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Introducing Direct Payments in Residential Care – the experience of care home providers

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This paper draws of the final report of the evaluation of Direct Payments in Residential Care trailblazer programme in England (Ettelt et al 2017), has been prepared for the Transforming Care Conference 2017 and should not be circulated or quoted.

Introduction

This paper summarises the findings from the evaluation of the Direct Payments in Residential Care trailblazers[3] in England as they relate to the experience of care home providers. Direct payments have been available to individuals who receive publicly funded adult social care in their own homes for about 20 years, but they have not been offered to service users in care homes until recently. In 2012, the Department of Health (DH) for England decided to test the extension of direct payments from community care to residential care. It invited local authorities (known as 'councils') in England to express interest in becoming pilot sites for direct payments in residential care and selected 20 pilot sites. It also asked the Policy Innovation Research Unit (PIRU) to conduct an independent evaluation of the programme. The pilot programme was conducted between January 2014 and June 2016. It began with 20 sites in different local authority areas in England. However, by September 2015, only 70 service users from pilot sites had accepted a direct payment. Six sites had withdrawn from the programme and a further four had not issued any direct payments by the end of the evaluation. The Government, which had planned to make direct payments available to care home residents throughout England from 2016, decided to postpone the national implementation of the programme following submission of the evaluation findings.

This paper aims to provide a brief overview of the findings from this evaluation focusing on the perspective of care home providers with knowledge or first-hand experience of the trailblazing scheme. Using data from the process evaluation, the paper brings together the analyses of a survey of care home owners and managers, alongside interviews with care home owners and managers, council managers and frontline staff, and national organisations representing care providers in the UK. The introduction of direct payments in

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[3] Note: the term 'trailblazer' – a synonym for 'pioneer' - was adopted by the UK Government because it was initially thought the programme would be implemented nationwide, and that lessons from the first 20 sites would be absorbed into future guidance documents on how to deliver direct payments in residential care. For the purposes of this paper we use the term 'pilot' for the sake of simplicity.

residential care required significant collaboration between service providers, commissioners of care services (i.e. council staff) and care recipients. The implementation of the scheme in participating sites turned out to be difficult and slower than expected reflecting the complexity of the task. As direct payments both involve a novel financial mechanism that involves allocating social care funding to service users directly and a new way of allocating responsibility for using these funds, care home providers emerged as being central to facilitating direct payments. This paper therefore explores their views and experience of participating in the trailblazer scheme to find out how they perceived the potential of direct payments to improve care for care home residents; whether direct payments can contribute to greater choice and control for care home residents; and reasons for supporting or not supporting the introduction of direct payments in residential care.

Social care in England

In the UK, public healthcare services are free at the point of use, provided by the National Health Service (NHS) and funded from general taxation. Social services, however, are not free at point of use, are provided mainly by independent sector agencies and are funded by a combination of central and local taxation and payments by service users and their families. The provision of adult social care in England is subject to both an assessment of need for care against needs-related eligibility criteria and a means-test of income and savings. People with savings above £23,250 (around EUR26,0000 are not generally eligible for publicly funded care. Those with savings below this level may need to make a contribution to the costs of their care from their income and savings. The value of the person's home is generally taken into account as part of savings for care home residents but not for users of home-based care. The Government has, however, proposed reforms to this system.

Long-term social care in England is usually taken to mean help with domestic tasks, such as shopping and preparing meals, assistance with personal care tasks, such as dressing and bathing, and professional support from social workers or occupational therapists... The system relies heavily on informal or unpaid care provided by family, friends or neighbours.(Comas-Herrera et al 2011). Home and day care services are provided by a range of mainly small, independent sector agencies. For people with additional care and support needs who are unable to live independently, care homes, also mainly in the independent sector, provide either personal care (assistance with meals, bathing, going to the toilet and taking medication) or personal care with nursing care.

Responsibility for assessing needs for social care and arranging care for those with eligible needs lies with local authorities. People assessed as being eligible for social care will receive a personal budget – the amount calculated by a local authority that it will cost to arrange the necessary care and support for an individual. People can ask for the personal budget to be delivered through direct payments (see explanation below) or for the care and support to be arranged on their behalf. According to figures from LaingBuisson (2015) relating to the UK residential care market, 41% of places are paid for privately, by the client themselves; 12% by local authority 'top-ups' (where the state covers some of the fee and the client or their relatives pay the remainder); 37% by local authority funding (where the state covers the whole of the fee); and 10% through the NHS.

