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INDICATIVE AND AGREED PERSONAL BUDGETS FOR OLDER PEOPLE: WHAT CAN WE LEARN FROM ONE LOCAL AUTHORITY'S RECORDS?

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Indicative and agreed personal budgets for older people: what can we learn from one Local Authority's records?

Amanda Burke and Ruth Hancock, May 2022

Abstract

The Care Act 2014 placed a duty on local authorities (LAs) in England to assign a personal budget to people assessed as eligible for social care support. In an exploratory analysis of local government administrative data, we focus on the relationship between the initial estimate of this budget, the 'indicative budget' (IB) and the final agreed budget (AB) arising from a care plan developed jointly by the LA and the older person. Differences between IBs and ABs have been noted in previous research and have led some to question the value of IBs and/or the process used to calculate them. Additionally, we extended previous published research to compare how the ratio between IB and AB varied by the type of services received, the principal reason that support was needed (e.g. physical or cognitive impairments) and the user's age and gender.

1. Introduction

This paper arises from analysis undertaken as part of the Business and Local Government Data Research Centre (BLGDRC), funded by the Economic and Social Research Council (ESRC)[a]. One of the aims of the BLGDRC was to explore the potential for local government administrative data to be used to carry out research for societal benefit. In this paper we report exploratory analysis of anonymised data provided to us by one of the 152 Local Authorities in England who are responsible for arranging social care. An earlier paper examined how the same data might be used to make projections of social care use and costs for older people[1]. Here we focus on the relationship between the initial estimate of the budget likely to be made available to an older person seeking care from the LA (the 'indicative budget' (IB)) and the final agreed budget (AB) arising from a care plan developed jointly by the LA and the older person. Differences between IBs and ABs have been noted in previous research and have led some to question the value of IBs and/or the process used to calculate them.

The Care Act 2014 placed a duty on local authorities (LAs) in England to assign a personal budget to people assessed as eligible for support for an ongoing need for social care. A personal budget is the

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monetary value of the services judged necessary by the council to meet to a person's support needs. The personal budget can be taken as a 'Direct Payment' so that an individual can arrange their own support, left with the LA who commissions services in consultation with the user, or taken as a mixture of the two approaches [2]. The personal budget aims to give users more control over the care they receive in order to promote personalised support rather than services that are 'one-size fits all' [3–5]. Current statutory guidance[6] states that:

> *"The allocation of a clear upfront indicative (or 'ball-park') allocation at the start of the planning process will help people to develop the plan and make appropriate choices over how their needs are met" (para 11.4)*

and

> *"An indicative amount should be shared with the person, and anybody else involved, at the start of the care and support planning" (para 11.7).*

The process of assessing need and arriving at an IB involves a Resource Allocation System (RAS)[7] through which the LA establishes an individual's support needs and the monetary value of the services to meet those needs. The initial stage of the RAS is an assessment to arrive at the IB; this is intended to give the individual seeking support a ballpark figure of the amount of funding required to meet their care needs. The individual's AB[b] is arrived at through detailed planning of the services required through the production of a Care and Support Plan [2]; this may be higher or lower than the initial IB.

The initial assessment for the RAS should be carried out in line with national eligibility criteria within government's statutory guidance [6]. Additional guidance has been produced by the Association of Directors of Adult Social Services (ADASS) [8] and campaigning organisation 'in-control', who pioneered the idea of personal budgets [9]. However, there is there is no single statutory assessment tool for carrying out this initial assessment nor for converting a person's assessed needs into an indicative monetary amount.

Three main approaches to carrying out personal assessments have been identified [4,10]. In their 2012 survey of English LAs Stewart et al. [11] found that, of the 138 LAs that responded, 59% used points-based self-assessment tools developed from the guidance mentioned above with each point awarded resulting in a fixed amount of funding (sometimes called a '£ per point' system,); 13% used a commercial assessment tool (FACE)[3] which is based on statistical modelling of the empirical relationship between needs and costs; and 28% used non-points based systems (for example, 'ready reckoning' whereby the practitioner estimates costs based a provisional care plan and hourly costs for different types of services). Series and Clements [4] found that of 20 LA's approached in a similar time-frame, 13 used points-based systems, a further three had moved away from a points based system due to concerns about their accuracy.

[b] This is also referred to as 'actual budget', however we have used the term 'agreed budget' to differentiate from 'actual package cost' in this paper.

Variations have also been found in the application of these different approaches including the content of assessment questionnaires, the method by which assessed needs are converted into points and then into monetary values, whether discretion can be applied or there is direct reliance on the resulting IB, the inclusion /exclusion from the IB of certain items e.g. transport, or equipment, the use of adjustments for factors not captured by the formulaic approach and/or the application of methods to keep the sum of all IBs within the available budget[4,10]. These variations can result in a wide disparities in IBs for the same support needs, for example, Asthana [12] used RAS processes from 33 local authorities for two exemplar clients and found IBs between £41 and £410 for one and £16 and £331 for the other.

A comparison of ABs and IBs in Hartlepool in 2009/2010 [13] found that, when aggregated, ABs and IBs were, on average, similar, with IBs being a little higher in a ratio of 1.08. However, a subsequent analysis found that, at an individual level, there was substantial variation in the ratio of ABs to IBs [5]. For example, in around 9% of the 512 cases analysed, the IB was found to be five times or more higher than the AB. The authors found similar results for three other councils, as did Series and Clements[4] in a separate study, leading them to question the value of IBs.

Clifford et al[3] have argued that the extent of such differences is much smaller when a statistical modelling method is used to derive IBs, rather than when there is reliance on a simple '£ per point' approach. They found a similar pattern of differences between IBs and ABs to the other studies for a London LA which used a '£ per point' system but when they applied the FACE modelling approach to that LA, the resulting IBs were much closer to the corresponding ABs, as they were for a different LA which had used the FACE RAS. However, updating their earlier paper, Slasberg et al. (2013)[14] reported that two councils who used the FACE system did not achieve any greater accuracy (in terms of differences between IBs and ABs) than the other 10 for whom they had data, leading them to question whether it is possible to standardise, measure and place a monetary value on needs. Simon Duffy, founder of 'in control' who pioneered the idea of personally budgets, describes IBs as a good idea come 'unstuck' where they are not approached as intended i.e. as offering general guidance in initial planning stages of care provision[15].

