



Ettelt, S; Perkins, M; Wittenberg, R; Mays, N (2013) Direct Payments in Residential Care Trailblazer Programme Evaluation. Preliminary Report. Technical Report. Policy Innovation Research Unit, London School of Hygiene and Tropical Medicine, London.

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Preliminary report

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Funding

This work is funded by the Policy Research Programme of the Department of Health for England, via its core support for the Policy Innovation Research Unit. This is an independent report commissioned and funded by the Department of Health. The views expressed are not necessarily those of the Department.



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1. Summary

The number of users of Direct Payments for community care – that is cash instead of care packages – has increased sharply in recent years reflecting a policy emphasis on ‘personalisation’. DPs are not, however, currently available for people in residential care.

The Law Commission recommended in 2011 that DPs should be extended to people living in residential settings, providing equality of access to DPs between people living in their own homes and those in residential care. The Government announced in its 2012 *Caring for our Future* White Paper that it would pilot DPs for residential care.

The Department of Health (DH) invited local authorities to express interest to be pilot sites for DPs in residential care. Twenty local authorities were selected to pilot such DPs over a two-year period, of which 18 are participating in the scheme. The Government then decided to empower all local authorities to offer DPs for residential care from April 2016. As a result, the pilot sites have become ‘trailblazers’ for the national roll-out of DPs in residential care.

This report is the first from the independent evaluation of the ‘trailblazers’. It is based on a scoping study carried out over the summer and autumn of 2013 consisting of a literature review, documentary analysis, interviews (June-September), collation of routine data and collection of descriptive data from trailblazers on their schemes for DPs.

The literature review of evidence on ‘cash-for-care’ schemes in the UK, the rest of Europe, the US and Australia found a range of different schemes in different countries, but limited evidence on their effectiveness or cost-effectiveness.

The 18 trailblazer sites, although not selected at random, in practice cover a spectrum of different types of areas in terms of geography and socio-economic characteristics. They account for somewhat under 20% of the population of England and at least 14% of all supported care home residents.

The local authorities running the trailblazers reported holding contracts with a total of 2,375 care homes in their areas (excluding four areas which have not yet provided this information). They support a total of 29,900 care home residents (excluding two areas which have not yet provided these data), of whom 79% are older people (aged 65 and over) and 14% are younger adults (aged 18-64) with learning disabilities.

Most sites expect to start offering DPs to users from January 2014 or earlier; but some sites do not expect to offer them before March 2014. A minority of sites have encountered problems in setting up the trailblazer (e.g. difficulty recruiting or retaining a dedicated project manager).

Most of the trailblazers plan to include in their DPs for residential care schemes older users (n=13 out of 18) and users with learning disabilities (n=14). A majority plan to include younger users with physical disabilities (n=10) while few (n=4) plan to include younger people with mental health problems.

The scale of the trailblazers is likely to be fairly modest. The sites expect that around 435 to 500 users will be offered and take up DPs for residential care during the trailblazer period (i.e. January 2014 to December 2015). Excluding one area, which plans to invite all its care homes to participate, the sites expect around 100 care homes to be involved, of which few will be nursing homes.



Most sites are considering offering support to users to facilitate choice. Many already offer a brokerage service in community care, which could be expanded to residential care or a similar approach could be adopted. These services are typically contracted out.

The majority of sites are considering use of a resource allocation system (RAS) that matches care needs and funding to determine a DP. However, as yet no RAS exists for residential care (although the use of RAS is well established in community care) and sites vary in their plans for developing and/or using a RAS.

Five sites have indicated that they plan to offer DPs for the full amount of fees, while two have stated that they plan to provide DPs for part payment only (e.g. to cover the care costs, but not the hotel costs for residential care). Four sites have decided to offer both types of coverage, based on the needs and capacity of the user requesting a DP. The remaining seven have indicated that they have not yet decided the amount covered by DPs or have not yet responded to our request for information.

Most sites do not anticipate substantial changes to their current approaches to assessing care needs and to making care plans for their clients. Most sites hope that the process of care planning will become more sensitive to the preferences of people admitted to care homes and that care plans will become more focused on outcomes and quality of care.

Most sites expect that councils will remain involved in contracting with providers. Only a small number thought it possible that the council could withdraw entirely from contracting with providers leaving contracting to the user and the care home.

Leads in trailblazer sites see an opportunity for the promotion of greater choice for care home residents and potentially for improvements in the quality of residential care. At the same time they have a range of concerns about the level of user take up of DPs, the range of choices that will in practice be offered and the potential impact on providers' finances. They are determined that the scheme will not put extra pressure on council budgets as a result of introducing DPs.

All sites indicated that they plan to monitor the introduction of DPs in residential care and/or plan to evaluate progress and outcomes. However, most sites were still at an early stage of developing their monitoring strategies at the time of the interview.

The remainder of the evaluation will comprise: a process evaluation to understand the different ways DPs are being offered to care home residents and the challenges arising from implementing them; an impact evaluation to assess the impact of DPs in residential care on users and their families, care home providers and the provider market, and councils and their staff; and an economic evaluation to examine, as far as possible, the relative costs and cost-effectiveness of different approaches to providing DPs in residential care.



2. Introduction

In July 2012, the Department of Health (DH) invited councils to express interest to be pilot sites for direct payments (DPs) for residential care with external evaluation. Twenty local authorities were selected to pilot, over a two-year period, whether and how DPs 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. Of these 20 councils 18 remain involved. Amended regulations have come into effect on 1 November 2013 to enable DPs for residential care to be legally disbursed in these local authority areas. Councils also invited local providers to participate in the pilots.

The Government subsequently decided to empower all councils to offer DPs for residential care from April 2016. Pilot sites have been turned into 'trailblazer' sites to reflect the new purpose of the scheme, which is to prepare for the introduction of DPs 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. This report is the first from the independent evaluation of the trailblazers. It is based on a scoping study carried out over the summer of 2013.

The aim of the scoping work was to provide a rapid, preliminary understanding of the different ways in which DPs in residential care are likely to be implemented in trailblazer sites, to provide the sites with early insights into how other sites are approaching DPs, and to provide advice to inform decisions about evaluation design and trailblazer implementation.

The specific objectives were:

1. To describe how each trailblazer site is approaching the implementation of DPs in residential care, what problems they have encountered, and what they expect to gain from the trailblazer and from implementing DPs in residential care more generally
2. To assess differences between trailblazer sites, including their previous experience of providing DPs; their provider landscape; the mix of funding residential care homes receive (e.g. the balance of council funded and privately funded residents) and the types of clients and types of residential care settings they aim to include in the trailblazer
3. To describe the existing systems in place for managing DPs in home-based care in sites, to explore opportunities for developing a common management information system for the DP sites and to identify the availability of individual-level baseline data (e.g. on service utilisation, costs)
4. To undertake a rapid review of the evidence on the costs and benefits of previous, relevant 'cash-for-care' schemes in social care in the UK and other selected high income settings that provide cash payments for residential care.

