The Care Act, Personalisation and the New Eligibility Regulations

A discussion paper about the future of care and support services for homeless people in England

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Abstract

As funding for Housing Related Support (formerly Supporting People) services continues to shrink, it is timely to revisit the question as to whether 'homeless people' are eligible for publically funded care and support, including personal budgets, organised through the local authority. The Care Act 2014 due to be implemented from April 2015 in England, heralds some positive changes which may serve to open the door to this funding stream which has rarely been used in support of 'homeless people'. As the law currently stands 'homeless people' as a service user group are not eligible for community care assessment (though people who are homeless and who fall into one of the 'eligible groups' by virtue of having a mental health or drug and alcohol problem may be). The Care Act 2014 removes reference to 'eligible' and 'ineligible' groups so that any adult with any level of need will have a right to an assessment. Exploring some of the ways in which homeless people have been excluded from care and support in the past, this paper outlines how homeless organisations can work with local authorities to ensure fairer and more consistent access and in so doing, potentially secure their own futures in the face of fewer 'block contracts' and more individualised forms of commissioning.

Key Words: Homelessness, care and support, housing related support, Care Act 2014, personalisation, personal budgets, eligibility

Introduction

The Care Act 2014 is the most significant reform of publicly funded care and support in England in 60 years. It fundamentally reframes local authorities' statutory duties from one of providing services for specific client groups to promoting wellbeing. It rescinds earlier legislation, including the NHS and Community Act 1990, with the aim of creating a single consistent route to establishing an entitlement to publically funded care and support. The Care Act 2014 further places personalisation on a statutory footing for the first time providing those who are eligible with a legal entitlement to a personal budget:

> 'To make the law fair and consistent, we want to remove many anomalies, which treat particular groups of people differently. We do not want people to be dealt with differently based on the type of service they need or where they receive it'
> (Department of Health, 2013 p1)

This policy review paper explores the implications of the Care Act 2014 for homelessness organisations and the people with whom they work. It is concerned principally with the 'culture shock' of the dawning realisation that following the removal of the Supporting People ring fence, the survival of many homelessness organisations now rests on the ability to assimilate the values and practices of the 'adult social care world'. We explore these values and practices with particular regard as to how they previously excluded many homeless people and, consequently the potential of the new eligibility regulations contained within the Care Act 2014 to overcome this. We begin, however, by charting how the 'parallel universe' comprising 'low-level-preventative-housing-related-support' has been quietly dismantled under austerity measures and the turn towards the valorisation of personalisation.

The assimilation of the Supporting People Programme within adult social care

In England, housing related support services for people who are homeless have developed largely in isolation from local authority adult social care. This stems back to the Supporting People Programme (Department of Social Security, 1998) which provided separate management arrangements and 'ring fenced' funding from 2003 onwards for a range of services designed to act as a bridge between general housing services and local authority social services (formerly personal social services). Whilst social services departments moved to refocus resources on crises intervention and higher levels of needs (mostly for personal care) with population ageing being a prime reason, housing providers were left to meet the needs of tenants requiring lower levels of support (Foord, 2005). Supporting People services were defined as 'housing related support' and encompassed a wide range of activities linked to helping people to obtain suitable housing, sustain their tenancy and gain skills and confidence. A key stipulation of the Supporting People Programme was that funding should not be used to provide direct 'care' but should focus on prevention and enabling people to maintain their independence.

Because the Supporting People Programme was positioned outside the community care legislation (NHS and Community Care Act 1990) this enabled many new groups who were not previously eligible for statutory support to receive some form of assistance. A defining feature of the Supporting People Programme was the proliferation of many innovative schemes and services designed to meet the needs of homeless people, people with substance misuse issues, ex-offenders, lone teenage parents, asylum seekers, refugees, gypsies and travellers, and other socially excluded or 'unpopular groups' (Foord, 2005 p6). Although many of these schemes were constructed by local funders or commissioners as providing preventative or lower levels of support, they often addressed complex social issues underpinned by high levels of multimorbidity linked mostly to mental health issues and drug and alcohol dependencies. In the homelessness sector, this complexity has increasingly been characterised as 'multiple exclusion homelessness' (Fitzpatrick et al., 2011; Cornes et al., 2011).

The end of the Supporting People Programme was signalled by the removal of the funding 'ring fence' in April 2009. This was justified principally on the grounds of enabling local authorities to make decisions as to where best to target resources to enable efficiency savings (Chartered Institute of Housing and Local Government Association, 2010). Assessing the risks associated with this, the Department for Communities and Local Government (DCLG, 2008) noted the concerns of local commissioners that the Supporting People Programme might be absorbed and then 'dissolved' within wider strategic planning and commissioning structures. In a recent survey of 83 commissioners from different areas across England, 45 reported that their dedicated Supporting People commissioning and procurement teams 'have either dispersed or integrated into the adult social care commissioning teams or have physically moved into closer geographical proximity within the same building' (SITRA, 2014 p22).

In the Care Act guidance (DH, 2014) it is significant that adult social care is now conceptualised as having a much broader 'care and support' function. This encompasses meeting needs relating to housing related support. While a clear boundary is to be maintained between the local authorities' 'care and support function' and their 'housing function' (e.g. to meet accommodation needs under the Housing Act 1996):

'There is nothing to stop local authorities in the care and support role from providing more specific services such as housing adaptations' (DH, 2014 p295 15.52).

The 'care and support' function is also envisaged as encompassing activities which were once in the domain of the Supporting People Programme, for example:

'Enabling individuals to recognise their own skills, ambitions and priorities and developing personal and community connections in relation to housing needs' (DH, 2014 p.295 s15.55).

