

Evaluation of Direct Payments in Residential Care Trailblazers

Final report

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Glossary

Direct payment	<p>A monetary payment made by local councils to individuals to meet some or all of their eligible care and support needs. The direct payment can be paid to the service user or to a family member or representative.</p> <p>This study distinguishes between ‘full’ and ‘part’ direct payments in residential care.</p> <p>A full direct payment is where the direct payment comprises the total sum of money (or entire personal budget) allocated to the service user to pay for their residential care. The full direct payment can include or exclude the user’s contribution i.e. it can be paid gross or net; contributions include, for example, a state or private pension. The full direct payment is normally used to pay for the whole care home fee.</p> <p>A part direct payment is where the direct payment is only part of the sum of money (or personal budget) allocated to the service user. The remainder of the personal budget is then managed by the council to pay for the service user’s care, i.e. it covers most of or the entire care home fee.</p>
Indicative budget	<p>An indicative budget is a sum of money resulting from a council’s assessment of the social care needs of a service user using a resource allocation system. The indicative budget is often reviewed against other criteria such as the fees charged by care homes appropriate for the level of need identified. The application of these considerations then results in a personal budget.</p>
Personal budget	<p>An allocation of funding from the local council to a service user based on an eligible assessed social care need. Personal budgets can be taken as a direct payment paid to the service user (or family member or representative on their behalf) or they can be managed by the council or a third party organisation on behalf of the user (in which case it is also referred to as an ‘Independent Service Fund’).</p>
Personal expenses allowance	<p>A personal expenses allowance is a weekly allowance (currently nationally set at £24.90) which councils are required to disregard when assessing user charges for residential care. While most sources of income are taken into account in the means test for residential care, the service user must be left with (at least) the personal expenses allowance.</p>
Personalisation agenda	<p>A government policy that aims to promote the delivery of public services that are tailored to both the needs and the preferences of citizens. In adult social care, personalisation is often equated with ‘choice and control’, although some have argued that the two concepts are not entirely identical.</p>
Project lead	<p>The council officer designated in each local authority participating in the trailblazer programme to lead their scheme.</p>
Residential care	<p>Long-term care provided to adults who stay in a residential setting rather than in their own home. In this study, residential setting relates to all registered care homes, including those that provide both nursing and personal care (nursing homes), and those that provide only personal care (residential care homes). Other care settings, such as extra housing, are excluded for the purpose of this study, as it was possible to receive a direct payment under community care arrangements in these settings before the trailblazer scheme commenced.</p>



Resource allocation system (RAS)	A mechanism for calculating an indicative budget or direct payment based on the care needs of a service user. A resource allocation system matches different levels of need to different levels of social care funding.
Support plan	A support plan is a document describing how an individual will use their personal budget to meet their support needs and achieve their identified outcomes. The support plan is usually developed by a social worker in cooperation with the service user and/or the family member and should be reviewed annually.
Third-party top-up payments	In residential care, individuals and their family members may decide to choose a care home whose fees exceed their personal budget. In this case, the family member (third party) may choose to make an agreed additional payment to cover the difference between the care home fee and the personal budget.
Trailblazer site	A council (borough, metropolitan district or shire county) with social services responsibility (CSSR) that has been selected to participate in the trailblazing scheme to test how direct payments can be used in residential care.



List of abbreviations

ADASS	Association of Directors of Adult Social Services
ASCOT	Adult Social Care Outcomes Tool
ASCS	Adult Social Care Survey
CQC	Care Quality Commission
DH	Department of Health
DP	Direct payment
DWP	Department for Work and Pensions
LA	Local authority
LCC	Local county council
LSE	London School of Economics and Political Science
LSHTM	London School of Hygiene and Tropical Medicine
MCA	Mental Capacity Act
PB	Personal budget
PIRU	Policy Innovation Research Unit
PSSRU	Personal Social Services Research Unit
RAS	Resource allocation system
SCIE	Social Care Institute for Excellence
SCREC	Social Care Research Ethics Committee



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Summary

In 2012, the Department of Health (DH) decided to test the extension of direct payments from 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. In late 2013, DH commissioned the Policy Innovation Research Unit (PIRU) to conduct an independent evaluation of the pilots, now called 'trailblazers'. This followed a scoping study conducted by PIRU in 2013.

The objectives of the evaluation were:

- To understand the different ways in which direct payments were 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).

Data collection

This final report of the evaluation of the trailblazer programme presents findings based on the following data collection methods:

- Baseline surveys of service users and family members who had accepted or declined the offer of a direct payment and, for those accepting a direct payment, a follow-up survey after 6 months.
- A web-based survey of care home providers whose trailblazer council had informed them about the direct payment scheme, to capture the views and experiences of care home managers and owners.
- Annual semi-structured interviews with project leads in participating councils.
- Semi-structured interviews with council and care home staff in four sites selected to examine the diversity of approaches to implementing direct payments.
- Face-to-face semi-structured interviews with service users and telephone interviews with family members accepting or declining a direct payment.
- Semi-structured interviews with representatives from national stakeholder organisations.
- Five case studies of individual users detailing the process of setting up direct payments.

Models of direct payments in residential care trailblazer sites

Three models of direct payments in residential care emerged during the programme. They differ in how the monetary value of the direct payment relates to the fee charged by the care home.

Model 1 involved basing the direct payment on the care home fee and making this payment available to the service user in full (minus the user's contribution).

Model 2 involved basing the direct payment on the care home fee (minus the user's contribution) but with only some of this money made available to the service user while the council continued paying the remainder to the care home.



Model 3 involved making an additional sum of money available to the service user to be spent as a direct payment, while the council continued to pay the care home fee in full (minus any user contributions).

Number and size of direct payments

Of the 20 original trailblazer councils in 2013, 14 remained at the end of the programme (September 2015). Of the remaining councils, two did not provide information for the evaluation and a further two were unable to arrange any direct payments in residential care. By the end of the programme, 71 people had accepted direct payments across all trailblazer sites and 40 direct payments were active. By March 2016, the number of active direct payments in care homes had reduced to 29 in nine councils. There were 19 active full direct payments (Model 1) and 10 active part direct payments (Models 2 or 3), with one trailblazer site accounting for 12 of the 29 direct payments. About three-quarters of the direct payments were for older people in residential care with the remainder for younger adults with learning disabilities, physical disabilities or mental health problems.

The total weekly cost of the 29 active direct payments in March 2016 was almost £9,000. The smallest monetary amount for a single direct payment was £8 per week for a part direct payment, while the largest was £1,250 per week for a full direct payment covering the whole care home fee.

The low uptake of direct payments limited the amount of data that could be collected from service users and family members. Findings have, therefore, to be interpreted with some caution.

Cost of administration and management

Most of the nine trailblazer councils that provided information on the administrative costs of their trailblazer scheme indicated that these costs had been fully met by their DH grants. Sites received £69,000 over three years to cover their administrative costs of running the programme; the four sites selected for the collection of additional qualitative data received an additional sum of £4,000 to £5,000 per year, totalling £85,000 over three years. There was considerable variation between councils in the number of full-time equivalent staff deployed on the schemes. All reported additional work for council staff working on administrative processes, or financial systems, or other IT or similar services, and all but one reported additional work for frontline care managers or other professional staff employed by the council.

Views and experiences of service users and family members

Sixty-eight completed baseline questionnaires were received by the end of March 2016. This included responses from 19 service users who had accepted a direct payment, 14 family members whose relatives had accepted a direct payment (including five from relatives of users who had also provided a completed questionnaire), seven service users who had declined a direct payment, and 28 family members of people who had declined a direct payment (including three from relatives of users who had also provided a completed questionnaire). A further eight questionnaires from four service users and four family members were returned at the 6-month follow up stage (including one service user whose family member also completed a questionnaire).



Thirty-four interviews were conducted with 25 family members and 8 service users between January 2015 and February 2016. Of the interviews with service users, six had accepted and two had declined a direct payment. Two service users who had accepted a direct payment participated in a follow-up interview.

In the survey, 13 out of 20 service users/family members who had taken up a direct payment said that they were very satisfied or fairly satisfied with the direct payment and seven said that they were neither satisfied nor dissatisfied. These respondents included people who were already in receipt of a direct payment (i.e. the direct payment was 'active') and people who had yet to receive a direct payment.

Among those interviewed who had an active direct payment, the picture was mixed, with some indicating that they were very satisfied with their direct payment, while others said that they would have been more satisfied if the direct payment had offered more relevant choice (although it was not always clear whether respondents were referring to their satisfaction with the direct payment or with the care home's services more widely). Among those who indicated satisfaction with their (part) direct payment, some welcomed the opportunity to access additional or different services such as day activities. A number of family members noted that they felt empowered by having more control over the budget. This view was also shared by some of those who had accepted, but not yet received, a (full) direct payment. The majority of those interviewed who took up a direct payment had lived in a care home for less than five years and many had had experience of using direct payments in community care. Those who were critical about direct payments tended to feel that they had received (too) little information and guidance on using a direct payment.

Service users and family members who declined a direct payment indicated that satisfaction with the quality of care in the care home was their main reason for declining. Some also expressed concerns that direct payments could disrupt the home's already high standard of care.

Findings highlighted the role of family members, care workers and advocates in facilitating service users' access to, and the use of, direct payments. Service users described the help they received from others to organise and to administer the direct payment. Some family members expressed doubts that service users could manage the direct payment on their own, both financially and with regard to using the direct payment to exercise choice and control over their services. In two follow-up interviews, service users expressed disappointment about the quality and frequency of information they had received after they decided to accept a direct payment.

Views and experiences of council staff

Forty-seven interviews were conducted with council staff involved in implementing the direct payment scheme. These comprised 26 interviews with project leads in two rounds and 21 interviews with frontline and other council staff involved in implementing the scheme in five sites.

Interviews with project leads and other council staff showed a high level of support for the idea of personalising services in residential care, but many were unsure about whether and how a direct payment would lead to more personalisation.

Those council staff engaged in implementing direct payments frequently found this to be a long and resource intensive exercise requiring substantial co-ordination, co-



operation and agreement between care home and council staff as well as service users and their families. Some staff revealed that they lacked confidence to promote the scheme to others and many reported difficulties engaging providers. However, most council staff recognised the benefits that direct payments had for some individuals who had participated in the scheme, notably for younger people with funding for day services that could be used as a part direct payment.

Council staff reported that it was more difficult to set up direct payments for older people, with the exception of those instances in which older residents received a full direct payment to cover their care home fees. Yet, while this gave users and families more control over the budget, at the time of the trailblazer this did not necessarily result in any additional choice over services received. Council staff also reported that implementation of the trailblazers was hampered by the preparations for the implementation of the Care Act 2014, the impact of ongoing adult social services budget cuts and substantial staff turnover in trailblazing sites.

Views and experiences of residential care providers

The survey of providers included responses from care home managers and owners in 85 care homes. These include 70 care homes that had no direct payment holder and 15 care homes with at least one resident with a direct payment. Nineteen interviews were conducted with managers and owners of care homes in the five sites selected for more detailed study on the basis that they represented different approaches to implementing direct payments in residential care.

Respondents without a resident with a direct payment had a number of concerns about direct payments: the appropriateness of direct payments for older people with dementia; the shift of responsibility for managing the payment from councils to users and their families who might not be willing to take on this additional task; and the potential financial risks to providers arising from direct payments. Among those providers that had at least one resident with a direct payment, views were divided on whether these residents were more likely to receive types of care and activities they preferred than those without a direct payment. A majority (9 out of 13) stated that having a resident with a direct payment increased demands on staff time.

Findings from interviews with care home owners and managers also indicated concerns about the feasibility of introducing direct payments in care homes. These included, in 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, and about whether the direct payments would provide real benefits to residents and their families. There was substantial scepticism as to whether having a direct payment would necessarily translate into enhanced choice and control over services received. Respondents providing residential care for younger adults tended to be more positive about the potential benefits of direct payments. However, among those caring for older people, scepticism prevailed as to whether direct payments would be able to bring about a more personalised service, especially given the current financial constraints. Managers and owners of care homes also questioned whether it was always appropriate for relatives to act and decide on behalf of service users in relation to their direct payment.

Findings from the survey resonate with findings from more detailed interviews with care home providers. Managers and owners of care homes for younger adults and older people differed in their views as to whether direct payments could achieve more



choice and control for their user group, with providers of residential care for older people more sceptical than those caring for younger people. These differences also reflect variations in care home fees and business models underpinning residential care provision for the two user groups.

Conclusions

This evaluation has a number of limitations principally as a result of the low uptake of direct payments by residents in care homes, which has limited our ability to collect interpretable quantitative data on outcomes and quality of life. However, the extensive number of interviews and the surveys support the following conclusions:

1. Some service users and family members benefitted from having a direct payment. In some of these cases, it offered a solution to a specific problem (e.g. self-funding service users who had become newly eligible for council funded residential care could remain in the same care home, although this typically incurred higher costs to the council or top-up payments by relatives). In other cases, service users previously holding direct payments in the community could continue to have control of their own budgets when entering residential care. However, the low uptake suggests that direct payments were not as attractive to service users and their families as had been expected, implying that potential benefits of direct payments were not self-evident to all prospective user groups.
2. The effect of direct payments in residential care on people's ability to exercise more choice and control over their services depended on the model of direct payments offered by councils and/or selected by service users and their families, and the funding arrangement underpinning each model. A direct payment covering the whole care home fee (i.e. representing a person's entire personal budget) seemed easier to be set up for councils, but was less likely to offer service users greater choice (although some reported a greater sense of control). A part payment was more difficult to implement unless specific funding was available that could be deployed in addition to the care home fee. If such funding was available, then it would more likely increase user choice anyway without the need for a direct payment.
3. The use of direct payments and their effects reflect differences in funding of residential care for different age groups. While older people (over 65 years) represented about three-quarters of all service users with a direct payment, they were less likely to experience increased user choice from having a direct payment, compared with younger adults. These differences appear to reflect underlying differences in funding available for younger and older people in residential care, with placements for people over the age of 65 years often attracting significantly less funding in relation to their needs than placements for younger people, allowing for less flexibility in the use of resources.
4. The findings also suggest that the cost of implementing the scheme was high in relation to its modest outputs. Setting up direct payments typically took a significant amount of time and effort for council staff and providers, as well as for service users and/or their family members. While some of the problems encountered may have been 'teething' problems – expected in any relatively novel programme, the findings suggest that setting up and managing direct payments incur extra transaction costs, including costs for organising activities or services that are intrinsic rather than likely to reduce over time. It is at least conceivable that similar (or better) effects could be achieved by other means: some interviewees suggested that more personalised services could be achieved irrespective of a direct payment.



1. 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 are not available in residential care other than for short periods of respite care. In July 2012, the Department of Health (DH) invited councils (local authorities) in England to express interest in becoming 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 (Law Commission, 2011).

Twenty local authorities were selected to pilot whether and, if so, 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 potentially increasing service user choice over how their assessed social care needs were met and promoting more personalised care in care homes. Amended regulations came into effect in November 2013 to enable direct payments in residential care to be legally disbursed in these pilot council areas. The DH provided financial support and advice to the pilot councils and commissioned the Social Care Institute for Excellence (SCIE) to organise regular meetings with project leads.

The Government decided in 2013 to empower all councils to offer direct payments in residential care from April 2016. Pilot sites were then re-designated as ‘trailblazers’ to reflect the new purpose of the scheme, which was to prepare for the introduction of direct payments in residential care nationally and to provide other councils not involved in the trailblazer programme with an opportunity to learn from the experience of the sites. Of the initial 20 councils invited to participate in the pilots in 2013, 14 remained at the end of the programme (September 2015). Of those councils, two did not provide information for the evaluation and a further two did not arrange any direct payments in residential care.

The DH 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 by PIRU in 2013. The evaluation team comprised 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 were:

- To understand the different ways in which direct payments were 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 fourth and final report from the independent evaluation of the trailblazers. A scoping report was published in autumn 2013 (Ettelt et al., 2013), a first interim report in January 2015 and a second interim report in November 2015. This report incorporates material from the interim reports and in effect supersedes them.



The aim of this report is to present a complete set of findings from all parts of the evaluation, which comprised: a survey of users and their family members; interviews with trailblazer leads, care home managers and council staff; interviews with users and family members, and with representatives of national organisations; and a survey of providers involved in trialling direct payments in residential care in the trailblazer programme.

It was the intention that the evaluation would inform guidance about the national roll-out of direct payments in residential care developed by DH. DH announced in January 2016, however, that the national roll-out of direct payments in residential care was postponed to 2020.



2. The Direct Payment in Residential Care Trailblazer programme

Direct payments have become a key mechanism by which people eligible for council funding are enabled to purchase their own care to meet their social care needs. These so called ‘cash-for-care’ payments provide an individual, their family members or representative, with cash in lieu of direct service provision, so that they can have greater choice of and control over how their social care needs are met. The current policy position in England is that people who are assessed as eligible for council-funded community (domiciliary) care have a right to a direct payment, and local councils have a duty to make them available to anyone who is able to manage them, either alone or with the assistance of a named person. However, residents of care homes have formally been excluded from having a direct payment for long-term residential care, with the exception of those placed by councils that became trailblazing sites. This has remained in place with the exception of those areas participating in the scheme, although direct payments are available in some instances to fund short stays in care homes (i.e. respite care) and to long-term residents in supported living arrangements that count as community care.

This chapter provides a brief overview of the background of direct payments and personalisation policies and outlines the policy objectives behind the direct payment in residential care trailblazers. It describes the selection of trailblazing sites and the support received by sites from the centre, and explains the process of identifying and commissioning the evaluation team.

2.1 A brief history of direct payments in adult social care

Direct payments were first introduced in 1997 under the Community Care (Direct Payments) Act 1996 for people with disabilities aged 18 to 64 years and have gradually been extended to all service user groups. Despite substantial enthusiasm for direct payments, especially among people with disabilities and their relatives, the initial uptake of direct payments was relatively slow and has remained uneven among councils. A number of reasons have been identified explaining the slow uptake of direct payments in the community, including a disinclination among some social workers and other frontline staff to promote direct payments to service users and the lack of support schemes for some user groups (DH, 2005a, Priestley et al., 2007, Fernandez et al., 2007, Ellis, 2007b, Taylor, 2008, Carr and Robbins, 2009). In 2003, the Government imposed a duty on councils to provide direct payments in the community (Gheera, 2012). From November 2009, direct payments were extended to service users lacking mental capacity if a ‘suitable person’ (family member or friend) is available to manage the payments on behalf of the person (Gheera, 2012). This group had previously been excluded from receiving a direct payment.

Since the mid-2000s, direct payments have also become a key approach for the Government to deliver its transformation agenda for social care, set out in the White Paper *Putting People First* (DH, 2007). This agenda promotes ‘personalisation’ in social care, which is understood as providing those needing social care and eligible for council funding with more choice of and control over services provided to them, as well as promoting a more personalised approach to commissioning services.

This agenda also saw the introduction of personal budgets in adult social care. Personal budgets refer to the allocation of funding from the council to a service user to reflect an assessed care need. Personal budgets can be taken either wholly as a direct payment, which is paid to the service user or carer directly, or managed by the council or third party organisation on behalf of the user (the latter option



often being referred to as an ‘Independent Service Fund’). It can also be taken as a combination of both i.e. part of the personal budget is taken by the user or carer as a direct payment with the remaining part managed by the council (Slasberg et al., 2012). Personal budgets have gradually been rolled out since 2008, yet the number of people having a personal budget varies substantially among councils (Glasby and Littlechild, 2016). Since April 2015, councils are required to provide all recipients of council-funded adult social care with a personal budget, irrespective of whether they receive care in their own home or in a residential care setting.

Despite the Government’s stated preference for direct payments over other approaches to personalising the response to meeting people’s eligible social care needs, the uptake of direct payments has remained relatively modest in the community. In 2013-14, only around 15 percent of adults eligible for council support for domiciliary care opted for a direct payment (NAO, 2016). Younger adults, i.e. those in the age group of 18 to 64 years with physical disabilities, were more likely to opt for a direct payment than other user groups, such as older adults and people with mental health problems (Fernandez et al., 2007). Although there is limited data on how direct payments are used in the community, the evidence suggests that the majority use their direct payment to employ a personal assistant. Figures presented in a recent report by the National Audit Office state that 42 percent of all adults and 66 percent of adults with physical disabilities aged 18 to 64 years use their personal budget (often accessed as a direct payment) to purchase services from a personal assistant (NAO, 2016).

There are restrictions on the use of direct payments. Currently, except in the trailblazer councils, direct payments cannot be used to pay for long-term care provided in a care home, but they are available for respite care for up to four consecutive weeks a year. However, direct payments can be used by people in care homes for non-residential care services, for example, to pay for a day care place or an alternative day-time activity (Independent Age, 2015). Direct payments cannot be used to purchase local authority services nor can they be used to pay relatives living in the same accommodation, although there may be exceptions (Gheera, 2012).

2.2 Personalisation

The agenda of promoting direct payments in adult social care and other sectors is closely linked to the policy aim of improving personalisation. ‘Personalisation’ has been promoted as *“the process by which services are tailored to the needs and preferences of citizens. The overall vision is that the state should empower citizens to shape their own lives and services they receive”* (Cabinet Office, 2007). From the mid-2000s onwards, personalisation has become one of the broad goals of social care reform although there are continued debates about the exact meaning of personalisation and the strategies underpinning the agenda to promote more person-centred care (Needham, 2011). In community care, the use of direct payments has somewhat narrowed the meaning of personalisation to user choice and control over services and support (Duffy, 2007). This link has been firmly established in the independence movement through the concept of ‘self-directed support’ (Duffy, 2007).

In residential care, in contrast, the link between personalisation, choice and control, and direct payments is less obvious and less well established. Indeed, care homes are often seen as places where people become ‘institutionalised’ and so are less able to live according to their personal preferences. A recent scoping study observes an unmet need for choice and control among older people in care homes with high



support needs, and that improved choice and control could increase their feeling of autonomy and thus their quality of life (Bowers et al., 2009). Studies also suggest that having a sense of control increases the quality of life and well-being of care home residents (King et al., 2012, Simmons et al., 2014, Hamilton et al., 2015, Bowers et al., 2009). Sandberg et al. (2001) note that entering residential care is often experienced as a loss of control over one's life.

Other studies, however, suggest that older people in care homes experience more control over their daily lives than some of those living in their own homes, challenging the view that living in residential settings is necessarily associated with less autonomy than living at home (Callaghan and Towers, 2014, Hillcoat-Nallétamby, 2014, Darton, 2011). Lewis and West (2014) go further and question the relevance of user choice for improving the quality of life of older people in residential care. In their view, the nature of the interaction between service user and care worker – the care relationship – can be more important for residents than choice. In a similar vein, Barnes (2011) argues that the policy narrative of personalisation seems to privilege choice and control over 'care', with the latter being associated with dependency and paternalism rather than empowerment. 'Care' may, therefore, become reserved for those not able to exercise choice and control.

The financial context of care provision also matters. While most practitioners and commentators agree that care home residents should receive personalised services, many acknowledge that there are limits to what can be achieved under current financial and organisational arrangements. For example, Bowers et al. (2001) demonstrate that social care staff have limited time to attend to individual residents and that time pressures crowd out activities that might be valued by residents but considered 'optional' by staff.

Taken together these studies suggest that the issue of personalisation in care homes may be more complex than assumed and that choice and control associated with having a direct payment may not automatically translate into more personalised care.

2.3 Evidence of impact of earlier direct payment or similar 'cash for care' schemes

There is now substantial experience of implementing direct payments and other 'cash for care' schemes in the community in England and elsewhere. This section provides a brief overview of relevant findings on the subject, focused on those aspects relevant to this evaluation. More substantial reviews of the effects of direct payments and the barriers to their implementation in community care have been published elsewhere (Ottmann et al., 2009, Gadsby, 2013, Glasby and Littlechild, 2016).

In England, uptake of direct payments in the community has been uneven (Fernandez et al., 2007, NAO, 2016). Younger adults with physical disabilities are more likely to take up a direct payment than older people, with older people feeling less confident than younger people in managing the responsibilities of an employer. Although initiatives such as the Individual Budget pilots programme have specifically aimed to expand access to direct payments (as a way of taking an individual budget) to older people, champions for direct payments have typically come from the disability movement but less so from older people themselves. There have been different explanations for the low uptake of direct payments among older people. One explanation offered is that direct payments have been mostly used to enable



recipients to employ their own carer or personal assistant (Lymbery, 2014, Wanless, 2006), with older people feeling less confident in managing the payment and employing their own staff than younger people.

Findings from the evaluation of the Individual Budgets pilots suggest that service users with an individual budget were more likely to report feeling in control of their daily lives and the services delivered to them compared with individuals in the control group (Glendinning et al., 2008). There was a suggestion that individual budget users had slightly better outcomes than service users without a budget, but these differences were not statistically significant. The study also showed that service users with higher cost support (i.e. larger budgets) achieved better social care outcomes than those with lower cost support. However, older people with an individual budget reported lower psychological well-being than those in the control group, with many indicating that they did not want the 'additional burden' of planning and managing their own support (Glendinning et al., 2008).

Findings from the Personal Health Budget evaluation suggested that personal health budgets had a positive impact on users' well-being and care-related quality of life, but little impact on their health status and no impact on mortality rates (Forder et al., 2012). However, health-related quality of life was not significantly improved in the budget group compared to those without a budget. Positive effects were limited to those under the age of 75 years and high-cost health budgets (£ 1,000 and over) were more likely to produce a positive impact on care-related quality of life and psychological wellbeing than lower cost budgets (Forder et al., 2012).

2.4 Experience of implementing direct payments or similar 'cash for care' schemes

In England, direct payments have been available in community (domiciliary) adult social care for selected groups and services since 1996 and are now available to almost all users assessed as needing community-based social services. However, despite the length of experience, the uptake of direct payments in the community has remained relatively low (DH, 2005b, Ellis, 2007a, Fernandez et al., 2007, May et al., 2007, Priestley et al., 2007, Taylor, 2008, Carr and Robbins, 2009, NAO, 2016).

While directing social care funds to service users sounds straight-forward in theory, establishing these schemes has been challenging (Ellis, 2007a, Glasby and Littlechild, 2002, Carmichael and Brown, 2002). In particular, the provision of direct payments and other 'cash for care' schemes required substantial changes in the beliefs, attitudes and behaviours of social care professionals both at the frontline and among the local leadership and senior management. There has been much debate about the impact of professional 'gatekeeping', suggesting that frontline staff regulate access to direct payments by selecting only those individuals whom they think direct payments might benefit. The reasons for adoption of selective rather than universal approaches include a perception that direct payments challenge professional norms and established practices (Taylor, 2008, May et al., 2007, Glasby and Littlechild, 2002, Priestley et al., 2010, Ellis, 2007b).

Further challenges to implementation have also been identified as arising from the structural and contextual factors of adult social care provision in England, especially the constraints in social care funding, the structure of the adult social care market and the mutual dependencies between providers, commissioners and recipients



of council-funded care (Glendinning et al., 2008). It has been argued that direct payments and other types of user-controlled budgets can only be useful to service users if the care market provides sufficient services to choose from and if there is sufficient funding available for users to access these choices. This is especially relevant for older people since funding is lower for them than for younger adults.

2.5 Policy objectives

In 2011, the Law Commission recommended that people with an eligible assessed care need should have access to direct payments in all settings, including in residential care (Law Commission, 2011). Specifically, the Law Commission noted that:

“extending direct payments to cover residential accommodation [...] would give some service users greater choice and control over the provision of accommodation and would mean they no longer have to rely on their preferences being acknowledged and implemented by local authority staff. Although direct payments would not be suitable for all people moving into residential care, in many cases the option of direct payments will be appropriate and we see no reason in principle for excluding people merely on the basis of the type of service being provided.” (Law Commission, 2011: 102-103)

However, the Law Commission also acknowledged that there are “practical questions concerning the economics of care home provision” that needed to be resolved for direct payments to be beneficial to care home residents and to society as a whole (Law Commission, 2011: 103).

In its 2011 White Paper *Caring for our future*, the Government agreed to test direct payments in residential care by initiating a pilot scheme in a number of councils in England.

“As part of our ambition to help more people experience the benefits of a direct payment, we will develop, in a small number of areas, the use of direct payments for people who have chosen to live in residential care, in order to test this approach.” (HM Government, 2012: 55)

In autumn 2013, the pilot scheme was rebranded as a ‘trailblazer’ programme, indicating the Government’s intention to make direct payments available to all eligible service users nationally by April 2016, with the national roll-out expected to coincide with other measures of social care reform resulting from the Care Act 2014. These measures – now postponed to 2020 – would have introduced a ‘cap’ on the costs of care for individuals who fund their social care support themselves and a duty on councils to arrange care for self-funders if requested.

2.6 Councils participating in the trailblazer programme

In July 2012, the Government invited interested councils in England to test the introduction of direct payments in residential care. Twenty councils were selected to participate. Two councils dropped out during the preparatory phase (March to December 2013) leaving 18 sites to continue as trailblazers during the period of the main evaluation (January 2014 to September 2015). Four more councils officially left the programme during the main evaluation. Two of the remaining 14 sites did not supply any data during the main evaluation, suggesting that they had left the programme without giving formal notice. The main findings therefore relate to 12



trailblazer councils. Two further sites supplied data but had no service user with a direct payment by the end of the programme.

The 18 trailblazer sites participating in the programme during the preparatory phase covered a variety of geographical regions (Table 2.1) with a total population of 9.4 million, about one fifth of the population of England.

Table 2.1 Geographical regions and populations included in participating councils in 2012

Council	Region	Type	Population 18 to 64 (000s)	Population 65 & over (000s)
Bristol	South West	Unitary	292	57
Cornwall	South West	Unitary	314	97
Dorset	South West	County	227	120
Enfield	London	London Borough	202	40
Gateshead	North East	Metropolitan District	124	36
Havering	London	London Borough	146	44
Hertfordshire	East	County	696	182
Hull	Yorkshire & Humberside	Unitary	166	37
Lincolnshire	East Midlands	County	428	156
Manchester	North West	Metropolitan District	350	48
Milton Keynes	East Midlands	Unitary	162	30
Norfolk	East	County	507	195
North Lincolnshire	Yorkshire & Humberside	Unitary	101	32
Nottinghamshire	East Midlands	County	481	150
Redbridge	London	London Borough	184	34
Staffordshire	West Midlands	County	516	165
Stockport	North West	Metropolitan District	171	53
Surrey	South East	County	697	203
Total			5,764	1,672

Three councils involved were London boroughs, three were metropolitan districts, five were unitary authorities and seven were county councils. Their older populations (aged 65 and over) varied in size: nine had older populations of less than 50,000, four had older populations between 50,000 and 150,000, and five had older populations exceeding 150,000.