We have not pursued two other early stage objectives which we had originally planned. These relate to developing a typology of emerging models of deploying DPs, understanding the feasibility and appropriateness of different approaches to controlled evaluation and exploring options for selecting comparator groups and outcome measures. We have not pursued the first because many of the trailblazer sites are still developing their plans for the provision of DPs in residential care in their areas.

Our methods for this preliminary report were:

- A rapid synthesis of the evidence on the costs and benefits of relevant DP schemes in social care in the UK and selected countries
- Telephone interviews with a staff member responsible for leading the pilot in each of the 18 pilot sites (n=18)



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- Collection of socio-demographic data on the trailblazer areas from Office for National Statistics (ONS) reports
 - Collection of additional data on numbers of service users and their plans for DPs from the sites (e.g. user groups included).

Data were collected between late March and early November 2013, with interviews with trailblazer leads taking place between June and September.

The specific objectives of the remainder of the evaluation, consistent with the changed policy context of a national roll-out of DPs, are:

- To understand the different ways in which DPs are being offered to residents of care homes and to examine the challenges arising from implementing DPs for users, carers, care home providers, and councils and their staff in trailblazer sites (*process evaluation*);
- To assess the impacts of DPs in residential care on 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 DPs for residential care, for both users and their families and local councils (*economic evaluation*).

Further reports of the findings relating to these objectives will be produced in December 2014 and December 2015.



3. Policy background to Direct Payments in Residential Care

Direct Payments (DPs) have become a key mechanism by which people are enabled to meet their eligible social care needs. These so called ‘cash-for-care’ payments provide the person with cash rather than services so that people have greater choice and control over how their social care needs are met. Direct payments were first introduced in 1997 under the Community Care (Direct Payments) Act 1996 for people with disabilities aged 18 to 64 and have gradually been extended to all user groups outside residential and nursing home settings. A duty on councils to provide DPs was introduced in 2003 (Gheera 2012).

Most people who are assessed as needing care services have a right to a DP. If a person wants a DP, local councils are under a duty to make DPs available to anyone who is able to manage them, alone or with the assistance of a named person. From November 2009, DPs were extended to those without capacity where a ‘suitable person’ (family member or friend) can receive and manage the payments on behalf of the person (Gheera 2012).

Since then, DPs have become a key mechanism for delivering the transformation strategy for social care, which was first announced in the document *Putting People First* (Department of Health 2007). This strategy has sought to offer care users with more choice and control through ‘personalisation’ in the way the needs of people requiring social care support are met. Also called ‘self-directed support’, the personalisation denotes an approach to providing services for people with disabilities to enable them to live as independently as possible. These reforms were first proposed in England, but have since been adopted in other parts of the UK (Slasberg et al 2012).

As part of this strategy, personal budgets were introduced, seen as the next stage in the development of the personalisation agenda. Personal budgets are an allocation of funding from the council to a service user to reflect an assessed care need. Personal budgets can be taken as a DP, i.e. paid out directly to the user, managed by the council on behalf of the user or taken as a combination of both (Slasberg et al 2012). Personal budgets have gradually been rolled out in England since 2008.

The value of the budget may be determined through a Resource Allocation System (an algorithm to determine an allowance or payment that matches a person’s care need with the funding available to meet his/her need, short: RAS) or by a practitioner estimating a cost based on what the person might have received using traditional services (Slasberg et al 2012; Think Local, Act Personal 2011a). It can only be given to a person who has been assessed as qualifying for council-funded social care and recipients are assessed for a financial contribution to the cost of their care package.

Personalisation remains central to current policy and is at the heart of the White Paper *Caring for Our Future* (Department of Health, 2012). The draft Care and Support Bill makes service users and carers eligible for on-going social care to have an entitlement to a personal budget, preferably provided as a DP, as part of their care and support plan. Although there was slow take up of DPs initially, the numbers have risen sharply in recent years, with younger adults more likely to opt for DPs than older people. Although there are no hard data on how DPs are used, it is believed that many users spend their DPs on employing personal assistants. The first National Personal Budget (POET) Survey found that personal budgets were most popular with users when delivered as DP, but also that DPs work well for older people and for younger people with disabilities (Think Local, Act Personal 2011b).



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

From April 2016, DPs will be made available to all eligible service users in residential care settings. This follows a recommendation from the Law Commission that aims to allow equal access to DPs to all recipients of care both in their own home and in care homes (Law Commission 2011).



4. Review of the international experience of 'cash-for-care' schemes

Introduction

The following sections review the evidence on 'cash-for-care' schemes implemented in a number of countries. DPs in England can be considered as one form of 'cash for care' scheme, although there are significant differences in how such schemes have been designed and implemented. This review brings together the international experience of 'cash-for-care' schemes in the United Kingdom (UK), Australia, the United States and a number of European countries.

Background to such schemes

In the past decades, concern has been growing about how to provide assistance to the growing numbers of people with social care needs, particularly in the context of ageing populations. While in the past social care was often seen to be the responsibility of families, increasing life expectancy means that there are many more people, especially older people, needing such support with activities of daily living from formal social care services and over much longer periods of time than before. In response, policy-makers have begun to develop formal long-term care (LTC) policies (Swartz et al. 2012) that aim to achieve a better balance between the dual need to expand social care and to curb public spending.

In the 1990s, the concern over the rising cost of long-term care in some countries led to social care reforms and the introduction of cash allowances, mostly targeted at people in the community. 'Cash-for-care' has come to be seen as one way of introducing greater flexibility into systems that were regarded as too supply-oriented, costly, and unresponsive to the needs of their users. In Sweden, for instance, the role of family caregivers was enhanced to reduce costs and cash payments were introduced to increase flexibility of funding (Da Roit and Le Bihan 2010). In Germany, similar concerns led to the creation of mandatory long-term care insurance. The benefits from the insurance scheme adjust for different levels of care dependency within which users can choose between receiving a care services or a cash payment (Heinicke and Thomson 2012).

Such schemes are often referred to as 'consumer-directed care', as they shift the responsibility for choosing care services from professionals to users. 'Cash-for-care' schemes tend to imply that services are purchased in the market place instead replacing the previous model dominated by state agencies. Such schemes take a variety of forms (Arksey and Kemp 2006), but typically involve the provision of cash payments, vouchers or personal budgets (Timonen et al 2006). Many schemes define how these payments can be used and have developed criteria for this purpose (Arksey and Kemp 2006). 'Cash-for-care' schemes have been criticised for 'commodifying' care, adding a price tag to services, some of which have previously been provided informally (Ungerson and Yeandle 2007).

Some common characteristics can be identified across schemes: they often provide a combination of monetary transfers to families with providing in-kind services; they aim to develop or establish a market for social care services in which providers compete for customers; they are driven by the idea of empowering users by increasing their purchasing power; and they promote care provision within families (Pavolini and Ranci 2008). All these schemes have to address issues of eligibility, define the degree of user choice and ensure that expenses remain within the overall budget. There are also concerns about potential impacts on (existing) local provider markets and on the provision of informally provided care services (Da Roit and Le Bihan 2010; Timonen et al 2006; Lundsgaard 2005).