Whatever the existential debates about the IBs, if they are to fulfil their intended purpose of providing a ballpark figure for personalised planning, they should, at least, provide a useful approximation of the AB, although what constitutes a 'useful approximation' may be open to debate. In this paper we use one LA's data to replicate previous research that compared IBs to ABs in LAs [3,5], extending the analysis to compare how the ratio between IB and AB varied by the type of services received as well as the principal reason that support was needed (e.g. physical or cognitive impairments) and the user's age and gender. This has the potential to identify where discrepancies exist and therefore where changes can be made to assessment procedures. We also provide headline data showing actual spend on services by the LA compared to AB and IB, as actual spend was found to differ from agreed budgets in this LA.

2. Methods

a. Deriving an indicative budget

In the LA for which we have data, IBs are arrived at using what is essentially a '£ per point' system. Needs are first assessed via a Personal Budget Questionnaire (PBQ) (see Appendix 1). This was developed by this LA in 2016 (revised 2017) in a series of workshops that included services users, carers, social care staff, user-group representative, and the public. Additionally, questionnaires from other local authorities were consulted with regards to content and format.

The PBQ assesses an individual's abilities to manage activities of daily living (ADLs), either themselves or with help from family, friends, or others. Assessed needs are therefore dependent both on an individual's levels of health, cognition, mobility, but also on the level of support available to them. Each point in the personal budget questionnaire attracts a fixed amount of budget, which is updated annually based on prices for commissioned care. For this LA's PBQ, there are a maximum of 423 points as follows: 94 for 'Nutrition', 182 for "Personal care', 26 for 'Looking after my home', 42 for 'Education, training, working and volunteering', 28 for 'Getting out and about', 40 for 'Personal Relationships' and 11 for 'Parenting'. In January 2019 the price per point for this LA was £147.11, capped at a total of £26,000 per year, although we note that some IBs are higher than this figure, the reasons for this are not clear.

b. The data

The anonymised dataset for this study was for individuals aged 65+ in receipt of social care in January 2019 in one LA. It included basic demographic information (gender and age group), as well as the individual's primary reason for requiring support ('primary support reason'), whether they had a personal budget, their funding source, their annual indicative budget (IB), annual agreed budget (AB) and the actual cost of services being received in January 2019, converted to a weekly equivalent.

The dataset supplied included records for just over 8,400 individuals, of whom 2496 had an IB (and therefore also an AB). Analysis took place for the subset of individuals with an IB that were labelled in the dataset as funded by the LA (n=2257) rather than funded, or part funded from other sources, including self-funded.

Indicative budgets were missing for a substantial proportion of cases, and that proportion varied according to service type, primary support reason and age/gender group (see Appendix Table A1). Hence results are may not be fully representative.

c. Analysis

The dataset comprised a record for each service an individual received. For example, if an individual received both home care and day care, there was a record for each. There were many different types of service, therefore a taxonomy of the higher-level service types was developed in consultation with the LA (Table 1) and each service was categorised using this.

Table 1: Higher-level service types

Service type
Day care
Direct payment
Funded Nursing Care (FNC)[c]
Home care
Long-term nursing care
Long-term residential care
Short-term residential or nursing care
Supported accommodation
Other

Each record for an individual included common information such as demographics and their overall IB and AB. Each record also included the actual weekly costs of the service in question, which we multiplied by 52 to create an estimated annual amount (we say this is an estimate because weekly costs may vary across the year, for example, where a budget has been allocated for the purpose of a one-off service in one week).

We created one record for each individual consisting of their gender, age group, primary support reason, IB, AB and the actual annual cost of delivering all their services, which we refer to as the actual package cost (APC). In addition, we recorded the individual's 'main service', this was the most expensive service type they received using the categories in Table 1. Further details can be found in Hancock and Burke (2022)[1].

For the exploratory analysis, we firstly examine the overall distribution of each of the three budget types (IB, AB, APC) and the relationship between the budget types. We then conduct further sub-analysis by main service type, primary support reason, and age/gender group for AB and IB.

3. Results

a. Distributions of indicative budgets, agreed budgets and actual package costs

Summary statistics for IB, AB and APC (Table 2) show that IB has a smaller range than AB or APC; this is presumably a function of the eligibility and scoring processes for IB and the conversion process from points to pounds. The mean and median for IB are similar, differing by only £332, unlike the means and medians for AB and APC which differ by several thousand pounds. The means and medians for AB and APC are also lower than for IB.

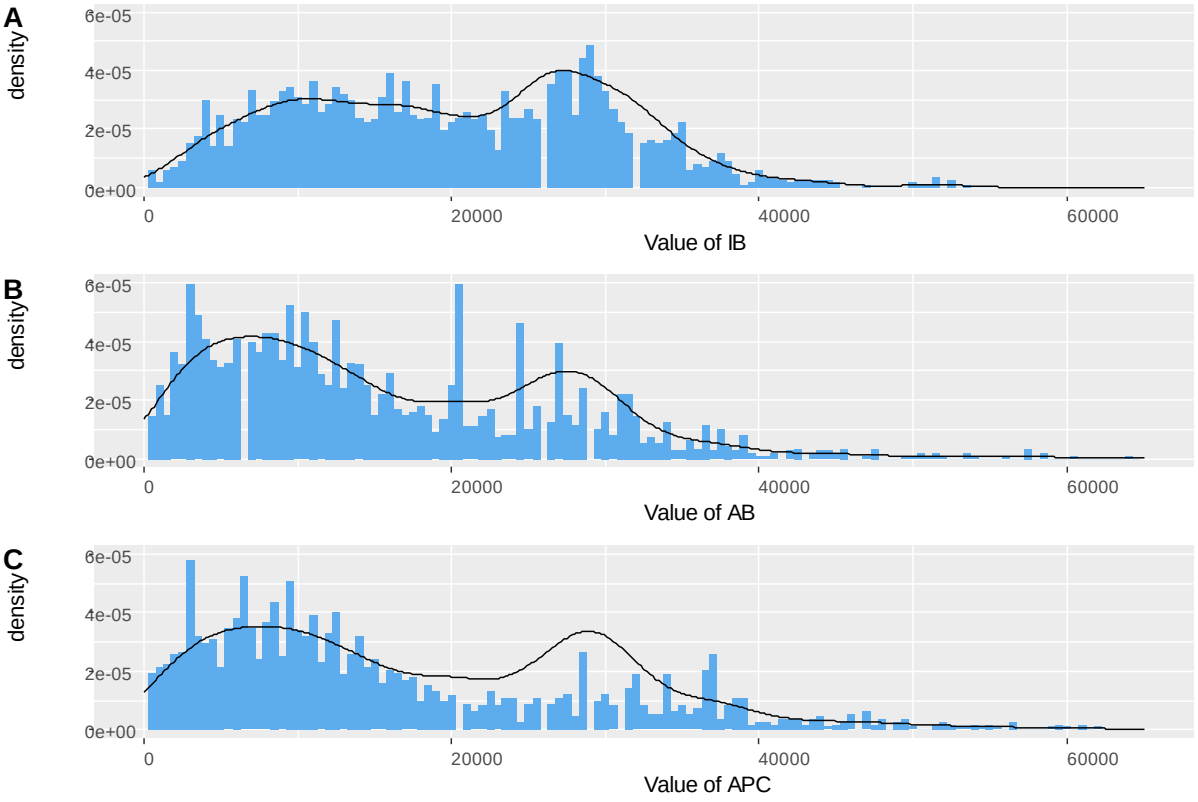
[c] This has been treated as a separate category because we assume its cost ultimately falls on the NHS. There are some cases whose only record is the FNC hence it is their 'main' service. It is also a secondary service alongside long-term nursing care (and short-term residential care which includes short term nursing care).