Changes to homelessness services due to reductions in Supporting People spending

There have been numerous reports that following the removal of the Supporting People 'ring fence' housing related support services for all service user groups have been subject to funding cuts (House of Commons Library, 2012). The most recent estimate based on a forthcoming Joseph Rowntree Foundation study by Hastings et al. suggests that Supporting People overall spending budgeted by local government in England reduced by 48.8% in real terms between 2010/11 (original budget) and 2014/15 (quoted in Bramley and Fitzpatrick, 2015).

SITRA has voiced concerns that housing related support funding in some areas may be completely engulfed by other adult social care priorities:

'[Supporting People] commissioners reported facing round after round of funding cuts to [housing related support] services, resulting in energy and attention being solely directed to sustaining some level of housing related support activity' (SITRA 2014, p3)

Perkins and Hunter (2014) express similar concerns as regards the future of public health spending following the transfer of responsibility for public health from the NHS to local authorities. In the homelessness and housing related support sector this is often mooted as a possible alternative funding stream by virtue of the need to tackle health inequalities:

'The provision of social care occupies around 80% of local government spending and many local authorities predict that with the severe cuts affecting their services, within a few years local government may be providing little else but social care (Perkins and Hunter, 2014 p225).

The impact of these changes on the homelessness sector is quantified by Homeless Link, the national umbrella organisation for homelessness organisations, in its annual survey of providers. Key findings from the survey carried out in 2013 (Homeless Link, 2014) are as follows:

- There are 1,271 accommodation-based homeless services in England. In addition to accommodation, accommodation-based homelessness services such as hostels and supported housing projects provide a wide range of support to single homeless people including 'key working'; meaningful activities (such as art and gardening); advice; resettlement; and education, training and employment. These services are funded principally through housing benefit payments and through a range of other statutory and voluntary or charitable sources. Over a third of these accommodation based services reported funding cuts.

- While local authority funding for 'Housing-Related Support' (HRS) (previously Supporting People) funding was the main source of funding for 76% of accommodation-based providers in the previous year, this had fallen to 58% in 2013.

- As in previous years, the funding contribution from other statutory bodies such as criminal justice, health and substance misuse was low, with each providing funding for only around 4 per cent of accommodation services. In addition to HRS funding, social services and other local authority grants remained an important additional funding stream, providing funding to 28% and 19% of accommodation projects respectively.

- There are 216 homeless day centres in England, providing a wide range of support, usually on a 'drop in' basis including advice and support on housing, employment and education. Day centres also provide facilities for personal care and meals for 'rough sleepers' and will work with people who have no recourse to public funds. 31 per cent of day centres services reported an increase in their income in 2013 as compared to only 8 per cent of accommodation based services. This reflects that homelessness day centres which are often run by faith-based organisations have traditionally relied more on their own charitable fundraising efforts.

Overall, Homeless Link (2014) found that although many accommodation projects have experienced a reduction in funding, the number of 'beds' they provide has not dramatically reduced. The main changes resulting from funding reductions appear to be in the range of services offered and the level of support available. About one fifth (19%) of projects with less funding reported reducing the provision of 'key working' and a third (33%) reported reductions of 'meaningful' activities. Half (48%) the projects with less funding also cut the numbers of frontline staff, while 41% reduced their back-office or administrative support. These changes suggest that projects are operating with fewer staff to support the same number of service users. This finding mirrors that of an earlier survey by Capita and Inside Housing where 40% of respondents reported handling the same number of cases with fewer staff (McCabe, 2012).

One important consequence of this reduced capacity may be the tightening of access or eligibility criteria since three quarters (74% compared to 63% in the previous year) of accommodation providers reported that they had 'turned away' people whose needs were perceived as too challenging or high for them to manage:

> 'When [these impacts are] considered alongside the increasing number of projects saying they are not able to work with individuals with high and complex needs, there is a concerning trend emerging in the sector where those who need support the most are at greatest risk of not being able to access this' (Homeless Link 2014 p52) .

While these findings would suggest that homelessness services have made significant efficiencies, Homeless Link (2014) caution that there will be a limit as to how much further this can happen before core services are affected. In this latest manifesto to end homelessness, it is concluded that localised funding decisions have left homelessness service vulnerable and that there is a need for a nationally coordinated, long-term homelessness strategy with the investment and secure funding base to deliver it (Homeless Link, 2015). According to Whiteford this may be justified on the grounds that:

'Supporting People has been shown to have produced savings of more than 3.4 billion for the treasury by intervening early to prevent more severe problems from developing… These significant and substantive gains were guided by the powerful locomotive of record funding levels to local authorities, charitable organisations and social enterprises' (Whiteford, 2012 p14).

Cash for care and the end of block contracts

While the cuts to homelessness and housing related support services are part of the economic austerity measures imposed by the Coalition government, they also need to be placed in the context of the fundamental shift that is taking place in the commissioning and delivery of adult social care. From 2007 onwards, the policy of personalisation has been pursued by successive governments (DH, 2007) especially in England. While its meaning is contested it has come to be most strongly associated with the devolution of budgets down to the individual or a nominated budget-holder (Needham, 2011). In England, 'personal budgets' are designed to facilitate micro or individualised commissioning and to enable people to have greater choice and control over their care and support. Personal budgets encompass direct payments to service users (cash for care) and a range of managed options, including Individual Service Funds (ISFs) (Miller and Sanderson, 2014) . ISFs allow people to nominate a provider of their choice to manage their personal budget on their behalf. Providers can then make a charge for both the support that is provided and, subject to the discretion of the individual local authority, for managing the personal budget itself.

