

A blue print for a person centred system of assessment and support planning

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Abstract

This paper describes the results of a two year collaboration between the author, acting in a consultancy role, and an English council that wanted to personalise its mainstream assessment and support planning system for adults. Convinced of the importance of personalisation for both ethical and pragmatic reasons, but not the accepted strategies to achieve it, the council sought a new approach. The project involved intensive work with all interests, bringing together ideas from published material with the local experience of service users, carers, practitioners, finance, IT and legal colleagues to arrive at a practical agenda for change. The starting premise was that resource led practice was the source of depersonalised supports, and that such practice was the inevitable consequence of the policy environment within which practice takes place. A new environment would have to be created. The council ultimately resolved not to implement a key element of the new environment which was particularly sensitive in legal and political terms. However, this was not before a comprehensive, deliverable 'blue print' for a person centred system was developed. The blue print is offered as a contribution to the search for a sustainable future for social care. This article outlines its development and provisions.

Keywords: Person centred practice, resource allocation, whole system, personalisation

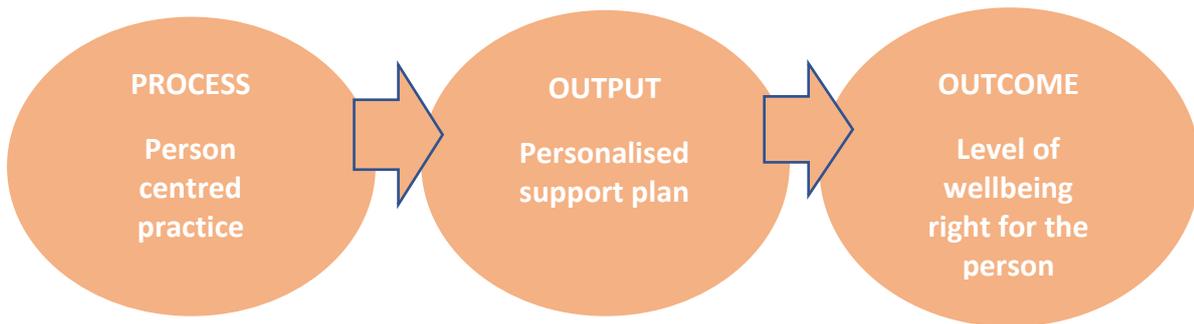
Background

The council engaged the author to help it find a way to personalise its assessment and support planning process as it had lost faith in the national strategy – based on 'upfront' allocations of money to empower service users to make choices about which supports to purchase (HM Government, 2008) to achieve it. The council believed that personalisation, as well as delivering a promise not yet fulfilled, would be the best pragmatic response to the growing gap between needs and resources. This is on the basis that personalised services get the best value for money, measured as the greatest level of wellbeing for the greatest number of people within its resources. A council may have a limited say about the size of its resource base, but a large say in how far it goes. The author was invited to work with the council given ideas he had previously published both in this journal and elsewhere. Of particular interest was work in relation to creating an approach to eligibility consistent with the Care Act 2014 and personalisation (Slasberg, 2013); a critique of the Care Act 2014 and the Government's implementation plan (Slasberg & Beresford, 2014); a critique of the strategy to deliver personalisation through personal budgets (Slasberg *et al.*, 2015a); and learning the right lessons from the early success of direct payments (Slasberg & Beresford, 2015b).

The council decided to abandon the upfront allocation of money process. It embarked on work to personalise its mainstream assessment and support planning system. There followed two years of intensive work involving practitioners, service users, carers, strategic managers, operational managers, along with legal, financial, IT and workforce development staff. It amounted to a root and branch review of the system to assess needs and plan support.

Overview

Diagram 1 illustrates how *person centred practice* came to be seen to be the fundamental building block expressed in terms of process, output and outcome. Person centred practice was seen as the *process* required to deliver the *output* of personalised supports, which are in turn the key to achieving the *outcome* of greater wellbeing.

Diagram 1. Process, output and outcome.

The focus was therefore on how to achieve person centred practice. It is neither a new term nor a new concept. With a long tradition in learning disability services, the Valuing People White Paper described it as ‘*essential to change lives*’ (Department of Health, 2001, p.12). Work for the Joseph Rowntree Trust identified person centred practice as the key to personalisation (Beresford *et al.*, 2011). The idea of being ‘person centred’, in contrast to being resource, or service led, resonates strongly with historically established doctrines and ethics in social work, the dominant professional group in social care.

Despite this, there is no evidence of person centred approaches having made an impact on the mainstream system. Think Local Act Personal, the body funded by government to promote the personalisation agenda recently described the system as an ‘institutional machine’ (TLAP, 2016, p.9).

This indicated that mere appeals to ‘best practice’ through rhetoric would not be enough. A review of the whole system, illustrated in **Diagram 2**, within which assessment and support planning takes place would be required.

Practice was seen to be central, but required a range of supporting elements to be congruent with it. A Resource Allocation Policy, to replace eligibility policies, had particular significance.

Person centred practice

The concept of person centred practice applies to all areas of social care (Manthorpe & Samsi, 2016). The first task was to give definition to what person centred practice should look like specifically in relation to assessment and support planning. A practical, deliverable definition that goes beyond the generalised rhetoric of person centredness was required. This was seen to be all the more important given the vulnerability of the assessment and support planning function to highly charged pressures that can blow it off course:

- political and managerial pressures, given it determines how public money is spent;
- pressure from families, given the risks associated with the vulnerability of their family members;
- pressure from other disciplines and agencies given the impact social care has on other services, notably the NHS.

The definition was addressed through three elements:

- a core purpose;
- four key principles;
- two elements of the delivery model.

Diagram 2. The components of a whole review of the system.

