RESOURCE ALLOCATION AT THE MICRO LEVEL IN ADULT SOCIAL CARE
A SCOPING REVIEW

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The Personal Social Services Research Unit (PSSRU) was originally established at the University of Kent in 1974. The branch at Manchester was established in 1996.

The PSSRU at Manchester has been part of the NIHR School for Social Care Research since the commencement of the School in 2009.

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Abstract (Summary)

Determining how public resources are allocated according to competing demands, local conditions and the needs and circumstances of users is a perennial challenge for social care. This review addresses a newly controversial and important activity in adult social care that was previously a core part of professional practice, namely resource allocation in relation to needs and desired outcomes at the individual level. It aims to provide an overview of the range of resource allocation approaches that have been adopted since the community care reforms of the 1990s, with a particular focus on more recent developments.

Policy themes pertinent to the allocation of social care resources were reviewed first to provide the context. A scoping review approach was then adopted to provide an overview of the state of knowledge in this area. The approach incorporates elements of the systematic review process while studies of varied designs and quality were considered.

Thirty two documents from a variety of sources were included (publication 1991-2012). Nearly half of these were unpublished reports. A summary framework separated studies into those conducted early in the review period arising from the community care reforms, and those conducted more recently in response to personalisation initiatives.

Studies in the early phase mainly described resource allocation process. It appeared that screening and assessment practice varied across types of teams and settings, with staff in specialist teams enjoying a greater degree of professional autonomy. The role of discretion was also evident in the implementation of the Fair Access to Care Services guidance and direct payments. There were marked variations in assessment tools for older people and a lack of clear linkage between assessment and care planning. It was also noted that the criteria used by care managers for the allocation of resources were unclear and inconsistent and decisions varied consequently. Examples of the construction of care packages and attempts to match needs to resources by classification of service users were also described.

Several approaches to resource allocation and variations in their application were reported in the second category. The former included the resource allocation systems (RAS) developed by In Control and FACE, approaches with a focus on outcome, and Individual Service Funds. Most developments found in the literature relate to authorities using the In Control model. The most important area of intra-authority variation is the practice of allocating resources to different user groups. Inter-authority variations were noted in approaches to needs questionnaire, and how identified needs were converted into points and different funding levels. Authorities also employed ‘inflators’, ‘deflators’, and ceilings to adjust the indicative budgets by different criteria such as need for specialist input. Quite often the indicative amount generated by RAS needed to be subsequently approved by a panel of managers. There was also evidence of inter-authority variation with regard to how carers’ contribution and needs were addressed by their RAS.

This review indicates that there is a lack of empirical evidence in terms of both quantity and quality with respect to resource allocation processes and approaches at the micro level. This is especially true for studies conducted in response to self-directed support initiatives as part of the personalisation agenda. In conclusion, perspectives on the principal approaches to resource allocation, the needs and contribution of carers, the role of discretion, the management of finite resources, and long-term prospects are discussed.

Key words

Resource allocation; resource allocation system; social care; needs; outcomes
Introduction

Determining how public resources are allocated according to competing demands, local conditions and the needs and circumstances of users is at the heart of social care practice. Over a third of local authority expenditure is on social care (ADASS, 2015). Resource allocation mechanisms in social care operate at three levels (Allen et al., 2004; DH, 2009a; Fraser & Estabrooks, 2008).

- At the macro level, local authorities receive funding from central government for services including social care, in addition to their own resources, based on formulae that take into account demographic and deprivation indicators.

- At the meso level, local authorities make decisions about the balance of resources allocated to different departments, services or geographical areas within an authority.

- At the micro level, decisions about individual care packages are made, often by care managers on the basis of assessment, sometimes sanctioned by more senior staff members in terms of priorities and financial sustainability.

In recent years, this professional-based allocation system is being replaced by more user-centred and ‘individualised’ systems, part of the ‘personalisation’ agenda in social care (Cm 6737, 2006; HM Government, 2007; DH, 2008a). Nevertheless, matching resources to needs remains a perennial issue (Knapp et al., 2004; ADASS, 2010). Whatever mechanism is adopted to allocate resources, the challenge is to develop a transparent resource allocation system in which the needs of individuals can be related clearly to the resources expended. Moreover, such an approach must be fair, workable, and financially sustainable.

To date, most publications on resource allocation have focused on the macro or meso level (Blackman & Atkinson, 1997; DCLG, 2012; Glasby, 2003; Fetter et al., 1980; Mays, 1995), and there is a dearth of empirical work regarding the micro level. This review focuses on the latter. It aims to provide an overview of the range of resource allocation approaches that have been adopted since the community care reforms of the 1990s, with a particular focus on more recent developments. The review is divided into four parts: policy context, method, findings and discussion.
Policy Context

This section reviews policy initiatives from central government relevant to the allocation of publicly funded social care resources by local authorities to service users. Where appropriate, there is a specific focus on older people and adults with a learning disability. Developments in relation to five inter-related themes – eligibility criteria, assessment of need and support planning, resource allocation processes, the needs and contribution of carers and managing finite resources – are discussed below (Table 1). They have been selected from the range of policy guidance subsequent to the introduction of the community care reforms of the 1990s, which has advocated that the provision of social care should: promote consistency in access to assistance across the country; encourage independence; fit individual needs; and give people choice and control over the care and support they receive. These are summarised in Table 2.

<table>
<thead>
<tr>
<th>TABLE 1 : Policy themes pertinent to the allocation of social care resources (1989–2012)</th>
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</thead>
<tbody>
<tr>
<td>Theme</td>
</tr>
<tr>
<td>Eligibility criteria</td>
</tr>
<tr>
<td>Assessment of need and support planning</td>
</tr>
<tr>
<td>Resources allocation processes</td>
</tr>
<tr>
<td>Carers</td>
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<tr>
<td>Finite resources</td>
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</tbody>
</table>

Eligibility criteria

The present process of determining eligibility for social care has its origins in the community care reforms which required local authorities to establish and publicise criteria of eligibility for assessment irrespective of point of entry into the service (Cm 849, 1989). Subsequently it was noted that eligibility criteria were often unclear and local authorities were required to develop guidance about ‘what sorts of people with what kinds of need qualify for what types of service’ (Cm 4169, 1998 p23). To promote this the Fair Access to Care Services (FACS) guidance was introduced (DH, 2002). This permitted local authorities to interpret the national eligibility bandings and criteria according to the needs of their community and local budgetary considerations, with the aim that individuals in similar circumstances, within a council area, should receive services capable of achieving broadly similar outcomes. This approach was intended to lead to more consistent decisions about eligibility for care and assistance across England. The requirements for a greater emphasis on prevention, early intervention and enablement, which were construed as an
investment in wellbeing and a means to delay or prevent needs escalating, resulted in revised FACS guidance (Cm 6499, 2005; DH, 2007; 2008a; 2010a). However, local discretion in its implementation remained with resultant variation in the response of different councils to individuals with apparently similar levels of need. More recently, proposals for a new assessment and eligibility framework have been articulated and subsequently legislated with associated regulations specifying needs that meet the eligibility criteria with regard to adults who need care and support and their carers respectively (Cm 7673, 2009; Cm 8378, 2012; DH, 2014; HMSO, 2015).

**TABLE 2 : Relevant policy framework 1989–2014**

<table>
<thead>
<tr>
<th>Date</th>
<th>Policy initiative</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989</td>
<td>Caring for People Community Care in the Next Decade and Beyond (Cm 849)</td>
<td>Objectives included: development of community services to allow people to receive care at home; provision of practical support for carers; and introduction of assessment and care management to achieve these. Choice and independence as underlying themes.</td>
</tr>
<tr>
<td>1997</td>
<td>Better Services for Vulnerable People (EL(97)62, CI(97)21) (DH, 1997)</td>
<td>Placed a new emphasis on the use of multidisciplinary assessment for older people with complex needs.</td>
</tr>
<tr>
<td>1998</td>
<td>Modernising Social Services (Cm 4169)</td>
<td>Proposed services to help adults to live independently. Committed to creating greater consistency in access to assistance and services provided to meet individual needs. Aimed for more integrated health and social care and higher standards of care.</td>
</tr>
<tr>
<td>1999</td>
<td>Caring about Carers: A National Strategy for Carers (DH, 1999)</td>
<td>The first national carers’ strategy. Reviewed range of support that carers need. Information, support and care for carers identified as the three strategic elements to help carers carry out their responsibilities.</td>
</tr>
<tr>
<td>2000</td>
<td>The NHS Plan (Cm 4818 I)</td>
<td>Introduced intermediate care as a new tier of services to allow people to remain at home immediately after or through a period of acute illness. Commitment to make care by a registered nurse free for all regardless of where it is provided.</td>
</tr>
<tr>
<td>2001</td>
<td>Valuing People (Cm 5086)</td>
<td>Aimed to enable adults with a learning disability to live full and independent lives as part of their local communities by the availability of a wider range of housing and employment and other meaningful daytime activities and the provision of support to carers.</td>
</tr>
<tr>
<td>2001</td>
<td>National Service Framework for Older People (DH, 2001a)</td>
<td>Designed to raise quality and decrease variation in service provision by specifying standards and service models, identifying strategies to support their implementation and milestones to monitor progress. Introduced the Single Assessment Process.</td>
</tr>
<tr>
<td>2002</td>
<td>Fair Access to Care Services Guidance on Eligibility Criteria for Adult Social Care, LAC (2002)13 (DH, 2002a)</td>
<td>Provided local authorities with a framework for setting their eligibility criteria for adult social care, to facilitate fairer and more consistent eligibility decisions across the country.</td>
</tr>
</tbody>
</table>
TABLE 2: Relevant policy framework 1989–2014 (cont.)

