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# Evaluation of the Individual Budgets Pilot Programme

## Final Report

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# Chapter 1      Piloting Individual Budgets

## 1.1 Introduction

Individual Budgets (IBs) are central to the aim of ‘modernising’ social care in England. They build on the experiences of direct payments and *In Control* and are intended to offer new opportunities for personalised social care.

Since the 1980s there has been growing interest among policy makers and service users alike in England in developing ways that enable adults who need support and help with day-to-day activities to exercise choice and control over that help. Growing dissatisfaction has been articulated, particularly by working age disabled people, about the inflexibility and unreliability of directly provided social care services. These have been argued to create dependency rather than promoting independence and impede disabled people from enjoying full citizenship rights (Morris, 2006). Instead, disabled people have argued for the right to exercise choice and control over their lives by having control over the support they need to live independently. This, they have argued, can be achieved by giving them the cash with which to purchase and organise their own support in place of in-kind provided services (Glasby and Littlechild, 2006; Morris, 2006).

A rather different set of policies have reflected the attempts of successive governments to reduce the control of social care service providers over the composition, timing and flexibility of services and make providers more responsive to the circumstances of individual service users. Thus the 1993 community care reforms made front-line care managers responsible for purchasing individualised ‘packages’ of services from a range of different providers, tailored to meet individual needs and preferences. At that time, the position of monopolistic authority service providers was challenged by the active encouragement of a ‘mixed economy’ of social care services, funded by local authorities (and increasingly also by individuals funding their own care entirely from their own private resources), but provided by a range of charitable and for-profit organisations.

More recently, policy commentators have argued for the active involvement of users in the co-production of services.

By putting users at the heart of services, enabling them to become participants in the design and delivery, services will be more effective by mobilising millions of people as the co-producers of the public goods they value. ...

(Leadbeater, 2004: 19-20)

Co-production is argued to introduce new incentives for providers to respond to individual demands; and new incentives for service users to optimise how the resources under their control are used in order to increase cost-effectiveness.

Co-production approaches:

... create a new way to link the individual and the collective good: people who participate in creating solutions that meet their needs make public money work harder and help deliver public policy goals. Self-directed services work because they mobilise a democratic intelligence; the ideas, know-how and energy of thousands of people to devise solutions rather than relying on a few policy makers ...

(Leadbeater *et al.*, 2008: 81)

By the mid-1990s, many local authorities were circumventing the legal restrictions on giving cash payments to individuals by making indirect payments to a trust fund or third party organisation which then passed them on to disabled individuals. The 1996 Community Care (Direct Payments) Act (implemented from April 1997) gave local authorities power to make cash payments, in lieu of services in kind, to adults aged 18 to 65 who were deemed 'willing and able' to make the necessary decisions. However, direct payments could not be used to purchase health care, local authority services or employ a close co-resident relative.

Subsequently three developments have taken place in direct payments policy and practice. First, the groups of people able to receive a direct payment instead of services have been extended. Since 2000 people aged 65-plus in England have been able to receive direct payments, as have carers, people with parental responsibility for disabled children and disabled 16 and 17 year olds. Secondly, to encourage people to take up direct payments, a £9 million Direct Payment Development Fund was launched in England in 2003. The Fund aimed to stimulate the development of organisations providing information and support to people wishing to use direct payments. Thirdly, Section 57 of the 2001 Health and Social Care Act made it mandatory (not just optional) for local authorities to offer direct payments to eligible individuals (that is, those eligible for social care services, who consent to and are able to manage payments).

There has been extensive research on patterns of take-up of direct payments and the factors that appear to facilitate or hinder take-up. Despite the measures listed above, take-up has remained highly variable: between the different countries within the UK; between local authorities within those countries; and between different groups of social care service users. Take-up rates are highest in England and lowest in Northern Ireland. People with physical and sensory impairments have consistently had higher rates of take-up while older people, people with learning disabilities and, particularly, people with mental health problems have much lower average take-up rates (Riddell *et al.*, 2005; Priestley *et al.*, 2006; Davey *et al.*, 2007). Direct payments appear to be more popular among more severely disabled people and among



younger age groups. There appear to be no differences in levels of income or wealth among direct payment users once benefit levels and age are controlled for (Leece and Leece, 2006). Local political and policy factors also appear to have a significant role (Fernández *et al.*, 2007).