Direct payments

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 in the UK since the mid-1990s but not available in residential care other than for short periods of respite care. They are framed in the literature as supporting people to live in the ways they choose rather than being prescribed services matching the assumptions of others on how they should live (Spandler, 2004:192).

Direct payments were first introduced in the UK in 1997 under the Community Care (Direct Payments) Act 1996 for people with disabilities aged 18 to 64 years and have gradually been extended to all service user groups.

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

This agenda also saw the introduction of personal budgets in adult social care. Personal budgets refer to the allocation of funding from the council to a service user to reflect an assessed care need. Personal budgets can be taken either wholly as a direct payment, which is paid to the service user or carer directly, or managed by the council or third party organisation on behalf of the user. It can also be taken as a combination of both i.e. part of the personal budget is taken by the user or carer as a direct payment with the remaining part managed by the council (Slasberg et al 2012). Personal budgets have gradually been rolled out since 2008, yet the number of people having a personal budget varies substantially among councils (Glasby and Littlechild, 2016). Since April 2015, councils have been required to provide all recipients of council-funded adult social care with a personal budget, irrespective of whether they received care in their own home or in a residential care setting.

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

There are also restrictions on the use of direct payments. Currently, direct payments cannot be used to pay for long-term care provided in a care home, but they are available for respite care for up to four consecutive weeks a year.

Residential care sector

There are currently 13,917 care homes in England, registered by the Care Quality Commission (CQC), the regulator for health and social care quality in England[4]. The private (for-profit) sector dominates the landscape of the residential care market. There are four major companies which deliver 15% of care beds between them (as of 2015).

The market has endured tough financial conditions in recent years, as reflected by a number of closures. Recent figures from the CQC (2016:62) show that between 2010 and 2015, there was a 12% reduction in the number of residential care homes, with an 8% decrease in total beds (from 255,289 to 235,799). However, for the same period, there was a 9% increase in nursing home beds (from 205,375 to 224,843). The CQC states that 2,444 care homes closed in England between 2010 and 2015 (CQC, 2016:63). The majority of these were small (1,433, or 59%), which suggests they may have been less resilient to financial pressures.

Table 1 shows the breakdown of residential care places and the sectors providing them.

	Number	Percentage
Number of places supplied by private sector	200,200	74%
Number of places supplied by voluntary sector	47,400	18%
Number of places supplied by local authority	21,700	8%
Total	269,300	

Table 1: as of 2014, number of residential care places in UK by sector (excluding nursing care)

Source: LaingBuisson (2015)

The pressure on adult care providers and uncertainty surrounding the market is driven by a number of conflicting demands, as described by the National Audit Office in a recent report on commissioning in the adult care sector (NAO 2016). These are:

- the increasing complexity of adults' care needs
- significant cuts to local authority budgets
- increasing costs for providers
- high staff vacancy rates

For these reasons care providers often base their service design on pragmatic concerns and avoidance of risk rather than diversification or community need (Andrews et al 2000).

[4] Care Quality Commission website, May 2017 http://www.cqc.org.uk/content/care-homes

Choice and control in residential care

Despite this backdrop of a challenging financial climate and the precarious nature of the market, residential care providers and local authorities are now under stronger requirements to deliver choice and control to service users.

The Care Act 2014 aims to hand people control of their own care and support, to enable them to receive the help they might need to enhance their well-being and improve their social connections. The budget awarded to people eligible for support should be an amount sufficient to meet their care and support needs, according to the Care Act guidance. The guidance adds that care services should "promote wellbeing, social inclusion, and support the vision of personalisation, independence, choice and control" (Department of Health 2014:110).

Yet the literature acknowledges that there are limits to what can be achieved under current financial and organisational arrangements. For example, Bowers et al. (2001) demonstrate that social care staff have limited time to attend to individual residents and that time pressures crowd out activities that might be valued by residents but considered 'optional' by staff.

