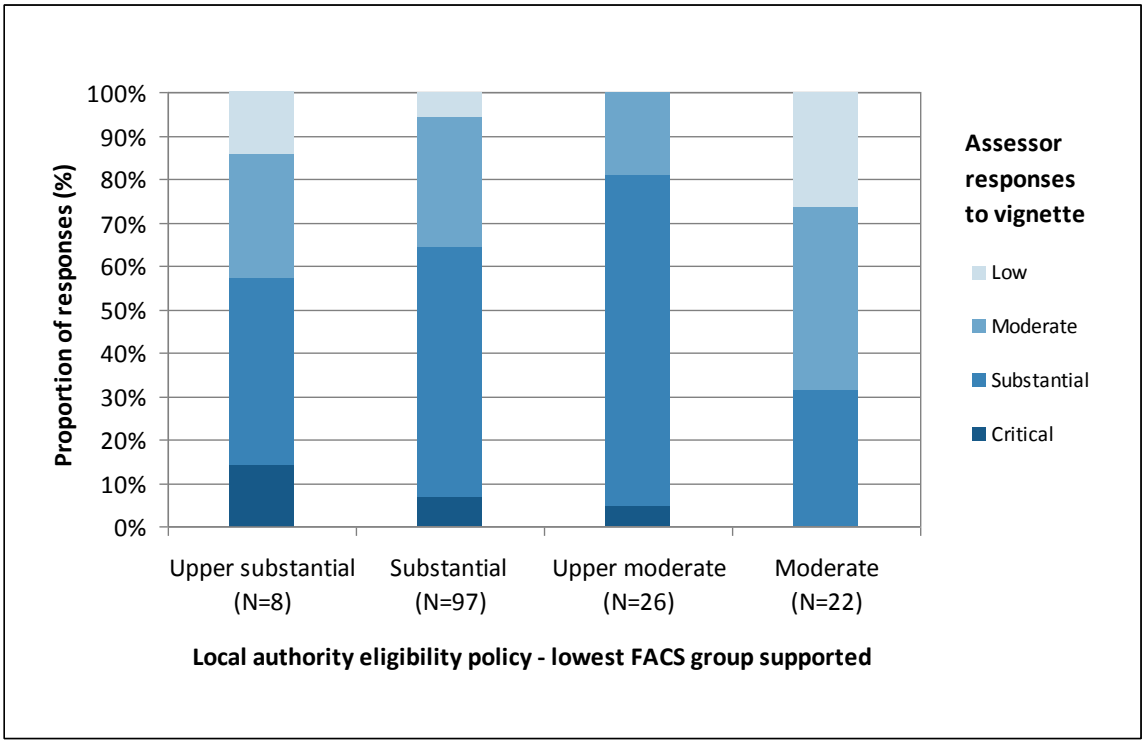
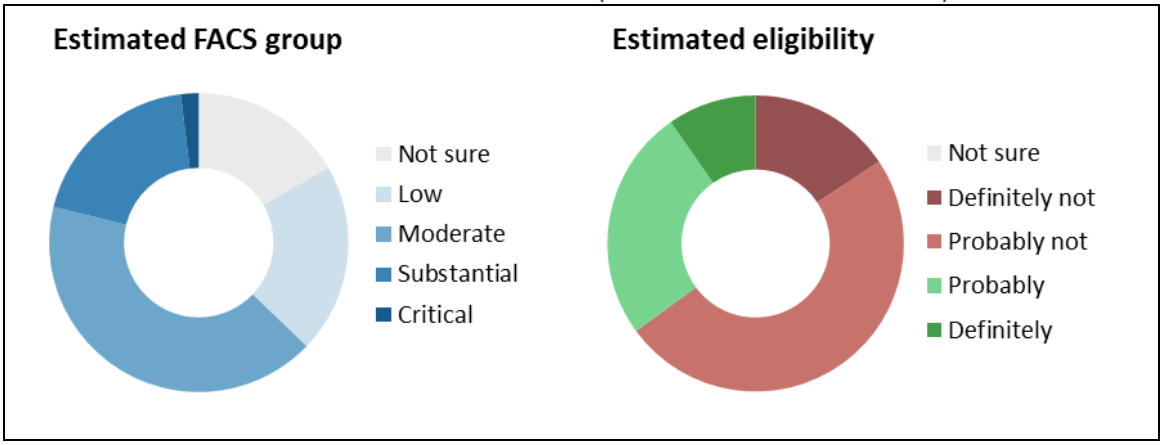