Eligibility, regulation, choice and coverage

Cash for care schemes are now in place in many countries in Europe, Australia, Canada and the US. However, these schemes vary substantially, often reflecting existing differences in providing welfare and in long-term care policies. (Da Roit and Le Bihan 2010; Da Roit et al 2007; Lundsgaard 2005).

In Europe, a number of schemes have evolved over time, such as the *Allocation Personnalisée à l'Autonomie* (APA) in France; the *Indennità di accompagnamento* (Companionship Indemnity) in Italy; the *Persoongebonden budget* (Personal Budgets, PGB) in the Netherlands, and the *Attendance Allowance* in Sweden. The US has a long history of cash-for-care programmes with a number of schemes existing, of which the 'Cash and Counseling' programme is the largest (Leece and Leece 2006; OECD 2005). In Australia, a new scheme is currently being initiated, called the Home Package Care System (Australian Government 2013).

The eligibility criteria for such schemes are typically defined to reflect the age, level of care need, and income of social care users (La Roit and Le Bihan 2010). In the Netherlands, the PGB is universal and age is not a criterion for eligibility. In France, in contrast, the APA is available only for people aged sixty and older. In England, all user groups have entitlement to receive a DP if they have eligible social care needs and satisfy the means test.

Schemes also vary with regard to how payments can be used and whether they provide cash payments only or a combination of cash and services. In Germany, Italy and Austria, recipients can spend their benefits as they wish. In Germany, most service users apply for cash allowances which enable them to maintain home care arrangements with the help of informal caregivers. However, the scheme only covers basic needs and must be supplemented by the user, the family or social assistance. Beneficiaries may choose between receiving services or a cash benefit (Da Roit and Le Bihan 2010).

There are also differences in the criteria for the use of cash transfers, the funding and co-payment system, the kind of working relations promoted by these schemes, and their mix of formal and informal care. Cash schemes may be funded either from central taxation as in the England, Ireland and Finland or from long-term care insurance as in the Netherlands and Germany (Timonen et al 2006; Pavolini and Ranci 2008; Heinicke and Thomson 2010). Some schemes are income dependent with small user co-payments (Netherlands and France), while for others the beneficiary's income has no impact on eligibility or on the amount of cash transfers (Italy, Austria, Sweden, and Germany) (Da Roit and Le Bihan 2010). The value of the allowance may be based on the number of hours of care needed (Netherlands) or the level of dependency (France, Germany and Austria) with the cash allowance linked to the recipient's needs and income (France) or associated hours of care (Austria; Germany). In Sweden, the Attendance Allowance must be used to fund a specific care package – defined as the number of hours per type of care – which are determined by the needs of the recipient.

In Sweden and the Netherlands, cash payments have remained very limited in relation to the overall coverage of long-term care schemes. In Sweden, only 0.1% of the older population and in the Netherlands 1.4% of those who could receive personal budgets have chosen to do so. Thus both countries continue to rely on their established social service models and most recipients still receive traditional services (Lundsgaard 2005).



This contrasts with countries in which cash payments are at the core of long-term care. In France, Austria, Italy and Germany recipients of allowances greatly outnumber the recipients of services (Da Roit and Le Bihan 2010). In Germany, cash allowances constitute almost 80% of spending on services for care recipients, with informal home care being the predominant way of providing care (Heinicke and Thomson 2010). In Austria, the universal cash-for-care scheme only reaches about 5% of the population (Österle et al 2012). In France, one aim of the policy is to boost employment in the care sector (Le Bihan and Martin 2010). In countries with fewer rules about how the cash payment is used (Austria, Germany, and Italy), the cash-for-care system is the most important form of mechanism for providing long-term care support. However, all the models are seen to have limited ability to cover high care needs; there is a reliance on the care, organizational capacity, and monetary contributions provided by families, and issues about the quality of care services (Le Bihan and Martin 2010).

In the US, programmes not only differ widely in the number of people covered by different schemes, but also in the extent to which state agencies provide support to service users in organising their care, dealing with associated paper work and the employment of personal care staff; only 12% of consumer-based home care schemes serve more than 5 000 people. Older data indicates that, by 2001, almost half a million people were in receipt of such programmes (Dale et al 2004). In Finland, where Service Vouchers are seen to be encouraging competition, efficiency and private-sector involvement, policy-makers envisage that the voucher system will cover, at a maximum, 10 per cent of all home-care services. It is however expected to expand the role of private providers (Timonen et al 2006).

Recent evidence from England shows that around three quarters of councils met the government's target of having 70% of eligible service users and carers on personal budgets by April 2013, although over two-thirds were provided as managed budgets (i.e. where councils are responsible for commissioning services, but users can still choose how their care needs are met and by whom) rather than as DPs (ADASS 2013).

In all countries, continuing concerns over costs have led to revisions in policy in recent years (Da Roit and Le Bihan 2010). In the Netherlands, the PGB has now been closed to new claimants, because of fears over escalating costs and fraud (Tinker et al 2013). The schemes in France and Germany are also under review. New schemes are emerging, however. In Australia, the new Home Care Packages Program will replace previous schemes for older people and carers (OECD 2005). Home care will be greatly expanded to assist people to remain living at home for as long as possible, and to introduce more choice and flexibility for people receiving care at home through Consumer Directed Care. The new scheme will have four levels of Home Care Package, including two new levels, replacing the former Community Packaged Care Programmes. A range of health and social care services and other services can be provided to support a person living at home.

Evidence on costs and cost-effectiveness of 'cash-for-care' schemes

While set up to increase choice, cash-for-care schemes are seen as a way of containing the costs of long-term care, particularly in countries such as Italy, Ireland and the US, where community services are relatively under-developed (Arksey and Kemp 2008; Timonen et al 2006). Yet, despite the concerns about rising costs of different schemes, there is very little evidence on the cost-effectiveness of such schemes and their impact on the public expenditure.



A study of 'cash-for-care' schemes in four countries, Home-Care Grants in Ireland, DPs in England, Service Vouchers in Finland and Personal Budgets in the Netherlands showed variation in the proportion of the costs of care covered by the different cash allowances (Timonen et al 2006). The proportion of the costs of care covered by the cash-for-care payment or voucher was high in the Netherlands and Finland (respectively); moderate in England; and low in Ireland (i.e. placing more financial responsibility on individuals and families). In Ireland, where social expenditure is a low proportion of the gross domestic product; 'cash-for-care' was seen as a way of controlling public expenditure (Timonen et al 2006).

The evaluation of Individual Budgets (IBs) in England (2005-2007) and the Cash and Counseling evaluations in the US (1998-2002) provide some evidence on the cost-effectiveness of such schemes. IBs sought to provide cash allowances to various user groups, aiming to bring together several separately regulated budget streams (Moran et al 2011). The evaluation of the IB programme found that, across all user groups, there is evidence of cost-effectiveness in respect to social care outcomes, but no advantage in relation to psychological wellbeing. IBs appear to be more cost-effective than standard arrangements on both the social care and psychological well-being outcome measures for the younger physically disabled and people using mental health services. However, for older people, there was no evidence that IBs were more cost-effective than standard care in terms of social care outcomes, although standard care arrangements were marginally more cost-effective than IBs with respect to psychological well-being in this group.