Other commentators suggest personalised care is less developed in residential care compared to other settings (Carr 2010), and the aforementioned report by the UK's National Audit Office (NAO) found the choice of providers in some regions of England was being restricted, especially for people using personal budgets alongside local authority-commissioned services. This is because some councils have been reducing the number of providers with whom they contract in order to create economies of scale; between 2010-11 and 2014-15, spending on adult social care fell by 7% by local authorities in England, and as a result, commissioners have been under pressure to keep fees to providers as low as possible (NAO 2016).

Prior to the passing of the Care Act, the Law Commission (an independent body which reviews different aspects of the law in England and Wales) recommended that direct payments should be extended to all settings, including in residential care (Law Commission, 2011), for all people with eligible assessed care needs. Specifically, the Commission noted that:

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

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

This paper will focus on the experiences and perspectives of providers in the introduction of direct payments in the residential care market.

Summary of the evaluation – objectives and models of direct payments

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

The evaluation of the pilot programme was conducted between January 2014 and June 2016. It began with 20 sites in different local authority areas in England. However, by September 2015, only 70 service users from pilot sites had accepted a direct payment. In addition, six sites had withdrawn from the programme and a further four had not issued any direct payments by the end of the evaluation (Wittenberg et al 2015). The Government decided to postpone the national implementation of the programme following submission of the evaluation findings.

The objectives of the evaluation were to explore the different ways in which direct payments were offered to residents and the processes of implementation; and the impact of the programme on service users and their families and other stakeholders. A full description of the aims and objectives, and methodology, is available in the final report (Ettelt et al 2017).

The evaluation found that the following models of direct payment were delivered by pilot councils:

a. **Full direct payment** - where the direct payment comprises the total sum of money (or entire personal budget) allocated to the service user to pay for their residential care.

b. **Part direct payment** - where the direct payment is only part of the sum of money (or personal budget) allocated to the service user The remainder of the personal budget is then managed by the council to pay for the service user's care, i.e. it covers most or all of the care home fee. This option typically involved council staff negotiating with care homes whether there was any part of the care home fee that could be used to allow the service user more choice.

Full direct payments would be expected to cover the entire care home fee; data from interviews with council employees showed they might give the user or family more control over the budget but typically did not result in additional choice of services. Part direct payments were typically linked to payments the service users received for daytime and social activities.

In both models, the amount available to service users after allowing for the core fee for the care home was small (Ettelt et al 2017).

Methods

This paper uses data collected for the evaluation. It particularly draws on interviews with owners and managers of care homes and a survey of care home providers.

Interviews with providers and stakeholder organisations

Semi-structured interviews were conducted with care home staff involved in planning and implementing direct payments. The interviews explored their general understanding of the purpose of the programme and their experience of direct payments in residential care during implementation. Nineteen interviews were carried out with managers and owners in care homes in five sites selected for more detailed study on the basis that they represented different approaches to implementing direct payments in residential care.

Interviews were also conducted with representatives of national stakeholder organisations. These represented provider associations from the private and charity sector and organisations representing service users .

Interviews were conducted face-to-face and recorded, with the permission of the participants, and later transcribed verbatim. The transcripts were then analysed in order to identify recurring themes in the context of existing literature.

Survey of providers

An online survey of care home providers was conducted in order to capture the views and experience of care home managers, owners or other senior care home staff member. The questionnaire included questions for care homes which had participated in the pilot scheme, those which had decided not to participate, and those care homes which expressed interest in participating but did not currently have a direct payment user.

The survey covered the following topics:

- For care home providers with residents holding direct payments: type and value of direct payments and how it was being used and managed; the effect of direct payments on residents receiving them, on family members and on other residents not participating in the programme; and the effect of direct payments on staffing arrangements, relationship with the council, costs of providing care, and administration and business development;

- For care home providers without any residents holding a direct payment, the reason/s for not having any direct payment user in the care home, including reasons for not participating in the pilot programme.

The survey was conducted electronically via Survey Monkey. Members of the research team contacted local authority project managers to ask for contact details of those care homes with which the local authority had a contract and which had been informed about the direct payments programme. These care homes need not necessarily have been participating in the programme.

A total of 114 responses were received; when these were further scrutinised and some incomplete responses were removed, 85 were included in the analysis. The response rate was around 15%.

The 85 responses related to 70 care homes which reported no direct payment users and 15 care homes which reported one or two direct payment users. In view of these small numbers, the results of the survey need to be treated with caution.

