# How Local Authorities in England Allocate Resources to Carers through Carer Grants/Personal Budgets.


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## Abstract

### Summary

English policy and practice guidance recommends local authorities offer personal budgets to all adults eligible for social care support using transparent and equitable allocation systems which maximise choice and control for users. This includes family and other unpaid carers as carers in England are entitled to their own personal budget. The Care Act 2014 strengthens carers' rights and places duties on authorities to assess and meet carers eligible support needs. However, little is known about how authorities assess and allocate resources to carers. This paper explores this information gap drawing on data from a survey of English local authorities in two regions completed by carers lead officers and complemented by follow-up telephone interviews with a sub-sample of these officers.

## Findings

Survey and interview results demonstrate wide practice variations around how social workers assess, calculate and distribute resources to carers. There is little uniformity across authorities. Carer eligibility criteria are used but thresholds

vary and are often unclear. Most grants/personal budgets are allocated as single annual payments but how the level of these grant/personal budgets are calculated varies with little standardisation.

## Applications

The paper develops the evidence base surrounding resource allocation to carers through carer grants/personal budgets. Findings are timely as the Care Act 2014 will strengthen carers' rights alongside the continuing personalisation of adult social care. Discussing local authority policy and practice around key objectives of equity, transparency and carer choice, implications for future social work practice and its development are considered in light of the Care Act 2014.

(250 words)

**Keywords**: Social Work, Carers, Personalisation, Direct Payments, Social Care, Local Authorities

## How Local Authorities in England Allocate Resources to Carers through Carer Grants/Personal Budgets

## Introduction

English policy and practice guidance (Department of Health (DH), 2010a; DH, 2010b; HM Government, 2010) recommends that local authorities should offer personal budgets to all adults eligible for social care support, including family and other unpaid carers, preferably in the form of a cash direct payment. Carers should be entitled to a personal budget in their own right, separate from that of the person they support. Local authorities are also advised to use a transparent and equitable approach in allocating resources to carers; this should be proportionate and not overly-time consuming or bureaucratic and should aim to maximise choice and control for carers (DH, 2010a).

These principles gain further importance as the Care Act 2014 (implemented from April 2015) in England strengthens carers' rights in relation to social care, making them equivalent to those of disabled and older people. The Care Act 2014 places a duty on local authorities to undertake assessments of family and other unpaid carers and to meet carers' eligible support needs. Personal budgets for carers are advocated, with clarity over how the levels of carer personal budgets are determined. Pre-legislative scrutiny of the Act (Joint Committee,

2013) emphasised the importance of transparency and recommended greater clarity over how the resources allocated to individual carers are calculated.

The Care Act 2014 has important policy and practice implications for local authorities and adult social care practitioners. However, little is known about how authorities currently assess and allocate resources to carers. This paper reports findings from a study of two regions in England that examined how local authorities assess carers' support needs, determine levels of personal budgets and allocate these to carers. The implications for future social work practice in the light of the Care Act 2014 are considered.

## Background

### Carer policy and support recognition

Amongst developed welfare states, England is unusual as carers have secured rights to assessments of their own needs, including those relating to education, employment and training. Significantly, these rights are independent of those of the person they support (Carers (Recognition and Services) Act 1995; Disabled Children Act 2000; Carers (Equal Opportunities) Act) 2004. Carer assessments are a pre-condition for the allocation of support to carers, but take-up of carer assessments remains problematic. In 2009-2010, only four per cent of carers reported having been assessed (Princess Royal Trust for Carers & Crossroads Care, 2011). Research has identified a number of reasons for this low take-up, including social work practitioners' continuing ambivalence towards and reluctance (for example because of time constraints) to offer carers separate assessments (Glendinning, Mitchell & Brooks, 2015; Mitchell, Brooks & Glendinning, 2015; Mitchell, Brooks & Glendinning, 2014). Social work practice is further hampered by reports of confusion over the eligibility criteria carers must meet in order to be allocated support and assessment tools that frequently marginalise carers' emotional needs (Seddon & Robinson, 2015; Repper et al., 2008; Seddon et al., 2007; Glendinning et al. 2015; Mitchell et al., 2015; Mitchell et al., 2014). Depending on the outcome of an assessment, carers may be allocated support – often some form of short break - to support them in their care-giving role. Since 2001, carers have been able to receive this support in the

form of a cash direct payment[1]. This offers carers greater choice and flexibility over the form and timing of breaks and other support[2]. However, without ring-fencing the budget for carer support at local authority level, funding has not always been available for carers and carer breaks (Moran, Arksey, Glendinning, Jones, Netten & Rabiee, 2012).