To facilitate increases in the purchasing of care and support by individual personal budget holders the bulk purchasing of services by local authorities and the use of block contracts such as those associated with the former Supporting People Programme are declining. As confirmed in the Care Act guidance (DH, 2014) social care and support commissioning is to become a force for 'market shaping' ensuring that service users and carers will have choice of support type and provider and can be assured of quality. In many areas this is already being achieved through the development of Framework agreements whereby local authorities establish a list of 'preferred providers' and set prices but do not give providers any guarantee of hours or custom, unlike block contracts where these elements were often guaranteed and service user choice limited to these providers (Rabiee, Glendinning and Baxter, 2013)

In Scotland, where 'cash for care' schemes have been implemented as part of the policy of 'Self-Directed Support' (SDS), Rosengard, Ridley and Manthorpe (2013) report that there is no reason why housing related support and modifications or equipment should not comprise part of a person's SDS package. In 2011-2012, while personal care was the main form of support purchased through individualised budgets in Scotland, 11% of packages also included the purchase of housing related support services. As noted above, the Care Act guidance (DH, 2014 p295) confirms that the interweaving of care with housing related and other forms of support is feasible in the context of English personal budgets.

Indeed, one of the benefits of using a personal budget is the potential for greater flexibility and integration. One major disadvantage of the Supporting People Programme was that in creating an artificial split between 'care' and 'support', it contributed to systemic problems which were not conducive to seamless services (Foord, 2005; Cornes et al., 2011). For example, older homeless people were often reported as falling through the 'cracks' in provision as their needs straddled

both care and support sectors, leading to disputes between agencies as to who was responsible (Crane and Warnes, 2001). Personal budgets have the potential to overcome these problems by removing the artificial barriers imposed by services. For example, where a person employs their own worker (a 'Personal Assistant' [PA]) they can expect integrated care in the sense that the PA can carry out both personal care and any other support tasks such as assisting the person to manage their household finances so long as they meet the outcomes that have been agreed with local authority.

Bolton (2014) suggests that personalisation can deliver savings for local authorities when delivered at scale and this may be particularly the case with regard to the development of a 'proper' Personal Assistant (PA) service. He estimates a PA to be about £1 an hour lower in cost than commissioned services even when paid the Living Wage. However, Roulstone (2013 p2) alerts us to the potential for a policy 'sleight of hand' in which a subtle change in language from 'personalisation' to 'personalised solutions' could mark the end of collective services and the expectation that 'self-provisioning must prevail in an era of chronic austerity'.

Indeed, there is some evidence that redirecting resources to promote individualised commissioning can impact negatively on the sustainability and quality of some existing services (Needham, 2013). There are, for example, reports of domiciliary care services becoming destabilised due to the increased use of zero hour contracts whereby the lack of certainty about income means that service providers are unwilling to offer staff guaranteed hours and are only willing to pay them for the hours when they work (Baxter et al., 2011). Although probably not ideal in any sector, these isolating arrangements will pose particular challenges for the homelessness workforce where there is a recognised need for support staff to have clinical supervision and the wider collegiate infrastructure embedded as part of 'Psychologically Informed Environments' (PIEs) (DCLG et al., 2012). This is necessary because of the distressing and emotionally challenging nature of the work where a lack of appropriate support and supervision is suggested to lead to poor practices and high levels of staff burnout and turnover (Scanlon and Adlam, 2012).

Increased individualisation also threatens the sustainability of some collective services and has already been linked to the closure of day centres and other buildings-based resources. As Needham (2013) points out, in a time of resource constraint these are becoming sites of contestation and delegitimization. Day centres for older people and people with disabilities are, she suggests, 'Increasingly associated with the 'one size fits all' provision of the pre-personalization era which makes them obvious targets for cost-savings at a time when adult social care budgets are being reduced substantially' (2013, p91). Touching on a research report by the charity Mencap (itself a day centre provider) which describes how the closure of day centres is leading to many personal budget holders 'being stuck at home', Needham concludes:

> 'Certainly the roll out of personalisation in a context of fiscal austerity… ensures that as local authority services are withdrawn, it can be difficult for people to access or even know what about is replacing them.' (2014 p4)

Readiness to contract with individual 'homeless' service users

The transformation of adult social care and support commissioning into a force for market shaping suggests that, even in era of 'post-austerity', consistent funding in the form of a Supporting People

style programme is unlikely to be reinstated so long as personalisation remains a policy goal. Furthermore, the broader developments taking place elsewhere in adult social care indicate that the survival of the 'support functions' embedded within many existing homelessness organisations may depend on the development of two key capabilities. First, is the ability to maximise any remaining local authority income by ensuring that day centres and other accommodation or buildings-based services are personalised in the sense of providing a bespoke rather than 'one size fits all' approach. Second, and perhaps most importantly given the likelihood of declining public sector funds for direct funding of services, such organisations need to develop the ability to contract with individual personal budget holders.

A recent review of personalisation in the homelessness sector carried out by Homeless Link (2014) suggests that while homelessness services are making good progress as regards the first of these capabilities, they remain largely ill prepared to contract with individuals. SITRA (2014) also reports that personal budgets are not common in housing related support services.

Focusing on the lack of integration across health, housing and social care, Cornes et al. (2011) describe how homelessness services often work with people with multiple and complex needs 'in house' rather than refer them to the local authority adult social care department. This may be the case even where people's needs may pose substantial and critical risks to their independence and well-being, meaning that they may be eligible for a (local authority) personal budget.

Indeed, while particular attention has been drawn to the slow uptake of personal budgets among people with mental health problems (Royal College of Psychiatrists and Associate of Directors of Social Services, 2013; Larsen et al, 2013) there has been very little awareness raising or campaigning about the rights of people who are homelessness or who fall into one of the other 'unpopular' groups. In particular, the need for staff skills development, especially as regard challenging stereotypical views about who can 'manage' personal budgets, are thought to be key in increasing uptake (Royal College of Psychiatrists and Associate of Directors of Social Services, 2013).