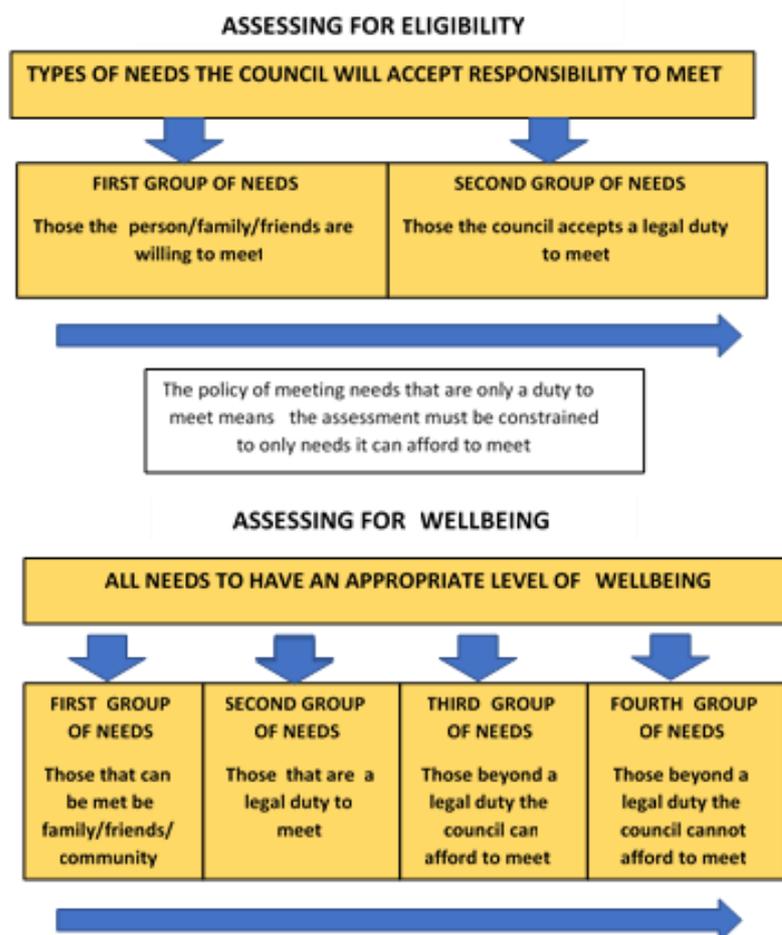
Core purpose

It was important to reflect on the core purpose of the assessment. Under the prevailing system this was seen as *assessing for eligibility*. Once people are deemed 'eligible', the level of spending is controlled by controlling the flow of their separate needs deemed 'eligible' and therefore a duty to meet. Budget holders, through case precedent rather than overt statements or formal policy, communicate the types of needs they will agree to fund. This can change as the budget situation changes. The assessment then identifies if the person can be said to have such needs. This process of resource allocation has been described as a form of 'street level bureaucracy', meaning it takes place beneath the radar of formal policy (Henwood & Hudson, 2008, p.122).

By contrast, the project recognised that a person centred approach to 'need' must build from the uniqueness of needs for care and support. Needs arise from the complex interplay of a large range of factors, each of which are highly variable. They can combine in infinite ways making each person unique. This approach to 'need' sits comfortably with the wellbeing concept that underpins the Care Act 2014. The Act defines 'wellbeing' by reference to nine broad areas (HM Government, 2014, para 1(2)). No reference is made to resources or affordability. The nine areas provide a canvas that places no restrictions on how individual 'need' is perceived. The challenge was therefore described as replacing *assessing for eligibility* with *assessing for wellbeing*. **Diagram 3** illustrates the differences.

Assessing for wellbeing creates new challenges in managing demand against budget. This is addressed in a later section.

Diagram 3. Assessing for eligibility and wellbeing.



Four key principles of person centred assessment and support planning

Freeing the process from the strictures of an eligibility policy was seen as a necessary, but not sufficient condition. It was necessary to more explicitly define what it looks like. The lead was taken from a fresh understanding of the success of people with the ability to take a cash payment to employ and manage their own support system (Slasberg & Beresford, 2015b). Research has shown this group to have consistently achieved good outcomes since the mid 1990's (Hasler *et al.*, 2004). It does not include people who use a direct payment to simply pay the invoices of regulated services. This group now comprises about two thirds of people with a direct payment (Skills for Care, 2015). The third national personal budget survey in 2015 showed that better outcomes were only achieved by people who employed their own personal assistants and were able to meet leisure and social needs. These are the characteristics of the original recipients of direct payments. On the other hand people who used regulated services did not achieve better outcomes whether or not they had a direct payment (Slasberg *et al.*, 2015a).

Four principles were identified. The support plans of this group were:

1. needs led;
2. self-directed;
3. strengths based;
4. cost effective.