Table 2. Summary table for three main budget types for 2019

	Min.	1st Qua.	Median	Mean	3rd Qua.	Max.	Total
IB	£260	£11,822	£20,872	£20,520	£28,524	£53,515	£46,293,342
AB	£35	£7,034	£13,676	£16,671	£25,824	£119,017	£37,608,855
APC	£35	£8,087	£16,605	£18,896	£28,910	£120,220	£42,630,349

Histograms depicting the distributions of IB, AB and APC are shown in Figure 1 for values up to £65,000 (15 values from AB and 13 values for APC exceeded this limit and were excluded), and with bin-widths of £500. A kernel density curve has been added to aid interpretation; this has a bimodal shape for all three budget types. AB and APC have longer tails to the right, and a higher numbers of cases close to zero than IB.

Figure 1: Histogram for indicative budget, agreed budget and annual package cost in pounds for 2019



b. The relationship between indicative budgets and agreed budgets and indicative budgets and actual package costs

Total IB per annum divided by total AB per annum is 1.23, and total AB per annum divided by total APC per annum is 1.09 (similar to the figure of 1.08 reported by Tyson [13]). This represents an average difference per person of £3,849 and £1,623 respectively, and a total difference of around £8.68m and £3.66m respectively (Table 3).

Table 3: Differences between IB and other budget types for 2019

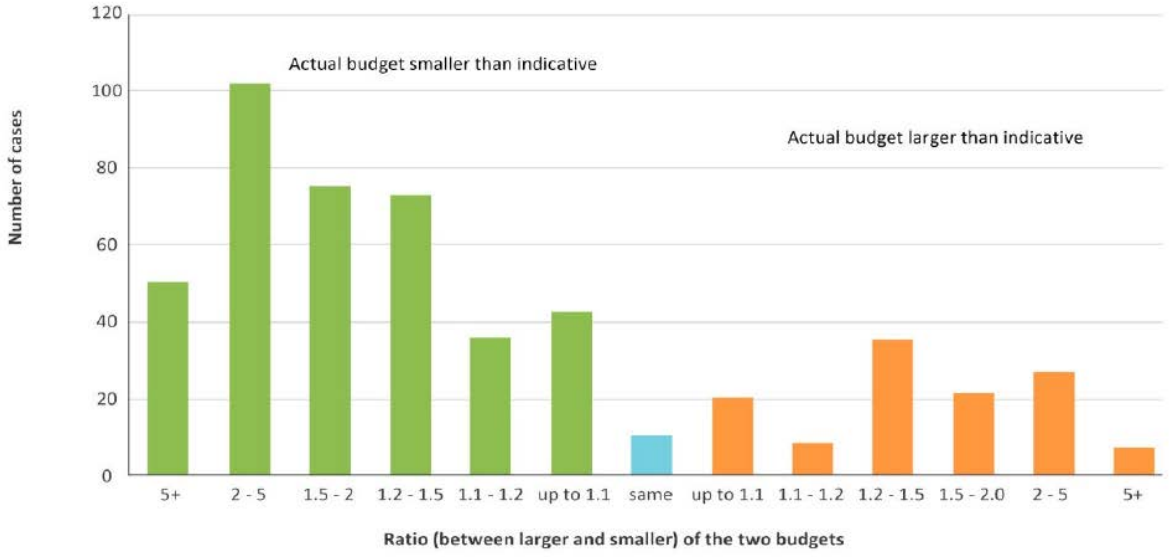
	N	IB/AB	IB/APC	IB-AB	IB-APC
Mean differences	2256	1.23	1.09	£3,849	£1,623

c. The distribution of the ratio between indicative budgets and agreed budgets

Following Slasberg et al. (2012)[5] we constructed ratios between IB and AB as the higher in value divided by the lower[d] and initially plotted them using the same ranges as the authors, with green bars representing cases where IB is higher than AB, and orange bars where IB is lower . Results follow a similar pattern to those previously reported where a '£ per point' system has been used, although this data shows a higher proportion of cases closer to 'equal' (figures 2 and 3A). Note that Slasberg et al's [5] sample was for the whole adult population whereas this sample is for 65+.