*Chart excludes 'not sure' responses

YOUNGER ADULTS WITH A MENTAL HEALTH CONDITION – VIGNETTE 6

Mr F, 26, has moderate learning disabilities and has been homeless on and off for the last four years. He has a history of alcohol and drug abuse and depression, and has been in contact to request help. He says that he is desperate to get work but doesn't know where to start.

ESTIMATED FACS GROUP AND ELIGIBILITY (ALL LOCAL AUTHORITIES)



ESTIMATED FACS GROUP BY LOCAL AUTHORITY ELIGIBILITY POLICY*

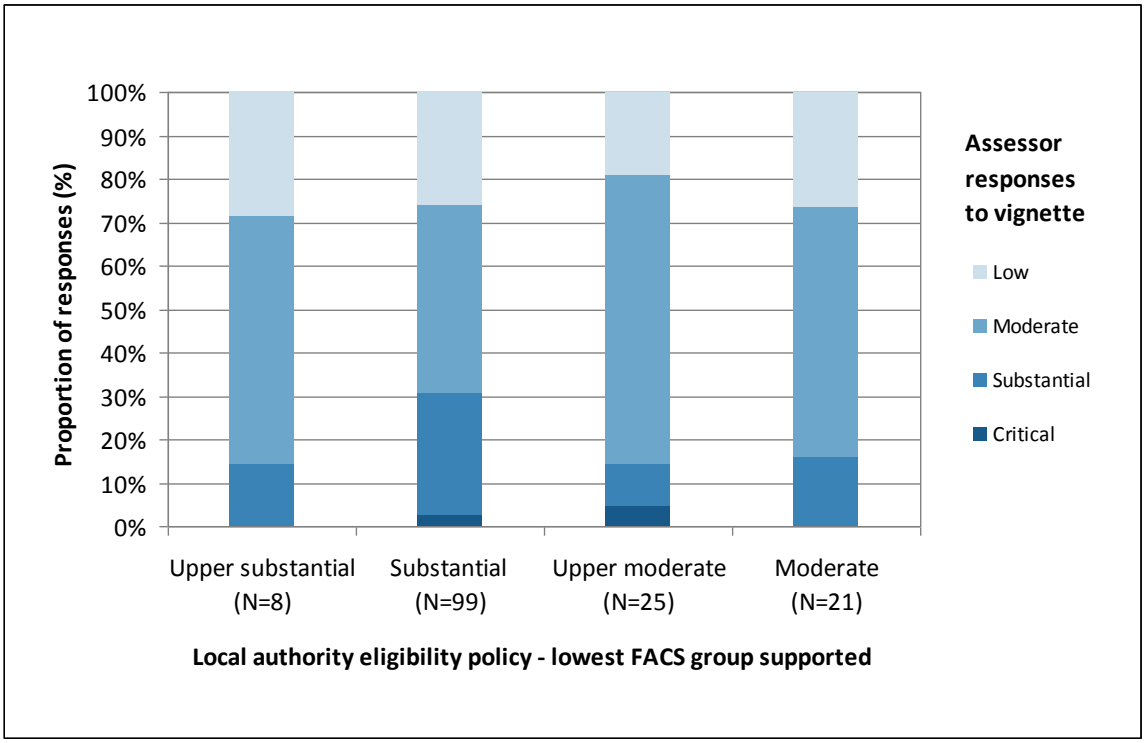


*Chart excludes 'not sure' responses

POLICY IMPLICATIONS

The results of the present survey provide the first comprehensive picture of the pattern of targeting of resources across FACS groups in England, and of the way in which care managers in different local authorities interpret and apply the FACS need definitions to individuals from different client groups and with varying combinations of need-related circumstances. We summarise below some of the key policy implications emerging from the results.

