

Evaluation of Direct Payments in Residential Care Trailblazers

Second interim report

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1. Summary

The Department of Health decided in 2012 to test the extension of direct payments from domiciliary (community) care to residential care. It invited councils to express interest in becoming pilot sites for direct payment in residential care and selected 20 pilot sites. It commissioned the Policy Innovation Research Unit (PIRU) to conduct a scoping study and then to conduct a full evaluation of the pilot sites, now known as ‘trailblazers’.

Of the 20 original trailblazer councils, 14 remain as trailblazer sites at the time of writing (September 2015). There is continued variation in progress among the councils. Of those remaining councils some have managed to successfully set up a number of direct payments (the earliest receipt of a direct payment was in April 2014) whilst some have arranged no direct payments in residential care to date. The trailblazer programme ended in September 2015.

This report is the second interim report of the evaluation of the trailblazer programme. It analyses data collected for the first 20 months, from January 2014 to August 2015. These comprise self-completed survey questionnaires to service users who had either accepted or declined a direct payment and their family members, a survey of the trailblazer councils about the costs incurred in administering and managing their scheme, and interviews with project leads, as well as interviews with providers and council staff in selected trailblazers, interviews with council leads in adult social care not involved in the trailblazer programme, and interviews with service users who had either accepted or declined a direct payment and their family members.

By the end of July 2015, a total of 70 service users had accepted a direct payment for their residential care and 30 of these people were reported to have had a direct payment in place.

Of the six councils providing cost data, most 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. There was considerable variation between councils in the number of full-time equivalent staff deployed on the schemes. All reported additional work for staff on administrative or financial processes such as 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.

At the end of July 2015, 59 completed questionnaires had been received from service users and family members. They related to 52 service users (22 accepting and 30 declining), as, in some cases, questionnaires were completed by both service users and family members. Nearly half of the questionnaires received were from family members of people who had declined the offer of a direct payment. A large proportion of the returned questionnaires (63%) related to three of the 14 trailblazers.

The majority of service users (or their relatives) completing a questionnaire were service users over 65 (69%). Almost half had a physical disability and almost a quarter had a learning disability with a small proportion suffering dementia or mental health problems. Some users had more than one condition. The vast majority of questionnaire returns (80%) came from those receiving personal care only and only 20% from those receiving nursing care.

Over two thirds of those accepting a direct payment had one to cover part of the residential care fee. Seven had a direct payment that covered the full care home fee. Most of those with a part direct payment were using this to pay for activities outside the care home, with a few (5 out of 14) using the payment for meals outside the care home.



Most service users and family members (15 out of 16 responses) said that they were fairly or very satisfied with the information and advice received about the direct payment. Twelve said that they were satisfied with their choice of care home and control over their direct payment. Seven people indicated that they were satisfied with ease of management of the direct payment.

Of those declining a direct payment, most said that this was because they were already satisfied with their care home arrangements. A few (6 out of 30) were concerned about the perceived extra work for themselves or their families as a result of having to manage a direct payment.

Findings from interviews with service users and family members (n=21) suggested that the decisions to accept or decline a direct payment in part reflected the level of satisfaction of service users and family members with the care home. Satisfaction with the quality of care in the care home was given as a reason for declining a direct payment and there were concerns that direct payments could disrupt the current provision of care in the home. In contrast, most families who had accepted a direct payment on behalf of a relative expressed feeling empowered to challenge the care home should its standards fall below par, suggesting that there could be aspects of the care home that could be improved. Overall, the majority of interviewees said that they were satisfied with the level of care at the home, irrespective of the decision to accept or decline a direct payment.

Many service users and family members noted the problems they had experienced with setting up a direct payment. Many of those receiving a “full” direct payment also expressed disappointment in the lack of flexibility in terms of how the funds could be used. Interviewees who spoke most positively about direct payments typically had had previous experience with direct payments for domiciliary care or felt they had received sufficient information from the council and/or care home staff, and had opportunities to discuss the options and implications of having a direct payment. There was a tendency among those who were critical about direct payments to feel that they had received (too) little information and guidance about having a direct payment.

Three case studies presented in this report detail different user journeys from accepting to receiving a direct payment. The cases comprise one service user with physical and learning disabilities accepting a payment for part of her care and two family members of service users over 65 years accepting a ‘full’ payment on behalf of their relatives.

These cases illustrate the time and effort of council and care home staff as well as the families of service users involved in setting up direct payments. These cases also show that going through this process can cause anxiety and stress for service users and family members.

Interviews with council staff (n=21) revealed a high level of support for the aims of the scheme, but many were unsure of the mechanism and effect of direct payment on service users and provider organisations. This was notable in respect of organisations providing care for older people where council funding provided little or no opportunity for flexibility in budgets to facilitate (wider) choice of activities. Council staff also expressed some concern about the benefit of direct payments for some service users, mainly those lacking capacity to make choices for themselves.

Council staff engaged in implementing direct payments frequently found this to be a long and resource intensive exercise requiring a good deal of co-ordination and



co-operation between various people and organisations, both within and outside the council and care homes. Some staff noted that they lacked confidence to promote the scheme to residents and some reported difficulties engaging care home providers in the process. However, many council staff felt that there could be benefits from direct payments, including increased job satisfaction for council and care home staff involved in helping service users to receive a more personalised service. Some of those involved in facilitating direct payments also reported to have seen some positive effects of direct payment on their clients and the care homes involved.

Findings from interviews with care home owners and managers (n=18) in five sites raised a number of concerns about the feasibility of introducing direct payments in residential settings. There were particular concerns about the potential impact of direct payments on the financial viability of care homes in the current financial climate, particularly those providing care for older people. There were also questions about the benefits of direct payments to residents of care homes and their families, and whether having a direct payment would necessarily translate into enhanced choice and control. Care homes that provided 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 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 about direct payments on behalf of service users.



2. Introduction

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

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

The Government subsequently decided in 2013 to empower all councils to offer direct payments in residential care from April 2016. Pilot sites were re-designated as ‘trailblazers’ to reflect the new purpose of the scheme, which was now to prepare for the introduction of direct payments in residential care nationally and to provide other councils not involved in the trailblazer programme an opportunity to learn from the experience of the sites. Of the initial 20 councils invited to participate in the pilot in 2013, 14 remained at the time of writing (September 2015). Of those councils, some had not yet arranged any direct payments in residential care.

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

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

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

This is the third report from the independent evaluation of the trailblazers and the second interim report of the main evaluation. A scoping report was published in autumn 2013 (Ettelt, Perkins et al., 2013) and a first interim report in January 2015 (Ettelt, Wittenberg et al., 2015).



The aim of this report is to present the findings from 20 months of the evaluation and to inform guidance about the future of direct payments in residential care developed by the Department of Health. Since the trailblazer schemes in most of the 14 sites started to offer direct payments later than originally envisaged, the report concentrates on qualitative findings from interviews with the service users and their family members, council staff and managers and owners of care homes since there is insufficient data to report on the impact of receipt of a direct payment on service users and their families. The report also includes findings from a survey of service users in residential care (and their relatives) and an account of the administrative costs of setting up direct payments in councils. The final report will include a complete set of findings from the survey of users and their family members, findings from further interviews with trailblazer leads, care home managers and council staff, findings from further interviews with users and family members and with representatives of national organisations, and results from a survey of providers involved in trialling direct payments in residential care in the trailblazer programme. The final evaluation report is due in June 2016.



3. Methods

The methods described below relate to those used in the stages of the evaluation described and discussed in this interim report. For a full description of the methods for the evaluation as a whole, please see Appendix 12.4, which is drawn from the research proposal.

This report analyses data collected in the first 20 months of the evaluation of the trailblazer programme, from January 2014 to August 2015. This comprises self-completed survey questionnaires completed by service users who had either accepted or declined a direct payment and their family members; a survey questionnaire to the trailblazers about the costs they incurred in the administration and management of their scheme; interviews with trailblazer project leads, as well as interviews with providers and council staff in selected trailblazer sites; interviews with council leads in adult social care not involved in the trailblazer programme; and interviews with service users who had either accepted or declined a direct payment and their family members. The report also draws on information gathered from quarterly reports on progress from trailblazer project leads; national steering group meetings; and quarterly regional meetings with project leads and other stakeholders as well as field notes from a number of project meetings held by individual trailblazer sites.

3.1 Survey of service users and family members

It was agreed with the project leads in each local authority that they would arrange to give or send a questionnaire to every service user who took up a direct payment for residential care or specifically declined the offer of a direct payment, except those who lacked capacity. They also agreed to give or send a questionnaire to a family member, friend or advocate of the service user wherever appropriate. Project leads agreed to inform the research team regularly how many questionnaires they had issued.

It was also agreed with the project leads that they would arrange to give or send a 6-month and a 12-month follow-up questionnaire to every service user who took up a direct payment for residential care, except those who lacked capacity, and to a family member, friend or advocate of the service user (if a family member had completed the first questionnaire). We provided easy read versions of the questionnaires for service users in addition to regular versions. The baseline and follow up questionnaires included questions about user satisfaction elicited from those accepting a direct payment by asking how satisfied or dissatisfied the service user or family member was with the arrangements relating to the direct payment, such as information and advice received about direct payments and ease of setting up the direct payment. The survey also included questions on social care-related quality of life assessed using the Adult Social Care Outcomes Tool (ASCOT) (Netten, Forder et al. 2010), but data on this are not reported here since the numbers are too low to be meaningful. Demographic information such as age, gender, user group (such as learning disability, physical disability and mental health difficulties), marital status and ethnicity was also covered. For those accepting a direct payment, there were questions about the experience of managing a direct payment and the choices facilitated by a direct payment. For those declining a direct payment, there were questions on reasons for declining the direct payment. Findings from the survey of service users and family members are presented in chapter 6.1.



3.2 Costs of administration and management

The project leads received a short questionnaire in June 2015 about their administration and management costs. This asked whether the trailblazer's administration costs were fully met by the Department's grant, how many extra staff were employed on the scheme and whether additional work was required on a range of functions. The results on costs are presented in chapter 5.

3.3 Sites for in-depth research

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 user/age groups; sites providing whole fee or part fee 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. The main characteristics of the four sites are listed in Table 3.1 below. The councils were located in the North West, Yorkshire and Humberside, London and the South East regions of England.