The socio-economic characteristics of the older populations in the trailblazers also varied considerably as follows:

- The proportion of the total population aged 65 years and over was around 18 percent across all trailblazer councils, varying from under 15 percent for five councils to over 20 percent for three councils;
- The proportion of older people living alone was between 32 percent and 38 percent for most trailblazer councils, but ranged from under 32 percent in four councils to over 38 percent in four councils.

The trailblazer sites supported 29,900 care home residents in total (excluding two areas which did not provide these data). These comprised 23,500 older residents (79 percent), 4,290 younger residents (aged 18-64 years) with learning disabilities (14 percent), 860 younger residents with physical disabilities (3 percent) and 1,260 residents with mental health problems (4 percent). These 29,900 supported residents comprised around 14 percent of all supported care home residents in England at the time.

Few of the councils (two or three in each case) were able to provide data on the numbers of NHS funded care homes residents, privately funded residents or residents funded by other councils in the care homes located within their area. This could have been useful information for selecting sites for more detailed study during the evaluation since the proportion of care home residents funded by sources other than the council may influence the way in which the introduction of direct payments for residential care affects the local care home market.

Fourteen councils reported holding contracts with a total of 2,375 care homes in their areas; the remaining four did not provide this information. Five councils had contracts with over 250 care homes in their area (highest number 385) and seven had contracts with fewer than 100 care homes in their area (lowest 40).

2.7 Central sources of support

The Department of Health provided financial support to councils so that councils could appoint an internal project lead to develop and implement the trailblazer scheme locally. Sites received £69,000 each over three years to cover their administrative costs of running the programme; the four sites selected for the collection of additional qualitative data received an additional sum of £4,000 to £5,000 per year, totalling £85,000 over three years. The Department also commissioned the Social Care Institute for Excellence (SCIE) to support the trailblazer programme through organising regular (four per year) workshops for project leads to discuss progress and share their learning and experience.

SCIE also provided and managed a dedicated on-line forum ('the Knowledge Hub') through which project leads and others (e.g. providers that project leads had involved in implementing the scheme) could exchange insights and experiences.

The Department also set up a Steering Group comprising key adult social care stakeholders including representatives from the Registered Nursing Home Association, Care England, Scope, Sue Ryder Care, Sense, SCIE, NHS England and the Department of Health. This group met twice a year in the first year of the evaluation and offered strategic advice to the programme. The evaluation team also reported to this group twice and received comments on its plans for the evaluation.



2.8 Commissioning of the evaluation

PIRU was initially only asked to undertake a feasibility and scoping study as part of its programme of work commissioned by DH as a DH core-funded policy research unit. This study was conducted between March and December 2013. Its aim was to provide a descriptive account of the characteristics, initial plans and progress of pilot sites in preparation for the main evaluation. The DH invited prospective evaluation teams to apply to conduct the main evaluation, but none of the proposals was seen as suitable and no team was selected. PIRU was subsequently asked to conduct the main evaluation.

The main evaluation was originally intended to be completed within two years i.e. by the end of December 2015. This was extended to June 2016 following a suggestion by one of the reviewers of the proposal to extend the period of follow-up of service users in receipt of a direct payment and their family members from 6 months to 12 months.

The evaluation was independent both of national policy and local implementation in that PIRU was not involved in the selection of pilot sites or in the decision to recast the programme as a 'trailblazer' scheme. The evaluation team also was not involved in designing any local implementation strategies and did not influence decisions by sites about the selection of service users or care homes. While trailblazer sites were asked to submit an estimate of the number of direct payments they expected to be able to achieve during the programme, these numbers were not used as targets by the evaluation or by DH. The evaluation team did not provide advice in response to queries from trailblazers relating to the policy but referred them to sources of guidance such as DH and SCIE.



3. The feasibility and scoping study

3.1 Objectives and methods

In March 2013, the Department of Health asked PIRU to conduct a scoping and feasibility study during the preparatory stage of the trailblazers, with the main evaluation expected to start in January 2014. Data collected for this report were interviews with project leads conducted between June and September 2013 in which project leads were asked to outline their plans for the trailblazers. In addition, the evaluation team asked project leads to provide an estimate of the number and types of service users to whom they aimed to offer direct payments. The chapter draws on these data. It presents the reasons given by project leads for participating in the programme and a description of the plans of the trailblazing sites based on information collected during the preparatory phase of the programme.

3.2 Reasons for participating in the programme

In July 2013, the Department of Health invited local authorities to participate in the scheme to develop the use of direct payments in residential care. Twenty pilot sites were selected by a sifting panel at the Department to participate in the scheme. Project leads interviewed for the feasibility report suggested a number of reasons for participating in the programme. Most leads stated that they expected that extending direct payments to care home residents would benefit service users, care providers and councils. The scheme also fitted well with the commitment of many councils to promote a more personalised approach to providing residential care as a way of improving quality of care and service user satisfaction and to increase the number of people taking up direct payments. It would also allow councils and providers to become better prepared for the upcoming funding reform in the sector that was expected to come into force in April 2016.

Many project leads highlighted the potential for the scheme to provide new ways of interacting with providers, and engaging in a dialogue, that might help to improve service users' experience of residential care. Councils were asked by the Department to describe their relationship with local providers and provide a list of providers interested in participating in the scheme. Most councils responded by noting that they had well established relationships with a number of care home providers and had structures in place (e.g. regular meetings of a local provider forum or care provider association) to facilitate collaborative work. Some mentioned that they intended to develop the pilot in partnership with providers. Most noted that they would focus on working with specific providers such as those with whom they had worked well in the past or whom they considered as innovative and interested in personalisation.

Some councils expected that participating in the trailblazers might force them to monitor more closely the costs of residential care and to develop a better understanding of the drivers of costs. This was particularly pertinent in areas in which councils considered themselves as 'price takers' rather than 'price setters' and where councils had little flexibility in contracting with providers due to a shortage of places and resources. Analysing the drivers of costs could also inform the dialogue with providers about the appropriateness of fees. Some councils had experienced legal challenges in recent years and were concerned about the adequacy and fairness of their funding arrangements with providers.

A few project leads felt that the scheme might help with cost savings to the council, as they noted that direct payments in the community were, in some cases, cheaper than council commissioned services as people only pay what they actually receive



rather than what the council commissions". However, in general it was felt that saving money was not the primary driver for implementing the scheme, although all councils initially expected the scheme to be at least cost neutral.

Project leads also suggested that providers might value the opportunity of being involved in the scheme for a number of reasons: to improve care for their residents; to participate in a high-profile government scheme; and to be at the forefront of innovative policy developments. Some also thought that providers could use the opportunity of this to gain a competitive advantage in attracting new clients.

3.3 Initial plans of trailblazing sites

In the preliminary scoping study most trailblazer sites expected to have direct payments set up by the end of 2013 and to start offering direct payments to service users and their families from the beginning of January 2014 or earlier. This was in line with the starting date for the trailblazers expected by the DH and reflected that enabling regulation had to be developed, which came into effect on 1st November 2013. However, some sites did not expect to be able to offer their first direct payment before March 2014. A number of sites encountered problems in the process of setting up the trailblazers and in planning the service changes required for offering direct payments. In some sites, these problems continued during the entire programme (Chapter 8). Prior to the start of the programme the research team asked project leads in each site to estimate the number and specify the 'user group' of participants they aimed to include in the trailblazer; to determine whether they planned to offer direct payments to existing residents of care homes or those newly admitted or both; and to estimate the number of care homes they expected to support the scheme (Table 3.1, see overpage).

3.4 Planned numbers of service users and user groups in trailblazer sites

In total, sites anticipated having between 435 to 500 service users in residential care with a direct payment during the life of the programme. This span resulted from some sites providing their target number as a range (e.g. '5-10' or '10-50'). These numbers indicate the number of service users that project leads in council sites expected to recruit at that time.

Sites varied with respect to the user groups to whom they wanted to offer direct payments during the trailblazer scheme. The majority of sites (n=13) indicated that they intended to include older people (aged 65 years and over) in the trailblazers; two sites planned to exclude older people at the initial stage of the scheme, with one site indicating that it planned to include this group at a later stage of the trailblazer. Older people, therefore, constituted more than half of the planned recipients of direct payments, with an estimated 285 to 300 older users of direct payments anticipated (Table 3.1).

Fourteen sites planned to offer direct payments to younger adults, i.e. those aged between 18 and 64 years, with learning disabilities, involving an estimated 86 to 132 individuals.

Ten sites planned to offer direct payments to younger adults with physical disabilities, around 40 individuals, and only four sites indicated that they planned to offer direct payments to younger adults with mental health problems, probably fewer than ten individuals.



Table 3.1 Plans for user groups, numbers of users per group and numbers of care homes in the trailblazers, by site, in October 2013

Site	User groups planned to be included in the trailblazers				Estimated number of users planned to be included in trailblazers				Number of care homes volunteering			
	Older people aged 65 and over	People 18-64 with learning disabilities	People 18-64 with physical disabilities	People 18-64 with mental health problems	Number of older people 65 and over	Number of people 18-64, learning disability	Number of people 18-64, physical disability	Number of people 18-64, mental health problems	Total number of people to be included	Number of people 18-64, mental health problems	Number of homes involved (total)	Number of homes providing nursing care involved
1	Yes	Yes	Yes	No	Not known	Not known	Not known	Not known	Not known	Not known	Not known	Not known
2	Yes	Yes	Yes	No	6	6	6	0	18	0	7	1
3	Yes	Yes	Yes	Yes	35	5	6	2	48	2	3	Not known
4	Yes	No	No	No	160	0	0	0	160	0	3	1
5	Yes	Yes	Yes	Yes	20	10	10	5	45	5	9-10	1
6	Yes	Yes	Yes	No	Not known	Not known	Not known	0	15-20	0	5	1
7	Yes	Yes	Yes	No	0	5-6	5-6	0	10-12	0	2	0
8	Yes	Yes	Yes	Yes	6	6	2	2	10-20	2	6+	1+
9	Yes	Yes	No	No	20-30	5-10	0	0	25-40	0	2	1
10	Yes	Yes	No	No	8	2	0	0	10	0	285	Not known
11	Yes	Yes	Yes	No	6	7	7	0	20	0	20	Not known
12	Yes	No	No	No	25	0	0	0	25	0	3	1
13	No	Yes	Yes	Not known	0	15	5	0	20	0	4-5	0
14												
15	No	Yes	No	No	0	10-50	0	0	10-50	0	25	0
16												
17	Yes	Yes	No	No	Not known	Not known	0	0	Not known	0	3+	Not known
18	Yes	Yes	Yes	Yes	Not known	Not known	Not known	Not known	20	Not known	8	6
Total					286-296	86-132	41-42	9	486-508	9	385-387	13



Project leads provided a number of reasons for including or excluding certain user groups in or from the trailblazers. Most indicated that they did not intend to purposefully exclude particular user groups, but that their decisions reflected a number of practical issues and concerns. Most commonly, the decision on user groups to be included reflected the residential population of the providers who had volunteered to support the trailblazers. These providers tended to already have an established relationship with the council. In addition, the sites which were particularly interested in testing direct payments for older people, noted that they wanted to test direct payments for this user group as it constituted the largest proportion of residents in care homes in their area, and their care had the largest impact on councils' budgets for residential care.

Previous experience of direct payments in community care has also shown that the uptake of direct payments was slow initially, with younger adults more likely to embrace options enabling more choice and control, but also involving more responsibility. There was a widely held view that young adults were more likely to benefit from having additional choices regarding their care; however, some conceded that this had not been tested for older people in residential care and hence should not be assumed. Others argued that direct payments should first be tested on disabled younger adults to understand the potential of direct payments to address some of the issues around placing younger adults in care homes, resulting from their often small numbers, highly complex needs and high prices charged for such places.

Other considerations included difficulties in involving different teams of social workers responsible for different user groups in the trailblazers; other ongoing changes that could affect the trailblazers, for example, ongoing organisational changes in services for people with mental health problems; and involving user groups whose care was mainly an NHS responsibility, such as people with mental health problems below the age of 65.

3.5 Plans to offer direct payments to existing care home residents or those newly entering a home

Sites varied with respect to whether they planned to include existing service users in residential care, or only new users of residential care (Table 3.2).

Some project leads indicated that, since only a small number of people with learning disabilities were newly admitted to residential care in any given year, there would be very few direct payment users in this group if eligibility was limited to new residents, especially as direct payments would be limited to those placed in homes that chose to participate in the trailblazers.



Table 3.2 Plans to offer direct payments to new or existing residents in care homes

	Plans to include existing residents	Plans to include newly admitted residents
Site 1	✓	✓
Site 2	✓	
Site 3	✓	✓
Site 4	✓	✓
Site 5	✓	✓
Site 6	✓	✓
Site 7	✓	✓
Site 8	✓	✓
Site 9	✓	✓
Site 10		✓
Site 11	✓	✓
Site 12	✓	
Site 13	✓	✓
Site 14	Not known	Not known
Site 15	✓	✓
Site 16	Not known	Not known
Site 17		✓
Site 18	✓	✓

3.6 Number of care homes participating in the programme

Almost all councils participating in the trailblazer programme indicated initially that they planned to offer direct payments to residents in care homes that opted to participate in the scheme. Only one site planned to offer direct payments to residents of all the care homes in its area (n=285). The remaining sites planned to offer direct payments to residents of a total of around 100 care homes.

The number of care homes choosing to be involved varied substantially between sites, ranging from 2 to 25 care homes, excluding the one outlier planning to include all care homes in its area. Given that care homes had to be willing to participate and could not be considered to be automatically supportive of direct payments, a number of sites suggested aiming for 5, 10 or up to 25 care homes. In each case, with the one exception mentioned above, this constituted a small proportion of the care homes active in the area. Only a small number of the care homes planning to participate were registered to offer nursing care (n=13). Most sites included only one nursing home, with only one site planning to include six nursing homes; this excludes the ‘outlier’ site that planned to include all care homes in its area.



3.7 Determining the value of direct payments

Establishing a mechanism to determine the value of direct payments was central to developing the scheme and a major challenge for many sites. From the outset, project leads recognised that direct payments should reflect the assessed needs of users and allow them to purchase the care that met those needs. There was also awareness of a legal obligation on councils to meet the care needs of people who are assessed as eligible for council-funded social care. However, the expectation was also that introducing direct payments should not create a need for additional funding from councils.

While some sites indicated that they welcomed an opportunity to review fee levels in the residential care home sector, many were concerned not to upset the market and push providers out of business. This applied particularly to those areas in which residential care home provision was already stretched and markets were considered fragile.

At the time of the interviews for the scoping study in 2013, many project leads were still unsure about how to determine the monetary value of direct payments. The approaches considered involved either a needs assessment from which an indicative amount would be derived that could be adjusted in light of the care available to constitute the direct payment or using existing costs/fee levels, adjusted for different levels of need, from which direct payments would be derived. Several leads indicated in the scoping study that they were in the process of undertaking measures to assess the ‘true’ costs of residential care, although these exercises proved complicated and were dependent on the willingness and/or ability of care homes to provide information about their costs. In addition, trailblazing sites had to decide whether the direct payment would cover the entire sum of money made available by the council for a user (i.e. all of his/her personal budget) or only part of it. In the latter case, the council would continue to make payments to the care home directly.

At this early stage, the majority of sites planned to use a Resource Allocation System (RAS) that matched care needs and funding to determine a direct payment. At the time of the study, no such RAS existed for residential care (the use of a RAS is well established in community care, although its use in local authorities is variable) and sites varied in their plans for developing and/or using a RAS. Suggestions varied among sites, including using an existing RAS (e.g. as developed for respite care); using and adjusting the RAS that existed in community care; developing a new RAS for residential care; and not using a RAS but exploring alternatives such as the Care Cost Calculator or the Calculating a Fair Market Price for Care tool, developed by Laing & Buisson and the Joseph Rowntree Foundation (Laing, 2008).

The role of the RAS raised a number of questions for project leads. For example, how much flexibility would be needed to be able to match the care needs of users, the council funding available and the need for providers to cover their costs? Was there a role for negotiation between councils and care homes, as was currently the practice in some sites? How would brokerage and decision support be factored into the RAS? How would current funding models, for example, the use of a banded system to set fee levels, need to be adjusted to accommodate the use of direct payments?

A number of sites stated that they hoped direct payments would help them to understand better any differences in fee levels and whether they were justified or not. There was concern that councils would require good insight into the actual costs of care provision and understand the reasons for variation in these costs among care



homes. Basing direct payments on care needs only would carry the risk of payments for some services being potentially higher or lower than fees paid before the introduction of direct payments. This could have helped to inform adjustments of fee levels, but it could also risk providers becoming unprofitable or councils overspending their budgets.

3.8 Needs assessment and care planning

Most project leads stated during the preparatory phase that they did not anticipate substantial changes to their current approaches to assessing care needs and to making care plans for their clients.

However, most project leads also expressed the hope that the process of care and support planning would become more sensitive to the preferences and wishes of people admitted to care homes. It was also suggested that it would be desirable if care and support plans became more focussed on outcomes and quality of care. Some project leads anticipated that offering direct payments would shift decision-making powers from care homes to service users, although there were also doubts as to whether this was realistic in the face of the high care needs of much of the care home population such as frail older people and those with advanced dementia.

There was a lack of clarity initially around sequencing of the initial assessment and planning processes given that, in most areas, only a small number of care homes were participating in the trailblazer. One of the questions arising at this stage was whether people would have to decide first on a care home and only then be offered a direct payment if the care home participated in the trailblazer or be offered a direct payment first with a limited choice of 'participating' care homes. In both cases, choice could potentially be compromised by the fact that in most sites only a small number of care homes had opted to participate in the scheme.

3.9 Contracting and relationships with providers

Most sites initially envisaged developing a new approach to contracting with care homes in recognition of the fact that decision-making power was likely to shift from the council to the user and an expectation that users would eventually make their own contractual arrangements with care homes.

However, most project leads expected that councils would remain involved in contracting with providers for a number of reasons. First, there would be users who chose not to take up a direct payment and thus required the council to make arrangements on their behalf. Second, councils would remain responsible for some part of the funding if they offered direct payments only for part of the care home fee. Third, councils would retain a duty of care towards users, even if they were not directly involved in organising their stay in a care home. Only a few project leads thought it possible that the council could withdraw entirely from contracting with providers.

Most sites anticipated that the role of councils would change under direct payments, even if councils continued to contract with care homes. However, at the beginning of the programme it was not clear what these changes would involve, with some leads suggesting that the role of the council might shift to providing brokerage services to support user choice; to developing templates for contracts between users and care homes to ensure that these were fair to all parties; and to maintaining oversight over



care packages agreed between users and care homes, to ensure that basic needs of users were met. Some worried that councils would lose a lever to influence the provider market and ensure standards if direct payments became the norm; in compensation, it was suggested that the system might move towards accreditation of providers.

Another initial concern was that not contracting with a council could also have repercussions for providers, for example, by increasing the rate of interest on bank loans, since those with council contracts currently tend to be able to obtain lower interest rates.

It was also not clear at this stage how contracting under direct payments would affect existing approaches to contracting, such as block contracting or spot contracting. In this respect, introducing direct payments could have provided an opportunity to review existing practices. Some councils were also providers of residential care and it was not clear whether and how direct payments could be deployed in council run care homes.

3.10 Potential risks and challenges identified by project leads during the scoping phase

There were a number of anticipated risks and challenges associated with introducing direct payments in residential care identified by those leading the projects within the sites.

First, there was concern that direct payments would fail to increase choice for residential care users, as providers might not be in a position or not be willing to offer additional options in terms of activities or services. It was also questioned whether care home residents, particularly frail older people, would want more choice if it came with the responsibility for managing a (potentially large) budget. It was also unclear how choice would come about, i.e. whether providers would be expected to make more options available or whether residents and their families would articulate a desire for more choice and demand new or different services in addition to those in existence.

Second, sites were concerned about the impacts of direct payments on care homes and the provider market, particular in relation to the financial viability of providers, with smaller care homes being most exposed if required to change their modus operandi. Two issues were articulated specifically: direct payments might shift the distribution of funding between providers, as people might vote with their feet and choose care homes that were able to offer a larger range of services; and direct payments might put care homes in a position of having to offer individual choices without being able to charge for additional services, thus shifting the financial impact of increased choice from councils to providers.

Third, many project leads indicated at this early stage that they were unsure about how to implement direct payments and about the extent of change the scheme would require in the way that residential care was funded. Some sites determined the scope of the direct payment to be a full payment covering the entire costs of care, others planned the scope to be a part payment (e.g. for care or activity costs as opposed to hotel costs) while others envisaged a choice or combination of these approaches. However, many sites had not yet decided the scope of payment by the time they were officially required to offer a direct payment (November 1st 2013).



3.11 Summary

The evaluation team conducted a scoping and feasibility study during the first year of the programme. This scoping study aimed to establish the plans of trailblazing sites for implementing the direct payment scheme to inform the decisions about the research design of the main evaluation. Trailblazing sites estimated that they would be able to facilitate between 435 and 500 direct payments to residents in care homes, covering all user groups with the majority anticipated to be older people. At the beginning of the programme, about 100 care homes were expected to support the scheme, often by developing options for direct payments in collaboration with councils. There were a number of key questions yet to be resolved including how to determine the monetary value of direct payments, whether to make all or only part of the council funding allocated to a service user (i.e. the personal budget) available as a direct payment and how direct payments would change existing processes of arranging residential care, including needs assessment and contracting.



4. Methods

4.1 Aims and objectives of the main evaluation

The overall aims of the evaluation of the Direct Payments in Residential Care Trailblazer programme were to understand the potential impacts of direct payments on care home residents, their families, councils and providers, and to explore how direct payments could be introduced in residential care to inform policy decisions at the Department of Health.

The aims of the evaluation shifted during the course of the programme, reflecting the changed purpose of the programme which moved from being a 'pilot' to becoming a 'trailblazer' scheme once the government had decided to roll-out direct payments to residents of care homes throughout England from April 2016. The introduction of direct payments in residential care was later postponed to 2020 together with other measures arising from the 2014 Care Act.

The specific objectives of the main evaluation were:

- To understand the different ways in which direct payments were 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 final report from the independent evaluation of the trailblazers. It follows two interim reports of the main evaluation submitted in November 2014 and September 2015, published in January 2015 and November 2015, respectively. A scoping report was published in autumn 2013 (Ettelt, Perkins et al., 2013).

4.2 Logic model

Early in the evaluation, it was agreed that it was important to have a clear understanding of the potential causal pathways underpinning the intervention being evaluated, and to conceptualise the intervention and its processes visually. A logic model was developed which enabled the evaluation to frame specific evaluative questions by looking at local context, implementation and outcomes.

A logic model is a tool which maps out the intervention, in this case the Direct Payment in Residential Care trailblazer programme, and makes logical connections between the necessary resources required to plan and implement the programme, and any expected outputs and outcomes, both short and long-term. Logic models were first introduced in the 1970s (Weiss and Weiss, 1998) and are widely used to inform the evaluation design of complex health and social care programmes (Hayes et al., 2011, Better Care Fund Implementation Support Programme, 2015, Lamont et al., 2016).

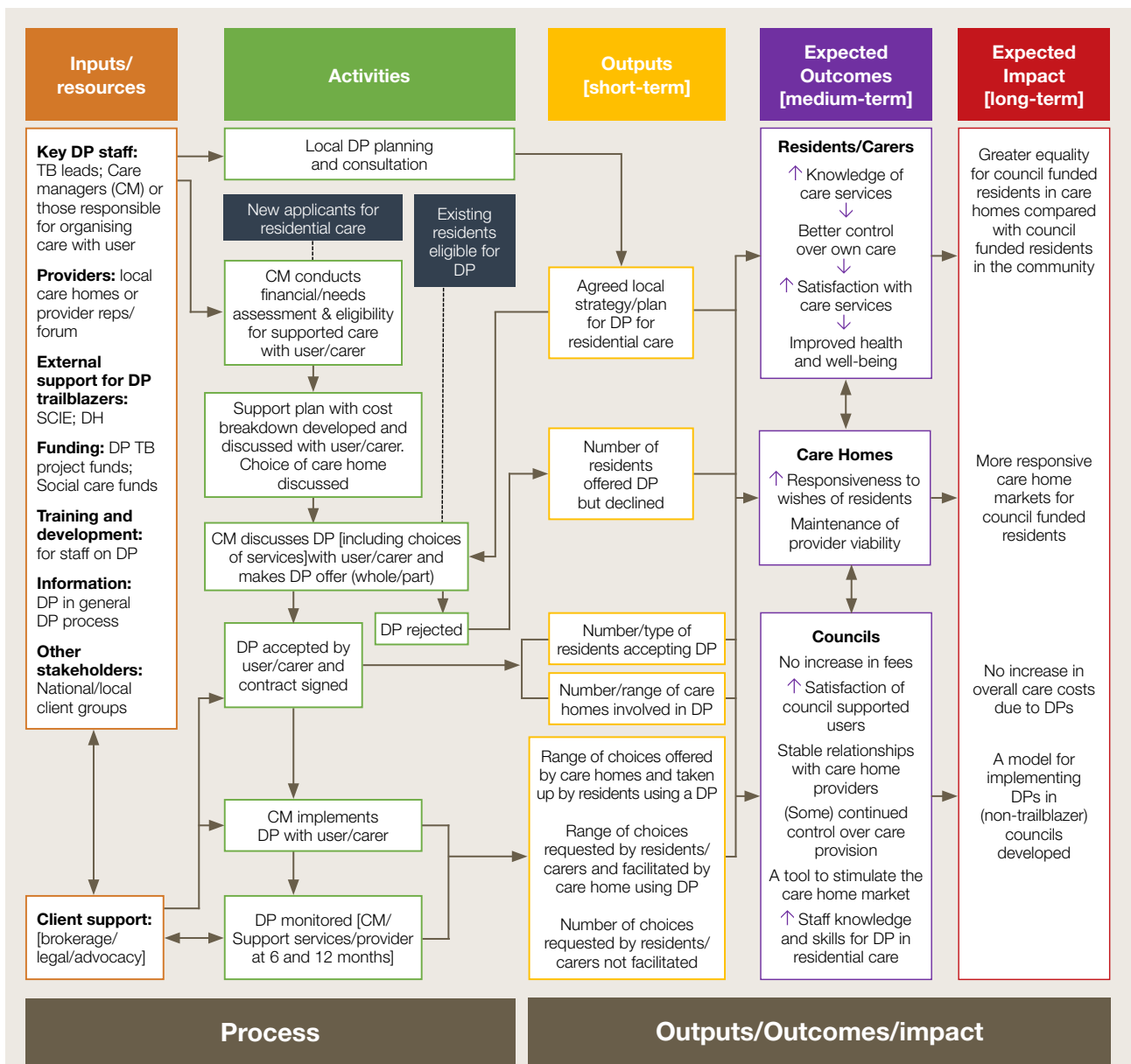
Using data collected in the scoping study, a broad, generic framework was initially developed. This was further revised and updated following feedback from a variety of stakeholders during the early stages of the trailblazer programme. Project leads were asked to identify key resources and steps in planning and implementing direct payments in their



local areas and to comment on whether their own plans fitted with the draft logic model. They were also asked to comment on any expected outputs and outcomes. Feedback was also received from members of the advisory group set up for this evaluation.

A working model consisting of a map outlining how key resources translated into activities and outputs and outcomes was developed along with key evaluative questions and indicators of evidence. The model was used to help develop topic guides for interviews and to inform the user and provider survey. The emerging model was not intended to be static or prescriptive; councils were free to determine their own pathways and to change the local implementation of the programme as they saw fit. The logic model is presented as Figure 4.1 below. A full version of the logic model along with evaluative questions, methods and indicators is presented as Appendix G.

Figure 4.1 Logic model of direct payments in residential care





4.3 Quarterly monitoring

Progress data were collected from the participating trailblazer sites at quarterly intervals throughout the programme. This included numbers of service users offered direct payments, numbers commencing direct payments, numbers of care homes participating, weekly direct payment amounts and weekly council payments to care homes. Other information, such as a summary of progress made to date, any key achievements, issues or identified risks to the programme's progress, including steps taken to mitigate these risks, was also collected. These data were collected through the progress reporting forms submitted by project leads to the Social Care Institute for Excellence (SCIE), completion of which was a condition of participation in the scheme. A monitoring form was developed to collect these progress data and SCIE helped facilitate this data collection for the evaluation team (Appendix G). Quarterly monitoring took place between November 2013 and February 2016. Data received each quarter were variable, with some sites returning their quarterly returns regularly and others periodically or not at all.

4.4 Surveys of users and families

Surveying the views, experiences and outcomes of direct payments for service users and their family members or friends was a crucial part of the evaluation. The service user and family member survey was designed as a self-completion questionnaire to capture the views of both those who had experience of using direct payments in residential care and of those who had declined an offer of a direct payment in residential care.

Four different baseline questionnaires for different groups of respondents were developed, colour-coded for ease of administration:

- Person accepting direct payment (Q1: yellow)
- Relative of person accepting direct payment (Q2: pink)
- Person declining direct payment (Q3: blue)
- Relative of person declining direct payment (Q4: green)

These questionnaires were developed in consultation with the project leads in the trailblazer councils and the members of the study's Direct Payments User and Carer Group. They drew in part on the questionnaire used for the national Adult Social Care Survey. The questionnaires comprised a short set of factual questions to be completed by the project lead or social worker before handing or sending the questionnaire to the service user or family member, a set of questions for completion by the user or family member, and, in the case of users, a short note to anyone helping the user to complete the questionnaire. A copy of each of the questionnaires is included in Appendix A.