<table>
<thead>
<tr>
<th>Date</th>
<th>Policy Initiative</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>Independence Well-being and Choice (Cm 6499)</td>
<td>Described a vision for social care: personalised services; individual budgets; a focus on preventative services; partnership working; and promotion of innovative models of service delivery.</td>
</tr>
<tr>
<td>2006</td>
<td>Our Health, Our Care, Our Say (Cm 6737)</td>
<td>Confirmed the vision set out in Cm 6499 through increased choice for people; the promotion of local initiatives to address inequalities in and improved access to community services; earlier intervention and better prevention services by health and social care agencies; and greater support for people with long term needs.</td>
</tr>
<tr>
<td>2007</td>
<td>Putting People First: A Shared Vision and Commitment to the Transformation of Adult Social Care (DH, 2007)</td>
<td>Established concordat between central and local government. Commitment to common assessment process for social care needs with greater emphasis on self-assessment; personal budgets to be provided for all eligible for publicly funded social care; and the interdependence of care and support with role of carers acknowledged.</td>
</tr>
<tr>
<td>2009</td>
<td>Shaping the Future of Care Together (Cm 7673)</td>
<td>Outlined a vision for a new care and support system. Proposed funding options for long term care and a national assessment system for care needs.</td>
</tr>
<tr>
<td>2010</td>
<td>A Vision for Adult Social Care: Capable Communities and Active Citizens (DH, 2010b)</td>
<td>Committed to reducing barriers between health and social care funding; extending personal budgets and use of direct payments for carers.</td>
</tr>
<tr>
<td>2012</td>
<td>Caring for Our Future: Reforming Care and Support (Cm 8378)</td>
<td>Focus on preventing need for formal care and support and extending control through personal budgets and direct payments. Proposed a national minimum eligibility threshold; and extending carers’ assessments and support.</td>
</tr>
<tr>
<td>2014</td>
<td>Care and Support Statutory Guidance (DH, 2014)</td>
<td>Issued under Care Act 2014, with detailed guidance on assessment including carers’ assessments, and care and support planning. Provided specific guidance on the elements and calculation of personal budgets legislated by the Care Act.</td>
</tr>
</tbody>
</table>
Assessment and care/support planning

The community care reforms defined assessment and care management as the mechanism for deciding the level of and arranging care and support, focussing on individual needs and whether these could be met while enabling the individual to continue to live independently. This was conceived of as a two stage process both of which were required to take account of local priorities and available resources. First, an assessment was undertaken to decide whether and what type of assistance should be provided. If this requirement was met, the second stage was the design of a care package tailored to individual need (Cm 849, 1989). Guidance relating to assessment and care planning for different user groups was produced later. Thus, person centred planning within the formal care management process was introduced for people with learning disabilities (Cm 5086, 2001). The Single Assessment Process was developed for use within older people's services. It sought to promote a more standardised and integrated approach to assessment and it was envisaged that, if appropriate, older people could self-assess within the process (DH, 2001a; 2001b). The principle of self-assessment was extended to other service user groups together with the potential for assessments to be undertaken by individuals or community organisations rather than local authorities (Cm 6499, 2005; DH, 2010b). The Common Assessment Framework was introduced within adult services to improve information sharing around multi-disciplinary assessment and care planning, (Cm 6737, 2006; DH, 2009b). Increasingly a focus upon outcomes within the assessment and care planning process has been emphasised, and the assessment and eligibility process remains as the framework to identify any level of need for care and support (DH, 2010a; 2010b; 2014).

Resource allocation processes

With regard to implementation of a care plan, it was initially recommended that where appropriate care managers were given delegated responsibility for budgetary management to promote a flexible response to need and make the best use of the available resources (Cm 849, 1989). To promote consistency of resource allocation between service users with similar needs, it was recommended that authorities and agencies issue guidelines to staff on the level of expenditure appropriate to different needs (SSI & SWSG, 1991a). As with the operation of eligibility criteria in adult social care services this allowed local discretion but also permitted potential inconsistency between authorities. Subsequently, the Community Care (Direct Payments) Act (1996) enabled local authorities to make cash payments as an alternative to services. Direct payments were intended to empower service users by allowing them control and choice over the help they used to meet their needs, and access was subsequently extended to older people (DH, 2000). Later, individual budgets – an allocation of funding from different streams which could be taken as a direct payment or managed by a care manager or third party - offered people the benefit of choice and control of direct payments without the potential burdens of managing the money (Cm 6499, 2005). Subsequently, personal budgets were identified as a means to promote self-directed support as part of the personalisation agenda in adult social care (Cm 8378, 2012; DH, 2007, 2010b).

Thus it can be seen that two different approaches to resource allocation and support planning are represented in the policy literature: a professionally led system and self-directed support. They are often conceived of as polar opposites. In this context it is relevant that there is a notable difference in the point at which the allocation of finance is determined in a professionally led system compared with self-directed support. Within the traditional professional-led care management system, the allocation of resources took place after the support planning process was complete i.e. finance was matched to support received. However, within self-directed support arrangements, the entitlement to support is decided following assessment and before support planning i.e. finance is not matched to subsequent support packages. This clear, upfront allocation of funding to enable service users to make informed choices about how best to meet their needs was seen as an essential component of transforming social care (DH, 2008a). For people with learning disabilities,
early results of a resource allocation system (RAS) were described as encouraging (Cm 6499, 2005; DH, 2008a). It continued to be permissible for the allocation of finance to be made before the support plan is constructed, irrespective of whether or not a care manager assists in the development of a support plan (Cm 8378, 2012). The Care Act 2014 placed personal budgets into law for the first time, and acknowledged both the utility and limitations of RAS models (DH, 2014).

**Carers**

Policy guidance and legislation have addressed both the contribution and support needs of carers. At the inception of the community care reforms it was made explicit that assessments should take into account the wishes of carers and their ability to continue to provide care (Cm 849, 1989). However, the needs of carers themselves were only formally recognised subsequently. The Carers (Recognition and Services) Act 1995 gave carers the right to an assessment by local authorities of their ability to care and to continue caring but it was also acknowledged that greater efforts needed to be made to recognise and cater for their needs (Cm 4169, 1998). The Carers Strategy made funding available to local authorities to enhance services specifically to support carers. It also identified the need for new legislation to allow carers to receive help in their own right (DH, 1999). The Carers and Disabled Children’s Act 2000 gave carers the right to ask for an assessment of their own needs to help them to continue to care, irrespective of whether the person they cared for received an assessment. It also permitted local authorities to provide assistance directly to carers and extended direct payments to them. Services for carers were not specifically defined, affording discretion in response to assessed need. The guidance that accompanied the Act stated that ‘any outcome valued by the carer may be a legitimate use of council resources if it genuinely will support the carers in their caring role or help them maintain their own health and wellbeing’ (DH, 2001c p 23). Support for carers has remained integral to the development of social care with plans to extend the right to an assessment to all carers and introduce a clear entitlement to assistance (Cm 6737, 2006; Cm 8378, 2012; DH, 2007, 2008b, 2010b). The latest guidance stated that a carer’s assessment must include a consideration of the carer’s potential future needs for support, and the impact of caring upon the carer’s daily life (DH, 2014).

**Finite resources**

A clear budgetary framework to accompany assessment and care management arrangements was recognised as an integral part of the infrastructure designed to support the introduction of the community care reforms. It was anticipated that decisions on service provision would take into account what was available and affordable. Care management was recognised as a means to manage resources effectively, especially for people with complex needs or when significant levels of resources were involved (Cm 849, 1989). Another important development with regard to managing resources was the publication of *Fair Access to Care Services* and associated guidance. Resource considerations were identified as one of the issues to be taken into account in the development and operation of eligibility criteria; in decisions regarding services provided to meet identified needs; and within the review process (DH, 2002; 2003a, b).

Subsequent guidance reflected both the demographic changes influencing future demand for care and financial constraints. At a strategic level, a shift of resources towards prevention and early intervention was identified as a means to achieve better value for money from existing resources (Cm 6737, 2006; Cm 8378, 2012; DH, 2008a). Local authorities were also encouraged to work with other statutory agencies and the voluntary sector to make better use of existing resources (Cm 6737, 2006; DH, 2008a). To exploit the opportunities to improve preventative services, local authorities were urged to work in partnership with the NHS and housing authorities (DH, 2010b). More speculatively, in proposals to change the care and support system for adults, a case was made for integrating funding streams (Cm 7673, 2009). At a micro level, two developments were evident. First, consistent with the strategic approach, local authorities were encouraged to use the
wider resources of the community when putting together care packages (Cm 6499, 2005). Second, while promoting self-directed support through measures such as self-assessment and personal budgets, the government acknowledged that these had to be constrained by the realities of finite resources (Cm 6499, 2005; DH, 2007; 2014). Overall however, in the past decade policy guidance has addressed the issue of the best use of financial resources primarily from a strategic inter-organisational perspective rather than decision making processes at the level of service recipients.