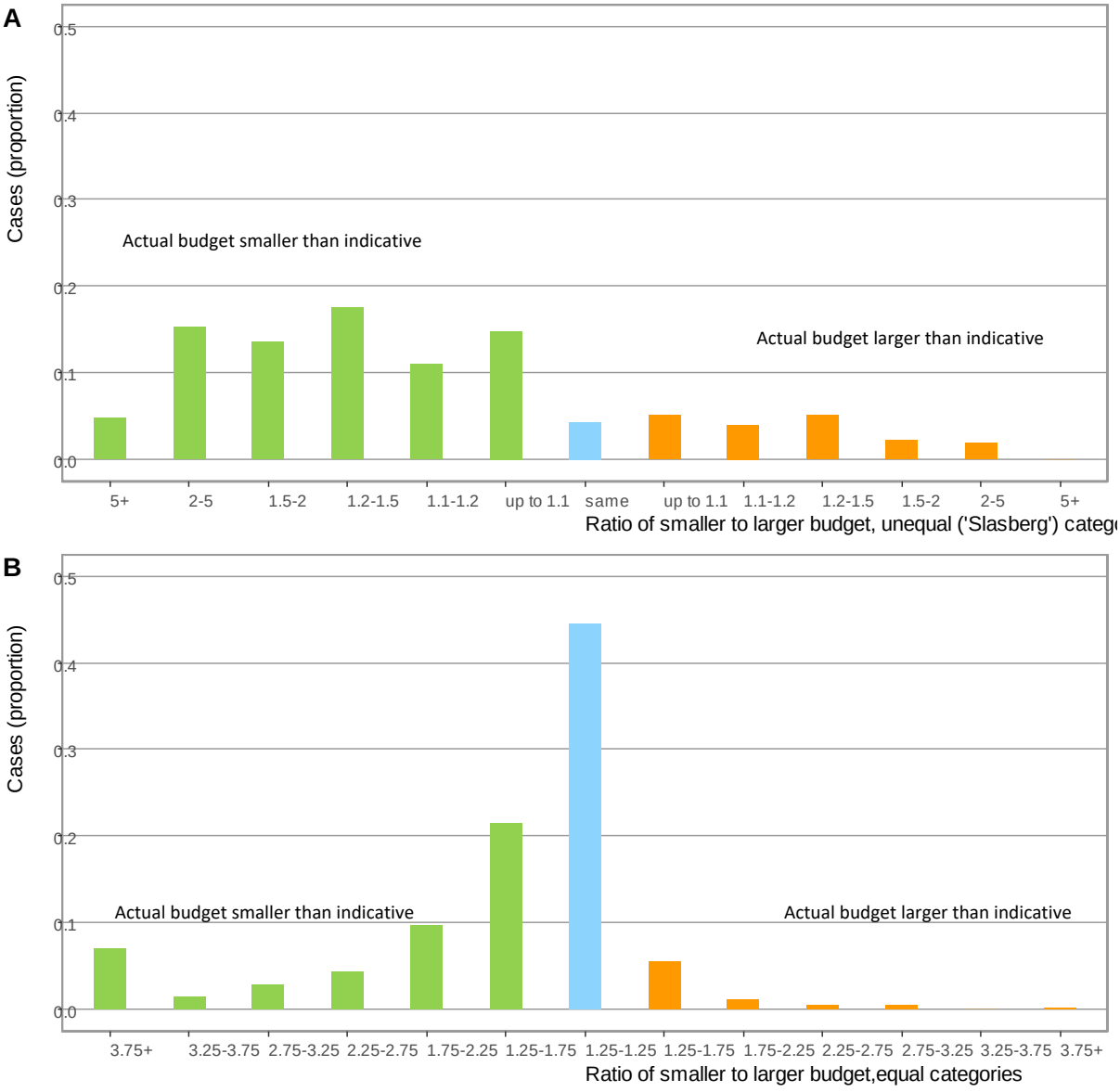
Using increments as per Slasberg et al. [5] have the benefit of showing small differences around the ratio of 1:1 (for example, 'up to 1.1', which Slasberg et al. considered close), but may result in the impression that there is a lack of central tendency in the data, as reported by Clifford et al [3]. We replotted the data using the same method (higher figure divided by lower) but using equal width bars, each representing a ratio of 0.5, and with an open upper category of over +/-3.75. This shows a different shape. The central bar which shows a ratio of plus or minus 0.25 holds around 45% of cases; these are cases where one budget is up to 25% higher than the other (Figure 3B).

Figure 2: 'Slasberg Ratios' for AB and IB for 2019, results for Hartlepool n=512 [5]. Ratios constructed as AB/IB where IB > AB, IB/AB where AB>IB. ***Reproduced from Slasberg et al. (2012)[5].***



[d] Note that this means that, in theory, the absolute difference between the IB and the AB or APC will not be the same for cases where the proportionate difference is the same but one has IB<AB and the other has IB>AB. However, in practice this had negligible effects on the categorisation of cases in our data.

Figure 3: Ratios constructed as AB/IB where IB > AB, and IB/AB where AB>IB (for 2019 data): A) 'Slasberg Ratios' for AB and IB for 2019, B) Ratios for AB and IB (annual budgets) with equal bin width intervals.



d. Indicative budgets, agreed budget and package costs by service type, primary support reason and demographics