Meanwhile, a White Paper on services for people with learning disabilities, *Valuing People* (DH, 2001), led to the development of a different approach to enable this group of social care service users to exercise choice and control over their support arrangements. Supported by social enterprise organisation *In Control*, this approach promoted a greater role for service users in assessing the level of support they need; the allocation of resources to individuals according to relative levels of need rather than according to the value of services allocated (as with direct payments); transparency over the level of resources allocated to each person; and support in planning how those resources are used to meet individual priorities and preferences. Whereas direct payments are generally used to employ personal assistants to provide help with personal care and daily living activities, *In Control* encourages greater flexibility and promotes the use of a wide range of ordinary community-based services and supports. *In Control* connects closely with the principles underpinning direct payments but has a broader aim of redesigning social care systems towards 'self-directed support' (Duffy, 2004). Initially, *In Control* piloted this approach to self-directed support in six local authorities but has since been extended to many more English local authorities.

## 1.2 The individual budget proposals

In 2005, three key policy documents were published. The Prime Minister's Strategy Unit (2005) report *Improving the Life Chances of Disabled People* included a wide range of proposals designed to remove the barriers to social inclusion and equality experienced by disabled people of all ages. The proposals included the piloting of individual budgets. Individual budgets were to bring together those resources from different funding streams (including local authority social care, housing-related support services, adaptations and equipment budgets) for which an individual is eligible into a single sum that can be spent flexibly according to the priorities and preferences of that person. The individual budget proposal was repeated in the UK *Strategy for an Ageing Population* (HM Government, 2005) and in a Department of Health Green Paper *Independence, Well-being and Choice* adult social care (DH, 2005), which also called for more opportunities for older and disabled people to exercise choice and control over how their support needs are met:

People could have individual support to identify the services they wish to use, which might be outside the range of services traditionally offered by social care. ... For those who choose not to take a direct payment as cash, the budgets would give many of the benefits of choice to the person

using services, without them having the worry of actually managing the money for themselves.  
(DH, 2005: 34)

### **1.3 The principles underpinning individual budgets**

A number of important principles underpin individual budgets (IBs) that distinguish them from conventional services, direct payments and *In Control*. These principles include a greater role for self-assessment; greater opportunities for self-definition of needs and desired outcomes; and increased opportunities for users to determine for themselves how they want those outcomes to be achieved. As noted above, for any individual, IBs bring together the resources from a number of different funding streams; in determining eligibility for these resources, multiple assessments are to be reduced or integrated. Crucially, IB holders should know how much money they are to receive; they should know how much relevant services cost; and they should be offered support in planning how they can best use the resources available to them to meet their needs.

Individual budgets also offer new opportunities to exercise choice and control for people who do not wish to manage a cash budget or direct payment themselves but prefer instead to receive local authority-commissioned services. The principles that individuals should know the level of resources available to them and how much services cost are intended to apply to local authority service options as well, thereby offering a potential incentive for councils to match standards of personalised and individualised services that may be offered in the private sector or through cash-based mechanisms such as direct payments (Glasby *et al.*, 2006). As well as receiving an IB as a cash payment, IB holders can therefore ask their local authority care manager to purchase services for them, up to the value of the budget. Additional options for deploying an IB include payment to a third party to manage on behalf of the recipient; giving the budget to a service provider, such as a domiciliary care agency, to manage and 'calling off' services as and when needed; or management by a trust fund on behalf of the user.

### **1.4 The individual budget pilot projects**

In July 2005 the Department of Health (DH) invited English local authorities with responsibilities for adult social care to bid to pilot individual budgets. In response, Sussex was designated the first pilot site and was expected to offer its first IB before the end of 2005. In November 2005, 12 other pilot sites were announced. These were: Barking and Dagenham, Barnsley, Bath and North East Somerset, Coventry, Essex, Gateshead, Kensington and Chelsea, Leicester City, Lincolnshire, Manchester, Norfolk and Oldham. All were expected to start offering IBs by April

2006 and to continue to do so up to the end of 2007. The DH provided resources – between £350,000 and £400,000 per site over two years – to support the implementation of IBs in the 13 pilot sites. Otherwise, sites were required to implement IBs within the constraints of their existing social care budgets. Additionally, considerable support was provided to sites, both individually and collectively, by the Care Services Improvement Partnership (CSIP).

A number of clear principles underpinned the IB pilots.