Summary

While the vision, principles, and objectives of adult social care have been addressed in policy in the last two decades, there has been a lack of explicit guidance on resource allocation at the micro level. This was especially the case during the second half of this period. Despite changes to the configuration of health and social care services in localities, local authorities continue to play the key role in delivering publicly funded care and support. This ensures that the mechanisms and processes by which local authorities allocate publicly funded social care constitute an issue of enduring importance, with guidance likely to focus increasingly on different approaches to resource allocation thereby blurring the apparently neat distinction between a professionally led system and self-directed support currently represented in the policy literature.
Method

A scoping review approach was adopted to provide an overview of the state of knowledge in this area (Arksey & O’Malley, 2005; Grant & Booth, 2009; Manthorpe et al., 2010). The approach incorporates elements of the systematic review process while studies of varied designs and quality were considered. Materials were included from a variety of sources, including systematic searches of selected databases, relevant websites, references from previous work (Challis et al., 2004), and personal contact. Hand searching of journals was attempted but not pursued since it was not fruitful.

Systematic searches were conducted in Social Care Online, PsycINFO, Medline, Cochrane, and OpenGrey. Embase and HMIC were also searched. The principal key words searched were: resource allocation; resource utilisation; decision making; assessment; care management; care plan(ning); care package. These were set within the context of the study by the use of another set of key words relating to social care as limiters including social care/services, community care/services. The main searches were conducted in the summer of 2012. In addition to the main sampling frame (Appendix 1), further decisions were made regarding the scope of the review. Since the focus was upon resource allocation processes and mechanisms for service users and carers, the extensive literature relating to assessment alone was deliberately excluded and only those concerning the link between assessment and care planning were included. Similarly, a service utilisation study would only be included if it described how a service allocation decision was made.
Results

Following the application of these criteria, 32 articles were included in the review. Of these, 20 were from searches of databases (Social Care Online: 16; PsycINFO: 4). None of the other databases searched made additional contributions to the review. Other sources included personal contact (5); previous work by the authors (2); searches of reference lists (2); author name (1); the Department of Health website (1); and selective hand searching of journals (1). Contents relevant to this study were extracted, including methodological, qualitative and quantitative findings.

Studies were separated into two groups. The first included those conducted early in the review period and mostly undertaken in the context of care coordination arising from the community care reforms of the 1990s where the assessment and care management process was largely led by professionals. The second included those conducted more recently in response to self-directed support initiatives within the personalisation agenda, especially the implementation of individual budgets and personal budgets. It is worth noting that, in practice, hybrid processes exist which overlap these two categories, and there is also an overlap between the publication dates. In this review, evidence relating to what is described as professional-led care includes eligibility, assessment and care/support planning, construction of care packages and care groupings, in short resource allocation processes. By contrast, studies more closely related to self-directed support address resource allocation methods.

Professional-led care

Most of the studies reported here owe their genesis to work undertaken to examine the roll out of the reforms of the 1990s. The remainder provide examples of initiatives to identify indicative care packages. The studies are summarised in Table 3.

Eligibility and access to care

Ellis et al. (1999) examined the impact of the community care legislation on decisions about eligibility for assessment by front line staff. It was found that in the initial stages of assessment and care management, screening and assessment practice appeared to vary between different types of teams and settings. While referrals to generic teams were scrutinised with the aim of screening out as many as possible, staff in specialist teams appeared to enjoy a greater degree of professional autonomy. Similarly, findings from a study examining the impact of the Fair Access to Care Services (FACS) guidance (DH, 2002) on assessments of older visually impaired people, suggested that its introduction had not made a substantial difference to the assessments of this particular user group due to the relative autonomy of the specialist assessors (Charles & Manthorpe, 2007), indicating the important role of discretion. Another study on the impact of FACS found that there was a high level of consistency in determining which needs were deemed eligible for care services by managers with responsibility for such decisions in two local authorities (Newton & Browne, 2008). Interestingly, it appeared that for cases labelled as ‘borderline’ the managers tended to use their professional judgement to decide that the needs were just above the threshold, regardless of where their authority had drawn that line. Both studies reported that some authorities had raised their threshold for eligibility subsequent to the introduction of FACS guidance due to financial constraints (Charles & Manthorpe, 2007; Newton & Browne, 2008). The exercise of discretion was again evident in the determination of eligibility for assistance in the implementation of direct payments. Here front line staff justified the use of discretion on the basis that direct payments were being used for low level support or for assistance that the local authority could not provide (Ellis, 2007).
Assessment and care/support planning

Several studies identified common issues with regard to assessment and care planning. The first was whether assessments were needs-led or service-led. While staff welcomed the needs-led philosophy, the concept was inherently ambiguous and they faced the difficulty of separating need in general from that for a particular service (Allen et al., 2004; Parry-Jones & Soulsby, 2001). A second constraint was the lack of resources so that staff were unable to provide preventative services to medium or low priority applicants, although they believed that this would produce a better outcome in the longer term (Foster & Barrett, 1996; Parry-Jones & Soulsby, 2001). The third issue was the quality of assessment tools. A lack of standardisation, structure and detail limited their capacity to gather reliable information for care planning and contribute towards the provision of aggregated data for service planning and purchasing purposes (Carpenter et al., 2005; Stewart et al., 1999). Analysis of a nationally representative sample of assessment documents for older people revealed that there was marked variability in the type and content of assessment tools used, and a lack of any clear linkage between assessment and care planning (Stewart et al., 1999). Another study noted that the criteria used by care managers for the allocation of resources were unclear and inconsistent; and decisions regarding the use of resources varied between decision makers (Foster & Barrett, 1996).

The construction of care packages

Allen et al. (2004) added to the understanding of micro-level resource allocation by exploring how frontline staff responded to the health and social care needs of adults undergoing stroke rehabilitation. They concluded that resource allocation processes were not confined to clinical interactions or financial oversight; rather they took place within the context of decision making by frontline health and social care professionals. One of the influences on these processes was the importance of private/personal finance in meeting gaps in State provision. A second was the way in which staff responded to resource constraints by negotiating levels of need to target achievable goals. There were also examples of ways in which service providers attempted to work round the interface of the health and social care systems to define needs in fundable ways. Leat and Perkins (1998) also explored the process of constructing care packages following assessment of need. The policy and local context under which care managers worked, in particular funding arrangements for a particular period of time and user group, constituted a major influence on the way care managers constructed and purchased care packages. Care managers also considered a range of other factors in this process. These included unit costs and whether or not travel costs were included, especially in rural areas; scales of charges for out-of-hours work; the way in which units were multiplied especially with respect to night care; and the minimum amount chargeable. The effects of grant-aid to voluntary organisations were also considered since services provided by these organisations were usually not part of the costed care plan, in effect free to budget holders. In addition consideration was also given to aspects of quality and the longer term implications of care packages.

Care packages and care groupings

Attempts to match needs to resources in a consistent way were also made by classification of service users and devising shared care packages. There are no examples of this in relation to community based care for older people. However, Resource Utilisation Groups version III (RUG-III) has been shown to effectively differentiate between nursing home residents who are receiving ‘low’, ‘standard’ and ‘enhanced’ registered nursing care time (Carpenter et al., 2003). There is also evidence of this approach in specialist mental health services. A needs assessment tool was developed and item scores were used to cluster service users, complemented by clinical expertise. For each of the 13 clusters generated a care package was developed, specifying the aims, what activities should be carried out to achieve them and by whom (Self et al., 2008). This model was further tested in more mental health provider trusts and was found to be generalisable across the participating trusts, and could be used as the basis for currency and tariff development (Care Packages and Pathways Project, 2006).
### TABLE 3: Studies related to the community care reforms