Across all user groups, IBs funded a mean of about £280 of support per week compared with an estimated mean weekly cost of about £300 for support packages for people receiving standard mainstream services, so very little difference in costs between the IB holder and the comparison group. While this difference was not statistically significant, the evidence suggests that IBs would be at least cost-neutral. The costs also varied considerably between user groups (Glendinning et al 2008).

There are older data from the Cash and Counseling Demonstration programme evaluation carried out in the US states of Arkansas, New Jersey and Florida over the period 1998–2001 (Brown et al. 2007). Medicaid beneficiaries were able to select their personal care worker and could choose to receive cash to pay the worker or use an intermediary as employer. The Medicaid Personal Care Services (PCS) is restricted to personal care that has been assessed as required and is included in the user's care plan but choice may be limited (Dale et al 2004). Users were given help with managing the cash, handling payroll and taxes and recruitment (Ottman et al 2013). All three Cash and Counseling programmes targeted people living with disabilities including elderly people; assistance was provided to support decision-making, planning and fund management. The programmes varied however in terms of benefits and allowances, and also the socioeconomic background of users and their families (Brown et al 2007; Ottman et al 2013).

The Arkansas programme reported that consumers in the programme were more satisfied with their care, with fewer unmet needs and at a cost that was slightly less than would have been the case under regular service provision. PCS expenditures were about twice as high for the treatment group, due mainly to the control group receiving far less care than it was authorized to receive (Dale et al 2004).

For the overall Cash and Counseling programme, the key finding was that, largely because the consumers in the Cash and Counseling arm of the experiment were able to get the authorized amount of paid care, expenditures for personal care services



were higher for the Cash and Counseling group than for the control group in each state and age group, except among the elderly in Florida. These higher expenditures were partially offset by savings in other Medicaid services, particularly those related to long-term care. In Arkansas, Medicaid costs were only 14% higher for the treatment group than for the control group. It was concluded that, to keep total Medicaid costs per recipient at the level incurred under the traditional system, consumer-directed, programs need to be carefully designed and closely monitored (Dale and Brown 2007).

Market impacts of 'cash-for-care' programmes

Wider economic impacts of cash-for-care on the informal care market and the provider market have been discussed in the literature. It has been argued that among the explicit or implicit aims of cash-for-care policies is the encouragement of informal care (Glendinning and Kemp 2006), where benefits may be used to pay informal caregivers, generally including close relatives; in such situations a link is created between cash allowances or *payments to the person needing care as well as income-support payments to the informal care givers* (Lunsgaard 2005).

The approach to the employment of relatives as carers varies across schemes. In countries such as Italy, the family remains the basis of care and there are few formal services; in France, private individuals may be employed, but not family members living with the beneficiary (Pavolini and Ranci 2008). Relatives may not be employed in Finland and Ireland (Timonen et al 2006). In England, Direct Payments may be used to employ personal assistants or home carers, buy services from a home care agency or buy other services, which the user has been assessed as needing (Arksey and Brown 2006), although family members cannot be employed except in exceptional circumstances. The danger perceived by some is that payments for informal care can attract informal care givers away from the normal labour market (Lunsgaard 2005). The role of informal care is increasingly recognised by policymakers in OECD countries (OECD 2005; Lunsgaard 2005).

There are also concerns over the development of a 'grey market' for care which has arguably been fuelled by cash-for-care, because for many families this solution is more convenient than informal family care (Österle and Hammer 2007). Schemes with a greater degree of regulation over the programme, as in France, provide greater control over the care market. By contrast, in Italy, Austria and Germany, cash-for-care schemes tend to favour the growth of a grey market in the care sector (Da Roit and Le Bihan 2010).

The provider sector is also impacted by cash-for-care schemes. Increasingly the care sector has opened up to private, for-profit providers and also cash-for-care schemes have created new forms of employment. A study of schemes in four countries (Timonen et al 2006) found that in each country, the predominant service providers are private-sector agencies and self-employed individuals.

Evidence on user experience and satisfaction

There is considerable evidence on the satisfaction of service users with such schemes (Osterle and Bauer 2012). Evidence from both the Individual Budget evaluation and the Cash and Counseling programme in the US showed that users are more satisfied with cash-for-care schemes than existing ways of providing care services (Dale et al 2004; Dale and Brown 2007; Glendinning et al 2008; Moran et al 2012; TLAP 2012). Some studies do report that cash-for-care payments enabled recipients to live in their own home rather than long-term institutional care (Österle and Bauer 2012).



The Individual Budget evaluation noted that such consumer-directed programmes resulted in greater consumer choice, sense of control and satisfaction with services although there were uncertainties over the impact for older people whose principal needs were for personal care, rather than for occupation and social participation as compared with the control group. In addition, they were reluctant to take on the burden of administering individual budgets (Ottman et al 2013). Those who benefitted most from having an IB were younger people with physical disabilities and people with mental health difficulties (Glendinning et al 2008; Moran et al 2013). Overall, the findings indicated that those people participating in the Individual Budgets programme reported better service satisfaction outcomes and sense of control over their lives than those using agency-directed care. Those receiving IBs felt more in control of their lives than the comparison group.

The evidence from England on DP take-up is similar; some user groups, younger physically disabled and people with Learning disabilities for example, take up DPs more readily than others (TLAP 2012, 2013). Older people were less interested in such schemes because of the burden of administration of the programme (Brown et al. 2007, Davey et al. 2007, Glendinning et al 2008). Accessible information and on-going support appear to be key to take up among this group as well as ensuring that people are fully involved in the support planning process. Well-trained front line staff is also important to success (TLAP 2012, 2013).

Evidence from states in the US that have introduced Cash and Counseling schemes (e.g. Arkansas) shows that consumers in the programme reported greater satisfaction with their care, with fewer unmet needs (Dale et al 2004). However, there are few studies of the costs of cash-for-care schemes compared with in-kind agency services or institutional care. Moreover the effect of cash-for-care payments on cost containment is likely to vary according to the design details of such schemes. Indeed it has been argued that better data drawn across countries is needed to answer several key questions on outcomes for the recipients of various LTC approaches (Swartz et al 2012).

Conclusion

The literature review has found that most 'cash-for-care' schemes have been initiated to give social care recipients greater choice and control over how their care needs are met. These schemes are typically part of a policy strategy that aims to increase personalisation and consumer-directed care, while also containing costs.

There is a lack of evidence of the cost-effectiveness of such schemes. A number of key factors likely to impact on the costs of such schemes have been identified in the review such as criteria for eligibility and the degree of user choice permitted under such schemes. The coverage of such schemes and their reliance on cash-for-care as the main way of supporting those with social care needs vary across countries. The evidence suggests that these schemes also have wider impacts on the provision of informal care and the provider markets, as well as the 'grey market' in some countries.