CURRENT SOCIAL CARE ELIGIBILITY THRESHOLDS IN ENGLAND

Responses to the survey and evidence from publicly-available documents both show that local authorities have tightened their eligibility thresholds overall since the introduction of FACS guidelines in 2003. At the time of the survey, the vast majority of authorities offered services to clients with critical or substantial needs only. Fewer than 2% of authorities have restricted eligibility to the critical FACS band, and around 5% only support clients with critical or those at the higher end of the substantial FACS band.

In terms of the allocation of resources across FACS groups the data show, as would be expected, significantly higher care packages for users classified in the higher FACS need groups, and in particular in the critical need group.

The results also suggest, however, important disparities in the allocation of resources within given FACS levels across users groups. Whereas it might not be altogether surprising, the results imply that higher levels of support are provided for critical cases in the learning disability and physical disability users groups than in the older people group.

These findings could be the product of a combination of factors. On the one hand, they might corroborate the findings from other studies suggesting a degree of ageism in the allocation of resources in social care (Forder 2008, Beecham et al 2008). On the other, this finding might reflect the greater emphasis of the revised FACS definitions on outcomes, and that users from different user groups require different types and volumes of support to achieve similar outcomes. Finally, they might suggest that the FACS needs classification does not capture an important element of variability in need between individuals, if “need” is understood in terms the amount of resources that an individual requires for their support (Culyer, 1976).

CARE MANAGER INTERPRETATIONS OF FACS GROUP DEFINITIONS AND OF LOCAL ELIGIBILITY POLICIES

As indicated above, the results from the vignettes require careful interpretation, given the rarefied context within which care managers were asked to make their judgements. In particular, the limited nature of the information contained in the vignettes might be expected to lead to greater randomness in the distribution of the answers collected than would otherwise be found.

Notwithstanding such limitations, the patterns of responses have some important policy implications.

- The results suggest the expected relationship between professional judgements about FACS group membership and the need-related characteristics depicted in the vignettes. Greater dependency, higher personal risk, and lack of informal care increase the FACS needs rating allocated by care managers.

- Importantly, however, the results show systematic differences (other things equal) in the classification of vignettes between local authorities, and in particular between local authorities with different eligibility thresholds. The results suggest that care managers from local authorities with more restrictive eligibility criteria were more likely to “up-code” the need rating given to the hypothetical cases in the vignettes.

THE POLICY ROLE FOR FACS NEEDS GROUPS

Arguably, FACS needs groups could contribute to the following policy objectives:

- Communicating with local constituencies: by stating publically the range of needs that are likely to be covered by the local authority, FACS needs definitions act as a mechanism for informing local constituencies of their support ‘entitlements’ and for managing local expectations.
- As a local eligibility assessment tool: FACS needs group definitions provide a broad guideline for care managers when assessing eligibility for local support.
- A tool for monitoring heterogeneity in access to services between local authorities: by providing statements of eligibility thresholds for all local authorities, FACS groups can be used to observe local variability in access to services in England.

- A central government policy lever: although not used for this purpose at present, FACS need groups could be used to set minimum national eligibility thresholds, or as a national mechanism for metering lifetime care needs as required by the capped funding model proposed by the Dilnot Commission (Dilnot Commission, 2011).

Although further research would be needed in order to address them, the results of the survey pose interesting questions about the use of FACS need groups for the objectives listed above. A number of key issues highlighted by the survey findings are summarised below.

Significant heterogeneity of care manager judgements.

Although it varied between scenarios and was likely to be exacerbated by the use of vignettes, the results suggest significant variability between care managers in the allocation of cases to FACS needs groups. For several of the vignettes, for instance, the range of judgements made by care managers spanned all the possible FACS levels (from low to critical needs).

This variability of care management judgements is likely to reflect a series of factors, including the fact that FACS groups use a simple set of needs statements to cover a wide range of situations, the resulting fluidity of the definition of the FACS levels, and their focus on wellbeing and care outcomes rather than on more tangible and transparent but arguably less relevant disability indicators (see Box 1). As a result, it can be difficult to link systematically and a priori the characteristics of cases to FACS need groups. Conversely, it is difficult to interpret the implications of differences in local FACS eligibility thresholds for local patterns of targeting of resources.

