

Evaluation of Direct Payments in Residential Care Trailblazers

Interim report

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1. Summary

The Department of Health decided in 2012 to accept a recommendation by the Law Commission to extend direct payments from domiciliary (community) care to residential care. It invited councils to express interest in becoming pilot sites for direct payments in residential care and selected 20 pilot sites. It subsequently decided in 2013 to empower all councils to offer direct payments in residential care from April 2016. It commissioned the Policy Innovation Research Unit (PIRU) to conduct a scoping study and then to conduct a full evaluation of the pilot sites, now known as 'trailblazers'.

This report analyses data collected over twelve months of the trailblazer programme from January 2014 to December 2014. This comprises self-completed survey questionnaires to service users who had either accepted or declined a direct payment and their family members; interviews with trailblazer project leads; and interviews with providers in selected trailblazer sites.

The Department of Health provided financial support and advice to the trailblazer councils and commissioned the Social Care Institute for Excellence (SCIE) to organise meetings at regular intervals. Nevertheless the establishment of the direct payment in residential care trailblazers proved challenging for local authorities. Two of the original 20 trailblazers dropped out at an early stage and a further four dropped out during 2014. Of the remaining 14 sites, some have only been able to offer direct payments in residential care from October 2014, and some still had no direct payment users in care homes by mid-December 2014. The earliest receipt of a direct payment was in April 2014. The trailblazer programme is now over the half-way point and is due to finish at the end of October 2015.

Information from the trailblazers indicates that a total of 69 users have reached a decision following discussion about a direct payment, with 45 people accepting in principle (but not necessarily as yet in receipt) and 24 declining.

As at the end of November 2014, 35 completed questionnaires had been received from users and family members. These comprise nine questionnaires from users who took up a direct payment, three from users who declined a direct payment, six from family members of users who took up a direct payment, and 17 from family members of users who had declined a direct payment. They relate to 30 users since in five cases both user and family members completed a questionnaire.

The vast majority of the users who responded or whose family members responded to the survey (80% of questionnaires completed) are aged 65 or over. The most common user groups are physical disability and 'other'. Twenty-four of the users were resident in, or entering, care homes providing personal care only. Eleven were resident in care homes providing both personal and nursing care. Three of the users who had accepted a direct payment reported that it covered their whole care home fee and six that it covered part of their fee.

Seven of the users who had accepted a direct payment reported using it for activities outside the care home and seven for activities within the care home. (More than one category could be indicated.) Six of the family members of users accepting a direct payment reported use of the direct payment for activities outside the care home and three for activities within the care home.

Early findings from the survey show that the majority of the service users replying to the survey who accepted a direct payment were very or fairly satisfied with the direct payment processes. In terms of overall satisfaction, five were very satisfied, two fairly



satisfied, two neither satisfied nor dissatisfied and none dissatisfied. The majority of family members (replying to the survey) of users who accepted a direct payment were very or fairly satisfied with the direct payment processes, but rather more were fairly satisfied and fewer very satisfied than for the service users. In terms of overall satisfaction, none were very satisfied, four fairly satisfied, two neither satisfied nor dissatisfied and none dissatisfied.

Among the service users who declined a direct payment and the relatives of people declining, the most common reason was that they were already resident in the care home and happy with the current arrangement. The next most common reason among relatives was that it would not give the user more choice and control.

Findings from the interviews with project leads (n=14) showed that project leads were supportive of the aim of the trailblazer programme to test the potential of direct payments to create more opportunities for choice and control for residents of care homes. However, project leads also raised a number of concerns about the feasibility of direct payments to improve choice and control for care home residents, especially for older people. There were also concerns about the potential impact of direct payments in local care home markets.

Project leads also reported problems of operationalising direct payments in residential care in the absence of a practicable mechanism to determine the monetary value of direct payments. Three 'models' of such mechanisms have been developed in the trailblazers: model 1 is based on a resource allocation system as it is already used in community care; model 2 uses the existing fees currently charged by care homes; and model 3 offers direct payments in the form of a small sum paid by councils in addition to the existing fee. Models vary in how they distribute the financial risks between councils and care homes, and in the extent of choice and control they are likely to offer to service users.

Findings from interviews with care home owners and managers in two selected sites (n=8) indicated substantial concerns from providers about the financial viability of direct payments in care homes if direct payments involve identifying flexibility within existing budgets. Owners and managers were also sceptical about the ability of direct payments to promote choice and control, with some arguing that person-centred care in residential settings should be embedded in routine practice in other ways and may not be achievable through providing the option of direct payment for people with high dependency.



2. Introduction

Direct payments are “monetary payments made to individuals who request to receive one to meet some or all of their eligible care and support needs” (DH 2014: 163). They have been available in domiciliary (community) care since the mid-1990s but were not available in residential care. In July 2012, the Department of Health (DH) invited councils to express interest to become pilot sites for direct payments in residential care with external evaluation. The initiative followed the recommendation of the Law Commission to extend direct payments to council-funded residents of residential care homes (The Law Commission 2011).

Twenty local authorities were selected to pilot whether and how direct payments for people in residential care could give them and their families control over the resources available to pay for all or some of their care, thereby increasing service user choice over how their needs are met and promoting person-centred care (‘personalisation’) in care homes. Amended regulations came into effect in November 2013 to enable direct payments in residential care to be legally disbursed in these local authority areas. The Department of Health provided financial support and advice to the trailblazer councils and commissioned the Social Care Institute for Excellence (SCIE) to organise meetings at regular intervals.

The Government subsequently decided in 2013 to empower all councils to offer direct payments in residential care from April 2016. Pilot sites have been re-designated as ‘trailblazers’ to reflect the new purpose of the scheme, which is to prepare for the introduction of direct payments in residential care nationally and to provide other councils not involved in the trailblazer programme an opportunity to learn from the experience of the sites. Of the initial 20 councils invited to participate in the pilot in 2013, 14 remain to date.

The Department of Health decided in late 2013 to commission the Policy Innovation Research Unit (PIRU) to conduct an independent evaluation of the trailblazers. This followed an earlier scoping study conducted during 2013. The evaluation team comprises researchers based at the London School of Hygiene and Tropical Medicine (LSHTM) and the Personal Social Services Research Unit (PSSRU) at the London School of Economics and Political Science (LSE).

The objectives of the evaluation, consistent with the changed policy context of the forthcoming national roll-out of direct payments, are:

- To understand the different ways in which direct payments are being offered to residents of care homes and to examine the challenges arising from implementing direct payments for service users, carers, care home providers, and councils and their staff in trailblazer sites (process evaluation);
- To assess the impacts of direct payments in residential care on service users and their families, care home providers and the provider market, and councils and their staff (impact evaluation); and
- To examine, as far as possible, the relative costs and cost-effectiveness of different approaches to providing direct payments in residential care, for both service users and their families and local councils (economic evaluation).

This is the second report from the independent evaluation of the trailblazers and the first interim report of the main evaluation. A scoping report was published in autumn 2013 (Ettelt, Perkins et al., 2013).



The aim of this report is to present the early findings from the first year of the main evaluation. Since the trailblazer schemes in most of the 14 sites started to offer direct payments later than originally envisaged, the report concentrates on qualitative findings from interviews with the trailblazer project leads in all areas and with care home managers and owners in two areas, in addition to some early findings from the survey of service users in residential care (and their relatives). Later reports will include a more complete set of findings from the survey of users and their family members, findings from further interviews with trailblazer leads, care home managers and local authority staff, findings from interviews with users and family members and with representatives of national organisations, results from a survey of providers, and an assessment of the costs of introducing direct payments in residential care in the trailblazer programme. These further interviews and surveys will be conducted in the course of 2015. A second interim report will be prepared in summer 2015. The final evaluation report is due in June 2016.



3. Methods

The methods described below relate to those used in the stages of the evaluation described and discussed in this interim report. For a full description of the methods for the evaluation as a whole, please see the appendix, which is drawn from the research proposal.

This report analyses data collected in the first twelve months of the evaluation of the trailblazer programme, from January 2014 to December 2014. This includes self-completed survey questionnaires to service users who had either accepted or declined a direct payment and their family members; interviews with trailblazer project leads as well as interviews with providers in selected trailblazer sites. The report also draws on information gathered from national steering group meetings, quarterly regional meetings with trailblazer leads and other stakeholders as well as field notes taken from a small number of project meetings and steering groups held by individual trailblazer sites.

3.1 Survey of service user and family members

We agreed with the trailblazer leads in each local authority that they would arrange to give or send a questionnaire to every service user who takes up a direct payment for residential care or specifically declines the offer of a direct payment, except those who lack capacity. They also agreed to give or send a questionnaire to a family member, friend or advocate of the service user wherever appropriate. Project leads agreed to inform us regularly how many questionnaires they had issued.

The survey data includes questions about user satisfaction elicited for those accepting a direct payment through asking how satisfied or dissatisfied the user or family member is with the arrangements relating to the direct payment, such as information and advice received about direct payments and ease of setting up the direct payment. The survey also includes questions on social care-related quality of life assessed using the Adult Social Care Outcomes Tool (ASCOT) instrument (Netten, Forder et al. 2010), but data on this are not reported here since the numbers are too low to be meaningful. Demographic information such as age, gender, user group (such as learning disability, physical disability, mental health difficulties), marital status and ethnicity is also covered. For those accepting a direct payment, there are questions about the experience of managing a direct payment and the choices facilitated by a direct payment. For those declining a direct payment, there are questions on reasons for declining the direct payment.

3.2 Interviews

We carried out semi-structured telephone interviews with the staff member (project lead) responsible for leading the trailblazer in each of the 14 sites. Interviews with this group are planned annually and two rounds have been conducted to date. The first round of interviews, conducted in July to September 2013, collected information about the plans of each trailblazer, including the number and types of service users they were planning to involve, the number of providers that had volunteered to trial direct payments, and their expectations of the additional choices direct payments might facilitate for users. The second round, conducted in July–October 2014, explored the progress made in facilitating direct payments and their experience of collaborating with providers and any adjustments made in direct payment processes.

We also carried out face-to-face, more detailed interviews with a number of care home managers and owners in two of four sites selected for more in-depth investigation (n=8). These four sites were selected with a view to obtaining coverage



of sites offering direct payments to different user/age groups, sites providing whole fee or part fee direct payments, sites working with a few care homes and those willing to include any care home, and sites in the north and the south of the country. Three sites were selected from those sites that had begun to provide direct payments by early September 2014, with one additional site selected in October. The current report includes the two sites that were selected first and for which interviews had been conducted at the time of writing. The interviews explored the initial perspectives of providers on the early stages of introducing direct payments.