**Provision of support for carers**

Cash direct payments are now promoted as the preferred mode of allocating personal budgets[3] to carers (DH, 2010b) as they can allow carers to have more choice and control over how they meet their own support needs (Fletcher, 2006). However, little research exists about how carers want to receive their support or how the levels of carer personal budgets are calculated. Think Local Act Personal[4] (2013) reports that carers want to have their own personal budgets and want to receive this in the form of a cash direct payment. However, this research is limited, largely to self-selecting groups of carers. Moreover, the number of carers with their own direct payment remains relatively small. In one English survey, only 4.8 per cent of carer respondents (n=1,386) had their own personal budget in the form of a direct payment (Hatton & Waters, 2013). There

[1] Direct Payment – direct cash payment instead of services in kind.
[2] Cash direct payments to be spent on services are different from social security benefits, such as the UK Carers Allowance and Australian Carer Payment, which replace the earnings of carers who are unable to continue in work because of their care commitments (Eurocarers, 2009; OECD, 2011).
[3] Personal Budgets – funding allocated to individuals following an assessment of their needs. Individuals can choose to take their personal budget as a direct payment.
[4] [4] Think Local Act Personal is an English partnership of central and local government organisations, the NHS, service providers and service user and carer organisations committed to improving health and social care through personalisation and community support

also appear to be variations in how personal budget levels to carers are calculated, as shown by a Carers Trust (2012) survey of 54 English local authorities. The Carers Trust survey found that the most common ways of determining levels of carer personal budgets were individual, points-based resource allocation systems, and broader tier or banding systems. Lump-sum, one-off payments were the most common method of delivery. Another recent survey of English local authorities also reported that just under half of the total number of personal budgets distributed to carers (n=51,191) were single one-off payments (ADASS, 2012).

Advocates of points-based resource allocation systems stress their potential for equity, transparency and reduced professional discretionary judgements, compared to less structured assessments where professional judgement can play a greater role, thus leading to increase risks of inequity. However, the importance and benefits of professional judgement in social work practice - social workers utilising their knowledge, skills and values to guide decision-making about appropriate responses to individual circumstances (Hardy, 2016) – remains an issue of ongoing debate with little consensus. The implementation of self-directed support and increased personalisation has, for some, raised questions about the role and scope of professional judgement, in the given increasing assessment, resource management and risk/safeguarding concerns (Evans, 2013; Ellis, 2014; Hardy, 2016).

The idea of a transparent and structured carers' resource allocation system[5], separate from that used to determine levels of personal budget for the older and disabled person they care for, is not new (Moullin, 2008). However, how to best develop such resource allocation systems and their usefulness remains unclear. For some (Slasberg et al., 2013; Series and Clements, 2013) resource allocation systems are narrow and inflexible, unable accurately to reflect individual needs. Moreover, although presented as objective, they appear not to eliminate social care practitioner discretion (Series & Clements, 2012). Others (Clifford, Saunders & Gibbon, 2013) argue that resource allocation models can be developed which are (or could be) more sensitive to individual needs and hence are useful tools to allocate monetary resources to individuals, including carers.

Whether carers should receive financial and other support in their own right, separate from that offered to older and disabled people, is also much debated (Keefe & Rajnovich, 2007). Within the disability movement, policies to support family and other unpaid carers have been criticised as reinforcing dependency for disabled, sick and older people (Shakespeare, 2000). Others stress the danger of conflating the needs and outcomes of carers and those they support (Arksey & Glendinning, 2007). Nevertheless, interdependencies, often derived from shared

[5] A Resource Allocation System is any set of rules that allows fair allocations to be made to people who require extra support. RAS are a key component of personal budgets (www.centre for welfare reform.org).

life histories (Larkin & Milne, 2014) frequently exist between disabled and older people and the family and friends that support them. Separate systems of support for disabled and older people and their carers risk overlooking these interdependencies (Fine & Glendinning, 2005; Kroger, 2009; Seddon & Robinson, 2015). Furthermore, services and support provided to disabled or older people can also have important benefits for carers (Pickard, 2004), both directly (for example, a break for the disabled or older person also gives the carer a break) and indirectly (for instance, carers can derive satisfaction from knowing the person they support receives good quality services). How best to provide support to carers is therefore complicated.