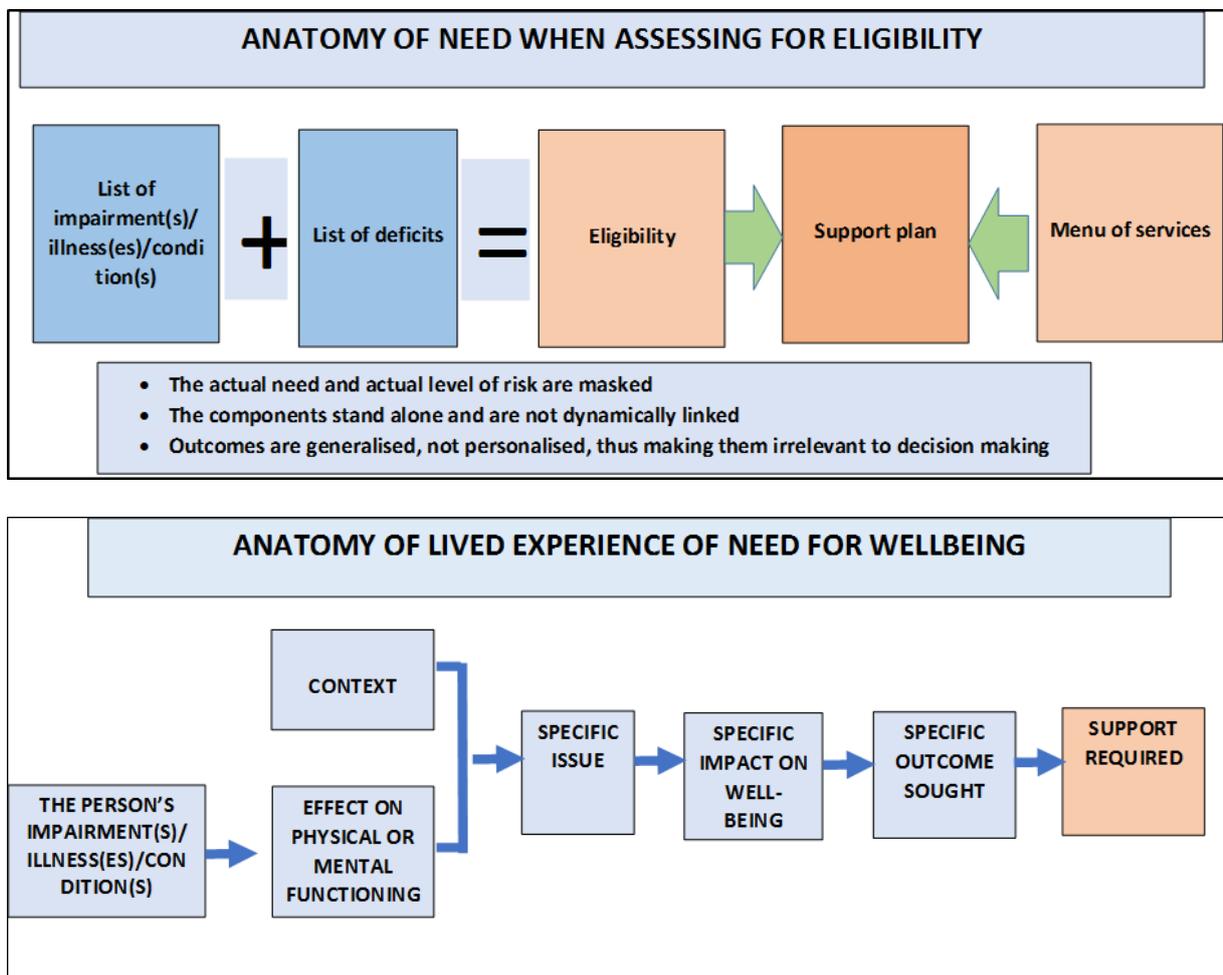
Principle one – needs led

The people who pioneered self-management adopted the slogan of ‘choice and control’ to emphasise their departure from the mainstream system, which was seen to offer neither. The slogan achieved sector wide and political traction. In the process, its meaning became conflated with rather different political ideas of empowering citizens through financial entitlements (Ferguson, 2007). This conflation of ideas was manifested in the personal budget strategy (HM Government, 2008), founded on the ‘upfront’ allocation of money to allow people to choose their own supports. However, this is not what brought success to those who self-managed. The start point for planning their support was not money and choice, but need. Crucially, however, their concept of ‘need’ was very different from the way councils viewed ‘need’ to determine eligibility. For them it derived from a view of how their life should be. For many, this was informed by the vision of ‘independent living’ (United Nations, Article 19). However, it could take other forms. It might be no more than wanting to go to bed at a normal time and having meals that are enjoyed.

All visions of ‘how life should be’ can be seen under the umbrella term of the ‘wellbeing’ the person seeks. ‘Needs’ therefore derive from the pursuit of wellbeing as envisaged by the Care Act.

The project came to realise this created a very different anatomy of need to the anatomy of need when assessing for eligibility (**Diagram 4**).

Diagram 4. Comparison of anatomy of ‘need’ under wellbeing and eligibility.



Principle two – self-directed

The identification of their 'needs' was controlled by the person. The complexities and nuances of 'need' for each individual made this a pragmatic more than just an ethical issue. It makes meaningful the slogan that people are 'expert in their own lives'.

However, self-direction was not taken to mean people should be left alone to do their own assessment. A small number may want and be able to self-assess independently. However, the majority would want and need the support of a practitioner to identify their needs and support requirements.

The concept of self-direction does, however, transform the dynamic between the person and the practitioner. When assessing for eligibility, the core dynamic is the practitioner gathering information to identify if there are any needs that might be eligible. This creates a power imbalance, with the person merely a source of information. When assessing for wellbeing, the practitioner and the person articulate and develop the person's analysis of their needs and how best to meet them. It requires partnership working. This can make a reality of the concept of 'co-production'.

Principle three – strengths based

A key issue for the group who self-manage is that they want public support to complement all they can do for themselves. This is a central requirement of having control over their lives, not just control over the support they receive. They have no interest in support that undermines their abilities or in any other way makes them dependent.

Principle four – cost effective

People who self-manage require only the most cost effective resource that will meet their needs. If the need is to get from London to Manchester, a Mini will usually suffice. Only if there are reasons a Mini could not meet the outcome in a reasonable way should a more costly vehicle be considered.

The project made clear, however, that cost effectiveness must not be used as a euphemism for cost cutting or in any compromise to the need being met. The case of McDonald V Kensington and Chelsea (Supreme Court, 2011) provided a helpful case scenario to illustrate the point. McDonald was a service user who needed to attend the toilet frequently at night but was unable to do so without assistance. The council originally agreed to provide a night time carer to make this possible. However, they then decided a much less costly service would be to offer her incontinence pads so she didn't have to get out of bed. This could be seen as a more cost effective way of meeting the need. However, the reality of the council's action was to alter her assessed need. Originally it was to be able to access the toilet at night but this was changed to be safe at night. This was not, therefore, a more cost effective way of meeting need but a re-definition of her need. It was a change the service user profoundly disagreed with. It failed to meet her need for dignity.

Cost effectiveness could not, therefore, be used to deliver affordability. Affordability would be addressed through a Resource Allocation Policy.

Two elements of the delivery model

The project then needed to define a model to deliver the above principles. Two key elements were identified:

1. **A common assessment process and format for the person and practitioner.** It was identified that partnership working to deliver authentic co-production would require the person and practitioner to work to the same assessment process and the same format for recording it. Conventional 'self-assessment' formats that act as no more than a prelude to the practitioner carrying out their own assessment fail this test. The assessment would no longer be dominated by rules to determine eligibility that are owned by the council and are obscure to the person. A common assessment process and format would enable the council to accept a person's self-assessment subject only to it being fit for purpose.
2. **The 'fitness for purpose' test.** The over-arching fitness for purpose test would be that the assessment and support plan will enable the person to have a level of wellbeing comparable to others in the community. It would have to be demonstrably person centred, meaning it is self-directed, needs-led, strengths based and cost effective. Assessments that failed the test would have to be developed to the point that they pass it.