Table 3.1 Characteristics of in-depth sites

Site Code	Council type	Type of direct payment offered	Service user groups targeted	Approach to implementation of direct payment
4	Metropolitan	Separate additional payment to selected residents	Older people	Payment made to care home to help 'personalise care'
7	County	Covering whole or part cost of residential care	All	Working with participating care homes
8	London Borough	Covering whole or part cost of residential care	All	DP offered at initial assessment and review for new and current eligible residents. Also promoted within selected providers
17	Unitary	Covering whole cost of residential care	All	Universal offer to all service users entering residential care

3.4 Interviews

One hundred and three interviews were carried out with a range of individuals and representatives of organisations. This included project leads at the councils, other council staff, care home managers and owners, representatives from national 'stakeholder' organisations and council leads from local authorities not participating in the trailblazer programme, as well as service users and family members who had either accepted or declined a direct payment. Table 3.2 lists the number people interviewed up to August 2015 and their roles (Appendix 11.1). Interview questions were derived



from information obtained during the preliminary study in 2013, a literature review and a logic model developed to guide the evaluation. Interviews were digitally recorded, transcribed, coded and analysed thematically using qualitative software (NVivo 10). Framework analysis was used drawing on Ritchie and Spencer's model (Ritchie and Spencer 1994). The analysis of the interviews with council staff, care home staff, service users and family members is presented in chapters 6 to 9 of this report.

3.4.1 Council and care home staff

We carried out interviews with council staff (n=21) and care home staff (n=18) involved in planning and implementing direct payments. These included care home managers and owners and council staff in the four sites selected for in-depth study as well as one further site chosen for 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 played in planning and implementing the direct payment scheme. The interviews explored their general understanding of the purpose of the programme and their experience of direct payments in residential care during the early implementation of the programme. Results from the analysis are presented in chapter 8.

3.4.2 Service users and family members

Interviews were conducted with 22 service users and family members across nine of the sites. Initially, service users and family members were recruited for interview by providing their details on an 'agreement to be contacted for interview' section on their completed and returned questionnaire. However, as the number of service users agreeing to be interviewed remained low, the team sought research ethics committee approval to adopt a more direct approach to recruitment, involving project leads and care home managers approaching services users who had been offered a direct payment with information about the evaluation and a request to agree to be interviewed. Service users with a direct payment were also offered a gift voucher to compensate for their time if they agreed to be interviewed. Ethical approval from the Social Care Research Ethics Committee (SCREC) was given for this approach in May 2015. The interviews explored issues around the expectations, processes and outcomes of an offer of a direct payment. Interviewers used the questionnaires completed by service users and family members to explore particular responses in more depth. Results from the analyses are provided chapter 6.

3.5 Case studies

Following recent discussion with the Department of Health (May 2015), it was agreed to prepare a small number of 'case studies' that charted the different user journeys and helped identify potential obstacles to inform policy development and guidance. Service users with different types of direct payments were purposively selected from a number of sites, identified with the help of project leads. Three direct payment users (including those managing a direct payment on behalf of their relative) consented to be interviewed: one service user with disabilities accepting a direct payment for part of her care; and two family members of service users over 65 years accepting a direct payment on behalf of their relative. The relevant council and social care staff most involved in setting up the direct payments were identified for interview for the three cases. 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. Twelve individuals were interviewed across the three case studies, including one service user, two family members, four council social workers or care practitioners, two care home managers and one owner, one project lead and one person working for an organisation contracted by the local council to provide direct payment support. On one occasion, a group interview was conducted with the service user, the care home manager and the council staff involved in facilitating her direct payment. Questions focused on reasons for accepting a direct payment, how the payment was set up and used, and whether any challenges had been encountered. The case studies are presented in chapter 7 of this report.

3.6 Limitations

As the number of service users accepting a direct payment have remained low the number of questionnaires received and interviews conducted with service users and family members with a direct payment have also remained low. In addition, many direct payments only commenced in 2015, providing us with limited opportunities to collect follow-up data.

There are plans to collect further data through a small number of follow-up interviews with care home and council staff within a few of the sites selected for in-depth study as well and through additional interviews with service users and family members. There are also plans to prepare a further one or two case studies to illustrate the user experience more fully. These methods will likely rely on continued support from some of the trailblazer sites, beyond the funding term of the scheme.



4. Current number of direct payments

Of the original 20 trailblazer councils, six have dropped out of the programme, leaving 14 local authorities across England planning to or delivering direct payments in residential care. The variation in progress among the remaining councils was still significant. The earliest receipt of a direct payment in a care home in one council area was in April 2014, while other authorities were yet to deliver their first direct payment at the time of writing (September 2015).

Table 4.1 shows the spread of direct payments across the trailblazer councils (the same numbering of site codes has been retained from the first interim report to allow for cross-referencing). The table is intended to show the outcome of discussions about direct payments with service users, according to data supplied by sites in their weekly updates. By the end of July 2015, 70 service users had accepted a direct payment, and 30 of them had direct payments in place. Two of the 14 trailblazers accounted for 30 of those who had accepted a direct payment and 18 of those with a direct payment in place. Fifty-six service users had declined the offer of a direct payment and 11 are currently considering the offer.

There are various reasons behind the disparity between the number of direct payments accepted and those currently active. Some of the direct payments may have been accepted in principle by the service user, and efforts to implement them in accordance with the wishes of the individual were under way. However, some of the direct payments had been implemented, but later cancelled due to changes in the service users' circumstances. Three people had died, while in other cases, service users sold their property and became self-funders. Finally, in one case, a person chose to have her services managed by the council, because she found the process too complicated.

Table 4.1 Number of direct payments accepted and declined

Site Code	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	Total
Direct payments accepted	5	1	0	19	0	4	7	2	0	0	7	11	0	1	5	0	0	8	70
Direct payments currently in place	1	2	0	7	0	0	4	2	0	0	3	11	0	0	1	0	0	0	31
Direct payments declined	8	1	0	0	0	3	21	5	0	0	0	4	0	3	6	0	4	1	56
Still considering	0	0	0	0	0	3	4	0	0	0	0	0	0	4	0	0	0	0	11

These figures are based on the latest data provided by the trailblazers, some recently (July or August) and some less recently (April or May). The data should be treated with some caution, partly because they may not be up-to-date and partly because some trailblazers did not have full data on the numbers who had declined the offer of a direct payment.



5. 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.

The lead for each trailblazer was sent a short questionnaire about their administration and management costs in June 2015. By mid-August six completed questionnaires had been received. Councils were reminded to complete the questionnaire and return it shortly.

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.

Four of the six councils estimated that the management and administration costs which they incurred on their scheme had been fully met by their Department of Health grants. One reported that their costs exceeded their grant, but did not state by how much. One reported that their costs had been less than their grant but that they would require their estimated saving against the grant to meet expected future costs. Part 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 1.5 fte over 18 months (or more specifically 0.5 over 18 months and 1.0 over 22 months to date). Most of the councils reported that this related to a project manager/project lead, as shown in Table 5.1.

Five of the six councils 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, and inform service users and their families about direct payments, carry out Mental Capacity Assessments and, where necessary, best interest decisions in relation to direct payments, refer to and instruct advocates, make referrals to support planners, liaise with service users, their families, advocates, support planners and residential staff, ensure that individual support plans met assessed need, complete care and support plans to include direct payments, and liaise 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.

Two 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.



All six 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 were: 4 hours per week over 6 months, 2 hours per week over 6 months, 2 hours per week over 30 months, 0.5 hours per week over 12 months.

The councils which offered full fee direct payments equated their direct payments with the amount they would otherwise have paid in care home fees. Those which offered part fee direct payments equated their direct payment plus their payments to the care home with the amount they would otherwise have paid in care home fees. This implies that the schemes operated by the six councils should be cost-neutral to councils apart from the extra administration and management costs. It should be noted, however, that the council which decided to use its Department of Health grant to make additional payments to care homes for extra activities chosen by users with direct payments was not among the councils which provided data on administration and management costs.

Four 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.

One council also mentioned extra administration costs for care homes. This was also mentioned in interviews. Some interviewees mentioned, for example, costs of organising meetings to inform residents about the scheme, costs of staff time exploring residents' requests for choice, and costs of administration and invoicing.

In summary, most of the six 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.

Table 5.1 Staff employed on the trailblazer scheme

Council site code	Staff (FTE) employed on the trailblazer scheme
1	1.20 over 23 months – (Job titles not provided)
2	0.25 over 27 months – Business Improvement Manager, Project Manager, Project Administrator, and others
6	0.33 over 18 months – Project lead
7	0.50 over 22 months (to date) and 1.00 over 18 months (to date but will extend) – Project Officer and Project Manager
12	0.50 over 6 months – Community Care Officer
14	0.20 over 12 months – Project manager



6. Views of service users and family members

This chapter presents the findings from two approaches to collecting data from service users in residential care and their family members. In what follows, findings from the survey and from interviews are provided in separate sections.

‘Service users’ are adults in need of social care (including nursing care) who either enter or already reside in a care home. Service users had all been assessed as eligible for council support. ‘Family members’ were (typically) close relatives of service users (such as son, daughter or parent) involved in making decisions about social care. Some family members had legal responsibility as the ‘suitable person’ under the Mental Capacity Act if their relative lacked capacity to make decisions on their own.

6.1 Findings from the survey of service users and family members

6.1.1 Number of completed questionnaires returned

All service users and family members who were offered a direct payment were asked to complete questionnaires about their views and experiences, whether they had accepted or declined the direct payment. Fifty-nine completed baseline questionnaires were returned to the research team by service users and family members between August 2014 and the end of July 2015 (Table 6.1). There were seven cases where both the service user and the family member returned questionnaires. Therefore the questionnaires relate to 52 service users (22 who accepted a direct payment, and 30 who declined). Almost half the questionnaires (46 percent) were from family members of users who had declined the offer of a direct payment. Over three-fifths (63 percent) of them were from just three of the 14 trailblazer areas.

Table 6.1 Number of questionnaires received between 1 August 2014 and 31 July 2015

Council name	Q1 returns	Q2 returns	Q3 returns	Q4 returns	Total
Unidentified	0	0	0	1	1
01	0	0	0	4	4
02	0	0	0	0	0
04	7	4	1	0	12
05	0	0	0	0	0
06	1	1	0	1	3
07	3	0	1	10	14
08	1	0	0	2	3
11	2	1	0	0	3
12	2	3	2	4	11
14	0	0	0	1	1
15	2	0	0	0	2
16	0	0	0	0	0
17	0	0	0	4	4
18	0	0	1	0	1
Total	18	9	5	27	59



Information supplied by the trailblazer councils showed that 96 baseline questionnaires had been handed out (21 to people who had accepted direct payments, 21 to relatives of those who had accepted direct payments, 14 to people who had declined a direct payment and 40 to relatives of service users who had declined). Given 59 completed baseline questionnaires, this represents a response rate of 61 percent. However, it should be noted that these data should be treated with caution; some sites reported difficulties in keeping track of exact numbers of questionnaires being issued, especially where those duties had been delegated to care home managers.