Furthermore, the protected funding afforded through the Supporting People Programme has enabled homelessness agencies to pursue their own approaches to personalisation which are in some key respects at odds with those developed in adult social care. In the homelessness and housing related support sector, personalisation is often assumed to be analogous with 'person centred care'. Therein personal budgets are 'recognised as one of the many ways of delivering personalised services, but not the central one' (SITRA, 2014 p15). In adult social care the goal is that everyone should be offered a personal budget:

> 'Personal budgets need to be included in the law as they are important for making care and support personalised. If they are not in law it will be more difficult to offer them to everyone. While some local authorities are already making great progress in this area, legislation is needed to make it happen everywhere' (DH 2013 p2)

Where personal budgets exist in homelessness services these tend to be financially managed or gifted through the service provider. This means that while people who are homeless may be offered a choice of worker or even a 'menu' of support activities from which to chose, they may not have the same choices as other adults to opt out of services altogether, and to employ their own workers or other means of having their care and support needs met. The personal budgets

provided through homeless services are usually limited to either a one off amount to enable a specific resettlement outcome or otherwise set at the level of 'pocket money' with the workers often remaining in control of the cash without the people necessarily knowing the amount that is available to them (Homeless Link, 2014). Discussing the evaluation of a personal budgets pilot for 'rough sleepers' in London, Hough and Rice (2010) make the point that unlike the 'personalisation model' in social care, there is no specific allocation system for the resources and no formal assessment of participants' needs. Personal budgets for the resettlement of 'rough sleepers' in what has now been taken forward as a Pan-London scheme have been set at a one off payment of up to £3,000 (Blackender and Prestige, 2014). Although not strictly comparable given that this one-off payment might be viewed more as an 'extra needs payment' or 'set-up fund' it is worth noting however, that the average (potentially) recurring annual personal budget organised through the local authority for person with a learning disability has been reported to be in the region of £27,000 with older people's budgets lower at around £14,000 (Age UK, 2012).

While the possible unwillingness to put people who are homeless in control of their personal budget could be construed as evidence of paternalism, evaluations of the personalisation pilots in the homelessness sector have consistently argued that, 'Personalised support is just as, if not more important as the budget' (Blackender and Prestige, 2014 p23). One advantage of the personalisation 'pilots' seems to have been that they enabled workers to spend more time with service users and to deliver the continuous more relational and non-conditional kinds of support that is most acceptable to them, thus:

> 'Personalised approaches seem to be most effective where workers are given time and flexibility to support clients as they require, with no time bound targets to achieve results with small case loads' (Homeless Link 2013 p30)

The argument that it is 'person-centred care' and not 'personal budgets' that people want is increasingly finding expression elsewhere in adult social care where there is a growing critique of the Coalition government's highly individualist and consumerist approach. A recent report by the Association of Directors of Adult Social Services (ADASS, 2012) for example, suggests that what matters most to older people is not so much who provides care and support, but what is available when and whether they feel they have a rapport and a relationship with that particular care worker.

As touched upon above, while homelessness organisations have tended to view adult social care practices as an 'alternative model' of personalisation, often acknowledging the need for greater integration and more shared learning (Homeless Link, 2014, SITRA, 2014), the Care Act 2014 gives eligible people rights to personal budgets (the adult social care model) for the first time. This means that:

> 'Everyone whose needs are met by the local authority… must receive a personal budget as part of the care and support plan, or support plan. The personal budget is an important tool that gives the person clear information regarding the money that has been allocated to meet the needs identified in the assessment and recorded in the plan. An indicative amount should be shared with the person, and anybody else involved, at the start of care and support planning, with the final amount of the personal budget confirmed through this process' (DH, 2014, p188).

Discussing what this is likely to mean for former Supporting People service users, SITRA observes that:

> 'For those who are eligible [for personal budgets organised through adult social care], care packages can still address many of the different [housing related support] needs of individuals and can be personalised. However, for service users, who do not fit the criteria, there is not any plan [in the five local authority areas studied] to deliver any direct support services, let alone personalised services' (SITRA, 2014)

This poses a dilemma for homelessness organisations, especially those with an advocacy role. Namely, how to reconcile the need to increase the uptake of (local authority) personal budgets so that homeless people continue to receive some form of support with the belief (that is widely held across the sector) that it is actually well resourced collective services that are the way forward. This touches on what West (2013) calls the 'ideological efficiency' of personalisation which serves to silence critiques of austerity by positioning these as inherently paternalistic and anti 'choice and control'.

Who is eligible for publically funded care and support?

For people who have care and support needs intertwined with homelessness the evidence so far suggests that policy is at a critical juncture. On the one hand, some authors argue that the end of the Supporting People Programme signals a further retrenchment of the welfare state and the withdrawal of support from 'unpopular groups':

> 'If you are homeless, with a drug and alcohol problem and a criminal past, your chances of finding help are becoming much slimmer. As homeless services continue to experience savage funding cuts they are increasingly being forced to turn away the most vulnerable' (Twinch, 2014 p1)

On the other hand, the Care Act 2014 opens up new opportunities for increased choice and control but mainly only for those people who are eligible for publically funded care and support. Importantly, the Care Act 2014 will introduce a new set of eligibility regulations with effect from April 2015. The new regulations will remove reference to 'eligible' and 'ineligible groups' so that any adult with any level of need will have a right to an assessment (DH 2013, 1.9). As we shall explore below, this has the potential to open-up access to adult social care and personal budgets among previously excluded groups including 'homeless people' and to potentially off-set some of the impacts of the austerity measures. However, securing the benefits from these changes will be far from straightforward and requires action now on the part of those who advocate for homeless people's rights.