Guidance for carrying out assessments and planning support was developed with practitioners, service users and carers. This included simple free text, semi-structured formats for capturing the assessment – one for service users and one for carers.

Four routes to complete the assessment were identified:

1. *Independent self-assessment* – the person would carry out the assessment themselves, making independent use of the guidance.
2. *Supported self-assessment* – the person would be supported by family, friends or a community or service user representative group. The person would have the capacity to control their own assessment but would value support in carrying it out.
3. *Practitioner supported assessments* – a council practitioner (or agent commissioned by the council) would support the person to deliver their assessment. These assessments must remain the person's own views of their needs and support requirements. If the practitioner had different views, the format would allow for them to be set out separately.
4. *Advocate led assessments* – the person does not have the ability to deliver their own assessment and so would require an advocate to do so on their behalf. The advocate may be a family member or friend if there is one both willing or able. If not, the advocate may be an independent person appointed by the council, or a council practitioner.

If a practitioner was supporting the assessment, or carrying out an advocate led assessment, they would apply the fitness for purpose test throughout the process. Should the council receive an independent or supported self-assessment, a practitioner would be required to assess its fitness for purpose and identify any work that may be required.

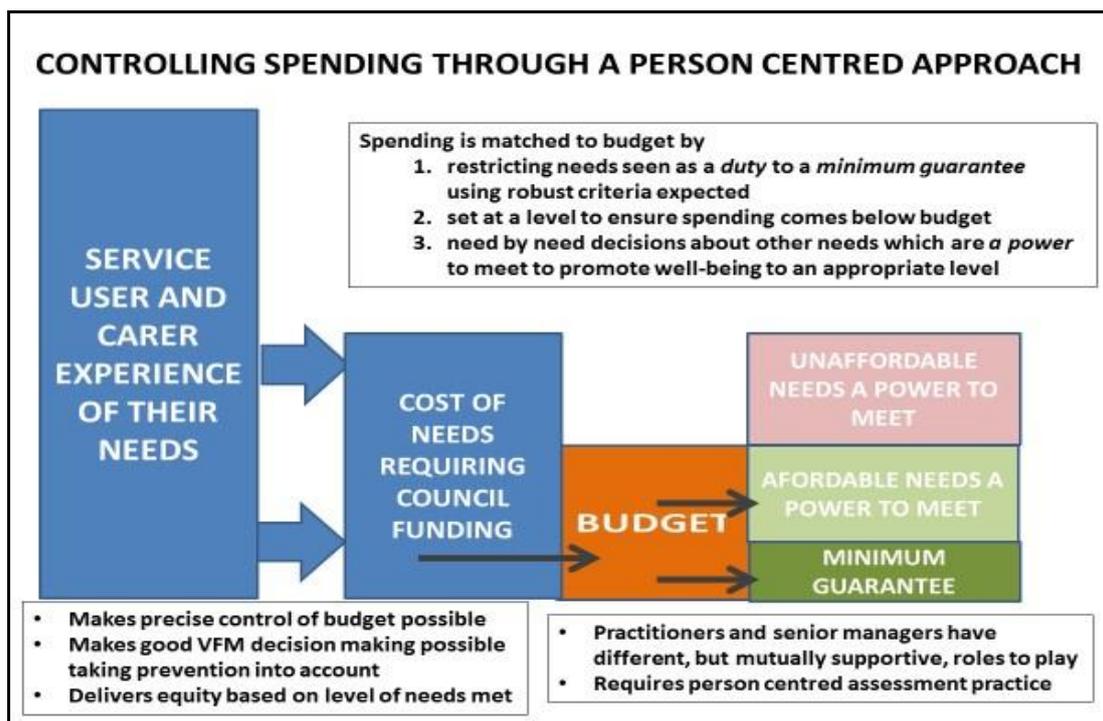
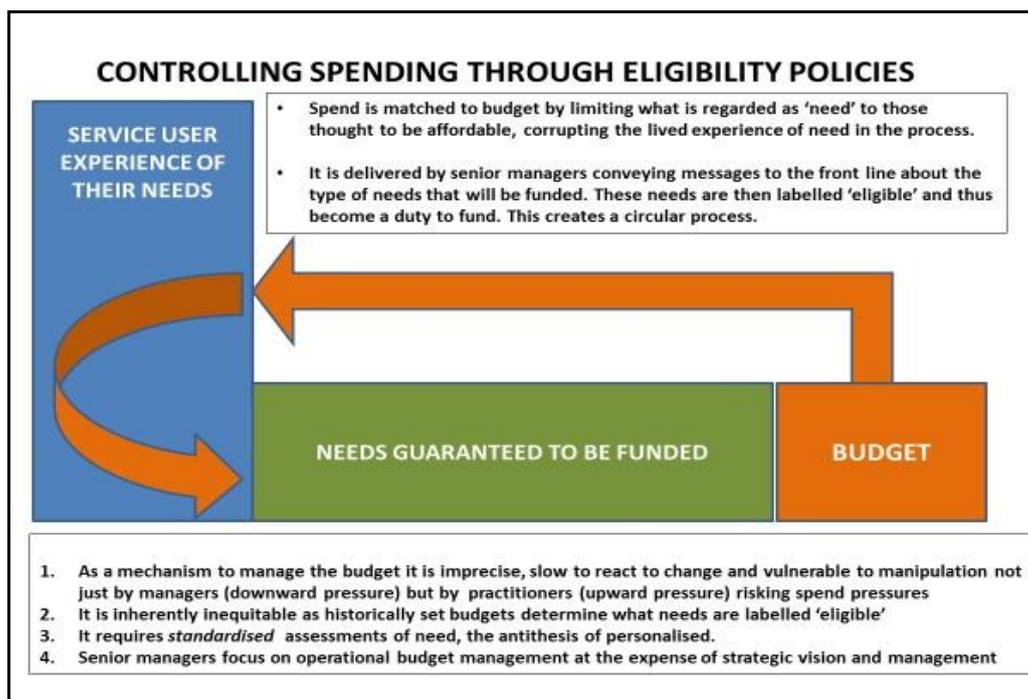
Resource allocation policy

When assessing for eligibility, spending is controlled by the 'street level bureaucracy' controlling the type and number of needs included in the assessment. When assessing for wellbeing, which must take place without regard to the availability of resources, spending is controlled by case by case decisions about which needs can be afforded and which cannot (**Diagram 5**).