<table>
<thead>
<tr>
<th>Authors (year)</th>
<th>Focus</th>
<th>Method/numbers</th>
<th>Key messages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allen et al. (2004)</td>
<td>Routine resource allocation processes in health and social care by front-line staff</td>
<td>Qualitative: case studies (interviews; observations; analysis of case notes) in an ‘interactionist’ framework Authorities: 2 Cases: 8</td>
<td>Demonstrated that resource allocation processes were not confined to formal organisational policies and procedures, rather they took place in the routine practices of front-line staff when negotiating care packages.</td>
</tr>
<tr>
<td>Care Packages and Pathways Project (2006)</td>
<td>The generalisability of a classification model (see Self et al. 2008 below)</td>
<td>Quantitative: administrative data/client records Mental health provider trusts: 6 Service users: 2287</td>
<td>Model was generalisable across trusts and demonstrated that it was possible and desirable to establish care packages based on evidence and best practice. Clinicians were able to allocate 94% of service users to one of the 13 clusters or groups. Costing work was also undertaken which provided initial support to the model and suggested it was possible to use it as the basis for currency and tariff development.</td>
</tr>
<tr>
<td>Carpenter et al. (2005)</td>
<td>Comparison of a standardised assessment instrument for community care with existing assessment tools</td>
<td>Quantitative: RCT Qualitative: interviews Authorities: 2 Social workers: 20 Older people: 384</td>
<td>Randomised study to evaluate an assessment tool (Minimum Data Set-Home Care: MDC-HC). Use of a standardised assessment was associated with much better coverage of key domains (functioning, activity and participation, and environment) than existing assessment instruments. Assessment documentation of unproven reliability and validity might jeopardise the interests of older people.</td>
</tr>
<tr>
<td>Carpenter et al. (2003)</td>
<td>Utility of the Minimum Data Set/Resident Assessment Instrument (MDS/RAI) and the Resource Allocation Groups version III (RUG-III) to identify registered nursing care needs</td>
<td>Quantitative Authoritys: 3; nursing homes: 4 Nurses: 24; care assistants: 56 Residents: 193</td>
<td>The RUG-III system effectively differentiated between nursing home residents who were receiving ‘low’, ‘standard’ and ‘enhanced’ registered nursing care. The findings could provide the basis of a reimbursement system for registered nursing time in long-term care facilities in the UK.</td>
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<td>Authors</td>
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<td>Method/numbers</td>
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<tr>
<td>Charles and Manthorpe (2007)</td>
<td>The impact of Fair Access to Care Services (FACS) on assessment of older visually impaired people</td>
<td>Qualitative: interviews Authorities: 1 Staff: 6</td>
<td>Suggested that FACS had not made substantial difference to the social care assessments of older visually impaired people by specialist assessors, reflecting their relative autonomy. Identified four factors which might have contributed to this: absence of FACS training for practitioners; collective agreement by practitioners about what they should do in practice; an ability and willingness by practitioners to use professional discretion; and the ambiguity of purpose at the heart of the FACS policy.</td>
</tr>
<tr>
<td>Ellis (2007)</td>
<td>Analysis of social workers’ approach as ‘street-level bureaucrats’ to the allocation of direct payments (DPs)</td>
<td>Qualitative: observation Authorities: 1 Adult social care teams: 4 (initial assessment-old age; care management and review-old age; younger disabled people; learning disabilities)</td>
<td>Policy ambiguity and a shortage of resources created the conditions for rationing access to assistance. The approval process constituted another layer of bureaucracy. Information about DPs was rationed at point of referral. Justifications for rationing included the perception that DPs were allocated for low-priority support or ‘extras’, which breached the principle of equity, and concern over financial abuse. Access was further limited by a series of assumptions about the potential recipient e.g. user group, class and ethnicity. An excess of demand over resources, indeterminate objectives and low level of control over the discretion exercised by front-line workers prevailed.</td>
</tr>
<tr>
<td>Ellis et al. (1999)</td>
<td>The impact of the community care reforms on assessment practice in social work teams</td>
<td>Qualitative: observation Authorities: 2 3 social work teams in each authority (5 community-based and 1 hospital team)</td>
<td>Decision-making with regard to procedures to determine eligibility for assessment varied between the setting and type of teams. Social workers viewed greater formalisation (i.e. assessment and care management arrangements) as a threat to their professional identity. Social workers used their discretionary power not to advance professional ideals but to manage otherwise overwhelming demands.</td>
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<tr>
<td>Authors (year)</td>
<td>Focus</td>
<td>Method/numbers</td>
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<td>Foster and Barrett (1996)</td>
<td>Evaluation of the assessment and care management arrangements</td>
<td>Qualitative: review of case files; interviews with a range of staff, and service users and carers. Authorities: 1. User group: adults</td>
<td>A comprehensive assessment was undertaken if a care home placement or a high cost domiciliary care placement was required. The criteria for the allocation of resources were unclear and inconsistent. Examples of individually tailored care packages were not found. Service allocation focussed on users whose needs were accorded a high priority. Practitioners believed provision of preventative services to medium or low priority applicants would produce a better outcome in the long term. Assessment and care management forms were not found helpful as a tool to identify need and plan care by staff, service user and carers; nor did they provide information for planning and development.</td>
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<tr>
<td>Leat and Perkins (1998)</td>
<td>The link between assessment of need and purchase of care</td>
<td>Qualitative: interviews. Authorities: 6. 4 care managers in each authority; other budget holding officers, contract officers, and financial allocation panel members; a range of other staff, and service users and carers. User group: adults</td>
<td>The creation and purchase of care packages involved comparing unit costs. More detailed considerations included: whether travel costs were included in the quoted unit cost; scales of charge for out-of-hours work; the way in which units were multiplied; the minimum chargeable unit, changes in price; and the effects of grant-aid to voluntary organisations. In some authorities care managers were required to obtain three quotes before agreeing to purchase any services in a care package. Creating a care package involved ‘dealing and juggling’ which resembled ‘street or stock markets rather than shops’.</td>
</tr>
<tr>
<td>Newton and Browne (2008)</td>
<td>The interpretation and application of the Fair Access to Care Services guidance</td>
<td>Qualitative: interviews (with vignettes/case studies); review of documents. Authorities: 2. 3 team managers and 1 senior practitioner</td>
<td>The two authorities had different eligibility thresholds at the time of the study. There was a high level of consistency in determining eligibility for services between interviewees with respect to all cases presenting different level of needs. In the case representing ‘borderline’ needs managers used their professional judgement to decide that the service user’s needs were just above the threshold, irrespective of where their authority had drawn that line. It was concluded that front-line workers draw on their experience and use their discretion, even with clear procedure guidance.</td>
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### TABLE 3: Studies related to the community care reforms (cont.)

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<th>Authors (year)</th>
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<th>Method/numbers</th>
<th>Key messages</th>
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<tr>
<td>Parry-Jones et al. (2001)</td>
<td>The implementation of needs-led assessment following the community care reforms</td>
<td>Longitudinal qualitative study: semi-structured interviews Across North Wales Community care (health and social care) practitioners: 41 (phase 1); 22 (follow-up)</td>
<td>There was a lack of consensus about the objectives of assessment both within and between disciplines. Social workers considered their assessments to be more resource-led than district nurses. For social workers need was a difficult concept to define and operationalise unless it met eligibility criteria and could be solved through standard service provision. Financial restrictions, eligibility criteria and prioritisation were identified as constraints of needs-led assessment. Social workers described a trend away from needs-led to resources-led assessments as cost ceilings for care packages reduced. Resource panels undermined both the needs-led approach and the professional autonomy of social workers.</td>
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<tr>
<td>Self et al. (2008)</td>
<td>The development and initial evaluation of a system of needs-based care packages</td>
<td>Qualitative and quantitative: participatory action research Mental Health Trust: 1 Service management team and other senior professionals; care co-ordinators from statutory and non-statutory services. Number varied at different stages Service users: 450</td>
<td>Existing approaches to determining intervention relied on medical diagnoses, undervaluing the contribution of other professional groups. A common assessment tool was developed by involving people from a range of professional backgrounds. Cluster analysis identified 10 clusters and 3 were generated by clinical expertise, with inclusion and exclusion criteria for each. A care package was developed for each cluster outlining the aims, activities to achieve them and by whom. This tool was identified as an empirically based framework linking care packages to needs, accessible to people from different levels and professional backgrounds. It was also identified as a means of informing service planning and commissioning decisions.</td>
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<tr>
<td>Stewart et al. (1999)</td>
<td>The content and coverage of assessment documents</td>
<td>Quantitative: review of documents Authorities: 50</td>
<td>The majority were generic documents; only 3 were older people specific. Some had a ‘core’ assessment of need and user group specific elements. Different documents were sometimes employed for different levels of assessment. There was variability in the content of assessment tools in terms of coverage, structure, and detail in 4 domains: functional; cognitive / mood / psychological; social environment; and clinico-medical. In the functional domain, activities of daily living and instrumental activities of daily living were present in most documents and responses were more structured and detailed for those than for the other 3 domains. Overall, the lack of structure and detail in most assessment documents made it difficult to generate reliable aggregated information for planning and purchasing.</td>
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</table>
Developments arising from personalisation initiatives

Several approaches to resource allocation developed in this context are reported here, together with variations in their application and emergent implementation issues. Studies included in this section are summarised in Table 4. The majority described a resource allocation system (RAS), typically consisting of a scored assessment questionnaire, either self or professionally administered, and a mechanism of translating this information into an indicative budget. Where the focus of a study was not explicitly on resource allocation, methodological details concerning the RASs are specified in the method section where available.

Approaches to resource allocation

- **In Control RAS**
  This approach was developed by In Control, a registered national charity, as a means of allocating Personal Budgets (Duffy, 2005). It considered what were deemed to be important areas of life and offered a simple, scored assessment questionnaire to calculate a level of support to achieve defined outcomes (Tyson et al., 2010). It also took into account the level of support available from family and others, with scope for individual authority weighting (Duffy, 2008). Initially it was designed for people with learning disabilities and subsequently extended to all user groups. Early versions required a level of intuitive judgement and the level of personal budget was set by reference to the cost of typical existing care packages. Later iterations allowed for the creation of a numeric value for different domains of need and allowed authorities to apply a ‘price per point’. This led to the development of what is now known as the ‘points based In Control RAS’ (Duffy, 2008; Tyson et al., 2010). This has been reported to be the most commonly used system to allocate resources in social care (Asthana, 2012; Audit Commission, 2010; Ridley et al., 2011; SCIE, 2011).

- **Common Resource Allocation Framework (CRAF)**
  Based on the In Control approach, ADASS (2010) proposed a Common Resource Allocation Framework (CRAF) to determine resource allocation for long term social care. It comprised a personal needs questionnaire including the level of informal support and the impact of this on the carer, a scoring sheet, and a financial framework focusing on how to translate the score from the questionnaire into an indicative resource allocation. Specifically, the CRAF recommended that councils operate a single RAS for all user groups so that needs were identified in the same way for everyone, and to adjust indicative allocations to reflect variations in current market costs of providing support. It also recommended that councils should set a level of contingency funding and avoid applying a ‘cost ceiling’ to the outputs of the RAS. Sometimes the CRAF and In Control RAS have been used interchangeably (Asthana, 2012). Limited empirical evidence relating to the operation of the CRAF was identified in the review due to the timeframe of this work.