**Carers and Personal Budgets**

Personal budgets for carers are part of the wider trend of developing cash-for-care schemes across Europe, North America and Australasia (Glasby & Littlechild, 2009). How far carers' needs and wishes are taken into account varies between different cash-for-care schemes (Moran et al., 2012). In England, research has focused largely on evaluating disabled and older people's own experiences of personal budgets rather than, as Larkin and Dickinson (2011) note, carers' experiences. Where carers have been considered, attention has focused on the impact on carers of personal budgets for the person they support. This research reports largely positive outcomes for carers, such as improvements in health and well-being (Carers UK, 2008; Moran et al., 2012; Hatton & Waters, 2013).

Improved quality of life outcomes for carers have also been reported amongst carers of people with personal health budgets (Davidson et al., 2012). These studies demonstrate complex interdependencies between carers and service users but they do not explore carers' receipt of personal budgets in their own right.

The study reported below aimed to fill this gap in evidence. It investigated how local authorities in England currently allocate resources to carers through carer personal budgets. The study, conducted between November 2013 and April 2014, explored what approaches authorities currently use to assess, calculate and distribute personal budgets to carers; and any anticipated changes following implementation of the Care Act 2014.

## Methods

The study involved an electronic, online survey to local authorities and follow-up interviews with a sub-sample of senior local authority officers with lead responsibility for carer support. Ethical approval was granted by the English Social Care Research Ethics Committee. The study was part of a broader project examining carers' roles in personal budgets and personalised adult social care (Glendinning et al., 2015; Mitchell et al., 2015; Mitchell et al., 2014)

### The survey

Survey questions drew on previous research, for example, the Carers Trust (2012) survey, and were developed in consultation with the Association of Directors of Adult Social Services (ADASS) and other researchers. Research colleagues piloted the survey on line to identify any technical glitches. The survey was short and contained open and closed questions. Questions focused on authorities' approaches to determining the level of personal budgets paid to carers; the eligibility criteria and assessment processes they used; the involvement of carers and carers' organisations in developing these processes; and any anticipated future changes. Respondents were asked to supply any relevant policy or practice guidance produced by their authority.

Due to time and resource constraints, the online survey was sent to local authorities in two English regions. One region contained 14 local authorities, the other 16. The regions were geographically dispersed and chosen following consultation with ADASS. They included unitary, metropolitan and two-tier authorities; and between them contained diverse urban, rural and ethnic populations. Carer lead officers in the 30 authorities received the survey in early December 2013. Email and telephone reminders (a minimum of two) were sent up to mid February 2014. The final response rate was 67 per cent, with 20 authorities completing the survey. Eight authorities did not respond and two authorities declined to take part.

**Table 1 Survey response rates**

| | Completed | Did not complete by deadline | Declined | Total number of LAs |
|---|---|---|---|---|
| Region 1 | 12 | 0 | 2 | 14 |
| Region 2 | 8 | 8 | 0 | 16 |
| **Total** | **20** | **8** | **2** | **30** |

**Survey data analysis**

Survey responses were first charted on an Excel spreadsheet. Data was then managed through a process of summarising and transferring the data onto a set of theme-based tables, drawing on principles from the Framework approach (Ritchie & Lewis, 2003). Themes were established from survey questions, initial reading of completed questionnaires and discussion between the researchers. Documents sent by survey respondents were read and relevant sections added to the summarised tables. One researcher led the process of data summarising, the other researcher advised and checked some of the charts for consistency. This process enabled data comparison; the identification of similar themes across and between responding authorities; and the drawing and verification of conclusions. It also facilitated data tracking, especially individual responses from survey respondents.

**Telephone Interviews**

Survey data was used to select three authorities for follow-up telephone interviews. These aimed to explore in more detail with carer lead officers the three main methods of allocating resources to carers revealed by the survey, namely: single standard lump-sum grants; points-based approaches to assessing individual carers; and broad bands of carer needs, with corresponding tiered payments. Interviews were conducted with the same local authority officer with lead responsibility for carers who had completed the survey in each of the three authorities. Interviews were semi-structured, with the topic guide developed from survey responses. This consisted of a set of core questions covering the authority's eligibility criteria; processes for assessing carers and determining levels of carer grants or personal budgets; how these were paid to carers; and any planned changes. Core questions were followed by questions customised for each authority, to probe in more depth their earlier survey responses. The interviews were audio recorded (with participants' verbal and written consent) and lasted 40 to 60 minutes.