3.3 Limitations

Only a small number of service users and family members have as yet returned completed questionnaires so quantitative data are limited at this stage and much of this report is based on the interviews with project leads and care home providers. The evaluation team experienced some delay in obtaining the necessary information in order to select four sites for in-depth analysis and some sites were recruited later than anticipated. As a result it was only possible to analyse data from two of the four selected sites. At the time of writing this report first stage interviews had been completed for three of the four sites and we plan to undertake interviews with the fourth site early in 2015. We will be carrying out further follow- up interviews with providers and council frontline staff in the in-depth sites, interviews with a selection of services users and family members who have accepted or declined a direct payment, interviews with other stakeholders (such as DH policy makers) and non-direct payment trailblazer local authorities, as well carrying out an on-line survey with care home providers, and a follow up survey with service users and family members accepting a direct payment.



4. Current number of direct payments

The establishment of direct payment schemes for residential care has proved challenging for Trailblazer local authorities. Two of the original 20 trailblazers dropped out at an early stage and a further four dropped out more recently for a variety of reasons including staff turnover in councils. Of the remaining 14, some have only been able to offer direct payments in residential care from October 2014, and some still had no direct payment users in care homes by late December 2014. The earliest receipt of a direct payment in a care home was in April 2014.

The survey of users and their family members is a key part of this evaluation. The survey, together with interviews with a small number of users and family members, forms the source of data on the characteristics of users who accept a direct payment in residential care, on those of users who decline the offer of a direct payment in residential care, on satisfaction with the process for users who accept a direct payment and on social care-related quality of life or both groups.

By the end of December, trailblazers reported having issued 74 questionnaires (see Table 4.1 below). The distributed questionnaires are spread across eleven of the remaining 14 trailblazers. These comprise 14 questionnaires to service users who took up a direct payment, ten to service users who declined a direct payment, 16 to family members of service users who took up a direct payment and 34 to family members of service users who declined a direct payment.

Table 4.1 Number of questionnaires issued by councils

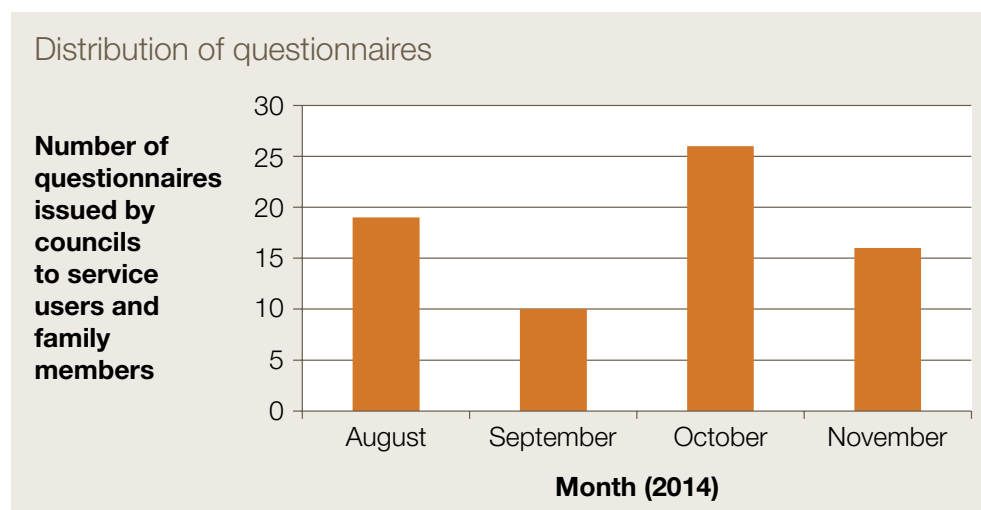
Q1 – people accepting a direct payment	Q2 – for family members of people accepting a direct payment	Q3 – for people declining a direct payment	Q4 – for family members of people declining a direct payment	Total
14	16	10	34	74

It is important to note that the number of service users accepting or declining direct payments who are given questionnaires need not match the numbers of family members given questionnaires. Some service users may have no family members or more than one family member involved in arranging their care. In addition, we have asked sites not to give questionnaires to users who lack capacity, for ethical reasons.

Figure 4.1 charts the rate of distribution of questionnaires in the first four months of the programme. A promising start saw 19 questionnaires issued in the month of August, followed by fewer (ten) in September. There was a steep rise in October, with 27 questionnaires distributed, and the amount dropped slightly to 18 during November. On average, 18 questionnaires have been issued each month.



Figure 4.1 Number of questionnaires issued by sites each month over duration of programme to date



As Table 4.2 shows, by the end of November, we had received 35 completed questionnaires¹, which relate to a total of 30 service users. These comprise nine questionnaires from users who took up a direct payment, three from users who declined a direct payment, six from family members of users who took up a direct payment (of which three are family members of users who also sent us a completed questionnaire) and seventeen from family members of users who declined a direct payment (of which two are family members of users who also sent us a completed questionnaire). These questionnaires are spread across seven of the remaining 14 trailblazers.

Table 4.2 Number of completed questionnaires returned

Q1 – people accepting a direct payment	Q2 – family members of people accepting a direct payment	Q3 – people declining a direct payment	Q4 – family members of people declining a direct payment	Total
9	6	3	17	35

The receipt of 35 questionnaires represents a response rate so far of 47%, out of the number of questionnaires issued to users and family members (74). However, the figures in Table 4.2 include one questionnaire returned without a reference number, which may not have been included in the count of those issued.

Table 4.3 shows the outcome of discussions about direct payments with service users, according to data supplied by sites in their weekly updates. It suggests a total of 69 outcomes from discussions after users were offered direct payments (45 people accepting and 24 declining). Almost half (19) of those accepting a direct payment are in one site, which is offering a small monthly direct payment as an extra payment to the care home for an activity chosen by the resident. However, it should be noted that the data may not be fully reliable. The TB leads have reported problems in gaining accurate data relating to the discussions with service users from participating care homes. It is also not clear whether direct payments listed as ‘accepted’ have

¹ Excluding one questionnaire which a family member returned without responding to any of the questions.



already been made available, as a number of procedural problems emerged in the process leading to delays (e.g. difficulties in opening bank accounts for people who had been in residential care for a long time). Some sites are not certain how many questionnaires have been issued since they have asked care home managers to discuss the direct payment scheme with users and hand out questionnaires.

Table 4.3 Number of direct payments accepted and declined

Site Codes	Direct payments accepted	Direct payments declined	Still considering	
1	5	5	2	
2	1	1		
4	19	0		
5	0	0		
6	0	1		
7	7	10		
8	2	1		
11	5	0		
12	0	0		
14	1	0		
15	5	6		
16	0	0		
17	0	0		
18	0	0		
Total	45	24	2	71 (total)



5. Views of service users and family members

The findings reported in this section are drawn from the 35 completed questionnaires we had received by the end of December. These comprise nine questionnaires from service users who took up a direct payment, three from service users who declined a direct payment, six from family members of users who took up a direct payment (of which three are family members of users who also sent us a completed questionnaire) and seventeen from family members of users who declined a direct payment (of which two are family members of users who also sent us a completed questionnaire). This means that we have completed questionnaires in respect of 12 service users who accepted a direct payment (out of 45 reported by the sites as accepting a direct payment) and in respect of 18 service users who declined a direct payment (out of 24 reported as declining a direct payment).

Age and client groups of participants

The age groups and user groups of the users who completed questionnaires are set out in Table 5.1. Note that users and carers could indicate more than one user group and that in five cases (three people who accepted a direct payment and two people who declined) both the family member and user submitted completed questionnaires.

The table shows that the vast majority of users (27, or 80% of questionnaires completed) involved in the survey are aged 65 or over, although, where family members of people who declined a direct payment are concerned, a significant proportion of the related service users were under 65 (44%). The most common client group was physical disability: 16 respondents (47%) fell into this category. Nearly half of respondents selected 'other' as a category; most of these stated 'older person' by way of explanation. Eight respondents were described as having learning disabilities.

Table 5.1 Age and client group of participants

	Aged under 65	Aged 65+	Learning disability	Physical disability	Mental health	Dementia	Other
Person accepting direct payment	0	9	0	2	0	1	8
Person declining direct payment	0	3	0	3	0	1	4
Relative of person accepting direct payment	0	6	1	2	1	1	1
Relative of person declining direct payment	8	9	8	9	0	0	3
Total	8	27	9	16	1	3	16



Type of care home placement

Twenty-four of the users were resident in, or entering, care homes providing personal care. Only 11 were resident in care homes providing both personal and nursing care (Table 5.2). Note again that the data from 35 questionnaires relate to 30 service users since in five cases both the family member and user submitted completed questionnaires.

Table 5.2 Type of care home placement (residential or nursing)

	Residential	Nursing
Person accepting direct payment	5	4
Person declining direct payment	2	1
Relative of person accepting direct payment	5	1
Relative of person declining direct payment	12	5
Total	24	11

Length of time in care home

Among the service users who accepted direct payments, there was a wide range of lengths of stay in the care home. Three had been in the care home between two and five years, two had been in the home for five years or more, one had been resident for between one and two years, and two had been in the home for between six and twelve months. (One of the questionnaires was missing data on this question.)

Among the service users declining direct payments, one of the users had been in the care home for between 12 and 24 months, one between two and five years, and one had been there for five years or more.

The majority of family members of service users accepting a direct payment (two-thirds) reported that their relative had been in the home for five years or more. A similar picture was found in the family members of service users declining a direct payment: 12 (71%) of the users related to the respondents had been in the home for five years or more, and two had been in the home for between two and five years. One person had been in the home for between one and two years, one between six and 12 months, and one between one and three months.

Satisfaction with the direct payment process

Although the sample size is small (based on only 15 questionnaires), early findings from the survey show that the majority of the service users who had accepted a direct payment were very or fairly satisfied with the direct payment processes. In terms of overall satisfaction, five were very satisfied, two fairly satisfied, two neither satisfied nor dissatisfied and none dissatisfied. The majority of family members of users who had accepted a direct payment were very or fairly satisfied with the direct payment processes, but rather more were fairly satisfied and fewer very satisfied than for the service users. In terms of overall satisfaction, none were very satisfied, four fairly satisfied, two neither satisfied nor dissatisfied and none dissatisfied.

Whether direct payment is whole fee or part fee and how it is used

Three of the users who had accepted a direct payment reported that it covered the whole care home fee and six that it covered part of the fee (Table 5.3).



Table 5.3 Whether direct payment covered whole or part of care home fee

	Whole fee	Part fee	Total
Person accepting direct payment	3	6	9
Relative of person accepting direct payment	2	4	6

Seven of the users who accepted a direct payment reported using it for activities outside the care home and seven for activities within the care home. (More than one category could be indicated.) Six of the family members of users accepting a direct payment reported use of the direct payment for activities outside the care home and three for activities within the care home (Table 5.4).