The questionnaires did not ask for the respondent's name, unless that person agreed to be contacted for an interview or asked to receive a summary of the research findings. Each questionnaire was given a reference number by the project lead so that the research team could link baseline with follow up questionnaires.

Each questionnaire collected information on the characteristics of service users, such as client group (e.g. physical disability, learning disability, memory loss or dementia), demographic details (age, gender, marital status and ethnicity), time lived in a care



home and whether the individual had previously received a direct payment in the community. In addition, the questionnaires for residents and family members of residents accepting a direct payment (Q1 and Q2) explored issues such as whether the direct payment had already started, the use of and choices relating to the direct payment (where it had started), and the level of satisfaction regarding different aspects of the programme (such as choice of care home, choice of services within the care home, and ease of managing and setting up a direct payment).

These two questionnaires also included questions on social care-related quality of life assessed using the Adult Social Care Outcomes Tool (ASCOT) to allow for comparisons between outcomes at baseline, 6-month follow-up and 12-month follow-up (Netten et al., 2010, Netten et al., 2012). The questionnaires also included questions from the Adult Social Care Survey about the person's activities of daily living. The questionnaire for family members of people accepting a direct payment (Q2) also explored the respondent's involvement in any decisions about whether to participate in the programme or discussions about whether to accept a direct payment. For those declining a direct payment and their family members, the questionnaires (Q3 and Q4) were considerably shorter, focussing on the reasons for declining a direct payment.

All baseline questionnaires asked whether the respondent would be happy to be contacted by the research team for an interview and whether they would like to receive a summary of the research findings. If they answered 'yes' to either question they were asked to provide their name and contact details.

Service users lacking capacity to consent to participate in the study were excluded from the survey for ethical reasons, but their family members were included.

4.4.1 Distribution of questionnaires and process of gaining consent

The research team briefed all project leads in councils about the process for administering the survey, set out in a flowchart and written guidance (Appendix B). Project leads were tasked with the responsibility for managing the distribution of questionnaires with the methods employed varying across council areas. Some project leads directly administered the questionnaires to clients and family members, while in other sites, social care professionals were asked to do this during initial discussions with service users and family members about direct payments, covering confidentiality and what participation in the study might involve. This process applied to all service users and family members of individuals who had been offered a direct payment, regardless of whether it was accepted or not.

Council care managers in most areas gave questionnaires directly to the users and their friends, families or advocates at this stage, along with written information about the study. However, in sites in which councils had decided to approach service users via care home managers it is possible that the questionnaire was handed to service users and families by the care home. Information at the beginning of the questionnaires invited service users to either answer the questions themselves, or to ask a family member, friend or advocate for assistance. They were requested not to seek the help of any care workers or other social services professionals. One council used trainees unrelated to the programme to help care home residents complete the questionnaires thereby being able to submit a relatively high number of questionnaires. The completed questionnaires were then returned directly to the research team using a stamped addressed envelope supplied with the questionnaire.



Consent to participate in the study was implied by the individual's decision to complete a questionnaire.

4.4.2 Follow up questionnaires

Service users and their family members who accepted a direct payment, but not those who declined, were invited to complete a follow-up questionnaire at six months after the baseline questionnaire had been completed.

Care managers in the relevant council were encouraged to give the six month follow-up questionnaire to the user during a regular care review, together with reminder information sheets about the study; questionnaires for the family member were sent. As with the baseline questionnaires, the completed follow-up questionnaires were returned to the research team via a stamped addressed envelope.

Initial plans to invite users and family members to complete a further questionnaire at 12 months were not pursued as in only a very few cases was the 12 months from baseline point reached before completion of data collection in April 2016.

4.4.3 Easy-read questionnaires

In addition to the standard versions of the questionnaires, detailed above, councils were also issued with 'easy-read' versions of the questionnaires, with enlarged print and pictorial content. These were specially designed for service users who might find the standard version difficult to understand (Appendix A).

Findings from the survey of service users and family members are presented in Chapter 7.

4.5 Survey of providers

A survey of care home providers was conducted in order to capture the views and experience of care home managers, owners or other senior care home staff member. The questionnaire included questions for care homes which had participated in the trailblazer scheme, those which had not participated and those care homes which did not have a direct payment user.

Most questions were (closed) quantitative questions with a smaller number of open-ended, qualitative questions. The survey (Appendix E) covered the following topics:

- For care home providers with residents holding direct payments: type and value of direct payments and how it was being used and managed; the effect of direct payments on residents receiving them, on family members and on other residents not participating in the programme; and the effect of direct payments on staffing arrangements, relationship with the council, costs of providing care, and administration and business development;
- For care home providers without any residents holding a direct payment, the reason/s for not having any direct payment user in the care home.

The survey was conducted electronically via Survey Monkey. Members of the research team contacted project managers to ask for contact details of those care



homes with which the local authority had a contract and which had been informed about the direct payments programme. These care homes need not necessarily have been participating in the programme. The email addresses of the care home providers were sought and added to the team's database.

Ten trailblazer councils provided a list of the care homes concerned, a total of around 750. However, some email addresses for the care homes proved to be invalid. When they were omitted, the total number of care homes invited to participate stood at 631.

4.5.1 Survey pilot and launch

The survey was developed by members of the evaluation's research team with drafts circulated to other colleagues with expertise in survey design for feedback. It was pretested internally by the research team and by other research academics. The survey was then piloted with a small number of care home managers. Participants were asked to complete the survey and provide individual feedback on question content and functionality. Following this several amendments were made to improve the survey design.

The research team estimated that it would take around 20 minutes to complete for those care home providers with direct payments, and around five minutes for those without. The survey was confidential in that participants in the survey were not asked for their name or that of the care home and no identifying details were shared with other parties.

The survey was launched in late November 2015 and closed at the end of March 2016. Emails were sent by the research team to all care home providers on the collated lists inviting them to participate in the survey; trailblazer leads helped by reminding care homes to participate.

4.6 Interviews

Semi-structured interviews were carried out with council and care home staff, representatives from national 'stakeholder' organisations and adult social care directors from councils not participating in the trailblazer programme, as well as service users and family members who had either accepted or declined a direct payment. The total number of people interviewed between January 2014 and June 2016 and their roles can be found in Appendix D.

Interview questions were derived from the preliminary study in 2013, a review of relevant literature on direct payments and personal budgets, and from the logic model developed to guide the evaluation (Appendix G). Interview questions, topic guides, consent forms, information sheets and other related interview documentation are included in Appendices C and D. As a number of interviews were to be conducted in care homes with vulnerable adults, an interview protocol on harm was developed and approved by the Social Care Research Ethics Committee (Appendix C). Interviews were digitally recorded, transcribed, coded and analysed thematically using computer software (NVivo 10 and 11). Framework analysis was used drawing on Ritchie and Spencer's model (Ritchie and Spencer, 1994). The Framework Method allowed for a systematic approach to thematic analysis of the large qualitative dataset. The analysis of interviews with council staff including those leading the project, care home staff, service users and family members is presented in Chapters 7 to 9 of this report.



4.6.1 Interviews with project leads in participating councils

We conducted two rounds of interviews with project leads within each trailblazer council during the programme. Each council assigned lead was approached for interview by a member of the evaluation team via email. Interviews were largely conducted by telephone and carried out in two time periods. A first round of interviews with project leads was carried out during August to September 2014. These interviews explored their experiences of setting up the trailblazers, any progress made including any initial barriers and challenges experienced, and any real or perceived benefit of direct payments for service users, family members, providers and councils. A second round of interviews took place with project leads in October 2015. This interview provided an update on progress and use of direct payments within the councils, and an opportunity for leads to describe and reflect on key challenges, highlights and benefits, and any learning relevant to future implementation sites. As indicated in Table 4.1, there were some changes to project leads within the councils during the lifetime of the programme, so it was not always possible to interview the same lead throughout.

Table 4.1 Project lead interviewees over lifetime of project

Site Code	Code name of lead(s)* interviewed for preliminary report (June-Sept 2013)	Code name of lead(s) interviewed for first round (Aug-Sept 2014)	Neither satisfied nor dissatisfied	Code name of lead(s) interviewed for second round (October 2015)
1	Site 1 project lead 1	Site 1 project lead 2	no interview (change of staff)	2 changes (one mid project)
2	Site 2 project lead 1	Site 2 project lead 2	Site 2 project lead 3	2 changes (one mid project)
4	Site 4 project lead 1	Site 4 project lead 1	Site 4 project lead 1	No change
5	Site 5 project lead 1	Site 5 project lead 2	Site 5 project lead 2	1 change (early project)
6	Site 6 project lead 1	Site 6 project lead 2	Site 6 project lead 2	1 change (early project)
7	Site 7 project lead 1	Site 7 project lead 2	Site 7 project lead 2	1 change (early project)
8	Site 8 project lead 1	Site 8 project lead 1	Site 8 project lead 1	No change
11	Site 11 project lead 1	Site 11 project lead 2	Site 11 project lead 2	1 change (early project)
12	Site 12 project lead 1	Site 12 project lead 1	Site 12 project lead 1	No change
14	Site 14 project lead 1	Site 14 project lead 2	Site 14 project lead 2	1 change (early project)
15	Site 15 project lead 1	Site 15 project lead 1	Site 15 project lead 2	1 change (mid project)
16	Site 16 project lead 1	Unavailable for interview	Unavailable for interview	Not known
17	Site 17 project lead 1	Site 17 project lead 2	Site 17 project lead 2	1 change (early project)
18	Site 18 project lead 1	Site 18 project lead 1	Site 18 project lead 2	1 change (mid project)

*Names of project leads coded for confidentiality



4.6.2 Interviews with other council and care home staff

We conducted interviews with council and care home staff involved in planning and implementing direct payments. Participants included managers and owners of care homes and council staff in the four sites selected for more in-depth study (see below) and for developing case studies. Project leads helped facilitate the recruitment process by identifying and contacting potential interviewees and organising suitable times and venues for the interviews. Interviewees were purposefully selected for their role in planning and implementing the direct payment programme. The interviews explored their general understanding of the purpose of the programme and their experience of direct payments in residential care during its implementation. Results from the analysis are presented in Chapters 8 and 9.

4.6.3 Sites selected for in-depth study

Four trailblazer sites were selected for more in-depth investigation. The sites were chosen with a view to obtaining coverage of sites offering direct payments to different service user groups; sites providing ‘full’ or ‘part’ direct payments; sites working with a few care homes and those aiming to include all care homes; 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 2014. The main characteristics of the four sites are listed in Table 4.2. The councils were located in the North West, Yorkshire and Humberside, London and the South East regions of England.

Table 4.2 Characteristics of in-depth sites

	Council type	Type of direct payment offered	Service user groups targeted	Approach to implementation of direct payment
Site 4	Metropolitan	Additional payment to selected residents	Older people	Payment made to care home to test whether these help ‘personalise care’ in selected care homes
Site 7	County	Covering whole or part cost of residential care	All	Working with participating care homes
Site 8	London Borough	Covering whole or part cost of residential care	All	Universal offer to all service users and working with selected care homes
Site 17	Unitary	Covering whole cost of residential care	All	Universal offer to all service users entering residential care

4.6.4 Interviews with service users and family members

Interviews were conducted with service users and family members in several trailblazer sites. A number of approaches for recruiting interviewees were developed in the course of the programme, with additional recruitment options being explored in response to the low number of direct payments taken up.



Recruitment and informed consent of service users

Service users were initially recruited by asking them for their details and agreement to be contacted on the final page of the user questionnaire. The service user was then contacted directly by a member of the research team using the contact details provided (such as telephone, post or email). The initial contact aimed to provide information about the aims of the evaluation and to ascertain if they were still interested in participating. Following the initial contact, more detailed information about the evaluation and the interview was provided by a member of the research team in the form of a participant information sheet, an accompanying letter and a consent form delivered via post or email (Appendix C). Follow-up contact was made about one week after sending the information to obtain informal consent for the interview and to organise a suitable date, time and venue for the interview. Interviews with service users were all conducted in person. In some cases, this meant liaising with the respective care home manager. The consent form was signed at the time of the interview.

While a sufficient number of family members of service users accepting and declining direct payments agreed to be interviewed, the number of service users willing to be interviewed remained substantially lower than set out in the protocol. The evaluation team adopted an additional, more direct approach to recruitment by asking project leads, care home managers and family members who had already been interviewed, to identify and approach service users who had been offered a direct payment. These service users were provided with a letter of invitation and written information about the evaluation (Appendix C). Service users with a direct payment were also offered a small store voucher to compensate for their time if they agreed to be interviewed. Additional approval by the Social Care Research Ethics Committee (SCREC) was sought and gained for this approach. In addition, a small number of service users were interviewed as part of the case studies (see below).

Recruitment and informed consent of family members

Family members who had indicated a willingness to be interviewed in the questionnaire were contacted by the research team. In cases where family members gave their telephone number, information about the research and interview was first provided orally, and, if the family member was interested in participating, further details about the evaluation and the interview were provided, including instructions (Appendix C) to return a signed 'consent to interview' form in a reply postage paid envelope or by email. Once written informed consent was obtained the research team contacted the family member to agree a suitable time for the interview. Almost all interviews with family member were conducted over the phone.

Interviews with those accepting a direct payment explored their expectations of direct payments, their experience of setting them up and using them, and whether they experienced any benefits from them. For those declining a direct payment, questions explored any prior knowledge and experience of direct payments in the community, how the direct payment in residential care was offered to them, and their reasons for declining. Interviewers abided by the protocol on harm approved by SCREC for all interviews carried out with service users (Appendix C). No circumstances arose in which the protocol needed to be activated. Results from the analyses are presented in Chapter 7.



4.6.5 Interviews with representatives from national stakeholder organisations

Seven interviews were conducted with representatives of national stakeholder organisations. These represented provider associations from the private and charity sector (Care England, the National Care Forum, and the Registered Nursing Homes Association) and organisations representing service users (Age UK, Carers UK, Alzheimer's Society and SCOPE). Organisations were purposefully selected. An invitation to participate was sent to the chief executive of each organisation along with information about the trailblazer scheme, the evaluation and the interview. Interviews were conducted with senior managers (e.g. chief executives, senior directors or policy managers). Interviewees were invited to comment on recent reforms of adult social care, challenges to the sector and the contribution direct payments might make in improving the experience of service users and carers in residential care. No interviews were conducted with policy-makers. However, opportunities were used to elicit views through informal conversation.

4.6.6 Interviews with councils not participating in the trailblazer programme

In preparation for the anticipated roll-out of direct payments in residential care in April 2016 we aimed to interview senior managers in councils that had not participated in the trailblazer scheme to understand whether and how they were preparing for the change.

In May 2015, we approached a stratified sample of 33 adult social care directors using the database of directors of adult social care available from the website of the Association of Directors in Adult Social Care Services (ADASS, 2016). The invitation email included information about the programme and its evaluation, and a request to consent to be interviewed, as a result of which two directors consented to be interviewed. Following this low response rate, follow-up emails were sent out. Further efforts to recruit interviewees were postponed until later in the year given that a policy statement on the national roll-out of direct payments in residential care was expected to be issued in September 2015. However, this statement was only issued in January 2016 when it was announced that the roll-out of the scheme was to be postponed to 2020. In light of these changes no further interviewees were recruited as it was seen as unlikely that adult social care directors would prepare for the implementation of the scheme given the new circumstances.

4.7 Case studies

The slow progress of the trailblazer scheme and its consequences for the collection of survey data was discussed with the Department of Health in May 2015. It was agreed that the evaluation team would prepare a small number of case studies that charted different 'user journeys' to inform policy development and guidance. Examples for case studies were explicitly not selected to illustrate user satisfaction but to understand better the process of facilitating direct payments. Service users were identified with the help of project leads and were purposively selected to represent user experiences with different types of direct payments.

After obtaining written consent, interviews were conducted with the service user, or, in cases where this was not possible, the family member involved in managing a direct payment on behalf of their relative. Council and care home staff involved in setting up the direct payments were identified and contacted for interview for four of the five cases. In one of the cases information was obtained from a standard follow-up



interview with the service user, supplemented by previous interviews conducted with council and care home staff. Information was also sought from the council project lead in each case, including supporting documentation if available, such as leaflets or guidance about the direct payment process. Questions focussed on reasons for accepting a direct payment, how the payment was set up and used, and whether any challenges had been encountered.

4.8 Cost data collection

Methods employed to collect data on the costs to councils for the administration and management of the scheme comprised a short questionnaire (Appendix G) sent out to all project leads towards the end of the programme (June 2015). The research team anticipated that the administration and management costs would be mainly, if not entirely, staff costs. The questionnaire therefore asked about costs arising from staff time devoted to activities and processes which would not have been conducted in the absence of the trailblazer programme such as: costs incurred in setting up the programme, including discussions within the council and with care homes providers, service users and other stakeholders; costs of additional discussions with users and their relatives which would not have otherwise have arisen; costs of IT services which would not otherwise have been incurred; and costs of finance processes required to set up and run DPs in residential care which would not have otherwise been required. The analysis of administration and management costs is presented in Chapter 6.

4.9 Research ethics and governance

This section describes the approvals that were sought for the research governance and ethical issues that arose during the course of the evaluation.

4.9.1 Research ethics approval

We sought ethical approval for the research from the Social Care Research Ethics Committee (SCREC). We were asked to provide a disclosure of harm policy, detailing the process by which any participants indicating on completed questionnaires that they might be at risk, would be handled. Ethical approval was given in May 2014 (Rec: 14/IEC08/0011). The approved disclosure of harm policy is attached in Appendix C.

In this first application to SCREC, we did not seek approval to involve people lacking capacity to consent in the research. We anticipated making a further application to SCREC later in the evaluation for work with this group, using short focussed questions delivered face-to-face by a researcher. In the event, we were unable to proceed with this part of the work for reasons detailed below.

We sought further SCREC approval in stages, submitting a number of substantial amendments as the work progressed. The SCREC provided helpful comments on these various submissions. The Committee approved all our survey documentation, interview guides and changes or additions to proposed methodology.

In addition to the SCREC approval, ethical approval for the research was given in April 2014 by the London School of Hygiene and Tropical Medicine Observational Committee (Ethics Ref: 7254).



4.9.2 Research governance approval

We sought the approval of the Association of Directors of Adult Social Services (ADASS) for this evaluation, and this was given in April 2014. We also sought research governance approval from each of the councils involved in the trailblazer programme. The processes required by the different councils were very varied, with some requiring detailed submissions. We had received approval from all the participating councils by autumn 2014.

4.9.3 Issues arising

As the evaluation proceeded it became clear that the number of service users taking up a direct payment was much lower than councils had anticipated.

As a result, very few service users were available for interview or offered to be interviewed. We therefore sought the approval of the SCREC to allow direct requests to service users for face-to-face interview, through a care manager, family or friend (already interviewed) or care home manager, to improve user recruitment for interview. We also sought approval to offer a store voucher as an incentive. All service users who were interviewed during the evaluation received the store voucher.

Family members told us in interviews that relatives lacking capacity were unlikely to take up the offer of a direct payment or be able to be interviewed, although, in principle, people without capacity or their relatives could have opted for a direct payment. For these reasons, after seeking the views of the SCREC and DH, we came to the view that it was no longer feasible to undertake this part of the work. We did not consider that this omission in the circumstances would compromise the findings from the evaluation.

The small numbers meant however that we were unable to explore wider issues of personalisation, including whether people would prefer other forms of personalisation that may or may not be achievable with a direct payment.

4.9.4 Direct Payment User and Carer Group (DPUCG)

We involved service users and carers in an advisory capacity over the course of our work in two ways.

Firstly, before seeking ethical approval from the Social Care Research Ethics Committee (SCREC), we consulted members of the standing Service User and Carer Advisory Group (SUCAG) at the Personal Social Services Research Unit (PSSRU) at LSE for early comment on the proposed work, our methods and on our early drafts of documents: the information sheets; the topic guide for face-to-face interviews with service users, both those taking up a direct payment and those declining. We sought feedback on the acceptability of the questions proposed and any we had omitted. In particular, we asked for comment on the style and presentation of the documents, their clarity and whether the information provided would enable participants to understand the research.

Secondly, we invited members of the Research Advisers group from the Quality and Outcomes Unit (QORU) at the University of Kent to sit on our Direct Payment User and Carer Group (DPUCG).



Five advisers agreed to join the group which met three times over the course of the study.

We asked the group to comment and advise on:

- Questionnaires, information sheets and consent forms;
- The proposed policy and likely implementation problems for care homes, users, family members and councils;
- Ideas on increasing user recruitment;
- Dissemination of findings at user/carer focussed conferences.

The group's input was extremely helpful in providing critical and insightful comments on the evaluation and the policy initiative. Practical suggestions on ways to improve user recruitment for interview were adopted (after SCREC approval). The group commented on the interim reports and suggested inclusions in the final report. Members also provided useful ideas for dissemination of the evaluation to user and carer audiences such as to provide a summary written in plain language for a lay audience.

4.9.5 Advisory Group to the Direct Payment in Residential Care evaluation

An advisory group of professionals from a range of backgrounds was set up to advise the research team as the evaluation proceeded. The group included two project leads from two of the trailblazer sites; a small number of academics with knowledge in the field; key staff from the DH and SCIE; and a representative of a national voluntary organisation. (Membership and terms of reference are at Appendix F). We also invited other groups to have representatives on the Group but they were unable to take up our invitation.

The group was asked to advise and support the research team in the following ways:

- to advise and support the research team on the relevance of the questions addressed in the study in the context of policy and practice;
- to advise on specific aspects of methodology for addressing the research questions;
- to advise on the engagement with users and carers, relevant voluntary organisations and care home provider organisations;
- to suggest effective ways to disseminate findings across a range of stakeholders, including users, carers, commissioners, providers and central government;
- to advise on promotion of the project to relevant stakeholders;
- to help develop a dissemination plan and impact maximisation particularly helpful given the policy delay;
- to provide advice on data analysis.

The input from the Advisory Group was helpful and constructive. The Group provided valuable advice on how best to proceed when it became clear that there would be far fewer users taking up a direct payment in care homes than councils had expected. Their advice on interpretation and analysis of the data was also extremely valuable.



5. Direct payments – numbers, models and user groups

5.1 Numbers and user groups

Of the initial 20 councils invited to participate in the pilot in 2013, 14 remained at the end of the programme (September 2015). Of those councils, two did not provide information for the evaluation and a further two did not arrange any direct payments in residential care.

The earliest receipt of a direct payment in a care home was in April 2014. By the end of the programme in autumn 2015, 71 people had accepted direct payments across all trailblazer sites and 40 direct payments were active at that time (Table 5.1). Thirty of the direct payment users were older people and nine were younger adults (with information missing on one person).

By March 2016, data received from project leads showed that the number of active direct payments in care homes had reduced to 29, spread across nine councils (Table 5.2). There were 19 active full direct payments and ten active part direct payments. One of the trailblazer sites accounted for 12 of the 29 of active direct payments.

351 offers of direct payments were made, of which one council accounted for 193. (This site had decided to offer a direct payment to all new entrants to residential care). The remaining councils made offers of between two and 50 direct payments.

Table 5.1 Number of direct payments active at the end of the programme, autumn 2015

	Number of DPs accepted	Number of DPs active at end of programme (autumn 2015)	User groups with DPs (autumn 2015)
Site 1	1	1	No information
Site 2	4	1	1 x older person (part)
Site 4	16	7	7 x older people (additional payment)
Site 6	5	3	3 x learning disability (part)
Site 7	4	4	2 x older people (part) 1 x physical disability (full) 1 x learning disability (part)
Site 8	3	3	1 x learning disability (full) 1 x older person (full) 1 x mental health (part)
Site 11	10	7	7 x older people (full)
Site 12	15	11	10 x older people (full) 1 x learning disability (full)
Site 14	0	0	0 x older people 0 x learning disability
Site 15	2	1	1 x learning disability (part)
Site 17	0	0	No information
Site 18	11	2	2 x older people with dementia (extra payment)
Total	71	40	

**Table 5.2 Number of direct payments offered, accepted, and active as at March 2016**

	Number of DPs offered	Number of DPs accepted	Number of DPs active (March 2016)	Active full DPs	Active part DPs
Site 1	193	1	1	0	1
Site 2	10	4	1	0	1
Site 4	17	16	0	0	0
Site 6	8	5	4	4	0
Site 7	21	4	3	1	2
Site 8	14	3	3	1	2
Site 11	12	10	2	2	0
Site 12	50	15	12	11	1
Site 14	7	0	0	0	0
Site 15	2	2	1	0	1
Site 17	5	0	0	0	0
Site 18	12	11	2	0	2
Total	351	71	29	19	10

There are various reasons behind the disparity between the number of direct payments accepted and those currently active. Some of the direct payments had been implemented but were later cancelled due to changes in the service users' circumstances. In several cases the person had died or their health had deteriorated to an extent that it was no longer appropriate to offer them a direct payment. Some people sold their property and became self-funders or moved to another care home outside of the council area. Some service users or family members changed their minds about having a direct payment. In one case, social workers in a trailblazer site cancelled a direct payment due to financial safeguarding concerns, while in another a person chose to have her services managed by the council, because she found the process too complicated. One council which offered additional payments to care homes for day activities ceased to do so when the programme ended.

5.2 Size of direct payments

Data provided by the project leads showed that the total weekly cost of the 29 active direct payments as of March 2016 was almost £8,700 (Table 5.3). The smallest monetary amount for a single direct payment was £8 per week, for a part direct payment, while the largest was £1,250 per week, for a direct payment covering the full care home fee.

**Table 5.3 Value of direct payments in the sites which delivered them in March 2016**

	Value of active direct payments – range (£ per week)	Number of DPs active at end of programme (autumn 2015) (£ per week)	User groups with DPs (autumn 2015) (£ per week)
Site 1	0 (no active DPs)	0	0
Site 2	20.55	20.55	20.55
Site 4	0 (no active DPs)	0	0
Site 6	120 to 173	579.85	144.96
Site 7	100 to 840	1121	373
Site 8	15 to 1250	1592.00	530
Site 11	359 to 397	756.00	378
Site 12	40 to 550	4539	454
Site 14	0 (no active DPs)	0	0
Site 15	37.22	37.22	37.22
Site 17	0 (no active DPs)	0	0
Site 18	25	50.00	25
Total		8695.62	

5.3 Calculating direct payments

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

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 specify how the sum of money that is provided as a direct payment is to be determined. Finding out how best to determine the monetary value of a direct payment that could be used as a model to inform the potential future roll-out of direct payments in residential care was thus one of the steps required for implementing the trailblazer programme.

In community (domiciliary) care, direct payments constitute one method of taking part or all of one’s allocated personal budget. Alternatively, the council or a third-party (e.g. a care agency) can manage the budget on behalf of the service user. Councils use different mechanisms to calculate the monetary value of 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’ nor the concept of a ‘direct payment’ were established at the beginning of the trailblazer programme.



The sum of money made available to service users in residential care largely derived from the fee paid to the care home in which the service user was placed. These fees typically reflect a range of factors, including the user's level of care need. Fee levels vary substantially between council areas and often also vary between care homes looking after people with the same level of need within the same area (NAO, 2016).

The Care Act 2014 formally introduced a universal duty on councils to provide service users in adult social care with a personal budget. This duty came into force in April 2015 and applied to residents in care homes as well to service users receiving domiciliary care.

“Everyone whose needs are met by the local authority, whether those needs are eligible, or if the authority has chosen to meet other needs, must receive a personal budget as part of the care and support plan, or support plan. The personal budget is an important tool that gives the person clear information regarding the money that has been allocated to meet the needs identified in the assessment and recorded in the plan.” (DH 2014: 152)

However, the implementation of personal budgets was still incomplete by the end of the trailblazer programme in September 2015, with a few councils indicating that they had not yet extended the concept of personal budgets to residential care.

5.3.1 Direct payments as ‘full’ or ‘part’ payments

A related question considered by project leads and their teams was how the direct payment related to the care home fee. In community care, direct payments can either cover the entire personal budget (i.e. the entire sum of money allocated to an eligible service user to cover assessed needs) or only part of it, with the remainder being managed by the council.

The same options exist for direct payments in residential care. The ‘full’ direct payment represents the entire personal budget, while the part payment is formed of a share of the personal budget. This share would be whatever the council agreed to pay directly to the service user, while it continued to pay the remainder of the fees for the care of the service user direct to the care home.

A ‘full’ direct payment made 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 service user contribution to the care home). The service user was then responsible for paying the care home fee. If the service user opted for a **part payment**, the council paid the (now reduced) care home fee and made any remaining funds available to the service user in agreement with the care home. This option typically involved council staff negotiating with care homes whether there was any part of the care home fee that could be ‘flexed’ to allow the service user more choice. In both models, the amount available to services users not used to pay for the core care home fee, if any, was 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).

By the end of the programme, of the 40 or so direct payments that had been issued, 21 constituted ‘full’ direct payments and 10 ‘part’ direct payments. There were also 9 ‘additional’ direct payments, which two councils had set up and which constituted



payments paid in addition to the care home fee that the councils continued to pay in full to participating care homes. Seven of these ‘additional’ direct payments were transferred to care homes to facilitate day activities for older people who had chosen to participate in the scheme. Hence they do not meet the definition of a payment ‘available to service users’, although they were meant to enable the council to try out whether having a small extra sum of money would stimulate a wider choice of activities for older people in these homes. Of the sites that had at least one service user in receipt of a direct payment at the end of the programme, three sites had issued part payments only, one site had issued full payments only and three sites had issued both part and full payments (in one site it was not clear).

In interviews, project leads provided a number of explanations as to why they had decided to offer part or full direct payments or both. One lead argued that his/her council had decided to offer full payments only, as part payments would involve transaction costs that would make direct payments inefficient. These transaction costs would arise through councils having to negotiate with care homes the portion of the care home fee that could be made available to service users for each individual ‘part’ direct payment. Another lead noted that offering direct payments as a full payment was more straight forward, as this would require the council to convert the care home fee, minus any assessed service user contributions, into a direct payment, which would then be used by the service user to pay the full care home fee. Part payments were favoured in situations in which service users attracted a payment for daytime activities which was already separate from the care home fee, which could then be converted into a direct payment without having to negotiate with care homes about disaggregating the care home’s agreed fee.