While the current eligibility criteria and guidance, often referred to as 'FACS' (Fair Access to Care Services) (DH, 2010) presents a mask of fairness and objectivity, it has been linked to Lipsky's (1980) work on street-level bureaucracy (or professional discretion). Ellis (2011), for example, suggests that because the eligibility criteria are naturally not able to fit every circumstance, and the number of people requiring 'processing' exceeds time and other resources available, rules are interpreted, bent, broken or ignored and tasks performed in ways that enable frontline staff to cope with the demands of the job. West (2013, p649) argues that because national policy relies on legal

ambiguity workers quickly become ambivalent about the rules and that judicial review is needed periodically to 'pull policy actors momentarily back to the rules diverting them from pragmatic politics'. Discussing the potential for safeguarding issues to arise out of progressively applying more restrictive eligibility criteria, Mandelstam (2013 p123) highlights one illustrative case where the regulator intervened on the grounds that the local authority that had visited a woman at home, assessed her as managing her own personal care and closed the case – having first recorded that she was unkempt, her knickers were round her knees, there was evidence of faeces on the floor and she was not taking her medication.

Slasberg (2013) argues that the 'elasticity' inherent in the current eligibility criteria hides major inequities between different user groups. Despite local authorities operating with the same eligibility criteria for all user groups, he notes that older people appear to have a much more restricted range of needs met than working age people (hence the differences noted above in the average amounts paid as personal budgets). There is evidence to suggest that people who are homeless fair particularly badly in getting their needs assessed and banded correctly and often fail to access an assessment at all (Crane and Warnes, 2001; Cornes et al, 2011). The pre-Care Act legislation is complex and ambiguous when it comes to 'homeless people'. People's eligibility for help depends (under the 1990 NHS and Community Care Act) first, on them falling within a defined category such as disability, age or mental disorder. It can be argued then that 'homeless people' do not fall within one of these eligible user groups and so are ineligible for a community care assessment. However, if a homeless person falls into one of the 'eligible groups' by virtue of having a mental health issue such as anxiety or depression or drug or alcohol problem then they are entitled to a community care assessment (see for example, R v Bristol CC, ex Penfold). Removing reference to particular groups was a specific recommendation of the Law Commission (Law Commission, 2011) on the grounds that it would make it easier to understand when the duty of assessment was triggered. As a result:

> 'It also follows that the ambit of the new [Care Act] legislation will be in principle wider than that of the existing legislation. This might mean that certain vulnerable adults who previously have been passed over by social services – on the grounds that they did not come within a certain user group defined in legislation – will in future not be excluded (Mandelstam, 2013 p.80)

As regards the second stage of the FACs eligibility test, another reason why the needs of homeless people may be discounted by social work assessors relates to the (miss)perception that homelessness is primarily a 'housing issue' or a 'lifestyle choice' and ipso facto linked to needs not 'high enough' to meet the eligibility criteria for adult social care (Cornes et al., 2011). The FACS guidance contains four bands which grade the seriousness of the risks posed to independence and well-being if needs are not addressed (DH 2010, p21). Needs are banded as low, moderate, substantial and critical with many local authorities only meeting those needs identified as substantial or above. At the highest end of the scale 'critical risks' are identified as those where, among other factors, life is or will be threatened or serious health problems have or will develop (DH, 2010 p21). The association of homelessness services with 'low level preventive support' in the Supporting People regime may have legitimized practice decisions in the operation of the FACs criteria that homelessness itself can be understood mainly as posing only low to moderate risks to independence. This is counter to the growing body of research evidence (see Hewett et al., 2012 for an overview) which demonstrates that long-term homelessness is characterised by

"tri-morbidity" (the combination of mental ill health, physical ill health, and drug or alcohol misuse) and that it is an independent risk factor for premature mortality where the average age at death is 40.5 years.

A further stumbling block to meeting the social care needs of some 'homeless people' has centred on inclusion. While the FACS guidance states that needs relating to social inclusion and participation should be seen as just as important as needs relating to personal care (DH 2010, p61) local authorities have increasingly disregarded this and restricted provision to a very limited range of personal care services (Raibee, Glendinning and Baxter, 2013). This has the effect of discouraging many homelessness workers from referring 'homeless people' to local authority adult services on the grounds that their needs will not be relevant other than in a very small number of cases where there is a clear need for personal care, for example, in the case of an older homelessness person who may need care that can only be provided in a care home rather than a hostel. As noted above, such referrals are themselves rarely straightforward and often lead to disputes between agencies as to which should take on responsibility (Crane and Warnes, 2001). This is linked to what has become known as the 'inverse care law' in which people with the most complex and very highest levels of need fall through the cracks in community care provision (Keane, 2001) with consequent impact on the acute sector:

> 'People's access to community services (from primary care… through to housing and social care) is regulated by complex and contradictory rules… These barriers to care result in more medical emergencies. Homeless people in England emergency departments five times more often as those people who are not homeless and are admitted 3.2 times as often… Despite high expenditure on unscheduled care for homeless patients the clinical outcomes are generally appalling' (Hewett et al., 2012 p1).

One important policy goal behind the introduction of new 'Care and Support (Eligibility Criteria) Regulations, 2014 (DH 2014) (see Appendix 1) is the desire to remove local variation or what is sometimes termed a post code lottery in which the threshold for entitlement to publicly funded care and support varies between local authorities. The Care Act 2014 sets a new national minimum threshold designed to be at the level of substantial or lower. In the new regulations, the bands have been replaced and the key trigger for determining eligibility now hinges on 'identifying how a person's needs affect their ability to achieve relevant outcomes, and how this impacts on their wellbeing' (DH, 2014 p96).

From a common sense point of view, this might be taken as very 'good news' for homeless people since it is difficult to think of a situation in which being homeless would not have a significantly negative impact on a person's wellbeing. However, the regulations are specific and nuanced and for advocacy purposes, what counts is not the fact of being 'homeless' but the associated morbidity. In the regulations needs must arise from physical or mental impairment or illness. Helpfully, the Care Act guidance (DH, 2014) makes it clear that relevant conditions include 'substance misuse' (p96) and with regard to mental impairment that, 'A formal diagnosis of the condition should not be required' (p96). This latter point is especially relevant to people who are homeless and who may be experiencing 'complex trauma' or 'personality disorder' since some may have been excluded from treatment and support on the grounds that they do not have a formal diagnosis (St Mungo's, 2009).