- **FACE RAS**
  This approach was developed by a commercial provider of assessment tools in collaboration with 27 local authorities to allocate resources to meet need (FACE, 2012). It used a single assessment tool for all care groups and employed an algorithm to address the fact that needs are not only single factors but interact with each other creating greater complexity. Therefore it was not deemed possible to disaggregate the individual item scores. To avoid spurious variance, standardised, rather than actual costs were used to develop the models. Nonetheless, some authorities made local decisions to build in various constraints into their RASs, such as ‘caps’ and ‘deflators’. A comparison of indicative budgets generated by the FACE RAS and actual support packages, (as indicated by correlations or ratios), suggested that this system had a high degree of accuracy (FACE, 2011; 2012). A recent survey reported 18 authorities to be using FACE tools for resource allocation purposes (Asthana, 2012).
**Equivalency and Outcome approaches**

The equivalency approach involved assessment of need, construction of an initial care plan, then translation of identified need and defined outcomes into equivalent finance for the personal budget, before detailed support planning. Thus, it used alternative means, for example, the number of hours of care rather than points, to convert information from assessments into personal budgets (Glendinning et al., 2008; Ridley et al., 2011). In one setting, this approach was used for its allocation of Direct Payments and Individual Budgets. The system highlighted the local authority’s poor information about service costs, and demonstrated a lack of sensitivity when applied in a rural setting. In some cases it resulted in higher Individual Budgets than would have been achieved through an alternative system of resource allocation (Ridley et al., 2011). It also featured in one of the Individual Budgets Pilot Programme sites [IB Pilot Programme] (Glendinning et al., 2008).

The outcome approach was similar to the equivalency method, but with a more explicit focus on outcomes in its approach to assessment and support planning. For example, one local authority based their resource allocation upon four outcomes: health and wellbeing; choice and control; economic and educational participation; and social and community participation. These were weighted by three categories: basic, standard and enhanced. Each category provided an indicative amount that formed the basis for guiding and reviewing support planning. Similar to the equivalency method, it did not use a points system. The needs and contribution of carers were also considered against the same outcomes and within the same categories (Audit Commission, 2010; Glendinning et al., 2008). The most important difference between the outcome and other approaches to resource allocation is that costs were calculated after assessments had taken place and support plans devised.

**Individual Service Funds**

An Individual Service Fund is described as a personal budget with all or part held by a chosen provider on an individual’s behalf without pre-determining specific support tasks. The provider is permitted to use the budget on their behalf in the way specified (Audit Commission, 2010; Ridley et al., 2011; Sanderson et al., 2011). The origins of Individual Service Funds lie with the deconstruction of a block contract, typically of a supported living setting or residential care home, and subsequent individual allocations. Examples have included a scheme where each person would pay an equal share of core costs and that of shared support, and they would have full choice and control over their discretionary fund, including the freedom to spend it with another provider. The Individual Service Fund has increasingly become a means of managing personal budgets for domiciliary care (Sanderson et al., 2011; Wilberforce et al., 2012).

**Criteria of variation**

Variations in the application of resource allocation systems were observed in the literature, both between and within authorities. In relation to the allocation of resources to service users several aspects of inter and intra authority variation were noted. There was also evidence of inter-authority variation with regard to the contribution and needs of carers in the resource allocation systems. Most of the commentary below relates to authorities using the In Control model, since little detail is available about other approaches.

The most important area of intra-authority variation was the practice of allocating resources to different user groups. With respect to the assessment questionnaire, three approaches emerged from the IB Pilot Programme sites: some adopted a generic assessment tool; others had a core assessment with additions to reflect the needs of different user groups; another employed different assessment tools for each service user group (Glendinning et al. 2008). With regard to the mechanism of translating assessment information into indicative budgets, some authorities adopted differentiated approaches by either using different point matrices or using a separate price per point allocation for each care group, to reflect historical patterns of spend and current market costs (Audit Commission, 2010; Duncan-Turnbull, 2010). In one example, the authority had...
a distinct version of the assessment questionnaire for each user group. All had the same eight domains as well as user group specific questions and weightings (Jenkins and Hay, 2010). A study of services for older people and those with mental health problems found that, of the five study sites, two used the same resource allocation system for all user groups, while the other three had a mental health-specific system. Where a generic system was used it highlighted inequalities in resource allocation between user groups within an authority. Older people with high care needs appeared to be relatively disadvantaged (SCIE, 2011).

Inter-authority variations were observed in respect of key elements of resource allocation systems. First, authorities differed with respect to the content of needs questionnaires (Audit Commission, 2010; Glendinning et al., 2008; Jenkins & Hay, 2010). Second, authorities varied in the way in which needs identified in the assessment questionnaire were converted into points (Audit Commission, 2010). Third, different mechanisms were deployed by authorities for matching points onto different funding levels. For example, a RAS can assign indicative personal budgets using a linear system in which each point awarded in the needs assessment receives the same allocation. Alternatively, allocations can use an approach that assigns a different amount of funding to each increase in need/point, or group of points, resulting in a non-linear relationship between needs and resources. It was suggested that the latter more closely resembled the observed tendency for care costs to rise more steeply as needs become more complex (Audit Commission, 2010). Moreover, authorities varied with respect to the degree of reliance on the direct application of a funding formula without also exercising discretion (Glendinning et al., 2008). Fourth, variations in the components of funding sources were noted between authorities. Some included resources for equipment in individual budgets, and it was suggested that transport might be included as a funding stream (Glendinning et al., 2008). Fifth, authorities also employed a variety of means to adjust indicative budgets. Adjustments such as ‘inflators’ (e.g. in recognition of the need for specialist input) and ‘deflators’ (e.g. where support could be shared) were used by some authorities. Some applied ceilings on the maximum sum of money available for Personal Budget holders (SCIE, 2011). It was also common for authorities to use their panel of senior managers to review, determine or approve the indicative amount (Glendinning et al., 2008; Ridley et al., 2011).

Inter-authority variation was highlighted in a study which compared the indicative Personal Budgets calculated using resource allocation systems provided by different authorities (Asthana, 2012). Based on the personal needs questionnaire, points and scoring system provided by 33 authorities, detailed analyses were carried out for two ‘exemplar’ clients: an older person with moderate-substantial needs (A) and an older person with substantial needs (B). The Personal Budgets awarded varied markedly - from £16 to £331 for person A and from £41 to £410 for person B, raising questions about reliability and validity of the tools.

Local authorities also varied with respect to how carers’ input was taken into account. In the majority, the level of informal care was included within the user’s assessment, which would typically result in a deduction from the user’s indicative budget. It was also noted that if unmet carer needs were identified, points could be added to the service user’s allocation to enable more formal support to be provided (Audit Commission, 2010; Glendinning et al., 2009). There had also been attempts to separate the needs of the service user from the support the carer was willing and able to provide. In a system described as ‘carer neutral’, the points allocated for the service user were based on no informal carer support and remained separate from the latter. While carer input was taken into account before monetary allocation, this approach was seen as responsive to changes in carer circumstances since with variations in the amount of support the carer could provide, there would be no need for further assessment (SCIE, 2011).

Two major approaches emerged with respect to how carers’ needs were addressed within resource allocation systems. The majority of authorities addressed these within the service users’ assessment and allocation, to varying degrees. For example, some authorities in the Individual Budgets pilot Programme included a set of questions in the user’s self-assessment to determine if the carer was in need of support. A minority had included questions that specifically addressed carers’ wishes in relation to employment, training/education and leisure activities. There were also instances where
there was an allocation for respite care within a service user’s Individual Budget (Glendinning et al., 2009). The second approach, adopted by a small number of authorities, was to develop a separate RAS for carers that reflected and supported their unpaid role (Audit Commission, 2010; Duncan-Turnbull, 2010). One site in the IB pilot Programme awarded Individual Budgets to carers in their own right through a separate carer RAS, resourced from its Carers Grant budget, while respite care was funded through the service user’s allocation of funds (Glendinning et al., 2009).

Operation

At a practical level, disaggregating or incorporating different funding sources for inclusion in a resource allocation system was acknowledged to be complex (Glendinning et al., 2008; Sanderson et al., 2011). Furthermore, in some resource allocation systems, adjustments for service needs, carer involvement, financial circumstances and service costs could not be readily identified (Asthana, 2012). On the other hand, in one authority, it was reported that the revised local eligibility guidance and the new resource allocation processes complemented each other (Jackson, 2008). It was also suggested that the evidence from the former might be used to validate the latter, in order that the right amount of money could be allocated to meet individual needs.

Another issue that emerged from the literature was the relationship between the indicative budgets generated by resource allocation systems and the actual packages of support. In some authorities the support plans that were implemented achieved savings against the indicative cost (Petch, 2009; Slasberg et al., 2012). On the other hand, the aggregated allocations generated by the In Control RAS in a hypothetical form for 300 users constituted 80 per cent of the actual expenditure on the same group (Duffy, 2005). However, the lack of a clear relationship between indicative allocations provided by resource allocation systems and actual care packages approved has caused concern about the accuracy and utility of these resource allocation systems and more generally, how decisions about care packages were made (Glendinning et al., 2008; Slasberg et al., 2012).
### TABLE 4: Studies related to personalisation initiatives