**Interview data analysis**

The researcher listened to each interview and developed a written summary. The summary was then analysed alongside the corresponding survey data for each of the three participants. Although viewed as a whole, the survey data and interview written summaries were kept separate in order to retain the option of

differential data reporting. One researcher took the lead in analysing the data, discussing ideas and emerging themes with the other researcher. This aided clarification of key themes; in particular, it highlighted those occurring in both the survey and the interviews.

The findings reported below synthesise data from the survey, local authority documents and telephone interviews.

## Findings

### Which carers are eligible for personal budgets?

Seven of the 20 authorities responding to the survey reported that eligibility for carer personal budgets[6] depended on a minimum number of hours per week spent caring – these minimum thresholds varied from 19 to 35 hours per week. A second cluster of authorities reported that eligibility depended on social work practitioner assessments of the impact of caring on carers' own health and well-being and/or the risk of breakdown in the care-giving relationship. Finally, a third group of survey respondents referred to 'established criteria'[7] – only carers providing 'regular' and 'substantial' care were eligible for a personal budget. However, no standard definitions of 'regular' or 'substantial' were given.

[6] Study participants used the terms grants, personal budgets and direct payments in varying ways, with little consistency between them. Here, the term personal budget is used, with additional clarification/explanation when required.

[7] Some respondents appeared to draw on Fair Access to Care Services criteria, usually used to determine eligibility for social care for older and disabled people. Fair access to care services has four levels of need – critical, substantial, moderate and low.

In addition, a number of authorities also employed further eligibility criteria, allocating financial support only to carers who were also assessed as having 'critical' or 'substantial' needs.

Methods for establishing whether carers met eligibility thresholds varied. For example, in one authority an initial screening tool with five fixed choice questions was used for all new carer contacts. These screening questions were then used to determine whether the carer should receive a full assessment or simply be signposted to other organisations and services.

In another authority, one carer lead officer described an

> *outcomes matrix which has a set of descriptors … the basic, standard and enhanced descriptors.*
>
> (Interviewee, metropolitan authority)

These descriptors were used to 'band' carers' needs as 'basic', 'standard' and 'enhanced'; only carers assessed as having 'standard' or 'enhanced' needs eligible for a personal budget.

A different numerical points system was described by another carer lead officer whereby answers to a standard set of care-related questions were assigned scores of one to three. A score of 19 or above (out of a possible 25) was regarded as an indication that a carer was providing a 'substantial' amount of care and thus met the threshold of eligibility for a personal budget. However, the carer lead officer acknowledged that this threshold was actually based on discretionary judgement:

> *… it was a bit of mathematics … but there wasn't a specific mathematical calculation that gave us that, it was just looking at it and thinking 'what do we think constitutes a large amount of care that would warrant funding' and that's how we came to it really.*
>
> (Interviewee, unitary authority)

Eighteen of the 20 survey respondents reported applying the same eligibility criteria to all groups of carers. However, two survey respondents noted their authority also required that carers must be 'financially in need'. In one authority this was interpreted as carers (or their partners, if appropriate) being in receipt of state benefits. This was explained as an equitable way of targeting carers most in need of support, especially in a context of limited financial resources.

**How levels of personal budgets are calculated for individual carers**

Over and above these minimum eligibility thresholds, there were wide variations in how authorities determined the actual level of the personal budget to be awarded to individual carers. For example, as noted earlier, one carer lead officer reported her/his authority used three bands of carer need; 'basic', 'standard' and 'enhanced'. Carers assessed as having 'standard' level needs received personal budgets 'up to £250'; those with 'enhanced' needs received 'from £250 to £500' per year (carers with 'basic' needs were ineligible for personal budgets). Within each band the exact amount allocated to each carer was reported to be flexible and decided through discussion about desired carer outcomes.

Five survey respondents reported their authorities used a points-based resource allocation system to determine the level of individual carers' personal budgets. One survey respondent supplied details of a scale which assigned carers points ranging from 0 to 100, depending on their level of need. Carers were eligible for a personal budget if they scored at least 42 out of 100 (each point had a designated monetary value which was used to calculate the actual amount for each carer). How this monetary scale had been devised was not clear. Another carer lead officer reported a similar approach but also did not know it had been developed.