6.1.2 Number of completed questionnaires returned

This section presents findings from the 59 completed baseline questionnaires received by the end of July 2015. This includes responses from 18 service users who had accepted a direct payment, nine from family members whose relatives had accepted a direct payment (including five from relatives of users who also sent a completed questionnaire), five from service users who had declined a direct payment, and 27 from family members of people who had declined a direct payment (including two from relatives of users who also sent a completed questionnaire).

The number of service users who were issued with questionnaires does not necessarily match the number of family members given questionnaires. This is because some service users may not have any family members who are in a position to complete a questionnaire. In addition, sites were asked not to give questionnaires to users who lacked capacity, for ethical reasons.

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. The total of 59 questionnaires includes seven easy-read (six for people accepting a direct payment, one for those declining). Four of them were from people aged under 65 who had learning disabilities.

A further four questionnaires from three service users and one family member were returned at the 6-month follow up stage. Most service users had not yet reached the 6-month follow up point.

Age and client groups of participants

The majority (69 percent) of the service users who completed a questionnaire or whose relative returned a questionnaire were aged 65 and over (Table 6.2). Almost half had a physical disability and almost a quarter had a learning disability. Much smaller proportions had dementia or mental health problems. 30 percent had other conditions. It should be noted that this is based on data entered by the council on the questionnaires and that more than one condition was indicated for some users.



Table 6.2 Age and client group of participants

	Aged under 65	Aged 65+	Learning disability	Physical disability	Mental health	Dementia	Other
Person accepting direct payment (q1)	7	11	4	7	1	1	9
Person declining direct payment (q3)	1	4	1	4	0	1	1
Relative of person accepting direct payment (q2)	0	4	0	2	0	3	1
Relative of person declining direct payment (q4)	9	16	9	12	1	2	4
Total	17	35	14	25	2	7	15

Type of care home placement

Over 80 percent 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 less than 20 percent were in care homes providing nursing and personal care (Table 6.3). A slightly higher proportion of those who declined a direct payment were in nursing homes (20 percent of those declining as against 17 percent of those accepting a direct payment).

Table 6.3 Type of care home placement

	Residential	Nursing
Person accepting direct payment	15	4
Person declining direct payment	3	1
Relative of person accepting direct payment	4	0
Relative of person declining direct payment	20	5
Total	42	10

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

Seven of the 22 users who accepted a direct payment had one to cover the full care home fee (less the assessed user contribution and any topping up required) and 14 had a direct payment covering only part of the care home fee (Table 6.4). One questionnaire, from a relative of a service user accepting a direct payment, left this question blank.

Table 6.4 Whether direct payment covered whole or part of care home fee

	Whole fee	Part fee
Person accepting direct payment	5	13
Relative of person accepting direct payment	2	1
Total	7	14



Three service users reported using the direct payment for paying the care home fee in full and two relatives said their family members used it for this purpose. One service user and two family members said they or their relatives used it to pay part of the care home fee. As Table 6.5 shows, the more frequent use of the direct payment (64 percent of users) was for activities outside the care home and the second most frequent was activities within the care home (40 percent). 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 6.5 Use of direct payment

	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	13	9	1	5	1
Relative of person accepting direct payment	1	0	0	0	0

Satisfaction with the direct payment process

The results from 16 questionnaires (12 service users and 4 family members) related to service users who accepted direct payments includes ratings for people’s satisfaction with direct payments. 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, nine people said they were very satisfied or fairly satisfied with the direct payment, with six people being neither satisfied nor dissatisfied (Table 6.6). No respondents reported any level of dissatisfaction.

In addition, 15 of the 16 respondents said they were fairly or very satisfied with the information and advice they had received relating to the direct payment, 12 said they were satisfied with their choice of care home (with one being neither satisfied nor dissatisfied, and one being fairly dissatisfied) and a further 12 said they were satisfied with the control over their direct payment (with two being neither satisfied nor dissatisfied). By contrast, only seven people reported being satisfied with the ease of management of the direct payment, with five 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...is money enough to do anything regularly – time to do added paper work (would it be better to pay for internal activities).”*



Table 6.6 Satisfaction with the direct payment process

Question for service user/ relative about satisfaction	Very satisfied	Fairly satisfied	Neither satisfied nor dissatisfied	Fairly dissatisfied	Very dissatisfied	Missing data
With the direct payment	5	4	6	0	0	1
Information and advice received about the direct payment	7	8	0	0	0	1
Choice of care homes	9	3	1	1	0	2
Choice of services within the care home	5	6	3	1	0	1
Personal control over the DP	4	4	7	0	0	1
Knowledge of how the DP is being spent	7	5	2	0	0	2
Ease of setting up the DP	5	5	5	0	0	1
Help from care home over use of DP	9	0	4	0	0	3
Ease of management of the DP	3	4	5	0	0	4

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, 19 users had been resident in a care home for over five years (Table 6.7).

Of the people who accepted a direct payment, four had lived in a care home for between one and three months, five had lived there for between 3 and 24 months, three had lived there for between two and five years and two for longer than five years. One was not yet living in a care home but planning to move into residential care soon. The majority of the people who declined a direct payment - 58 percent, or 17 out of 29 - had lived in their care home for longer than five years. Three had lived in the home for between two and five years and nine for less than two years.



Table 6.7 Length of time in care home

Questionnaire type	Less than 1 month	1-3 months	3-6 months	6-12 months	12-24 months	24 months – 5 years	5 years or more	Not resident in care home	Total
Service user accepting direct payment	0	0	1	2	2	3	2	1	11
Relative of service user accepting direct payment	0	4	0	0	0	0	0	0	4
Service user declining direct payment	0	0	0	0	1	1	2	0	4
Relative of service user declining direct payment	0	3	4	1	0	2	15	0	25
Total	0	7	5	3	3	6	19	1	44

Typical reasons for declining

Thirty people – service users and family members – who declined a direct payment provided reasons for their decision (Table 6.8). Since people could give more than one reason, there are 36 responses. Over three-fifths (63 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, in a comment on a questionnaire, one family member praised the wide variety of activities already available at the care home, such as days out, yoga, and arts and crafts. They went on to express 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 County Council have previously always handled finance of service will create tension – at least initially – between the provider and the service user’s representative/carer.”*

For 6 of the 30 people, the reason for declining was a concern that the direct payment would mean work for them or their family. In three 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 and commented: *“I feel that direct payment is complicating matters and creating problems because many people in receipt of these payments can’t manage their own affairs, this will result in debts being built up, which will be difficult to recover.”*



Table 6.8 Reasons for declining

	Person declining direct payment	Relative of person declining direct payment	Total
Did not think direct payment would give them more choice and control	0	3	3
Did not feel that they had sufficient information to make the decision to take a direct payment	0	1	1
Did not feel they were given enough time to make decision	0	0	0
Concerned that direct payment would mean work for them or family	2	4	6
Already resident in care home and happy with arrangement	3	16	19
Other reason	1	6	7

6.2 Findings from interviews with service users and family members

This section presents the findings from the interviews that were held with service users and their family members, friends or advocates (referred to as family members henceforward). By end of July, 21 interviews had been carried out with 22 service users and family members in nine project sites. In one instance (site 12), a service user and a member of their family had been interviewed at the same time.

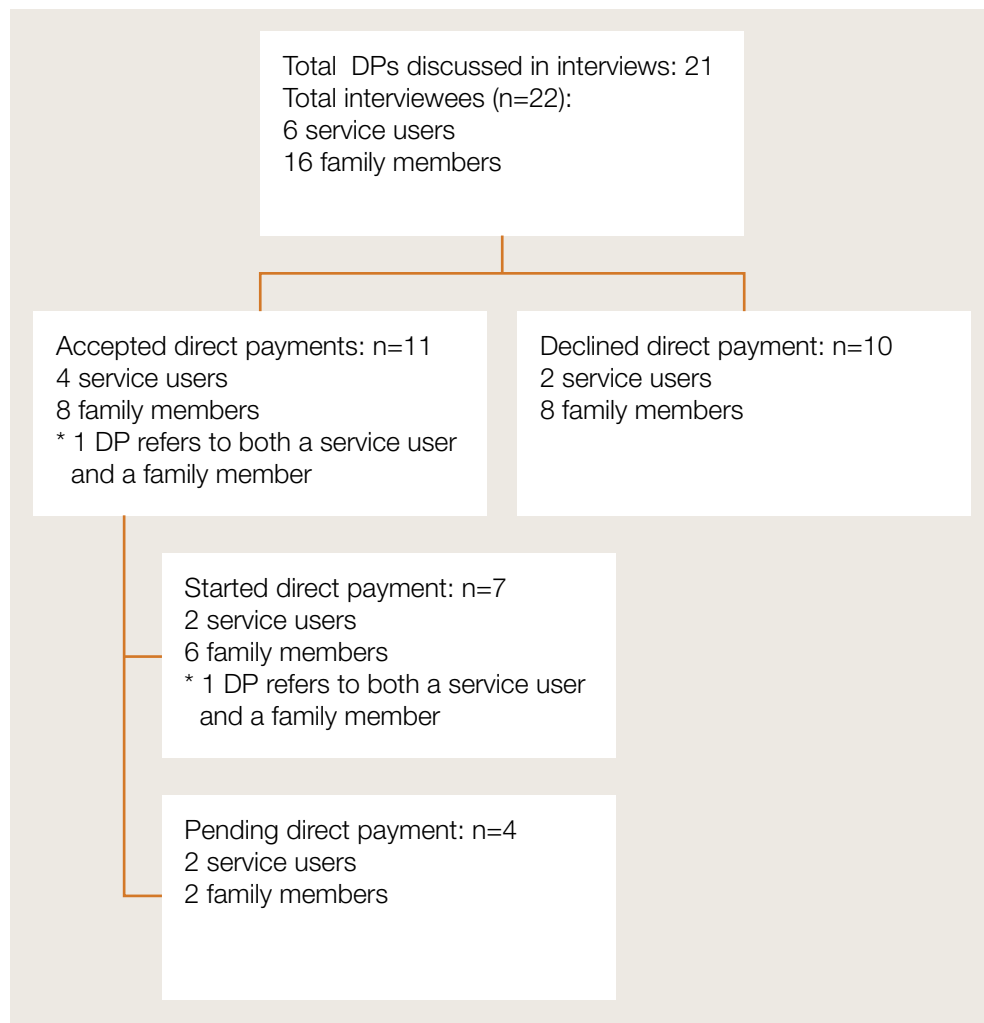
Sixteen interviews were conducted with family members over the phone, and one face-to-face. Of these interviewees, eight were with the family member of service users who had accepted a direct payment and eight with family members of service users who had declined a direct payment.

All six interviews with service users were conducted in person at their place of residence. Of the service users participating in an interview, four had accepted a direct payment and two declined.