Eligibility policies work on the premise that all assessed needs must be met, whether informally or through public funding. The belief that this is required by the law is, however, unfounded. In the landmark *Barry V Gloucestershire* judgement (House of Lords, 1997) Lord Clyde, who articulated the case for allowing councils to take their resources into account when deciding what a need is – which is the foundation stone of eligibility policies – said:

It is enough for the purposes of the present case to recognise that they (resources) may be a proper consideration.

Diagram 5. Controlling spending through eligibility policies and a person centred approach.



The word 'may' is key. It makes clear that defining 'need' in the context of resources is a policy option, albeit one that the law permits, but not a requirement. Government subsequently created a national eligibility policy that gave councils permission to define the needs they would treat as a legal duty to meet to match their budget (Department of Health, 2002).

The project was aware that the Care Act 2014 clarified the law in this area. It provides that assessed needs requiring council funding are divided between those that the Local Authority has a duty to meet and those for which it has the power to do so. Needs that are a duty to meet have to be met regardless of their cost; needs that are a power to meet can be unmet if the

council cannot afford to meet them. This makes possible case by case decisions with the assessment no longer having to be constrained to manage affordability.

The first requirement is to control spending on those needs that are deemed a duty to meet. It was resolved this should form a minimum guarantee of needs to be met. The minimum guarantee had to have the following qualities:

- It had to be robustly defined, to ensure consistent and therefore fair application.
- It had to be accessible to all and therefore transparent.
- It had to result in spending comfortably within budget, otherwise would be undeliverable and become compromised.
- It must not replicate the approach of eligibility policies based on standardised types of need.

This was delivered by using the concept of the universal human needs (Maslow, 1954). All personal needs – identified using the anatomy of need in **Diagram 4** – can be mapped to the universal human needs. This draws on a natural process of thought to weigh the importance of their needs – if I don't have food and shelter, I won't live; if I don't get to see my friends and family, I will be miserable and feel worthless. This enabled a clear boundary between the two groups of needs:

- The minimum guarantee would be all needs that placed survival or safety at risk. This was made possible through applying a council wide interpretation of what is meant by 'significant impact on wellbeing' in the Eligibility Regulations. This is addressed in a later section.
- All needs that risked quality of life, such as for self-worth and self-realisation would be treated as a power to meet, and so subject to resource availability.

In terms of service user and carer interests, this had the initial appearance of being counter-intuitive and risky. There is a perception that councils are minimalist through choice – they do only that which they have no choice but to do. There was concern that the council would latch on to the minimum guarantee of survival and safety as being all they had to do and thereby drastically reduce spending. However, the risk would be mitigated by the following two factors:

1. Restricting spending in this way would clearly be a breach of the duty imposed by the Care Act to promote wellbeing in all decisions it makes. To restrict needs met in this way would clearly be unlawful.
2. The holistic assessment for wellbeing would mean information about needs not met would be known. It would be aggregated and made available for strategic purposes. The council would be politically exposed locally.

Practitioner understanding

The above is a quite different approach for practitioners from the part they play within the 'street level bureaucracy'. Not only is this a role they are very familiar with and had the skill set to deliver, it affords them a measure of power through the gaming behaviour that working to criteria allows. A key part of the strategy was to engage practitioners in the underlying philosophy in the hope of piquing their professional interest.

It was also important to provide practical guidance. Key to this was grasping the need to work with two thresholds compared to just one under eligibility based systems:

1. The first is between needs that the council would accept within scope for assessment and needs which should be a private responsibility as they are needs beyond a level of wellbeing comparable to others.
2. The second is between assessed needs that are a public responsibility to fund that fall above or below the minimum guarantee.

Needs scenarios were used to illustrate how this might have been applied. **Table 1** was used to illustrate the status of the different groups of needs. It shows how the two thresholds result in three groups of needs. The first is needs the council would not consider it appropriate for council funding. The other two groups are those that the council would consider appropriate for council funding that would come within the minimum guarantee as they risk survival or safety and therefore a duty to meet, and those that would be above the minimum guarantee as they risk quality of life and therefore a power to meet.

Equity and value for money

Eligibility policies have a primary focus on equity. The evidence is that they fail to achieve this (RIPFA, 2015) with the ‘street level bureaucracies’ dominant. The council also wanted to address the longstanding concern that through the focus on crisis and deficits they create dependency whilst also encouraging gaming behaviour. These effects have serious consequences for value for money. The Resource Allocation Policy was designed to remedy both these failings.

- Equity would be guaranteed in the short term in relation to the minimum guarantee. Above the minimum guarantee, equity between user groups would be measured by the volume of quality of life (power) needs met by budget holders. The level of equity between user groups the council wanted would be achieved through the way the overall budget is distributed between budget holders.
- Value for money would be delivered through the decisions about which quality of life needs are met by budget holders. Budget holders would take into account the impact on wellbeing that meeting the need would have and the personal outcomes to be achieved alongside the cost. This would enable the greatest level of wellbeing for the greatest number of people.

Table 1. Examples of need scenarios.