Other respondents reported a range of methods which drew more heavily on social workers' judgements about a carer's situation to determine the level of the personal budget. With Some survey respondents in this group reported that the impact of caring on the carer's health and well-being was used to guide decisions about the level of a carer's personal budget. Others reported establishing a specific need on the part of the carer and then identifying appropriate support/services, with the costs of serving as a guide to the level of the personal budget:

> *The amount allocated to each carer is based on what the carer wants to use the grant for, for example, if gym membership is the agreed support service and gym membership cost £135 then the carer would apply for £135.*
>
> (Survey respondent, county authority)

However, maximum levels of personal budgets were still subject to defacto ceilings.

**Processes for assessing carers for personal budgets**

Three-quarters of survey respondents reported that carers' eligibility for a personal budget was usually established in the course of a standard carer assessment, conducted separately from any service user assessment. Amongst

the remaining responding authorities, joint assessments involving both service users and carers were reported, while one carer lead officer noted that allocating resources to carers did not necessarily require a prior carer assessment – indeed, a separate carer assessment could take place after a carer's threshold eligibility for a grant/personal budget had been determined.

**Table 2 Processes for assessing carer eligibility**

| **Usual approach to assessment (authorities n=20)** | | |
|---|---|---|
| Separate carer assessment | Joint assessment with service user | Not always dependent on assessment |
| 15 | 4 | 1 |

**Table 3 Responsibilities for conducting carer assessment**

| **Assessments conducted (authorities n=20)** | | |
|---|---|---|
| By in-house staff | Outsourced | Combination (in-house and outsourced) |
| 10 | 1 | 9 |

Carer assessments were conducted in-house by local authority staff in half of the 20 local authorities responding to the survey. A further nine authorities used both local authority social workers and voluntary organizations, mainly local carers' centres. Only one survey respondent reported offering carers a choice between in-house or outsourced assessments.

Only two survey respondents whose authorities used both in-house and outsourced assessments described measures to ensure consistency between these assessments. Both reported that local authority managers and social workers were involved in training non-authority staff who conducted assessments. In one of these authorities, direct communication between local and non-authority staff was reportedly assisted by a 'carers champion' in each team who acted as communication link. The remaining 18 authorities responding to the survey did not report any measures to safeguard the consistency of outsourced assessments.

**Levels of carer personal budgets – standard or variable amounts?**

**Table 4 Levels of personal budgets paid (authorities n=20)**

| **Same amount for all carers** | **Variable amount depending on:** | | | |
|---|---|---|---|---|
| | Points awarded | Broad bands | Number of hours caring | Impact of caring role |
| 5 | 5 | 1 | 2 | 7 |

In three-quarters of the 20 survey authorities, levels of carer personal budgets varied according to levels of carer need; the remainder allocated a single standard amount to all eligible carers. Among authorities paying the same

standard amount to all qualifying carers, levels of personal budgets ranged from £60 to £300, with £200 most frequently reported. In authorities reporting variable levels of carer personal budgets, levels ranged from 'up to £200' to no fixed maximum (although de facto ceilings were nevertheless reported). For instance, in one authority requests for carer personal budgets over £1,000 were reported to be infrequent and required social work practitioners to obtain special approval. Between these extremes, upper limits of £250, £300 and £500 were reported.

A few survey respondents described the processes by which levels of carer personal budgets were set. These were often adhoc and involved, for example, comparing the total available budget against the numbers of carers who were anticipated to apply for help. A similar process for setting standard grants was also reported:

> *It's a fixed sum, it's £200 and that sum was chosen because, you know, the pot of money that was available and the carer numbers that there were likely to be …*
>
> (Interviewee, unitary authority)

Some reservations were expressed about the inflexibility of single standard payments for all carers. For example, one survey respondent noted that

standard payments could be unresponsive to individual variations in carer need or the impact of the caring role on carers' personal health and well-being, which could lead to potential inequity.

None of the survey respondents reported currently charging carers for support or services.

