Common resource allocation framework

Financial framework

Introduction

This document outlines the purpose of the financial framework, its principles and the process for developing the financial elements that underpin the common resource allocation framework.

It outlines a minimum set of requirements and process for enabling any local authority, at any stage of implementing personalisation, to develop a financial framework as part of an overall resource allocation system (RAS).

A spreadsheet tool is available which can be used together with this document to create a working RAS.

Key question

The aim of the financial framework is to answer the following question:

“How do we translate the final score from an outcomes or needs based personal needs questionnaire into an indicative resource allocation?”

The diagram below shows the three key components of the common resource allocation framework. The financial framework relates to the third box (indicative budget calculation) and offers a mechanism and process for establishing the “allocation table” that translates scores into indicative allocations.
Key output

The key output from the financial framework is an “allocation table” showing scores from 0% to 100% and the indicative allocations for each score. An example is shown at the end of this document.

Principles

The financial framework is based on a number of principles, as set out below:

a) For all people across all care groups
   The framework covers all people in all situations across all care groups. Care groups are defined as Learning Disabilities (any age), Older Persons (65+), Physical Disabilities (under 65), Mental Health (under 65) and other.

   Note: This categorisation links directly to the Department of Health definitions for care, for the purposes of the EX1. The DH classifies any service user 65+ as an Older Person.

b) Same allocation table for all service users
   A key principle underpinning the common resource allocation framework is equity for all service users. To satisfy this principle, all service users and care groups should have the same allocation table. The personal needs questionnaire is a needs-led questionnaire, and if needs are higher the score and linked indicative resource allocation will reflect this.

   This will present a unique challenge for some councils and if, after detailed support planning, it is found to be impossible in the current market to meet assessed needs and desired outcomes within the indicative allocation, then this allocation may be enhanced, subject to a suitable approval and sign off process. Councils may wish to consider time-limiting this enhancement, subject to market shaping activities, further exploration of options and a further review at a predetermined point in time. Councils may also wish to set thresholds at which different approval and sign off processes apply, to minimise unnecessary bureaucracy and delay.
Early in the implementation of personalisation, the number of these ‘enhancements’ may be significant, however after the system has bedded in councils should set a threshold at which a further review of the RAS would be instigated e.g. if less than 90% of all indicative RAS allocations were found to be sufficient to meet assessed needs / planned outcomes.

The evidence from councils is that in order to support this principle, two areas of work require attention:

- Market development to equalise opportunities for all care groups
- The possibility of budget realignment (i.e. achieving local budget equity across care groups)

Any actions across these two areas are likely to take considerable time to implement and have an impact, therefore initiatives should commence as soon as possible.

c) Ongoing need
Only financial information that relates to meeting ongoing needs of a service user should be included. For example, community equipment, care management costs, IT systems etc should not be included. A local authority may decide to include portions of budgets, if agreed that a certain amount of the budget can be made available to service users for them to have choice and control over.

d) All social care budgets
Apart from the point above, the financials included to calculate the allocation table should cover ALL social care budget areas (i.e. residential care, day care, home care etc).

e) Standard score range
The range of possible scores from the personal needs questionnaire is 0% to 100%, therefore the allocation table will give indicative allocations covering this range of scores.

The financial framework shows scores as percentages. This is to support organisations who may want to allocate a different total number of points to their questionnaire, for example 200 points. In this case the
organisation would double all of the percentage values, as they are out of 100% to reflect 200 points being allocated across all the questions.

f) Gross allocations
The allocation table represents gross resource allocations, i.e. before any personal contributions (charges) are introduced, alternative funding streams identified, and/or any adjustments for informal support are made.

Process

Before the following process can be followed the local authority must ensure that it has the following resources available:

1. An agreed personal needs questionnaire
2. An agreed scoring sheet linked to the questionnaire

The common resource allocation framework includes these resources, ready for councils to utilise.