Table 5.4 Use of direct payment (respondents could choose more than one option for this part of the survey)

	Payment of care home fee in full	Payment of care home fee in part	Activities outside the care home	Activities within the care home	Care taking place within the care home	Meals outside the care home	Meals within the care home	Total
Person accepting direct payment	2	1	7	7	0	3	1	9
Relative of person accepting direct payment	3	1	6	3	0	0	0	6

Typical reasons for declining a direct payment

Among the service users who declined a direct payment and the relatives of people declining, the most common reason (in 100% of users declining and 75% of relatives of users declining) was that they were already resident in the care home and happy with the current arrangement. The next most common reason among relatives was that it would not give the user more choice and control. People who cited this reason gave a variety of explanations in the ‘further comments’ section of the survey. One family member said that the user, who has learning disabilities, did not have the mental capacity to decide whether or not she would like a direct payment, and suggested that the programme was “not designed for residents with LD’s who cannot understand the issues involved”. Another relative commented that they couldn’t see any benefits to direct payments “whatsoever”, adding that it was “a complete waste of time like robbing Peter to pay Paul”. Among both users and relatives, a minority said they were concerned that a direct payment would mean more work for them and their family.

Numbers of users and family members agreeing to be interviewed after the survey

Three relatives of users who agreed to have a direct payment and nine relatives of users who declined a direct payment have agreed to be interviewed. No service users have so far indicated their agreement to be interviewed.



6. Views of trailblazer leads

Project leads were asked about how they had approached developing the Direct Payments in Residential Care trailblazer in their areas. This section presents how project leads understood the aims of the trailblazer programme; how they developed the local trailblazer in the local authority; how they approached and collaborated with providers; how they offered direct payments to service users and their families; and the challenges arising from contextual circumstances, including the impact of the forthcoming implementation of the Care Act 2014 and current resource pressures on local authority-funded adult social services.

One of the challenges for project leads was that they had to implement the Direct Payment in Residential Care trailblazer in the absence of a 'model' for determining the monetary value of the direct payment (i.e. the personal budget). Hence, the trailblazers have involved considerable developmental work, which has required substantial collaboration between local councils, providers and service users in residential care.

6.1 Understanding the aims of the Direct Payment Trailblazers

Reconciling the two aims of the trailblazers – introducing direct payments and increasing choice and control ('personalisation') for residents in care homes – has been challenging so far.

Project leads indicated that they were generally supportive of the Government's personalisation agenda in social care and agreed with the desirability of giving more choice and control to residents of care homes. When interviewed in 2013, most project leads had agreed that current arrangements often did not offer much meaningful choice for council-funded residents and only limited control over the services provided to them, particularly for older people (Ettelt, Perkins et al. 2013).

Most councils offered service users a choice of care home, although this depended on the number of vacancies available in a given local care home market. Once admitted to a care home, choices tended to be limited, with marked differences reported in the degree of choice among older people and younger adults. In care homes for older people, users may have some influence on the decoration of their rooms and perhaps have several menu options, but little control over how the majority of services are provided to them.

Project leads noted that some care homes delivered an exceptionally personalised service already, while others did not have the capacity, or awareness, to do so. The general perception was that care homes tended to focus on meeting needs with less attention given to individual preferences as to how those needs should be met. An example of this difference could be attention given to fulfilling dietary requirements rather than accommodating the likes or dislikes of a person for particular food items.

This perception of the limits of choice within care homes was reiterated in the interviews with project leads in 2014. Project leads noted that the priority given to meeting needs to a large extent reflects the high level of dependency of residents in residential care. However, project leads also suggested that care homes could and should be more responsive to the preferences of their residents. Cost pressures and associated pressures on staffing were mentioned as key reasons why care homes found it difficult to accommodate individual preferences such as for a specific daytime activity (e.g. going to the pub, garden centre or to church) over and above those



that are offered to groups or all residents (e.g. Bingo, pottery). This was particularly pronounced in relation to residents in care homes for older people; younger adults with learning or physical disability were seen as often having substantially more choice, especially over their day-time activities. Project leads also mentioned that care home managers sometimes underestimated the desire of residents to receive an individualised service:

“Even with some of the more enlightened homes, there is still a tendency to promote the good work that they are doing on personalisation. So it is all right for George over there. We make sure he has this coming in and that coming in, so he is all right, isn’t he? And George is sitting here saying ‘no, not really’.”
(Site 7)

Direct payments – it was hoped – would give residents (and/or their families or representative) a lever to influence decisions about the services provided to them and incentivise care homes to be more responsive to their preferences.

“The whole ethos around personalisation and supporting people is much more than just meeting their basic needs in life. It is how they will meet their outcomes in a much more well-rounded personal way in responding to individuals. I do think the direct payments as a mechanism could help kick that along. It has done it in the community and I do not see why it will not do it in residential care and in time offer the same momentum to change.”
(Site 12)

However, while project leads indicated agreement with the aim of the trailblazer programme to enable a more personalised care home service, in principle, many expressed doubts about whether direct payments would be able to achieve this aim in practice. Responses from project leads highlighted three key concerns:

1. whether and to what extent service users would value additional choice, given their high dependency and level of need;
2. whether service users (and/or their families) would be able and willing to exercise additional choice and control, i.e. make decisions about using the direct payment and do the supporting paperwork; and
3. whether direct payments would provide a mechanism (i.e. constitute an appropriate policy tool) to promote choice and control in residential care.

While all of these concerns represent questions to which the trailblazer programme is expected to find answers, many project leads noted that the relationship between direct payments and choice and control (i.e. personalisation) is based on a substantial number of assumptions and may not be straight forward.

Some project leads indicated that their understanding of the aim of the trailblazers had shifted in the second year of the programme, with more emphasis given to establishing direct payments as a funding mechanism in itself rather than to promoting personalisation through direct payments. Some noted that in their view the dual objective of introducing direct payments and promoting personalisation, although compatible in theory, tended to drift apart in practice, with some worrying whether direct payments could do more harm to residential care than good (e.g. to undermine the objective of personalisation by increasing financial pressures on care homes).



Interviews suggest that these changes in perception in part had resulted from the difficulties experienced by many project leads in setting up the trailblazers. Convincing care homes to participate in the trailblazers had been challenging in many council areas, with care home managers and owners sceptical about the risks associated with direct payments to their business model and their way of delivering care (see sections 6.3.5 and 7.1). While all sites indicated at application stage to have established good working relationships with care homes in preparation of the trailblazers, some care homes reconsidered their commitment and withdrew from the trailblazer once the programme had commenced. Many project leads also expressed doubts about whether they had found a workable mechanism for calculating direct payments (section 6.2.1). A key concern was whether direct payments would be an appropriate tool to stimulate person-centred care, which was seen as potentially different from giving users choice and control by allowing them to use a budget to make their own purchasing decisions.

Project leads also reflected on the resource constraint in adult residential social care. Councils have a legal obligation to meet an eligible assessed need for residential care and they can be (and have been) challenged to comply with the law. However, to be able to place service users within a care home, councils have to ensure that there are sufficient care homes in the local market and that these offer placements that meet assessed needs at a cost councils can afford. Project leads were thus aware that they needed to pay fee levels that allowed care homes to recover their costs or risk that care homes might exit the market or exclusively concentrate on self-funding residents.

Given the resource constraint on councils, project leads tended to link choice with the concept of the assessed need as it is used by councils to determine the level of funding attracted by service users. Choices (or preferences or wants), in this view, are only permissible if they can be used to meet a specific outcome (e.g. participation in the community). Outcomes are determined through the needs assessment procedure and set out in the support plan of each service user. The concept of choice is thus linked (and de facto restricted) to the concept of need and related outcomes. As one project lead explained, the point of choice in residential care is to meet a need rather than purely “a want”. While there may not be a sharp boundary between a need and a want in practice (for example, when it comes to social needs or needs for activities), perhaps especially for people with high dependency, the distinction made indicated the conceptual difficulty faced by project leads who have to square the legal duty of councils to meet assessed needs with the severe resource constraint in times of austerity, while at the same time trying to accommodate a policy goal of personalisation.

Some project leads suggested that in principle care homes could be supported in other ways to offer more person-centred services. For example, some councils actively encouraged care homes to build support networks of volunteers or help care homes to establish links with service providers in the community as part of the trailblazer. It was also noted that councils already had some levers for stimulating personalisation, which may not have been used sufficiently in the past:

“The project has made us realise that, and obviously we have not done this before so it is still something different what we have done, but nothing different to what we could have done.” (Site 6)



6.2 Calculating direct payments

6.2.1 What is a direct payment in residential care?

Project leads reported that establishing a mechanism for determining the monetary value of direct payments had been a key challenge to date.

The Care and Support Statutory Guidance issued under the Care Act 2014 provides a definition of direct payments as “monetary payments made to individuals who request to receive one to meet some or all of their eligible care and support needs.” (DH 2014: 163) This definition conceptualises direct payments as a mechanism for administering payments to service users as opposed to the council paying providers as usual. However, it does not stipulate how the sum of money that is provided as a direct payment is determined. It was thus seen to be one of the purposes of the trailblazer programme to develop approaches to deriving a direct payment that could be used as a model to inform the future roll-out of direct payments in residential care.

The distinction between ‘personal budgets’ and ‘direct payments’ is currently only established in community care, where ‘direct payment’ denotes one way of making a ‘personal budget’ available, which would otherwise be managed by the council. In community care, councils use different mechanisms or strategies to calculate personal budgets, for example, by using a resource allocation system (RAS) or a ‘Ready Reckoner’. In residential care, neither the concept of a ‘personal budget’ (that would apply to the entire sum of money a council spends on purchasing residential care for a service user in a given month) nor the concept of a ‘direct payment’ is currently well established. The Care Act 2014 however stipulates that all service users meeting local authority eligibility criteria must receive a personal budget in future, including those in residential care. It is notable that the Law Commission asked the Government to consider extending direct payments to residential care but did not make any references to establishing personal budgets as part of the process (The Law Commission 2011). However, in community care, the possibility of receiving a direct payment rests on the ability of councils to determine a personal budget.

Project leads and their teams considered two options to calculate a direct payment: (a) the direct payment as covering the full payment that the council would make to meet an eligible assessed need for residential care, or (b) the direct payment as covering a part of the former payment only. The full payment (according to this logic) would represent the entire personal budget, while the part payment would represent a share of the personal budget. This share would be whatever the council decided to pay directly to the service user, while it continued to pay the remainder of the fees for the care of the service user to the care home.

However, determining the value of the full or the part payment has not been an easy task, with many project leads expressing severe doubts about whether the approach they have chosen will meet the expectations of the Government and will be workable in the long-term.