**How often are carer personal budgets paid?**

**Table 5 Frequency of payments to carers**

| Frequency of payment | Authorities (n=20) |
|---|---|
| Annual payment | 13 |
| Less frequent than annual | 2 |
| More frequently than annual (predominately monthly) | 1 |
| Carers have option of annual or monthly payments | 2 |
| Carer personal budget included in service users personal budget | 2 |

Amongst the 20 survey respondents, 13 local authorities were reported to make only annual payments of carer personal budgets. Three authorities reported making monthly payments to carers, but only one of these reported that

monthly payments were their only method of payment. Two authorities reported that carer personal budgets were paid through the personal budget of the person they supported without apparently acknowledging that this could compromise carers' choice and control over how they used the payment.

Most survey respondents reported that their authority generally awarded lump sum payments to carers as these were easier to administer, especially as the amounts awarded were relatively small:

> *One off payments are the least bureaucratic and the quickest way to make a payment. They do not require a separate bank account or any monitoring.*
>
> (Survey respondent, county authority)

This practice of making lump sum payments was justified by five survey respondents on the grounds that carers were thought to prefer these because they were compatible with how they used their personal budgets, for example to pay for gym membership, holidays and driving lessons. Lump sum payments were also considered by social workers to give carers more choice and control:

> *It's giving them more control because they can use it when they want to meet the outcomes that have been identified.*

(Interview, metropolitan authority)

Only two authorities offered both lump sum and regular monthly payments. Both reported that annual grants were more common than regular payments, because of the relatively small size of payments and the administrative work that carers could experience with more frequent payments. However, some carers were reported to prefer monthly payments, especially if these were used for regular services such as paying a cleaner. It was also felt that monthly payments could facilitate easier household budgeting for 'carers that had quite short or tight incomes'.

There was no evidence that carers were consulted about how they preferred their personal budgets to be paid.

Two survey respondents noted that their local authority effectively rationed carer personal budgets through restricting the frequency of payments. In one authority, carers could only apply for a personal budget every three years; in the other, preference was given to carers that had not received a personal budget the previous year. Several other survey respondents noted that carers had to be reassessed for a personal budget each year as there was no automatic, ongoing entitlement. Managing and meeting carer expectations of continuing entitlement to a carer personal budget in the context of increasingly restricted local authority resources was acknowledged to be a growing problem.

Flexibility and monitoring of carer personal budgets

Half the survey respondents provided information on how much flexibility carers had over the use of their personal budget. All reported their authorities allowed carers flexibility as long as the personal budget was used to meet agreed carer outcomes and not for the service user. However, two survey respondents expressed concerns about the difficulty of monitoring how lump sum annual payments were actually used; there were anxieties that these annual payments could easily be amalgamated into general household finances. Nevertheless, routine auditing of carer personal budgets was not undertaken.

**Future plans**

Eleven survey authorities reported plans to change their current arrangements. Four of these referred to the need to review arrangements following implementation of the Care Act 2014 but were awaiting further guidance. However, three of these four authorities reported that they were considering moving to a points-based system. This was partly in response to increased demand on limited budgets.

Attitudes towards the future adoption of points-based systems were mixed. On one hand, they were recognised to offer potentially greater transparency, equity

and consistency. One social worker whose authority now used a points-based system pointed out that previously:

> *… it was just a bit of a free-for-all and we had to go on was what we [i.e. social workers] thought would be a useful amount for somebody [i.e. carers] …*
>
> (Interviewee, non-metropolitan authority)

And another interviewee also reflected that a points-based system could offer greater rigor:

> *… I think we need something so there's definite boxes to tick, definite scores that we can use to help judge how much we give, that's more consistent ....*
>
> (Interviewee, metropolitan authority)

On the other hand, points-based systems were considered relatively blunt instruments for identifying the needs of individual carers, where numbers of hours spent caring might bear little relation to the actual impact of caring on carers health and well-being.

## Discussion

### Findings overview

This study examined the approaches currently used by a sample of English local authorities to determine the grants/personal budgets awarded to carers, and any plans to change these in the future. Data were obtained through a survey completed on behalf of 20 local authorities from two English regions and telephone interviews with three of the 20 survey respondents. The findings add to the evidence base, particularly data reported by the Carers Trust (2012), by documenting how local authorities calculate budget levels for carers and the outsourcing of carer assessments and grant delivery - areas previously under-researched.

The findings indicate wide variations in how authorities and social work practitioners currently assess, calculate and distribute personal budgets to carers. The provision of 'regular' and 'substantial' care, or caring for a minimum number of hours per week, were frequently used as basic eligibility thresholds. Further eligibility criteria included receipt of state benefits and the risk of breakdown in the care-giving relationship, based on social work practitioner assessments.