To develop the financial framework and resulting allocation tables, the following steps should be followed:

1. Select a sample of service users
   - This sample needs to be statistically significant, therefore the number in the sample needs to be sufficient to satisfy this criterion.
   - A process for helping you calculate a statistically significant sample size is included at the end of this document.
   - This sample needs to be drawn from current service users and be representative of the size of the each service user group. For example, if there are 1,000 older people and 500 physical disabilities service users in an authority then there should be 66 older people are 33 physical disability cases in the sample of 100
   - It is also advantageous to ensure an adequate cross section of service users within each care group. For example, some residential care service users, some day care service users etc. It would be unrepresentative to have 100% residential care clients and none from other areas
• Where possible, this sample should also be selected on a random basis (i.e. from within those care and service user types)

2. Complete personal needs questionnaire
• Request that a selection of care managers complete the personal needs questionnaire on the selected number of the sample cases. In order to complete this task, the care manager will require some knowledge of the service user and ideally they would be on their current case load. However, resources and the necessary knowledge allowing, you may also wish to have a second care manager validate those scores, to improve the qualitative output of the process
• It is important to brief all care managers on the purpose of the exercise and to run through the personal needs questionnaire before starting. Resolving any questions at this stage will ensure greater consistency across the sample.
• In addition, it is very important to clearly describe how the personal needs questionnaire should be completed and how data should be collected and collated.

3. Identify current resource usage
• Collate the total amount of current resources that each service user utilises and cost this level of resource usage
• These figures should be gross
• Also, it is important to include the costs for services that the service user utilises which are not attributed (for most councils) to individual service users (i.e. day centre usage). Essentially, if a service user is utilising a service to meet a need and is to be given the flexibility to choose whether this service is still what they wish to access to meet their needs, whether that be in-house or other, then it should be included in the current resources being used. In some instances, this will require councils to accurately cost in-house services and apportion these to service users based on their level of resource usage, i.e. if a service users currently utilises the day centre for one day, then this has different resource implications than if the service users accesses it for three days
• If you plan to exclude some current social care funding from your RAS for strategic purposes (e.g. re-ablement, early intervention and prevention resources)

4. Collate needs and financial information
   • Use a standard spreadsheet template (one is available as part of the framework resources) for collecting and collating this information

5. Generate allocation table
   • Use a standard spreadsheet template (one is available as part of the framework resources) to calculate the allocation table

6. Set contingency level
   • Establishing a level of contingency is important to the functioning of the financial framework. The reasons for having a contingency include:
     o For some service users, the indicative resource allocation may not be adequate to meet their assessed needs. This will only be fully known after support planning. If, at the point of agreeing a final support plan value, an increase indicative allocation is required then the contingency element enables this to be affordable and sustainable
     o There may be some double running costs for services, particularly during the initial stage of implementing personalisation
     o Some councils are locked into block contracts and in house provision which will take time to change
   • Using the spreadsheet template, set a contingency percentage on the allocation table
   • Councils are free to set whatever level of contingency they feel is appropriate for them
   • The councils in the framework development group had contingencies ranging from 15% to 25% and experience shows that as personalisation becomes embedded into the system of social care this contingency factor can be reduced
7. **Undertake variance analysis**
   - Using a spreadsheet template (one is available as part of the framework resources), undertake variance analysis comparing actual resource usage for all sample cases and the indicative resource allocations based on the scores from the sample personal needs questionnaires.
   - This analysis is important as it offers additional information to support the decision making process.
   - Note: it is expected that on an individual case-by-case basis that there will be variances (i.e. some receiving more resources and some less), however overall analysis should begin to indicate an averaging out of variances across the sample.

8. **Undertake reasonableness test**
   - It is important that the outputs from the process so far are checked for their reasonableness.
   - One of the key reasonable tests is to check the impact that ‘outliers’ may be having on the allocations. How you define ‘outlier’ is a local decision, but could relate to any very high cost or low cost cases in your sample. It is important to ask, if these are removed from the analysis, what impact does this have?
   - If it is shown that a very small number of cases has a large impact on the allocation tables, then a decision needs to be made on whether to include or exclude this data. This is due to the fact that these data may impact the results.
   - As experts within your own localities and financial positions, all output and analysis should be checked for ‘reasonableness’, essentially asking the following three questions:
     - Does the allocation table feel reasonable (i.e. do the indicative allocation amounts look broadly sufficient to meet assessed care needs, at each of the various scores)?
     - Will this output enable us to move forward with personalisation and offer greater choice and control to citizens?
     - Are we confident that this will work within the system framework (or process) we have designed which has the required checks and balances in it?
• If the answer to any of these questions is ‘No’, you may wish to consider the following options:
  o Consider the impact of any inclusions / exclusions, and whether amending these would enable you to answer these ‘reasonableness check’ questions positively
  o Review your sample personal needs questionnaire scores, to assess whether they are accurate (if you did not get a second care manager to validate them as part of your initial exercise, you may consider doing this now)
  o Revise your score weightings (this should be seen as a last resort)