The four FACS bands provide a general framework for grading clients according to their needs, and provide a picture of the overall level of coverage at the local authority level. Beyond this, however, the capacity of the FACS framework to accurately determine or measure eligibility across councils is largely dependent on whether they can be applied to individuals' needs and councils' policies precisely, consistently and appropriately.

At present, the majority of councils have set their eligibility threshold for publicly-funded care at the substantial needs level. However, the fact that a large proportion of authorities use additional measures to grade clients into 'upper' and 'lower' FACS sub-categories suggests that for many the FACS thresholds are too broad a set of criteria to precisely determine (or reflect) the policies implemented at the local level. Furthermore, FACS need groups are generally used by local authorities to manage "entry" into the system, but not for setting levels of support (e.g. the intensity of the care package or the size of the personal budget). In that sense, a very important element of the local variability in the targeting of resources is set using other mechanisms, such as the resource assessment system (RAS).

Potential for "up-coding" of needs.

The relative subjectivity in the relationship between need-related factors and FACS needs categories is also important when speculating about their potential role as a policy setting tool. Given the inherent importance of the judgement of the person carrying out the assessment when allocating a FACS group to an individual, changes in policy expressed in terms of FACS needs groups might not generate the expected effects. Policy changes aiming at tightening eligibility criteria, for instance, might lead to shifts in the interpretation by front-line workers of the different FACS groups, and to a relaxation in the need circumstances required to meet the new heightened eligibility threshold.

The results of the survey appear to suggest the existence of such "up-coding" effects (whereby users receive a higher FACS rating than might be suitable), with care managers in areas with more restrictive eligibility policies more likely to consider, other things equal, that individuals belonged to higher need groups than those in areas with more generous eligibility thresholds.

Transparency versus flexibility

Going forward, the question is whether it is possible for the current FACS groups to fulfil all the roles outlined above, or whether a number of assessment tools might need to be developed. A key consideration in this regard is the existence of trade-offs between more transparent need eligibility criteria, based on algorithms linked to specific combinations of needs indicators of the type used in social and/or private insurance systems, and need criteria which maintain enough flexibility to allow for a more holistic assessment of the range of factors that might affect a person's need for support.

Care managers taking part in the survey often viewed the assessment process as a necessarily flexible interpretation of the interactions between need, risk and informal support that could not realistically be captured by a rigid algorithm. On the other hand, the survey results suggest, comparing local variability in access to social care services on the basis of the current FACS groups presents significant challenges of interpretation. Furthermore, care managers perceived the process of determining FACS eligibility as highly subjective, and as a process which could lead to an eligibility 'lottery'.

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Henwood M and Hudson B (2008) *Lost to the System? The Impact of Fair Access to Care. A report commissioned by the Commission for Social Care Inspection for the production of The state of social care in England 2006-07*

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APPENDIX 1: SURVEY PART 1 QUESTIONNAIRE (PRINTABLE COPY)

SURVEY OF FAIR ACCESS TO CARE SERVICES ASSESSMENT CRITERIA

SHEET 1: INTRODUCTION

Thank you for agreeing to participate in this survey of Fair Access to Care Services assessment criteria.

Confidentiality
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. 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.

Completing the survey
If the 'previous' and 'next' buttons do not function due to your Excel security settings, please navigate through the survey using the tabs at the bottom of the page. We have tried to make all questions as clear and relevant to all local authorities as possible. If you find it necessary to provide extra information or clarification about any of your responses, however, please use the 'notes' field to the right of the corresponding question.

Queries
If you have any queries, or need help completing the survey please contact Tom Snell at t.r.snell@lse.ac.uk or 0207 193 3553. If you need a printable version of the survey for reference, this can be provided on request.

1. Your contact details

Name	
Job Title	
Local Authority	
Telephone	
Email	

SHEET 2: ELIGIBILITY POLICY

2. What is your current eligibility policy for publicly-funded care packages for the following FACS bands?

	Always Supported	Sometimes Supported	Never supported
Critical	○	○	○
Substantial	○	○	○
Moderate	○	○	○
Low	○	○	○

SHEET 3: INFORMATION

In the next two sections we would like to know about the number of people on the books to receive a publicly-funded care package and levels of expenditure on care packages by FACS group.