Once a physical or mental impairment has been identified, the next test is to determine if as a

result of this, the person is unable to achieve two or more of the outcomes that are specified in the regulations (see Appendix 1). There are ten outcomes which lie on a spectrum encompassing both personal care, inclusion and housing related support ranging from 'managing toilet needs' to 'accessing and engaging in work, training, education and volunteering' to 'maintaining a habitable home environment'. In the guidance maintaining a habitable home environment encompasses, 'Support to sustain their occupancy of the home and to maintain amenities, such as water, electricity and gas' (DH, 2014 p98). Finally, the local authority must then consider whether the adult's needs and their inability to achieve the outcomes above cause or risk causing a significant impact on their wellbeing. According to the guidance:

> 'The term "significant" is not defined by the regulations, and must therefore be understood to have its everyday meaning' (DH, 2014 p.99)

Given what is known about the very high levels of physical and mental impairment (morbidity) in the homeless population and the very poor outcomes associated with this (e.g. premature mortality), then the new eligibility regulations do appear to potentially open the door to many people falling within this previously excluded group. As an indicative figure, research on severe and multiple disadvantage in England which uses data linkage to quantify the number of individuals who have overlapping experiences of homelessness, substance misuse and offending (where mental ill-health and complex trauma is a very common complicating factor) suggests that the 'average' local authority might expect to receive around 1,470 referrals over the course of a year (Bramley and Fitzpatrick, 2015). However, Slasberg's (2013) warns that the new regulations could potentially amount to 'no change at all' if the underpinning resource allocation system remains unchanged wherein only those needs that can be afforded by the local authority will described as sufficiently 'significant'. In effect, he alerts us to the potential for continued discretion and elasticity in professional judgement and interpretation.

Indeed, recasting homelessness as principally an issue of 'impaired health' is not without its drawbacks. Collingbourne (2014) mourns the assent of the Care Act 2014 as a missed opportunity to leave behind once and for all the 'medical model' of disability and to move to an approach based more explicitly on securing the rule of law and human rights for people. In particular, she criticises the failure to introduce a clear statutory right to live independently and to be included in the community. The concept of independent living (and the social model of disability) which is at the heart of the disabled people's movement melds together the civil and political rights to autonomy and participation with the socio-economic right to the support services essential for their exercise. Under the Care Act 2014, while local authorities have a statutory duty to carry out an assessment, support remains very firmly a welfare entitlement subject to the 'gift' (or denial) of the local state.

Recommendations

In summary, visioning what 'next practice' will look like for people who have care and support needs entwined with experiences of homelessness is necessary given the removal of the Supporting People ring fence and the implications of the Care Act 2014. On the positive side, personal budgets offer an opportunity to promote increased choice and control and to meet individual outcomes. On the downside, there is evidence that individualisation may be associated with significant retrenchment of the welfare state especially when it comes to 'unpopular groups'

defined as requiring only low level preventive support.

In seeking to address issues of retrenchment it may be helpful to view the Care Act 2014 not as a new charter of rights and responsibilities but as a potential window of opportunity through which some of the poor and exclusionary practices described above might be challenged. There is a need for homeless organisations to forge new collegiate working relationships with commissioners in adult social care and to become actively engaged in the implementation phase of the Care Act. This engagement should aim to 'negotiate' how the new eligibility regulations will be implemented locally. It should seek to raise awareness about concepts such as 'multiple exclusion homelessness' which broaden understandings of homelessness beyond issues of housing accessibility and poor lifestyle choices. As Hewett et al. point out, the increasing evidence that homelessness is an independent risk factor for premature mortality should encourage us to 're-examine the inverse care law and rebalance the provision of health [and social care]' (submitted p4).

For front line workers in homelessness organisations, it will be important that they receive training and become well-versed and confident in the application of the new eligibility regulations and have the skills and knowledge to actively promote the increased uptake of the personal budgets. For social work assessors it will be important to ensure that they have the skills to undertake assessments with homeless people who may have had previous negative or poor experiences of their local authority. There is also a need for closer integration with colleagues in 'homeless health' to ensure that the **significant impacts and outcomes** of the specific kinds of morbidity experienced by homeless people are well evidenced and understood in the context of the new social care and support assessment process. Finally, progress will need to be closely monitored especially as regard the increased uptake of personal budgets among 'unpopular groups'. While focussing on the need to increase the uptake of personal budgets may be perceived to detract attention away from what is happening to collective services, this is in some respects unavoidable given the funding black hole which has been created in some areas by the end of the Supporting People Programme.

References

Age UK (2012) *Age UK Uncovers unfair care funding post code lottery.*
http://www.ageuk.org.uk/latest-news/archive/age-uk-uncovers-unfair-care-funding-postcode-lottery/ [Accessed 1.2.15]

Association of Directors of Social Services (2012) *The Case for Tomorrow*. London: ADSS

Baxter, K., Wilberforce, M. and Glendinning, C. (2011) Personal budgets and the workforce implications for social care providers: expectations and early experiences, *Social Policy and Society*, 10(1) 55-65.

Blackender, L and Prestidge J. (2014) Pan London personalised budgets fro rough sleepers. *Journal of Integrated Care*. 22(1) 23-26

Bolton, J. (2014) *Finding Savings in Adult Social Care – Presentation for ADASS Seminar*
http://www.adass.org.uk/uploadedFiles/adass_content/events/1.%20John%20Bolton%20Presentation%2026.09.14.pdf [Accessed 1.2.15]

 Bramley, G. and Fitzpatrick, S. (2015) *Hard Edges: Mapping Severe and Multiple Disadvantage England.* London: Lankelly Chase Foundation

Chartered Institute of Housing and the Local Government Association (2010) *Supporting People: Supporting Service Change in a Time of Pressure.* London: CIH/LGA.