PRIVATE RESPONSIBILITY	PUBLIC RESPONSIBILITY	
	NEEDS A POWER TO MEET	NEEDS A DUTY TO MEET
The person would like a walk-in shower to improve the bathroom both for own use and so the home is more suitable for visitors who stay overnight.	The person is able to wash only with the support of their partner. A walk-in shower would enable the person to do so independently which will increase their dignity.	The person has lost the ability to carry out personal hygiene tasks. The person does not live with anyone able to support them. Without support they would become unclean.
The person is accustomed to a regular change of clothing during the day so they are dressed differently according to time of day.	It takes the person a long time to get dressed at the start of the day and the end of the day, although not to the extent it stops them carrying out other tasks essential to daily living.	The person is not able to dress or undress themselves. Without support they would remain in the same clothing day and night.
The person is a disabled parent and needs support to enable their child to get to a private school which the person wants in order to give the child an educational advantage.	The person is disabled and a single parent of a teenager. They are unable to get him to one of his favourite sporting activities. There are no family or friends able to do so and without support, he will not be able to go.	The person is disabled and a single parent of a toddler and not able to carry out any of the physical care required. There is no extended family to help. Without support, the child would not be cared for and would have to be removed from the person’s care.

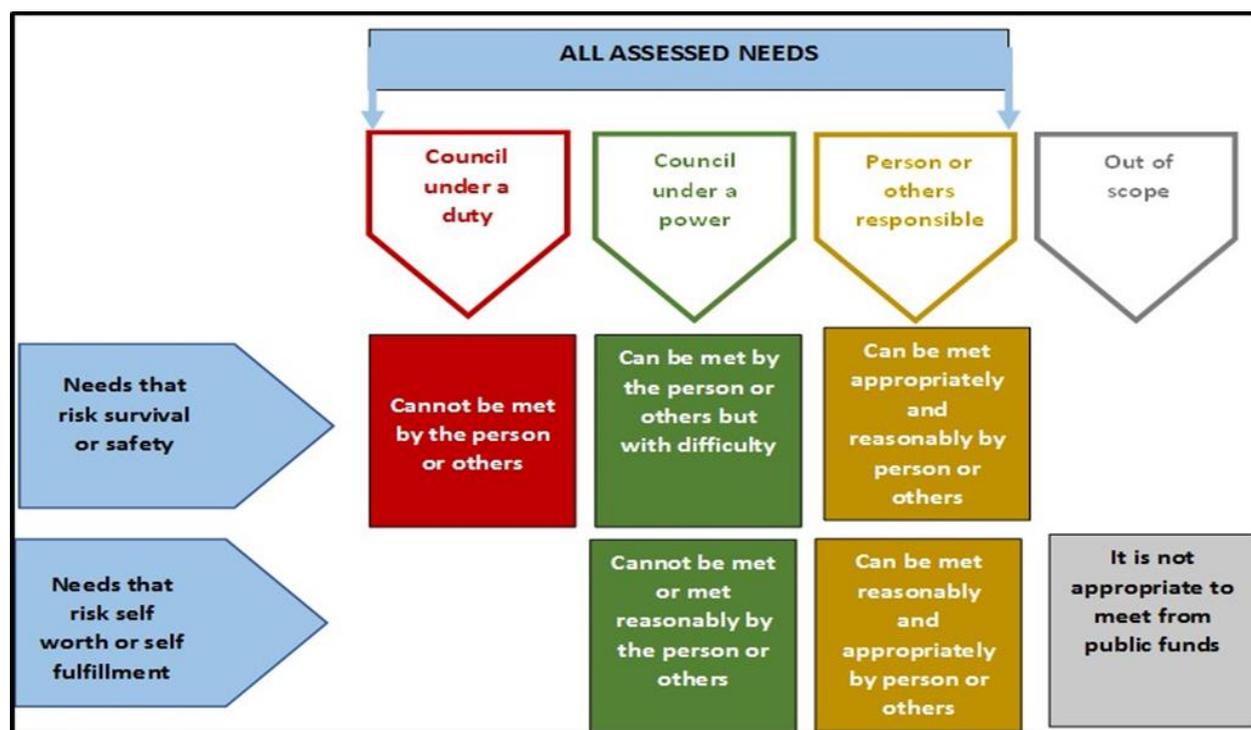
Diagram 6. The groups of needs under the Resource Allocation Policy.

Diagram 7 illustrates how value for money is balanced with equity in a person centred resource allocation system.

Prevention

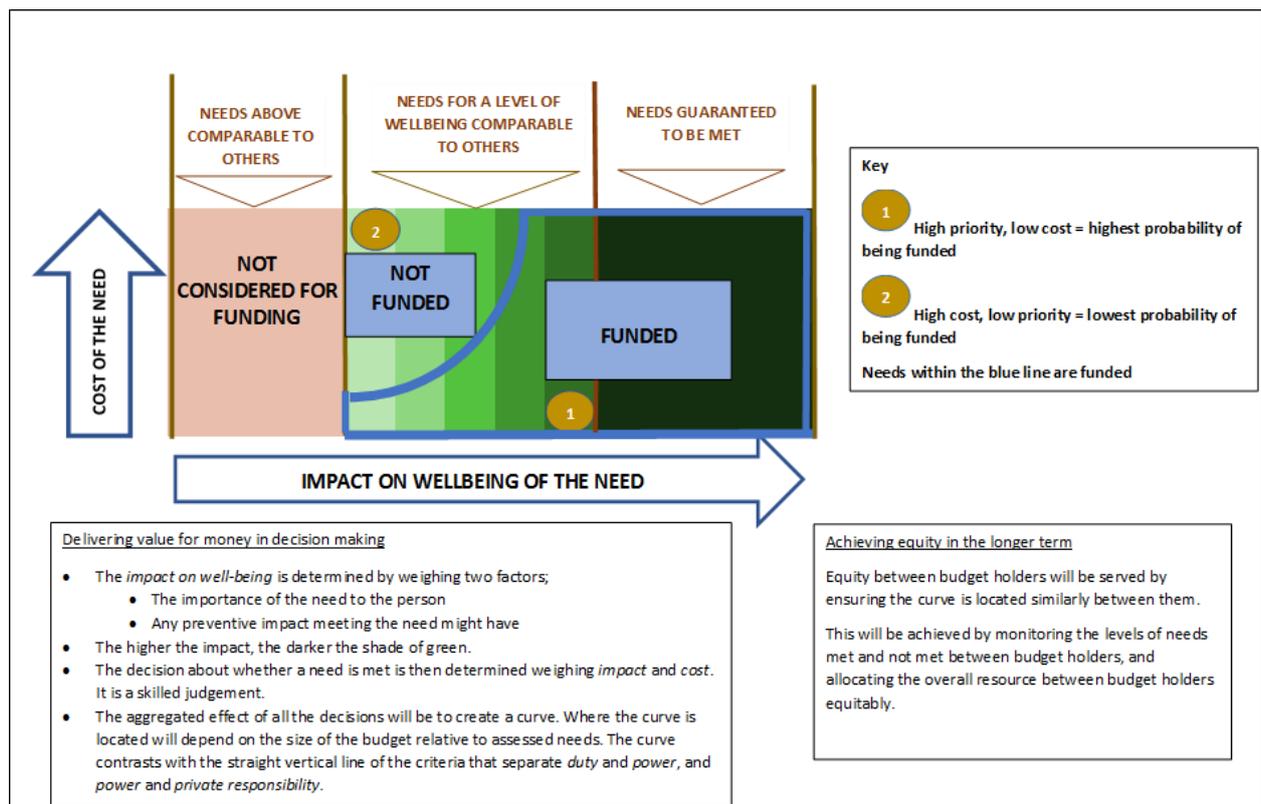
An important consequence of the value for money approach was the ability to move prevention from the margins to the mainstream. Under eligibility policies, prevention has come to be seen as delivered outside of mainstream support planning through ring-fenced 'preventive' services. However, needs with a preventive value are no less unique to the person than continuing support needs. For example, maintaining social contacts could be key to preventing loss of mood and motivation, and may require some council resource but not a 'preventive' service.