“I think for me the question still remains about whether we are doing it the right way. Although I am not sure if it is the right way, but in terms of how we are calculating the direct payment and how we have got the providers to break down their costs and what the issues are around that, because I think there are some issues around that, but it seemed like the most straight forward way for us at the time.” (Site 6)



6.2.2 Initial plans for using the resource allocation system

In the interviews conducted in 2013, many project leads indicated that they expected to use the resource allocation system (RAS) developed in community care to determine the value of direct payments in residential care. Many councils use a version of the RAS in community care, although approaches vary significantly between councils. A RAS typically uses an algorithm that translates points attributed to different levels of need identified in several areas of the user's life into a sum of money. This sum of money then forms an indicative (personal) budget. The indicative budget is used to inform decisions about how the assessed care need of an eligible service user can be met in the local provider market. In practice, this often involves the indicative budget being adjusted in some way (up or down), for example, by a review panel. Some councils do not use a RAS to determine personal budgets in community care, but use a version of a 'Ready Reckoner' (which translates an assessed care need into the number of hours of care required to meet the need), or other approaches (Series and Clements 2013).

When interviewed in September 2014, most project leads noted that they had changed their plans for determining the monetary value of direct payments in residential care, with a large number noting that they had abandoned the idea of using the RAS. Two councils had decided to continue using the RAS (see below).

Project leads who decided against the RAS indicated that they felt that the RAS was incompatible with the current approach to paying for residential care, which relies on care homes receiving an agreed fee. Some also noted that fee levels paid by the council differed between user groups, with care home fees paid for the care of younger people with learning disabilities, physical disabilities or mental health problems tending to be substantially higher than fees for the care of older people. They also suggested that councils rely on care homes accepting the level of payment the council was willing to provide to purchase care home placements for a given user group. After all, most care homes participating in the trailblazer programme operate as private (for profit or not-for-profit) businesses and contribute to the trailblazer on a voluntary basis, which means that they can opt out of the trailblazer if they wish (which some have already done). Using the RAS was thus seen as a risk to the provider market and to the success of the trailblazer, if care homes withdrew their participation as a result of its application:

“Those are the biggest challenges I think. And ideally it would be great if we could break down and cost everything separately and then people could make even bigger choices about what they do. But sadly because of our fee system and the funds that we have available we are not able to do that.” (Site 3)

6.2.3 Emerging models of direct payments in residential care

During our annual interview, we asked project leads to share with us their current plans for determining the monetary value of the direct payment in residential care.

Based on their responses, three models of calculating direct payments in residential care emerged so far:

- Model 1 – The direct payment is based on user needs (using the RAS)
- Model 2 – The direct payment is based on the care home fee
- Model 3 – The direct payment is based on a fixed amount paid in addition to the care home fee



Model 1: direct payments based on user needs (using the RAS)

Project leads in the two councils that decided to use a version of the RAS indicated that they planned to use the needs assessment process to determine the monetary value of the direct payment (i.e. the indicative personal budget for a resident in a care home). The project lead in one council did not provide specific information about the type of RAS being used in residential care and whether it would differ from the RAS used in community care. The project lead in the other council noted that his council planned to use the same RAS for direct payments in the community and in residential care, and that this RAS was the same for all groups of service users.

Project leads planning to use a version of the RAS for this purpose stated that they would offer direct payments to cover the **full payment only**. The service user could then use the direct payment to choose a care home that would accept the level of payment available. It is yet unclear what happens if the service user is not able to secure a place if care homes do not accept the direct payment. One option mentioned by project leads would be to adjust the indicative budget. An alternative would be to allow service users to 'top up' their direct payment, although this may not be compatible with the statutory duty on the council to fund care that covers the entire assessed need.

Model 2: direct payments based on the care home fee

Project leads from a large majority of councils (n=10) suggested that they planned to base the value of a direct payment on the fee they would pay to a care home if a service user were placed in this home under usual arrangements; i.e. without having a direct payment.

Determining the direct payment in this way requires an eligible service user with an assessed care need to choose a care home first (from those available to council-funded users) and be accepted by this care home. The council then determines the direct payment based on the fee they would pay for the chosen placement. The amount of the direct payment, as a share of the care home fee, was typically negotiated with the care home on a case-by-case basis. Project leads opting for this approach indicated that this would help ensure that service users would be placed in a care home appropriate to their assessed need. It would also mean that care homes could expect a set level of income from the resident with a direct payment (assuming the direct payment holder used her/his direct payment to pay her/his care home bill). One project lead suggested a variation of this approach in which the direct payment would be based on the care home fee up to a certain level; i.e. the direct payment would be capped currently at £346 per week. Another variation suggested would base the value of the direct payment on the day care payment the care home receives in addition to the care home fee (for younger adults). A further variation would be to base the direct payment on the element of the fee that would go towards funding day opportunities; this element would be determined based on an hourly rate agreed with care homes and a number of hours determined to meet this need. An alternative approach suggested would base the direct payment on the sum that represents the disposable income of the user per month (about £100) as an element of the care home fee.

Councils that have decided to base direct payments on care home fees offer direct payments to cover the full payment, part of the payment or a choice of both.

A direct payment covering the **full payment** would make the full payment available to the service user either net (after collecting any contribution such as a pension from the user) or gross (leaving the collection of the contribution to the care home). The service user is then responsible for paying the care home fee. If the service user opts



for a **part payment**, the council pays the care home fee and makes any remaining funds (potentially ‘flexed’ by care homes) available to the service user in agreement with the care home. In both models, the amount available to services users that is not used to pay for the care home fee, if any, is likely to be small. Alternatively, as some of the variations of this model suggest, the element of the fee that is ‘flexed’ is based on payments made by the council to fund day activities (where such an element exists).

Project leads opting for this approach indicated that the decision to base direct payments on existing care home fees was informed by pressures on the councils to secure placements for an assessed care need within a set budget and compatible with the fee structure of the local care home market. They argued that providing the service user with a direct payment that is higher or lower than the fee set by the care home would expose the council to the risk of either overpaying for a given need (i.e. waste taxpayers’ money) or underpaying, which may lead to users being priced out of the market and/or care homes becoming financially unsustainable if the fee was lower than the cost of the placement.

Model 3: direct payments based on a fixed amount paid in addition to the care home fee

Project leads in two councils proposed to make direct payments available as a **part payment**, paid in addition to the current care home fee. The councils will continue to pay care home fees directly to providers with some extra funding available to help establish direct payments.

One project lead explained that the council decided to set aside a sum of £20 per month for each service user to allow for additional staff time of two hours per month in the form of a direct payment. A second council decided to provide £25 per service user per week to be spent on additional activities via a direct payment. The stated purpose of these approaches was to find out how the additional money would be spent by users, whether additional funding facilitates more person-centred care and to what extent users benefit from having access to additional staff time and/or money to facilitate extra activities within or outside the home.

Table 6.1 Emerging models of calculating direct payments in residential care

Model	Description	Type of payment	Number of councils
Model 1	Direct payment calculated based on a version of the RAS	Full payment	2 councils
Model 2	Direct payment based on care home fee	Part or full payment	10 councils
Model 3	Direct payment as a fixed sum in addition to care home fee	Part payment	2 councils

At the time of writing, the implementation of Model 3 was most progressed in one site with another site starting to offer direct payments as an additional fixed sum. Model 2 was beginning to be implemented in a number of sites, although progress of implementation varied. Model 1 was being implemented in one out of the two sites adopting this model.



6.3 Developing the local direct payment trailblazer

Project leads indicated that developing direct payments in residential care required collaboration across a number of teams in councils. All project leads noted having established a project board or steering group to help plan the trailblazer and coordinate activities. Many of these boards had already been formed in 2013 and many had subsequently undergone changes in membership, often due to council staff being reallocated following council restructuring. Boards served a number of purposes including helping to develop a local model for determining the monetary value of direct payments in residential care, and communicating council policy and practice on direct payments in residential care to operational staff and other stakeholders, as well as ensuring senior management support for the project. Board composition varied reflecting differences in the organisation of adult social care in councils. Core membership included staff from finance, commissioning and service teams, and others as appropriate. Some also included service users or their representatives.

Many project leads indicated that setting up the trailblazer was an (unexpectedly) arduous and slow process, especially since there was no model that councils could follow to implement the programme. In this sense, the programme is a true trailblazer.

“People are finding it very challenging and difficult to think about how direct payments in the community work and translating that into residential care because there is no model to follow and we have got to try and come up with one.” (Site 12)

Respondents held different views about whether there should have been more guidance from the Department of Health, with some agreeing that the payment mechanism should be established locally through the work of trailblazers, while others wished for a clearer central steer. The Department of Health had commissioned the Social Care Institute for Excellence (SCIE) to organise quarterly meetings for project leads and an online platform for project leads to exchange information and experiences. The Department also commissioned expertise from one of the trailblazing councils prior to the programme to inform emerging implementation strategies in sites.

6.3.1 Strategies and plans for implementing direct payments

Interviews with project leads revealed two basic approaches to operationalising direct payments in residential care. The first approach was to offer direct payments only to a selected group of individuals, for example, existing or new residents, or residents of particular care homes that had volunteered to support the trailblazer. This way the council had control over the numbers of potential direct payment users and potential resource implications.

The second approach involved potentially offering direct payments to all existing and new residents in care homes used by the council. This was done by integrating information about direct payments into the regular procedures for assessing care and planning support. This approach was seen by some as more pragmatic and more in line with the expectation of future roll-out.

“We already had it all in place, so it just fits in with our normal procedures and processes. Like you said, it’s nothing special. It’s offered as an extra service that people may find of benefit.” (Site 11)



Several project leads indicated that their initial plans had changed over time. Some sites had initially planned to offer direct payments only to those currently resident in those care homes that participated in the trailblazer, but were now considering broadening the offer to a larger number of homes or user groups for reasons of equity and/or to generate interest from a wider pool of providers and users in response to the slow progress of the trailblazer. Two sites planned a universal offer, but only to new applicants for residential care.

“I think now we are starting to think what would be the reason that other people could not be offered [a direct payment] and we will be looking to open it up more widely.” (Site 6)

6.3.2 Involving residential care providers

Project leads agreed that it was important to involve providers in the development of the trailblazer. It was noted that many care homes were very interested in direct payments, especially at the beginning of the trailblazer, and supportive of the aim of improving person-centred care in residential settings. The trailblazers also benefitted initially from a desire among care homes to collaborate with the councils to prepare for the implementation of the Care Act 2014.

Participation of providers in the trailblazer is voluntary and councils were not given additional funding to provide incentives for providers to participate (although some funding was provided to help with additional administration). Being reliant on the willingness of care homes to collaborate voluntarily, many councils had approached providers with whom they had collaborated on previous occasions. Discussions about direct payments often proved to be sensitive with care home owners and managers concerned that direct payments could add further pressure on already strained budgets in times of austerity.