When the interviews were held, seven direct payments had been set up and started and four were pending. Figure 1 below provides a summary of the numbers of interviewees by type, the decisions taken about a direct payment, and whether or not the direct payment had started at the time of the interview.



Figure 6.1 User type and direct payment status



Using a topic guide, the semi-structured interviews explored issues around the expectations, processes and outcomes of an offer of a direct payment. The topic guide included questions on interviewees’ prior awareness and experience of direct payments, reasons for accepting or declining a direct payment, the types of discussions held, and information received when a direct payment was offered, uses of the direct payment, management of the direct payment, and level of satisfaction with care services and the direct payment.



6.2.1 Characteristics of interviewees

Table 6.9 below describes the number of service users and family members interviewed per project site.

Table 6.9 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 6	0	1	1	0	0	1	1	0	0	1	0	0
Site 7	3	4	2	5	0	2	3	4	0	0	1	6
Site 8	0	1	0	1	n/a		0	0	1	1	0	0
Site 12 ²	1	6	5	1	5	0	0	1	5	2	3	1
Site 14	0	1	0	1	n/a		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	n/a		0	0	1	1	0	0
Site 18	1	0	0	1	n/a		0	1	0	0	0	1
Total	6	16	11	10	5/11	6/11	6	6	9	6	4	11

¹ Type of direct payment refers to participants who accepted a direct payment only (n=11).

² One interview was with a service user and a family member at the same time (site 12). Number of interviewees for site 12 is counted as 7; overall number of interviewees counted as 22. Number of direct payments offered is counted as 21.

Eleven interviews involved service users and family members who had accepted the offer of a direct payment and ten interviews concerned direct payments which had been declined. Five of the “accepted” direct payments consisted of the “full” fee which councils would otherwise have transferred to the care home. Six service users received direct payments covering part of the care home fee only. In one site, this payment was made to the care home rather than the service user directly and involved a sum (£20 per month) paid in addition to the regular care home fee.

Of the accepted direct payments (n=11), seven service users (or family members on their behalf) had started to receive direct payments at the time of the interview: four were “full” direct payments and three were “part” direct payments (two in Site 4, one in Site 15).

The majority of the interviews (n=15) were conducted with service users (n=1) or relatives of services users (n=14) who were aged 65 years and older, of whom nine were over the age of 84 years. Amongst service users aged 65 years and older, eight had accepted a direct payment and seven had declined the offer. Three of the service users under 65 years had accepted and three had declined a direct payment.

Over half of the interviews (n=11) involved service users who had lived in the current care home for over five years. Of these, five had accepted a direct payment and six had declined the offer. Three out four service users living in their current care home between 1 and 5 years had accepted the offer of a direct payment; and three out of six service users living in their current care home for less than one year had accepted a direct payment.



6.2.2 Expectations of service users and family members

Previous understanding of direct payments

Interviewees were asked about their knowledge of direct payments before they were informed about the option of a direct payment in residential care. Several interview participants (n=16) 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 user’s change in funding arrangements, for example, when they moved from funding their care themselves to receiving council funding.

A minority of interviewees (n=6) discussed that they had had prior knowledge of direct payments. Two family members explained that they had had experience with managing a direct payment while the service user lived in the community. In both cases, the family members suggested that their previous experience in the community was one of the reasons for accepting 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.

Reasons for accepting

The reasons for accepting or declining a direct payment were discussed in the interviews. Table 6.10 lists the range of reasons for accepting a direct payment cited by interviewees.

Table 6.10 Characteristics of interviewees

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 (empowerment)
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 direct payment was to provide service users with more choice in terms 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 inferred 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, which improved their sense of confidence and control.

Better control was often expressed in terms of financial control, which several family members explained led to them feeling empowered to voice their concerns with the care provider should they become dissatisfied with the services:



“Because the payment is coming from us, rather than from the council, if there is something we were not happy about, I feel that I’m more able to take a stand.” (Family member, Site 12)

Indeed, 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 at the time 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 the service user to a different home if she felt the needs of her relative were not being met.

A few family members explained that they perceived 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.

Reasons for declining

Interviewees who declined a direct payment gave a range of reasons for their decision. Table 6.11 lists the main reasons given for declining the offer of a direct payment.

Table 6.11 Reasons for declining 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
Direct payment could be used dishonestly
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 are 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. One 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. One 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 enroll 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 his individual 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.

6.2.3 Processes of setting up a direct payment

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.



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. In all cases, the direct payment had been accepted.

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 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 in the first instance:

“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. She further related that after speaking to other relatives about it, she deduced that the PIN was for an account that had been opened for the service user’s direct payment.

A small number of interviewees explained that they had received adequate information about direct payments. Three family members and one service user explained that they met the council or the care home staff (or both) on several occasions to discuss the option of a direct payment. As a consequence they expressed that they were satisfied with the level of detail they were given and were able to take an informed decision. Of these cases, two had accepted a direct payment and two had declined, of whom one did so because the care provider had declined to support the programme.

6.2.4 Setting up and managing a direct payment

Several of the 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 it 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” (Site 12) to transfer the funds into



the account. A similar story was provided 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 agreed to take up 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 to 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.

Interviewees (n=8) 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 two cases, the family member explained that they had had positive experiences with 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.

However, one family member of an older person commented that although they had found managing the direct payment relatively simple after the “teething” problems had been addressed, they found that their relative would find it difficult to manage a direct payment by him/herself:

“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)

6.2.5 Effects of direct payments

Using a direct payment

The interviews also explored how direct payments were being used. Seven of the eleven direct payments that had been accepted had already started at the time of the interview. In all cases of service users receiving a “part” direct payment (n=3), the funds had been used 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 and trips to a garden centre. In the cases where service users received a “full” direct payment (n=4), the funds were used exclusively to pay the care home fees:

“[The direct payment] covers the care fees and that is it, basically. [The service user] does not have any left at the end of the month.” (Family member, Site 12)

A few family members receiving a “full” direct payment expressed disappointment that they did not have more options to use the direct payment:



“[We would like] more flexibility [in terms of] what we can use it for. Sometimes [the service user] will say: ‘Get me out of this place. I am bored’.”
(Family member, Site 12)

Another family member explained that the (full) direct payment only covered the care home fees. 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]” (Site 12) with the care home. Indeed, all 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.

Three “part” and one “full” direct payment had not yet been transferred to users and had thus not formally started. The interviewees (two service users and one family member) who had not yet received their “part” direct payment, stated that their intention was to use the funds for leisure activities outside the care home. In the case of the “full” direct payment which had not yet started, the family member 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

During the interview, 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 indicated 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 s/he was dissatisfied with, such as the level of attention given to the personal hygiene of his/her relative, perceived friction between the care home staff, and the amount of information they received about the wellbeing of his/her 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 his 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 four instances in which the direct payment has already been received, interviewees (three family members and one service user) 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). However, one 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.

Of the remaining three cases who had begun receiving direct payments, one 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 payments (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)

Another family member inferred that she was satisfied with using a direct payment, but stated that she would rate having the direct payment higher if it were 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)

The third family member who was using a direct payment did not give a numerical rating but implied that she did not perceive any benefit from having a direct payment:

“I cannot just get [the service user] a wheelchair, or this [or that] that the [service user] needs. [The direct payment] is not for that. So, it would be no different if the council were [making the payments] or if I’m doing it. [Except] there is more administration. There are not really more choices, because there are no choices to make.” (Family member, Site 12)

The ratings also varied among interviewees who had accepted a direct payment, but who were still waiting for it to be transferred to their accounts (n=4; two service users and two family members). One service user gave a low rating of her current circumstances. However, she voiced the expectation that the direct payment could allow her to participate in outings and subsequently gave a hypothetically high rate. Another service user, who did not provide a rating, similarly expressed that her life could be improved with a direct payment if this meant she were able to engage in activities she enjoyed, such as going to the theatre.



One family member who had not yet received the first 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)

6.2.6 Summary

Responses from service users and family members suggest that the decisions to accept or 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. In contrast, most families who had accepted a direct payment on behalf of a relative expressed feeling empowered to challenge the care home should its standards fall below par, suggesting that there could be aspects of the care home that could be improved. Overall, the majority of interviewees expressed that they were satisfied with the level of care at the home, irrespective of the decision to accept or decline a direct payment.

Many interviewees noted the initial problems they had had with setting up a direct payment. Many of those receiving a “full” direct payment also expressed disappointment about the lack of flexibility in terms of how the funds could be used. Responses also suggest that the views, expectations and experiences of service users and their family members were heavily influenced by the information they were given in the process of discussing and, if they decided to accept, setting up a direct payment. Interviewees who spoke most positively about direct payments typically had experienced direct payments in the community or felt they had received sufficient information from the council and/or care home staff and had had opportunities to discuss the options and implications of having a direct payment. There was a tendency among those who were critical about direct payments to also feel to have received (too) little information and guidance on having a direct payment.



7. Case studies of service users with a direct payment

This chapter presents three case studies of service users with a direct payment.

Case studies were not part of the research strategy initially, but have been added to the evaluation at the request of the Department of Health to understand better the steps required to set up direct payments in residential care, by focusing on the experience of individual service users. The case studies thus aim to trace the ‘user journey’ from the decision to accept a direct payment to the payment becoming operational; i.e. money received by the service user and/or choices made on how to use the direct payment. The cases have been selected for this purpose and are not meant to illustrate particular effects of direct payments on service users. However, it has not been possible to trace these ‘journeys’ in their entirety, as some direct payments were still at the final stages of being set up at the time of writing.

The case studies were based on interviews and discussions with those involved in organising the direct payment, including the service users (where possible), family members, care home managers, and the social worker and project leads at the respective councils.

7.1 Mary

Mary is 85 years of age and has lived in a residential home for a little over a year. She suffers from dementia and progressed Parkinson’s disease, and needs a high level of care including personal care.

Before she entered residential care, Mary lived in a flat under an independent living arrangement with a relatively low level of support for about two years. She was also supported by her two daughters. However, when her level of need increased this became unsustainable and her daughters decided that Mary would be better looked after in a residential care home.

Mary was admitted as a self-funder initially. Her daughters are satisfied with the care she receives and the friendly environment of the care home. The care home has rooms for 54 people and provides residential care for older people, many of whom have dementia. It is part of a large privately owned chain of care homes that operates in the region.

Mary had already been living in the care home for a few months when her daughters applied for her to be council funded in autumn 2014. Council social workers then assessed her care need and determined her financial contribution. In January 2015, it was agreed that the council should fund a long-term placement for her. The care home was happy to accept the rate that the council would pay for the placement.

The council’s Review Panel raised the issue of whether Mary should be offered a direct payment. A social worker then visited the daughter who is most involved in Mary’s care to discuss the option of a direct payment in residential care. This was accepted and the council agreed to make the entire care home fee available as a direct payment. It then took until May 2015 to set up the direct payment, with the first regular payment to the care home made in July 2015.