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<tr>
<th>Authors (year)</th>
<th>Focus</th>
<th>Method/numbers</th>
<th>Key messages</th>
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<tr>
<td>ADASS (2010)</td>
<td>The development of a Common Resource Allocation Framework (CRAF)</td>
<td>Descriptive Authorities: 18 Users: not applicable User groups: generic User/Carer consulted: yes</td>
<td>The RAS tools included in the framework are based on materials previously developed by In Control. CRAF included a personal needs questionnaire, questionnaire scoring sheet, and a financial framework. The tools are generic.</td>
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<tr>
<td>Asthana (2012)</td>
<td>Variations in access to social care for older people in England, particularly whether authorities using the Common RAS would offer similar indicative budgets to individuals with similar needs</td>
<td>Quantitative: national survey and secondary data Authorities: 33–152 Users: not applicable User group: older people User/carer consulted: not applicable</td>
<td>Fifty eight (n=134) used the Common RAS (derived from CRAF) and some used similar systems. Analysis using 33 RASs for two ‘exemplar’ clients revealed large differences in indicative budgets. In some RASs, adjustments for service needs, carer involvement, financial circumstances and service costs could not be readily identified.</td>
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<tr>
<td>Audit Commission (2010)</td>
<td>Examination of personal budgets in adult social care, including the method for allocating funding to individuals</td>
<td>Qualitative and quantitative: inspection/audit (interview of authority staff, case studies; and secondary data analysis) Authorities: 8 (maximum) Users: not applicable User group: 4 generic; 2 specific; 2 not known User/carer consulted: not applicable</td>
<td>Seven used a locally developed points-based model based on that of In Control, with varied approaches to developing the needs questionnaire and price-points system. Two of these used a separate price per point allocation for each user group, where the ‘mental health’ category received the least. The eighth used an outcome-based model. Some were developing a separate RAS for carers. Resource allocation systems should be affordable, transparent and equitable for all user groups. It should provide an indicative rather than final budget.</td>
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**TABLE 4: Studies related to personalisation initiatives (cont.)**

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<tr>
<td>Duffy (2005)</td>
<td>Exploration of the resource allocation element of In Control within the wider model of self-directed support</td>
<td>Descriptive</td>
<td>The professional-led system had a number of perverse consequences. Four key principles should underpin RAS: open to scrutiny; informing people of their entitlement before support planning; financial efficiency; and flexibility and responsibility in how entitlement could be used. Described three examples where individual funding, instead of block services, enabled people to return home from institutions. Described the development of the In Control RAS: through analysis of typical previous/existing care packages. One authority applied the In Control RAS in a hypothetical form to 300 users. The aggregate of the individual budgets was 80% of the actual expenditure on the same group, suggesting that while some people received inadequate levels of support some were over supported.</td>
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<td></td>
<td>Authorities: 7 Users: no information User group: learning disability User/carer consulted: no information</td>
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<td>Duffy (2008)</td>
<td>The expansion of self-directed support to include all user groups and the development of In Control RAS</td>
<td>Descriptive (with administrative data)</td>
<td>Summarised the development from RAS Version 1 to 5 to include all user groups by making it more sensitive to complexity of needs and costs at different levels. V1 – personal budgets (PBs) were set according to three criteria: need, complexity, and informal support. Dependent on intuitive judgement. V2 – PBs were set by correlating them with existing care packages. Needs were identified using a tabular approach with key indicators mapping on to the relevant levels of funding. V3 – a numeric value was put on different domains of need. V4 – allowed authorities to apply a ‘price point’ that would be multiplied by the figure that represented the level of need. V5 – could be delivered through the internet.</td>
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<td>Users: 60 people in 6 authorities initially; over 2,500 in 107 authorities by the end of 2007 User group: initially for people with learning disabilities; then generic User/carer consulted: no information</td>
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### TABLE 4: Studies related to personalisation initiatives (cont.)

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<tr>
<td>Duncan-Turnbull (2010)</td>
<td>Evaluation of self-directed support and the implementation of personal budgets in Hertfordshire</td>
<td>Qualitative: focus group and questionnaire&lt;br&gt;Authorities: 1 (users: 41; carers: 29; staff: not specified)&lt;br&gt;Users: no information&lt;br&gt;User groups: 4&lt;br&gt;User/carer consulted: yes</td>
<td>No detailed information on the assessment questionnaire.&lt;br&gt;Each user group (four) had different point matrices giving different levels of points under each of the domains.&lt;br&gt;Users and carers identified the importance of taking into account fluctuating needs as part of the assessment process.&lt;br&gt;Recommendations: one RAS for all user groups; development of a separate RAS for carers.</td>
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<td>FACE (2011)</td>
<td>Comparison of the accuracy of two RAS models</td>
<td>Quantitative: secondary data analysis&lt;br&gt;Sample 1: 61 older people (1 authority)&lt;br&gt;Sample 2: 271 users (1 authority, no information on user group)&lt;br&gt;User group: no information&lt;br&gt;User/carer consulted: not applicable</td>
<td>There was a higher consistency between the indicative budgets produced by the FACE RAS and the actual budgets than those produced by the In Control model. In the latter there was no central tendency in actual cases and even a lack of it in indicative budgets used for recalibration. This suggested that the indicative budget generated by the In Control RAS was having no impact on determination of the size of personal budgets (cf. Slasberg et al. 2012).</td>
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<tr>
<td>FACE (2012)</td>
<td>An explanatory document on the workings of the FACE RAS</td>
<td>Descriptive/illustrative&lt;br&gt;Authorities: 27&lt;br&gt;Users: 2,000&lt;br&gt;User groups: generic&lt;br&gt;User/carer consulted: no information</td>
<td>This was developed using measures of need to generate a set of scores; examining a group of service users with similar needs; and working out a formula that predicted the cost of meeting those needs.&lt;br&gt;An algorithm, instead of a simple price per point method, was used to take into account interactions between needs. A strong and consistent relationship between needs and costs was established.&lt;br&gt;The system is generic.</td>
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### TABLE 4: Studies related to personalisation initiatives (cont.)

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<tr>
<td>Glendinning et al. (2008)</td>
<td>National evaluation of the individual budgets (IBs) pilot programme, including description of RASs</td>
<td>Qualitative: interviews, Authorities: 13, Users: 100 each authority, User groups: varied across authorities, User/carer consulted: yes, (number not specified)</td>
<td>Nine sites were using a RAS questionnaire, with varied reliance on a direct application of a funding formula. One site employed an outcome-focused approach to assessment and support planning. Three used a variety of outcome-focused methods but with an upfront allocation of IBs. A panel of senior managers was involved in the majority of decisions regarding the allocation of IBs. Variations in whether the RAS form was for: all; multiple; or single user groups. More variations in whether individual sites had adopted a single price per point for all user groups. Some sites included equipment in their RASs; some argued that transport should be included as a funding stream. Concerns about the match between allocation and needs. Over half of service users stated that they did not know how the amount of their IBs had been calculated.</td>
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<tr>
<td>Glendinning et al. (2009)</td>
<td>The impact and outcomes of individual budgets (IBs) on carers, including how carers were accounted for in the assessment and RAS processes</td>
<td>Qualitative and quantitative: interviews, Authorities: 13 (maximum), Carers: 129, Carers’ lead officers: 12, IB lead officers: 13, Users: not applicable, User group: not applicable, User/carer consulted: yes</td>
<td>Sites addressed carers’ needs to a varying extent within the service user (self- ) assessment process and RAS. Concerns were raised about IB service user assessments, including the lack of a ‘trigger point’ to prompt service users and staff to think about carers’ needs, and the difficulty of addressing a range of carers’ needs within service users’ RAS. Typically the presence of an informal carer could deduct points generated by a service user’s RAS. Conversely, if informal carers were unable or unwilling to continue providing the current level of care, points could be added. A small number of joint user-carer IBs were awarded. Some service user IBs included respite care for a carer. Two sites developed a separate carer RAS. IBs received by carers ranged from £100 to £2,200.</td>
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TABLE 4: Studies related to personalisation initiatives (cont.)

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<tr>
<td>Jackson (2008)</td>
<td>The implementation of individual budgets in Oldham</td>
<td>Descriptive Authorities: 1 Users: no information User groups: no information User/carers consulted: yes</td>
<td>Described the development of a self-assessment questionnaire designed to relate the resulting scores to an indicative amount of funding. The scoring system was built and revised against existing budgets. It was noted that the revised Fair Access to Care Services guidance and the new RAS processes complemented each other. Social care budgets were aligned or integrated with other funding streams e.g. Independent Living Fund and community equipment funding.</td>
</tr>
<tr>
<td>Jenkins &amp; Hay (2010)</td>
<td>The implementation of self-directed support and personal budgets in Cambridgeshire, including the development of a RAS</td>
<td>Descriptive Authorities: 1 Users: 260 (learning disability) Evaluation: questionnaire (56 users, 36 carers, 12 care managers) User group: initially people with learning disabilities; subsequently redesigned for other user groups. User/carer consulted: yes</td>
<td>In Control’s RAS V3 was piloted and developed in services for people with learning disabilities. It incorporated additional support for individuals with complex needs. A RAS questionnaire was developed for each user group. Each had the same eight domains but also included user group specific questions. Concluded it was essential to establish patterns of spend for each user group to inform future allocations. It was important to involve care managers in the development and roll out of self-directed support and RAS.</td>
</tr>
<tr>
<td>Petch (2009)</td>
<td>A summary of separate evaluation reports on the introduction of personal budgets</td>
<td>Descriptive Authorities: 5 Users: 56, 66, 17, 46, and 10 respectively User group: no information User/carer consulted: no information</td>
<td>In Control model was used. Most focused on people with learning disabilities. With regard to the relationship between resources made available to individuals and their needs, most of the reports documented more appropriate match when a RAS was applied compared with the former care management system. The support plans that were implemented often achieved savings against the indicative cost.</td>
</tr>
<tr>
<td>Authors (year)</td>
<td>Focus</td>
<td>Method/numbers</td>
<td>Key messages</td>
</tr>
<tr>
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<tr>
<td>Ridley et al. (2011)</td>
<td>Assessment of the impact of interventions to improve uptake of self-directed support, including a brief description of resource allocation processes</td>
<td>Qualitative and quantitative: interviews and focus groups; case studies, learning sets; and administrative data Authorities: 3 (Scotland) Users: no information User group: initially learning disability; then applied to a wider range of client groups. User/carer consulted: no information</td>
<td>All three sites adapted some form of self-assessment originated from In Control. Two used models based on In Control. The third used a system known as an ‘equivalency method’. It highlighted the local authority’s poor information about service costs, and demonstrated a lack of sensitivity when applied in a rural setting. All sites either set up or used its existing resource allocation panels to decide the allocation of resources and approve packages. Two sites increasingly used Individual Service Funds.</td>
</tr>
<tr>
<td>Sanderson et al. (2011)</td>
<td>The role of Individual Service Funds (ISFs) in delivering personalised care and support</td>
<td>Qualitative: case studies Multiple sites/schemes (e.g. a small group home and a national provider) Users: 6 and 4 respectively (in the two examples) User group: varied between schemes User/carer consulted: yes</td>
<td>ISF is a particular form of personal budget, often derived from the deconstruction of a block contract. Key features of an ISF: all or part is held by a provider; no specific tasks predetermined; flexibility to roll money over into future weeks or months; written information about arrangement; and portability between provider agencies. Included examples of partial disaggregation in residential services for older people and those with mental health problems; and full disaggregation for people with learning disabilities.</td>
</tr>
<tr>
<td>SCIE (2011)</td>
<td>A summary of the experiences of older people and those with mental health problems in using self-directed support and personal budgets (PBs), including a brief description of the RASs used</td>
<td>Qualitative: interviews and focus groups Authorities: 5 (2 with partner mental health trusts) Users: 46; carers: 23; staff: 40; and 12 provider organisations User group: 2 generic; 3 generic + mental health specific User/carer consulted: 1 authority</td>
<td>In Control or modified models were used. Two sites used the same single points-based RAS for all client groups; the other three had a generic RAS and a mental health-specific system. Two sites had ceilings on PBs and three had not. Some sites used ‘inflators’ and ‘deflators’ to adjust resource allocation. One had a ‘carer neutral’ RAS where points allocated for service user remained separate from carer input although the latter was taken into account before monetary allocation. PB holders, carers and staff felt that contingency planning should be strengthened and suggested a number of ways in which this could be achieved.</td>
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</table>
## TABLE 4: Studies related to personalisation initiatives (cont.)