However, determining the value of the full or the part payment was not an easy task, with many project leads expressing doubts about whether the approach they had chosen would 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.” (Project lead, Site 6)

5.3.2 Initial plans for using the approach used for direct payments in community care

In the interviews conducted for the scoping study 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 varied 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. At this time only two councils had decided to continue using the RAS.

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 relied 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 paid for the care of older people. They also suggested that councils relied on care homes accepting the level of payment the council was willing to provide to purchase care home placements for a given user group. Also most care homes that participated in the trailblazer programme operated as private for profit or not-for-profit businesses and contributed to the trailblazer on a voluntary basis, which means that they were able to opt out of the trailblazer if they so wished (which some did). 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.” (Project lead, Site 3)

5.3.3 Models of direct payments in residential care

While there were a number of models emerging during the trailblazing programme, towards the end of the programme it became increasingly clear that the RAS approach was not proving to be workable, which left sites with little option but to start from the existing fees charged by care homes. However, from April 2015, councils have been required to provide service users in residential care with a personal budget. While not all trailblazer councils had made the transition to personal budgets during the course of the programme, an increasing number of sites began using some form of resource allocation system to calculate indicative budgets and determine personal budgets.

At the end of the programme, three models of calculating the monetary value of direct payments in residential care were used in sites.

Model 1 involved basing the direct payment on the care home fee and making this payment available to the service user in full (minus the user’s contribution).

Model 2 involved basing the direct payment on the care home fee (minus the user’s contribution) but with only some of this money made available to the service user while the council continued to pay the remainder to the care home.

Model 3 involved making an additional sum of money available to the service user to be spent as a direct payment, while the council continued to pay the care home fees in full (minus any user contribution). This model, however, was not cost neutral to councils.



Model 1 was most simple to set up as it did allow care homes to maintain the same fee level only that this fee was now paid for by the service user or family rather than the council. This model was used in several sites, with one site producing the highest number of direct payments compared with other sites (12 'full' direct payments by March 2016).

Model 2 included 'part' direct payments that involved negotiating with care homes whether they could release part of their fee to be made available to service users so that they could use their direct payment differently. This model was most easily applied in cases in which funding existed for day time activities or day care services. This approach was also more likely to find support from care homes. Some care homes, especially for younger adults (i.e. those under the age of 65), already had systems in place which allowed residents to use services outside their own home during the day, or who invoiced the council for day care activities that they provided themselves in-house.

Model 3 was phased out towards the end of the programme, with one site conceding that it had not met the definition of a direct payment as the additional funding was transferred to care homes (although earmarked for use for a specific service user) rather than service users. This model would not seem to be financially realistic if direct payments in residential care were rolled out more widely.

5.4 Care and support planning

Support planning emerged as the crucial link between providing service users and their families with the option of a direct payment and their ability to use the direct payment to purchase care of their own choice. There was consensus among project leads that service users should be able to use their direct payment as creatively and innovatively as possible so that they could enjoy more personalised care. However, they were also clear that whatever the direct payment was used for, it had to meet the outcomes set out in the user's support plan.

When interviewed in 2013, most project leads stated that they did not anticipate substantial changes in their current approaches to assessing care needs and to making care plans for their clients. However, most also expressed the hope that the process of care planning would become more sensitive to the preferences and wishes of people admitted to care homes. Some anticipated that offering direct payments would shift decision-making power from care homes to users, although there were also doubts as to whether this was realistic, particularly for frail older people, those with advanced dementia or people lacking mental capacity.

It was also anticipated that more and different information about care homes would be required to enable meaningful choices at the stage of care and support planning. Responses varied as to whether this information could be generic, i.e. relevant to all residents using direct payments or applicable on a case-by-case basis only. One project lead, in a council that offered both full and part payments, noted that social workers needed to have substantial knowledge about the local care market and the services available to service users to enable users and their families to make informed choices. This would require social workers to be knowledgeable about the supply of such services both within care homes and outside them (e.g. services accessible to care home residents being offered in the community).



A case study in the same council illustrated the complexity of the process of support planning which involved several meetings between the council social worker, the care home manager, the family and the service user. In this case, the direct payment was seen as an opportunity for a long-term resident with a physical disability and moderate learning disability to become more independent in managing her own affairs including money, albeit with support. However, setting up the direct payment was complicated by difficulties experienced when opening a bank account (for someone who as a long-term resident did not have a passport or other proof of identity). In a second interview, conducted in 2015, the service user also reported having had difficulty in spending the direct payment due to a lack of clarity about how it could be spent and difficulty in organising support to enable participation in activities outside the home. Her experience hints at the possibility that having a direct payment may require support that goes beyond the initial support planning and support for managing the financial aspects of the direct payment.

Interviews with project leads and other council staff indicated that support planning activities could be highly variable irrespective of users having a direct payment. While it was accepted that every service user should have an annual review of their care arrangements, council staff also noted that these reviews did not always happen as regularly as they should. Some also commented that support planning could be improved in many cases but that this was constrained by the heavy workload of social workers.

5.5 Financial transactions for direct payments

Direct payments involve the transfer of funding allocated to a service user from the council to the user or his/her family or representative. To facilitate this financial transaction a number of options were considered during the programme. The majority of the remaining sites (n=7) that managed to set up direct payments transferred the direct payment to a bank account held by the service user or family. In some cases, the money was transferred to the bank account of the service user, but managed by his/her family (with power of attorney). In a few cases, the money was transferred to a holding or virtual account managed by an external organisation.

An alternative explored by some councils was to make funding available on a prepaid card or eCard. This meant that the council could transfer the direct payment directly onto the user's prepaid card at regular intervals. This would allow councils to monitor the spend via a web based system and spending could be controlled for risk by blocking spending by category (such as restricting access to cash machines), and could also be set up to specify which providers or suppliers could accept payment of the card. The advantage of this was that councils would be able to reconcile and check spending more easily as this information would be held or at least accessible to the council. However, while some councils anticipated that having a prepaid card would simplify the financial transactions and reduce the paperwork required to reconcile payments, it was not always possible to introduce these cards since their introduction required a decision by the council beyond the scope of the trailblazer (and potentially additional investment).

Setting up a direct payment could be lengthy and more difficult than anticipated, despite some councils having made considerable efforts to prepare their internal systems and develop processes before starting to make offers. Project leads observed that such delays could cause a degree of anxiety for some of the service users and family members involved.



Reasons for delay in getting the direct payment set up included difficulties in opening bank accounts for service users who had lived in residential care for a long time and therefore lacked the required evidence of personal identification. Other difficulties involved co-ordinating processes and financial systems to enable efficient transfer from one payment system to another; and co-ordinating meetings with service users, family members and council staff, to ensure formal acceptance of a direct payment and to ensure that the appropriate support planning was in place for the user to be able to identify choices facilitated by the direct payment.

In other cases, setting up a direct payment and arranging the financial transfers was relatively straightforward. In the case of a direct payment covering the whole care home fee, in one case, the payment was requested and set up within the space of four weeks. This direct payment was used by the service user to select a care home outside her council area.

“And, they [the care home] were in agreement, as long as the home received the funding that they require, for the placement, then whether it came directly from [one council], or from [another council] to the service user, and then... you know, it didn't impact on them, as long as they got a commitment for the funding”. (Council staff, Site 8)

5.6 Use of direct payments – exercising choice and control

During the trailblazer programme, direct payments were used in a number of ways to purchase services in residential care. A key difference was whether the direct payment covered the care home fee in part or in full or whether it represented an additional payment. How the direct payment was spent also varied by service user group, users' preferences and their ability, for example, to participate in activities outside the home.

Residents with a full direct payment were expected to use the direct payment to cover the care home fee. There were several instances in which service users had paid for their own care until recently (i.e. they had been self-funders) and decided to take up a 'full' direct payment once they qualified for council funding. In these cases, these service users could remain in the care homes they had been living in when they were self-funders. However, in one site this meant that the council paid slightly more than their usual care home fee. In another instance, the care home accepted the lower rate offered by the council.

In a few cases, having a direct payment enabled service users to access a care home outside the area of the council which funded their care. In one case, the user could access a specific care home of her/his choice, but the family was required to make a substantial financial contribution to make up the full care home fee.

Where service users used a direct payment to cover the care home costs, this usually involved paying for all essential care identified in the support plan. This left no or little room for additional choice. Some service users and families noted that they expected that having a direct payment could strengthen their position if they had to negotiate changes to services with the care home. Yet these effects could not be observed during the trailblazer as people reported that they were happy with the care provided by the homes.



Residents who received a direct payment for part of their personal budget continued to have their care home fees paid by their council. The direct payments were used to support residents to access day care services and other activities that were not offered by the home under usual arrangements. These included day services in other care homes (e.g. art classes) and service provided in the community. One long-term resident with a physical disability used his/her direct payment to pay for an internet connection. Cultural activities outside care homes involved visits to the theatre or participating in book club meetings. Some of these activities could have taken place without recourse to a direct payment, although they often depended on the willingness of care homes to provide additional support and/or change their own practices. They also depended on how easy or difficult it was to organise assistance and transport, which in some cases incurred additional costs not covered by the direct payment (e.g. transport fares, entry tickets for an accompanying person). While it was emphasised that direct payments should be used to meet outcomes set out in the person's support plan, it was not always clear whether choices made by users were easily compatible with outcomes (e.g. whether the purchase of a CD player or the CD of a favourite singer would meet an identified social need).

In the two sites which provided additional payments for older people, these payments were used to organise activities and create social opportunities for users (who were very frail). In one site, this option was chosen with the explicit aim of testing whether having a little extra funding allocated to individual users would result in better personalisation. This approach was inspired by the experience of other care homes that had invested in staff developing one-page profiles of residents in order to better understand their personalities and act upon their preferences. In this site, several direct payments were set up at a sum of £20 per month. The number of individuals accepting a direct payment had initially been higher but for a variety of reasons the process of organising the direct payment was discontinued for some (e.g. because of the declining health or death of the resident). Reported uses of these payments included trips to the park, garden centre, cafes or the local fish and chip shop and the care home organising a manicure at the wish of a resident. However, these activities took place infrequently and were difficult to sustain due to the declining health of residents and seasonal effects on their willingness and ability to leave the home. In the other site, which made an additional £25 per week available to older people with dementia, two of these payments were taken up by residents and used to pay for trips to museums, garden centres, parks and shopping centre.

5.7 Delivering services purchased with a direct payment

Services purchased with a direct payment also reflected the three models. For those who received a direct payment that covered the care home fee in full, services were delivered by the care home as usual. The direct payment then paid for the whole care package offered by the care home.

For those with part payments and additional payments that were spent on activities or day care, these services were provided by a variety of individuals and organisations. In some cases, the care home facilitated participation in activities outside the home. This was either covered by the part payment (e.g. funding additional time of a carer to take people to the garden centre) or it was not covered by the payment which meant that the care home was likely to have made available additional staff time. For example, having an internet connection established in her/his bungalow required the help of the care home on whose grounds the service user lived. Participation in external day services also required transport that relied on support from the care home.



In other cases, the care home did not get involved in organising activities. One site commissioned a care agency that also supported service users in the community to provide carer support to enable people to participate in social activities outside the care home. This service incurred a small additional charge (as it does in the community). This arrangement also required family members to help organise support, mediate between the care agency and the care home, and manage expectations from the service users.

In a few instances, service users with a 'part' direct payment found it difficult to organise support to participate in social activities outside the care home. In one case study, the resident would have required a personal assistant to take her/him outside the home but it was not clear to her/him whether the direct payment was sufficient to pay for this service. While an external organisation helped with the financial aspects of the direct payment, this did not include support for deciding whether an arrangement was workable or appropriate.

While these are only a few examples, reflecting the small number of direct payments issued, they illustrate that service users with a direct payment are likely to require various types of support to help them capitalise on having a direct payment. This seems most straightforward in cases in which the direct payment is used to choose a care home. However, in those cases in which having a (part) payment involved selecting and organising additional services, many service users required support to be able to make informed decisions about the options available to them and to facilitate participation in activities and services outside the care home in which they resided.

5.8 Broker and support organisations

As outlined above, there were a number of instances in which broker and support organisations were involved in facilitating direct payments. The examples highlight that these organisations took different roles: in some cases an external organisation was used to help service users and families with managing the financial aspects of the direct payment, for example, by prompting service users and care homes to keep the receipts of services used or provided and by reconciling this information with the council. In other instances, a care agency was involved in organising carer support for people who wanted to take part in activities outside the home. Other services from external organisations mentioned were a brokerage service that provided decision support for people lacking cognitive capacity. However, given the small number of examples in which such agencies were used, their role in helping facilitating direct payments is yet to be explored in more detail.



6. Costs of administration and management

This section relates to the costs incurred by the trailblazer councils in the administration and management of their direct payments in residential care trailblazer schemes. It is important to recognise that, since the nature of the schemes varied between councils as described elsewhere in this report, the administration costs could reasonably be expected to vary.

In June 2015, the lead for each trailblazer was sent a short questionnaire about their administration and management costs. Nine trailblazer sites returned completed questionnaires over a seven month period between July 2015 and February 2016.

As an indication of the types of costs to include, the questionnaire advised councils that the administration and management costs would be mainly, if not almost entirely, staff costs; that is costs arising from staff time devoted to activities and processes which would not have been conducted in the absence of the trailblazer programme. These could include: costs incurred in setting up the programme, including discussions within the council and with care homes providers, service users and other stakeholders; costs of additional discussions with users and their relatives which would not have otherwise have taken place; costs of IT services which would not otherwise have been incurred; and costs of finance processes required to set up and run direct payments in residential care which would not otherwise have been required.

Five of the nine councils estimated that the management and administration costs which they incurred on their scheme had been fully met by their Department of Health grants. It is unclear however whether councils included all the costs which they incurred in working with individual service users to offer and establish an active direct payment. Two of the councils reported that their costs exceeded their grant, with one of these stating that they incurred £7,500 in additional expenditure. Two councils said that their costs had been less than their grant (with one reporting savings of £20,000 and another of £30,000). However, this came with the caveat that they would require their estimated saving against the grant to meet expected future costs. The former council, with savings of £20,000, said part of this had been allocated to pay for support planning, brokerage and additional advocacy and part for publicity materials to be produced later to share positive stories from the project.

The number of full-time equivalent (fte) staff deployed on the scheme varied from 0.2 fte over 12 months to 2.0 fte over two years. Most of the councils reported that this related to a project manager/project lead, as shown in Table 6.1.

Eight of the nine councils explicitly reported that the programme involved additional work for frontline care managers or other professional staff employed by the council, which would not otherwise have arisen. One mentioned twelve hours extra work per week over twelve months, to carry out up-to-date reviews, informing service users and their families about direct payments, carrying out Mental Capacity Assessments and, where necessary, best interest decisions in relation to direct payments. Other tasks included referring to and instructing advocates, making referrals to support planners, liaising with service users, their families, advocates, support planners and residential staff, ensuring that individual support plans met assessed need, completing care and support plans to include direct payments, and liaising with the council's finance section. Another mentioned three hours per week over 27 months, for meetings with providers, negotiating rates with providers, additional visits, and additional administration time.

Five councils reported that the programme involved additional work for staff concerned with arranging contracts with care homes and managing the care home



market and two that it did not involve additional work for these staff. One council, for example, provided an estimate of three hours per week over 2 months, to write addendums for contracts to allow for direct payments and meetings to discuss this. Other councils mentioned that this work involved meeting and negotiating with providers and raising awareness of the programme generally.

All nine councils reported that the programme involved additional work for staff working on administrative processes or financial, charging or invoicing systems or other IT or similar services. Specific estimates ranged from 30 minutes to two hours per week, over periods ranging from six months to two years.

Five councils reported additional administration and management costs, beyond those mentioned above. These covered: development and delivery of training, finance support, business and customer support, setting up a new electronic payment card scheme, preparation of leaflets and fact sheets, stationery and postage.

Table 6.1 Staff employed on the trailblazer scheme

	Staff (fte) employed on the trailblazer scheme	Job titles
Site 1	1.2 over 23 months	(Job titles not provided)
Site 2	0.25 over 27 months	Business Improvement Manager, Project Manager, Project Administrator, and others
Site 4	0.40 over 25 months	Project Manager
Site 6	0.33 over 18 months	Project Lead
Site 7	0.50 over 22 months (to date) and 1.00 over 18 months (to date but will extend)	Project Officer and Project Manager
Site 11	0.25 over 27 months	Project Manager
Site 12	0.50 over 6 months	Community Care Officer
Site 14	0.20 over 12 months	Project Manager
Site 15	2.0 over 24 months	Project Manager/Head of Service-Policy & Development/ Assistant Head of Finance/Performance Manager/Project Support Officer/Customer Finance Team Manager

6.1 Summary

In summary, most of the nine trailblazer councils which provided this information indicated that the costs which they had incurred on administration and management of their scheme had been fully met by their Department of Health grants. There was considerable variation between councils in the number of full-time equivalent staff deployed on the schemes. All reported additional work for staff working on administrative processes or financial, charging or invoicing systems or other IT or similar services, and all but one reported additional work for frontline care managers or other professional staff employed by the council.



7. Views of service users and family members

7.1 Findings from the survey of service users and family members

This section presents findings from the 68 completed baseline questionnaires received by the end of March 2016. This includes responses from 19 service users who had accepted a direct payment, 14 from family members whose relatives had accepted a direct payment (including five from relatives of users who also sent a completed questionnaire), seven from service users who had declined a direct payment, and 28 from family members of people who had declined a direct payment (including three from relatives of users who also sent a completed questionnaire).

Councils were issued with ‘easy-read’ versions of the questionnaires, with enlarged print and pictorial content, for service users who might find the standard version difficult to understand (Appendix A). The total of 68 questionnaires includes eight easy-read (six for people accepting a direct payment, two for those declining). Four of these were from people who had learning disabilities.

A further eight questionnaires from four service users and four family members were returned at the 6-month follow up stage, including one ‘dyad’ (where both the service user and the relevant family member completed a questionnaire). One follow-up questionnaire was received at around the 12-month stage from a service user who had previously completed a baseline questionnaire. However, the service user had incorrectly filled out a baseline questionnaire in this case.

Table 7.1 shows the breakdown of returned questionnaires from the 18 trailblazer sites; it is likely that in some of the sites, no questionnaires were issued at all given that some of them dropped out before reaching that stage of the project.

Table 7.1 Number of questionnaires received from 1 August 2014 to 31 March 2016

Council	Q1 returns (person accepting direct payment)	Q2 returns (relative of person accepting direct payment)	Q3 returns (person declining direct payment)	Q4 returns (relative of person declining direct payment)	Total
Unidentified	0	0	0	1	1
Site 1	0	0	0	4	4
Site 2	0	0	0	0	0
Site 3	0	0	0	0	0
Site 4	7	4	0	0	11
Site 5	0	0	0	0	0
Site 6	2	2	0	1	5
Site 7	3	0	3	10	16
Site 8	1	1	1	2	5
Site 9	0	0	0	0	0
Site 10	0	0	0	0	0
Site 11	2	1	0	0	3
Site 12	2	6	2	4	14
Site 13	0	0	0	0	0
Site 14	0	0	0	1	1
Site 15	2	0	0	0	2
Site 16	0	0	0	0	0
Site 17	0	0	0	5	5
Site 18	0	0	1	0	1
Total	19	14	7	28	68



The trailblazer councils gave survey questionnaires to 40 of the 71 service users who accepted the offer of a direct payment. For ethical reasons, councils were asked not to give questionnaires to users who they believed lacked capacity. Nineteen of the 40 service users returned completed questionnaires, a response rate of 47.5%. In addition, 14 family members of people accepting a direct payment returned a survey. The number of service users who were issued with questionnaires did not necessarily match the number of family members given questionnaires. This is partly because some service users may not have had any friends or family members who were in a position to complete a questionnaire and partly because users lacking capacity were not given questionnaires.

There were seven questionnaires returned from people who declined a direct payment and 28 from family members of people declining a direct payment. That makes a total of 68 completed baseline questionnaires, relating to a total of 57 service users (25 accepting, 32 declining) as in some cases both the service user and one of their friends or family members completed questionnaires.

Characteristics of the service users

We analysed the data concerning the 28 cases in which a completed questionnaire was returned either by a service user accepting a direct payment or by a family member of a person accepting a direct payment. The findings, however, need to be treated with caution because of the small numbers. Most of the service users were women (19 women compared to nine men) and aged over 65 – four people were aged 65-74, four were aged 75-84, and nine were 85 or older. Just two were aged 18-34.

As the data from Table 7.2 shows, the most common impairment for people accepting a direct payment was physical disability, accounting for 18 people, or nearly two-thirds of the sample. This was followed by learning disability (11), dementia (6), sensory difficulties (5), and mental health problems (4). It should be noted that people could select more than one of these conditions.



Table 7.2 Client group and whether aged over or under 65 (excluding family member responses where the corresponding service user completed a questionnaire)

	Aged under 65	Aged 65+	Sensory impairment	Learning disability	Physical disability	Mental health	Dementia	Other
Person accepting direct payment (Q1)	8	11	3	1	13	3	5	3
Relative of person accepting direct payment (Q2)	2	7	2	7	5	1	1	0
Person declining direct payment (Q3)	2	5	1	0	6	1	2	1
Relative of person declining direct payment (Q4)	9	15	8	9	15	2	2	0
Total	21	38	14	17	39	7	10	4

Overall, the majority (64 percent) of the service users who completed a questionnaire or whose relative returned a questionnaire were aged 65 and over (Table 7.2). Of the service users under the age of 65, 10 accepted a direct payment and 11 declined a direct payment. Of the service users aged 65 years and older, 18 accepted a direct payment and 20 declined.

Two thirds had a physical disability and just over one quarter (29 per cent) had a learning disability. Seventeen percent had dementia. It should be noted that more than one condition was indicated for some users.

Service users and family members were asked a number of questions about the service user’s ability to perform personal care tasks (Activities of Daily Living, ADLs) and domestic tasks (Instrumental Activities of Daily Living, IADLs). The findings on the four ADL/IADL questions asked on both service users and family members are presented in Table 7.3.



Table 7.3 Activities of daily living – responses from the service user and family member survey

	Service users accepting a direct payment (DP) 19 respondents	Family members of service users accepting a DP (regarding the service user’s capabilities) 9 respondents	Service users declining a DP 7 respondents	Family members of service users declining a DP (regarding the service user’s capabilities) 23 respondents	Total 58 respondents
Do you usually manage to get around indoors by yourself?					
Can easily do this myself	9	3	4	7	23
Have difficulty doing this myself	6	1	0	5	12
Can’t do this myself	4	6	3	11	24
Do you usually manage to get in and out of bed by yourself?					
Can easily do this myself	7	2	2	7	18
Have difficulty doing this myself	4	1	0	3	8
Can’t do this myself	8	6	5	13	32
Do you usually manage to feed yourself?					
Can easily do this myself	17	3	6	12	38
Have difficulty doing this myself	1	3	0	6	10
Can’t do this myself	1	3	1	5	10
Do you usually deal with finances and paperwork?					
Can easily do this myself	1	0	0	1	2
Have difficulty doing this myself	2	0	2	1	5
Can’t do this myself	13	9	5	21	48

The task where people were most likely to respond with ‘can’t do this by myself’ was dealing with finances and paperwork: 48 service users or their family members said they could not do this themselves, compared to five who said they had difficulty doing it, and only two who could do it easily by themselves. The task where people were least likely to respond with ‘can’t do this by myself’ was feeding: only ten service users or their family members said they could not do this themselves, compared to ten who said they had difficulty doing it and 38 who could do it easily by themselves.



There was a more even spread of responses across the three categories ('can easily do this myself', 'have difficulty doing this myself', and 'can't do this myself') for the other two tasks. Twenty-three respondents said they could get around indoors by themselves easily, compared to 24 who said they could not do this themselves.

Type of care home placement

Three-quarters of those who accepted a direct payment and completed a questionnaire or whose relative completed a questionnaire were in care homes providing personal care only and just over 20 per cent were in care homes providing nursing and personal care (Table 7.4). A similar proportion of people who declined a direct payment and completed a questionnaire or whose relatives completed a questionnaire were in residential care (77 per cent) versus nursing care (23 per cent).

Table 7.4 Type of care home placement (excluding family members where the corresponding service user has completed a questionnaire)

	Residential placements	Nursing placements
Data from person accepting direct payment	15	4
Data from person declining direct payment	5	2
Data from relative of person accepting direct payment	6	2
Data from relative of person declining direct payment	18	5
Total	44	13

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

Nine of the 28 users who accepted a direct payment had one to cover the whole care home fee (less the assessed user contribution and any topping up required) and 17 had a direct payment covering only part of the care home fee (Table 7.5).

Table 7.5 Whether direct payment covered the whole or part of the care home fee

	Whole fee	Part fee
Data from person accepting direct payment	4	15
Data from relative of person accepting direct payment	5	2
Total	9	17

Activities

As Table 7.6 shows, the most commonly reported use of the direct payment (57 per cent of users) was for activities outside the care home and the second most frequent was activities within the care home (39 per cent). Some respondents gave details of the activities they or their relatives had taken advantage of using a direct payment, such as sightseeing trips, visiting a garden centre, and watching football.



Table 7.6 How residents participating in the programme used the direct payment (excluding those questionnaires from family members where the service user completed a questionnaire)

	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
Person accepting direct payment	3	1	14	9	1	6	1
Relative of person accepting direct payment	5	3	2	2	2	1	0
Total	8	4	16	11	3	7	1

Length of time in care home

Service users and relatives were asked how long they or their family member had been living in the care home in which they were currently residing. Among the respondents as a whole, including both those accepting and those declining a direct payment, 25 users had been resident in a care home for over five years (Table 7.7), the most commonly reported category for this variable. Smaller numbers of people reported being in a care home for between two to five years (nine), and between one and two years (five).

Of the people accepting a direct payment, seven had been in a care home for five or more years, six had been in a care home for between two and five years and four had been in a care home for between one and two years.

Table 7.7 Length of time each resident has spent living in a care home, not necessarily the current one (excluding those questionnaires from family members where the corresponding service user has completed a questionnaire)

	1-3 months	3-6 months	6-12 months	12-24 months	2-5 years	5+ years	Not resident in care home
Data from person accepting direct payment	0	1	2	2	3	6	1
Data from person declining direct payment	0	0	0	1	1	4	0
Data from relative of person accepting direct payment	1	1	1	2	3	1	0
Data from relative of person declining direct payment	2	4	1	0	2	14	0
Total	3	6	4	5	9	25	1



Of the service users who had lived in the care home for five years or more, seven accepted a direct payment and 18 declined. In contrast, of the service users who had lived in the care home for less than five year, 16 accepted a direct payment and 11 declined.

Typical reasons for declining

Thirty-one people – service users and family members – who declined a direct payment provided reasons for their decision (Table 7.8). Over three-fifths (61 percent) of those declining the offer of a direct payment did so on the grounds that the person in question was already resident in a care home and happy with the arrangement. For example, one family member praised the wide variety of activities already available at the care home, such as days out, yoga, and arts and crafts and expressed concern that accepting a direct payment *“is likely to lead to a reduction in the services the care home can afford to offer”*. Those views were reflected in a comment from another family member who said: *“I feel that introducing direct payments into a relationship where provider and [council] have previously always handled the finance of the service will create tension – at least initially – between the provider and the service user’s representative/carer”*.

Table 7.8 Reasons for declining a direct payment (excluding those questionnaires where the corresponding service user has completed a questionnaire)

	They did not think that taking a DP would give them more choice and control	Did not feel that they had sufficient information to make the decision to take a DP	Did not feel they were given enough time to make decision	Concerned that DP would mean work for them or family	Already resident in care home and happy with arrangement	Other reason
Person declining direct payment	0	1	0	2	4	5
Relative of person declining direct payment	4	1	0	3	15	1
Total	4	2	0	5	19	6

For five of the 30 people, the reason for declining was a concern that the direct payment would mean work for them or their family. In four cases, they did not think that taking a direct payment would give them more choice and control. One relative of a service user declining a direct payment felt that the policy might not be suitable for some client groups, particularly people with learning disabilities. The relative commented: *“I spent several weeks and attended several meetings getting to understand what is involved. In the end, it seemed clear to me that direct payments are not designed for residents with [learning disabilities] who cannot understand the issues involved, although it is a good idea for those with more understanding who need more choice in their lives. The service user in question is very happy in her care home and her finances are well looked after”*.



Satisfaction with the direct payment process

The results from 28 questionnaires (19 service users and 9 family members) relating to service users who accepted direct payments include ratings of people’s satisfaction with the scheme. The data exclude questionnaires completed by family members whose relatives holding a direct payment had also completed a survey. Respondents (except those who completed the ‘easy read’ version of the questionnaire) were asked how satisfied they were about the following aspects: information and advice, choice of care home, choice of services within the care home, personal control over the direct payment, knowledge of how direct payment is spent, ease of setting up the direct payment, help from the care home over using the direct payment, and ease of management of the direct payment. Overall, 13 people said they were very satisfied or fairly satisfied with the direct payment, with seven people being neither satisfied nor dissatisfied (Table 7.9). No respondents reported any level of dissatisfaction. The findings, however, need to be treated with caution because of the small numbers.

Table 7.9 Level of satisfaction with the direct payment, both service users and family members’ responses combined (excluding those questionnaires where the corresponding service user has completed a questionnaire)

	Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied
Information and advice received about direct payments	9	9	3	0	0
Choice of care home	11	3	1	1	1
Choice of services within the care home	7	7	3	1	1
Personal control over direct payment	7	5	8	0	0
Knowledge over how direct payment is spent	11	5	3	0	0
Ease of setting up the direct payment	8	6	7	0	0
Help from care home over use of direct payment	15	0	5	0	1
Ease of management of the direct payment	4	7	6	0	0
Ease of management of the direct payment	4	7	6	0	0
Overall level of satisfaction with the direct payment	9	4	7	0	0



Some respondents wrote additional comments on the questionnaire explaining their position, with varying degrees of approval. One relative of a service user with a direct payment covering the whole care home fee hinted at some frustration at the process, saying: *“I am finding it is taking time being set up. I am not running this yet, just been told about it, but no involvement in what’s happening”*. (Given that the questionnaires were returned at various stages throughout the project, it is to be assumed that the level of satisfaction may also change depending on the progress of setting up the direct payment.)