Studies show that users report greater satisfaction when using 'cash-for-care' to meet their social care needs and value the choices and control these schemes can provide. For older people, concerns about the bureaucracy involved in setting up and managing budgets remain. However, satisfaction of older people with DPs was higher in places in which users were supported in making choices by well trained staff and received good quality information.



5. Characteristics of trailblazer sites

The 18 trailblazer sites have a total population of 9.4 million and cover somewhat under one-fifth of the population of England. Although not selected at random, in practice they cover a spectrum of different types of areas (Table 1). Geographically by region:

- Three are in London (Enfield, Havering, Redbridge)
- One is in the South East (Surrey)
- Two are in the East (Hertfordshire, Norfolk)
- Three are in the South West (Bristol, Cornwall, Dorset)
- Three are in the East Midlands (Lincolnshire, Milton Keynes, Nottinghamshire)
- One is in the West Midlands (Staffordshire)
- Two are in Yorkshire and Humberside (Hull, North Lincolnshire)
- One is in the North East (Gateshead)
- Two are in the North West (Manchester, Stockport)

Three of the councils involved are London Boroughs, three are metropolitan districts, five are unitary authorities and seven are counties. Their older populations (aged 65 and over) vary in size: nine have older populations of less than 50,000, four have older populations between 50,000 and 150,000, and five have older populations exceeding 150,000.

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

- The proportion of their total population aged 65 years and over is around 18% across all areas, varying from under 15% for five areas to over 20% for three areas;
- The proportion of older people living alone is between 32% and 38% for most areas, but ranges from under 32% in four areas to over 38% in four areas;
- The proportion of older people receiving Attendance Allowance, an indicator of disability (although affected by any differences in take-up rates), is between 10% and 15% for most areas but ranged from under 15% in six areas to over 20% in two areas;
- The proportion of older people living in rented accommodation varies between less than 20% in four areas to over 40% in three areas;
- The proportion of older people receiving Pension Credit, an indicator of low income, is also widely dispersed ranging from under 15% in three areas to over 30% in two areas.

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

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

Few of the councils (two or three in each case) were able to provide data on the numbers of NHS funded care homes residents, privately funded residents or residents funded by other councils in the care homes located within their area (Table 2). This would have been useful information since the proportion of care home residents funded by sources other than the council may influence the way in which the introduction of DPs for residential care affects the local care home market.



Only three councils provided information on the number of their supported residents who required third party 'top up' payments to meet their care home fees. If this information is not available to most councils, it will be difficult for them to monitor whether the introduction of DPs has an impact on the proportion of supported residents requiring top-up payments.

16% of all the supported residents in the twelve trailblazer sites, which provided this information, are in care homes located outside the council area. This seems important since it may prove more complex for councils to include within their trailblazer care homes outside their area.



6. Plans for trailblazers

The following section summarises the information provided by project leads in trailblazer sites interviewed for this preliminary report (in what follows they are referred to as 'sites'). It reports on their plans for the trailblazers and outlines the benefits and challenges they anticipate will result from introducing DPs for residential care. Interviews were conducted with all the project leads between June and September 2013.

At the time of writing this report, 16 out of 18 sites have provided additional numeric information about their plans for the pilots, for example, specifying the number of participants they aim to include in the pilots and the number of care homes they expect to support the scheme during the pilot (Table 3). In addition, we asked sites to indicate whether they plan to offer DPs to cover the full or part payment for care homes, to which eleven have responded to date.

At the time of the interview, most sites expected to have DPs set up by the end of the year and to be able to start offering DPs to users from January 2014 or earlier. This is in line with the starting date expected by the DH and reflects that enabling regulation had to be developed and has since come into effect on 1 November 2013. However, some sites do not expect to be able to offer their first DP before March 2014.

It is worth noting that a minority of sites have encountered problems in the process of setting up the trailblazers and in planning the service changes required for offering DPs (e.g. trouble recruiting or retaining a dedicated project manager). It seems possible that a number of sites are not as well progressed in preparing for DPs as it was anticipated earlier in the process.

User groups planned to be included and anticipated numbers of users per group

Sites vary with respect to the user groups to whom they aim to offer DPs during the trailblazer. The majority of sites (n=13) indicated that they intend to include older people (aged 65 years and over) in the trailblazers; two sites are currently planning to exclude older people at the initial stage of the trailblazer, with one site indicated that it plans to include this group at a later stage of the pilot.

Current plans indicate that, in total, older people will constitute more than half of the recipients of DPs during the course of the trailblazer, with an estimated 285 to 300 older users of DPs anticipated (out of an estimated total of 435 to 500 users).

14 sites plan to offer DPs to younger adults (aged between 18 and 64 years) with learning disabilities during the period of the trailblazer, involving an estimated 70 to 120 individuals.

Younger adults with physical disabilities will be offered DPs by ten sites, involving about 40 individuals in this group. Only four sites have currently indicated that they want to offer DPs to younger adults with mental health problems, potentially involving fewer than ten individuals. This group may have to be excluded from the quantitative evaluation for this reason.

Sites provided a number of reasons for including or excluding certain user groups in/ from the trailblazer. Most indicated that they do not intend to purposefully exclude particular user groups from the trailblazers, but that their decisions reflected a number of practical issues and concerns. Most commonly, the decision on user groups to be included reflects the residential population of the care homes whose providers have volunteered to support the trailblazer. These providers, typically, already have an established relationship with the council.



In addition, sites particularly interested in testing DPs for older people noted that they want to test DPs for this user group as it constitutes the largest proportion of residents in care homes in their area and whose care has the large impact on councils' budgets for residential care.

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

Other considerations include difficulty involving different teams of social workers responsible for different user groups in the trailblazer; other ongoing changes that the trailblazer would potentially conflict with, e.g. ongoing organisational changes in service for people with mental health problems; and involving user groups whose care is mainly an NHS responsibility, such as people with mental health problems below the age of 65.

Sites vary with respect to whether they plan to include existing or only new users of residential care. Some sites have indicated that, since numbers of people with learning disabilities newly admitted to residential care are typically quite low in any given year, there would be very few DP users in this group if eligibility was limited to new residents, especially as DPs will be limited to those placed in homes that choose to participate in the trailblazers. It may be easier to limit eligibility for older people to those who are newly placed in residential care, given their larger numbers.

Number of care homes participating in the trailblazers

There is currently only one site that plans to offer DPs to residents of all the 285 care homes in its area. The remaining sites plan to offer DPs to residents of a total of around 100 care homes.

The number of care homes choosing to be involved substantially varies between sites, ranging from 2 to 25 care homes, excluding the one outlier planning to include all care homes in its area. Given that care homes have to be willing to participate and cannot be considered to be automatically supportive of DPs, a number of sites suggested aiming for five, ten to 25 care homes per site. In each case, with the one exception mentioned above, this constitutes a small proportion of the care homes active in the area. Only a small number of the care homes planning to participate are registered to offer nursing care. Most sites will include only one nursing home, with only one site planning to include six nursing homes; this excludes the "outlier" site that plans to include all care homes in its area.