9. Agree allocation tables and sign-off

• Follow the required sign-off process in your council to agree the allocation table
• At this point it is important to agree a review date for the RAS, not any sooner than a calendar year. You may wish to consider the lead time needed to change your RAS (any consultation requirements, administrative infrastructure changes and Committee / Member decisions) and begin any review process six to nine months before the point at which you are seeking to implement a change

10. Financial framework complete

• At this point you should have the allocation table required to calculate indicative resource allocations for service users based on the score generated from the personal needs questionnaire.
### Example indicative allocation table

<table>
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<th>Score</th>
<th>£</th>
<th>Score</th>
<th>£</th>
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<th>£</th>
<th>Score</th>
<th>£</th>
<th>Score</th>
<th>£</th>
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<td>96%</td>
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</table>
Example allocation graph (using dummy data)
Calculating a statistically significant sample size of cases

Theory
The size of the sample you need to select will vary depending on how much confidence you want to have over the results. The higher your requirements the more you will need to sample. The process set out below is one way to determine how many cases you need to look at to obtain a meaningful result.

The two main criteria to look at are the confidence level (how sure you can be the results are reliable) and the confidence interval (how much variation you can live with). For the sort of analysis being undertaken here a confidence level of 95% would give a high level of assurance when allied with a confidence interval of + or – 5%. A confidence interval of more than +/-10% should be avoided if possible.

Sample Size
The number of people you need to sample to be able to say your results have statistical validity will vary with the size of population you are sampling from but for each set of confidence levels and intervals there will always be an upper limit. For 95% confidence and a 5% confidence interval the maximum necessary sample size would be 384, however this would only be needed for populations of 500,000+. The equivalent sample size for a population of 1,000 would be reduced to 278.

It is important to note that these sample sizes are only sufficient if you are truly generating a random sample. If you wish to ensure that your sample adequately covers certain areas e.g. the four main care groups, then you need to treat each as a separate population. If the 1,000 mentioned above was actually four distinct populations of say 700:200:50:50 and you wanted to sample each one independently then you would need to test 468 cases in total, nearly doubling the work. Once you start to split your population down into lots of smaller sub groups the number of cases required can quickly become daunting but that is the only way to be confident the results in each area are reliable.

Limiting the Sample Size
If you wish to reduce the sample size you could treat all your service users as one population. If you do so you should compare the sample selected to your
wider population to ensure you have sufficient diversity and all major groups covered, you may need to resample if this does not work first time but the size of the sample should minimise this. You should avoid selecting additional cases to fit gaps in your sample if possible. If the samples are not random all the statistical validity is lost.

If you take this approach then you need to be careful when drawing conclusions from your sample, you can only draw conclusions about the whole population, not any particular subset. If you wanted to draw conclusions about the impact on say, Learning Disabilities, you would need to treat them as a separate population and increase the sample size accordingly.

Alternatively to reduce sample sizes you could increase the tolerances you are happy to work with, e.g. use a confidence interval of +/-10%.
Examples and a Calculator
The table below gives some sample sizes for various populations and confidence levels. The spreadsheet is embedded in this document so if you enter your own authority’s cared for population(s) into the shaded cell it will give you appropriate samples sizes for a 95% confidence level using your own data.

### Desktop sample size calculator

<table>
<thead>
<tr>
<th>Enter your care population:</th>
<th>1234</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of confidence:</td>
<td>95%</td>
</tr>
<tr>
<td>Your sample size:</td>
<td>293</td>
</tr>
</tbody>
</table>

### An example

<table>
<thead>
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<th>Total number of service users supported by the council:</th>
<th>Size of sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>1000</td>
<td>278 211 164 131 106 88</td>
</tr>
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<td>1500</td>
<td>306 227 173 136 110 90</td>
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<tr>
<td>2000</td>
<td>322 236 179 140 112 92</td>
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<td>333 241 182 142 114 92</td>
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</tr>
<tr>
<td>20000</td>
<td>377 263 194 149 118 96</td>
</tr>
</tbody>
</table>

### Key Points
- more confidence = bigger samples
- more specific conclusions = separate samples = bigger samples