Project leads therefore had to reassure providers that they would not be financially compromised by participating in the trailblazer, with some providers suspecting that councils (or central government) would be looking for new opportunities to save money. Some councils also lost providers who had initially been willing to participate when it became clear to them that no additional funding was available for the trailblazer and that direct payments could potentially result in funding being directed away from the care home (i.e. it could be spent on services provided outside the home). There was also a realisation in many councils that they needed providers' input to inform the development of the programme.

“We worked with a number of providers ... and they suddenly realised that there was light at the end of the tunnel and they didn't feel that we were going to be trying to shaft them or close them down, you know.” (Site 7)

“For me, sort of, giving the olive branch, and opening up again, to say, we cannot do this on our own, we need to, you need to be part of it. So, that helped, I think, in some regards.” (Site 18)

Successful providers could then be used as exemplars to help expand direct payments to other care homes and service users.

“The strategy at the minute is to try and get it right for one provider and get a couple of case studies together so thathe can stand up there and say it's not that scary.” (Site 14)



Project leads suggested that providers were involved in the project in a number of ways, with some working very closely to advise the council and help steer the project, while others mainly organised access to existing residents so that project leads or social workers could speak to them about direct payments.

Two main aspects of provider involvement were identified by project leads: (a) helping the council develop direct payments, for example, by thinking through the financial implications and by providing cost data; and (b) helping identify service users and family members as potential candidates for direct payments and communicating the aims of direct payments to them.

6.3.3 The role of providers in developing direct payments

A number of project leads indicated that they had involved providers in developing direct payments in residential care. Methods of engaging with care homes differed between sites, as did the groups of service users (e.g. learning disabilities, older people, and physical disabilities) in these care homes. Most councils worked with a selected group of providers, while a few decided to offer direct payments to all service users and work with care homes one-by-one once a direct payment had been accepted. The latter approach was chosen by some in response to difficulties experienced in identifying care homes that would want to participate in the trailblazer.

Working with providers to develop the direct payment model was perhaps one of the more challenging aspects of the programme, according to project leads. In some areas, council leads worked with providers intensely to identify opportunities for flexibility in the current care home fee system, which required discussion about the extent to which current fee levels covered costs, the distribution of these costs, how distinctions could be made between the costs of care and costs of accommodation ('hotel' services) and whether it was possible to set aside a part of the current fee to allow service users additional choice. These discussions also involved an assessment of the risks associated with different options for determining a direct payment, risks related to choice and control, for example, when a resident might be employing a personal assistant, as well as risks associated with safeguarding and accountability, and expectations of the Care Quality Commission (CQC).

Care homes in these sites thus were instrumental in helping project leads to develop a model for deriving direct payments (i.e. determining their monetary value). However, some project leads also noted that care homes could be reluctant in providing information about costs and that council staff sometimes would find it difficult to have this conversation with providers.

**“Having those detailed financial discussions with the care home providers does not seem to fit very well with what they see their role and function being.”
(Site 2)**

However, other project leads reported that the experience of collaborating with care homes on the trailblazer in order to understand their costs was very helpful for the trailblazer and beyond:

“As a result of this relationship building that we have been doing, two of the homes agreed to actually cost out their service, and identified potential flex. And that has been really helpful.” (Site 1)



6.3.4 Role of providers in recruiting service users

Some trailblazers have involved providers to identify and recruit potential recipients of direct payments in their care homes. Most project leads noted that it was important to sufficiently inform care homes about the trailblazer so that care home staff could inform service users and family members appropriately about direct payments.

However, this approach could create some uncertainty, as it was not always clear how care home personnel would approach service users and whether they would provide sufficient information. Care home staff may have their own views or feel unsure about the desirability of the direct payment for the home and/or the user.

“We have had a situation where we do not actually know how the conversation went. We had a provider...that attends the provider reference group, he talked to staff at the home about the direct payments, and left it to the staff at the home to talk to the service users, without anybody else being present. So, we were not actually party to the conversation that they had, and neither was he. And then, we got a message back to say, no, nobody wanted it [the direct payment].” (Site 8)

“So the route that care homes basically approach people or approach users is not that easy to go if they themselves are not sure whether they approve of it.” (Site 2)

Other sites opted for an approach in which they directly contacted service users as well as care homes and provided information to both. A few councils opted for an alternative approach to identifying potential service users, having a discussion about direct payments with them first, followed by a conversation with a chosen care home about the opportunities to use a direct payment in the home.

6.3.5 Risks identified through collaboration with providers

Project leads expressed a number of concerns that providers involved in the trailblazer had raised during the trailblazer. These included potential risks arising from direct payments to their business model and potential loss of income, as well as risks to safeguarding, provider capacity and risks associated with current regulatory practice.

Risks to the business model and income of care homes

Risks to the current business model of care homes was a prominent concern of providers reported by project leads. In some sites, initial interest in the project was tempered once providers realised there was no extra funding available to support the introduction of direct payments and that there was no guarantee of income once direct payments were offered to residents.

“I think that they thought they were going to be able to get extra money and when they realised that we wanted to achieve this within the existing cost of the care home placement, they were not wishing to continue.” (Site 2)

Project leads accepted that the concern of providers about the potential of direct payments to impact negatively on their income was within the context of already tight budgets for adult residential care, especially for homes providing care to older people. Project leads noted that councils in some areas had not increased residential care fees for a number of years or only offered minimal increases below inflation. Direct



payments were thus seen as an additional risk to the financial stability of care homes, especially those for older people. A project lead noted a care home manager saying:

“We cannot survive now with the local authority’s rate, so if you are going to take money or you are going to take that element away from us, we will not be able to manage that.” (Site 18)

Project leads also reported that care homes found it difficult to identify the costs of individual services, as this runs against the current approach to establishing care home budgets (which is currently largely based on pooling the costs of all residents).

They also reported concerns of providers about the necessity of ‘breaking down’ the costs of running a care home, specifically hotel costs and care costs, to be able to give service users with a direct payment a choice between receiving services in the home and services delivered by other care providers. These concerns included the difficulty of separating hotel and care costs and the difficulty of distinguishing ‘fixed’ costs associated with running a home from more flexible costs that could be associated with the care of an individual service user.

Providers challenged the assumption that part of their budget could be ‘flexed’, i.e. made available to pay for additional or other services to allow for wider choice, without impacting on their overall financial stability, with some indicating that there could only be a small amount, if any, considered ‘spare’ or set aside, for example, for activities during the day. Some care homes providing services to older people noted that councils already underfunded their services by paying rates that were lower than the costs of running the care home. This required homes to recover additional funding from self-funding residents or risk going out of business. Project leads also reiterated concerns of care homes about additional choices provided to service users with a direct payment requiring care homes to provide fewer services to other residents, if monies were directed away from the care home. As one project lead recalled from a discussion with a provider:

“You really should be paying us £480 because that’s what it actually costs. One of the real difficulties is that we cannot say to them, here is £425, how much can you now release back to each customer.” (Site 3)

Project leads also mentioned concerns of providers about service users potentially not paying their care home fees or not paying their fees in full if they had responsibility for a direct payment. Some project leads were asked by providers to guarantee their income, which some leads agreed to in order to prevent providers leaving the trailblazer (i.e. by choosing model 2 or model 3). This seemed particularly important to smaller care homes which were seen as being more vulnerable to the loss of income from individual purchasing decisions.

Safeguarding, capacity and regulation

Project leads mentioned a number of concerns expressed by providers about the potential of direct payments to impact on the quality and safety of the care they provided if funding were directed away from their services or if they were required to organise additional services within the same budget.

The possibility of residents employing their own carer or personal assistant caused particular concerns, with questions arising about the responsibility of care homes for vetting external carers, ensuring that carers had appropriate insurance cover and



holding them to account, especially if service users and their families were unable to exercise these responsibilities themselves.

Doubts were also raised about the Care Quality Commission (CQC) being sufficiently aware of the direct payments in residential care trailblazer and its involvement in promoting personalisation. Being able to meet CQC expectations of service standards was a frequent concern expressed by providers according to project leads. For example, would CQC be aware of the fact that some individuals with a direct payment could choose to opt out of joint activities offered in the home or would this be held against the home?

“You are regulated to do that, I am not going to continue to take this risk that I am going to be penalised, marked down.” (Site 8)

Concerns about direct payments becoming an additional demand on limited staff time were also mentioned by project leads. An example mentioned was the risk assessment that would be required if a service users decided to participate in an activity outside the home. It was felt that services users and their families would likely require additional support from care home staff to be able to manage their direct payment.

6.3.6 Involving service users and their families

A variety of methods and approaches were employed to involve service users and their families in the direct payment trailblazer. Many project leads reported having involved service users at the planning stages of the programme, for example, by inviting service users or representatives of user groups to participate in steering groups or planning workshops.

Project leads used a number of approaches to recruiting service users and families into the trailblazer, often in combination. This involved offering the direct payment and informing prospective users about the aims of the trailblazer and the potential opportunities involved when using a direct payment. This task often involved the project lead, care home staff, council social workers and council care review teams. In a few cases, council staff were approached by service users directly, requesting a direct payment.

Project leads in some councils directly approached service users, for example, by organising information events, such as coffee mornings in care homes, and by disseminating leaflets informing about direct payments. Service users (and/or their families) who expressed an interest in taking up a direct payment were then invited to meet with the project lead or a social worker individually for further discussion.

In some areas, project leads worked through care home staff to identify service users who they thought could have an interest in and/or benefit from direct payments. Care home staff would then set up a meeting between the service user and the project lead or council social worker who would explain the direct payment to the user. In some cases, care home staff provided information about direct payments directly.

Council social workers also approached potential users of direct payments. They were normally briefed directly by the project lead through, for example, briefing workshops or project meetings, or by their team manager. Social workers typically used the needs assessment process (for new applicants) or a care review meeting (for existing



residents) to discuss direct payments with potential users. In some cases, this was followed by a more in-depth discussion between the project lead and the user.

Council care review teams were also involved in some sites to identify potential users. In one site, the project lead shadowed the review team for a day to support the recruitment process.

In a few cases, the project lead was approached by service users and/or family members directly who requested information about direct payments after having heard about them through other care home residents. However, such requests had been rare, largely as a result of limited publicity undertaken to promote direct payments.

Most project leads noted that identifying service users and families had been (unexpectedly) time-consuming and laborious. They also stated that they experienced scepticism from service users and their families about the appropriateness of direct payments and felt that they had to 'sell' direct payments to them. A number of reasons were suggested to explain the reluctant response from service users and/or families, for example, difficulties in considering the specifics of the funding mechanism during a time of crisis; satisfaction with the service currently received; and concerns about the direct payment impacting on the care home and the care provided by the home.

Some project leads noted that the process of identifying and informing service users could be frustrating, with some examples given of service users and families losing interest after being interested initially.