Findings from the care home provider survey and interviews

Sixteen of the responses stated that they were participating in the pilot scheme in principle but none of their residents had been offered a direct payment. Twelve said they participated in the programme but no resident had as yet accepted a direct payment, while 36 stated that they were not participating in the pilot programme. Almost all the non-participating care homes indicated they had not been informed about the direct payment programme.

The interview participants were from a combination of owners and managers of care homes, some of whom were participating in the pilot programme, and others which were not.

The following sections present data from the care home providers, both the survey and interviews, under different headings according to theme. (It is not known whether the same people who took part in the interviews also responded to the survey, as the data from the survey was anonymous.)

Choice and personalisation

Care home owners and managers taking part in the pilot explained the various uses of direct payments regarding their residents in the survey responses. Some provided positive feedback regarding the impact of the initiative on people's lives, and as a method for delivering personalisation, although significant difficulties were reported in implementation.

Ten care home managers and owners responding to the survey said the direct payment/s were used for personally arranged activities outside the care home, five for personally arranged meals taking place outside the care home, four for personally arranged activities taking place within the care home, two for personally arranged care within the care home involving specific services or activities, and one for personally arranged meals within the care home. (Direct payments could be used for more than one of these activities - they are not mutually exclusive - and there were missing values for three care home responses.)

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

Some comments from care home providers participating in the pilot were very positive. For example, one interview with a director of a residential care provider with around 500 residents across several sites, which had decided to participate in the pilot programme. This director explained that residents were already given a choice of activities and services, but

the introduction of direct payments encouraged the provider to become even more creative in the provision of support. This was “because if we are providing a range of things that people don’t want, if people are in receipt of a direct payment they will go elsewhere. So it does, it forces our hand to make sure that we change to deliver what people want to receive from us.”

By contrast, a manager of another care home, which had several residents holding direct payments covering part of the fee, expressed the view in a survey response that the system was “based more on want than need”. They explained that one resident, whose relatives had been encouraging the local council to increase funding for the person’s care package, had a direct payment budget “significantly higher” than other residents with the same level of assessed need. The respondent added:

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

The interviews also covered how direct payments worked in practice, from the perspective of providers participating in or with knowledge of the pilot programme. One of the care home owners and managers explained that the professionals in their care home created a profile of each resident based on their needs and preferences. The manager then referred to the profiles and discussed possible uses of direct payments with each resident.

> *“…we did the personal centre profiles, which looked into what was important to them, throughout their life, how we could best support that, within the home anyway? And, we asked somebody that knew them well, what they liked most about them? And then, say, for instance, we knew that one of our gentleman always used to go to a chippy, that he rates the best chippy in [the local town], so that’s on his outcomes, for us to take him there. And, the other lady, that we took to the garden centre, she liked animals, she likes, she used to like the garden, and everything. And, she also enjoys a cup of tea, and a chat, so the garden centre that we go to actually has a pet place as well, so it’s sort of the flowers, and it’s also got tea rooms, a café restaurant, so that sort of ticked quite a few of her boxes. And we asked, we just asked them, we have an idea, and we just say, what do you think?”*

In other cases the direct payment appeared to be less effective in increasing personalisation in the care home environment. One survey respondent with at least one user with an active part direct payment said the time-consuming nature of the scheme resulted in administrative costs. If these costs were to be taken from the direct payment itself, the respondent said the model would not be cost effective:

> “Careful thought is required as to what a meaningful direct payment level would be. If it is going to be the [local authority] fee then there will be little by way of funds left available for the recipient to notice any difference.”

In cases where the direct payment covered the whole care home fee, interviewees also felt that the programme may not have resulted in additional choice.

Overall, owners and managers were supportive of the aim of the pilot to improve opportunities for better personalised care in residential care settings. Those working in care homes for older people were particularly appreciative of the aim of the initiative, noting that this group of residents was usually given very limited choice of services within care homes. Managers working in care homes 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 (but this may depend on their cognitive and physical capacity to choose activities).

Challenges of implementation

The implementation of direct payments presented various challenges to the care homes involved in the programme. As previously mentioned, there was a distinction in the model of the payments, between 'full' and 'part' direct payments. Part direct payments presented particular difficulties for providers in disaggregating the costs of different elements covered by the care home fee. (Typically, care home fees are calculated by assessing the needs of individual residents, and by allocating the cost of caring for the needs and preferences of individuals, alongside the 'hotel' costs required to provide all residents with meals, laundry etc.)