Who should be included?
Responses should only include people receiving ongoing care packages (either in the community, residential care or nursing care). Clients that are ONLY receiving one-off or short-term care or assistance such as equipment, adaptations and re-ablement should not be included.

Timescales
Information on the *number* of clients should refer to the number of clients receiving ongoing care packages on a given day, whereas total gross expenditure should be expressed over the course of an entire year. Where possible, please provide *client numbers* relating to March 31 2011 and *total gross annual expenditure* relating to April 2010 - March 2011. If this is not possible, please provide the closest available information (you will be able to specify which time period your figures relate to).

Sampling
Where exact figures cannot be provided, please provide an estimate based on a representative sample of users. So that we know which figures are based on estimates, please mark each response as 'ACTUAL' or 'ESTIMATED' using the fields provided.

SHEET 4: SUPPORTED INDIVIDUALS

3. How many OLDER PEOPLE (all adults aged 65 and above) are on the books to receive a publicly-funded care package in the following FACS groups? For categories in which no individuals are supported, please enter '0'.

	Number of individuals	Actual	Estimated
Critical		○	○
Substantial		○	○
Moderate		○	○
Low		○	○
Total		○	○

4. How many ADULTS WITH A PHYSICAL DISABILITY (aged 64 or below) are on the books to receive a publicly-funded care package in the following FACS groups? For categories in which no individuals are supported, please enter '0'.

	Number of individuals	Actual	Estimated
Critical		○	○
Substantial		○	○
Moderate		○	○
Low		○	○
Total		○	○

5. How many ADULTS WITH A LEARNING DISABILITY (aged 64 or below) are on the books to receive a publicly-funded care package in the following FACS groups? For categories in which no individuals are supported, please enter '0'.

	Number of individuals	Actual	Estimated
Critical		○	○
Substantial		○	○
Moderate		○	○
Low		○	○
Total		○	○

6. How many ADULTS WITH MENTAL HEALTH NEEDS (aged 64 or below) are on the books to receive a publicly-funded care package in the following FACS groups? For categories in which no individuals are supported, please enter '0'.

	Number of individuals	Actual	Estimated
Critical		○	○
Substantial		○	○
Moderate		○	○
Low		○	○
Total		○	○

7. How many adults in the OTHER / ASYLUM user category are on the books to receive a publicly-funded care package in the following FACS groups? For categories in which no individuals are supported, please enter '0'.

	Number of individuals	Actual	Estimated
Critical		○	○
Substantial		○	○
Moderate		○	○
Low		○	○
Total		○	○

8. Please indicate the date(s) to which these figures correspond. (e.g. 31 March 2011)

SHEET 5: EXPENDITURE

9. What is the total gross annual expenditure on OLDER PEOPLE (all adults aged 65 and above) by the following FACS groups? For categories in which no individuals are supported, please enter '0'.

	Gross annual cost (£)	Actual	Estimated
Critical		○	○
Substantial		○	○
Moderate		○	○
Low		○	○
Total		○	○

10. What is the total gross annual expenditure on ADULTS WITH A PHYSICAL DISABILITY (aged 64 or below) by the following FACS groups? For categories in which no individuals are supported, please enter '0'.

	Gross annual cost (£)	Actual	Estimated
Critical		○	○
Substantial		○	○
Moderate		○	○
Low		○	○
		○	○

Total		

11. What is the total gross annual expenditure on ADULTS WITH A LEARNING DISABILITY (aged 64 or below) by the following FACS groups? For categories in which no individuals are supported, please enter '0'.

	Gross annual cost (£)	Actual	Estimated
Critical		○	○
Substantial		○	○
Moderate		○	○
Low		○	○
Total		○	○

12. What is the total gross annual expenditure on ADULTS WITH MENTAL HEALTH NEEDS (aged 64 or below) by the following FACS groups? For categories in which no individuals are supported, please enter '0'.

	Gross annual cost (£)	Actual	Estimated
Critical		○	○
Substantial		○	○
Moderate		○	○
Low		○	○
Total		○	○

13. What is the total gross annual expenditure on adults in the OTHER / ASYLUM user category (aged 64 or below) by the following FACS groups? For categories in which no individuals are supported, please enter '0'.