Collingbourne, T. (2012) The Care Act 2014: a missed opportunity. Web Journal of Current Legal Issues 20(3) 1-35

Cornes, M., Joly, L, Manthorpe, J., O'Halloran, S., and Smythe, R. (2011) Working Together to Address Multiple Exclusion Homelessness, *Social Policy and Society,* 10(4), 513-522

Crane M. & Warnes A. (2001) The responsibility to care for single homeless people. *Health and Social Care in the Community* 9 (6), 436–444.

Department for Communities and Local Government (DCLG) et al. (2012) *Psychologically Informed Services for Homeless People, Good Practice Guide*. DCLG, London.
http://www.southampton.ac.uk/assets/imported/transforms/peripheral-block/UsefulDownloads_Download/A6FD3BB1EB2A449987C12DFF91EF3F73/Good%20practice%20guide%20-%20%20Psychologically%20informed%20services%20for%20homeless%20people%20.pdf
[Accessed 1.2.15]

Department for Communities and Local Government (2008) *Changing Supporting People funding in England: Results from a pilot exercise – Summary*. London: DCLG

Department of Health (2007) Putting People First: A Shared Vision and Commitment to the Transformation of Adult Social Care. London: DH

Department of health (2010) Prioritising Need in the Context of Putting People First: A whole system approach to eligibility criteria for social care. London: DH/

Department of Health (2013) Fact Sheet 2. The Care Bill – Who is entitled to public care and support. London: DH
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/268679/Factsheet_2_update__tweak_.pdf [Accessed 1.2.15]

Department of Health (2014) *Care and Support Statutory Guidance*. London: DH.

Department for Social Security (1998) *Supporting People: A new policy and funding framework for support services.* London: HMSO

Ellis, K. (2011) Street level bureaucracy revisited: The Changing face of frontline discretion in adult social care in England. *Social Policy and Administration* 45(3) 221-224

Fitzpatrick, S., Johnsen, S and White, M. (2011) Multiple Exclusion Homelessness in the UK: Key Patterns and Intersections, *Social Policy and Society,* 10(4) 501-512

Ford, M and Simic, P (2005) *Housing, Community Care and Supported Housing – resolving contradictions.* Coventry: The Chartered Institute of Housing

Hewett N, Halligan A, Boyce T. (2012) A general practitioner and nurse led approach to improving hospital care for homeless people. BMJ 2012; 345-349

Hewett, N., Maguire, N., O'Connell, J., Perri, P. and Withers, J. (submitted) Inclusion Health 2 Health inequalities: what should we do? *The Lancet*

Homeless Link (2013) *Personally Speaking A review of personalised services for rough sleepers.* London: Homeless Link   http://www.homeless.org.uk/sites/default/files/site-attachments/Personally%20speaking%20Dec%202013.pdf [Accessed 1.2.15]

Homeless Link (2015) *Let's Make the Difference: A manifesto to end homelessness*. London: Homeless Link.
http://www.homeless.org.uk/sites/default/files/site-attachments/Make%20the%20Difference%20-%20a%20manifesto%20to%20end%20homelessness.pdf [Accessed 1.2.15]

Hough, J. and Rice, B. (2010) *Providing Personalised Support to Rough Sleepers*. York: Joseph Rowntree Foundation. http://www.jrf.org.uk/sites/files/jrf/supporting-rough-sleepers-full.pdf [Accessed 1.2.15]

House of Commons Library (2012) The Supporting People Programme: Research Paper 12/40. London: House of Commons.
www.**parliament**.uk/briefing-**papers**/rp12-43.pdf [Accessed 1.2.15]

Keene, J. (2001), *Clients with complex needs,* Interprofessional Practice, London: Blackwell Publishing.

Law Commission (2011) Adult Social Care. *Law Com no.326 London: TSO.*

Larsen, J, Ainsworth, E., Harrop, C., Patterson, S., Hamilton, S., Szymczynska, P., Tew, J., Manthorpe, J. and Pinfold, V. (2013) 'Implementing personalisation for people with mental health problems: a comparative case study of four local authorities in England', *Journal of Mental Health* 22(2): 174–182.

Lipsky, M. (1980) *Street level Bureaucracy: Dilemmas of the individual in public services.* New York: Russell Sage Foundation.

Mandelstam, M. (2013) *Safeguarding Adults and the Law*. London: Jessica Kingsley.

McCabe, J. (2012) Staying afloat *Inside Housing,* 13th July http://www.insidehousing.co.uk/staying-afloat/6522720.article [Accessed 1.2.15]

Miller, R. and Sanderson, H. (2104) *Individual Service Funds Handbook: Implementing Personal Budgets in Provider Organisations.* London: Jessica Kingsley Publishers.

Needham, C. (2014, early online) The spaces of personalisation: Place and distance in caring labour. *Social Policy and Society*. DOI:10.1017/S1474746414000281

Needham, C. (2011) *Personalising Public Services: Understanding the Personalisation Narrative.* Bristol: The Policy Press.

Needham, C. (2013) Personalization: From day centres to community hubs? *Critical Social Policy*. 34(1), 2014, pp.90-108.

Perkins, N and Hunter, D. (2014) Health and Well-being Boards: a new dawn for public health partnerships? *Journal of Integrated Care*, 22(5/6) 220-229

Rabiee, P., Glendinning, C. and Baxter, K. (2013) How far do managed personal budgets offer choice and control for older people using home care services? *SSCR Research Findings.* London: NIHR School for Social Care Research.