One care home manager interviewed for the evaluation observed:

> *"Maybe the government should just look at putting some sort of figure on just giving them more, as a separate payment, just for activities, because rather than me have to sort out what we've paid out, on it… I don't know, it's very difficult. I think it's a very, very difficult thing to work out, the funding side of it."*

The possibility of creating multiple invoices for individual services provided to residents was not seen as a viable solution. Not all care homes would be in a position to cost services in this manner. One owner of a home noted that his staff already found it difficult to keep adequate records of essential care provided to residents, reflecting pressures on staff to attend to several aspects of care simultaneously, and competing demands on their time and attention. Breaking down these services into individual elements that could then be invoiced separately would require the use of these services to be scrupulously recorded, which was seen as unrealistic.

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

In addition, the difficulty of preparing for the future cost of a direct payments programme was highlighted by an interviewee from a provider representative organisation, who argued that personalising services would increase the cost of care home provision and that costs would vary tremendously depending on the person's needs:

> *"Well, any personalised care could cost more, but then it might cost less in other areas. It… If you just got the one rate fits all, which it does for older people – far less*

for younger adults with learning disabilities, of course – you will get a far bigger range in terms of what their personal care needs are. But the more that's put in people's hands, they might find ways to be more effective and efficient with their money, but personalised care currently, if you just look at the costs of care studies and what's funded, it absolutely means that the costs will have to rise to fund, but it might be different for each person."

Part of the complexity of existing funding arrangements within the residential care market arises from a significant proportion of clients paying the fees themselves (as 'self-funders'). In some cases, care home providers reported instances of their state-funded business being subsidised by self-funding clients. This is because of a disparity of rates paid by privately-funded residents and those covered by local authorities, where financial contracting arrangements are often very tight. As one care home owner explained:

"The local authority [places] are being subsidised by private pay, particularly the further north you go. If all our private pay just paid the same rates as local authority, we wouldn't have a business; we'd close the homes. It's one of the best-kept secrets that private pay are subsidising. Down south, where there's much higher percentage of private pay, it's not such an issue. But up here when you have local authorities who for several years have gone with no increases or very small increases… and we have a legal challenge going at the moment…because they've had a zero percent increase last year, a zero percent the year before, 1% proposed this year, you can't survive on that."

Within this difficult financial climate, a representative of a national organisation representing care providers expressed concern about a potential mismatch between the true cost of the services intended to be covered by direct payments, and the direct payments themselves. During an interview for the evaluation, the representative gave the example:

"So if a council gives £500 – I'm just plucking a figure out of the air – to that care home for my place currently, if they now say we're going to transfer that into a direct payment but oh, by the way, we've now worked that out and we think that that should be £400, of course that's going to have an impact. It's going to seriously undermine the business and the person won't be able to pay."

In another interview, a care home manager raised similar concerns:

"There's no benefit to us, to encourage [direct payments], because, we would want all of that money, to go to care, because you're looking at £300 shortfall, if this person decides to hold £100 of that back, we're in an uncertain situation. "

The care providers' survey also included comments from some owners and managers involved in delivering the direct payments pilot about the impact this had on their relationship with the local authority. The responses were mixed. On one hand, some problematic incidents occurred – for example, "the appointed suitable person had to wait several months for payment from the Council". Another respondent commented: "Trying to get correct money from them has been very difficult resulting in meetings and nobody seems to move quickly in our county council. Very frustrating."

However, another provider suggested their relationship with the local council had improved since the pilot had started.

Anticipated impact of direct payments on the relationship between care home providers and service users

Some care home owners and managers feared that the risk of a shortfall or discrepancy between the cost of care and the amount covered by direct payments would be further exacerbated by the possibility of residents defaulting on payments.

This view was reflected by a manager from a provider organisation, interviewed for the evaluation. They explained that providers were comfortable with receiving the payments directly from the local authority, but the introduction of direct payments would create an additional financial risk.