“The family, they were all up for it, and now all this work has been done, and now it is not happening. So, it is a lot of work for not much reward at the moment. That is how it feels.” (Site 8)

6.3.7 Contextual challenges

The workload associated with the preparatory work undertaken by councils in anticipation of the introduction of the Care Act 2014 had also impacted on the development of the trailblazer in some areas.

There was some confusion initially about the relationship between the Care Act 2014 and the Direct Payment in Residential Care trailblazer, with some project leads wondering about the implications of the Act for the approach to costing care home placements and setting care home fees.

Project leads also talked about the uncertainty surrounding the potential impact of the Care Act on care home fees. This included the impacts on care homes arising from self-funders being able to ask the council to organise their placement and then pay the same rate as the council. It was noted that this could change the mix of income for providers and challenge their current model of cross-subsidising care.

In contrast, some project leads found it useful to link the trailblazer more directly to the Care Act to give additional importance to the trailblazer. This was seen as a useful strategy to convince both care homes and other council staff to give priority to the development of direct payments. This also meant that briefings and events dedicated to the Care Act could be used to inform about direct payments.



“I talked about the benefits to them...getting ready for the change, being ahead of the game, looking at how you will prepare to change your model.” (Site 12)

Project leads also noted that councils were currently undergoing substantial organisational changes including the restructuring and relocation of teams and having to make efficiency savings due to reduced adult social care budgets.

“I think all local authorities are in a difficult place. We have just had another series of briefings from our Chief Exec telling us how many millions we have got to save over the next few years.” (Site 1)

“We lost the majority of our steering group because we had another round of voluntary early retirement and voluntary severance.” (Site 3).

“We did have a specific self-directed support team who would provide direct support to people who were taking a direct payment. We lost that team into our corporate finance team and a bit of that work was lost really. And we did have a very focused personalisation team who would have at one point led on things like this that we have lost.” (Site 6)

In some sites, the combined effect of having to deal with austerity and to prepare for the implementation of the Care Act created an environment that made it difficult to continuously focus on the direct payment trailblazer. This was exacerbated in sites in which project leads or other key personnel were allocated to other positions and left the project. Some sites also reported a general shortage of staff available to commit time to the trailblazer.



7. Perspectives of residential care providers

The following section presents findings from the interviews with managers and owners of care homes. Interviews were conducted in two sites. Site 4 is a metropolitan district in the North West of England, and Site 7 is a county council in the South East. Both councils volunteered to be focal ('in-depth') sites for the purpose of this study.

Four representatives of providers were interviewed in each site. Care homes in Site 4 all provided care for older people, most of whom were living with dementia. The model of direct payments chosen in this site focused on providing a small sum of money (£20 per month) to fund additional services (e.g. day activities). Care homes in Site 7 provided care for people with learning or physical disabilities (or both), most of whom were younger adults under the age of 65 years. The direct payment offered could be taken as a full or part payment, with the part payment likely to be limited to the funding that care homes would attract to fund day services.

Care homes involved in the interviews also varied in size, with the smallest home providing six places (of which three were occupied at the time) for people with moderate learning disabilities and the largest home providing care for over 40 older residents. One care home in Site 7 largely worked with residents with high dependency arising from long-term degenerative illness such as multiple sclerosis; care in this home tended to be co-funded by the NHS. All homes in Site 4 were privately owned and run, with one home belonging to a group of homes previously owned by the council; homes in Site 7 all belonged to charitable organisations. Interviewees in Site 4 included managers and owners of care homes, including one manager of a care home that had decided not to participate in the trailblazer. Interviewees in Site 7 included care home managers only.

Owners and managers were generally supportive of the aim of the direct payments in residential care trailblazer to improve opportunities for more person-centred care in care homes. Owners and managers in care homes for older people were particularly appreciative of the aims of the initiative, noting that this group of residents was usually given very limited choice when admitted to a care home. Managers in care homes working with younger adults also appreciated the opportunity to offer more choice although most of them suggested that residents of their facilities typically already enjoyed a substantial amount of choice (depending on their cognitive and physical capacity to choose activities).

However, owners and managers voiced a number of concerns about the potential impact of direct payments on the funding of residential care, which could pose a risk to the financial sustainability of care homes. Concerns were also raised about the feasibility of introducing direct payments in care homes which may have implications for costing and invoicing, recording of services provided, and the additional staff time required for organising activities and other individualised services. A second set of concerns related to the ability of direct payments to provide service users with more choice and control over the services they received, and the extent to which direct payments would allow care homes to provide a more person-centred approach to care in residential settings.



7.1 Concerns about funding and financial viability

Owners and managers of care homes voiced substantial concern about the potential financial impact of offering direct payments on care homes.

Most questioned the compatibility of direct payments with the current business model of care homes that relies on the pooling of income from all residents (i.e. council-funded and self-funded) into one budget from which the care home covers all its costs. The ability of care homes to switch to a different – individualised – model of identifying costs was judged as limited, especially for smaller homes with little capacity to generate economies of scale in administration and provision of care. In addition, owners and managers of care homes for council-funded older people judged the financial situation of these care homes (in the North West of England) as already precarious, which would be further exacerbated if residents were given the opportunity to allocate funding away from the care home to buy services from external providers or to demand more individualised services in the home without additional funding. Managers and owners of care homes in this area also reported that they were seeing larger private for-profit companies entering the local market and increasing competition for self-funding residents on which they relied to compensate for the shortfall in funding for council-funded residents.

They also suggested that care homes would find it difficult to invoice service users for services provided to them, as care homes currently do not price services individually and do not have the structures in place or the staff available to be able to do so. One owner of a home noted that his staff would find it difficult to keep adequate records of essential care provided to residents already, reflecting pressures on staff to attend to several aspects of care simultaneously and competing demands on their time and attention. Breaking down these services into individual tasks that could then be invoiced for would require the use of these services to be scrupulously recorded, which was seen as unrealistic.

However, 'itemising' care homes bills seemed less of a problem with some of the care homes for younger adults in the South East, although here the direct payment only related to day services which the care home already priced individually and received separate funding for. There was similar scepticism in these homes about whether it would be possible and appropriate to break down costs for core services delivered by the homes.

One care home owner noted that his home would be able to cope with the setting up of a new costing system, but expressed a preference for such a system to be developed nationally; i.e. placing uniform requirements on care homes but potentially also paying national prices. However, he was less confident about whether his home (which offered care for older people) would survive the transition given the current financial climate and the shortfall of funding for residents placed by the council.

Care home owners involved in discussions with the council in preparation for the trailblazer described it as impossible to clearly distinguish the 'cost of care' from the 'hotel costs' in residential settings. They also questioned the assumption that hotel costs could be considered as 'fixed' while care costs were 'flexible' and thus more responsive to the wishes and choices of residents.

One owner of a small number of care homes for older people with dementia explained that in his view the costs of 'hotel' and 'care' tended to overlap and wondered how a boundary between both types of costs could be defined, for example, if a resident wanted to pay hotel costs only and purchase care from a personal assistant:



“They are paying for the hotel costs. They are not paying for care. What if they have a fall? They are in dementia homes. What if two people get into a fight? What if somebody gets really agitated? We have had people waking up one morning saying ‘Where am I? Where am I, who are you, how have I got here?’ [...] So that requires a lot of one-to-one reassurance, a lot of time. Are we going to bill them separately for that?” (Care home owner 1, Site 4)

Another care home owner noted that the costs of running a care home (composed of hotel costs as well as some care costs) would not necessarily decrease if individual residents chose to purchase external services. Care homes may thus be required to charge the amount of the entire direct payment to cover their costs. This would leave nothing or only a small amount for users to spend on anything else.

It was also suggested that the costs of care and board per resident tended to fluctuate with levels of occupancy, which in current proposals would not be factored into a direct payment. This could expose smaller homes with fewer residents to additional financial risks.

A care home manager in Site 4 noted that organising additional ‘individualised’ activities for older people placed an additional demand on staff time. While the current version of the direct payment in this area offered a small amount of extra funding (£20 per month per resident), it was still felt that organising (even if this did not involve providing) additional services (such as a trip to the garden centre or watching a football game in a local pub) would impact on limited staff time.

Another concern about the workload of care homes related to the possibility of providers having to chase payment from service users or their relatives, whoever was managing the direct payment. It was noted that getting residents to pay the care home directly already proved difficult in situations where users had spent their personal allowance on something facilitated by the home that was not care or hotel services (e.g. for a theatre ticket or a personal item purchased by the home on behalf of the user).

The current funding climate was identified as a major constraint on the feasibility of the trailblazer, with providers unwilling to enter into any scheme that would increase their financial risks. Several owners and managers (in the North West) observed that current council fees for placements of older people already did not cover the costs of their care. The low level of funding from the council had led to a situation in which care homes relied on self-funders to cover their costs, which in effect was leading to self-funders paying substantially higher rates than the council for the same care.

“I have local authority funded and self-funded [residents]. Irrespective of needs you will find I charge the self-funders more. If I did not do that I would not be able to provide services just based on local authority fees because they are really less than what it actually costs me to look after them.”
(Care home owner 1, Site 4)

In one example, the fees paid by the council and by a self-funder for an identical placement in a care home for older people differed by almost £300 per week. Cost pressures on care homes for older people, as one owner explained, had increased substantially in recent years. This was exacerbated by the fact that people were being admitted to care homes later in life when their needs were more progressed, with care homes having to cope with a higher average level of dependency.



There was thus scepticism as to whether direct payments would have any benefits for care home providers in the current financial climate:

“The direct payment will not make things better for providers. It won’t. The only thing that will make things better is if there is a full and honest review of care home fees in an objective, honest, open, transparent way and there is recognition that local authority fees are too low and that the industry has been subsidised by the 40-odd percent of the people who pay private fees.”
(Care home owner 2, Site 4).

7.2 Concerns about choice and control

Owners and managers also voiced doubts about whether residents would obtain more choice and control by receiving a direct payment, although they all agreed that care should be person-centred and responsive to service users’ preferences.

One aspect of this was the question of whether residents had sufficient capacity to make their own decisions and/or ability to appreciate the degree of choice and control potentially resulting from these decisions. This seemed particularly pertinent for managers of homes for people with severe learning disabilities, cognitive impairment associated with advanced degenerative disease and older people in the later stages of dementia. A manager of a care home that did not participate in the trailblazer noted that doubts about the suitability of direct payments for people with dementia led to their decision not to participate.

In such cases, relatives (or other suitable people) would be expected to take these decisions. Relatives, they argued, would often already feel quite challenged and sometimes overburdened by the responsibilities associated with deciding on behalf of a family member who lacks capacity. This was particularly (but not exclusively) pertinent to older people who, as was pointed out, were often admitted to a care home in a situation of crisis as a measure of last resort when the family had reached a point where it was unable to cope. In the experience of care home managers, some relatives would not automatically know how to act in the person’s best interest as perceptions about needs and preferences could vary between the person and the family. At worst, care homes and their residents could be exposed to financial misuse or even abuse of direct payments.