	Gross annual cost (£)	Actual	Estimated
Critical		○	○
Substantial		○	○
Moderate		○	○
Low		○	○
Total		○	○

14. Please indicate the time period(s) to which these figures correspond. (e.g. April 2010 to March 2011)

SHEET 6: ASSESSMENT INFORMATION

15. How is information on physical tasks recorded during assessment?

	Older people	Physical disabilities	Learning disabilities	Mental health	Other / Asylum
Information for all clients is collected in a standardised set of questions	○	○	○	○	○
The type and level of information collected varies between clients	○	○	○	○	○
This information is not collected	○	○	○	○	○

16. How is information on household tasks recorded during assessment?

	Older people	Physical disabilities	Learning disabilities	Mental health	Other / Asylum
Information for all clients is collected in a standardised set of questions	○	○	○	○	○
The type and level of information collected varies between clients	○	○	○	○	○
This information is not collected	○	○	○	○	○

17. How is information on informal care from friends and relatives collected during assessment?

	Older people	Physical disabilities	Learning disabilities	Mental health	Other / Asylum
Information for all clients is collected in a standardised set of questions	○	○	○	○	○
The type and level of information collected varies between clients	○	○	○	○	○
	○	○	○	○	○

This information is not collected	☐	☐	☐	☐	☐

18. How is information on mental health (anxiety, depression, loneliness etc) recorded during assessment?

	Older people	Physical disabilities	Learning disabilities	Mental health	Other / Asylum
Information for all clients is collected in a standardised set of questions	○	○	○	○	○
The type and level of information collected varies between clients	○	○	○	○	○
This information is not collected	○	○	○	○	○

19. How is information on risk of harm to the client or other people recorded during assessment?

	Older people	Physical disabilities	Learning disabilities	Mental health	Other / Asylum
Information for all clients is collected in a standardised set of questions	○	○	○	○	○
The type and level of information collected varies between clients	○	○	○	○	○
This information is not collected	○	○	○	○	○

20. How is information on risk of deteriorating needs recorded during assessment?

	Older people	Physical disabilities	Learning disabilities	Mental health	Other / Asylum
Information for all clients is collected in a standardised set of questions	○	○	○	○	○
The type and level of information collected varies between clients	○	○	○	○	○
	○	○	○	○	○

This information is not collected ☐ ☐ ☐ ☐ ☐

SHEET 7: ASSESSMENT TOOLS

21. Is a standard assessment procedure used across the authority?

- ○ Yes
- ○ No

22. Is the same assessment form used for all user groups?

- ○ Yes
- ○ No

23. Which, if any, of the following third-party toolkits are used for needs assessment? (Select all that apply)

- ☐ CAT
- ☐ EASY-Care
- ☐ FACE (Functional Assessment of the Care Environment for Older People)
- ☐ MDS: Assessment Tools for Older People
- ☐ NOAT: Northampton Overview Assesssment Tool
- ☐ STEP: Standardised Assessment of Elderly People in Primary Care in Europe
- ☐ Other (please specify)

24. How is assessment information stored by the council? (Select all that apply)

- ☐ Scanned records
- ☐ Word processor documents (eg Microsoft Word)
- ☐ Standardised dataset (eg Microsoft Access)
- ☐ Paper records
- ☐ Other (please specify)

SHEET 8: DETERMINING FACS GROUPS

25. Please give a brief description of how the council determines FACS group (Does it use fixed rules, e.g. anyone with a certain number of ADL problems will be in the 'critical' group, or a more general form of guidance?)

26. Is the FACS group recorded on the assessment documentation?

◯	The exact FACS group of an individual is recorded
◯	Whether an individual is eligible is recorded but not the exact FACS group
◯	No

27. Please give a brief description of the process used to determine the size of an individual's care package (hours of support or amount of cash allowance). Does this take into account their FACS group, or does it rely on a score based on other factors?

SHEET 9: CARE MANAGEMENT

28 How many care managers provide assessments for each of the following user groups?

Older people / adults with a physical disability	
Adults with a learning disability	
Adults with mental health needs	
Other / asylum	
Total (excluding double counting)	

29 What proportion of care managers for each user group are qualified social workers? (%)(If you do not have access to these figures, please provide an estimate if possible)

Older people / adults with a physical disability	
Adults with a learning disability	
Adults with mental health needs	
Other / asylum	
Total (excluding double counting)	

SHEET 10: DOCUMENTATION

In order for us to understand as much as possible about the processes used to determine FACS groups, it would be very helpful to see documents that are used by the council for the assessment process.