> *"And then, who… I know we've got the money, at the minute, we get it direct form the council, but obviously, my understanding is that maybe a family member, or something like that. Well, how do we know they're not going to just run off and spend it?"*

The interviewee also expressed concern about residents or family members potentially "blowing the whole year's budget" if they were given direct payments covering several months' worth of care home fees. Other participants suggested that the potential for 'bad debt' would be increased if responsibility for paying the care home fees was transferred to residents and their family members.

Within the survey, care home owners and managers were asked about their experience of participating in the pilot programme (although the numbers were limited, as previously mentioned). There was no clear consensus about whether care home workers were able to understand client preferences better as a result of the direct payments programme, or about whether residents and family members had become better informed about options and choices.

Reasons for providers not participating

Findings from interviews with council employees suggested they thought many care homes were supportive of the concept of direct payments. However, during discussions with providers about the possibility of implementing the programme, some care home managers and owners expressed concern that direct payments could add further pressure on already strained care home budgets in times of austerity. In addition, some providers, who had initially been willing to participate, withdrew from the programme when it became clear that no additional funding was available for the pilot and that direct payments could potentially result in funding being directed away from the care home (i.e. it could be spent on services provided outside the home).

This viewpoint was reflected in one particular interview with an owner of a care home for older people, a registered charity, who explained that the decision not to take part in the pilot programme was mainly driven by discussions with the residents' families.

"[A council officer] came in and explained it all. I'd given the residents' families the paperwork beforehand for them to have a look at, had a conversation with one of them on the phone about it at my home here. But they took the view that [care home] could be damaged by this, that it's a charity, it's putting all its money back in, has no profit at the end of the year, puts all its money back into care. They were concerned there was the potential for [care home] to be damaged financially, and they said it's like taking… one lady said it's like if somebody on the corner is shaking a tin, it's like grabbing the tin and running off with it, quote, unquote."

Another care home manager, from a provider which was not participating in the programme at the time of the interview, seemed unsure about the way the local authority was handling direct payments in the local area. For example, the manager was confused about whether it would only be available to new entrants to residential care or to existing residents as well.

Three care home managers participating in the survey of providers reported that they had been informed, but decided not to participate. The reasons were either they did not believe that their residents could benefit from a direct payment or that they were waiting to see how the programme would develop.

Conclusion

Care home owners and managers were generally supportive of the objective at the heart of the direct payments programme, of expanding the level of personalisation within residential care. This was particularly resonant among professionals working with older people, although it would depend on the individual's cognitive and physical capacity to choose and take part in a wider selection of activities. The owners and managers who took part in the direct payments pilot found that the programme was beneficial towards residents and their families in some cases, in helping to identify and meet their needs and preferences.

However, the difficult financial conditions of the residential care market, in the context of reductions in the number of residential care beds, made providers less likely to consider participating in the programme. This may reflect the characterisation of care providers being financially risk-averse, as suggested by the literature (Andrews et al 2000). The risks in this case, as illustrated by the findings from the interviews and survey, included the possibility of service users and their families defaulting on payments for care home fees, the mismatch between the value of the direct payments and the full cost of care services, and the difficult, time-consuming task of separating or 'itemising' costs within the overall fee in order to deliver part direct payments, that some managers and owners expected to be associated with having service users taking part in such a programme.

Care providers participating in the pilot programme valued the contribution made by colleagues in local authorities charged with implementing the scheme. In many cases the strength of partnerships between the two stakeholder groups – providers and local authorities – was vital for the facilitation of direct payments.

The lack of quantitative data resulting from low take-up of direct payments across the pilot sites meant the possibility of drawing strong conclusions from the overall evaluation was limited.

However, the qualitative findings from interviews were not without value. Many care home managers and owners raised the discrepancy between the rates offered by local authorities for state-funded residents, and the actual cost of care. They feared that direct payments would do little to improve this long-standing problem, which itself inhibits personalisation within the care market.

Most providers agreed that little funding would be left to promote choice and control using direct payments, after the core costs of the care service were taken into account. On the other hand, an observation from one care home manager participating in the programme, that one resident received a much larger personal budget through a direct payment compared to others who declined a direct payment, was striking.

Such limitations and inequalities suggest that more thought is required around the best method of implementing direct payments in residential care, before the Law Commission's vision of expanding the mechanism to all mainstream care settings (Law Commission 2011) can be realised.

Acknowledgements

This work has been 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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