Facilitating choice

Most sites emphasised that it would be desirable for users of residential care to be able to exercise more choice and control over the care they receive, particularly once they have been admitted to a care home. However, almost all sites also voiced scepticism as to whether DPs are likely to create additional choice, given the constraint on budgets for adult residential care. Some also expressed concern as to whether users would want to have more choice and control if this involved taking on responsibility for a potentially large sum of money.



Many sites wondered how DPs could be expected to promote choice: would users demand choice once they have been offered a DP? If this were the expectation, would they be able to exercise such choices, for example, in the case of frail older people and/or those with dementia? Users may require support to exercise choice, but what kind of support would be appropriate, who would provide it, and how would it be paid for?

An alternative view was that providers could offer more choices, for example, by offering additional services or activities. It was argued that in this way providers could develop a competitive advantage over providers that offer fewer choices. However, this can only be expected if providers are in a position to offer choices, which was seen as optimistic by some sites, given that many providers, perhaps particularly smaller care homes, operate on very small profit margins.

This raises the question about the role of councils in facilitating choice for users and in developing the local care home market to make providers more responsive to individual needs. Can councils expect that choices will develop 'naturally' once DPs have been established as a funding option and what would be the range of choices offered?

Most sites considered offering or organising support for users to facilitate choice. A range of options were suggested to this end. Many sites already offer a brokerage service in community care, which could be expanded to residential care or a similar approach could be adopted. These services were typically contracted out, for example, to user-led organisations or other not-for-profit or for-profit organisations; but brokerage services offered in-house were also seen as an option. In addition, sites considered that social workers, care home staff, and/or the families of users participating in care planning had a role in supporting choice. Brokerage services could also tie in with other initiatives to improve information about local care home markets, such as e-marketplaces and other internet based tools or platforms; peer brokerage schemes; and internal choosing and purchasing schemes currently used in some sites. It was pointed out that it may be difficult to provide decision support to users who choose to take their DP to a care home outside the area of the council and to those bringing a DP from another council, as this would be an additional burden on already stretched services.

Some choices may be difficult to accommodate for reasons of health and safety or Care Quality Commission regulation, such as employing personal assistants, who may pose a risk to other care home residents and would need to be vetted.

Most sites agreed that individuals who are unable to make decisions for themselves (e.g. those with severe dementia) may still appreciate additional choice and should have access to a DP. However, these users may need additional support, which could be provided, for example, by a close relative, someone with Power of Attorney or other "suitable person".

Setting the DP level

All sites agreed that DPs should not increase the costs of adult residential care for councils as budgets are already stretched considerably.

Sites noted that they do not expect that offering DPs will reduce their spending on residential care, but were concerned about the potential of DPs to "bust the budget". Experience of DPs in community care has shown in some areas that spending can fall in the long run, as users spend their DPs only on those aspects of care they actually want; but sites agreed that making savings is not an objective of introducing DPs.



Determining the level of DPs appears to be a major challenge for sites. Sites recognised that DPs should reflect the assessed needs of users and allow them to purchase the care that meets these needs. However, this should neither create a need for additional funding from councils nor cause providers to become underfunded and exit the market.

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

At the time of the interviews, many sites were still unsure about how to determine the level of DPs. The approaches considered involved either a needs assessment first, from which an indicative amount would be derived, which then constitutes the DP (which may be further adjusted and reviewed in light of the care available) or using calculations of providers' care costs or fee levels as a starting point, with DPs derived from existing costs/fee levels, adjusted for different levels of need. Several sites indicated that they were in the process of undertaking measures to assess the 'true' costs of residential care, although the experience so far has shown that these exercises are complicated and are dependent on the willingness and/or ability of care homes to provide information about their costs.

The majority of sites suggested using a Resource Allocation System (RAS) that matches care needs and funding to determine a DP. However, as yet no RAS exists for residential care (although the use of RAS is well established in community care) and sites varied in their plans for developing and/or using a RAS. Suggestions ranged from using an existing RAS (e.g. as developed for respite care); using and adjusting an existing RAS (e.g. as used in community care); developing a new RAS for residential care; not using a RAS, but exploring alternatives such as the Care Cost Calculator or the Calculating a Fair Market Price for Care tool, developed by Laing & Buisson and the Joseph Rowntree Foundation.

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

Some sites stated that they hoped DPs will help them to understand differences in fee levels and whether they are justified or not. This implies that councils would require good insights into the actual costs of care provision and understand the reasons for variation in these costs. Basing DPs on care need only would carry the risk of payments for some services being potentially higher or lower than fees paid before DPs. This may help to inform adjustment of fee levels, but it may also risk providers becoming unprofitable.

Sites acknowledge that determining DPs will be a sensitive exercise with potential impacts on care users, care home providers and council budgets. Matching care needs and provider costs may be more straight-forward in areas, in which fee levels are relatively homogenous, than in areas, in which fees paid for the same service vary between homes. However, the exact impacts of DPs on different groups still remain to be seen and will be further explored in the rest of the evaluation.

These impacts are also likely to reflect the proportion of care home fees covered by DPs. To date, five sites have indicated that they plan to offer DPs for the full amount of fees, while two stated that they plan to provide DPs for part payment only (e.g.



to cover the care costs, but not the hotel costs). Four sites decided to offer both types of coverage, based on the needs and capacity of the user requesting a DP. The remaining seven sites have indicated that they have not yet decided the amount covered by DPs or have not yet responded to our request.

Needs assessment and care planning

Most sites stated that they did not anticipate substantial changes to their current approaches to assessing care needs and to making care plans for their clients.

However, most sites also expressed the hope that the process of care planning will become more sensitive to the preferences and wishes of people admitted to care homes. It was also suggested that it would be desirable if care plans would become more focused on outcomes and quality of care.

Some anticipated that offering DPs will shift decision-making power from care home providers to users, although there were also doubts whether this was realistic, particular for frail older people and those with dementia.

More and different information about care homes may be required to enable meaningful choices at the stage of care planning. Responses varied as to whether this information could be generic, i.e. applicable to all residents using DPs, or applicable on a case-by-case basis only.

Some noted a lack of clarity about the sequencing of the assessment and planning processes, given that in most areas only a small number of care homes are participating in the trailblazer. Would people have to decide first on a care home and then be offered a DP if the care home participates or would they be offered a DP first with a limited choice of care homes?

It was also not clear how care planning for those using DPs would tie in with other approaches for improving personalisation and choice currently developed by some councils, for example, by using user profiles or by supporting activities that aim to increase opportunities for volunteering in the community.

Contracting and relationships with providers

There was some diversity of opinion as to whether offering DPs in residential care would require a new approach to contracting with providers. Most sites envisage developing a new approach to contracting in recognition of the fact that decision-making power will shift from the council to the user and an expectation that users will eventually make their own contractual arrangements with care home providers.