In another trailblazer site, a relative of a woman aged 85 or over with a direct payment which also covered the whole fee, was more positive: *“It has really taken the pressure off, as there is now more time to sell mother’s house”*.

In addition, 18 respondents said they were fairly or very satisfied with the information and advice they had received relating to the direct payment. Fourteen said they were satisfied with their choice of care home (with one being neither satisfied nor dissatisfied, and two being dissatisfied or very dissatisfied) and a further 12 said they were satisfied with the control over their direct payment (with eight being neither satisfied nor dissatisfied). By contrast, only 11 people reported being satisfied with the ease of management of the direct payment, with six giving neutral ratings for this category (neither satisfied nor dissatisfied). There were very few additional comments made by service users and family members on this subject in the ‘additional comments’ section on the questionnaires. However, one relative, who had recorded their relative as being neither satisfied nor dissatisfied with the direct payment, said: *“Not very clear about direct payment – but know it will be difficult for home to implement... would it be better to pay for internal activities”*.

Outcomes for service users

The questionnaires to service users, but not those to family members, included questions on outcomes. These comprised the Adult Social Care Outcomes Tool (ASCOT) instrument version for use in care homes.

A total of 26 service users completed a baseline questionnaire. Nineteen of these service users accepted a direct payment, of whom 11 were aged 65 and over and eight were aged under 65. Six of them completed an easy read version of the questionnaire – one person aged 65 and over and five aged under 65. Seven of the 26 service users declined a direct payment, of whom five were aged 65 and over and two were aged under 65. Two of them completed an easy read version of the questionnaire – one person aged 65 and over and one aged under 65. Not all of the questions on outcomes were included in the easy read version of the questionnaire.

The ASCOT domain most relevant for this study of direct payments in residential care is the domain on control over daily life. The responses from the service users, including those who completed the easy read version of the questionnaire, are set out in Table 7.10.



Table 7.10 Service user views on how much control they have over their daily lives

Which of the following statements best describes how much control you have over your daily life?				
	I have as much control over my daily life as I want	I have adequate control over my daily life	I have some control over my daily life but not enough	Total
User accepting direct payment				
Aged <65	7	1	0	8
Aged 65+	3	7	1	11
User declining direct payment				
Aged <65	0	1	1	2
Aged 65+	3	2	0	5
Total	13	11	2	26

Seven service users aged under 65, all of whom accepted a direct payment, indicated that they had as much control over their daily life as they wanted. Six service users aged 65 and over, of whom three accepted a direct payment and three declined one, also indicated that they had as much control as they wanted. Two service users aged under 65 and nine service users aged 65 and over indicated that they had adequate control. Only two service users indicated that they had some control over their daily life but not enough; and no service users indicated that they had no control over their daily life. It is noticeable that, while seven out of ten younger users said that they had as much control over their daily lives as they wanted, only six out of 16 older users said that they had as much control as they wanted. All of the service users indicated that staff or care and support services helped them to have control over their daily lives.

Another ASCOT domain which is very relevant for this study of direct payments in residential care, is the domain on how service users spend their time, in effect whether they can do what they enjoy. The responses from the service users, including again those who completed the easy read version of the questionnaire, are set out in Table 7.11. The findings need to be treated with caution because of the small numbers.

Table 7.11 Service user views on how they spend their time

Which of the following statements best describes how you spend your time?					
	I'm able to spend my time as I want, doing things I value or enjoy	I'm able to do enough of the things I value or enjoy with my time	I do some of the things I value or enjoy with my time but not enough	I don't do anything I value or enjoy with my time	Total
User accepting direct payment					
Aged <65	6	0	2	0	8
Aged 65+	4	6	1	0	11
User declining DP					
Aged <65	1	1	0	0	2
Aged 65+	3	2	0	0	5
Total	14	9	3	0	26



Six service users aged under 65, all of whom had accepted a direct payment, indicated that they were able to spend their time as they want, doing things they enjoyed or valued. Seven service users aged 65 and over, of whom four had accepted and three declined a direct payment, also indicated that they were able to spend their time as they wanted, doing things they enjoyed or valued. Six service users aged 65 and over, but none aged under 65, indicated that they were able to do enough of the things they valued or enjoyed. Seven service users indicated that they were able to do some of the things they valued or enjoyed with their time but not enough. None indicated that they did not do anything that they valued or enjoyed.

Also relevant for this study of direct payments in residential care is the domain on social contacts. The responses from the service users, including again those who completed the easy read version of the questionnaire, are set out in Table 7.12. Again the findings need to be treated with caution because of the small numbers.

Table 7.12 Service user views on social contact with others

Thinking about how much contact you've had with people you like, which best describes your social situation?					
	I have as much social contact I want with people I like	I have adequate social contact with people	I have some social contact with people, but not enough	I have little social contact with people and feel socially isolated	Total
User accepting direct payment					
Aged <65	5	2	0	1	8
Aged 65+	6	4	1	0	11
User declining DP					
Aged <65	1	1	0	0	2
Aged 65+	3	2	0	0	5
Total	15	9	1	1	26

Five service users aged under 65 who accepted a direct payment and one who declined a direct payment said they had as much social contact as they wanted with people they liked. Two people aged under 65 accepting a direct payment and one who declined a direct payment said they had 'adequate social contact'. One younger person who accepted a direct payment said they had little contact with people and felt isolated.

Ten of the eleven people aged 65 or over and who accepted a direct payment and all five who declined a direct payment said they had either as much social contact as they wanted with people they liked or 'adequate social contact'. The remaining older person accepting a direct payment said they had some social contact with people, but not enough. There was no clear pattern in the responses between people who accepted a direct payment and those who declined. While none of the people who declined a direct payment indicated they did not have enough social contact or felt isolated, there were only seven respondents in this category.



7.2 Interviews with service users and family members

7.2.1 Characteristics of interviewees

This section presents the findings from the interviews that were held with service users and family members and advocates (referred to as family members henceforward). Between January 2015 and February 2016, 34 interviews were conducted with 25 family members and 8 service users. One interview was carried out with both the family member and the service user at the same time. Two interviews with service users were conducted with a care worker in attendance. Four interviewees were interviewed on two separate occasions: one family member and two service users took part in both an initial – as well as a follow-up – interview and one family member (advocate) was interviewed on two separate occasions regarding two different service users.

Ten face-to-face interviews were held with service users, two of which were follow-up interviews. Of the interviews with service users, six service users accepted, and two declined, a direct payment. The two service users who participated in a follow-up interview both accepted the offer of a direct payment.

Twenty-three interviews with family members were conducted over the telephone. Four interviews with family members were carried out in person with a member of the evaluation team. In three instances, the family member and the service user were interviewed together in a face-to-face interview. In two of these interviews, the family member/advocate was a paid carer from the care home. In another instance, a family member was interviewed on two occasions: an initial interview over the telephone and a face-to-face follow-up interview.

At the time the initial interviews were conducted, 15 service users had received a direct payment and five service users had accepted a direct payment, but were still waiting for the payments to be transferred. Two service users who had reported at their initial interview that their direct payment was pending, reported at the follow-up interview that they had started receiving a direct payment. At the time of writing (Spring 2016), 17 direct payments had started, two were pending and one participant, who reported a pending direct payment when interviewed, had withdrawn from the project.

Of the interviews with family members, 19 related to the experience of service users who had accepted a direct payment and nine were about the experiences of service users who had declined a direct payment.

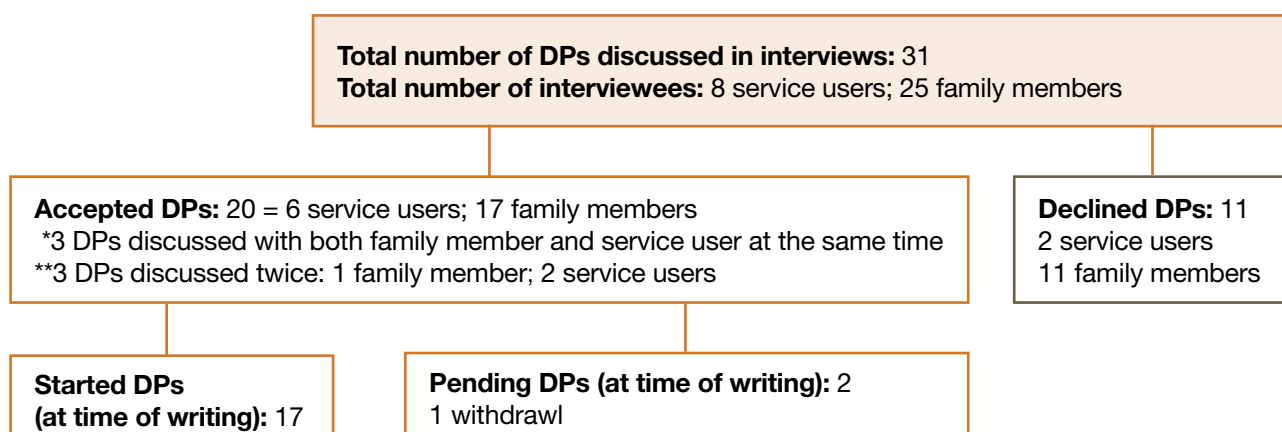




Table 7.13 Characteristics of interviewees

	Interviewee		Direct payment decision		Type of direct payment ¹		Age of service user (years)			Time in care home (years)		
	User	Family member	Accepted	Declined	Full	Part	<65	65-84	85+	<1	1-5	5+
Site 4	0	2	2	0	0	2	0	0	2	1	0	1
Site 6²	1	3	4	0	0	4	4	0	0	1	1	2
Site 7³	4	6	3	6	1	2	5	3	1	0	1	8
Site 8	0	2	1	1	1	0	1	0	1	2	0	0
Site 12⁴	1	10	9	1	9	0	1	2	7	5	4	1
Site 14	0	1	0	1	0	0	1	0	0	0	0	1
Site 15	1	0	1	0	0	1	1	0	0	0	0	1
Site 17	0	1	0	1	0	0	0	0	1	1	0	0
Site 18	1	0	0	1	0	0	0	1	0	0	0	1
Total	8	25	20	11	11/20	9/20	12	7	12	10	6	15

¹ Type of direct payment refers to accepted direct payments only (n=20).

² One advocate (family member) from site 6 was interviewed twice about 2 different service users. This is counted as 1 interviewee.

One service user was interviewed alongside a (paid) carer. The paid carer is counted as a family member.

³ Two service users (SU) from site 7 were interviewed twice. This is counted as one interview for each SU.

One service user was interviewed alongside a (paid) carer. The paid carer is counted as a family member.

⁴ One interview in site 12 was held with a family member and service user at the same time. This is counted as 1 service user and 1 family member.

One family member was interviewed on two separate occasions. This is counted as 1 interviewee.

Twenty interviews involved service users who had accepted a direct payment and eleven interviews concerned direct payments that had been declined. Of the accepted direct payments (n=20), there were equal numbers of ‘full’ and ‘part’ direct payments.

The majority of the interviews (n=19) concerned a direct payment for a service user aged 65 years and older, twelve of whom were aged over 84 years. Amongst the service users aged 65 years and older, eleven had accepted a direct payment and eight declined the offer.

Fewer than half of the interviews (n=15) involved service users who had lived in the current care home for over five years. Of these, seven had accepted the offer of a direct payment and eight had declined. Eight of the service users living in the care home for over five years were aged 65 years and older; seven were aged under 65 years. Seven out of ten service users who had lived in the current care home for less than a year accepted the offer of a direct payment and three declined. Eight out of the ten service users who had lived in the current care home for less than a year were aged 65 years and older. All six service users who had lived in the current care home between one and five years accepted a direct payment. Of these, three service users were aged 65 years and older and three were aged under 65 years.

7.2.2 Expectations of service users and family members

Interviewees were asked about whether they had had any knowledge of direct payments before they had been approached about a direct payment in residential care. Several interview participants (n=17) commented that they had not been aware of direct payments before being involved in the trailblazer. Some interviewees noted



that they had learned of direct payments because of the service users' change in funding arrangements, for example, when they moved from funding their care themselves to receiving council funding. Another family member said that they had been unaware of the offer of a direct payment and only became aware once they received a study questionnaire.

Fourteen interviewees discussed that they had had prior knowledge of direct payments. Seven family members explained that they had had experience with managing a direct payment while the service users lived in their own homes. Of those who had prior experience with direct payments, six accepted the offer of a direct payment in residential care.

Some family members also mentioned that they worked as health or social care practitioners, which had given them some exposure to direct payments. One service user explained her awareness of direct payments came from the experience of a close family member who used a direct payment in the community.

Reasons for accepting

The reasons for accepting or declining a direct payment were discussed in the interviews. Table 7.14 lists the range of reasons cited by interviewees for accepting a direct payment.

Table 7.14 Reasons for accepting a direct payment

Gives service user more choice in their “extra” activities (e.g. leisure, beauty treatments, entertainment)
Allows the family to “take a stand” if they are dissatisfied with the care at the home
Provides instrumental support to the service user
Continues previous experience with direct payment in the community
Simplifies administration of payment: helps consolidate payments from different sources
Improves transparency of care home fees

The most common reason given for accepting a ‘part’ direct payment was to provide service users with more choice of activities:

“I am going to go to all the art galleries in London ... and National Trust properties.” (Service user, Site 7)

Several interviewees also noted that having a direct payment gave them a greater sense of control. A few family members expressed the view that using a direct payment made the care home fees more transparent to them, which improved their sense of confidence and control. As in the case of Anne (Box 1), better control was often expressed in terms of financial control, which several family members explained had led them to feel more empowered to voice their concerns with the care provider should they become dissatisfied with the services.



Box 1 Case study Anne

Anne is 94 years old and had been receiving a direct payment for community services to enable her to live in her own home. This was managed by her son, Graham. Following a diagnosis of dementia Anne was assessed as requiring residential care and a care home was chosen. Graham was happy managing his mother's direct payment in the community and requested that this be transferred to pay for her full cost of residential care. This was agreed by both the council and care home. Graham said that the direct payment had little bearing on the choice of care home, as this was made prior to the transfer, but added that this had been an empowering experience for him. It has enabled him to feel some level of control in his mother's care, by enabling him to resolve small problems with the care home manager quickly and amicably. He also felt that, should he feel that his mother would benefit from a change of care home, it would be quite straightforward to do. So far, the family is happy with the care Anne has received at the current care home and Graham has not yet used the direct payment to facilitate any major changes.

One family member was classified as having declined the offer of a direct payment, but stated that she had been unaware of the offer being made when her relative was admitted to a care home. However, she stated that, with hindsight, she would have reconsidered her decision. The family member reflected that by *"taking hold of the purse strings"* she could perhaps demand better quality of care from the care home, or move her relative to a different home if she felt her needs were not being met.

Six family members suggested their previous experience in the community was one of the reasons for accepting a direct payment in residential care:

"Because I've used [a direct payment] with dad at home, we can continue to do it with the nursing home. It's easy enough once it's set up." (Family member, Site 12)

A few family members explained that they perceived a direct payment as a simpler solution for managing payments to the care home. They felt that transferring the user contribution to the council and the 'top up' to the care home was complicated, and that a direct payment offered an opportunity to consolidate funds coming from several sources into a single bank account from which one payment would be made to the care home per month. However, arranging for these funds to come together had proved cumbersome in the beginning. A few family members also suggested that managing the direct payment allowed them to continue their involvement in caring for the service user.

7.2.3 Becoming informed about direct payments

Interviewees were asked about the type of information received about direct payments. Many interviewees noted that they had been approached individually by a care manager, social worker or other member of the council staff. In many cases, the information was given by staff members from both the care home and the council. Interviewees from one site mentioned that information sessions were held by the council at the care home for a group of residents.

Five family members and four service users stated that they had received adequate information about direct payments. Interviewees explained that they had met the council or the care home staff (or both) on several occasions to discuss the option



of a direct payment. As a consequence of these meetings, they expressed that they were satisfied with the level of detail they were given and were able to take an informed decision, as expressed by one family member:

“In fact, the literature was there, the facility was there for me to question anything that I didn’t quite understand. [That being said] I thought it was all pretty clear. The explanation I got at the meeting was fine and I wasn’t really in any doubt how [the direct payment] would work.” (Family member, Site 8)

Of these cases, five had accepted a direct payment and four had declined, of whom one did so because the care provider had declined to support the programme.

Four interviewees, two service users and two family members, explained that they only received information orally and suggested that additional written information would have been helpful. Two family members of service users who were aged 64 years or younger explained that the information was given in pictorial form. In one case, the family member discussed the value of using alternative methods for explaining the information and obtaining consent:

“[The] social worker is really good at going through things with [the service user]. Sometimes if you read things out [to her], she can understand it, but she can’t read the information. They give [the information] as a matter of course, but they tend not to write things down if they can avoid it. They put it in a different way for her.” (Family member, Site 6)

Many interviewees expressed that they were dissatisfied with the amount of information they had received about direct payments. One family member explained that the information provided was unclear and that they did not understand where the direct payment funds came from. The family member further commented that the care home staff also did not appear fully informed about direct payments. Another family member also explained that the information was difficult to understand and sometimes inaccurate:

“We were given a pamphlet but it is very difficult to understand. It can be very daunting to fill in the forms and more help could be offered. The council even suggested that [the family] open a bank account in [the service user’s] name- but this is fraud. They need to train their staff on what is legal.” (Family member, Site 12)

Other interviewees discussed the poor quality of the information presented to service users. One family member suggested that the information was not presented appropriately:

“[Someone] came out to speak to [the service user] about how [the direct payment] would work. [The explanation] was really inaccessible. [They] were very quick and [it appeared as though the service user] didn’t understand what he had to do with the money. [It] was totally bamboozling for us all when they came to explain it. It didn’t make a whole lot of sense.” (Family member, Site 6)

Another family member indicated that they did not recall discussing the direct payment option with anyone. The family member further explained that they first became aware of direct payments when they received a questionnaire (designed for someone who had declined) for the study in the post. One family member said that she viewed the initial information provided about the auditing process as inadequate which, she implied, left her unprepared for managing the direct payment:



“I’m going to have to get a bank statement to send to them. They are asking me to send copies of documents and I have to keep the [original] documents for three years for auditing purposes. This is what it says on this form I have just received this morning. This is new to me completely. Also, I don’t actually have a photocopier.” (Family member, Site 12)

In particular, three family members commented that very little information was provided after they took the decision to accept a direct payment. One family member stated that she had not received any further information after her initial discussion with a social worker. She reported that she subsequently received a personal identification number (PIN) in the post with the service user’s name, but without an explanation of what it was for. After speaking to other relatives about it, she had deduced that the PIN was for an account that had been opened for the service user’s direct payment.

Three interviewees also explained that they did not receive adequate information about how to use the direct payment. One service user explained that they did not receive an explanation of how to use the swipe card that gives access to the direct payment funds. Two other interviewees suggested they did not receive information about what they could spend the direct payment on:

“I want written down exactly what I can spend [the direct payment] on and what I can’t spend it on. The first meeting I had with them, it sounded as if I would spend it on anything. But as the meeting progressed, they started to say I couldn’t spend it on everything I was thinking of spending it on. It’s not been spelt out.” (Service User, Site 7)

7.2.4 Managing a direct payment

Most interviewees suggested that service users needed assistance with managing the direct payment. All family member interviewees confirmed that they managed the direct payment on behalf of the service user. Two advocates for service users explained their role in helping service users both to understand the direct payment process and to express their wishes for how they want to use the direct payment. One advocate also noted that she managed the financial aspects of the direct payment.

The service users also discussed how they managed the direct payment themselves and what help they received from third parties. One service user explained that his “carer” helped manage the paperwork. One service user implied that the care home “administrator” assisted with the paperwork, and one service user mentioned that an independent advocacy agency managed the financial aspects of the direct payment. In June’s case study (Box 2), the care home staff and the social workers were instrumental in helping her access and arrange a direct payment.

Box 2 Case study June

June is 65 years of age with physical and learning difficulties and has lived in residential care for most of her life. June uses a wheelchair and requires support for some of her personal care as well as other aspects of her life. Although June was generally happy with her care arrangements, she felt that she wanted to engage in other activities than those offered by the home, such as going to the theatre or taking computer courses at a local college.

continued >



Box 2 Case study June continued

She was also keen to start managing her own money through operating a personal bank account. The care home agreed that the funding they currently received from the council to organise day activities for June could be offered to her as a direct payment. The council would continue to pay her residential care and support costs directly to the care home and June would have support from a third party organisation to help her manage her accounts.

Despite all parties agreeing, setting up the direct payment was complicated by difficulties encountered when trying to open a bank account for June. As June had been living in residential care for over 43 years she did not have the requisite two forms of identification to satisfy the bank. A letter from the chief executive of the care home was regarded as insufficient. After around six months, due mostly to the persistence of June and her care home key worker, involving numerous telephone calls and visits, the bank was finally persuaded to open an account for June. The direct payment was then set up, a support plan was agreed and the money transferred.

Several interviewees who accepted a direct payment reported difficulties with setting it up. A recurring theme in the interviews was the length of time it took to open a bank account or for the funds to be transferred into the account. Many interviewees expressed the view that the delay left them feeling uncertain about the process:

“It seemed to take a long time. And I thought, what is going on? Is this happening or not? Is there something I’ve missed?” (Family member, Site 12)

One service user reported that the funds had not yet been transferred to the designated account, a year after her initial discussions with the council. One family member noted that they had to “chivvy [the council] along” to transfer the funds into the account. A similar experience was relayed by another family member who stated that they had made several phone calls to the council before the funds were eventually transferred, five months after they had accepted the direct payment.

A number of interviewees stated that setting up the direct payment was “complicated”. For example, one family member commented that the auditing process was more onerous than expected, as they had to print and send copies of the payments made with the direct payment to the council. Another family member described the experience as “a nightmare” as miscommunication between the family member, the council and the care home resulted in the interviewee receiving a letter to appear in court for missed payments to the council. One service user described the confusion that ensued when trying to use their direct payment to pay for broadband internet, where the invoice was sent to him, rather than the advocate who managed the paperwork.

Some interviewees who had started to receive direct payments at the time of the interview expressed that once the initial difficulties had been overcome, managing the direct payment was straightforward:

“Once it’s set up it actually works very well.” (Family member, Site 12)



In seven cases, family members explained that they enjoyed managing a direct payment whilst the service user had lived in the community. Because they already had a designated bank account and they understood how direct payments worked, they expected the management of the direct payment in residential care to be unproblematic. One service user explained she had a close family member who was currently using a direct payment in the community, which inspired her to accept the offer of a direct payment.

However, a few family members discussed the difficulties that service users would have with managing the direct payment on their own. For instance, one family member of a service user who had accepted the offer of a direct payment, commented that it would be difficult to administer a direct payment without access to the internet. A family member of an older person who accepted a direct payment, commented that although he had found managing the direct payment relatively simple after the “teething” problems had been addressed, he found that his relative would find it difficult to manage a direct payment by himself:

“I think that anyone who is in a care home and who is getting funding, it is going to be a bit beyond them to do [the direct payment] for themselves. I do think they would definitely need somebody, either a relative or someone appointed, to do it for them. [My relative] definitely would not be able to.”
(Family member, Site 12)

Similarly, one family member of a service user who declined a direct payment expressed the view that direct payments should not be offered to everyone in residential care:

“[The service user] wouldn’t be able to manage it and she wouldn’t be interested in doing it. She’s very clear that she doesn’t want the stress or the responsibility ... I feel very strongly that [direct payments] shouldn’t just be across the board. I think [the council] should think about the people they give it to and they should listen to their [care] workers as to whether the people are capable of managing it or not.” (Family member, Site 7)

7.2.5 Use and effects of direct payments

The interviews also explored how direct payments were being used. Of the 20 direct payments that had been accepted, 17 had started at the time of writing. Service users who were receiving ‘part’ direct payments, used the funds to go on excursions outside the care home. Examples of how service users had employed the direct payment included cinema tickets, meals in a pub or restaurant, art lessons, shopping excursions and trips to a garden centre. One interviewee explained that the service user accepted the direct payment to pay for extra care which would allow her to “do something different” from the activities organised by the care home (Family member, Site 6). The interviewee further explained that the direct payment also enabled the service user to change her support provider such that she could have more flexibility to do the activities she enjoys at the times she wants to do them.

In the cases where service users received a ‘full’ direct payment, the funds were used exclusively to pay the care home fees. Mary’s case (Box 3) illustrates the experiences of several family members, where the ‘full’ direct payment did not provide the service user with more options.



Box 3 Case study Mary

Mary is 85 years old and has lived in residential care for a little over one year. Mary has dementia and progressed Parkinson's disease, and requires a high level of personal care. She resides in a privately run care home offering residential care for 54 older people, many with dementia.

Mary and her family accepted a full direct payment to allow her to remain in the care home of her choice. She had been previously paying for her care as a 'self-funder' and her daughter, who has power of attorney, was experienced in managing her mother's finances. Her daughter was keen to continue with this arrangement and the direct payment was viewed as a way to do so. However, it proved to be a long and arduous process to set up the payment, involving a significant number of phone calls to coordinate the various parts of the payment. Apart from the value of being able to continue to manage her mother's finances, Mary's daughter did not feel that having a direct payment offered any additional choices to her mother as the money only pays for the care home fee: *"It's not as if that there is money for anything else – like [mum's] hair dressing and chiropody. We pay for that separately. So, the [direct payment] money is just for her care. I can't see any difference [to if the council paid the care home]."*

However, the family member further commented that if the service user wanted to do an activity that was not covered by the fees, she could use the direct payment to negotiate *"changes within her care [plan]"* with the care home. Indeed, many family members who had accepted a full direct payment agreed that they could use the direct payment as leverage and demand better service or change care homes if the needs of the service users were not being met:

"If certain things aren't quite right, I'll just remind them that I'm paying the bill."
(Family member, Site 12)

A few family members (n=2) also discussed that using a direct payment gave them a sense of control over the perceived uncertainties around having a council-funded place in residential care:

"It's almost giving me the control that using my own money would give me... [By] using [a direct payment], I am not concerned that [the council will] decide that they can't afford [for the service user] to go to this particular care home any longer, because they're putting fees up [for example] and [the council] are going to put [the service user] somewhere else and we've got to lump it. In that scenario [with a direct payment], I have the choice of where she goes, because I have the money, [I don't] feel railroaded into something I don't approve of simply because of financial constraints." (Family member, Site 8)

At the time of the interviews, three direct payments (one 'part' and two 'full') had not yet been transferred to users and had thus not formally started. Since the interview, the service user of the 'part' direct payment dropped out of the programme. In both cases of the 'full' direct payments which had not yet started, the family members explained that they expected to use the funds to pay for the care home fees only.



Satisfaction of service users and family members with direct payments

Interviewees were asked to rate how the needs of the service user were being met by the care home on a scale from 1 to 10 (1 being very dissatisfied and 10 extremely satisfied). For interviewees who had accepted a direct payment, the question referred to the contribution the direct payment had made to satisfy the needs of the service user in the home. For interviewees who had declined a direct payment, the question related to their overall level of satisfaction with the care of the service user in the home.

Overall, interviewees who had declined a direct payment rated their level of satisfaction with the care provided in the care home as high: eight out of ten – or higher – indicating that they were satisfied or very satisfied with the care. This was often accompanied by a positive statement about the care received:

“I would say nine ... I have no complaints at all.” (Family member, Site 7)

One family member, who had declined as a result of not being adequately informed about the option of a direct payment, initially rated her satisfaction highly. However, she also explained that *“there is always room for improvement”* (Site 17). This family member subsequently noted several aspects of the service that they were dissatisfied with, such as the level of attention given to the personal hygiene of their relative, perceived friction among the care home staff, and the amount of information they received about the wellbeing of their relative. Two respondents who indicated that they had declined the offer of a direct payment did not rate their satisfaction on the scale. In one of the two cases, a family member said that they were highly satisfied with the care provided in the care home:

“I cannot speak highly enough of the facility, and the people and the care [the service user] receives.” (Family member, Site 7)

In the other case, the service user suggested that her needs were being met:

“Yes [my needs are met]. Sitting in the lounge day to day wouldn’t be for me ... I sit in the garden or go to town. When my son and daughter come, then I go to the city with them, or wherever I want to go.” (Service user, Site 18)

Interviewees who had accepted a direct payment provided a range of responses. In most cases in which the direct payment has already been received, interviewees indicated that they were very satisfied (NB: respondents with a direct payment did not always differentiate between their satisfaction with the care provided and their satisfaction with receiving a direct payment). One family member rated the direct payment as *“quite high ... a 7 or 8”* (Site 6) and explained that the direct payment allowed the service user to do something different, but also suggested that the rating was lower because *“it hasn’t all been smooth running”*. Likewise, another family member suggested that they became very satisfied with the direct payment only once the initial problems with setting up the payment had been addressed. Another family member rated the value of having a direct payment as very high, but subsequently gave a lower rating for their overall satisfaction with “social services”. The reason given for the lower satisfaction was that the family had been required to make large financial contributions as the service user had initially been classified as a self-funder and was only offered the option of a direct payment when she qualified for council funding.

Another family member said that she was satisfied with using a direct payment, but stated that she might have given a higher rating if the direct payment was needed to apply pressure to the care home to improve care:



“I would say at the moment about seven because we haven’t actually wanted to make any changes to the service she is getting. But it could be higher in the future if we need to do anything like that.” (Family member, Site 12)

Of the remaining cases that had begun receiving direct payments, interviewees gave less positive ratings. One family member gave a rating of 3 and explained that the service user would get more value from the direct payment if he was able to engage in activities that really interested him. Another family member indicated that she was neither satisfied nor dissatisfied with having a direct payment. She further explained that her relative did not make full use of the direct payment (which consisted of an additional payment of £20 made by the council to the care home):

“I don’t feel that it’s beneficial for [the service user]. I don’t think [the service user] gets enough out of it ... I’d say [the value that the direct payment has given to the service user is] about five, really.” (Family member, Site 4)

Two service users who participated in both initial and follow-up interviews amended their ratings of the direct payment between interviews, suggesting that the direct payment failed to meet their expectations. At the first interview James (see Box 4), who was waiting to use the direct payment as planned, gave a low rating of his current situation, but voiced the expectation that the direct payment could allow him to participate in outings and subsequently gave a hypothetically high rate. However, at the follow-up interview the service user gave a “middling” rating for his social activities and suggested it would be higher if he were able to do the activities he wanted.