The direct payment Mary receives, managed by her daughter on her behalf, consists of the council rate adjusted for Mary’s income from her and her late husband’s pension. She retains a weekly allowance of about £23. The direct payment is transferred by the council to a bank account that her daughter opened for this purpose. She was initially asked to open a second bank account for the top up,



but as the top-up was waived this was not needed. The daughter also signed a contract with the care home company and the company set up a direct debit so that its financial team could invoice the family directly. The council then provided her with a list of dates indicating when payments are made from the council so that she could plan when to pay the care home. The daughter is required to keep all bank statements and invoices which she has to submit annually for financial audit. She also keeps an eye on any financial transactions in case anything goes wrong.

Overall, it has taken much longer to set up the direct payment than expected. Mary's daughter had managed her mother's finances before Mary went into care and she was not afraid of the paperwork involved in managing the direct payment. However, in her view, the process of setting up the direct payment was cumbersome, involving a significant number of phone calls to coordinate the various parts of the payment and a fair degree of uncertainty as to whether the direct payment would go ahead as expected.

As Mary and her daughters are satisfied with the care Mary receives in the care home, the direct payment is not used to fund any additional services. Additional choice was not the rationale for Mary's daughter when deciding to accept the direct payment. Instead, her motivation was to try out something new and to use her experience in managing finances to help the council to test a new system. She also felt that council workers were keen on her having a direct payment. In her view, having a direct payment does not make any difference to the care her mother receives.

"I can't think how it would benefit us at all. Because, if they would [i.e. the council] have done it, they would have done exactly the same as me, and they would have got mum's money out of her account and they would have paid here. I don't think it would have made any difference whatsoever." (Daughter)

She also explained that the payment covers the care home fee, but does not allow for additional purchases beyond the services covered by that fee.

"It's not as if I can spend any of that money. Say, mum needs a wheelchair. I can't spend that money, because that's for her care...I'd have to buy her a wheelchair either out of my money or her money. Her private money. So, it's not as if there is money for anything else. Like her hair dressing and chiropody, we pay for that separately. So, that money, because it's audited, you see, is just for care. So, I can't see why there would be any difference." (Daughter)

The care home is not yet in a position to break down its costs of care for individual residents and thus to list services that residents can 'opt out' from (e.g. if relatives want to wash the clothes of residents themselves rather than having them laundered by the care home). The care home manager indicated that she expects homes to be able to disaggregate these costs in future to allow residents and their relatives to make their own choices.

7.2 June

June is 66 years of age and has lived in residential care for 43 years. Before she moved into care she lived with her parents. June has physical disabilities with moderate learning difficulties and currently uses a wheelchair. She requires support for some of her personal care (such as bathing and personal hygiene) and other aspects of her life.



June has spent almost her entire adult life in the same care home. The home is a charitable organisation providing residential care for 17 adults with physical disabilities and learning disabilities, aged between 26 and 66 years. These include adults with Down's syndrome or severe autism as well as people with disabilities following a stroke or road traffic accident. The care home also provides supported living for 45 people and day care services for residents and external clients. Around a third of the care residents require support for their personal care and most require a high level of emotional support.

The care home volunteered to be included in the scheme at the invitation of the council's project lead for the trailblazer in early 2014. Personalisation had already been high on its agenda and the home wished to be at the forefront of the initiative. The home had a history of collaborating with the council and most of its residents were council funded (including placements from other councils). The aims of the trailblazer also fitted well with the care home's practice of promoting person-centred care.

The care home then hosted a coffee morning for residents where the project lead explained the direct payment to residents and invited anyone interested to participate. Three residents expressed an interest in direct payments, one of whom was June. A follow-up meeting was set up with June, her siblings, the care home manager, a social worker and the project lead to discuss the direct payment and a mental capacity assessment was completed to ensure that June (who was keen to manage the direct payment herself) had sufficient capacity to accept the direct payment. Although June had been allocated a staff member at the care home to help with completing forms and other paperwork, it was agreed that she needed more specific support if she were to manage the direct payment herself. She would also require support from a social worker to review her needs, develop her support plan, and help her set up financial arrangements for the direct payment.

June agreed to manage her direct payment with assistance from an external organisation contracted by the council to advise and support people with direct payments. June could have chosen to have her direct payment managed by this organisation entirely or to have the payment transferred onto a prepaid card. However, both options did not appeal to her as her main motivation was to have more control over her finances and learn how to manage money with as little support as possible.

The direct payment was agreed to be a partial direct payment of £181 per week. This reflected the weekly sum that the care home had previously received from the council to fund day care activities for June. Although June is already 66 years of age the council has continued making these payments due to her particular circumstances as a long-term resident in this care home. The council has continued to pay the remaining care home fee, i.e. around £700 per week, directly to the care home. This arrangement addressed concerns by June's siblings who worried that June might not be able to handle the entire care home fee.

June is pleased with having more control over her direct payment and relishes the fact that it was her decision to take it up:

"It was my decision really but they [my siblings] had to know I was doing it". (June)

Arriving at the sum for a (part) direct payment was relatively simple in the case of June, as the care home had already received funding for day activities from the council as a separate sum in addition to the usual fee that covers care and hotel costs.



Once the direct payment was agreed a bank account needed to be set up for June. This became a major challenge as June (as a long-term resident) did not have two forms of identification available as required by the bank. A letter from the chief executive of the care home was regarded as insufficient by the bank. After about six months, mostly due to the persistence of June and her care home key worker, the bank was eventually persuaded to open an account for June in early 2015.

June then signed the direct payment agreement with the council. A change in contract between the home and the council was not necessary as the accommodation and care costs were not affected. The agreement specifies the amount of the direct payment and includes stipulations of how it is to be used (according to the support plan).

The direct payment agreement is underpinned by June's support plan that has been developed by her named social worker in discussion with June, the care home staff member dedicated to her care and the direct payment advisor. The plan identifies activities for which the direct payment could be used based on June's choices and specifies the support June requires to make them happen. It also sets out the arrangements with regard to monitoring and review including the evidence the council requires on how the direct payment has been spent. June receives support throughout this process from the council, the care home and the direct payment advisor.

The direct payment is now being paid directly to June's bank account. Her plan is to use this to organise a trip to the theatre as well as for training in IT and using a computer. She also plans to visit events involving horse riding, which she has always enjoyed but has not been able to attend. This will require transport and personal assistance support, which can be funded from the direct payment. The direct payment will also be used to pay for her usual day activities.

June values the prospect of having more control over her activities. This optimism is shared by her social worker who notes that the process of setting up the direct payment for June involved both some anxiety and a sense of opportunity:

“[June could] be all keen and be... a little bit apprehensive too, but then the next visit it is, you know, actually this [the direct payment] is a good thing. She's certainly known from the start that actually, yes, I want to give this a go and so it is good.” (Social worker)

This sentiment is also shared by staff at the care home who have been supportive of June having a direct payment despite the additional demand on their resources:

“Yes, it has cost extra staff time. Obviously the running around, the phone calls to the bank, chasing up documents...because it's something that people[service users] are keen to do, the staff have not minded doing it ...because they can see [June is] happy to do it and the staff...they have done it in their own time... they are just happy to do it.” (Care home manager)

7.3 Henry

Henry is 87 years old and has lived in residential care for the past three years. Before moving into care he lived in his own home supported by his son and daughter-in-law, who lived next door to him. Financially, he was able to support himself with his State Pension and Attendance Allowance.



Three years ago, Henry was advised by his general practitioner to seek a temporary placement in a residential home. His health had deteriorated and he required more intense care. His family selected the care home for a temporary stay at first, which eventually became permanent. The care home is privately run, and offers residential and nursing care for up to 53 adults. About 90 percent of its current residents have dementia.

Henry fully paid for his residential care as a self-funder for a short time until he became eligible for council funded care. The council now pays for his residential care, to which Henry adds his assessed financial contribution (except for his weekly allowance of about £23). He also receives nursing care funded by the local Clinical Commissioning Group (CCG) (currently £110.89 per week). In addition, his son contributes a top-up payment to the care home of £31 per week.

Henry and his family were initially approached by the owner of the care home who was supportive of the idea of testing direct payments in residential care. The owner organised an information event with the council's project lead and interested residents and their families in the care home. Henry and his son accepted the offer of a direct payment and follow-up meetings were arranged to discuss how to organise the paperwork and financial transactions. Henry did not want to manage the direct payment so his son and daughter-in-law (who has power of attorney) agreed to do so on his behalf.

Henry and his family are satisfied with the care and support received at the care home. They selected the care home themselves based on its reputation and feel reassured by it having won awards for the quality of the care it provides. The direct payment therefore is not intended to provide any additional choices or facilitate changes in the care Henry receives. However, the son indicated that the direct payment would increase the family's confidence to demand any changes they might want to make to Henry's care in the future:

"If I want my dad to do something or he wants to do something, [the owner] can do it. If [the owner] doesn't want to do it, you've got the right then to say, well, we will take his money and go somewhere else, and it gives you that bit more confidence that you have not got to go through the councils." (Son)

Their main motivation for taking up the direct payment was that it promised to simplify the financial transaction. Specifically, it would allow the family to bring all the payments together in one bank account, from which one transfer would be made to pay the care home. This would replace the need for the family to organise the transfer of Henry's personal contribution to the council and pay the top-up fee separately.

"It [the direct payment] seemed a very good idea of how it came over because originally my dad's money was in the post office, then the council paid [the nursing home], and then as a third party I would pay the top-up. When the bill came from the council, [my wife] had to go to the post office, pull the money out, [transfer it] into the bank, then we had to write a cheque to the council, then I personally had to write another cheque [for the top up payment] to the nursing home. To do a direct payment seemed a really good idea at the time." (Son)

They hoped that with a direct payment the council would pay their assessed net contribution for Henry's residential care into a bank account opened for this purpose as a direct payment. The family would then transfer Henry's financial contribution and the top-up payment into the same bank account and pay the care home bill from this account.



However, setting up the financial transaction was not as straight forward as expected. In April 2015, a direct payment of £577 per week was agreed by the council, based on the current rate paid to the care home. The direct payment does not include the nursing care element which, under current arrangements, the council receives from the CCG and pays directly to the care home (although in future it may be possible to include the CCG payment in the direct payment).

There was some delay in transferring Henry's pension to the new bank account. Henry's family had to ask local authority staff to accompany them to the local Department of Work and Pensions office to explain the direct payment programme and vouch for the accuracy of the transaction. A further complication was that no provision had initially been made for Henry's personal allowance, which was now transferred to the direct payment bank account as part of his pension. As this was seen as not being sufficiently transparent, the family was asked to open another bank account to keep the personal allowance separate from the direct payment. For simplicity and to avoid further confusion, it was eventually agreed that the personal allowance remains in the direct payment account for the time being and that this would be addressed in the future.