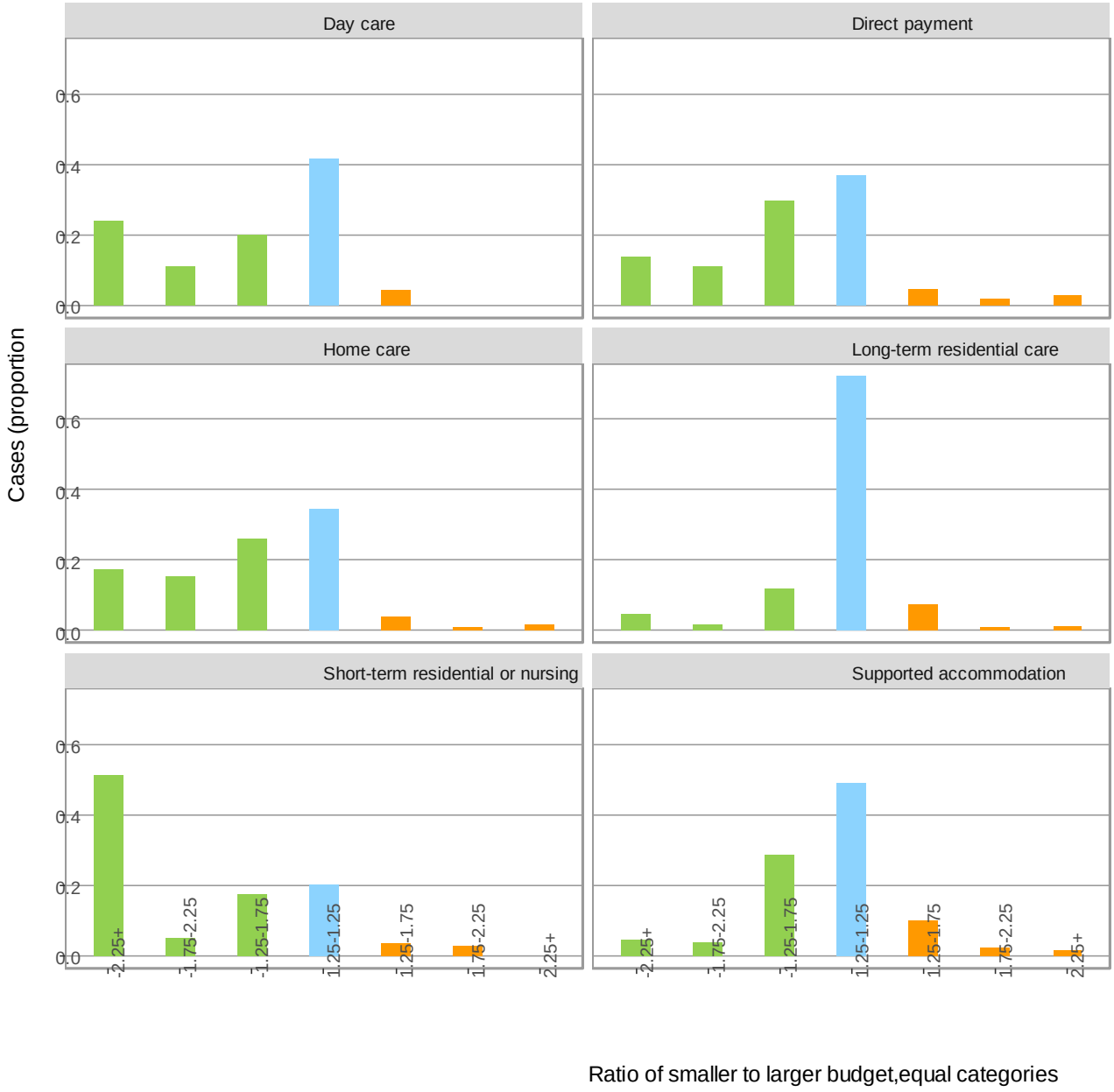
Sub-analysis was carried out to explore the ratio of IB and AB within i) main service types, ii) primary support reasons, and iii) age/gender groups. The ratio of the two budgets can be seen in Table 4.

Table 4: Ratio of IB to AB for 2019 within i) main service types, ii) primary support reasons, and iii) age/gender groups. Ratios are arrived at by dividing IB by AB when IB is higher and vice versa.

AB in relation to IB	Number	Mean IB	1.75+	1.25-1.75	1.25-1.25	1.25-1.75	1.75-2.25	1.75+
i) Main Service								
Home care	1058	£16,431	32%	26%	35%	4%	1%	3%
Long-term residential care	568	£29,165	7%	12%	72%	8%	1%	2%
Direct payment	155	£21,428	25%	30%	37%	5%	2%	5%
Supported accommodation	127	£25,582	9%	28%	49%	10%	2%	4%
Day care	121	£13,844	35%	20%	41%	4%	0%	0%
Short-term residential or nursing	119	£21,536	57%	18%	20%	3%	3%	3%
Other	92	£11,343	45%	16%	31%	4%	3%	5%
Long-term nursing care	16	£30,723	6%	6%	44%	44%	0%	0%
ii) Age and gender group								
Male: 74 or under	208	£19,964	24%	18%	41%	9%	4%	7%
Male: 75-84	285	£19,155	28%	21%	42%	6%	1%	3%
Male: 85 or over	317	£18,958	31%	20%	42%	5%	1%	2%
Female: 74 or under	238	£20,185	25%	17%	46%	7%	2%	5%
Female: 75-84	451	£20,935	26%	25%	42%	5%	1%	2%
Female: 85 or over	753	£21,685	23%	22%	48%	5%	1%	2%
iii) Primary Support Reason								
Physical Support	1709	£19,778	25%	23%	44%	5%	1%	2%
Memory and Cognition	269	£22,909	29%	20%	46%	5%	0%	0%
Other	151	£24,293	23%	16%	43%	11%	3%	6%
Mental Health Support	127	£20,961	27%	13%	46%	6%	5%	9%