Box 4 Case study James

James is 63 years old and has lived in residential care for over ten years. He requires a wheelchair for mobility and needs help for personal care. He lives in his own separate adapted dwelling in the grounds of a care home for people with disabilities. James agreed to have a direct payment for part of his care so that he can install and rent a personal internet connection, as well as for supporting personalised activities.

Despite the direct payment being agreed, and being paid into James’ account for a number of months, he has not been able to undertake the activities of his preference as staff and transport have been difficult for the care home to organise. He has, however, been able to participate in some group activities in areas of interest. There are concerns that he might lose some or all of his unspent direct payment money as the council may seek to recoup it.

Another service user who also had not received the direct payment at the time of the first interview, did not give a rating but expressed that their life could be improved with a direct payment if this meant they were able to engage in activities they enjoyed, such as going to the theatre. The service user did not give a rating of the direct payment at the follow-up interview, but implied that, although the money had come in, they were not using it for the activities they really wanted to do. In this case, the service user used her direct payment primarily to engage in activities that did not require ‘one to one’ personal assistance (e.g. group activities organised outside the care home during weekdays) rather than engaging in individual trips out at the weekend as desired. For this service user, organising individual activities proved difficult, largely due to a lack of clarity about what the direct payment could be used for, resulting in some level of dissatisfaction.

“I do [regret taking the direct payment] a bit.” (Service User, Site 7)



On the other hand, one family member who had participated in an initial and follow-up interview gave the direct payment a high rating at both interviews. However, in the interviews, the family member described a slight misunderstanding when transferring the direct payment from the community to the care home, which caused a minor delay in receiving the funds. The family member further explained that the confusion was resolved quickly, nevertheless, the setback affected their perceptions of the efficiency of the process and he rated the direct payment lower than he would have otherwise. Unlike for the service users who had participated in two interviews, the direct payment discussed had been active at the time of both interviews with the family member.

One family member who had not yet received the first instalment of the direct payment did not provide a rating, but noted that the value of having a direct payment was that it empowered families to make choices about how service users' needs were met:

“We know that the money is not tied to that particular care home. We have got flexibility. If there is a problem and we need to move [the service user] for whatever reason, then we could.” (Family member, Site 12)

Finally, one family member stated they had not started the direct payment in residential care because the service user had not moved into the care home at the time of the interview. However, the family member rated the “idea” of having a direct payment (in residential care) as very high because of positive experiences of using a direct payment in the community:

“I would have to say ‘10’ because it has made a massive difference to [the service user’s] life and to ours.” (Family member, Site 6)

7.2.6 Reasons for not taking up a direct payment

Interviewees who declined a direct payment gave a range of reasons for their decision. Table 7.15 lists the main reasons given for declining the offer of a direct payment.

Table 7.15 Reasons for not taking up a direct payment

No perceived benefit as the user and family were satisfied with the status quo
Direct payment would interfere with the services provided by the care home
Taking up a direct payment was discouraged by the care provider
The direct payment would destabilise the sense of security of the service user
The direct payment was too complicated to administer
The care needs of the service user were too complex to be able to benefit from a direct payment

The most often stated reason given for declining a direct payment was that interviewees were satisfied with the quality of care at the care home and they did not expect any additional benefits from having a direct payment. Some family members also expressed concern that direct payments could compromise the quality of services in the care home. They noted that if care home staff responded to the “extra” demands of individuals with direct payments, they risked taking away scarce resources from other residents of the home:



“The home that [the service user] is in, is first class and not over-priced. If you go somewhere else, the fees would be double. It is a charitable organisation run by the Church, and [the service user] does not pay for many of the activities [the provider] arranges for [the residents]; everything is ploughed back into the [care] home. I’m not prepared to take money away from them to give to [the service user] to spend because it’s like robbing Peter to pay Paul.” (Family member, Site 8)

In two cases, a direct payment was declined as a result of the service providers not wanting to participate in the scheme. In another case, a family member explained that they had initially been interested in taking up a direct payment, but the care home did not want to take part in the programme. Similarly, a service user mentioned that he had declined the direct payment partly because the potential carer he approached to accompany him on trips outside the home suggested that a direct payment would be too difficult and too costly to administer.

Other respondents also noted that they had declined a direct payment because they thought it was too complicated to manage. In particular, one service user commented that he could not manage the direct payment on his own and did not have a family member willing to manage the direct payment on his behalf. In another case, a family member commented that her relative *“refused to have anything to do with [a direct payment] ... [and] wouldn’t want the stress”* (Family Member, Site 7). The family member also implied that she did not want to manage the direct payment on the service user’s behalf.

Another family member who declined also perceived direct payments as too complicated:

“I read the national press about the possible complications of receiving direct payments and paying a carer. There is a possibility that you are the carer’s employer and therefore you are obliged to enrol them in a pension and it could get more complicated...when I got the information [from the council], I [considered this report in my decision] as well.” (Family member, Site 12)

Less frequent reasons for declining a direct payment included one family member’s view that a direct payment would undermine the sense of security of service users in the home. Another family member worried that direct payment funds could be used fraudulently:

“Surely if you pay the [care home fees] to a person, and that person then has to pay it to the home, then there is a margin for some skulduggery...”
(Family member, Site 17)

Similar concerns were voiced in a separate interview with a family member who had accepted a direct payment. Finally, one service user refused a direct payment due to his complex health care needs. In light of these needs, he perceived the costs of participating in activities outside the care home to be too high and he did not believe a direct payment would adequately cover the expense. Consequently, he did not perceive that a direct payment would be of benefit to him.

7.3 Summary

Sixty-eight completed baseline questionnaires were received by the end of March 2016. These included responses from 19 service users who had accepted a direct payment, 14 from family members whose relatives had accepted a direct payment (including five from relatives of users who also sent a completed questionnaire), seven from service users who had declined a direct payment, and 28 from family members



of people who had declined a direct payment (including three from relatives of users who also sent a completed questionnaire). A further eight questionnaires from four service users and four family members were returned at the 6-month follow up stage, including one service user whose family member also completed a questionnaire.

Thirty-four interviews were conducted with 25 family members and 8 service users between January 2015 and February 2016. Of the interviews with service users, six had accepted and two declined a direct payment. Two service users who had accepted a direct payment participated in a follow-up interview.

In the survey, thirteen service users/family members who had taken up a direct payment (of 20 in total) said that they were very satisfied or fairly satisfied with the direct payment (with seven being neither satisfied nor dissatisfied). These responses were given by those who were already in receipt of a direct payment (i.e. the direct payment was 'active') and those who had yet to receive a direct payment.

Among those interviewed who had an active direct payment, the picture was mixed, with some indicating that they were very satisfied with their direct payment, while others said that they would be more satisfied if the direct payment had offered more relevant choice (although it was not always clear whether respondents referred to satisfaction with the direct payment or with the care home's services more widely). Among those who indicated satisfaction with their (part) direct payment, some welcomed the opportunity to access additional or different services such as day activities. A number of family members noted that they felt empowered by having more control over the budget. This view was also shared by some of those who had accepted, but not yet received, a (full) direct payment. Interviews indicated that the majority of those who took up a direct payment had lived in a care home for less than five years and many had experience of using direct payments in community care. Those who were critical about direct payments tended to feel to have received (too) little information and guidance on having a direct payment.

Responses from service users and family members suggested that the decision to decline a direct payment in part reflected the satisfaction of service users and family members with the care home. Satisfaction with the quality of care in the care home was the main reason for declining a direct payment and there were also concerns that direct payments could disrupt the home's high standard of care.

Findings also highlighted the role of family members, care workers and advocates in facilitating service users' access to, and the use of, direct payments. In interviews, service users described the instrumental help they received from others to organise and to administer the direct payment. Similarly, some family members expressed doubts that service users could manage the direct payment on their own, both financially and with regard to usefully impacting on choice and control. In the two follow-up interviews service users expressed disappointment about the quality and frequency of information they received after they took the decision to accept a direct payment.

These findings suggest a degree of uncertainty amongst care practitioners and providers about how to support users with a direct payment in residential care settings and underpin the importance of effective communication between council staff, care home personnel and service users.



8. Views and experiences of council staff

This section presents the views and experiences of council staff of implementing the direct payment scheme and setting up direct payments for individual service users. The findings include how the aims of the direct payment trailblazer were understood by project leads, the strategies employed to promote the scheme, their experience of provider engagement and involvement, and their views of the challenges to implementing the scheme. The chapter also presents data from council staff interviews on how direct payments were used by service users and their families, the benefits derived from having a direct payment, and the contextual factors shaping the implementation of the scheme.

This chapter draws on the interviews with project leads and frontline staff in councils involved in implementing the scheme and setting up direct payments for service users. The interviews are described in more details in Chapter 4.

8.1 Characteristics of council staff

A total of 47 interviews were conducted with council staff involved in implementing the direct payment scheme. Twenty six interviews were conducted with project leads in two rounds. This involved 20 individuals as some of the original project leads had left the programme and interviews were carried out with their successors. In addition, 21 interviews were conducted with frontline and other council staff (such as adult social care commissioners or care managers) involved in implementing the scheme in five sites, involving 22 individuals.

Project leads: Project leads were named by each council as leading the project within their authority. Leads held commissioning or other management roles within their council. Most had a social work background, with a few also having backgrounds in social work administration or management. Some project leads worked with project managers, appointed by their councils to support the work, and had sponsorship from senior member(s) of the councils' directorate such as the director of adult social care.

Other council staff: Twenty one interviews were carried out with frontline council staff in five sites: four of these were sites selected for in-depth study and there was a further site included to obtain data for a case study. Project leads in each site facilitated the process of identifying relevant personnel by sending out invitations to participate in the evaluation to relevant colleagues. This included social workers or assistant practitioners working directly with service users and others working in a management capacity in adult social care.

It is important to note that the majority of interviews with council staff were conducted between July 2014 and January 2015 when most sites were still in the process of setting up their direct payment schemes and had not yet recruited service users. A small number of interviews with council staff in two sites were conducted in May and June 2015. These were to inform case studies on the service user journey and were added to the second interim report on request of the Department of Health.

A final set of interviews was conducted with twelve project leads in October 2015 after national support for the trailblazing programme had formally ended. Table 8.1 summarises the number and professional roles of those participating in interviews.

**Table 8.1 Characteristics of council staff participating in interviews**

	Number of interviews conducted	Roles of interviewees (number of interviewees per role ¹)
All sites	14 (round 1) 12 (round 2)	Trailblazer project lead (14) Trailblazer Project manager (1) Trailblazer project lead (12) Trailblazer project manager (1)
Site 4	5	Council service manager (5) Social worker (1)
Site 7	4 1 group interview	Assistant social work practitioner (3) Support manager (council contracted support organisation) (1) Social worker (1) Support manager (1) Trailblazer project lead (1)
Site 8	7	Social worker (4) Council service manager (2) Council broker (1)
Site 12	2	Social worker (2)

¹ Some interviews were conducted with more than one person (e.g. a joint interview with a project lead and a project manager).

8.2 Understanding the aims of the Direct Payment Trailblazer at the early stage of the programme

Project leads and other council staff indicated that they were generally supportive of direct payments as a tool for stimulating personalisation. Many had experience of direct payments in the community where they were viewed as providing more flexibility and choice for users of social care services. When interviewed in 2013, during the preparatory stage, most project leads had agreed that current arrangements for long-term residential care 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 et al., 2013).

Project leads conceded that 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.

This perception of the limits of choice within care homes was reiterated in the interviews with project leads during the implementation phase of the programme in 2014. Leads commented that the priority given to meeting needs largely reflected the high level of dependency of residents in residential care, especially for older people. However, they 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 a specific daytime activity over and above those that are offered to groups or all residents. 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 a more 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 alright 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’.”
(Project lead, 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.” (Project lead, Site 12)

However, while project leads and other council staff agreed, in principle, that the aim of the programme was to enable a more personalised residential care home service, many expressed doubts about whether direct payments would be able to achieve this aim in practice. There was uncertainty about how the direct payment scheme might be implemented, especially in relation to older people with dementia and other service users with limited capacity to make their own choices through the use of a direct payment. Interviewees also mentioned that they believed that the council funding available for residential care provided little flexibility for more and different choices. This was particularly observed in relation to the care of older people.

Changes in perceptions about the aims of the scheme over time

Some project leads indicated that their understanding of the aims of the trailblazers had shifted during the course of the programme, with more emphasis given to establishing direct payments as an end in itself rather than a means to achieving personalisation. Some noted that 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 also do harm to the quality of residential care (e.g. undermine the objective of personalisation by increasing financial pressures on care homes).

Interviews suggest that these changes in perception in part resulted from difficulties experienced by many project leads in setting up the trailblazers. Convincing care homes to participate in the trailblazers was challenging in many council areas, as care home managers and owners were often sceptical about the risks associated with direct payments to their funding and their business model of pooling funds and achieving economies of scale in care provision (Chapter 9). Many project leads



also expressed doubts about whether they had found a workable mechanism for calculating direct payments. A key concern was whether direct payments would be an appropriate tool to stimulate more personalised care, which was seen as potentially different from giving users control over a budget to make their own purchasing decisions.

8.3 Implementing the Direct Payment in Residential Care programme

Interviews with project leads and other council staff involved in setting up local trailblazers identified a number of areas of complexity and challenge. These included developing local strategies for planning and developing the trailblazers, including creating an appropriate model for both calculating the payment and implementing the scheme, as well as engaging and involving the key stakeholders.

8.3.1 Initial plans for developing the direct payment programme

At interview in 2014, project leads indicated that implementing the programme required collaboration across a number of council ‘in-house’ teams. 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, communicating council policy and practice on direct payments in residential care to operational staff and other stakeholders, and 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, adult social care service teams, and others as appropriate; some also included representation from service users.

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 have been established locally through the work of trailblazers, while others wished for a clearer central steer.

Interviews with council staff identified a range of approaches for implementation the direct payment scheme in all five trailblazer sites selected for in-depth investigation. These are summarised in Table 8.2.



Table 8.2 Plans for setting up direct payments in five trailblazer sites

	Approach to implementing the scheme	Further information
Site 4	Separate additional payment to selected residents	Provision of a separate cash payment as a 'direct payment' to personalise care for a number of older residents in participating care homes. Three care homes participating.
Site 7	Full or part direct payment offered to selected residents in selected care homes	Participating care homes help the council with recruiting residents to consider either full or part direct payment on a case-by-case basis.
Site 8	Universal offer of full or part direct payment to new or current residents (all client groups)	Full or part direct payments offered at assessment stage for new residents eligible for council support or at review for current eligible residents. Project leads work with providers and social care teams to promote direct payments to service users.
Site 12	Universal offer of full direct payment to new or current residents (all client groups)	Full direct payments offered at assessment stage for new residents eligible for council support or at review for current eligible residents. Project leads work with providers and social care teams to promote direct payments to service users.
Site 17	Universal offer of full direct payment to those entering residential care (all client groups)	All new eligibility assessments for residential care are offered a direct payment. If accepted social care teams liaise with the care home to seek agreement to accept the direct payment as payment for care home fees.

These plans reflect two broad strategies for operationalising direct payments in residential care. The first was to offer direct payments to a *selected group of individuals*, for example, residents of particular care homes that had volunteered to support the trailblazer. In this way, the council would retain some control over the numbers of potential direct payment users and consequently any potential resource implications. The second approach involved offering direct payments to *all people living in care homes used by the council or entering residential care for the first time* (universal offer). In these cases, information about direct payments was integrated into the standard procedures for assessing care and planning support. This approach was seen by some as more pragmatic and more in line with the expectation of a future roll-out in 2016.

“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.” (Project lead, Site 11)

However, it also meant that the council had less control over the demand for direct payments.



Plans also varied with regard to the type of direct payment offered, either to cover all residential care fees (as a full direct payment); part of the fees for activities or other services (part direct payment); or as an additional payment on top of the existing care home fee.

Interviews with several project leads revealed that their initial plans had changed over time with some sites broadening their offer to a larger number of care 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.

“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.” (Project lead, Site 6)

8.3.2 Experience of engaging and involving providers

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.

There was also a realisation in many councils that they needed providers' input to inform the development of the programme.

“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.” (Project lead, Site 18)

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

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

Project leads noted that many care homes were interested in direct payments, especially at the beginning of the trailblazer, and were supportive of the aim of better personalising care in residential settings. Some trailblazer sites also benefitted initially from a desire among care homes to collaborate with the councils to prepare for the implementation of the Care Act 2014.

However, as the programme evolved, discussions about direct payments often proved to be sensitive, with care home managers and owners concerned that direct payments could add further pressure on already strained care home budgets in times of austerity.

Project leads therefore had to reassure providers that they would not be financially compromised by participating in the trailblazers, 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 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).

Views about the role of providers in developing direct payments

Most councils worked with a selected group of providers, while a few decided to offer direct payments to all groups of local service users eligible for council support 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 wanted to participate in the trailblazers.

Working with providers to develop the direct payment ‘model’ was one of the more challenging aspects of the programme, according to project leads (this is explored in more detail in Chapter 9. In some areas, project leads worked with providers intensively to identify opportunities for flexibility in the current care home fee system. This required discussion about: a) the extent to which current fee levels covered costs; b) the distribution of these costs between service users; c) how distinctions could be made between the costs of care and costs of accommodation (‘hotel’ services) and d) whether it was possible to set aside a part of the current fee to allow service users additional choice.

Care homes in these sites were therefore instrumental in helping project leads to develop a model for determining the monetary value of direct payments. However, some project leads also noted that care homes could be reluctant about providing information on costs and that council staff sometimes found 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 [social workers] see their role and function being.” (Project lead, 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.” (Project lead, Site 1)

Views about the role of providers in recruiting users

Some trailblazer councils involved providers in identifying and recruiting potential recipients of direct payment in their care homes. Most project leads noted that it was important to provide care homes with sufficient information about the trailblazer so that care home staff could inform service users and family members appropriately about direct payments.

However, this approach did create some uncertainty, as it was not always clear how the care home personnel approached service users and whether they provided sufficient information to enable an informed choice. Some leads suggested that care home staff might have had their own views about the direct payment or that they might have been unsure about the desirability of the direct payment for the home and/or the user.



“We have had a situation where we [council project leads] do not actually know how the conversation went. We had a provider...that attends the [council’s] 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 [the direct payment].” (Project lead, 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.” (Project lead, Site 2)

Other sites opted for project leads to contact service users and care homes directly and provided information to both, for example at ‘themed coffee mornings’. A few councils opted for an alternative approach to identifying potential service users with the project lead or social worker having a discussion about direct payments with the service user first, followed by a conversation with a chosen care home about the opportunities to use a direct payment in the home.

8.3.3 Views on risks and challenges for 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 were a prominent concern of providers reported by project leads and other council staff. 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.” (Project lead, Site 2)

Project leads accepted that the concern of providers about the potential of direct payments to reduce their income was within the context of already tight budgets for adult residential care, especially for homes providing care to older people. It was 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. In an interview, one project lead spoke about a care home manager as 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.”* (Project lead, Site 18)

Council staff particularly noted that care homes had difficulties reconciling the idea of a part payment made available to the service users from the existing care home fee with their current way of operating. More specifically, they 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. While it was later noted that it may not be necessary for care homes to disaggregate their costs, it was unclear during the programme how else part direct payments could be made available in the absence of additional funding.

Project leads also mentioned concerns of providers about service users potentially not paying their care home fees for activities or services, 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 do in order to prevent providers leaving the trailblazer.

Concerns about the impact of the direct payment on providers' current funding and costs of care were echoed in interviews with council frontline staff. Staff reported that some care home managers were unwilling to engage in the scheme and that there was an element of provider resistance. Much of this was related to the concerns that care home managers and owners had about council funding for long-term social care and this funding being insufficient to cover the costs of care, particularly for older people.

Safeguarding and regulation

Council staff reported 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 concern. Questions arose 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 those responsibilities themselves. Doubts were also raised about the care regulator, 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, care homes were regulated to provide activities for clients in their care. The questions both project leads and care home managers were grappling with was whether CQC inspectors were likely to be aware of the fact that some individuals with a direct payment could choose to opt out of joint activities offered in the home and whether this would be held against the home. Providers were generally reluctant to take the risk until getting a clear steer from the regulator. One project lead recounted a conversation with a provider, discussing the concern the care home had about accepting a direct payment for individual choice of activities for a client in his care home:

"[Providers are] saying, 'when I have an inspector come in and say, 'why aren't you providing daytime activities for this person? You're regulated to do that', I'm not going to continue to take this risk that I'm going to be penalised, marked down'." (Project lead, Site 8)



8.4 Promoting, agreeing and activating a direct payment

Once the scheme was set up locally, council staff spoke of particular concerns emerging in a variety of areas. This included difficulties promoting the scheme to service users and their family members.

8.4.1 Promoting direct payments to service users and their families

The majority of council staff interviewed noted that direct payments had the potential to provide some service users with more and potentially better options to have their social care needs met in care homes.

A number of project leads felt that some of their frontline staff could not see the value of direct payments for service users and “struggled to sell it for the positives” (Project lead, Site 17). Others felt that stressed or overworked staff might perceive someone with a direct payment as “more work” (Project lead, Site 8). This led to concerns among project leads about whether and how direct payments were explained to service users and family members.

A number of frontline staff expressed their lack of confidence in promoting direct payments. Practitioners had few templates to draw on, which was felt especially by those who did not have much experience of direct payments in the community. In cases in which the benefit of the initiative was not immediately obvious, having the required knowledge and confidence to promote direct payments to service users and their family members, was considered important.

Project leads provided various forms of support and guidance to service users and families including written leaflets and information sheets. These were at various stages of development at the time of the interviews and some frontline staff were relying on their own understanding of direct payments to field questions from service users, their family members and from providers. Some staff found this challenging.

“It is really difficult to promote something. I can’t talk for the team, but I know when we have had team discussions, and when you have just been chatting, I think we [social workers] are all in the same boat. The message that I get constantly is, well, we don’t really know enough about [direct payments in residential care]. We don’t really mention it because we are not really sure.”
(Social worker, Site 17)

Most project leads and council staff suggested that identifying and engaging service users and families had been (unexpectedly) time-consuming and laborious. They also stated that they experienced scepticism from some 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 at the same time as making the decision about entry to residential care; 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 enthusiasm after being initially interested.



“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.” (Project lead, Site 8)

Making the offer at the time of entry to residential care, particularly during a time of crisis, such as following a fall or because of a general deterioration in health and ability to self-care, presented a number of challenges for the council staff involved. This was especially visible in a site that opted to offer direct payments during the normal process of assessment before the service users entered residential care. As a social worker explained, the assessment process could be lengthy and involve complex information exchanges, with the direct payment being offered only at the end of a long and often difficult conversation.

“I’ve gone out obviously to assess somebody for residential care, generally speaking the families are in crisis for some reason. Obviously, they’re distraught, they might be guilt-ridden. It might be really hard for the person if they’ve got capacity to come to terms with this change in their life. So, I’m talking to them about all of that, and then having to tell them about the financial process, if they’ve got property, and filling in a white financial assessment form, and at the same time, I’m then having to go on and have a discussion about direct payments in residential care. Now, that meeting could be two hours. It’s too much. It’s just too much. So, I don’t think that that offer is placed at the right place.” (Social worker, Site 17)

Discussing an offer of a direct payment was often less challenging for practitioners engaged with service users and family members currently receiving residential care, particularly if the care home agreed to accept the full or part direct payment, but getting full formal acceptance from users and family members frequently proved resource intensive.

Explaining direct payments to residents often involved a number of meetings of council and care home staff with users and their families to discuss individual choices and support arrangements. There were also examples where family members eventually decided not to take up a direct payment because the process was seen as too complex.

“There have been numerous cases where, after a lot of work the service user’s family member has said, ‘actually I don’t want to do this’ or because care homes have been a little bit...putting up barriers, that it’s taken so much time that by the time you are getting to that point the family member says, ‘all right, I am not going to be bothered’.” (Project lead, Site 12)

8.5 Challenges to setting up direct payments

Council staff noted that setting up a direct payment could be lengthy and more difficult than anticipated, despite councils having made considerable efforts to prepare their internal systems and develop processes before starting to make offers. They observed that such delays could cause a degree of anxiety for some of the service users and family members involved, for example, in a case in which it was not clear whether and when the family should begin to pay care home fees and cease paying the user contribution to the council.



Reasons for delay in getting the direct payment set up included difficulties in opening bank accounts for service users who had lived in residential care for a long time and therefore lacked the required evidence of personal identification. Other difficulties involved co-ordinating processes and financial systems to enable efficient transfer from one payment system to another and co-ordinating meetings with service users, family members and council staff, to ensure that support planning was in place for the user to be able to identify choices facilitated by the direct payment.

Interviews with council staff exposed a number of other concerns relating to staff capacity and resources, for both councils and providers. In the site adopting the approach of providing an extra payment for personalised activities (Site 4), organising activities for individual residents who had accepted this additional payment proved to be more time consuming than expected. Council staff noted that care home staff spent much of their time understanding the wishes and abilities of residents to undertake activities, and researching local events and communal activities in which residents could participate. However, undertaking these activities was, in some cases, hindered by the fluctuating physical abilities and varying health needs of residents (e.g. older people feeling less confident to leave the home during the winter) raising questions about the sustainability of the activities funded for by the direct payments.

8.6 How council staff observed the use and benefits of direct payments

In council areas where direct payments were taken up by care home residents and their families, council staff observed that direct payments were used to pay for a range of services and activities which were often seen as beneficial to residents. However, the use of and benefits derived from direct payments varied between recipients, particularly between those receiving full and part direct payments, and between younger and older residents of care homes.

8.6.1 How 'full' and 'part' direct payments were being used

Where full direct payments were offered and accepted, service users were typically expected to cover the entire care home fee, which, as some council staff observed, may or may not have enabled more choice. Project leads, in those areas in which full direct payments were offered, stated that these payments were mainly used to cover the care home fee, which might give the user or family more control over the budget but typically did not result in additional choice of services. The direct payment would still cover the same care home 'package' of services as without a direct payment.

In several instances, full direct payments were employed to enable self-funders who had become eligible for council funding (i.e. reached the required threshold for financial support), to remain in their care home of choice. This was seen as a benefit to them, although it often cost the council more money. It also enabled them to continue to maintain control of their finances.

"The direct payment is just a way of [delivering a personal budget] and it means that the person who's controlling it has got a bit more say in that and I think that's the important difference." (Project lead, Site 12)

In another council, a full direct payment was employed to access a care home place of choice outside of the council area. In this case, the direct payment facilitated the



service user and family members' preferred choice of care home. As the social worker involved in this case noted, the family was happy with the quality of services received in the home by their mother, who had dementia. As an out-of-area placement, the direct payment was perceived as the tool which allowed the individual to choose a specific care home, which would not have been available otherwise. As a result, both the user and the family were happy with the arrangement facilitated by the direct payment.

“She [the service user] may have got the choices [on how she wants to live], but it depends on where she goes. She may have got those choices. But with the direct payment, [it’s] helping her to choose exactly where she wants to go ... It’s the choice of home which is really, really important.” (Social worker, Site 8)

Part direct payments varied in size, with older people typically having smaller direct payments than younger adults with disabilities. Project leads and frontline staff reported a number of instances in which direct payments were taken up by younger adults with physical or learning disabilities. Part direct payments were typically linked to payments the service users received for daytime and social activities, which were available to younger people in residential care. In such cases, the part direct payment was used for a variety of purposes, for example, to allow the service user to participate in activities outside the home offered by different providers.

For older people, part direct payments tended to be small, including in those two areas in which an additional sum was offered as a direct payment. In these cases, council staff reported that (older) residents enjoyed being able to use the payment to fund activities of their choice (e.g. a visit to a garden centre or local pub or having a manicure).

“I suppose that I was fairly cynical about [the direct payment] but then I have been to the reviews with the two people who are having [a direct payment] and have seen how it has really improved their life and their well-being.”
(Project lead, Site 18)

Another project lead noted that in her/his experience the wishes of older residents could be very modest. However, sustaining these activities in this population posed difficulties both with regard to staff availability to support the activity and the fluctuating health status of residents.

Some council staff also observed that many of these services or activities could have been organised through direct commissioning, without the use of a direct payment, if more attention was given to individual preferences.

8.7 Effects of contextual issues on the scheme

Council staff reported that two factors external to the programme affected the implementation of direct payments in residential care during the trailblazing scheme in trailblazing councils. These were the work involved in preparing for the implementation of the Care Act 2014, with most of its elements expected to come into effect between April 2014 and April 2015, and the fact that councils were undergoing significant, and in some cases repeated, reorganisation as a consequence of the cuts to centrally allocated funding for local authorities.

There was some confusion initially about the relationship between the Care Act 2014 and the Direct Payments in Residential Care trailblazer, with some project leads



wondering about the implications of the Care Act for the approach to costing care home placements and setting care home fees. Discussions in the first year of the scheme particularly focussed on the possibility of providers having to disaggregate their costs by distinguishing ‘care’ from ‘hotel’ costs. A similar distinction is made in the Care Act. However, this was increasingly seen by council staff as a distraction given that the challenge of getting providers to split their costs emerged as almost insurmountable during the programme, as providers (especially for older people) argued that the fees paid by the council already failed to cover their costs.

Project leads also talked about the uncertainty surrounding the potential impact of the Care Act on care home fees. This included the impact 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. This aspect of the Care Act 2014 was later postponed to 2020.