Sorting out the financial transaction was not helped by the fact that at the initial stages there were different care workers involved in providing advice to the family, some of which was contradictory:

“I think there were four, five care workers helping us with it, and then one lost the files and it just went on and on and on. It went on for about a year...I know we're the first to do it but it is an absolute nightmare...My dad couldn't do it. It was very stressful for me and [my wife].” (Son)

Advice on sequencing the payments caused another set of teething problems, as the family was initially asked to stop paying Henry's pension to the council and was then issued a red letter demanding payment. As a consequence, the process of setting up the direct payment was experienced as stressful by Henry and his son.

The difficulty of setting up the direct payment also had an effect on the care home, which at one point ceased to receive any payments. When payments resumed, staff at the care home were unsure about how the payments related to the fees that had been received previously:

“Well, I think, at the moment, we're still trying to understand where the payments are coming from and how much they are, because no two payments have we had yet that have been the same. So we're saying, well, look, what is going on here?” (Care home owner)

While the direct payment has now been set up and payments are being made regularly, the family is still sceptical of the sustainability of the arrangement:

“I'm not confident that all the money is going to keep going in. You know what I mean? I was just going to leave it for six months and then you can look at the bank statement and say, oh, his pension goes in there, that goes in there, that goes in there, invoice that day, right, I'll do it on the 31st. But how it is at the moment, as soon as we get the invoice [from the nursing home], [we] pay direct to the nursing home.” (Son)



7.4 Summary

This chapter has presented three case studies detailing the user's 'journey' from accepting to receiving a direct payment. The case studies illustrate that setting up a direct payment can take considerable time and effort from all parties involved, including the council social worker, the care home manager and the service user and/or the family members involved in his/her care, and can cause stress and anxiety for the user/family.

Council staff have to inform interested service users about the potential benefits of a direct payment as well as about the responsibilities associated with having a direct payment, such as retaining receipts and participating in yearly audits. They also help coordinate between the service user (or family), the care home, others involved (e.g. DWP and banks) and often multiple sections of the council's administration to get the direct payment underway. These case studies demonstrate that there were a number of specific issues that required attention and coordination, for example, setting up a bank account for a long-term resident and coordinating the timing of the first payment.

These cases also highlight the involvement of care home managers and their staff in setting up the payment and in supporting service users in making choices facilitated by the direct payment. In two cases presented here, the (whole) payment was used to pay for the care home fee in its entirety, leaving little or no room for additional spending. In both cases, the family members indicated their satisfaction with the care arrangement in their respective homes, but also expressed the view that managing the direct payment would be a helpful lever to demand changes if they felt these were required. However, the cases also suggest that service users and family members played an active role in facilitating the direct payment, which included tasks such as opening bank accounts and arranging for payments to the care home, monitoring progress, and, in the case of June, planning activities for themselves (albeit with substantial support from the care home and others).



8. Views of council staff

This section presents findings on how council staff experienced the initial stages of implementing the direct payments scheme. Key topics emerging from the interviews are: strategies of promoting the direct payment; timing and context of making an initial offer; provider engagement and involvement; and barriers and challenges to setting up direct payments and implementing the scheme.

8.1 Characteristics of council staff

Nineteen interviews were carried out with council staff involved in setting up the direct payment programme in the four trailblazers selected for in-depth study. Project leads in each site facilitated the process by sending out personal invitations to participate in the evaluation to a range of key personnel. This included social workers working at the frontline as well as those working in adult social care in a management capacity. Interviews were carried out mostly face-to-face at the participant’s place of work. The aim of this round of interviews was to elicit initial thoughts and experiences of planning and implementing the direct payment in residential care trailblazer scheme.

Most interviews were conducted between September 2014 and January 2015, at a time when most sites were only just beginning to implement their direct payment schemes. A small number of interviews with council staff in two sites were conducted in May and June 2015, to obtain information to inform the case studies of the service user journey. Questions in these interviews focused on how direct payments were set up and used by residents in care homes. Table 8.1 (see appendix 12.3) summarises the number and professional roles of those interviewed.

8.2 Strategies for implementing the direct payment scheme

Interviews with council staff identified a range of plans for implementation of the direct payment scheme in all five trailblazer sites. These are summarised in Table 8.1.

Table 8.1 Strategies for setting up direct payments in five trailblazer sites

Site	Approach to implementing the scheme	Further information
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.
7	Direct payment offered to selected residents in selected care homes	Participating care homes help the council with recruiting residents to consider either whole or part direct payment on a case-by-case basis.
8	Universal offer of whole or part direct payment to new or current residents (all client groups)	Whole 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.
12	Universal offer of whole or part direct payment to new or current residents (all client groups)	Whole 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.
17	Universal offer of whole 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 the two broad strategies for implementation identified in the previous interim report (Ettelt et al, 2015). Project leads described their intended approaches to implementing the direct payments scheme as follows: a) offering direct payments to a selection of service users in participating care homes (Sites 4 and 7), or b) offering direct payments to all clients eligible for council support for their adult social care needs (Site 8 and 17). Two sites, site 8 and site 12, have taken a dual approach combining a universal offer to all clients with actively promoting direct payments in selected care homes. Site 8 offers both whole and part payments and site 12 offers full payments only. Site 17 has opted to offer the full payment to all service users eligible for social care support at the point of assessment before entering residential care. Site 4 collaborates with a few selected care homes offering an extra payment (as a direct payment) to promote personalisation for a number of selected residents.

8.3 Promoting direct payments

Council staff 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. Having a direct payment could, according to the majority of those interviewed, provide increased opportunities for some service users to explore different options to meet their needs better. It would also fit well with the ethos of some care homes of encouraging greater independence and choice, such as care homes promoting a recovery model of care for service users with mental health problems or those providing residential care for younger adults with learning or physical disabilities. A number of those interviewed also viewed the process of setting up direct payments as potentially leading to greater job satisfaction and improved staff morale for those working at the frontline, such as social workers or care home staff, particularly if direct payments allowed them to spend more time with their clients discussing choices and planning their support. Some council managers viewed the scheme as an opportunity to improve quality and efficiency in the care home sector as care homes may have to become more responsive to the wishes of their clients as a result of direct payments.

However, there was some uncertainty about how the direct payment scheme might be implemented, especially in relation to older people and service users with limited capacity to make their own choices. Council staff 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, who often enter residential care with a high level of complex needs, including dementia, which limits their ability to benefit from increased choice and control through a direct payment. Many viewed personalisation for these service users as relating to choice and control over everyday living, such as in what to wear and eat and how to spend their day. Such choices are reliant on personal interactions between service user and carer rather than choices facilitated through a direct payment. It would be more a case of ensuring good, personalised care and support planning, rather than individuals having a direct payment.

Other perceptions about direct payments in residential care echo those described in the previous interim report. These are broadly categorised as those involving potential issues around safeguarding, council and provider staff capacity to support the scheme, and lack of provider and service user engagement. There was also concern from some council managers about the potential for direct payments to limit choice for some service users if the council loses its ability to control costs if the care home contracts



with service users directly. Care homes may then, potentially, be in a position to impose higher fees on residents. Some council staff also feared that service users might incur additional costs if care homes used direct payments as an opportunity to charge council funded clients with a direct payment private self-funder rates.

A small number of frontline staff expressed their lack of confidence in promoting direct payments to their clients. This varied between the sites and largely reflected issues common to piloting initiatives 'new to the sector'. Practitioners therefore 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. Council staff, such as social workers, were often relying on their own local knowledge and understanding of direct payments to field questions from providers as well as service users and their family members. Some staff found this a challenge. This is illustrated in the following quotation from a practitioner working in a trailblazer that was offering direct payments to all service users entering residential care, but had yet to have anyone accept a payment:

“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 are all in the same boat. The message that I get constantly is, well, we don’t really know enough about it. We don’t really mention it, because we are not really sure.” (Social worker, Site 17)

8.4 Offering direct payments

Council staff said that they made the initial offer of a direct payment either during their normal assessment, during the care review processes or through targeting service users within participating provider organisations, depending on the approach chosen by each site (Table 8.1). Making the offer at the time of entry to residential care, particularly during a time of crisis, 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. The assessment involved detailed and complex information exchanges between the social worker and the user and/or family, and the offer of a direct payment therefore came 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 Work Practitioner, 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, but getting full formal acceptance from users and family members frequently proved resource intensive. Interviews with council staff indicated that in some sites the direct payment was actively promoted by participating care homes, either by council project leads or care home managers, or both. This meant that practitioners were able to discuss the direct payment with clients whom they knew were already interested, and had an opportunity to address any anxieties about management and support directly. This often involved a number of meetings of council and care home staff with users and their families to discuss individual choices and support arrangements (also see the case study 'June').

In some cases, service users and family members were happy to accept a direct payment, as they were seen as simplifying administration for a family member (site 12) or as enabling access to a particular care home (see case studies 'Henry' and 'Mary').

8.5 Experience of engaging providers

Interviews with council staff indicated that the level of provider engagement in the programme varied within and between the sites. As noted above (Table 8.1), several councils approached providers directly to work in partnership with council staff to enable users to receive direct payments in residential care.

Council staff working with selected providers reported a high level of engagement of providers in the scheme. This included care home managers helping current residents consider an offer of a direct payment by organising themed coffee mornings with residents, family members and council staff, or by care home managers actively contributing to promotion events or 'direct payment scheme provider forums' organised by the council. Some care home staff also supported the implementation of the scheme by providing dedicated support to service users to enable them to manage their direct payment, including helping set up bank accounts and assisting with the organisation of activities paid for with the direct payment. This partnership approach between the service user, the care home and the council in setting up and managing a direct payment is also described in some detail in the case study of June.

However, not all care home managers were keen to engage in the scheme and some council staff mentioned a degree of provider resistance. Much of this was related to the concerns of care home managers about local authority funding for long-term social care and this funding being insufficient to cover the costs of care, particularly for older people. Thus it was felt that there was no flexibility for additional choice within the existing budget. There were also specific concerns about care homes not being able to distinguish the care costs from other costs. In one site this led to providers threatening to opt out of the scheme, which led the council to provide the direct payment as an extra payment in addition to continuing paying the care home fee directly:

“There was a real worry. I don't think they [care home managers and owners] were particularly negative, they were worried more than anything, about how they would actually implement that, given that they struggle on a day to day basis with staffing levels, with funding implications.” (Social worker, Site 4)



8.6 Challenges to setting up direct payments

As mentioned previously, most interviews with council staff were conducted during the early phase of the direct payment scheme, when few direct payments were in place. More recent interviews identified a number of barriers and challenges to the set-up of direct payments. These mostly related to specific cases of arranging for a direct payment.