However, most sites expect that councils will remain involved in contracting with providers for a number of reasons. First, there will be users who choose not to take up a DP and thus require the council to make arrangements on their behalf. Second, councils may remain responsible for some part of the funding if they offer DPs only for part of the care home fee, thus requiring contractual underpinning. Third, councils will retain a duty of care towards users, even if they are not directly involved in organising their stay in a care home. Only a small number of sites thought it possible that the council could withdraw entirely from contracting with providers and that contracting will be between the user and the care home only.

Yet even if councils continue to contract with care homes, most sites anticipate that the role of councils will change under DPs. However, it is as yet unclear what these



changes will involve, with some suggesting that the role of the council may shift to provide brokerage services to support user choice; to develop templates for contracts between users and care homes to ensure that these are fair to all parties; to maintain oversight over care packages agreed between users and care homes, to ensure that basic needs of users are met; to consider regulating fees and top-ups, to ensure that providers do not shift the financial burden from councils to users; and, more broadly perhaps, to ensure that care home providers remain in business and are financially sustainable. Some worried that councils would lose a lever to influence the provider market and ensure standards if DPs became the norm; in compensation it was suggested that the system might move towards accreditation of providers.

Not contracting with a council may also have repercussions for providers, for example, by increasing the rate of interest on bank loans, since those with council contracts currently tend to be able to obtain lower interest rates. Sites also noted that providers were concerned about making losses if users defaulted on their payments.

It is not yet clear how contracting under DPs will affect existing approaches to contracting, such as block contracting or spot contracting. In this respect, introducing DPs may provide an opportunity to review existing practices. Some councils are also providers of residential care; it is not clear yet how DPs will be deployed in council run care homes and whether it is possible to use the same approach as for other types of care home provision.

Opportunities and benefits identified by sites

The main benefit sites identified was to be able to provide users of residential care with a greater range of options when going into a care home.

Many noted that DPs could offer a way of expanding the personalisation agenda to residential care and to people who are particularly vulnerable and in need of support. It is also hoped that DPs will help improve outcomes in the residential care sector, enhance the quality of care provided in care homes, and improve the experience of care by users and their families. Some suggested that DPs could stimulate a culture change in care provision and help councils to develop the residential care market to make care providers more responsive to individual needs.

However, sites recognised that these expectations were tempered by the constraints on council funding available for residential care; the challenges of implementing DPs; and a range of assumptions about how DPs could contribute to such changes.

There was scepticism about whether providers will want to participate in offering DPs, since enabling choice, for example by offering more activities or care options, is likely to increase the costs and organisational effort of providers.

Sites argued that providers might value the opportunity to improve care for their residents; to participate in a high-profile government scheme; and to be at the forefront of innovative policy developments. Participating in the trailblazers may also allow them to prepare for DPs before they become national policy in April 2016. Some also suggested that providers may use the opportunity of using DPs and developing more choices to gain a competitive advantage in attracting users/customers.

Councils may also benefit in several ways from the introduction of DPs. In the first instance, it may provide a new way of interacting with providers and engaging in a dialogue that may help to improve users' experience of residential care.



It was also suggested that participating in the trailblazers may force councils to monitor more closely the costs of residential care and to develop a better understanding of the drivers of costs. This may be particularly pertinent in areas in which councils are “price takers” rather than “price setters” and where councils have little flexibility in contracting with providers due to a shortage of places and resources. Analysing the drivers of costs could also inform the dialogue with providers about the appropriateness of fees. Some councils have experienced legal challenges in recent years and are thus concerned about the adequacy and fairness of their funding arrangements with providers.

Related to the concern about costs and fees, some sites also noted that introducing DPs might help to prepare for the introduction of the social care funding reforms in 2016, which will require councils to distinguish between care costs and hotel costs in care homes. However, as thinking about DPs in residential care evolves, it seems likely that the link between the introduction of DPs and the wider funding reforms may not be straight forward.

Risks and challenges identified by sites

Site identified a number of risks and challenges associated with introducing DPs in residential care.

First, there was concern that DPs may fail to increase choice for residential care users, as providers may not be in a position or not be willing to offer additional options in terms of activities or services. It was also questioned whether care home residents, particularly frail older people, would want more choice if it comes with the responsibility for managing a (potentially large) budget. It is also unclear how choice will come about, i.e. whether it is expected to be offered by providers or demanded by residents.

Second, sites were concerned about the impacts of DPs on providers and the provider market, particular in relation to the financial viability of providers, with smaller care homes being perhaps most vulnerable to changes in their modus operandi. Two issues were specifically articulated: DPs may shift the distribution of funding between providers, as people may vote with their feet and choose care homes that are able to offer a larger range of services; and DPs may potentially put providers in a position to have to offer choice without being able to charge for additional services, thus shifting the financial burden for offering choice from councils to providers.

Third, many sites indicated that they were still unsure about how to implement DPs and about the extent of change this would require in the way that residential care is funded. Some sites have determined the scope of the DP to be a full payment covering the entire costs of care, others plan the scope to be a part payment (e.g. for care costs as opposed to hotel costs) while others envisage a choice or combination of these approaches. However, many sites had not yet decided the scope of payment at the time of interviewing, and/or had not indicated their preference by the end of October 2013. Finding a way of matching user needs and provider fees, within the funding constraint, is another key challenge to councils, as described in more detail above.

All sites indicated that they plan to monitor the introduction of DPs in residential care and/or plan to evaluate progress and outcomes. Typically, sites noted that they would adopt an interim approach to collecting and analysing management information during the trailblazer period (e.g. data collection on a separate spread sheet) integrating DPs in residential care into their existing mainstream monitoring systems in the longer run. However, most sites were still at an early stage of developing their monitoring strategies at the time of the interview.



7. Conclusions

This preliminary report is derived from data collected between late March 2013 and early November 2013 from a literature review, interviews with the project leads in the 18 trailblazer sites and quantitative data collected from the sites and from official sources.

It is important to bear in mind that the sites were not legally able to start offering DPs for residential care until 1 November 2013. This report relates to a period of planning for the trailblazer schemes.

The literature review has found that most 'cash-for-care' schemes have been initiated to give social care recipients greater choice and control over how their care needs are met. These schemes are typically part of a policy strategy that aims to increase personalisation and consumer-directed care, while also containing costs.

There is a lack of evidence of the cost-effectiveness of such schemes. A number of key factors likely to impact on the costs of such schemes have been identified in the review such as criteria for eligibility and the degree of user choice permitted under such schemes. The coverage of such schemes and their reliance on cash-for-care as the main way of supporting those with social care needs vary across countries. The evidence suggests that these schemes also have wider impacts on the provision of informal care and the provider markets, as well as the 'grey market' in some countries.

Studies show that users report greater satisfaction when using 'cash-for-care' to meet their social care needs and value the choices and control these schemes can provide. For older people, concerns about the bureaucracy involved in setting up and managing budgets remain. However, satisfaction of older people with DPs was higher in places in which users were supported in making choices by well trained staff and received good quality information.