30. Please indicate below whether you have an electronic copy of the following documents available that you would be happy to share with us?

Council guidance on eligibility criteria	◯ yes	◯ no
Assessment forms	◯ yes	◯ no
Review forms	◯ yes	◯ no
Guidance on determining care package size	◯ yes	◯ no

31. In addition to Fair Access to Care Services implementation, one of the topics to be covered in the forthcoming White Paper on Care and Support will be charging for domiciliary care.

Do you have the following documentation available to assist with the development of this paper?

Charging policy for domiciliary care (including disability-related expenditure calculations)	◯ yes	◯ no

Please email copies of both sets of documents, if available, along with this survey once it has been completed.

SHEET 11: END OF SURVEY

Many thanks for taking the time to fill out this survey. Once all sections have been completed, please email to Tom Snell at t.r.snell@lse.ac.uk along with the documents listed in the previous section.

32. If you have any further comments about eligibility criteria, or any of the responses provided in this survey, please add them here.

APPENDIX 2: VIGNETTE RESPONSES

Older people vignette 1

Estimated FACS group (N=343)		Estimated eligibility (N=314)	
Not sure	15%	Not sure	0%
Low	4%	Definitely not	4%
Moderate	30%	Probably not	31%
Substantial	47%	Probably	37%
Critical	4%	Definitely	29%

Older people vignette 2

Estimated FACS group (N=333)		Estimated eligibility (N=311)	
Not sure	11%	Not sure	0%
Low	15%	Definitely not	17%
Moderate	42%	Probably not	50%
Substantial	27%	Probably	20%
Critical	5%	Definitely	14%

Older people vignette 3

Estimated FACS group (N=326)		Estimated eligibility (N=312)	
Not sure	9%	Not sure	0%
Low	1%	Definitely not	3%
Moderate	8%	Probably not	7%
Substantial	70%	Probably	38%
Critical	12%	Definitely	52%

Older people vignette 4

Estimated FACS group (N=323)		Estimated eligibility (N=309)	
Not sure	7%	Not sure	0%
Low	1%	Definitely not	0%
Moderate	6%	Probably not	3%
Substantial	72%	Probably	31%
Critical	14%	Definitely	66%

Older people vignette 5

Estimated FACS group (N=316)		Estimated eligibility (N=305)	
Not sure	6%	Not sure	0%
Low	2%	Definitely not	1%
Moderate	13%	Probably not	9%
Substantial	67%	Probably	39%
Critical	12%	Definitely	52%

Older people vignette 6

Estimated FACS group (N=316)		Estimated eligibility (N=300)	
Not sure	8%	Not sure	0%
Low	32%	Definitely not	34%
Moderate	50%	Probably not	48%
Substantial	9%	Probably	12%
Critical	1%	Definitely	6%

Younger adults with a physical disability vignette 1

Estimated FACS group (N=299)		Estimated eligibility (N=283)	
Not sure	11%	Not sure	0%
Low	16%	Definitely not	15%
Moderate	53%	Probably not	51%
Substantial	20%	Probably	26%
Critical	1%	Definitely	8%

Younger adults with a physical disability vignette 2

Estimated FACS group (N=293)		Estimated eligibility (N=287)	
Not sure	3%	Not sure	0%
Low	1%	Definitely not	0%
Moderate	8%	Probably not	4%
Substantial	71%	Probably	30%
Critical	16%	Definitely	65%

Younger adults with a physical disability vignette 3

Estimated FACS group (N=291)		Estimated eligibility (N=274)	
Not sure	8%	Not sure	0%
Low	2%	Definitely not	4%
Moderate	37%	Probably not	29%

Substantial	48%	Probably	38%
Critical	5%	Definitely	29%

Younger adults with a physical disability vignette 4

Estimated FACS group (N=285)		Estimated eligibility (N=276)	
Not sure	4%	Not sure	0%
Low	0%	Definitely not	0%
Moderate	9%	Probably not	4%
Substantial	73%	Probably	36%
Critical	14%	Definitely	61%