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 formal acceptance of a direct payment and 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 was relatively straight forward. In the case of a direct payment covering the whole care home fee, 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. The care home was already providing the service user with short-term care and it was her and her family's preferred choice for the long-term. The care home was unwilling to accept the service user as a council-funded resident, arguing that all its beds assigned to council-funded residents were already allocated. However, it was willing to accept the service user as a private client, at a higher (self-funder) rate. As the family agreed to pay the difference between the council fee and the self-funding rate, the service user could use the direct payment to secure this place.

“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)

In this case, the direct payment facilitated the preferred choice of care home. The family, according to the social worker involved, appeared happy with the level of personalised 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, [its] helping her to choose exactly where she wants to go... It's the choice of home which is really, really important.” (Council staff, Site 8)



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 extra 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 that residents could participate in. 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).

Council staff also noted the amount of time spent on reassuring participating service users and family members, and explaining the practicalities of managing a direct payment.

8.7 Summary

In summary, interviews with council staff revealed a high level of support for the aims of the direct payment in residential care programme but many were unsure how this might work or be of benefit for some provider organisations or individuals. This was notable for organisations providing care for older people where council funding was often restricted, providing little or no opportunity for any flexibility in budgets to enable additional choice. There was also some concern about the benefits of direct payments to some service users, mainly those lacking capacity for choice and control.

Those staff engaged in implementing direct payments frequently found this to be a long and resource intensive exercise requiring a good deal of co-ordination and co-operation between various people and organisations, both within and outside the council and care home. Some staff revealed that they lacked confidence to promote the scheme to others and some reported difficulties engaging providers. However, many council staff recognised the potential benefits that could be had from participating in the scheme, including increased job satisfaction for themselves and others working at the frontline, through enabling greater service personalisation for residents. Those working with service users and family members were already seeing some of the benefits of this for their clients and for the participating care home staff.



9. Views of residential care providers

The following section presents findings from the interviews with managers and owners of care homes. Interviews were conducted in five trailblazer: two metropolitan districts in the North West of England; a county council in the South East; a unitary district in Yorkshire & Humberside; and a London Borough. Four councils volunteered to be focal ('in-depth') sites for the purpose of this study. Data from a fifth area was added, as care home managers in this council area were interviewed for a case study.

Between two and six representatives of providers were interviewed in each site, totalling 18 interviews to date. Care homes included both homes run by charitable organisations and homes in the private-for-profit sector (Table 9, Appendix 12.2). 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 6 residents with moderate learning disabilities and the largest home having capacity for over 100 older people with personal 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=9) 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.

9.1 Desirability of direct payments and person-centred care

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

However, owners and managers voiced a number of concerns about the potential impact of direct payments on the funding of residential care, which could pose a risk to the financial sustainability of care homes. Concerns were also raised about the feasibility of introducing direct payments in care homes which may have implications for costing and invoicing, recording of 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 allow care homes to provide a more person-centred approach to care in residential settings in practice.

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. Owners and managers also raised questions about the impact of direct payments on other residents in the home who did not have a direct payment.

9.2 Funding and financial viability

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 relies on the pooling of income from all residents (i.e. council-funded and self-funded) into one budget from which the care home covers all its costs. The ability of care homes using this business model to switch to a different – individualised – model of identifying costs was judged as limited, especially for smaller homes with little capacity to generate economies of scale in administration and provision of care. In addition, owners and managers of care homes for 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 were seeing larger companies entering the local market thereby increasing the competition for self-funding residents on which 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 many 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 found it difficult to keep adequate records of essential care provided to residents already, reflecting pressures on staff to attend to several aspects of care simultaneously and competing demands on their time and attention. Breaking down these services into individual 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 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 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 were ‘flexible’, and thus could easily be made more responsive to the wishes and choices of residents.

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

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

Another care home owner noted that the costs of running a care home (composed of hotel costs as well as some care costs) would not necessarily decrease if individual residents chose to purchase external services. 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 by providing residents with a choice of activities that included 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 make 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 would place 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 (even if this did not involve providing) additional services (such as a trip to the garden centre or watching a football game in a local pub) would impact on limited staff time at the expense of other residents.

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 not care or hotel services (e.g. for a theatre ticket or a personal item purchased by the home on behalf of the user).

The current funding climate was identified as a major constraint on the feasibility of the 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 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 has not been accompanied by an increase in funding.

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 have been 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 drops, 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)

9.3 Choice and control

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

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 severe dementia may not benefit from the type of choices that could be achieved through a direct payment (e.g. certain activities outside the home). However, 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 person-centred care would involve giving them time to dress themselves to the best of their abilities rather than dressing them. The latter would be less time consuming, but also less desirable for the older person:

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

Choice and control, in this example, 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. This meant that 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 undertake 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. Under current arrangements, 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 benefited from being involved in decision-making routinely. It was seen as questionable whether a direct payment would offer any additional choice to them, while it would require the residents to make more complex decisions involving financial transactions. This home was also earmarked for transition to supported living, which will allow residents to access direct payments in the community, if they so wish.



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 has 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)

9.4 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 lacks capacity. This was particularly (but not exclusively) pertinent to older people who, as was pointed out, were often admitted to a care home in a situation of crisis as a measure of last resort when the family had reached a point where it was 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 from relatives of residents who had been offered a direct payment relating to the financial management of the 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 manages 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 his funds that were



used for funding 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 many as previously funded.

9.5 Summary

Findings from interviews with care home owners and managers (n=18) in five sites raised a number of concerns about the feasibility of introducing direct payments in residential settings. There were particular concerns about the potential impact of direct payments on the financial viability of care homes in the current financial climate, particularly those providing care for older people. There were also questions about the benefits of direct payments to residents of care homes and their families, and whether having a direct payment would necessarily translate into enhanced choice and control. Care homes that provided 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 making decisions on behalf of service users.



10. Discussion

This interim report expands, and builds on, the previous interim report published in March 2015.

The number of direct payments taken up has remained relatively low with 70 users accepting a direct payment by July 2015. Of those 70 users, only 30 were reported to be in receipt of a direct payment (i.e. the direct payment was 'active') and 40 to have accepted one in principle but were not yet in receipt of it in summer 2015. This total reflects an increase since the previous interim report, where 45 had accepted a direct payment in principle by November 2014, but none had received one in practice. It should be noted that 2 of the 14 trailblazers account for 30 of those who had accepted a direct payment and 18 of those with a direct payment in place.

Given the small number of service users with a direct payment to date, it is worth pointing out that the programme has remained small. Uptake of direct payments in residential care has remained far lower than the 400-500 which the trailblazers projected during the scoping and feasibility phase of the programme.

10.1 Types of direct payments

Since the previous report, there has been some convergence in the ways direct payments are calculated. With the exception of the two sites that have provided extra payments in addition to continuing paying the care home fee, all remaining (active) sites have offered direct payments based on the care home fee. Those sites that initially planned to develop a new resource allocation system (RAS) similar to the RAS used for direct payments in the community have since reconsidered their approach or have withdrawn.

Councils varied in whether they offered a direct payment for all or 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. This meant that council and care home staff found a way to avoid having to break down the costs of care in care homes, which had been a substantial concern in earlier interviews with providers. This approach also 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 tended not to provide service users with additional choices, perhaps with the exception of a choice of care home in a few cases.

Service users who received a part payment tended to use them to purchase specific services or items (e.g. cinema tickets). The most prominent services mentioned were day activities, organised both outside and within the care home. This option was mostly used by younger adults in residential care and facilitated by care homes that already offered a degree of choice in activities to their residents. Younger adults also tended to receive specific funding for such activities that could be provided as a part payment without care homes having to break down their costs.

10.2 Experience of having a direct payment

This report brings together different accounts of the experiences of direct payments by service users and their families. These reflect in part different methods of data collection – survey questionnaire and interview – but also the diversity of experiences of direct payments by service users and their relatives, both in terms of how direct



payments are perceived (including by those who have declined the offer) and how they are experienced in practice (i.e. by those who have an 'active' direct payment).

Nine service users/family members (of 16 in total) said that they were very satisfied or fairly satisfied with the direct payment (with six 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 four indicating that they were very satisfied with their direct payment, while three said that they would be more satisfied if the direct payment had offered more 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 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 those who had accepted, but not yet received, a direct payment.

In a number of instances, direct payments were reported as being of direct benefit to service users, by giving them more flexibility in selecting a care home or facilitating additional choice of activities.

- 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').
- A service user was keen to move to a specific care home outside the council area that did not accept her as a council funded resident (paying a council rate). Her family was happy for her to have the direct payment and to pay the additional fee charged by the care home that accepted her as a self-funder.
- A younger adult who recently moved into a care home was able to continue to employ her personal carer using a part direct payment in residential care. She had previously received a direct payment in the community. Her family member stated that this made a crucial contribution to her continuity of care.

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 those 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 (n=3) indicated that they did not think that taking a direct payment would give them more choice and control. At interview, some family members of those who 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 person-centred 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 (i.e. mostly declined but some accepted) taking up a direct payment.



This concern points to the role of family members in managing the direct payment on behalf of their relatives and in making choices for them. Some care professionals questioned whether relatives would be willing to take on these tasks. The low take up of direct payments during the 20 months of the trailblazers suggests there may be reluctance by some relatives, although there are likely to be other reasons (e.g. lack of information about direct payments; the approach of offering direct payments only to selected individuals in some places). On the other hand, interviews with family members also suggested that some appreciated the opportunity to manage their relatives' finances and contribute to their care.

Overall, the picture of user experience has remained variable with no clear trend emerging from the combined data collected for this study. However, the limited data available suggest that it is easier to facilitate direct payments either as a whole fee (although this does not seem to result in increased choice within care homes, but in one case led to increased choice of care home), or as a part fee for service users who are already in receipt of council funded day activities (who thus may already have a degree of choice) than facilitating direct payments in other ways (e.g. as a part payment for older people).

10.3 Setting up direct payments

The limited scale of the programme suggests that implementing the trailblazers has been challenging. The previous report already described these challenges in some detail, based on interviews with project leads and a number of owners and managers of care homes. Challenges identified included difficulties encountered by council staff in gaining support from providers, convincing other council staff of the potential of the programme, and identifying service users and family members who were willing to take up a direct payment. Care home owners and managers expressed concerns about the impact of direct payments on their business model and the sustainability of their funding. They also questioned whether direct payments would be able to achieve more choice and control in the context of residential care. Findings from interviews with council staff and with managers and owners of care homes presented in this report broadly confirm these earlier findings.