<table>
<thead>
<tr>
<th>Authors (year)</th>
<th>Focus</th>
<th>Method/numbers</th>
<th>Key messages</th>
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</table>
| Slasberg et al. (2012)  | The proximity of indicative budgets and actual allocations             | Quantitative: the ratio of indicative budgets to actual allocations and its distribution. | Considerable discrepancies between indicative budgets generated by the In Control RAS and actual allocations.  
For the majority of cases in both samples, the actual allocation was smaller than the indicative amount.  
Concluded that the decision on allocation was not based on the indicative amount but a separate process. |
|                         |                                                                        | Sample 1: 512 cases (1 authority)  
Sample 2: 5,000 cases (3 authorities)  
User groups: no information  
User/carer consulted: not applicable |                                                                                                                                         |
| Tyson et al. (2010)     | Reflections on the experience of adult social services departments in developing and testing the operating system, particularly resource allocation processes | Descriptive  
Multisite: number of authorities and users varied in different phases.  
Users: not applicable  
User group: majority were people with learning disabilities.  
User/carer consulted: no information | The In Control RAS assessment questionnaire covered important areas of life.  
A scored questionnaire was used to calculate a level of support needed to achieve defined outcomes in each area.  
Initially cost and needs information was drawn from existing care packages; subsequently information from personal budget holders was used to recalibrate allocation levels.  
Stated that almost all authorities currently offering people personal budgets were using a variation of In Control’s RAS. |
| Wilberforce et al., (2012) | The implications of personal budgets (PBs) on commissioning and market development | Qualitative: interviews  
Study 1: 4 local authority commissioning managers; 32 providers  
Study 2: 7 commissioning managers; 16 providers | Revealed three broad approaches to contracting.  
One was known as ‘provider accounts’ and included the facility for the provider organisation to hold the resources contained within the individual budgets on behalf of the service user and spend it on their support as they directed.  
Recognition from providers and commissioning managers that PBs had additional transaction cost implications which were more likely to be borne by providers. |
Discussion

Following the Community Care reforms of the 1990s, assessment and care planning processes were the principal means of allocating resources to people in diverse circumstances. The development of tools designed to translate the complexity of social care need into a cash sum is relatively young and this is reflected in the literature. Here we consider several key issues which have emerged from scrutiny of this available evidence.

Quality of the underlying evidence

This review indicates that there is a lack of empirical evidence in terms of both quantity and quality with respect to resource allocation processes and approaches at the micro level. This is especially true for studies conducted in response to self-directed support initiatives as part of the personalisation agenda. Most of the studies in this category described the implementation process in localities, with resource allocation methods being a small part of the description. There is also a dearth of evaluation studies of the effectiveness of these approaches, especially on outcomes for service users, and the long-term financial implications for authorities. An overall concern about the quality of the literature is noteworthy. While 12 of the 13 publications concerning studies conducted in the context of professional-led care were peer-reviewed journal articles, only seven of the 19 concerning resource allocation methods were journal papers, with three documenting single authority implementation processes. Some of the papers and most reports in this category were found to lack methodological vigour, and often the style of reporting made it difficult to discern necessary information. Nonetheless, the review provides an overview of resource allocation processes under professional-led care and approaches developed in response to self-directed support initiatives. Major findings with respect to prevalent approaches, variations with respect to user groups, how informal care was taken into account, and the utility and predictive accuracy were confirmed by a study published after the review period (Series & Clements, 2013).

Principal approaches

Descriptions and appraisals of principal approaches to resource allocation by other authors, in addition to those already described in the findings, are summarised in Table 5. While there was limited information on these approaches initially, more evidence emerged around the time of this study. With respect to methodology, the complex relationship between need and costs was only addressed by FACE through the use of algorithms to reflect the potential interactions between different needs. This, and the use of standardised costs, made the designers of FACE confident in the predictive utility of the model and that it would facilitate long-term financial sustainability (Clifford et al., 2013). There was no information to verify the statement from other authors due to the commercial confidentiality of the FACE RAS. In practice, implementation support provided with the FACE RAS, such as IT support, enabled authorities to avoid certain operational problems experienced by those who adopted early In Control versions of RAS. On the other hand, the In Control and related CRAF approach allowed authorities more autonomy to adapt and decide the mechanisms of their own RASs, and were perceived to be more simple and accessible. However, there remain concerns over the accuracy of the In Control model, the lack of substantial psychometric analysis of its properties, and the implications for long-term financial sustainability.
TABLE 5: Multiple perspectives on approaches to resource allocation

<table>
<thead>
<tr>
<th>Methodology</th>
<th>Operation</th>
<th>Financial sustainability</th>
<th>Predictive utility</th>
<th>Perceived transparency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professionally led</td>
<td>Open to high degree of subjective variability (Duffy, 2005)</td>
<td>Undermines person-centred planning (Duffy, 2005)</td>
<td>Authorities maintain control over rationing process (Duffy, 2005)</td>
<td>Assessment and care management arrangements were designed to reduce the scope of professional discretion (Ellis et al., 1999)</td>
</tr>
<tr>
<td>In Control</td>
<td>Attempt to be inclusive of all needs; real costs were used to develop (Thom, 2011)</td>
<td>Dual assessment process (Jackson, 2008; SCIE, 2011)</td>
<td>Dependent on past/existing care package values (Thom, 2011)</td>
<td>Accessible and simple to understand but there may still be a concern (Thom, 2011)</td>
</tr>
<tr>
<td>FACE</td>
<td>Use of statistical modelling to provide a robust relationship between need and costs (Thom, 2011)</td>
<td>Clear link to assessment (Thom, 2011)</td>
<td>Addressed the interaction between different needs and services required (FACE, 2012)</td>
<td>Information withheld due to commercial confidentiality (Asthana, 2012; Series and Clements, 2013)</td>
</tr>
<tr>
<td>CRAF</td>
<td>Based on In Control (ADASS, 2010) Simple, brief, and easy to complete (Clifford et al., 2013)</td>
<td>Failed to address implementation issues (FACE, 2012)</td>
<td>Possible financial consequences of inaccuracies in indicative allocation not recognised (FACE, 2012)</td>
<td>Appears to be simple and easy to understand (FACE, 2012)</td>
</tr>
</tbody>
</table>

1 The paper did not specify that these relate to the In Control approach. However, the sample (20 Maximum) were drawn from the In Control programme. One was using FACE and another was developing its own RAS: neither provided details and were therefore excluded from further analysis.
RAS and carers

The review suggests that the majority of authorities quantify the contribution of informal carers within the service users’ RAS, typically with a resultant reduction in the allocation to service users, a finding confirmed by a more recent study (Series & Clements, 2013). Although this is consistent with current social care practice, its fairness has been questioned (PRTC and Crossroads, 2009; Series & Clements, 2013). While local authorities could not afford not to discount the indicative amount where informal carers were able and willing to provide care, it has been suggested that the service users’ RAS could be more transparent with regard to carers’ contribution, such as those termed carer neutral in which service users’ need and carers’ contribution are more readily separable (Glendinning et al., 2009; SCIE, 2011).