Care home managers registered concern about whether a financial mechanism such as direct payments would be suitable for facilitating the types of choices and/or person-centred care they thought would be most desirable for service users. In their view, this mainly related to staff having more time to look after individual service users and their specific needs. One example given related to older people with dementia, for whom person-centred care would involve giving them time to dress themselves to the best of their abilities rather than dressing them. The latter would be less time consuming, but also less desirable for the older person:

“Am I going to let them struggle dressing themselves? That is personalisation in a day to day running of a care home instead of doing everything for them. It is very difficult to explain. A direct payment does not automatically mean, for me, personalisation.” (Care home manager, Site 4)

Choice and control, in this example, happens within the context of routine care provision rather than as a service that can be purchased separately.



Some managers in homes providing care to (mostly) younger adults with physical and/or learning disabilities (in Site 7) were more optimistic about the potential for enhanced choice offered by direct payments and their benefits for their residents. Some of these care home managers (in Site 7) felt more comfortable with the idea of linking personalisation to payment. However, those supportive of the idea indicated that their care home already provided a substantial amount of choice of day services for their residents. They noted that they were already invoicing the council for individual day services, reflecting that these services were funded in addition to the ‘core’ costs of care.

In contrast, a manager from the same region wondered whether direct payments would force care homes to charge residents with a direct payment for services that were currently included in the overall offer of the home, even in cases in which the care package for an individual resident would not include such a service (e.g. physiotherapy). It was questioned whether residents, who were not in receipt of a direct payment and unable to pay extra, would have to be excluded from these services. This was perceived as undesirable. It might also require homes to price services that had previously been offered free of charge (e.g. families borrowing a suitable vehicle from the home if they wanted to take a resident for an outing).

A manager of a home that provided long-term accommodation for a small number of adults with moderate learning disabilities noted that his residents already had substantial influence on their living arrangements and benefited from being involved in decision-making routinely. It was seen as questionable whether a direct payment would offer any additional choice to them, while it would require the residents to make more complex decisions involving financial transactions. This home was also earmarked for transition to supported living, which will allow residents to access direct payments in the community, if they so wish.

Concern was also expressed about the effect of direct payments on those residents who were not in receipt of a direct payment, in particular, if funding is taken away from the care home that would otherwise cover the costs of a service that would be shared and thus available to all residents:

“I see it as a way forward, really, for people to have a little more autonomy, a little more independence, maybe, but I just think that you will have to really consider the [consequences]. Because we have our set staffing levels and we know what we can afford, and we know what we can manage with, on a daily basis. And if some of those staffing levels drop, because people want to pay someone to go out, that could have an effect on everybody else who might not be on a direct payment.” (Care home manager, Site 7)

Overall, owners and managers of care homes in these two sites raised a number of concerns about the feasibility of introducing direct payments in residential settings. There were particular concerns about the potential impact of direct payments on the financial viability of care homes in the current financial climate, particularly those providing care for older people. There were also questions about the benefits of direct payments to residents of care homes and their families, and whether having a direct payment would translate into enhanced choice and control in practice. The tenor was that while person-centred care is desirable for residents and carers alike, providers questioned whether direct payments would be able to bring about personalisation, especially given the current financial constraints.



8. Discussion

This interim report presents initial findings from a questionnaire survey of service users in residential care and their family members, from interviews with project leads and from interviews in two sites with care home providers involved in the Direct Payment in Residential Care trailblazer.

Project leads reported that by November 2014, 71 direct payments had been offered, of which 45 had been accepted by service users and their families. These numbers are considerably lower than the 430 to 500 projected in our previous report based on interviews with project leads in autumn 2013, although these related to the whole of the trailblazer programme and project leads were not expecting to have reached these numbers by this stage. Recent interviews suggested that the number of care homes currently involved in the trailblazer is also lower than previously planned, with a number of providers having withdrawn from the trailblazer programme since last year. At the time of writing, six out of 14 sites do not yet have a service user who has accepted a direct payment in residential care. Only nine questionnaires have been returned by service users accepting a direct payment to date, three by service users declining the offer of a direct payment, and 23 from family members of those accepting and declining. Sites have told us that in all 45 users have accepted a direct payment and 24 have declined a direct payment.

Interviews hinted at a number of implementation difficulties that local trailblazers have faced that may help explain the slow progress. Difficulties particularly revolved around a lack of clarity about the financial mechanism underpinning the direct payment policy, doubts about the compatibility between direct payments and local provider markets, and questions about the extent to which direct payments are able to promote person-centred care in residential and nursing homes. Some councils had also experienced changes of project leads and were required to prioritise work carefully in view of the combination of cuts in budgets and the implementation of the Care Act 2014.

Determining the monetary value of direct payments

Project leads suggested that a large majority of sites had decided against their initial plans to use a version of the RAS to determine the monetary value of direct payments. While the purpose of the trailblazers is to identify approaches to determining the value of direct payments and to test their feasibility, the absence of a working model for deriving direct payments in residential care has made it more difficult for project leads to persuade providers to participate in the trailblazer. The difficulty of not having an agreed mechanism for calculating the monetary value of direct payments may reflect the fact that the concept of personal budgets is not yet established in residential care.

Interviews indicate that both councils and providers see considerable risks in implementing direct payments in residential care: for care homes, these risks are mainly financial, especially if direct payments result in service users receiving payments lower than the fees that the council currently pays for their care (which is possible when using a RAS); for councils, risks include care homes possibly going out of business or concentrating on self-funding customers. This could lead to a situation in which councils may find it difficult to find placements for service users who it has a legal duty to support. Service users with a direct payment (covering in principle the full care home fee) could find themselves in a situation where in practice care homes do not accept their payment or require them (i.e. their families) to pay in addition to secure a place.



It has also been suggested that care homes may be tempted to treat service users with a direct payment as self-funders. However, to date only one such case has been reported and in this case it was seen as beneficial as it helped secure a place chosen in another council area which otherwise would have been unavailable to a council-funded individual (and the family was willing to pay the difference).

Implications of different funding models of direct payments

This report has identified three potential models for determining the monetary value of direct payments emerging from the trailblazers. Each model has different implications for councils, providers and service users, and generates different potential risks and benefits for each of these groups.

Model 1 is based on a RAS (or alternative mechanism, such as a 'Ready Reckoner'). This was initially considered as an option by many councils, largely because it already exists in community care. However, if unadjusted, a RAS is likely to produce payment levels that differ from those currently paid for placements of some residents. It is understood that councils use different types of RAS, with some councils using the same RAS for all service users, while others use different RASs for different user groups, and some do not use a RAS at all (Series and Clements 2013). Some councils also use substantial discretion to adjust the results from a RAS (i.e. the 'indicative budget') to what they judge as adequate for users to purchase care (Series and Clements 2013).

In principle, a RAS is based on the idea that a given social care need translates into a corresponding sum of money that allows a user to purchase her/his own care. In effect, this means that the same level of need attracts the same level of funding. However, current funding practice in residential care suggest that fees paid for placements of older people are considerably lower than those for younger people (HSCIC 2014). Even if councils were to use different RASs for different user groups, there is still a risk of a RAS producing funding levels that are different from those currently paid for residential care, especially in those areas (and for those user groups) in which care homes attract different levels of funding for the same level of need. Using a RAS to derive direct payments (i.e. personal budgets) in residential care on a larger scale could have the effect of redistributing funding both between groups of service users and between care homes.

Model 2 bases direct payments on existing care home fees. The monetary value of the direct payment in this model then depends on the care home fee that the council would pay for a placement in the absence of a direct payment. With only a small number of care homes participating in most trailblazers, this has required that service users (or family) first select a care home and are then offered the option of taking a sum equivalent to part or the whole of the fee as a direct payment.

By using this model the council could mitigate the financial risks to providers (and the reputational risk to the council associated with potentially not adequately funding an assessed need that could arise under Model 1). It could also limit the choice of care home for service users if only a small number of homes were willing to support direct payments (as in the trailblazer). There were a number of variations of this model reported, including one version which suggested that the fee provided as a direct payment would be capped. This approach is likely to be closest to what the Law Commission had in mind when it recommended the expansion of direct payments



to residential care (The Law Commission 2011). Whether a direct payment of this type would create more or less choice for service users would then depend on the compatibility of the council's funding limit with the price structure of the local provider market (i.e. if many care homes accepted the fixed fee there might be more choice, or less choice if they did not).

Another option is to use the existing care home fee to derive a sum of money that can be offered as a 'part payment' version of a direct payment. There were several versions of this option reported by project leads. For example, the council and care homes negotiated a sum that could be made available ('flexed') within the current care home fee. This tended to be small or non-existent for older people. Project leads in some councils indicated that there was more flexibility in the funding for younger people with disabilities. These approaches tended to 'flex' the additional funding paid for day services for these groups; this was done as a fixed sum - i.e. the day service element of the fee, or based on an estimate of hours needed.

Model 3 bases the direct payment on a set amount of money, currently paid in addition to the care home fee. One council has decided to make £20 available per month for older residents, which can be used to organise individual day activities. A second council offers £100 per month per person. While this model has the potential to offer additional choice of activities it is not clear whether this (or any) approach will enhance person-centred care more broadly (see below).

Model 3 was specifically chosen by councils to mitigate the financial risks faced by providers, to persuade them to continue collaborating in the trailblazer and to be able to test opportunities for personalisation within care homes. However, it is not clear how this model can be financially sustainable beyond the trailblazer, or how it could be scaled up without additional funding being provided. Moreover, since it could only ever cover a small part of the care needs of individuals, it does not really amount to a personal care budget.

Opportunities for personalisation through direct payments

Interviews suggest a degree of scepticism about the ability of direct payments to create opportunities for choice and control and/or to improve person-centred care in residential settings. Similar scepticism had been voiced on previous occasions, for example, in the evaluation of the Individual Budgets pilots (Glendinning, Challis et al. 2008).

In relation to choice and control, interviewees noted that direct payments would require additional decisions to be taken either by service users or by their relatives to purchase services, which some said overestimates the capacity of most care home residents to contribute to such decisions and underestimates the responsibilities already exercised by family members. This consideration was especially mentioned in relation to older people (with dementia) with high dependency and younger people with cognitive problems. There may also be a potential for misuse in the sense that relatives (or other representatives) might take decisions on behalf of the service user that do not increase the wellbeing of the user as seen by the user. Offering direct payments to all existing and prospective residents in residential care may thus require careful judgement about the risks and benefits arising from direct payments for users and families.