Carers' eligibility for a personal budget (and sometimes also the level of the budget) was usually established through a separate carer assessment, but who conducted these assessments varied. In some authorities all carer assessments were conducted by local authority-employed social workers; in others,

assessments were outsourced. In three-quarters of authorities replying to the survey, variable levels of carer personal budgets, depending on assessed levels of carer need, were reported. Most authorities reported a maximum level for carer personal budgets, ranging from £200 upwards but those without clear maximum levels still appeared to have defacto ceilings. Lump sum annual payments were more common than regular monthly payments. Annual reassessments for carer personal budgets were also common, with some local authorities restricting eligibility to carers who had not received a personal budget in the past year. Survey respondents emphasised the growing importance of managing carers' expectations of receiving a personal budget.

**Discussion**

Current DH guidance (DH, 2010a) on carer personal budgets emphasises principles of equity, transparency and the maximisation of carers' choice and control. How far does current practice appear to be consistent with these principles?

***Equity***

Equity has several dimensions. It can mean treating carers with similar levels of need similarly; treating carers with different needs and caring roles differently; and ensuring that carers in different authorities have broadly similar outcomes. This study found that nearly all the responding authorities reported applying the

same eligibility criteria to different groups of carers, irrespective of the type of disability or needs of the person they were supporting. Additional criteria were also commonly applied to help identify carers providing 'substantial' amounts of care, those for whom care-giving had greatest impact or those on low incomes and hence, in greater need of support. To this extent, eligibility criteria appeared equitable. However, authorities awarding the same standard level of personal budget for all eligible carers did not appear to treat carers with different levels of need (above basic eligibility thresholds) differently. Moreover, where councils did identify carers with different levels of need - and therefore potentially eligible for different levels of carer personal budgets – systems for assessing these levels varied widely.

Points-based resource allocation systems were considered by some study respondents as more equitable, as standardised questions and weightings could facilitate consistent approaches and outcomes (that is, the level of personal budgets allocated to individual carers). On the other hand, standardised questions about the amount of help given could fail to capture the actual impact of care-giving on individual carers that might be revealed through in-depth practitioner discussions. Seddon and Robinson (2015) similarly note the risk that standardized assessment tools might eclipse practitioner-carer discussions and relationship building. This difference of opinion between study respondents mirrors wider debates surrounding the sensitivity and equity of standardised,

points-based resource allocation systems, compared with professional judgments about the appropriate level of resources to be allocated in response to individual needs and circumstances (Clifford et al., 2013; Series & Clements, 2012; Slasberg et al., 2013).

This study revealed considerable inequity between local authorities, with authorities using different systems to assess eligibility and employing different thresholds for carers to meet. There was apparently little consistency between authorities in what were considered to be 'substantial' levels of care-giving. Furthermore, although reported by only a couple of survey respondents, further inequity between authorities were created where additional income-related eligibility criteria had to be met.

Considerations of equity were also raised by the conduct of carer assessments. Outsourcing carer assessments to voluntary organisations or other agencies was relatively common, with only some authorities reporting active measures to ensure consistency between those conducting assessments. Equity was also called into question by those authorities reporting highly individualised approaches to carer assessments based on discussions between social care practitioners and carers. Finally, there appeared widespread financial inequities, with local authorities reporting wide variations in maximum and minimum levels

of carer personal budgets. Similar diversity was also reported in the Carers Trust (2012) survey.

***Transparency***

Although social care practice guidance (DH, 2010a) and pre-legislative scrutiny (Joint Committee, 2013) of the Care Act 2014 both emphasise the importance of transparency in the allocation of resources to carers, little transparency was found in this study. This, once again, mirrors earlier findings reported by the Carers Trust (2012). In the current study, some authorities reported discretionary approaches based on practitioner/carer discussions during individual carer assessments. Even where points-based systems were in operation, study participants acknowledged a lack of transparency over eligibility thresholds or the weighting of points in determining levels of carer personal budgets. Indeed, these were often unclear to study respondents.

**Maximising choice and control for carers**

Central to current care policies and practice is the aim of maximising choice and control for individuals with social care support needs (DH, 2010a, 2010b; HM Government, 2010). This also applies to personal budgets for carers, with cash direct payments for carers the preferred option. Most study authorities paid carer personal budgets directly to carers rather than through the service user's personal budget.