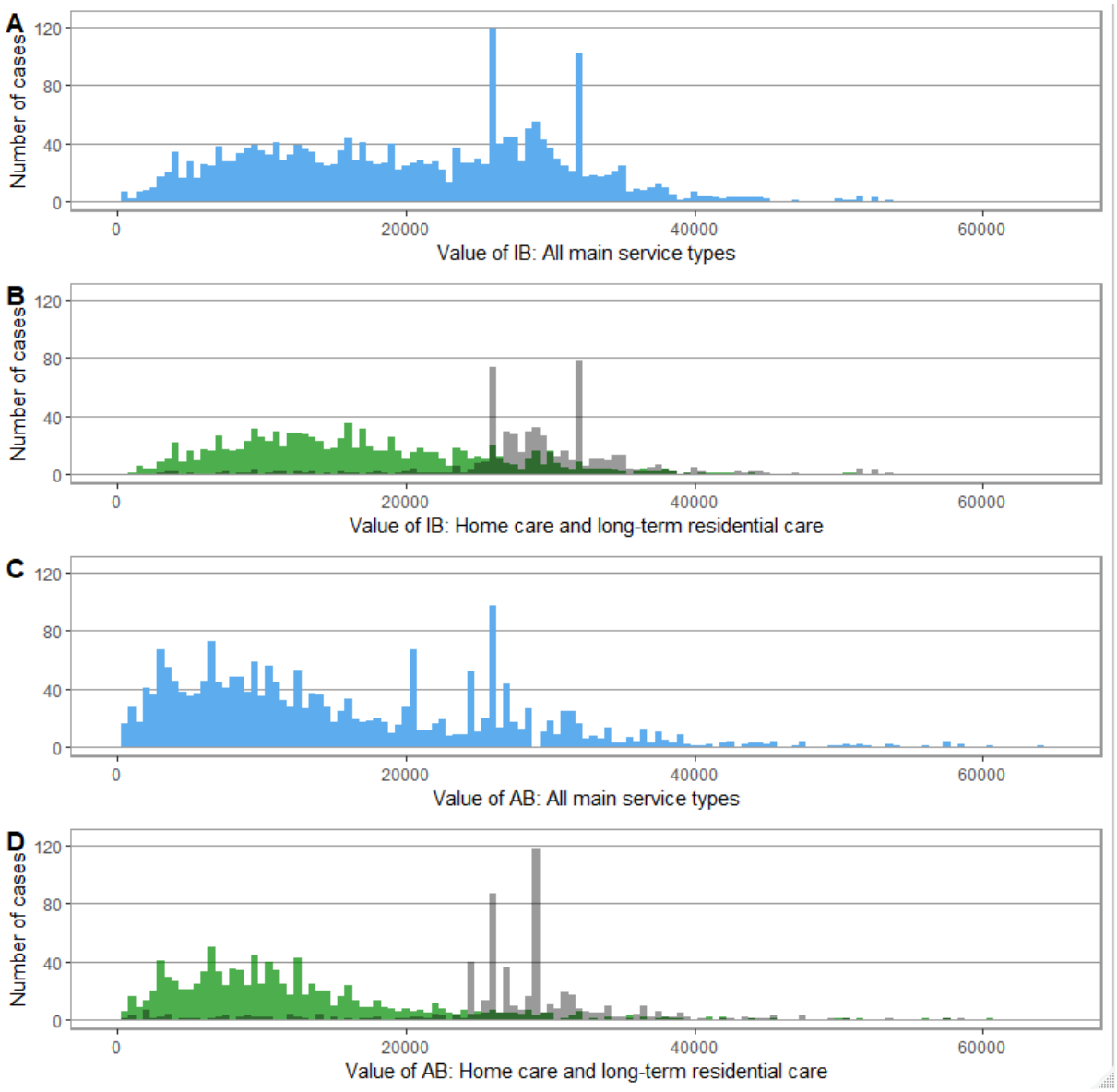
There is greater variation in the percentage of cases the range +/-1.25-1.25 for main service type than for gender group or primary support reason. We illustrate results for six main service type in Figure 4, (omitting service types 'other' and 'long-term nursing care' for which there are only 16 and 95 cases respectively). Long-term residential care has the highest proportion of cases within the +/-1.25-1.25, short-term residential or nursing the highest proportion where IB is 2.25+ times higher than AB.

Figure 4: The percentage of cases within each interval for 2019. Ratios constructed as AB/IB where IB > AB, IB/AB where AB>IB



We further illustrate differences between IB and AB by plotting a histograms for the distribution of 'home care' and 'long-term residential care' (Figure 5). With home care it is possible to identify a difference in shape indicating a greater number of cases with lower budgets for AB when compared to IB.

Figure 5. The distribution of IB and AB (201)9 for all services (Figures 5A and 5C in blue), and for home care (Figure 5B and 5D in light green to the left) and long-term residential care (Figure 5B and 5D in grey to the right with dark green for overlap with home care)



e. Levels of indicative budgets and their relationship to main service type

Taking a lead from Kingston et al (2018) [16] who segmented over 65s who were not independent as having low, medium or high dependency, we used levels of IB as a proxy for levels of dependency in order to explore the relationship between levels of need and main service type. We present the results using quintiles rather than tertiles, as the latter were found to result in a large central category with mixed results for main service type (Table 5).

Instances of long-term residential care mostly fall in the top two quintiles of assessed need; supported accommodation, which offers a lower level of support, falls mostly in the middle and top two quintiles. Short-term residential care is more dispersed; this might be because people are being

supported temporarily for reasons other than significant issues with ADLs as per the RAS questionnaire, for example, breakdown in care arrangements, or an unsuitable property. Home care falls largely in the bottom two and middle quintiles, but there are still a number of cases whose assessed need was in the top two quintiles; these presumably individual with high levels of need who cannot or do to wish to leave their homes. Day care cases are predominantly in the bottom quintile of assessed need.

Table 5: Quintiles of IB and main service for 2019

Main service group	Lowest IB				Highest IB
	1	2	3	4	5
Home care	28%	32%	23%	9%	8%
Long term residential care	3%	2%	7%	45%	43%
Direct payment	15%	17%	30%	17%	19%
Supported accommodation	4%	12%	38%	20%	26%
Day care	49%	19%	20%	5%	7%
Short-term residential	21%	13%	22%	21%	23%

4. Discussion

This analysis was undertaken to explore the potential for local government administrative data to be used to carry out research. While the analysis was exploratory, it was driven by previous research in this area. When examining the ratio between indicative and agreed budgets at an individual level, we found a similar distribution to Slasberg et al (2012)[5] and Clifford et al[3] (2013), with IB generally being higher than AB, and in many instances, several times higher; one difference in this analysis was a slightly greater number of cases where IB and AB were similar. It is interesting to note these similarities in the findings, as the previous research took place prior to the implementation of the 2014 Care Act which required LAs to roll-out personal budgets (and hence IBs), and the processes for allocating personal budgets would therefore have been still quite new. It should also be noted that, while we focus exclusively on older people, the sample for the Slasberg et al (2012)[5] study was concerned with all adults.

Our study looked at the actual costs of delivering the care package (APC) as well as the AB; overall we found that in 2019, while AB was £3,800 lower than IB, APC was £1,600 lower. APC, which is the actual cost of delivering services, is thus closer to IB than AB. The reasons for differences between AB and APC are not clear, but may be due changes, or increases in costs after an agreed budget has been set, or unexpected costs. APC was recorded as a weekly amount in the data base and is updated regularly, rather than an annual amount that is fixed as part of the planning process; it is therefore more responsive to changes in users' needs and may be affected by short-term deviations from the Care Plan.

Analysis by main service, primary support reason and age/gender group showed more variation in the relationship between IB and AB for main service type than the other subcategories. This may be because the pounds per point allocation method results in a linear increase in IB for each additional

'need-point'. However, the cost of providing care does not necessarily follow this trajectory, as it may be influenced by the type of care, for example, possible step-changes between the cost of providing residential and non-residential care, and other factors such as contracting arrangements.

We found that the IB for long-term residential was closer to the agreed budget than other main service types. Home care, which was the most common main category, had 32% of cases where IB was 1.75 times or more higher. Packages of home care were generally smaller in value than residential care because, at least amongst older people, they tend to cater for people at the lower end of the scale of needs that LAs are able to support. While the differences between IBs and ABs for home care may be large in proportionate terms, they may not be large in absolute terms.