Interviews with project leads and care home managers suggest that younger adults in residential care were considered to be more likely to benefit from direct payments than older people. This was particularly noted in relation to day services and other activities during the day (although this may also be a product of the difficulties of devising a funding mechanism that goes beyond identifying the funding available for day activities as the direct payment). However, others suggested that there may be a need for more diverse day activities for older people as well. In our small sample of care homes, younger people were already offered considerable choice of day services and appeared to be able to influence decisions relating to their care and accommodation to some extent (although some project leads were sceptical whether this would apply to all care homes for those under 65 years).

A distinction was also made between choice and control associated with using the direct payment as a funding mechanism that allows service users to purchase their own services, and others types of person-centred care. Some interviewees indicated that person-centred care, perhaps especially for people with high dependency and limited capacity (such as older people with severe dementia), may be embedded in routine care rather than constitute a separate service, which can be purchased in addition to existing services. It was therefore questioned whether direct payments would be able to improve the potential for person-centred care (which relies on adequate staffing and time available from staff for individual residents), especially if weighed against potential risks to care homes' financial viability.

The current financial context of council-funded adult social care

It was also noted that care homes in some council areas were already in a difficult financial position and were, for this reason, unable to accept the additional financial risks potentially arising from direct payments. Care home owners in particular noted that the current council rate (for older people) would not allow them to cover the cost of care for council-funded residents. In our sample, this issue seemed particularly pronounced in council areas in the North of England and care homes for older people.

Given the current financial constraints on council budgets for adult social care, it may be important to consider that care homes (in some areas) are already in a situation of financial stress, which may exacerbate the financial risks associated with direct payments (if used at a larger scale and depending on the financial model underpinning the payment). Care homes in one focal site (Site 4) also reported that they were seeing larger private for-profit companies entering the local market and increasing competition for self-funding residents on which they relied to compensate for the deficit associated with council-funded residents.

There was also uncertainty about the effects of the changes following implementation of the Care Act 2014. This uncertainty may further reduce the willingness of providers to support the expansion of direct payments into residential care. A particular concern for providers mentioned in interviews is the potential financial impact of future changes relating to placements negotiated by councils for self-funded individuals. Project leads in councils also conveyed a sense of uncertainty about the impact of the Care Act 2014 on local provider markets. While the Care Act provided an opportunity for project leads to promote direct payments as part of the implementation of the Care Act, project leads also reported that restructuring undertaken in preparation for the changes led to a loss of staff and senior support and, in some councils, tended to undermine efforts to implement the direct payment trailblazer.



9. Outlook

The analysis presented in this interim report raises a number of questions for the remainder of the evaluation:

1. Which approach to direct payments in residential care is the most effective way to promote person-centred care with greater user choice in care homes?
2. Which approach to direct payments is least likely to disrupt or destabilise local provider markets or risk upward pressure on council budgets?
3. Which approach is least likely to generate inequalities between care home residents with direct payments and those without them?
4. More fundamentally, are direct payments a good way to promote more person-centred care with greater user choice in care homes?

Subsequent analysis of the data collected for this evaluation will aim to address these questions in more detail, for example, by comparing impacts and outcomes of direct payments between different models of calculating the monetary value of direct payments (i.e. based on a version of the RAS, based on the existing care home fee or using a fixed sum as additional payment). This will require that sufficient data will be collected in the survey of service users and their families for all three models (and, ideally, the different versions of each model). This in turn will depend on the numbers of services users offered direct payments during 2015 and on the response rates to the survey by service users and family members. The evaluation team is exploring, in consultation with the trailblazers and the Department of Health, additional options to increase participation in the survey, including increasing the number of users of direct payments to be interviewed.

Assessing impacts on care homes and local care home markets, for example through the survey of providers, will depend on care homes being exposed to direct payments for a period of time so that it is possible to distinguish potential/expected impacts (i.e. concerns) from actual impacts. This is more likely to be achieved if a model of direct payments can be found that is acceptable to care homes such that more care homes agree to participate in the trailblazer.



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Appendix

Methods section of research proposal

Research methods involving all sites

1. Telephone interviews in spring/summer 2013, 2014 and 2015 with a staff member responsible for leading the trailblazer in each of the 18 sites. The first round of interviews was conducted in July-September 2013, to collect information about the plans of each Trailblazer site, including the number and types of service users they are planning to involve, the number of providers that had volunteered to trial direct payments, and their expectations of the additional choices direct payment may be able to facilitate for users. Future interviews will explore the progress made in facilitating direct payments and experiences of collaborating with providers and of adjusting their processes (such as needs assessments or care reviews) to the use of direct payments if required.
2. Quarterly collection from trailblazer sites of key data, especially on numbers offered direct payments, numbers commencing direct payments, numbers of care homes participating, weekly direct payment amounts and weekly council payments to care homes (where direct payments cover only part of the fee). The first round of this data collection took place in November 2013.
3. A survey of a sample of providers in the 18 Trailblazers about their reasons for taking part (or otherwise) in the Trailblazers and their views about the likely impact on their work load, their current business model, their prices and the local provider market. This survey is aimed at scoping the issues experienced by providers and to provide the foundation for further exploration in a few selected sites (see below).
4. A cohort study of all residential care users who have been offered and accepted a DP for residential care and have capacity to consent to take part in the study. We plan to use the ASCOT instrument (Netten et al, 2011), when the person signs a DP agreement and 6 months and 12 months later. This will allow us to examine users' self-reported quality of life before and after they have received a DP. This survey would also involve collecting additional data about the users participating in the study, such as age, gender, user group, ethnicity, marital status etc. The survey is discussed further below. The survey questionnaire will be administered by the care manager responsible at the council for the user's care arrangements, when the user has been offered and accepted a DP and has signed (or is about to sign) the DP contract with the council (i.e. after an earlier care planning meeting between the care manager and the user and/or his family). This way it is ensured that the DP user has been using the DP for a length of time before the 6 months follow up.
5. Residential care users who have been offered a DP and have declined (i.e. non-DP users) will also be asked to participate in the survey. The survey will be similar to the one for users who have accepted a DP, with some additional questions about their reasons for declining. This questionnaire will be given out by the care manager as part of the care planning meeting with the user, after the user has been offered and has declined a DP. This data will be collected to understand the user's reasons for declining a DP and to explore whether this group systematically differs from the group of DP users. Data will be collected at the point of care planning (or review for existing residents) only, as there is no need for a follow up collection for the purpose of this study since the evaluation is not designed to compare DP users with those without a DP.



6. We envisage that the approach to using the ASCOT questionnaire will be similar to the one adopted by councils for the annual Adult Social Care Survey (ASCS), with the exception that the questionnaire will be handed to residential care users by care managers rather than sent by post, to ensure that the study is explained to users and/or their families appropriately and to maximise the completion rates. The questionnaire contains the ASCOT measures and other questions, e.g. about the DP user's experience of the process of setting up their DP and of choices facilitated by their DP. The availability of data from this survey for supported care home residents will enable us to compare the characteristics of those offered DPs for residential care with supported care home residents more generally, but it is not our intention to treat the ASCS sample of care home residents as a control group for this study.
7. A survey of family members of residential care users taking up a DP (DP users) and of those who have declined a DP (non-DP users). This survey will encompass some of the questions included in the survey of DP users and non-DP users, respectively, as they are relevant to carers and/or can be answered from the carer's perspective. The survey will be given out by the care manager alongside the questionnaire for DP users/non-DP users. This survey will explore the role of family carers, many of whom will be supporting the residential care user in the day-to-day management of the DP, and their perception of the impacts and value of DPs. Their perspective will be particularly important to understand the impact of DPs on users lacking capacity (who have been excluded from the user survey for reasons of feasibility and research ethics).
8. An estimation, data permitting, of the costs of facilitating DPs to councils and the costs of taking up DPs for users and/or families. These estimates will depend in large part on whether there are sufficient numbers of users taking up DPs for different sorts of services to enable robust estimates of costs to be calculated, as well as whether councils are successful in establishing the costs of DPs and remaining services.
9. An estimation of the relative cost-effectiveness of different approaches to providing DPs (part or full payment), depending on whether it is feasible to collect sufficiently robust information on the costs of DPs and other costs arising from their use. We will attempt to relate these costs to the likely benefits of DPs for services users, with the caveat that sufficient data are required on both benefits and costs to calculate robust estimates.

Research methods involving a sample of sites only

10. Face-to-face, more detailed interviews with project leads in councils and other relevant staff, including frontline staff, at 3-4 sites selected on the grounds of their different approaches to deploying DPs (up to 5 interviews per site). It will be particularly relevant to interview frontline staff such as social workers and care managers as they will be key in facilitating the use of DPs in residential care. They will also be able to report about any challenges in implementing DPs experienced by users/families, providers and themselves. These interviews will be undertaken in two rounds (in year 1 and year 2) to explore and contrast their expectations and experience of working with users who have taken up a DP.
11. Face-to-face, more detailed interviews with managers (and potentially owners where appropriate) of selected providers in the same 3-4 areas, to further explore what impacts the introduction of DPs for some of their residents has had on the day to day management of the care home (e.g. changes in staff working patterns)



and to their business model. The perspective of providers and their staff will be important to understand the challenges (if any) for providers arising from DPs and to assess whether these have an impact on the viability of providers and the stability of the provider market. These interviews will be undertaken in two rounds (see interviews with project leads and frontline staff).

12. Face-to-face interviews with 20-25 service users about their experience of DPs (e.g. during admission to residential care or at the 6 months review). Interviews will be semi-structured and themes covered will include the reasons for taking (or not taking) up DPs, the management of DPs and support received to facilitate this; and the benefits in terms of greater choice and control. These interviews will be held within the 3-4 sites, to be able to cover some of the diversity associated with different user groups and fee levels covered by the payment. In cases where the service user is believed by social services staff to lack capacity to consent to be interviewed, we will follow the procedures of the Mental Capacity Act if inclusion in the study of this group of users is approved by SCREC (see below).

Other methods, not involving sites

13. Telephone interview survey of a stratified sample of non-Trailblazer local authorities looking at their perceptions of the likely benefits and costs of offering DPs in residential care in future, their concerns about the scheme, and their plans setting out how they intend to implement DPs for residential care from April 2016.
14. Face-to-face interviews with a small number of DH officials involved in developing the policy on DPs and responsible for delivery of the Trailblazer programme at national level, to understand their plans for DPs, how DPs are likely to link with other on-going policy changes that affect adult social care, such as the introduction of the cap on care fees for those who have the means to fund their own care.
15. A limited number of face-to-face or telephone interviews with representatives of provider umbrella organisations, relevant voluntary organisations and local authority social services (e.g. ADASS; Age UK). Their perspectives will be relevant to provide the background of changes in relation to adult social care, the challenges the sector is facing, and the contribution DPs are likely to make to improving service users' experience of their residential care.
16. A synthesis of the likely limited evidence on the costs and benefits of relevant DP schemes in social care in the UK and selected other countries. We have been asked to provide such an overview to inform our and the DH's thinking about DPs.

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