Devolution of budgets and financial control

Social care presents unique challenges in relation to financial control. Spending is highly volatile, with multiple changes on a daily basis. The change from controlling spending by constraining the flow of needs to be met to making case-by-case decisions called for a very different approach to financial control to deliver a person centred approach to resource allocation. The first issue was to acknowledge the need to devolve budgets to team level. Firstly, the volume of decisions to be made would increase making it unrealistic for senior managers to deliver. Secondly, there would need to be a good level of understanding of each case and skilled decision making applied.

Diagram 8 illustrates the difference between what the project called the centralised control of spending required to deliver control through eligibility policies, and devolved control. The key to control of spending is the calculation of the Finance Officer of the rate of spending and the projected spend to the year end. Under a centralised system, the financial projection is instead translated into a high level message to budget holders indicating whether there needs to be any change in the rate of spending. This is delivered at the 'street level' by budget holders adjusting the needs deemed 'eligible'.

Diagram 7. Delivering equity and value for money.



Under the devolved system (**Diagram 8**), the financial projection is converted into a monthly target. This is calculated each month to ensure spending is at the correct rate so spend matches budget by the year end. The budget holder is then provided with information on a daily basis to show movements in their committed spend. This information enables the budget holder to manage their rate of new commitments to enable them to spend to their monthly target. At a time when budgets are contracting, new spend only takes place against cessations of services currently received by others.

Budgets were devolved by the project and the required system of financial controls was put in place.

Specification for information technology

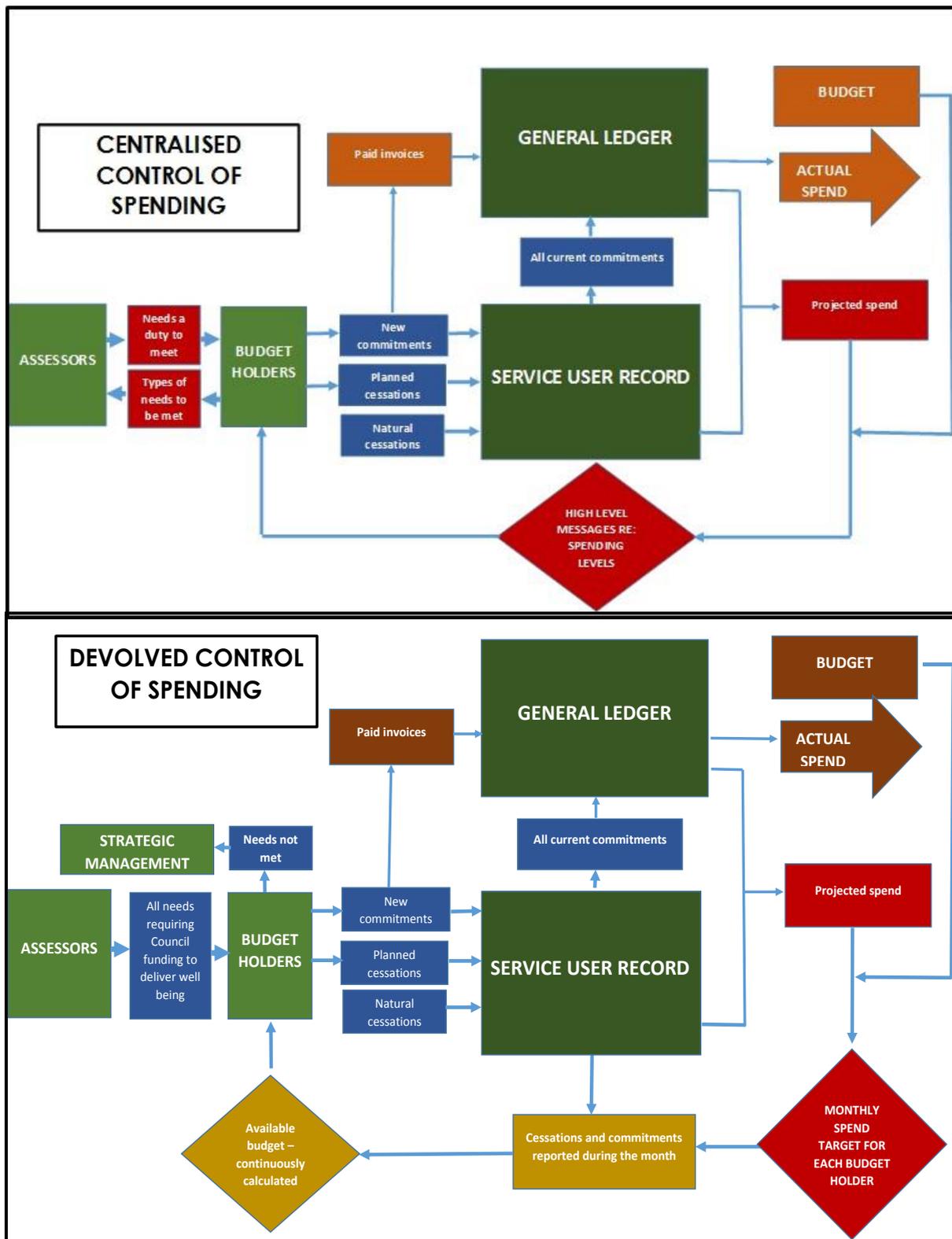
The role of IT was seen as critical. They had to ensure the forms were designed to deliver the agreed format. This applied to internal forms, and also the forms made available publicly for use in the community.