The question of how to address the needs of and allocate available resources to carers needs also to be considered. Both the present and other studies indicate that to address a range of carers’ needs and those of service users’ in a single RAS could be challenging (Glendinning et al., 2009), a possible consideration behind the view of the Association of Directors of Social Services’ current position that funding for support to carers need not be included in the development of RAS for the social care needs of service users (ADASS, 2010). However, the same guidance also stated that creating a RAS for the purpose of allocating small sums of money to carers may be disproportionate. Nevertheless, there is evidence to show that an increasing number of carers are receiving a personal budget and more authorities are using a carers’ RAS, thus making the issue more pertinent (Carers Trust, 2012). Equally important is the widely recognised need for central and local government to find ways to enable people to care, for example, through replacement care for service users, or ‘credits’ for carers which would provide credits relating to the amount of care provided (PRTC and Crossroads, 2009; DH, 2009c). It has been argued that cost savings might be created by reducing lost tax revenues, welfare benefits expenditure and health care spending on the carer; and residential care admissions due to carer stress. It is also important to view resource allocation as part of support to carers which also involves assessment and eligibility, and support planning (Carers Trust, 2012; Glendinning et al., 2009).

The role of discretion

With regard to professionally led care, guidance that accompanied the introduction of the community care reforms acknowledged that discretion within the resource allocation process would be necessary to permit individualised responses to differing levels of need (SSI/SSWG 1991a). In this sense practitioners undertaking care planning were ‘street-level bureaucrats’, public service workers with substantial discretion in the execution of their work (Lipsky, 1980). It was also suggested that organisations issued guidance on the levels of expenditure appropriate to different needs and that responsibility for budgetary expenditure be shared between a practitioner and their manager. The latter were charged with the responsibility that resources were, ‘deployed with economy, efficiency and effectiveness’ emphasising that services were provided within finite resources (SSI/SSWG 1991b).

The introduction of personal budgets, together with the increased emphasis on self-directed support as part of personalisation in adult social care services, resulted in the development of a process of allocating resources to meet need taking place before the completion of a care plan (DH, 2008a). The purpose of such resource allocation systems has been described as providing a means to calculate the amount of money a person required and thereby inform the care planning process (ADASS, 2010; Series and Clements, 2013). Furthermore, it has been confirmed that legally resource allocation systems cannot dispense with the discretionary element of resource allocation. Rather they offer a ball park figure to guide decision making with the capacity for personal budgets to be above or below this figure to reflect individual circumstances (Series and Clements, 2013). Thus, in the administration of resource allocation, practitioners continue to act as street level bureaucrats, and the necessity of the discretionary element is formally recognised by
the Care Act 2014 (ADASS, 2010; DH, 2014).

However, from the information presented it is difficult to make an informed judgement about the fidelity of the operation of the resource allocation systems identified in the literature review, and without this objective judgements about the role of discretion in the process cannot be made. Whilst the approaches identified in the literature review described how they were developed there were few examples of the results of their application in practice. The role of professional discretion was absent, for example, in the inter-authority variation described by Astana (2012). This supports the view of Series and Clements (2013) that issues of transparency and comprehensibility are of paramount importance in understanding the operation of a resource allocation system and the necessary role of the application of discretion at the level of the professional assessor or through management oversight as described above.

Management of finite resources

It is axiomatic to the delivery of adult social care that services are provided within a budget (Cm 849, 1989; DH, 2007; 2014) and it is therefore appropriate to appraise the contribution of RASs to this objective. What is the value of the contribution of a RAS to this process? The idea of using simple tools such as those described in the literature review (for example the points based In Control RAS) to allocate resources to individuals in social care is attractive. However, there are major risks and significant potential errors. In the majority of resource allocation systems presented in the literature, the number of cases involved is too few to begin to be sure of the validity of the calibration of the tool. This is in contrast, for example, to work undertaken in other spheres to develop indicative costings for care packages (Carpenter et al., 2005; Self et al., 2008).

Furthermore, the complexity of needs and circumstances and the fixed resources of the adjudicating body mean that there can be no ‘gold standard’ for a RAS by which a service user receives a financial allocation derived from quasi objective measures. Thus the underlying objective of a RAS must be understood. The literature review suggests that in the early stage of their implementation resource allocation systems have been interpreted as more than a guide to an indicative allocation of resources. However, in informing resource allocation for service users there is no indication that issues of specificity (identification of ‘true negatives’ – where indicative allocations are wrong) and sensitivity (identification of ‘true positives’ – where indicative allocations are correct) have been taken into account in the construction of tools or their application. This means that reliance on these tools risks the misallocation of resources both in response to individual needs and for the agency responsible for the funding.

The literature review also highlighted the multiplicity of factors which influence the allocation of resources. These include historic patterns of expenditure for different service user groups (SCIE, 2011); the availability of carer support and the ‘value’ placed on this in the context of the allocation of resources (Glendinning et al., 2009; SCIE, 2011); and area specific factors such as rurality or deprivation (Brand et al., 2012; Ridley et al., 2011). Moreover, the literature review has demonstrated that organisational mechanisms to scrutinise resource allocation decisions in place before the introduction of resource allocation systems remain (Glendinning et al., 2008; Perkins, 1998). This demonstrates that the latter is only one of a number of factors which influence the level of support a service user receives.

Long-term prospects

Following the introduction of the community care reforms the allocation of resources to meet needs became part of the assessment and support planning process. However, as this review has demonstrated there has been little research on this aspect of the process. The more recent introduction of the concept of resource allocation systems has focused attention on this. Five
methods were highlighted in this review: the CRAF, equivalency and outcome approaches, individual service funds, the In Control approach and that developed by FACE.

The extent to which they have achieved ‘proof of concept’ in the sense that they provide the realisation of an approach to resource allocation within adult social services which demonstrates its feasibility at least in principal to verify its long-term potential is worthy of conjecture (Carsten, 1989). This literature review has demonstrated that while all five methods have been utilised they have not been subject to the extensive investigation and research characteristic of a feasibility study. In the majority of analyses presented in the literature, the number of cases in relation to each approach is too few to begin to be sure of the validity of the calibration of the tool. The exception is purported to be the FACE tool.

While the idea of using simple tools to allocate resources to individuals in social care is superficially attractive there are major risks and significant potential errors in their application. These include:

- the complexity of individual circumstances (including support from carers) which may be irreducible to a simple formula.
- the impact of wider environmental factors such as housing and neighbourhood to decisions about the feasibility and cost of support.
- the potential for certain needs or problems to occur together and interact to increase (or decrease) the cost of support.
- the capacity for a tool to be correct on average across a population and yet markedly wrong in any individual case.

This suggests that it will be difficult to verify the long-term potential of the five resource allocation systems described in this review, another feature of proof of concept (Carsten, 1989). Nevertheless resource allocation mechanisms will remain integral to the process of assessment and support planning. One possibility is that certain features of the approaches described above rather than any one single approach will become embedded in local arrangements for assessment and support planning as they continue to evolve, embracing both self-directed support and professional-led support planning.
Limitations and future research

In this review we have necessarily taken a targeted perspective, especially in relation to literature relating to the community care reforms, by specifically focussing only upon literature relating to resource allocation, thereby excluding the extensive literature on assessment and care planning. It should also be noted that at the time the research was undertaken much of the literature on resource allocation tools was newly emerging and consequently there was little rigorous evaluation. Not only were there marked variations in the quality of the work included, but the state of development of the literature did not really permit systematic analysis of the quality of contributions by standard criteria.

Related to the concern about the quality of evidence was an underlying concern about the adequacy, accuracy and validity of the tools developed as resource allocation systems given the general lack of psychometric evaluation (Series and Clements, 2013; Slasberg et al., 2012; Clifford et al., 2013). Emerging from this review, beyond concerns about the quality and viability of the current tools in use, there would appear to be a need to address the relative needs weights for different user groups and how to include the contribution of carers.
Conclusion

Perhaps we may conclude that resource allocation to individuals with complex, multiple and varying needs is too complicated to be left to over-simplified solutions. There remains the challenge to accommodate different perspectives about need; a concern over the employment of unproven techniques in determining resource allocation; the general lack of psychometric evaluation of RAS tools; and the potential insensitivity of these to complex and multiple needs. As recognised by the recent policy guidance, alternative approaches, such as more traditional resource allocation processes, could be more suitable to some particular user groups to ensure that the personal budget is appropriate to meet needs (DH, 2014).
References


Petch A (2009) How effective so far have personal budgets been? Community Care, 2.7.09, 32–33.


References outside literature review


Cm 849 (1989) Caring for People: Community Care in the Next Decade and Beyond, HMSO, London.


References


Department of Health (2010b) A Vision for Adult Social Care: Capable Communities and Active Citizens, Department of Health, London.


Appendix 1

TABLE A1: Sampling frame for the literature review

<table>
<thead>
<tr>
<th>Inclusion criteria</th>
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</table>
| **Participants/care recipient group** | Adults (18-64) with mental health problem  
Adults (18-64) with physical disabilities  
Adults (18-64) with learning disabilities  
Older people (65+) |
| **Service** | Social care or social services for adults and older people |
| **Location** | Completed in the UK (including Northern Ireland) |
| **Dates** | Data collected 1991 or later (The NHS and Community Care Act passed)  
Published 1991 or later |
| **Design/study type** | Empirical (quantitative and qualitative) work using both primary and secondary data and a variety of methodologies including case studies and national surveys |
| **Focus of study** | Resource allocation mechanisms for service users and carers |
| **Study design/nature of reference** | Non peer reviewed literature |

<table>
<thead>
<tr>
<th>Exclusion criteria</th>
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| **Intervention type** | Hospital based interventions/services/treatment without a social care component  
Housing interventions without a social care component  
Employment interventions/services without a social care component |
| **Location** | Outside the UK (including Northern Ireland) |
| **Design/study type** | Administrative reports of organisations |
| **Study design/nature of reference** | Individual client case studies  
Book reviews  
Dissertation/PhD theses |