The Care Act (2014) strengthens carers' rights, however, the Act's accompanying focus on whole family approaches - considering the needs of an individual in the wider context of their family and its interdependencies (see Morris et al., 2008; Hughes, 2010 for a review of whole family approaches) – appears to accentuate the ongoing debate about whether to provide support for carers directly as individuals or indirectly through the support (including the personal budget) of the person they care for.

Survey respondents reported that carers had choice and control over how they used their personal budget with few restrictions on the type of services or support they purchased, as long as their choices met agreed carer support needs and outcomes. Such limitations were less marked in this study than in the Carers Trust survey (2012), which reported a lack of flexibility in the range of support services carers were permitted to choose (see also Seddon & Robinson, 2015).

Most study authorities awarded carer personal budgets in the form of annual lump sum cash payments; here, the findings are consistent with the Carers Trust (2012) and ADASS (2012) surveys. In this study, annual lump sum payments were thought by carer lead officers to be preferred by carers themselves (however, there was an absence of reported empirical evidence to support this) and were recognised to be administratively simpler for both local authorities and carers.

Regular monthly payments are more time consuming and labour intensive to distribute, especially when relatively small amounts are involved, as is the case with many carer grant/personal budgets. This is entirely consistent with current practice guidance (DH, 2010a) which reminds local authorities of the need for proportionate arrangements. However, in practice, there was little evidence of choice for carers over whether their personal budget was paid as an annual lump sum or monthly payment. Furthermore, the strengthening of carers' rights in the Care Act 2014 raised concerns around additional pressures on social workers as respondents' anticipated increased demand for both carer assessments and personal budgets. Managing increases in carers' expectations, especially in the context of ongoing austerity and its impact on local authority budgets, resources and staffing (Lymbery, 2013; Glasby, 2014) may become a major challenge for social care practice with family carers.

**Future and practice implications**

The authorities in this study anticipated the need to develop their practice, following the strengthening of carers' rights in the Care Act 2014. However, most were waiting for further guidance before making detailed plans - at the time of writing; guidance was being discussed and developed by the Government in England. Bearing in mind the principles of equity, transparency and optimising choice and control, this study suggests that policy and practice guidance around the following issues could be helpful:

- Establishing minimum eligibility thresholds above which carers can be considered for a personal budget.
- Who should conduct assessments for carer personal budgets and ensuring good quality, consistent assessments when these are out-sourced.
- The merits of different resource allocation systems for calculating the actual levels of carer personal budgets, bearing in mind the accompanying need for proportionality over the relatively small sums of money involved.
- Whether carers should be offered a choice to receive their personal budget as a single lump sum or as ongoing monthly payments.
- Improving consistency between authorities.

In practice, some tensions are likely to remain between equity, transparency and proportionality, and ensuring assessment and resource allocation systems are sufficiently sensitive to individual carer needs and circumstances. Nevertheless, on the basis of this small study, some improvements in the equity and transparency of approaches appears desirable. Further research to inform guidance may also be helpful, drawing on larger samples of authorities. One issue for further research, given current controversy, would be the development, implementation and outcomes of point-based resource allocation systems for carers. A second issue is carers' own experiences of and preferences for resource allocation as this is largely uninvestigated. In this study social work practitioners

largely reported what they believed carers wanted or preferred. More systematic consultations with carers may highlight different preferences.

**Limitations**

The study covered two English regions. However, given the substantial diversity of responses both within and between the regions there is no reason to think the regions (or the authorities within them) were unrepresentative. Bias may have arisen from the relatively low survey response rate, with respondents reporting better developed practice and provision for carers compared to non-responding authorities. The study also captured a specific point in time, with further changes likely, following the Care Act 2014.

Carer lead officers, who are likely to be best placed to report on carer-related practice in their authority, were the main informants for both the survey and interviews. However, they may have reported official local authority policy (particularly in the survey) and may not have always been familiar with current frontline practice. Despite this, to the extent they reported 'official' policy; these reports are an important guide to professional practice. Finally, although only three interviews were conducted, the authorities chosen represented the main methods of resource allocation reported in the survey and provided important additional qualitative insights.

## Ethical Approval

Ethical approval for this study was given by the Social Care Research Ethics in England Committee [REC Number **11/IEC08/0008**].


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