They also had to make the following key operational and strategic reports available:

- the daily reports to budget holders to show movement in spending commitments;
- reports which showed whether budget holders were achieving their monthly targets;
- reports which documented the levels of need met, and the levels of need not met, by budget holder;
- the change in service users' self-rating of wellbeing from point of assessment to initial review six weeks later as a measure of the outcome of the process.

The project was able to deliver all of these requirements.

Diagram 8. Comparison of controlling spending via eligibility and person centred approach.



Workforce structure and development

It was identified that moving from a resource led to a person centred approach to practice would have major implications for the workforce in terms of both the skill base and structure.

There were early discussions about the potential to make significant structural changes. One of the four routes to deliver assessments noted above was those that could be carried out from within the community. It was speculated this would form the most frequently used route, potentially delivered by community based organisations, including those that are user led. It would be expected they would develop the skills to support people to consistently deliver 'fit for purpose' assessments. These organisations would bring the benefits of knowledge of locality and of user group experience. Such a move would be made possible by transfer of resource. The council's retained workforce will test all assessments for fitness for purpose as well as support people to develop their assessments if they fall short of being fit for purpose. This will often be where there are complex dynamics. They will also carry out assessments for those who choose not to engage in the process, or who lack capacity and there is no advocate. The internal workforce would be reduced but it would also be predominantly, if not entirely, qualified.

The resonance of the value base of a person centred system with professional ethics would be expected to enable qualified staff to act as leaders and role models.

Appeals policy

The practice process is designed to enable co-production through partnership working between the practitioner and person. Nonetheless, practitioners remain in a position of power in that they decide if the person's assessment is fit for purpose and they also decide if a need is a duty or power to meet. Throughout, reasonableness of judgement is key. It is therefore appropriate that service users and carers should have a process of appeal to challenge the practitioner's judgements.

The Care Act does indeed have provision for independent appeals. However, this section of the Act has been delayed until at least 2020 given there was to be a cost consequence. The Council nonetheless decided to develop an appeals system that, while not fully independent, did give service users and carers access to 'offline' opinion that would be binding.

Compliance with the Care Act

The system was seen to be compliant with the primary legislation. However, it contravened two key elements of the Statutory Guidance.

The first was that it ignored the advice that an upfront allocation of money should precede support planning. Both from its own experience and awareness of the evidence from around the country, the council did not believe upfront allocations had the desired effect. Continuing to deliver it would not only waste bureaucratic time, but create a distraction from the process required to deliver fit for purpose assessments and support plans.

The second was in relation to resource allocation and the determination of when a need was a duty to meet. The Eligibility Regulations (Department of Health, 2014a) set out three conditions to determine if a need is a duty to meet. The first is that the need must arise from a physical or mental impairment; the second at least two of fourteen listed generic 'outcomes' must be affected; the third that there must be a 'significant impact on wellbeing'.

The decisive condition was seen to be the judgement required in the third condition. The Statutory Guidance (Department of Health, 2016) advises:

In making this judgement, local authorities should look to understand the adult's needs in the context of what is important to him or her. Circumstances which create a significant impact on the wellbeing of one individual may not have the same effect on another. (Para 6.110)

The effect of this would be to make all needs that are important to each person a legal duty to meet. This is undeliverable when the service has to spend within a budget. The effect would be to give the green light for the 'street level bureaucracies' to continue their function of matching spend to budget. The only change would be to language. Indeed, Government expected no real change in spending patterns, with the new threshold operating at the same level as the previous 'substantial' level, which is where the 'vast majority' (DH, 2014b) of councils already operated. Early evidence is that it has succeeded (PSSRU, 2015).

For reasons set out above, this system of resource allocation requires an assessment process incompatible with being person centred.

The development work took place in the context of advice from the internal legal team that the law allowed statutory guidance not to be applied if there were cogent reasons.

Concluding the collaboration

The author ceased involvement at the point the council's advice from the legal team became that it would be unlawful to contravene the Statutory Guidance in relation to application of the Regulations.

Much of the required infrastructure in relation to budget devolvement, financial control and IT had been developed and was in place. The assessment guidance and formats had been agreed and issued. However, the Resource Allocation Policy did not receive the council's support at the appropriate level of seniority. At the time of writing, therefore, it remained untested.

Conclusions

The non-implementation of the Resource Allocation Policy meant that the project failed to test the theory that resource led practice is the product of eligibility policies that control spending through categorising and controlling the flow of needs, and that person centred practice would become the norm if this was replaced with a Resource Allocation Policy to enable case by case decisions about affordability.

The project did, though, lend further weight to the theory. The practitioners' guide and guidance for the assessment had been developed and was issued during the project; there was a substantial resource put into learning development; the essential IT reports and financial controls were all in place. Despite these conditions being created, the service remained in the grip of the 'street level bureaucracies' with no discernible movement to person centred practice. Traditional, resource led practice by and large continued and was simply captured using different forms and processes.

On a positive note, the time during which the council prevaricated about the Resource Allocation Policy allowed the depth of work to be carried out with all relevant groups to enable the creation of a 'blue print' for delivering person centred practice.

However, it would require a very high level of managerial determination for any individual council to go against national policy on such sensitive matters. Until there is change to the national policy, expressed through the Statutory Guidance, the movement from resource led working as the norm to person centred working as the norm is unlikely to happen.

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