The PBQ for this LA includes a possible 182 points for 'Personal Care', this is 43% of the total number of available points. With 'nutrition' accounting for another 22% of the total available points, five other categories account for the remaining 35% of points. While the total number of points was 423, funding in 2019 was £147.11 per point, capped at £26,000 per year; this means that, in theory, 178 points were required to reach the full possible budget (in practice a number of cases appear to have exceeded this cap). We found that those with a main service of residential care were most likely to be in the top two quintiles for IBs, home care in the middle and lower two quintiles, and day care in the bottom quintile. This illustrates the different types of care packages that are more common at different levels of 'dependency' [16].

A limitation of this analysis is that it is restricted to the administrative data of one LA. Access to similar data for a much larger number of LAs would increase the robustness of the findings and allow fuller examination of the effect of different RAS approaches and other differences across LAs. The fact that a substantial proportion of cases in our data did not have an IB (or indeed a personal budget) for reasons that we have not been able to identify is also a limitation. Furthermore, we have not been able to assess to what degree differences between IBs and ABs may be due to different approaches in the RAS across different LAs, which has been the subject of debate in previous studies [3,14,17].

This analysis has demonstrated some of the difficulties LAs may encounter in developing processes to estimate budgets for users in a manner that is transparent, understandable, and accurate. The estimation is dependent not only on an individual's levels of need, but also on the type of service they receive and this is not entirely predictable. For example, while most service users with high levels of need (as indicated by the IB) received some type of residential care, this is not always the case. The use of IBs does have the advantage of providing an equitable baseline across different types of services users where the same process is used. While differences between IBs and ABs has led some researchers to question their value and utility, it is difficult to form a judgement on this matter using this type of analysis. This is because the figures do not tell us how the IB is communicated and used in practice, what meaning it has to those using it, and how important an accurate IB is to those receiving services and those working with them. Perhaps one lesson from this research and previous similar studies is that a different kind of study is needed to answer this question before further research of the kind presented here is warranted.

5. References

1. Hancock R, Burke A. *Projecting Local Social Care Use and Costs for Older People Using Local Authority Records on Older Service Users.* Norwich: University of East Anglia, Health Economic Group WP 22-01.; 2022.

2. Department of Health and Social Care. Care Act factsheets. GOV.UK. Published 2016. Accessed July 11, 2021. https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets/care-act-factsheets

3. Clifford P, Saunders R, Gibbon L. Modelling the relationship between needs and costs: how accurate resource allocation can deliver personal budgets and personalisation. *Research, Policy and Planning*. 2013;30(2):107-120.

4. Series L, Clements L. Putting the cart before the horse: resource allocation systems and community care. *Journal of Social Welfare and Family Law*. 2013;35(2):207-226. doi:10.1080/09649069.2013.800288

5. Slasberg C, Beresford P, Schofield P. How self directed support is failing to deliver personal budgets and personalisation. *Research, Policy and Planning*. 2012;29(3):161-177.

6. Department of Health and Social Care. Care and support statutory guidance. GOV.UK. Published 2022. Accessed July 11, 2021. https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

7. Resource allocation systems. think local act personal. Published February 27, 2008. Accessed July 11, 2021. https://www.thinklocalactpersonal.org.uk/Browse/SDSandpersonalbudgets/Resourceallocationsystems/

8. Association of Directors of Adult Social Services (ADASS). *Common Resource Allocation Framework*.; 2009.

9. Poll C, Duffy S, Hatton C, Sanderson H, Routledge M. *A Report on in Control's Second Phase: Evaluation and Learning 2005–2007*.; 2008. Accessed July 11, 2021. https://scholar.google.com/citations?view_op=view_citation&hl=en&user=VzN9MnIAAAAJ&citation_for_view=VzN9MnIAAAAJ:u-x6o8ySG0sC

10. Challis D, Xie C, Hughes J, Clarkson P, Davies S, Stewart K. *Resource Allocation at the Micro Level in Adult Social Care: A Scoping Review*.; 2016.

11. Stewart K, Hughes J, Challis D, et al. Understanding Resource Allocation Processes in Social Care for Frail Older People: Lessons from a National Survey. *Journal of Long-Term Care*. 2021;(2021):43-57. doi:10.31389/jltc.21

12. Asthana S. *Variations in Access to Social Care for Vulnerable Older People in England: Is There a Rural Dimension?* University of Plymouth; 2012.

13. Tyson A. *Self Directed Support in Hartlepool 2006-9*. In Control Publishing; 2009.

14. Slasberg C, Beresford P, Schofield P. The increasing evidence of how self directed support is failing to deliver personal budgets and personalisation. *Research, Policy and Planning*. 2013;30(2):92.

15. Further Apologies for the Complex RAS. Simon Duffy. Published 2015. Accessed April 16, 2022. https://simonduffy.info/blog/further-apologies-for-the-complex-ras

16. Kingston A, Comas-Herrera A, Jagger C, MODEM project. Forecasting the care needs of the older population in England over the next 20 years: estimates from the Population Ageing and Care Simulation (PACSim) modelling study. *The Lancet Public health*. 2018;3(9):e447-e455. doi:10.1016/S2468-2667(18)30118-X

17. Slasberg C, Beresford P, Schofield P. Response to the paper 'Modelling the relationship between needs and costs: how accurate resources allocation can deliver personal budgets and personalistion. *Research, Policy and Planning*. 2013;30(3):193.