The findings also suggest that setting up individual direct payments when the offer was accepted was challenging and time intense for council staff. Responses to the survey suggest that less than half of the service users and family members who responded to the question on satisfaction with direct payments were satisfied with the process of setting them up (7 of 16 responses in total). Interviews with service users and family members, and with council and care home staff, also suggest that some service users/families experienced anxiety and stress during the process of organising the direct payment.

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 would be 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 by themselves. The picture emerging to date is that each direct payment has 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.



The report provides only limited information about the administrative costs of the trailblazer scheme. Six 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. There was considerable variation between councils in the number of full-time equivalent staff deployed on the schemes. In principle, these differences could be important in explaining variation in the progress of the trailblazers. However, the data are too limited to substantiate such conclusions. All councils have so far committed themselves to facilitate direct payments at no additional cost to the council (by basing direct payments on the care home fee), with the exception of one that may continue its (small scale) approach to offering an extra payment. However, the current 'case-by-case' approach to setting up individual direct payments suggests that the transaction costs involved in setting up a direct payment in residential care may exceed the transaction costs incurred in arranging a care home placement without a direct payment.

10.4 Information about direct payments

This report highlights that setting up direct payments requires 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 for implementing the trailblazer programme by all parties involved. The absence of clear and comprehensive information was also noted by council staff as a key 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, 15 (out of a total of 16) 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 at least two types of information about direct payments noted as particularly relevant.

a) Information about the processes involved in setting up and managing direct payments.

These processes affect 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.

b) Information about the potential benefits of direct payments.

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. Findings presented in this interim report suggest that some service users/families benefited from having a direct payment. However, they also suggest that the costs of setting up these payments (in terms of staff time and effort) have been relatively high (see below).



10.5 Impact on care homes

As discussed in the previous report, many managers and owners of care homes have taken a cautious stance towards direct payments. While the managers and owners interviewed for this study agreed that there was potential (and a need) for more personalisation in residential settings, many were sceptical about the extent to which direct payments could contribute to this aim.

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 that cared 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).

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. This mostly applied to care homes for younger people with disabilities. These homes already make 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 would be most successful in places which 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 refusing to participate such as concerns about funding). However, there may be a variety of reasons for such lack of support, including lack of resources such as staff time and concerns about shortfalls in funding.

10.6 Preliminary assessment of the costs and benefits of direct payments in residential care

The findings presented in this interim report are based on a preliminary analysis and do not provide a definitive assessment of the costs and benefits of direct payments in residential care. In relation to benefits for service users and families the picture continues to be mixed. A small number of service users and families reported that they benefited directly from having a direct payment, for example by being able to access a particular care home (although at substantial additional cost to themselves) or by choosing activities that had not been previously available to them. Some family members said that they saw value in having control over the budget in principle, even though in most cases this had not yet been translated into negotiations about changes in service delivery. On the other hand, many service users and families declined the offer of a direct payment, hence the small scale of the programme. There is substantial uncertainty about the exact number of those who declined a direct payment: the numbers provided by sites are likely to underestimate the numbers of those who declined as some sites had little oversight over the process of offering direct payments to service users. Some of those interviewed said that they saw no benefit in having a direct payment. However, others (e.g. council staff) suggested that the low uptake of direct payments might also reflect insufficient information about them, making it difficult for staff to promote them.

Some participants in the programme argued that the benefit of the direct payment was dependent on what service users saw as a benefit. The experience captured in this study (and presented in the earlier report) has shown that there are practical



limits to the feasibility of this position. Councils also need to decide whether there are choices that they would not like to see supported by a direct payment in residential care. For example, some councils decided against the use of a direct payment to purchase alcoholic beverages (although a trip to the pub was seen as appropriate), meals (if they are already provided by the care home), holidays or theatre tickets.

Other benefits seem to result indirectly from direct payments. Most notably, there have been examples of service users/families, care home managers and council staff having more intense discussions about the needs and preferences of the user thus affecting change without using the direct payment to pay for a specific service. In such cases, discussions arising from the offer of a direct payment acted as a catalyst for improvements for the service user but the direct payment itself was not required to implement the improvements (although it could play a role if families have the opportunity to take the direct payment elsewhere if they so wish).

However, the findings also suggest that the cost of implementing the scheme was high in relation to its modest outputs. While all but two sites 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. This report does not provide an estimate of the average administration cost per direct payment as the final number of direct payments is not yet known. However, data from interviews suggest that setting up direct payment involved substantial staff time. Thus the costs of setting up these initial direct payments are likely to have been high. The costs of administration are likely to 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. It is also unclear whether the costs of setting up direct payments in councils that did not participate in the scheme will be lower than in trailblazing councils.

The findings also suggest that the costs and benefits of direct payments will be influenced by how direct payments are set up. A direct payment covering the full fee seems easier to set up for councils and care homes, but is less likely to offer service users and family members greater choice of services within the care home (although some may appreciate the feeling of control over the budget). A part payment may be more difficult to set up, especially if this involves identifying those parts of the care home fee that can be used more flexibly. However, where this is possible such a part payment may provide greater choice of services within or outside the care home. This route seems most promising for younger adults who receive an additional payment for day activities, but less feasible if such payments are absent (e.g. care for older people).

It is important to note that this study explores whether direct payments in residential care are promoting choice, control and other objectives of personalisation as perceived by the service users and their families; but it is beyond the scope of this project to determine whether direct payments are the best way to promote these objectives.

10.7 Limitations of this study

This report has to be interpreted with caution. Findings from this evaluation relate to a very small programme, with only 30 direct payments currently active.

There are severe limitations to the scale of data that could be collected, particularly as regards the survey of service users and family members (n=59 in total). If these responses



are disaggregated according to various relevant criteria, for example, service users and family members or types of service users (e.g. older people versus younger adults), the numbers become extremely small. For example, there have so far been very few responses to the 6 month follow up questionnaire (n=4) and none to the 12 month follow up questionnaire. This is mainly because few users have yet reached 6 months since they accepted a direct payment. There are likely to be more questionnaires for analysis at the time of the final report in June 2016, but there are unlikely to be large numbers given that the trailblazer programme comes to an end in October 2015.

The data collected through interviews are more substantial with over 100 interviews conducted to date. However, many individuals interviewed for this study had no or limited experience of 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 and concerns about direct payments from the experience of receiving and using a direct payment (service user, family member) or supporting one (care home manager, council staff). 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 necessarily to facilitate additional choice.

It is important to recognise that service users and family members who have 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 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 selected themselves into the programme and thus may not be representative of all councils in England potentially implementing direct payments in residential care.

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 of 'scaling up' or 'rolling out' such programmes, due to better resourcing, more focused attention on producing results within a given timeframe and the fact that councils volunteered to participate and thus can be assumed to have been particularly motivated to succeed. This may be so, but, given the small scale of the programme to date, the challenges of its implementation and the number of sites that have left the scheme, the outputs produced are modest (i.e. only 30 'active' direct payments). It is possible that the numbers of direct payments will rise over time, with more experience and more resource. This report hints at a number of procedural problems around coordinating and communicating direct payments that future participants may find easier to resolve. Establishing direct payments in the community has also not been a straight forward journey. However, while this interim report allows some insight into the processes involved in setting up direct payments, it does not conclusively answer the question as to whether such issues are 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.



11. References

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12. Appendix

12.1 Total numbers of interviews conducted

Table 3.2 Total number of interviews conducted to date (July 2015)

Group	Number of interviews	Comments
Project leads ¹	18 14	First round in 2013 Second round in 2014
Representatives from national stakeholder organisations ²	7	Carers UK, National Care Forum, SCOPE, Care England, Age UK, Alzheimer’s Society, Registered Nursing Homes Association
Care home staff	18	Care home managers and owners within 5 sites (4, 7, 8, 12, 17)
Council staff	21	Social workers, assistant practitioners, community care officers, change managers, council brokers and commissioning managers in 5 sites (4, 7, 8, 12, 17)
Non TB sites	2	Contacted total of 33 directors of adult social care, 2 responses to date
Service users and family members	21	16 family members 6 service users
Group interview	1	1 group interview with SW, TB lead, CHM for case study – site 7)
Total	103	110 individuals (as some interviews conducted with more than one person)

¹ Analysis of interviews included in last interim report (February 2015).

² Analysis of interviews to be included in next report.



12.2 Interviews with council and care home staff: Numbers and roles

Table 8.1 Interviews with council and care home staff

Site Code	Number of interviews carried out to date	Roles of interviewees (number of people interviewed)
4	9	Care home managers (1) Care home directors/owners (3) Council social care managers (3) Council workforce development (1) Social worker (1)
7	9	Care home managers (4) Social workers and assistant practitioners (4) Support worker for direct payments (1)
8	13	Care home managers (6) Council social care managers (3) Social workers (4)
12	4	Care home owner (1) Care home manager (1) Social workers (community care practitioners) (2)
17	4	Care home owner and manager (2) Care home manager (1) Social care practitioners (2)
Total	39 interviews	Total of 40 individuals interviewed



12.3 Characteristics of care homes interviewed

Table 9.1 Characteristics of care homes of which owners and/or managers were interviewed

Site Code	Sector	Number of places	Type of residents	Type of care	Funding sources
1	Private, in a group of three homes	32	Older people, including dementia	Residential only	Council and self-funded
2	Private	31	Older people, including dementia	Residential only	Council and self-funded
3	Private, in group of seven	n/a	Older people, including dementia	Residential and nursing	n/a
4	Owned by NHS	6	Learning disabilities	Residential only	Council funded
5	Private	23	Physical and learning disabilities	Residential only	n/a
6	Charitable		Learning disabilities	Residential only	n/a
7	Charitable, operating internationally	39	Physical and learning disabilities	Residential and nursing	Council funded and continuing care
8	Charitable, in group of 15 homes		Learning disabilities and mental health	n/a	n/a
9	Private	10	Mental health	Residential only	Council funded
10	Private	34 (in two homes)	Mental health	Residential and supported living	n/a
11	Charitable (religious)	18	Older people	Residential and sheltered housing	n/a
12	Charitable (religious)	105	Older people	Residential and nursing	Council and self-funded
13	Charitable, in group of 10		Learning disabilities	Residential only	Council funded
14	Charitable, in group of 11	40+	Older people, mostly with dementia	Residential only	Mostly council funded
15	Charitable	25	Physical disabilities	Residential only	Council funded and continuing care
16	Private	n/a	Older people with dementia	Residential only	Mostly council funded, some self-funded
17	Private	54	Older people, mostly dementia	Residential only	Council and self-funded
18	Private	53	Older people, many with dementia	Residential and nursing	Council and self-funded



12.4 Methods section of research proposal

Research methods involving all sites

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



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

Research methods involving a sample of sites only

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



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

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

Other methods, not involving sites

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

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