Royal College of Psychiatrists and the Association of Directors of Adult Social Services (2013) *The integration of personal budgets in social care and personal budgets in the NHS*. Position Statement ps01/2013 http://www.rcpsych.ac.uk/pdf/PS01_2013.pdf [Accessed 3.2.15]

Roulstone, A., Harrington, B., and Se Kwang Hang (2013) Flexible and personalised? An evaluation of a UK tailored employment support programme for job seekers with enduring mental health problems and learning difficulties. Scandinaivan. *Journal of Disability Research* 16 (1). pp. 14-28. ISSN 1501-7419

Rosengard, A., Ridley, J. and Manthorpe, J. (2013) Housing support and personalisation: observations from the Scottish Self- Directed Support Test Sites. *Housing, Care and Support* 16 (3/4) 136-144

Slasberg, C. (2013) A proposed eligibility framework to support delivery of the government's vision for a new care and support system. *Journal of Care Services Management,* 7(1) 26-37.

Scanlon, C. and Adlam, J. (2012a) The distressing effects of working in (dis)stressed homeless organisations. *Housing, Care and Support*, 15(2), 74-82.

SITRA (2014) *Commissioning for Choice and Control*. London: SITRA
http://www.sitra.org/documents/commissioning-for-choice-and-control/?preview=true [Accessed 1.2.15]

St Mungo's (2009) *Down and Out? The final report of St Mungo's Call for Evidence: mental health and street homelessness. London: St Mungo's*

Twinch, E. (2014) Turned Away. *Inside Housing*, 14th March
http://www.insidehousing.co.uk/turned-away/6526672.article [Accessed 1.2.15]

West, K. (2013) The grip of personalisation in adult social care: Between managerial domination and fantasy. *Critical Social Policy* 33(4) 638-657)

Whiteford, M. (2013) New Labour, Street Homelessness and Social Exclusion: A Defaulted Promissory Note? Housing Studies. Vol. 28 Issue 1 pp. 10-32.

DRAFT STATUTORY INSTRUMENTS

2014 No. 000

SOCIAL CARE, ENGLAND

The Care and Support (Eligibility Criteria) Regulations 2014

The Secretary of State makes these Regulations in exercise of the powers conferred by sections 13(7) and (8) and 125(7) and (8) of the Care Act 2014(a).

A draft of this instrument has been laid before and approved by a resolution of each House of Parliament in accordance with section 125(4)(a) of that Act.

Citation and commencement

1. These Regulations may be cited as the Care and Support (Eligibility Criteria) Regulations 2014 and come into force immediately after section 13(7) of the Care Act 2014 comes fully into force(b).

Needs which meet the eligibility criteria: adults who need care and support

2.—(1) An adult's needs meet the eligibility criteria if—

(a) the adult's needs arise from or are related to a physical or mental impairment or illness;

(b) as a result of the adult's needs the adult is unable to achieve two or more of the outcomes specified in paragraph (2); and

(c) as a consequence there is, or is likely to be, a significant impact on the adult's well-being.

(2) The specified outcomes are—

(a) managing and maintaining nutrition;

(b) maintaining personal hygiene;

(c) managing toilet needs;

(d) being appropriately clothed;

(e) being able to make use of the adult's home safely;

(f) maintaining a habitable home environment;

(g) developing and maintaining family or other personal relationships;

(h) accessing and engaging in work, training, education or volunteering;

(i) making use of necessary facilities or services in the local community including public transport, and recreational facilities or services; and

(j) carrying out any caring responsibilities the adult has for a child.

(3) For the purposes of this regulation an adult is to be regarded as being unable to achieve an outcome if the adult—

(a) is unable to achieve it without assistance;

(b) is able to achieve it without assistance but doing so causes the adult significant pain, distress or anxiety;

(c) is able to achieve it without assistance but doing so endangers or is likely to endanger the health or safety of the adult, or of others; or

(d) is able to achieve it without assistance but takes significantly longer than would normally be expected.

(4) Where the level of an adult's needs fluctuates, in determining whether the adult's needs meet the eligibility criteria, the local authority must take into account the adult's circumstances over such period as it considers necessary to establish accurately the adult's level of need.

Needs which meet the eligibility criteria: carers

3.—(1) A carer's needs meet the eligibility criteria if—

(a) the needs arise as a consequence of providing necessary care for an adult;

b) the effect of the carer's needs is that any of the circumstances specified in paragraph (2) apply to the carer; and

(c) as a consequence of that fact there is, or is likely to be, a significant impact on the carer's well-being.

(2) The circumstances specified in this paragraph are as follows—(a) the carer's physical or mental health is, or is at risk of, deteriorating; (b) the carer is unable to achieve any of the following outcomes—

(i) carrying out any caring responsibilities the carer has for a child;

(ii) providing care to other persons for whom the carer provides care;

(iii) maintaining a habitable home environment in the carer's home (whether or not this is also the home of the adult needing care);

(iv) managing and maintaining nutrition;

(v) developing and maintaining family or other personal relationships;

(vi) engaging in work, training, education or volunteering;

(vii) making use of necessary facilities or services in the local community, including recreational facilities or services; and

(viii) engaging in recreational activities.

(3) For the purposes of paragraph (2) a carer is to be regarded as being unable to achieve an outcome if the carer—

. (a) is unable to achieve it without assistance;

. (b) is able to achieve it without assistance but doing so causes the carer significant pain, distress or anxiety; or

. (c) is able to achieve it without assistance but doing so endangers or is likely to endanger the health or safety of the carer, or of others.

(4) Where the level of a carer's needs fluctuates, in determining whether the carer's needs meet the eligibility criteria, the local authority must take into account the carer's circumstances over such period as it considers necessary to establish accurately the carer's level of need.

The Social Care Institute of Excellence has produced a training guide on the application of the eligibility criteria:

http://www.scie.org.uk/care-act-2014/assessment-and-eligibility/eligibility/outcomes-care-support-needs.asp

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