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.”
(Project lead, Site 12)

Project leads also noted that councils were undergoing substantial organisational changes during the scheme 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.” (Project lead, Site 1)

“We lost the majority of our steering group because we had another round of voluntary early retirement and voluntary severance.” (Project lead, 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 focussed personalisation team who would have at one point led on things like this that we have lost.” (Project lead, Site 6)

In some sites, the combined effect of having to deal with austerity and to prepare for the implementation of the Care Act (before key reforms were postponed to 2020) 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.



8.8 Summary

Interviews with project leads and other council staff revealed a high level of support for the idea of personalising services in residential care, but many were unsure about whether and how having a direct payment would lead to more personalisation.

Those council staff engaged in implementing direct payments frequently found this to be a long and resource intensive exercise requiring substantial co-ordination, co-operation and agreement between care home and council staff as well as service users and their families. Some staff revealed that they lacked confidence to promote the scheme to others and many reported difficulties engaging providers. However, most council staff recognised the benefits that direct payments had for some individuals who participated in the scheme, notably for younger people who attracted additional funding for day services that could be used as a part direct payment.

Council staff reported that it was more difficult to set up direct payments for older people, with the exception of those instances in which older residents received a full direct payment to cover their care home fees. Yet while this gave users and families more control over the budget, at the time of the trailblazer this did not necessarily result in any additional choice. Council staff also reported that the implementation of the trailblazers was hampered by the preparations for the Care Act and by councils forced to reorganise and downsize as a result of ongoing budget cuts leading to substantial staff turnover in trailblazing sites.



9. Views and experiences of residential care providers

This chapter brings together findings from the analysis of two sets of data: a web-based survey of providers in trailblazer areas and interviews with care home managers and owners involved in the scheme.

9.1 Findings from the care home provider survey

This section presents findings from a survey of care homes managers and owners. The survey was conducted electronically via Survey Monkey. After a small pilot it was launched in late November 2015 and closed at the end of March 2016. A total of 631 care homes in ten of the trailblazers were invited to participate, as explained in Chapter 4.

The survey was designed to capture the views of providers and the experience of implementing direct payments in care homes; most of the survey comprised closed questions with a smaller number of more open-ended questions.

A total of 114 responses were received. Of those who answered the question about their position in their organisation, the respondents were mostly care home managers (70%), with the remainder being care home owners. Some of the respondents clarified this by giving their specific titles, such as ‘Assistant Director’, ‘Regional Manager’, ‘Care Home Administrator’ and ‘Chairman’.

Twenty responses contained so little information – often just the name of the council area and whether or not the care home had any direct payment users – that they were excluded from analyses. One other response was excluded because it was identical to another survey response, suggesting a duplicate. Thus, 93 care homes provided unique and complete or substantially complete response, a response rate of 15%.

These 93 care homes comprised 70 care homes which reported no direct payment users, 15 care homes which reported one or two direct payment users and eight care homes which reported several or many direct payment users. That any care home had many direct payment users is inconsistent with information reported by trailblazer councils, and some of the eight concerned stated that they did not participate in the trailblazer programme.

Investigation of this issue revealed a misunderstanding. Three homes indicated that they specialised in respite care or day care, for which community care direct payments had been available. Discussion with a trailblazer council showed that at least one area had an arrangement known as a direct payment in which the council made a block payment to a care home for day care activities. While it is possible that one or two of these eight care homes did have a direct payment user under the trailblazer scheme, it is highly doubtful. We have therefore excluded them from the analysis.

9.2 Care homes with no direct payment users

The 70 care homes which reported no direct payment user under the trailblazer scheme comprised 52 residential care homes and nine nursing homes, with nine providing other types of care. 51 of these care homes were privately owned and 18 were registered charities (with one missing value). Thirty of them were part of a care home chain or provider group. Of these 12 were part of a chain of 20 or more care homes, eight part of a chain of six to 19 care homes and ten part of a chain of two to five care homes. Thirty-six of the care homes did not know what proportion of their residents received some level of council support to fund their care. Seventeen reported that over 75 percent of their residents received council support, nine that 51 to 75 percent received council support and nine that 11 to 50 percent received council support.



Sixteen of the responses from care homes stated that they were participating in the trailblazer scheme in principle but none of their residents had been offered a direct payment. Twelve said they participated in the programme but no resident had as yet accepted a direct payment, while 36 stated that they were not participating in the trailblazer scheme. Almost all the non-participating care homes indicated they had not been informed about the direct payment programme. Only three care homes reported that they had been informed, but decided not to participate (two of the three giving their reasons as they did not believe that their residents could benefit from a direct payment and one was 'waiting to see how the other care homes got on with it') and one that it had been informed but decided to participate at a later stage.

Table 9.1 Characteristics of care home survey respondents

	Care homes with direct payment holders	Care homes without direct payment holders	Total – all care home providers who took part in the survey
Care type			
Residential care	10	52	62
Nursing care	2	9	11
Other types of care	1	9	10
Missing	2	0	
Organisation type			
Privately owned	11	52	63
Registered charity	2	18	20
Council owned	0	0	
Missing	2	0	
Part of a provider chain			
Yes	8	30	38
No	5	40	45
Missing	2	0	
Size of the care home chain			
2-5 care homes	4	10	14
6-10	0	3	3
11-19	1	5	6
20 or more	3	12	15
Proportion of residents receiving council-funded support			
11-25%	2	3	5
26-50%	2	6	8
51-75%	0	9	9
Over 75%	4	17	21
Don't know	7	36	43
Number of registered places in care home			
up to 10	3	16	19
11-39	8	38	46
40 or more	2	15	17
Missing	2	1	
Types of residents			
Older adults (65 & over)	5	36	41
Adults (18-64) with learning disabilities	5	23	28
Adults (18-64) with physical disabilities	1	3	4
Adults (18-64) with mental health problems	2	6	8
Other	0	2	
Missing	2	0	



9.3 Views from care home providers where no residents held a direct payment

Some of the respondents to the survey made comments within the questionnaire explaining their position. One provider, which did not have any residents with direct payments, suggested that the programme was not “a workable idea” because many of their residents had dementia and were unable to manage finances, and many residents did not have a bank account and “would not meet the criteria for the banks to open a new account”. The provider added: *“It seems OK for younger people with physical disabilities, but not for older people with dementia.”*

Some providers raised concerns about residents and family members who may be put off by the idea of holding a direct payment, and the responsibility that might come from managing it. One care home respondent, with no direct payment holders in their care home, explained this potential issue in detail:

“Unfortunately by the time relatives have placed their loved one in paid for care and support they are often at a stage in their life where they want as little hassle and change as possible. The whole concept of direct payments worries relatives and there isn’t yet enough accessible information that is delivered in person to relatives that gives them assurances that they won’t have to administer the monies if they don’t want to but rather a third party will do so on their behalf.”

Other comments about the programme indicated a sceptical attitude about the motives of commissioners in local authorities in introducing such initiatives, which they feared were driven by a desire to reduce costs. *“Generally any innovative ideas generated from our commissioners are designed to reduce spending and cut fees”,* one respondent noted, adding that they had not been given enough information about the programme to understand what it might mean for the provider or the residents. The respondent added:

“All we can see is an increased workload for ourselves and all the issues of chasing outstanding debt coupled with the conflict of interests and complications of evicting someone if they refused to pay.”

Another respondent said s/he might be interested in taking part in the direct payment programme, but nobody from the local council had met her/him to discuss it further, while another raised concerns about possible financial abuse occurring when people receive direct payments. A manager from one of the care homes which reported having at least one direct payment holder said safeguarding issues had arisen as a result of a direct payment.

9.4 Care homes with direct payment users

Fifteen care homes reported that they had residents in receipt of a direct payment under the trailblazer scheme. This was after exclusion of those homes which reported substantial numbers of direct payment recipients seemingly not under the trailblazer scheme. Of these 15 care homes, seven reported one direct payment user, four reported two direct payment users, two reported three direct payment users and one five direct payment users (with one missing value). Of these care homes, four reported having direct payments covering the full care fee, with five direct payments of this



type in total (one care home had two residents with direct payments, and the other three care homes had one each). Ten care homes said they had residents with direct payments covering part of the care home bill, with 15 direct payments of this type in total. However, these figures should be approached with caution, given that three care homes said they had at least one resident with a direct payment, but failed to specify whether they were full or part-fee.

Six of the care home providers responding to the survey said they received additional funding from the council, exceeding the usual care home fee. These amounts, in descending order, were as follows:

Table 9.2 Care homes with direct payments with additional funding

Care home with direct payment attracting additional funding from the local authority	Amount (£) per individual per month
Care home 1 (from site A)	1125
Care home 2 (from site B)	150
Care home 3 (from site A)	80
Care home 4 (from site C)	40
Care home 5 (from site C)	40
Care home 6 (from site D)	6

Three of these cases relate to care homes in sites which made additional payments (Model 3, see Chapter 5).

The 15 care homes with direct payment holders were concentrated in six counties or boroughs. Eleven were residential care homes and two were nursing homes, while one stated it provided supported living and another stated it provided both residential and nursing care. Seven provided care for older people and eight for other user groups.

Eleven care homes stated they had been approached by the council about the scheme, one had been approached by a social worker in respect of an individual resident and one by the resident or resident’s family. (There were two missing values.) Thirteen care homes indicated that they had promoted direct payments to their residents and one that it had not done so (with one missing value). Nine care homes discussed the direct payment individually with residents and/or family members, one at a meeting with all residents and family members and three both with individuals and collectively at a meeting.

Ten care homes reported use of the direct payment for personally arranged activities outside the care home, five for personally arranged meals taking place outside the care home, four for personally arranged activities taking place within the care home, two for personally arranged care within the care home involving specific services or activities, and one for personally arranged meals within the care home. Note that direct payments could be used for more than one of these activities – they are not mutually exclusive – and that there are missing values for three care home responses.



Respondents from seven care homes indicated that their resident requested the activity, three that a family member of the resident requested it and three that another person who regularly supports the resident requested it. Two care homes indicated that they offered the activity and had not been requested by residents or their family members to do so.

Some of the comments from care home providers participating in the trailblazer were very positive. One remarked that the direct payment programme was *“an excellent initiative and should be continued”*, while another praised the hard work of the coordinators at the council in promoting awareness of the initiative.

However, an assistant director of another provider, which was also participating in the programme, called for a cautious approach in rolling out direct payments in residential care more widely.

“I feel that the LA still have much to learn and do before they implement Direct Payments for those in residential care,” they said. “The trailblazing group worked hard to make it happen in our care homes but the LA departments do not communicate with each [other] and there is no joined up thinking within the LA...I also feel that it will have a detrimental effect on the ‘Care Market’.”

However, some concerns were noted by other respondents participating in the programme. One manager of a care home, which had three residents holding direct payments covering part of the fee, expressed the view that the system was “based more on want than need”. They explained that one resident, whose relatives had been encouraging the local council to increase funding for the person’s care package, had a direct payment budget “significantly higher” than other residents with the same level of assessed need. The respondent added:

“Whilst we try hard to ensure everyone gets a range of weekly social activities, this one individual gets a much larger range of activities and holidays, in my view, far in excess of what someone of his age range would be experiencing out in ‘the world’. My concern is that as increasing amounts of social care money is being used to fund ‘wants’ for the few, the ability for local councils to fund basic needs for the most will diminish.”



Table 9.3 Responses from the care home survey regarding the effects of direct payments on residents

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Missing
Direct payments make it more likely for residents to receive services they prefer	4	3	2	3	1	2
Direct payments make it more likely for residents to take part in activities that they want	3	3	2	4	1	2
Direct payments enable residents to be better informed about their options	3	2	5	2	1	2
Services available to residents have not changed since the introduction of direct payments	5	2	0	4	2	2
Activities available to residents have not changed since the introduction of direct payments	3	1	4	4	1	2
Direct payments enable care home staff to better understand the preferences of their clients	2	4	3	2	2	2
Direct payments enable family members (or other carers) to become better informed about the options of care available for their relatives	2	3	6	1	1	2
Direct payments benefit all our residents, not only those receiving the payment	2	2	2	5	2	2
Residents who receive a direct payment appear more satisfied with their care	1	3	3	3	3	2
Family members (or other carers) of residents in receipt of a direct payment appear more satisfied with the care of their relatives	1	1	6	2	2	3

Results from the section of the survey covering satisfaction with the direct payment and the impact of direct payments on residents and other stakeholders showed that most respondents agreed that the programme had a positive effect on residents participating in it, but there were more mixed responses regarding the impact direct payments had on other residents and family members. Seven respondents either agreed or strongly agreed that direct payments make it more likely for residents to receive services they prefer. Meanwhile six said that they make it more likely for



residents to take part in activities that they want, two neither agreed nor disagreed with this statement, and five disagreed. However, seven providers agreed (including five who strongly agreed) with the statement that “services available to residents have not changed since the introduction of direct payments”.

Respondents were also asked whether care home staff were able to understand client preferences better as a result of direct payments, but there was no clear pattern of responses. Six respondents said they agreed with this statement, three neither agreed nor disagreed, and four disagreed. There was a lack of consensus about the impact of direct payments on other residents and family members. Five respondents agreed that direct payments enabled family members to become better informed about care options for their relatives, although six neither agreed nor disagreed. Seven disagreed with the suggestion that “*direct payments benefit all our residents, not only those receiving the payment*”, and four disagreed, with six neither agreeing nor disagreeing, that “*family members (or other carers) of residents in receipt of a direct payment appear more satisfied with the care of their relatives*”.

Finally, respondents were asked whether the relationship with their council had changed as a result of the direct payment, and the survey allowed space for respondents to elaborate on their answers in an open-ended comment section; below are some extracts from this section.

Table 9.4 Responses from the care home survey regarding the provider’s involvement with care planning, and relationship with the council

Care home	Has the approach to care planning for residents in your care home changed?	Have you become involved in council care planning?	Comments explaining whether the provider’s relationship with the council has changed as a result of the direct payment
1	Yes	Don't know	Better relationship with promoters of direct payment.
2	No	No	Our care planning was always person centred in our organisation. There have been issues around the LA setting up their systems to manage this process and this took some time. Each department failed to communicate with the other re the process and this led to frustration on the carer that was supporting the process. It was good to have a dedicated commissioner in place to manage the “journey” with us as well as a trailblazer contact member of staff.
3	Yes	No	I feel better informed and have a direct contact at the council as a result of a resident having direct payment.
4	No	Don't know	No changes. All contact has been good and questions answered.
5	No	No	Yes very much so. Trying to get correct money from them has been very difficult resulting in meetings and nobody seems to move quickly in our county council. Very frustrating.
6	No	No	The appointed suitable person had to wait several months for payment from the Council.



Results from the 15 respondents from care homes with residents with direct payments suggested there was minimal impact on staffing levels and the types of staff used, but a significant proportion reported changes in the amount and structure of working hours for staff as a result of the programme. The most common response to the question about whether staffing levels had changed was ‘not changed’ (10 out of a total of 13 responses), and most respondents said the types of staff had not changed (11 out of 13). However, nine out of 13 respondents said that demand on staff time had increased as a consequence of direct payments. More than a third (5 out of 13) care home providers said staff now provided additional services in their spare time, although nearly half (6 out of 13) said they did not. Two respondents said they did not know.

Seven care home providers answered ‘yes’ to the question asking if overall costs had increased due to changes in administration as a result of direct payments compared to five who answered ‘no’, and one who did not know. This may be partly explained by the responses to another question on whether the amount of paperwork had increased as a result of direct payments. Seven agreed that this was the case, while two neither agreed nor disagreed, and two disagreed. Also, most respondents felt that there had been changes to the administrative processes in the care home as a result of direct payments. Responding to the statement, “*There have been no significant changes to our administrative processes resulting from direct payments*”, only two respondents agreed, whereas one neither agreed nor disagreed, and nine disagreed.

9.5 Findings from interviews with residential care providers

The following section presents findings from the interviews with managers and owners of care homes in five trailblazer sites (Chapter 4). It also includes the perspectives of three national organisations representing care home providers interviewed for this study.

Between two and six representatives of care home providers were interviewed in each site, totalling 19 interviews. Care homes included both homes run by charitable organisations and homes in the private-for-profit sector (Appendix E). One home was owned by the NHS but operated and funded by the local council. Homes varied in size, with the smallest home providing places for six residents with moderate learning disabilities and the largest home having capacity for over 100 older people with personal care and nursing care needs. Seven care homes were part of a group of homes, with groups varying in size, ownership status (e.g. charitable, family run, or public limited) and area of activity (e.g. local, regional, international).

Homes provided care for all types of service users included in the direct payment scheme, including older people with and without dementia (n=10) and adults of all ages with physical disabilities (n=3), learning disabilities (n=6) and mental health problems (n=2). Two homes offered care for people with learning and physical disabilities. All care homes offered residential care. Four homes also provided nursing care. Two homes offered residential care in combination with sheltered housing (for older people) or supported living (for people with mental health problems). All care homes had council-funded residents, some exclusively so. The majority received funding from a mix of sources, including from councils, self-funding residents and, in some cases, from the NHS as payment for continuing care. A number of care homes for older people also charged top-up fees from their residents and family members.



The majority of interviewees were managers of care homes (n=15), in addition to a smaller number of care home owners (n=4), all of whom were involved in the day-to-day running of the home and group of homes.

9.5.1 Desirability of direct payments and personalisation in residential care

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

This positive sentiment was echoed by representatives of provider associations interviewed in spring 2015, with one noting that they had supported the suggestion of the Law Commission to expand offering direct payments to residents in care homes.

“It’s something that we campaigned for when the proposals were put forward with the Law Commission, and we very much felt that this was an issue of choice for individuals but, actually, our interest came from the very start of the process so that if people were thinking about what their care options were, they wouldn’t be impeded in making that decision because only home care offered a direct payment and the care home option didn’t.”

(Representative of provider association 1)

“I agree [with introducing direct payments] because I think that the policy should be equitable. I think the status of residential care is portrayed as negative and last resort, and if it brings it into seen as a spectrum of care and it isn’t linear that if you go through these certain processes in your life this is where you end up, I think if it’s seen as a positive choice.”

(Representative of provider organisation 2)

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 because of potential implications for costing and invoicing, recording of individual services provided, and the additional staff time required to organise activities and other services for individual residents. 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, in practice, allow care homes to provide a more personalised approach to care in residential settings.

Care home owners and managers judged the role of families and representatives as crucial for supporting the service user in managing a direct payment and in making decisions about how to use it. However, there were concerns about the ability and willingness of family members to support residents, especially older people, and for them to assume the added responsibility of dealing with a direct payment, with some relatives said to be already struggling to cope.



9.5.2 Impact on funding and financial viability of care homes

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

Most questioned the compatibility of direct payments with their current business model that relied on the pooling of income from all residents (i.e. council-funded and self-funded) into one budget from which the care home covered all its costs. The ability of care homes using this business model to switch to a different, more individualised model of identifying costs was judged as limited, especially for smaller homes with little capacity to generate economies of scale in administration and the provision of care. In addition, owners and managers of care homes for older people whose residents were mostly or entirely funded by the council, judged the financial situation of their care homes 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. Owners and managers of care homes in some council areas also reported that they felt already under pressure economically, irrespective of the direct payment scheme, with larger companies entering the local market and thereby increasing the competition for staff and for self-funding residents on whom they relied to compensate for the lower fees negotiated by councils.

They also suggested that care homes would find it difficult to invoice service users for individual services provided to them, as some care homes currently do not price and identify 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 already found it difficult to keep adequate records of essential care provided to residents, 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 elements that could then be invoiced separately would require the use of these services to be scrupulously recorded, which was seen as unrealistic.

'Itemising' care homes bills seemed less of a problem for some of the care homes for younger adults whose managers or owners were interviewed for this study, although here the direct payment related only to day care services which the care home had already priced individually and for which it received separate funding. However, there was similar scepticism in these homes about whether it would be possible and appropriate to break down costs for core (personal care) 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 low fees paid by the council.

Care home owners involved in discussions with one council in preparation for the trailblazers described it as impossible to clearly distinguish the 'cost of care' from the 'hotel costs' in residential settings. They also questioned whether hotel costs could be considered as 'fixed' while care costs could be seen as 'flexible', and thus could easily be made more responsive to the preferences 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, Site 4)

Another care home owner noted that the costs of running a care home would not necessarily decrease if individual residents chose to purchase external services. This was particularly mentioned in relation to minimum staffing required to ensure the safety of residents in the home at all times. 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.

Owners and managers identified a number of services they considered could be requested by service users or their relatives to be taken out of the general ‘package’ of care. Examples included allowing families to wash the resident’s clothes themselves rather than having them laundered by the home (this would not include bed linen and towels for which the home has to ensure the maintenance of specific hygienic standards); allowing residents to opt out of meals; and choosing to participate in some activities in other ways than those offered by the home.

Activities were judged as one of the most promising aspects of residential care for which a direct payment could be beneficial. A number of care homes providing services to adults with learning and physical disabilities noted that they felt well prepared to allow for more flexibility such as providing residents with a choice of activities including those offered by other providers. In one case, the care home also accepted clients from outside the home to participate in its own day services and the manager felt confident that this business model was compatible with direct payments. Using the direct payment to pay for activities was also seen as straightforward in administrative terms, given that many councils already made a separate payment for day activities in addition to funding a care home place. Managers commented that this arrangement could lend itself to a ‘part payment’, with the council continuing to pay the care home directly for care services. For residential homes that were able to provide additional flexibility around the payment for day services, it was noted that participating in the direct payment scheme could be an opportunity to distinguish themselves in the care home market.

A care home manager noted that organising additional ‘individualised’ activities for older people placed more 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 additional activities (such as a trip to the garden centre or watching a football game in a local pub) impacted on limited



staff time at the expense of other residents, even if this did not involve the home in providing these activities.

Another concern about the workload of care homes related to the possibility of providers having to chase payments from service users or their relatives, depending on who 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 neither care nor 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 trailblazers, with providers unwilling to enter into any scheme that would increase their financial risks. Several owners and managers observed that current council fees for placements of older people did not fully cover the costs of the care they provided. 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, Site 4)

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 advanced, with care homes having to cope with a higher average level of dependency. However, respondents noted that the increase in needs had not been accompanied by an increase in funding.

“I think the problem with that is that many good care homes are not available to a large percentage of the patients, because the top up is so great. In the early days [...] the top up [charged by care homes] was averaging £10 to £20 a week. Now you see it’s £150 to £200 a week and maybe even more than that. Which shows how far away from the real cost of care local authorities have got by deliberately holding it down, so that holding it down, that’s the way that they are satisfying their budgets, is by controlling the price. And so the control is going away from the individual and it’s going to the fund, the funding body, the local authority.” (Representative of provider organisation 3)

“The other anxiety would come with anybody, I think, that’s funded by the local authority, which is, is the money enough? Have I got the choice I want, not just at the service within the home but of the home that they want to go in? And if you look at the current rates available through a contract, let alone through a direct payment, the wide range of choices is not available to somebody funded by their local authority because they simply won’t pay some of the rates that other homes ask for. So, top-ups are being required throughout, I would have said.”
(Representative of provider organisation 1)

As a consequence, it was argued, having a direct payment based on the council rate would make no difference to service users who were still unable to afford more



expensive care homes unless they were able to pay a, potentially substantial, top-up. Owner and managers of smaller homes in particular noted that direct payments could add pressure to their operations. As smaller businesses they felt already exposed to higher financial risks than larger homes since their income had become more volatile as councils had moved gradually from block to spot contracting. They argued that direct payments would render their funding even less predictable, making it more difficult to engage in long-term planning and staffing.

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, Site 4)

Some managers also expressed concern about the effect of direct payments on those residents who were not in receipt of a direct payment, in particular, if funding were to be taken away from the care home that would otherwise be available to 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)

9.5.3 Choice and control for residents of care homes

While owners and managers shared a general appreciation of the policy goal of direct payments to increase person-centred care in care homes, they were more sceptical about the prospect of whether direct payments were an appropriate tool to achieve this aim. Specifically, owners and managers voiced doubts about whether residents would obtain more choice and control by receiving a direct payment.

One aspect of this was the question of whether many residents had sufficient mental 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 had led to their decision not to participate.

Many commented that the degree to which service users could benefit from additional choice and control might reflect differences in care need, with people with a high care need being less able to be in control of a direct payment or to make choices about how to use the payment. For example, someone with advanced



dementia might not benefit from the type of choices that could be achieved through a direct payment (e.g. certain activities outside the home). Yet this did not mean that they should not be offered choice. However, their choices were likely to be more closely linked to their usual care and facilitated by 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 personalised 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, happened within the context of routine care provision rather than as a service that could only be purchased separately. Another care manager agreed that people with limited cognitive abilities should be given choices, but these choices would need to be simplified (e.g. a choice between two or three meals or a choice between specific items of clothes) to help the resident exercising choice.

One care home for older people had experimented with offering tailored activities to residents with a direct payment to explore opportunities for personalisation. Care home staff had developed a one-page profile together with the older person that covered his/her likes and dislikes. Based on this profile, the care home staff would then work with the person to find out whether he/she would like to undertake an activity outside the home. Some individuals chose to be taken to a local garden centre or to the pub to watch football. The care home manager reflected that these activities were extremely well received. However, they also proved to be time consuming to organise and difficult to replicate, mostly because of changes in a person's health and desire to undertaken such outings, for example, during the winter.

Some managers in homes providing care to adults with physical and/or learning disabilities 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 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. These particularly related to day services for their residents and others, which was supported by additional funding made available for this purpose. Managers of two of these homes also noted that their homes were in transition to becoming a facility for supported living or provided supported housing alongside more traditional models of residential 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).



Managers also worried about the effect that having to ‘itemise’ and price individual services could have on current practices of providing care in care homes on an equitable basis. The argument was that if care homes began to unpack the costs of care of individuals, this would expose the difference in funding provided for those placed by the council and those who are currently funding their care themselves, as well as differences in cost related to different levels of care need. Currently, it was argued, care homes would try to avoid categorising people in these ways and try to treat all its residents as equitably as possible. If direct payments required homes to monitor the costs for each resident individually, this would undermine the current practice of not categorising residents by their ability to pay and level of care need.

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 benefitted 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 would allow residents to access direct payments in the community, if they so wished.

Owners and managers stressed that efforts to improve person-centred care should never negatively affect the quality or comprehensiveness of care that the care home had a duty to provide.

“I think it would be lovely to have a model of social care that everybody could have what they want. But it is down to the budget at the end of the day, and the budget is not there.” (Care home manager, Site 7)

9.5.4 Involving relatives and other suitable persons

Care home owners and managers noted that in cases in which the service user did not have capacity, relatives (or other suitable persons) would be expected to take decisions about whether to take up a direct payment and to exercise choices on behalf of the service user.

They argued that, in practice, relatives often already felt quite challenged and sometimes overburdened by the responsibilities associated with making decisions on behalf of a family member who lacked 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 no longer able to cope. Some noted that relatives had decided against taking up a direct payment because they thought their relative would not benefit from it. Managers also reported that some families did not want the additional responsibility associated with managing a direct payment. Specifically, they did not want to have to manage money, pay invoices and keep receipts. One manager noted that her care home looked after a number of very old people (90 years and over) whose children would already be in their sixties or seventies (“even grandchildren can be in their fifties”) and would not wish to have the added responsibility of managing a direct payment.

There was also awareness that the person’s choice may not be the same as the choice made by a family member. 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.

Another manager observed that some relatives were apprehensive of the direct payment potentially directing funding away from the care home. In a care home that was run by a charitable organisation, one family member was reported saying that having a direct payment to benefit their relative would feel like "grabbing the (charity) tin" if it were to put the charity at a disadvantage.

Owners and managers also reported a variety of queries relating to the financial management of the direct payment from relatives of residents who had been offered a direct payment, including whether the direct payment, if under the control of the younger resident with disabilities, would affect arrangements in relation to a trust fund which managed the income of that person.

One manager noted that a family was hesitant to take up a direct payment for their relative as this was seen as potentially risking the provision of his day services. The direct payment was initially intended to free up some of the funds that were being used to fund his current day care arrangements and to invest some of this in other activities. However, the family feared that the council might in future take the opportunity to reduce his allocation for day services on the grounds that the user himself had decided that he did not need as much as had previously been funded.

9.6 Summary

Findings from the survey of care home providers are based on responses from 70 care homes that had no direct payment holder and 15 care homes with one or two residents with a direct payment. Key findings include a number of concerns stated by those without a resident with a direct payment including scepticism about the appropriateness of direct payments for older people with dementia; the shifting of responsibility for managing the payment from councils to users and their families who may or may not be willing to take on this additional task; the financial risks to providers potentially arising from direct payments; and the potential motives of councils with regard to the future of care funding. Among those providers that had at least one resident with a direct payment, views were divided on whether these residents were more likely to receive a service they preferred than those without a direct payment, with a majority (9 out of 13) stating that having a resident with a direct payment did increase demands on staff time.

Findings from interviews with care home owners and managers (n=19) in five sites also indicated concerns about the feasibility of introducing direct payments in care homes among providers. These included, in 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, and about the benefits of direct payments to residents of care homes and their families. There was substantial scepticism as to whether having a direct payment would necessarily translate into enhanced choice and control. Respondents providing residential care for younger adults tended to be more positive about the potential benefits of direct payments. However, among those caring for older people, scepticism prevailed as to whether direct payments would be able to bring about a more personalised service,



especially given the current financial constraints. Managers and owners of care homes also raised questions around the role of relatives acting and deciding on behalf of service users.

While findings from the survey are based on a very small number of care homes with a direct payment user and a larger number of care homes without a direct payment user, they broadly resonate with the findings from interviews with providers. Managers and owners of care homes for younger adults and older people differed in their views as to whether direct payments can achieve more choice and control for their user group, with providers of residential care for older people being more sceptical than those caring for younger people. These differences also reflect differences in care home fees and business models underpinning residential care provision for the two user groups.



10. Discussion

This final report presents the findings from the main evaluation of the Direct Payment in Residential Care trailblazer programme that ran from January 2014 to September 2015. The evaluation was conducted between January 2014 and June 2016, with data collection ending in March 2016. The report brings together the results from the evaluation across all methods of data collection. It therefore updates and expands the two interim reports published in March 2015 and November 2015, in which some results were previously presented.