Younger adults with a physical disability vignette 5

Estimated FACS group (N=286)		Estimated eligibility (N=279)	
Not sure	2%	Not sure	0%
Low	0%	Definitely not	0%
Moderate	2%	Probably not	1%
Substantial	52%	Probably	18%
Critical	44%	Definitely	82%

Younger adults with a physical disability vignette 6

Estimated FACS group (N=285)		Estimated eligibility (N=275)	
Not sure	7%	Not sure	0%
Low	0%	Definitely not	0%
Moderate	6%	Probably not	5%
Substantial	49%	Probably	28%
Critical	38%	Definitely	68%

Younger adults with a learning disability vignette 1

Estimated FACS group (N=188)		Estimated eligibility (N=180)	
Not sure	11%	Not sure	0%
Low	7%	Definitely not	3%
Moderate	33%	Probably not	29%
Substantial	45%	Probably	44%
Critical	4%	Definitely	23%

Younger adults with a learning disability vignette 2

Estimated FACS group (N=188)		Estimated eligibility (N=183)	
Not sure	9%	Not sure	0%
Low	0%	Definitely not	3%
Moderate	1%	Probably not	2%
Substantial	42%	Probably	20%
Critical	48%	Definitely	76%

Younger adults with a learning disability vignette 3

Estimated FACS group (N=186)		Estimated eligibility (N=165)	
Not sure	18%	Not sure	0%
Low	2%	Definitely not	1%
Moderate	16%	Probably not	13%
Substantial	54%	Probably	47%
Critical	10%	Definitely	39%

Younger adults with a learning disability vignette 4

Estimated FACS group (N=185)		Estimated eligibility (N=163)	
Not sure	23%	Not sure	0%
Low	8%	Definitely not	10%
Moderate	34%	Probably not	40%
Substantial	29%	Probably	39%
Critical	5%	Definitely	10%

Younger adults with a learning disability vignette 5

Estimated FACS group (N=182)		Estimated eligibility (N=169)	
Not sure	10%	Not sure	0%
Low	7%	Definitely not	4%
Moderate	44%	Probably not	34%
Substantial	39%	Probably	51%
Critical	0%	Definitely	11%

Younger adults with mental health needs vignette 1

Estimated FACS group (N=161)		Estimated eligibility (N=150)	
Not sure	9%	Not sure	0%
Low	16%	Definitely not	15%
Moderate	45%	Probably not	46%

Substantial	26%	Probably	31%
Critical	4%	Definitely	7%

Younger adults with mental health needs vignette 2

Estimated FACS group (N=159)		Estimated eligibility (N=146)	
Not sure	13%	Not sure	0%
Low	2%	Definitely not	3%
Moderate	13%	Probably not	14%
Substantial	49%	Probably	40%
Critical	23%	Definitely	43%

Younger adults with mental health needs vignette 3

Estimated FACS group (N=156)		Estimated eligibility (N=144)	
Not sure	14%	Not sure	0%
Low	42%	Definitely not	27%
Moderate	37%	Probably not	62%
Substantial	7%	Probably	10%
Critical	0%	Definitely	1%

Younger adults with mental health needs vignette 4

Estimated FACS group (N=158)		Estimated eligibility (N=143)	
Not sure	15%	Not sure	0%
Low	4%	Definitely not	3%
Moderate	20%	Probably not	15%
Substantial	54%	Probably	50%
Critical	8%	Definitely	31%

Younger adults with mental health needs vignette 5

Estimated FACS group (N=157)		Estimated eligibility (N=140)	
Not sure	10%	Not sure	0%
Low	8%	Definitely not	5%
Moderate	27%	Probably not	21%
Substantial	50%	Probably	47%
Critical	5%	Definitely	27%

Younger adults with mental health needs vignette 6

Estimated FACS group (N=156)		Estimated eligibility (N=134)	
Not sure	17%	Not sure	0%
Low	21%	Definitely not	16%
Moderate	42%	Probably not	49%
Substantial	19%	Probably	25%
Critical	2%	Definitely	10%