6. Appendix

Table A1: NCC social care users aged 65+ by main service type, whether has a Personal Budget and whether has a non-zero Indicative/Agreed Budget

Main Service	% of all users	% with Personal Budget	% with Indicative Budget	% with Agreed Budget
Day care	3.3	86.2	46.0	45.7
Direct payment	4.8	90.9	40.0	40.0
Home care	32.9	71.5	40.3	40.3
Long-term nursing care	5.5	74.6	20.2	20.2
Long-term residential care	35.5	70.1	20.8	20.7
Other	2.8	51.0	41.8	41.8
Funded Nursing Care Contribution (FNC)[e]	4.2	3.4	0.6	0.6
Short-term residential or nursing care	2.7	72.9	57.6	57.6
Supported accommodation	8.2	71.6	20.1	20.1
Primary Support Reason				
Physical	71.8	68.1	31.1	31.1
Memory/cognition	13.0	67.2	27.4	27.4
Mental Health	7.4	69.6	23.4	23.4
Other	7.7	83.8	25.8	25.7
Age and gender group				
Men, 65-74	9.0	78.8	30.7	30.7
Men, 75-84	11.9	66.5	32.0	31.8
Men, 85+	12.8	63.1	32.1	32.1
Women, 65-74	10.5	79.9	29.8	29.8
Women, 75-84	19.4	69.6	30.1	30.0
Women, 85+	36.2	66.7	27.4	27.4
All (n=8422)	100	69.2	29.6	29.6

[e] This has been treated as a separate category because we assume its cost ultimately falls on the NHS. There are some cases whose only record is the FNC hence it is their 'main' service. FNC is more commonly a secondary service alongside nursing care

Appendix: RAS tool used by NCC

LAS Assessment and Reassessment: RAS 17/10/2018

Area	ADL	Response
Nutrition	1) Bringing food into the home	a. I can do this without help b. I have enough help from friends/family/others around me to do this c. I need support from elsewhere to do this
	2) Preparing light meals, snacks and drinks	a. I can do this without help b. I have enough help from friends/family/others around me to do this c. I need support from elsewhere to do this
	Number of times a day	1 to 3
	Number of days a week	1 to 7
	3) Preparing main meals	a. I can do this without help b. I have enough help from friends/family/others around me to do this c. I need support from elsewhere to do this
	Number of times a day	1 to 3
	Number of days a week	1 to 7
	4) Eating and drinking	a. I can do this without help b. I have enough help from friends/family/others around me to do this c. I need support from elsewhere to do this
	Number of times a day	1 to 3
	Number of days a week	1 to 7
Personal care	5) Washing and keeping clean (personal hygiene)	a. I can do this without help b. I have enough help from friends/family/others around me to do this c. I need support from elsewhere to do this
	Number of times a day	1 to 3
	Number of days a week	1 to 7
	6) Managing toileting and continence needs - this is where you may find the toilet difficult to use or to access safely	a. I can do this without help b. I have enough help from friends/family/others around me to do this c. I need support from elsewhere to do this
	Number of times a day	1 to 3
	Number of days a week	1 to 7
	7) Getting dressed and undressed and being suitably clothed	a. I can do this without help b. I have enough help from friends/family/others around me to do this c. I need support from elsewhere to do this
	Number of times a day	1 to 3
	Number of days a week	1 to 7

	8) Having extra people to help with personal care (double-up) - this is where two people may be needed to help with things like getting you in and out of bed, bathing or using a toilet. It may, however, also be needed at other times	a. I don't need two people to help me with this b. I have two people to help me when needed c. I need support from elsewhere to do this
	Number of times a day	1 to 3
	Number of days a week	1 to 7
	9) Having someone with me throughout the night - this is where it may have been assessed that, for your safety, you need an additional person to be with you overnight	a. I don't need someone to be with me overnight b. I have enough help from friends/family/others around me to do this c. I need support from elsewhere to do this
	Number of nights a week	1 to 7
	Please select if it has been assessed that this support is for someone who is awake throughout the night	Yes No
Looking after my home	10) Having a safe home	a. I can do this without help b. I have enough help from friends/family/others around me to do this c. I need support from elsewhere to do this
	Number of times a week	1 to 7
Education, training, working and volunteering	11) Taking part in education and training	a. I can do this without help b. I have enough help from friends/family/others around me to do this c. I need support from elsewhere to do this d. I do not want to do this/this is not relevant to me
	Number of times a week	1 to 7
	Number of times a month	1 to 3
	Number of times a year	1 to 11
	12) Working or volunteering	a. I can do this without help b. I have enough help from friends/family/others around me to do this c. I need support from elsewhere to do this d. I do not want to do this/this is not relevant to me
	Number of times a week	1 to 7
	Number of times a month	1 to 3
	Number of times a year	1 to 11

Getting out and about	13) Getting there/gaining access – this is about identifying your options and making safe arrangements	a. I can do this without help b. I have enough help from friends/family/others around me to do this c. I need support to help me get there safely d. I need someone to provide one-to-one support to help me get there safely e. I need someone to provide specialist one-to-one support to help me get there safely f. I need two people to provide support to help me get there safely g. I do not want to do this/this is not relevant to me
	Number of times a week	1 to 7
	14) Using the facilities once I get there	a. I can do this without help b. I have enough help from friends/family/others around me to do this c. I need support to do this safely d. I need specialist one-to-one support to do this safely, but not all of the time e. I need specialist one-to-one support to do this safely at all times f. I need two specialist people to do this safely g. I do not want to do this/this is not relevant to me
	Number of times a week	1 to 7
Personal relationships	15) Maintaining existing/making new personal relationships	a. I can do this without help b. I have enough help from friends/family/others around me to do this c. I need support from elsewhere to do this
	Number of times a week	1 to 7
	Number of times a month	1 to 3
	Number of times a year	1 to 11
Parenting	16) Having parental responsibility for a child - this is where you have parenting or other caring responsibilities e.g. as a parent, step-parent, or grandparent	a. I am able to carry out my parental responsibilities safely without support b. I have enough help from friends/family/others around me to carry out my parental responsibilities safely c. I need support from elsewhere to do this d. I do not have any parental responsibilities
	Number of times a day	1 to 3
	Number of days a week	1 to 7
Respite for my carer(s)	17) Short periods of respite – this is where, from time to time, you feel you need to take short periods of respite from your usual pattern of giving	a. I do not need these b. I have enough help from friends/family/others around me to enable me to take the short periods of respite I need

	support. A short period would give you just a few hours away, perhaps a morning or afternoon	c. I need support from elsewhere to take short periods of respite d. I do not have a carer
	Number of times a week	1 to 7
	Number of times a month	1 to 3
	18) Longer periods of respite – this is where you need to have a longer period of respite from your caring role. You may not know precisely when this will be needed but you can make an estimate by looking ahead	a. I do not need these b. I have enough help from friends/family/others around me to enable me to take the breaks I need c. I need support from elsewhere to take longer breaks d. I do not have a carer
	Number of times a month	1 to 3
	Number of times a year	1 to 11
	Number of full weeks a year	1 to 6