The number of direct payments taken up under the trailblazer programme was relatively low with 71 users having accepted a direct payment by July 2015 (Chapter 5). Of those 71 users, only 40 were reported to be in receipt of a direct payment (i.e. the direct payment was 'active') at the end of the programme in September 2015. Only twenty-nine were reported to be in receipt of a direct payment in March 2016, six months after the programme had officially come to an end. Service users with direct payments were based in ten council areas only, with the other ten trailblazer councils either having left the programme officially (n=6) or unofficially (n=2) or without having any service users accepting a direct payment (n=2). The number of service users with a direct payment also varied among the remaining sites, with one site having more than 10 service users with a direct payment while others had one or two.

The number of service users having a direct payment remained small throughout the programme and was significantly lower than the 435 to 500 users estimated by project leads in participating councils during the preparatory phase of the trailblazer programme. These numbers suggest that implementing the Direct Payment in Residential Care programme in the trailblazers was much more complicated than anticipated by policy-makers.

The difficulty of both setting up the scheme and recruiting service users into the trailblazer affected the evaluation of the programme. The small number of direct payment users means that quantitative findings from the survey of service users and family members are inevitably limited. While all methods of data collection set out in the proposal for this evaluation were applied (with the exception of the interviewer-administered survey of service users lacking capacity and the interviews with DH representatives), the emphasis of the study had to shift from quantitative data collection and analysis to interviews (n=111) and case study research. Nevertheless, while the focus on qualitative work has in some respects limited the generalisability of our findings, it provided a level of depth and detail to understanding the complexities of setting up direct payments and implementing the programme.

This chapter revisits the three objectives of the evaluation: (1) to understand the different ways in which direct payments were offered to residents of care homes and to examine the challenges arising during the implementation; (2) to assess the impacts of direct payments in residential care on service users, their families, care home providers and council staff; and (3) to examine, as far as possible, the cost and cost-effectiveness of different approaches to providing direct payments in residential care.



10.1 Different ways of implementing direct payments in residential care

Trailblazer sites differed in three ways in how they implemented direct payments in residential care, as follows (1) to whom direct payments were offered during the trailblazer programme (i.e. service user group); (2) how direct payments were offered to service users; and (3) how direct payments were calculated and how they were used. The following sections illustrate how decisions taken during the implementation of the programme shaped the ‘activities’ set out in the logic model and explain how and why ‘outputs’ from the programme such as the number of people that had opted for a direct payment and the choices that they had been able to make had come to pass.

10.1.1 Service user groups included in the trailblazers

Sites varied in the service user groups to whom they offered direct payments in residential care. Project leads indicated during the preparatory phase of the programme that they intended to offer direct payments to residents in care homes including those for older people, younger adults with physical and learning disabilities, and younger adults with mental health problems. These early plans were often determined by the type of care home provider (e.g. for older people) they had approached and which had initially agreed to support the programme. The selection of providers also influenced considerations as to whether service users should be approached who already lived in a care home as opposed to those who were entering a care home for the first time. These plans changed during the programme often in response to project leads and other council staff facing resistance from providers and/or having problems identifying service users and families willing to take up a direct payment.

Of those who had taken up a direct payment in residential care, about three-quarters were older people and a quarter were younger adults with disabilities. Within the latter group only two people with a mental health problem decided to take up a direct payment in residential care.

10.1.2 How direct payments were offered to service users

Sites also varied in how they offered direct payments to residents in care homes and their family members. Some sites principally worked through care home providers and asked them to identify suitable service users to whom a direct payment could be offered. In other sites, direct payments were offered mostly through council frontline staff and in some cases directly by project leads. In most sites, the approach was selective, initially to control the risk to the council of having a large number of direct payments with unknown implications for placements and costs. A few sites also made a ‘universal’ offer, which meant that direct payments were in principle available to all new or existing care home residents, although how the offer was made and whether this was done so routinely is unclear. However, given the very small number of direct payment users in these sites, a robust ‘universal’ approach seems unlikely.

The selective approach taken to offering direct payments in residential care is likely to have contributed to the low uptake of direct payments. However, whether the uptake would have been higher if a different approach had been used is uncertain, as the limited experience from sites that offered direct payments more broadly suggests that uptake was dependent on other factors as well (e.g. how the direct payment was calculated in relation to the care home fee and how it could be used to enable choice and control).



10.1.3 How direct payments were calculated and how they were used

Establishing a mechanism for determining the monetary value of direct payments in residential care was a key challenge throughout the programme. Similar problems had afflicted the implementation of the Individual Budgets Pilots in 2006-08 and were identified by evaluators as a key factor for explaining the delay in implementing the individual budget scheme (Glendinning et al., 2008). This problem was initially thought to have been resolved because direct payments already existed in community care. However, calculating direct payments in residential care posed an entirely new challenge, with many councils being less able to influence the cost and price of care in the local care home market than in the market for domiciliary care.

There were two main questions that needed to be resolved by trailblazing councils: the first related to how direct payments were calculated in the absence of personal budgets in residential care (until April 2015) and how this budget related to the existing care home fees charged in the local care home market. The second question related to deciding whether direct payments covered all of a service user's personal budget (i.e. a 'full' direct payment) or only part of it (i.e. a 'part' direct payment). Trailblazing sites found different answers to these questions, resulting in three models of direct payments in residential care.

Determining the personal budget of service users eligible for council-funded adult residential care

The first question to be addressed was how the value of a direct payment was to be determined and what it would be based on. In community care, personal budgets were determined through assessing the social care needs of service users which translated into a monetary value for their personal budget (at this stage also referred to as 'indicative' budget). The personal budget is typically calculated 'gross', which means that it includes the financial contribution of the service user. The personal budget can then be taken as a direct payment, i.e. paid to the user in cash, or it can be managed by the council or a third party. In residential care, this mechanism of determining the value of a personal budget, and by extension a direct payment, was absent during most of the programme. Councils have been required to provide a personal budget to service users in care homes since April 2015 only.

Most sites initially anticipated having to develop a resource allocation mechanism similar to the one used in community care. It was initially thought that this would involve asking care homes to disaggregate their costs to distinguish their 'care' costs from their 'hotel' costs. The option of developing a resource allocation system for direct payments in residential care was however subsequently deemed too complicated by most project leads and was abandoned as a consequence.

It also became obvious that such a resource allocation approach could result in personal budgets that were very different from the amounts currently provided by councils for care home placements. This would pose a risk to the ability of councils to find placements for service users in need of residential care and a risk to care homes and local care home markets if the approach resulted in lower rates than currently paid. Moreover, the programme was planned to be 'cost neutral' to councils, which meant that councils were not supposed to pay more for placements than they were paying before direct payments had been introduced.

As a consequence, most remaining sites opted for a solution that based the direct payment on the existing care home fee that is typically negotiated between councils



and care homes, i.e. the fee charged by the care home for service users placed by the council.

Only two sites opted for direct payments that comprised an addition to the existing usual care home fee. In these cases, the councils continued to pay for the care home placement, but provided direct payment users with an additional small amount of money to fund additional activities.

Towards the end of the programme, an increasing number of sites moved towards introducing personal budgets in residential care, with some using a resource allocation process to determine an indicative budget that was then adjusted to form a personal budget. However, these budgets were largely based on the existing care home fees charged by care homes in the local areas.

Determining whether the direct payment covered the care home fee in part or in full

The second decision sites had to make was whether they offered direct payments that covered the entire ('full') care home fee or only part of the care home fee. Some offered service users a choice of full or part payment. In those sites that offered the direct payment as the full payment, it was typically used to pay for the council contribution to the care home placement in full (along with the user's contribution). This approach minimised the financial risk to providers and thus seemed to reflect concerns voiced by care home managers and owners about the potential threat of direct payments to their financial sustainability. However, this use of direct payments appeared not to provide service users with much additional choice, perhaps with the exception of a choice of care home.

Part payments were most prominent among younger adults who received specific funding for daytime services or activities that could be provided as a part payment without care homes having to break down their costs and/or making some of their income from fees available to service users. In principle, a part payment could be established by negotiating with the care home whether part of the care home fee could be made available to the service user. However, there were a few examples of this approach and interviewees reported that providers were hesitant to agree to a reduction in their fees.

Three models of direct payments in residential care

As a result, three models of direct payments emerged from the Direct Payment in Residential Care trailblazer programme.

Model 1 involved basing the direct payment on the care home fee and making this payment available to the service user in full (minus any user contribution).

Model 2 involved basing the direct payment on the care home fee (minus any user contribution) but with only some of this money made available to the service user while the council continued to pay the remainder to the care home.

Model 3 involved making an additional sum of money available to the service user to be spent as a direct payment, while the council continued to pay the care home fee in full (minus any user contribution).



10.2 Challenges arising during the implementation

The limited scale of the programme suggests that implementing the trailblazer programme was challenging. Challenges identified included difficulties encountered by council staff in developing clear messages about the potential benefits of direct payments to residents in care homes; convincing providers to participate in the scheme; and finding service users and family members who were willing to take up a direct payment.

10.2.1 Unclear messages about the potential benefits of direct payments

This report highlights that setting up direct payments required substantial coordination and communication between service users/families, council staff and care home managers. Incomplete or inconsistent information about direct payments was identified as a key obstacle to implementing the trailblazer programme by all parties involved (as one of the ‘inputs’ into the programme identified in the logic model). The absence of clear and comprehensive information was also noted by council staff as a major obstacle to promoting direct payments to both service users/families and care homes with confidence.

A number of service users and family members also indicated in interviews that they would have preferred more and better information about direct payments, including about the processes of setting up and managing the payment. In the survey, however, 18 (out of a total of 21) service users and family members said that they were fairly or very satisfied with the information and advice they had received relating to the direct payment.

There were two types of information about direct payments noted as critical for offering direct payments to potential users and their families. First was information about the processes involved in setting up and managing direct payments which affected service users and family members, managers of the care homes accepting users with the direct payment, and council staff involved in offering advice on direct payments and in coordinating the process of setting them up. Second was information about the potential benefits of direct payments where council staff noted in interviews that they were not able to communicate potential benefits of direct payments with confidence. Care home managers and owners also expressed doubts about the ability of direct payments to increase choice and control for service users and their families. This is understandable given the absence of scientific evidence of the benefit of direct payments in residential care during a trailblazer programme. However, compared with direct payments in community care, there was also a notable absence of advocacy from national organisations representing service users or demand from service users themselves and their families or advocates.

10.2.2 Lack of enthusiasm from providers

Many of the managers and owners of care homes interviewed for this study took a cautious stance towards direct payments. While they agreed that there was a need for more personalisation in residential settings, many were sceptical about the extent to which direct payments could contribute to this aim. As a consequence, provider support for the programme – identified as a key ‘input’ in the logic model – was limited.

Managers and owners noted that facilitating additional choices resulting from a direct payment could be difficult under current cost constraints. This was especially



a concern for those caring for large numbers of council-funded older people. Such care homes tended either to decide not to participate in the programme or to accept direct payments only if they covered the full care home fee or were paid in addition to the care home fee (in two council areas). These findings point to the substantial influence providers had on the implementation of direct payments in residential care. They also suggest that applying direct payments in care homes was very different from their use in community care, largely because of the difference in the ‘business model’ underpinning residential care, compared to community care. This model crucially relies on pooling resources across the care home’s residents to benefit from economies of scale in a matter which is not feasible for community care. Consequently, individualising services in residential care is likely to incur higher costs than delivering services for a group of care home residents sharing the same staff, the same accommodation and the same resources.

Those who felt best placed to accommodate residents with a direct payment were managing homes that already offered a substantial degree of choice, for example, by offering a range of day activities or liaising with external service providers. This mostly applied to care homes for younger adults with disabilities. These homes already made substantial efforts to offer choice and control in residential care highlighting that the direct payment in residential care trailblazers are not the first initiative aimed at improving personalisation. This may mean that direct payments are likely to be more successful in places that already support personalisation (at least as far as day activities are concerned), while those homes with a less personalised approach may not be as supportive (although, again, there may be other reasons for declining to participate such as concerns about funding). It also suggests that the ability of care homes to accommodate direct payments (especially ‘part’ direct payments) rests on the level of funding provided for council-funded residents, with funding for older people consistently reported as significantly lower than funding for younger adults with disabilities in relation to their needs.

10.2.3 Difficulties in finding service users and family members willing to take up a direct payment

Councils differed in how they approached service users and their families, with some councils heavily relying on providers to identify service users to whom direct payments could be offered. Most councils had made decisions about which user group to target, and indeed were asked to do so at the beginning of the programme. These decisions were often led by pragmatic concerns taking account of the type of providers willing to support the scheme, and the experience, and position in the council, of the project lead. While most councils reconsidered their approaches during the trailblazer, often in response to the difficulties in recruitment experienced, some approaches resulted in direct payments being offered to a narrowly defined group of service users.

Demand for direct payments in residential care proved to be limited. Family members responding to the survey who had declined the offer of a direct payment largely stated that they were happy with the care currently provided to their relatives.

In interviews, a number of family members who had declined a direct payment also stated that they did not see how having a direct payment would improve the care received by their relatives. This was particularly pronounced among family members of older residents. This contrasts with the experience of some residents and their families who were satisfied with having a direct payment and who reported that they



had been better able to participate in activities they liked or were enabled to stay in a care home of their choice as a result of having a direct payment.

Some project leads also reported that they were unsure in what way and with how much information and explanation direct payments were offered to service users and their families by council frontline staff and whether staff had had sufficient time to engage with the programme given their workload. Such concerns echo debates about the role of frontline staff in promoting direct payments in the community, in which some have argued that staff used considerable discretion in offering (or not offering) direct payments (Ellis, 2007b, Glasby and Littlechild, 2016).

10.3 Key outcomes of direct payments for service users in residential care and their family members

This report brings together different accounts of the experiences of direct payments by service users and their families. These may be the result, in part, of different methods of data collection – surveys and interviews – but may also reflect the diversity of experiences of direct payments by service users and their relatives, both in terms of how direct payments were perceived (including by those who declined the offer) and how they were experienced in practice (i.e. by those who had an ‘active’ direct payment). These findings reflect some of the (medium-term) outcomes (e.g. satisfaction with the direct payment and the service provided) and the (short-term) outputs of the programme (e.g. the range of choices experienced), set out in the logic model.

Thirteen service users and family members (of 20 who provided information on satisfaction with the direct payment) said that they were very satisfied or fairly satisfied with the direct payment (with seven being neither satisfied nor dissatisfied). These responses were given by those who were already in receipt of a direct payment (i.e. the direct payment was ‘active’ in the sense that the user/family had received a payment) and those who had yet to receive a direct payment.

Among those interviewed who had an active direct payment, the picture was mixed, with some indicating that they were very satisfied with their direct payment, while others said that they would be more satisfied if the direct payment had offered more relevant choice (although it was not always clear whether respondents referred to satisfaction with the direct payment or with the care home’s services more widely). Others noted that they wished direct payments had been set up more easily. Among those who indicated satisfaction with their direct payment, some welcomed the opportunity to access additional or different services such as day activities. A number of family members noted that they felt empowered by having more control over the budget. This view was also shared by some of those who had accepted, but not yet received, a (full) direct payment.

In the case studies, direct payments were reported as being of direct benefit to service users and/or family members, by giving them more flexibility in selecting a care home or facilitating additional choice of activities. However, when revisiting some of the participants, we found that that these benefits did not flow automatically from having a direct payment and required continued efforts to be sustained.

- A service user with moderate learning and physical disabilities appreciated the opportunity of having a part direct payment that would allow her to organise day activities for herself (e.g. organise a theatre visit) and help her learn how to manage money on a small scale (case study ‘June’). However, when revisiting the case, the



- service user suggested that it was more difficult than she had expected to sustain activities and to spend the direct payment.
- An older service user with dementia was able to stay in the care home of her family's choice when reaching the threshold for council support, and her family were able to continue to manage her finances, through agreeing a full direct payment to cover all care home fee costs (case study 'Mary'). In this case, the family member reported feeling in control of the budget, although she also noted that the direct payment did not lead to her relative having more choice within the home.
 - A younger service user (under 65) with physical and mobility difficulties was able to set up and pay for an internet connection in his separate accommodation in a care home and plan activities using a part direct payment (case study 'James'). When following up this case the service user reported to have had difficulties in organising activities and experienced confusion with the billing for the internet connection.

Others expressed the view that having a direct payment would be of limited or no benefit to them. Over three-fifths (19 out of 31) of respondents declining the offer of a direct payment (and completing the questionnaire) noted that the reason for declining was that the person was already in a care home and happy with the arrangement. A small number of family members (n=4) indicated that they did not think that taking up a direct payment would give them more choice and control on behalf of their relative. At interview, some family members of those who had received a full payment used to cover the care home fee expressed disappointment about the direct payment not providing more flexibility and choice.

There were also concerns voiced by care home managers/owners and council staff about some service users not being able to benefit from direct payments, such as older people with advanced dementia or people with severe disability or frailty that limited their scope for choice. While interviewees emphasised that these groups were equally deserving of a service respectful of their personal preferences, they questioned whether direct payments would help them achieve this aim. This view was shared by some relatives of service users who had considered taking up a direct payment, with most declining and a few accepting.

Overall, user experience remained variable with no clear pattern emerging from the combined data collected for this study. The limited data available suggest that it is easier to facilitate direct payments either as a full direct payment covering the whole care home fee, or as a part direct payment for service users who are already in receipt of council-funded day activities, than facilitating direct payments in other ways. However, findings also suggest that full direct payments did not offer much additional choice, although in some cases family members enjoyed feeling more in control of the budget. This somewhat contrasts with findings from the Personal Health Budget evaluation which found that people with a high-amount personal health budget (an annual budget of more than £1,000) were more likely to experience benefits from having a budget than those with a low-amount budget (less than £1,000 per year) (Forder et al., 2012). With direct payments in residential care, a large (full) direct payment may not offer much choice if it covers the care home's costs for the usual 'package' of care services, while a smaller (part) direct payment may offer some flexibility in funding services, for example, outside the home, if the funding is available to do so. However, the authors also point out that the positive effect of larger personal health budgets depended on whether it provided a sufficient level of resource in relation to the patient's needs (Forder et al., 2012).

In some cases, having a full direct payment in residential care led to a wider choice of care home and allowed self-funding residents reaching the threshold for council funding



to remain in the home that they had originally chosen. However, this typically involved either the council or the family making additional payments (i.e. exceeding the council rate or paying a higher top-up, respectively). Those receiving a part direct payment were more likely to report experiencing additional choice. It was noticeable however, that younger adults with disabilities were likely to have more options to choose from and more funding available for daytime activities than older people. This is likely to exacerbate existing inequalities in funding care for younger and older adults.

It is important to note that this evaluation explored whether direct payments in residential care were promoting choice, control and other objectives of personalisation as perceived by the service users and their families; but it was beyond the scope of this project to determine whether direct payments are the best way to promote these objectives. Further investigation of the meaning and practicalities of personalisation in residential care will be needed to establish the potential for more personalised care in care homes within the constraints of collective provision and funding of residential care.

10.4 Costs of setting up direct payments

The report provides only limited information about the administrative costs of the trailblazer scheme. Nine councils responded to our request for this information. Most of them indicated that the costs which they had incurred on administration and management of their scheme had been fully met by their Department of Health grant. However, there was considerable variation between councils in the number of full-time equivalent staff deployed on the schemes. In principle, these differences in administrative costs could explain the differences between councils in progress in implementing direct payments, but this cannot be stated with certainty. It is also possible that the level of funding available (compared with some earlier schemes such as the Individual Budgets pilots) only allowed for limited additional capacity in councils (with funding being identified as a key resource in the logic model). This is pertinent given that councils had little ability to make their own investments in the scheme given the decrease in local authority funding for adult social care in recent years. At the beginning of the programme, all councils committed to facilitate direct payments at no additional cost to the council, although two councils eventually decided to make an additional payment to the care home, and some councils used the opportunity of the scheme to pay increased care home fees in a small number of cases.

Findings from the interviews with service users and families, council staff and care home managers and owners suggest that setting up individual direct payments when the offer was accepted was challenging and time intensive for council staff. Particular challenges arose in coordinating processes between different teams/departments within councils and between the three key stakeholders of direct payments; i.e. the service user/family, the care home and the council. The specific issues identified as having caused problems and delays in making the direct payment available varied in each case, although there was a suggestion that some adaptation of internal systems and processes was required. Some issues related to specific user groups. For example, opening a bank account emerged as a particular challenge for long-term residents of care homes wishing to manage the direct payment themselves. The picture that emerged is that each direct payment involved substantial time and commitment from council staff to work through specific issues in collaboration with care home staff and users/families on a one-off basis. In some cases, these commitments also extended to care home staff and family members, both when setting up the direct payment and when using the direct payment to fund activities. These findings could not be quantified in monetary terms.



While data on the administrative costs of direct payments are insufficient to support firm conclusions, the 'case-by-case' approach to setting up individual direct payments observed during the trailblazer scheme suggests that the transaction costs involved in setting up a direct payment in residential care exceeded the transaction costs incurred in arranging a care home placement without a direct payment. However, the size of such transaction costs is likely to depend on the type of direct payment and the extent to which it relies on individual providers to agree to the arrangement. Full direct payments and part direct payments based on an existing payment for day activities may be the easiest and least costly to facilitate. It is possible that when (and if) direct payments in residential care are offered to and accepted by substantially larger numbers of service users the administrative cost per user will be lower because of economies of scale.

10.5 Conclusions

Given the small scale of the programme, with only 40 direct payments taken up by service users, the findings about the benefits and costs of direct payments have to be treated with caution.

10.5.1 Some service users and families benefitted from having a direct payment

In relation to benefits for service users and families the picture was mixed. A small number of service users and families reported that they benefitted directly from having a direct payment, for example by being able to access a particular care home (although typically at additional cost to their family or the council) or by choosing activities that had not been previously available to them. In some cases, the direct payment provided a solution to a problem, for example, it allowed service users who had become newly eligible for council funding to remain in the same home as before. Some family members said that they saw value in having control over the budget, in principle, even though in most cases they had not yet used this lever to negotiate any changes in services. This contrasts with the finding that many service users and families declined the offer of a direct payment, often stating that they were happy with the care provided and/or that they saw no benefit from having a direct payment.

10.5.2 Whether direct payments increase choice and control depended on the model of direct payment and the funding available

The findings suggest that the benefits and costs of direct payments are influenced by how direct payments are set up. A direct payment covering the whole fee seemed easier to set up for councils and more likely to be supported by care homes, but was less likely to offer service users and family members greater choice of services within care homes (although some appreciated the feeling of control over the budget). A part payment may have been more difficult to set up, especially if this involved identifying (and negotiating with care homes) those parts of the care home fee that could be used more flexibly. However, where this was possible such a part payment may have provided greater choice of services within or outside the care home. This route seemed most promising for younger adults who received an additional payment for day activities, but less feasible where such payments were absent (e.g. for older people).



10.5.3 There are differences between user (age) groups, largely due to differences in care funding

Findings from this evaluation suggest that there are differences between service user groups and that these mirror patterns observed in earlier research on direct payments in community care and on individual budgets, although for different reasons. Previous research suggested that older people were less likely to benefit from having a direct payment than younger people, mostly because they felt more vulnerable and less able to capitalise on choice and control offered by a direct payment (Glendinning et al., 2008, Clark et al., 2004). While older people in this study represented about three-quarters of all service users with a direct payment, this evaluation suggests that they are less likely to experience increased user choice from having a direct payment, compared with younger adults. However, unlike the case of direct payments in the community, these differences appear to be triggered by differences in funding available for younger and older people in residential care, with placements for people over the age of 65 years often attracting significantly less funding in relation to their needs than placements for younger people, allowing for less flexibility in how this funding can be spent.

This evaluation was unable to explore differences in outcomes between care home residents who were able to exercise choice and control and those who have no or limited capacity to do so. The Mental Capacity Act stipulates that the interests of service users with no, limited or fluctuating capacity can be represented by family members or others. Indeed there were several cases in which family members or other representatives decided to take up and manage a direct payment on behalf of a user. Future research should seek to establish whether direct payments in residential care managed by a family member on behalf of a person lacking capacity result in more personalised outcomes for the service user.

10.5.4 Direct payments incurred transaction costs

The findings also suggest that the cost of implementing the scheme was high in relation to its modest outputs. While all but two sites eventually decided to base direct payments on existing care home fees (i.e. their scheme was cost neutral in this respect), those who provided information on administration costs indicated that the cost of setting up direct payments was equal to their Department of Health grant. Data from interviews suggest that setting up direct payments involved substantial staff time both at the council and at care homes. In some cases, service users and family members also spent a significant amount of time helping to set up the direct payment. Thus the costs of setting up these initial direct payments are likely to have been high. The costs of administration may decrease over time (i.e. the marginal cost of additional direct payments will be lower than the average cost of direct payments in the initial phase of implementing the scheme); but the extent of this reduction is unclear.

In addition, findings suggest that arranging activities and other ways of spending the direct payment that go beyond transferring the funds to the care home to cover the costs of the care package can involve a significant amount of time. In some cases, care home staff became involved in organising activities paid for by direct payments. In other cases, families were reported to have invested much time in organising, for example, an additional carer paid for by the direct payment to accompany a resident to a social event. In addition, case studies of a few service users with direct payments showed that the benefit of having a direct payment was also dependent on the ability of the service user, the family and those who support them to sustain the use of the direct payment.



Such examples suggest that using direct payments to increase the range of activities for residents in care homes is not straightforward and can require continued efforts to organise and coordinate service and support. These findings are consistent with the experience of direct payments in the community (Arksey and Baxter, 2012).

10.6 Limitations of this study

The findings set out in this report have to be interpreted with a degree of caution. The findings relate to a very small programme, with only 40 direct payments active at the end of the scheme. It is worth emphasising again that these small numbers were, in part, the effect of the approach to implementing the scheme (e.g. working with selected providers only) and the difficulties encountered in this process rather than an intentionally small study design; the evaluation was designed to evaluate a much larger programme.

There are thus severe limitations in what could be collected, particularly as regards the survey of service users and family members (n=68 baseline questionnaires in total). If these responses are disaggregated, for example between service users and family members or between different groups of service users (e.g. older people versus younger adults), the numbers in each sub-group become extremely small. Moreover, there were very few responses to the 6-month follow up questionnaire by the end of data collection (n=7) and none to the 12 month follow up questionnaire. This was mainly because when data collection for the evaluation ended in April 2016, few users had had their direct payment for 6 months. As a consequence of these problems, the outcomes of the programme outlined in the logic model could not be measured with certainty as they relate to a small number of service users only.

The data collected through interviews are more substantial with a total of 111 interviews conducted during this evaluation. However, some individuals interviewed for this study had limited or no experience of having (or having residents with) direct payments at the time of the interview. This can in part be expected from a novel initiative, but it also reflects the continued low number of recipients of direct payments. While this does not mean that these interviews were less relevant (for example, views of care professionals involved in the process of setting up the trailblazers but with no direct payment in place yet), it is difficult to separate early perceptions of and concerns about direct payments from the experience of receiving and using a direct payment or supporting one over a longer period of time. However, many of the issues raised resonated with all groups of interviewees, such as the importance of having sufficient information and doubts about the ability of direct payments in themselves necessarily to facilitate additional choice and personalisation of services.

It is important to recognise that service users and family members who had been offered a direct payment may have been approached because staff saw them as especially likely to benefit from direct payments. This means that those participating in the trailblazers (and in this study) may well not be representative of the population to whom direct payments would be offered if the programme were to be rolled out. This would still hold if the uptake of direct payments were higher. Moreover, the trailblazer councils volunteered to participate in the programme and were selected by the panel at the Department of Health based on their proven commitment to personalisation, and thus may not be representative of all councils in England implementing direct payments in residential care if the approach were to be rolled out.

There are also questions about the effects of the programme being a pilot or, more



precisely, a trailblazer. It is often assumed that pilots produce better outcomes than subsequent efforts at ‘scaling up’ or ‘rolling out’ such programmes, due to better resourcing, more focussed attention on producing results within a given timeframe and the participants being volunteers keen to take part in the pilot and particularly motivated to succeed. While the outputs of the trailblazer programme were modest, given the challenges of its implementation, it is possible that a general national roll-out of direct payments in residential care would have produced even more modest outputs per council.

It does seem possible however that when (and if) direct payments in residential care are introduced throughout the country, councils will in time be able to overcome at least some of the procedural problems around explaining the potential benefits, and setting up and coordinating direct payments. The establishment of direct payments in the community also took many years and was not a straight forward journey (Fernandez et al., 2007). However, while this evaluation provides some insight into the processes involved in setting up direct payments in residential care, it cannot conclusively answer the question as to whether the challenges encountered were initial ‘teething problems’ only; nor does it provide definitive evidence about the extent to which direct payments can make a contribution (if limited) to achieving more choice and control in residential care.

10.7 Recommendations for policy

If the Government confirms that direct payments in residential care will become available throughout the country from 2020, the findings of this evaluation of the trailblazer programme suggest that:

- The Department of Health should consider issuing good practice guidance to councils based on the experience of the trailblazers and the findings of the evaluation to ensure that each council does not need to grapple individually with the challenges involved in setting up direct payments in residential care.
- Councils should consider providing detailed information about their direct payments for residential care scheme for service users and their families, care home providers and their own care management staff: the evaluation suggests that more and better information will be important.
- Councils and other stakeholders should consider arranging suitable training about direct payments in residential care for frontline staff in councils and in care homes.
- Councils should aim to promote good communication about direct payments arrangements between themselves and the care home providers with which they have contracts.
- Service users and their family members may require support from council social care staff or from advocacy or advisory services to manage direct payments in residential care as in the case of direct payments in the community: councils should ensure that this is available.
- Councils should recognise that setting up direct payments in residential care may involve additional administrative costs and require additional staff time for councils and care homes in comparison with usual arrangements for care home placements.
- Councils and the Government may want to consider whether direct payments are likely to be more successful with a higher level of funding for residents in care homes, especially older people, to increase opportunities for the direct payment to offer greater choice and control for the service user.
- Direct payments in residential care schemes should be monitored so that further lessons can be learned about barriers to their success and how best to overcome them: the Department of Health may want to arrange such monitoring.



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