The trailblazer sites, although not selected specifically to be nationally representative, comprise a mix of different types of areas in terms of region, formal authority type, size of population, age distribution, disability rates and rates of low income in old age. At least 14% of all supported residents in England are supported by the participating councils.

Most of the trailblazer sites plan to include in their DPs for residential care schemes older users (n=13) and users with learning disabilities (n=14), a majority plan to include younger users with physical disabilities (n=10) while few (n=4) plan to include younger people with mental health problems.

The scale of the trailblazers will be fairly modest. The sites expect that around 435 to 500 users will be offered and take up DPs for residential care during the trailblazer period. Excluding one area that plans to invite all its care homes to participate, the sites expect around 100 care homes to be involved, of which few will be nursing homes. The numbers of users and homes involved in any given sites can therefore be quite small.

The sites have different approaches for determining the level of the DPs. Some plan that the DPs will be sufficient to cover the full care home fee (subject to user contributions), some plan that they will cover only part of the fee (for example care costs but not hotel costs) and some propose to test both of these approaches. Seven councils have not yet decided which approach to adopt.

The trailblazer site leads see an opportunity for the promotion of greater choice for care home residents and potentially for improvements in the quality of residential care. At the same time they have a range of concerns about the level of user take up of



DPs, the range of choices that will, in practice, be offered and the potential impact on providers' finances. They are determined that the scheme will not put extra pressure on council budgets.

While some of the sites have made key decisions on the operation of their scheme, others are still considering key issues such as the level of DPs they will offer. The next few months will be a period of early implementation for some sites, but of continued planning for others.

The next steps in our evaluation will include quarterly monitoring of key indicators such as numbers of users taking up DPs, collection of information on outcomes from users, and interviews with front line staff in councils, care home managers, national organisations and, subject to ethical approval, users and unpaid carers. The feasibility of the quantitative outcome analysis will be dependent on the numbers of users receiving DPs in each site during the trailblazer period.



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9. Appendix

Table 1 Trailblazer site councils by type, region and population

Council	Region	Type	Population 18 to 64 (000s)	Population 65 and over (000s)
Bristol	South West	Unitary	292	57
Cornwall	South West	Unitary	314	97
Dorset	South West	County	227	120
Enfield	London	London Borough	202	40
Gateshead	North East	Metropolitan District	124	36
Havering	London	London Borough	146	44
Hertfordshire	East	County	696	182
Hull	Yorkshire & Humberside	Unitary	166	37
Lincolnshire	East Midlands	County	428	156
Manchester	North West	Metropolitan District	350	48
Milton Keynes	East Midlands	Unitary	162	30
Norfolk	East	County	507	195
North Lincolnshire	Yorkshire & Humberside	Unitary	101	32
Nottinghamshire	East Midlands	County	481	150
Redbridge	London	London Borough	184	34
Staffordshire	West Midlands	County	516	165
Stockport	North West	Metropolitan District	171	53
Surrey	South East	County	697	203
Total			5764	1679



Table 2 Number of care home residents, per site

Site	Number of adult residents (aged 18+) in care homes within a local authority area, by source of funding (excluding placements outside the local authority area)						Number of residents in care homes placed and funded by the council				
	Total number of users in care, all sources of funding	Number of users funded by council	Number of fully self-funded users	Number of users funded by the NHS	Number of users funded by other local authorities	Number of those funded making 'top ups'	Total number of older people (65+)	Total number of people with learning disabilities (18-64)	Total number of people with physical disabilities (18-64)	Total number of people with mental health problems (18-64)	
1	1746	820	Not known	184	Not known	23	687	63	28	42	
2	8698	3280	Not known	Not known	Not known	133	3232	803	154	190	
3	2614	1272	Not known	Not known	Not known		1075	44	43	100	
4	Not known	1144	Not known	Not known	Not known	Not known	951	122	28	38	
5	3500	1030	Not known	Not known	Not known	Not known	976	20	22	12	
6	1295	1169	39	87	Not known	Not known	1006	183	48	58	
7	6365	2895	Not known	Not known	Not known	Not known	1722	1019	40	50	
8	Not known	514	Not known	Not known	Not known	Not known	383	67	16	48	
9	Not known	1155	Not known	Not known	Not known	140	625	161	13	66	
10	Not known	1634	Not known	Not known	Not known	Not known	1135	188	36	39	
11	Not known	4803	313	5	9	Not known	3921	483	70	296	
12	Not known	3630	Not known	Not known	Not known	90	2929	492	111	85	
13	Not known	649	Not known	Not known	150	Not known	548	80	11	10	
14											
15	Not known	3244	Not known	Not known	303	Not known	2636	400	92	113	
16											
17	1740	1404	Not known	205	Not known	Not known	1366	165	85	111	
18	Not known	390	Not known	Not known	Not known	Not known	300	Not known	Not known	Not known	
Total	25958	29033	352	481	462	386	23492	4290	861	1258	



Table 3 Plans for user groups, numbers of users per group and numbers of care homes included in the trailblazers, by site

Site	User groups planned to be included in the trailblazers					Estimated number of users planned to be included in trailblazers					Number of care homes volunteering	
	Older people aged 65 and over	People 18-64 with learning disabilities	People 18-64 with physical disabilities	People 18-64 with mental health problems	Number of older people 65 and over	Number of people 18-64 with learning disabilities	Number of people 18-64 with physical disabilities	Number of people 18-64 with mental health problems	Total number of people to be included	Number of homes involved (total)	Number of care homes providing nursing care involved	
1	Yes	Yes	Yes	No	Not known	Not known	Not known	Not known	Not known	Not known	Not known	
2	Yes	Yes	Yes	No	6	6	0	18	7	1		
3	Yes	Yes	Yes	Yes	35	5	6	2	48	3	Not known	
4	Yes	No	No	No	160	0	0	0	160	3	1	
5	Yes	Yes	Yes	Yes	20	10	10	5	45	9-10	1	
6	Yes	Yes	Yes	No	Not known	Not known	Not known	0	15-20	5	1	
7	Yes	Yes	Yes	No	0	5-6	5-6	0	10-12	2	0	
8	Yes	Yes	Yes	Yes	6	6	2	2	10-20	6+	1+	
9	Yes	Yes	No	No	20-30	5-10	0	0	25-40	2	1	
10	Yes	Yes	No	No	8	2	0	0	10	285	Not known	
11	Yes	Yes	Yes	No	6	7	7	0	20	20	Not known	
12	Yes	No	No	No	25	0	0	0	25	3	1	
13	No	Yes	Yes	Not known	0	15	5	0	20	4-5	0	
14												
15	No	Yes	No	No	0	10-50	0	0	10-50	25	0	
16												
17	Yes	Yes	No	No	Not known	Not known	0	0	Not known	3+	Not known	
18	Yes	Yes	Yes	Yes	Not known	Not known	Not known	Not known	20	8	6	
Total					286-296	71-117	41-42	9	436-508	385-387	13	

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The Unit is funded by the Policy Research Programme of the Department of Health.

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