- Sites were to develop ways of enabling service users to play a greater role in the assessment of their needs.
- Individuals should know the level of resources available to them before starting to plan how they wish their support needs to be met. Here, sites were encouraged to build on the experiences and tools developed by *In Control*, particularly *In Control's* Resource Allocation System (RAS). Developing a RAS is an iterative process: an individual's level of need across a series of domains is scored to give a total number of points; the individual scores of, say, 100 people are aggregated; and the global social care budget is divided by the total number of points to obtain a cash value for each point. An individual's IB is therefore a product of their total number of points and the price per point that is derived from this process. Repeated iterations of the process may be required to balance the competing requirements for an equitable redistribution of resources between people with similar levels of need, the allocation of sufficient resources for people with particularly high or low level needs, and the overarching requirement to remain within existing budgets. IB levels calculated through these processes may subsequently be adjusted following discussions between care managers and potential IB users.
- Sites were to test out the opportunities for integrating resources from several different funding streams into a single IB. In addition to adult social care, the resources to be included in IBs were: Access to Work; the Independent Living Fund (both the responsibility of the Department for Work and Pensions); Supporting People and the Disabled Facilities Grant (both the responsibility of the Department for Communities and Local Government); and local Integrated Community Equipment Services, which were funded from pooled social care and NHS resources. In moving towards integration of funding streams, pilot sites were to experiment with aligning eligibility criteria and aligning or integrating assessments, with the aim of reducing the number of different assessments an individual had to undergo. It was not clear at the start of the pilot projects how far these funding streams would retain their existing identities, purposes and accountability arrangements; sites were encouraged to explore how far integration could be achieved within existing legislative and administrative arrangements and identify any barriers to integration that they encountered.

- In planning how to use their IB, individuals were to be encouraged to identify the outcomes they wished to achieve and the ways in which, ideally, they wished to achieve these outcomes, rather than simply opting to use existing services. Moreover, whereas direct payments are generally used to employ a personal assistant, IBs could be spent on a wide range of existing services; to purchase ordinary community or commercial services (for example, lunch in a pub rather than meals-on-wheels); or to pay relatives and friends for the help they give.
- Sites were encouraged to experiment with a range of options for deploying IBs. As well as offering direct cash payments, other possible deployment options included: care manager-managed accounts; provider-managed accounts; and payments to third party individuals and Trusts.

## **1.5 Evaluating the IB pilot projects**

The potential implications of IBs are profound. They imply major changes in: organisational arrangements, processes, culture and professional roles within local authority adult social care services; in the roles of voluntary and user-led organisations; and in the expectations and responsibilities of social care service users. Conventional approaches to assessment and care management – professional-led assessments and the purchase by care managers of services on behalf of users – may no longer be appropriate. New skills in supporting users to plan their support arrangements, and brokerage expertise to enable IB holders to get the best ‘deal’ from their budgets, may be needed instead. Service providers may experience reduced demand for traditional services and new pressures to provide different types of services in different ways if they are to remain viable. IBs also involve new risks, for services and users alike, particularly exposure to new financial risks associated with managing fixed budgets.

With such far-reaching implications, it was therefore vital to know whether IBs offer better outcomes than conventional services and, if so, at what costs. Consequently in July 2005 DH invited the three English research units with DH-funded programmes of research on adult social care to bid for the evaluation of the IB Pilot Projects. The three units – the Social Policy Research Unit at the University of York, the Personal Social Services Research Unit at the Universities of Kent, Manchester and LSE and the Social Care Workforce Research Unit at Kings College London – agreed to submit a joint bid. The evaluation team (hereafter referred to as the Individual Budgets Evaluation Network – IBSEN) began work in August 2005 and a formal proposal was submitted in November 2005. Following feedback from scientific referees and discussions with DH policy officers, a revised proposal was submitted in January 2006. The evaluation formally went ‘live’ in April 2006 and ended in March 2008. This report covers the activities carried out during that two-year period.

Over and above the formal evaluation, the IBSEN team began setting up contacts with the 13 local authorities as soon as their pilot site status was announced in autumn 2005. Early discussions with the pilot sites covered arrangements for data collection and monitoring of sites' early plans. These activities were reported to DH in May 2006 (Browning, 2006). An early deadline for the evaluation team was to provide evidence for DH to include in its submission to the Treasury as part of the 2007 Comprehensive Spending Review. Drawing on early evidence from the evaluation, a series of papers was presented to DH in October 2006. These papers dealt with sites' early experiences of implementing IBs, drawn from a first round of interviews with IB project leads; details of the implications of IBs for staff training, care management practice and adult protection (Manthorpe *et al.*, 2008a; 2008b); interviews with 14 early users of IBs (Rabiee *et al.*, forthcoming); and details of the costs of implementing IBs.

A separate, linked study of the impact on carers is due to report in autumn 2008.



## Chapter 2 The Individual Budgets Pilot Projects

### 2.1 The pilot local authorities

#### 2.1.1 Demographic and socio-economic characteristics

In summer 2005 local authorities in England with responsibility for adult social care were invited to bid to pilot IBs. The 13 successful sites were announced in autumn 2005. One site was committed to offering IBs by the end of the year, with the remainder offering their first IBs by April 2006.

The pilot sites included two London boroughs, five metropolitan authorities, four county (shire) authorities and two unitary authorities. Table 2.1 summarises their key features.

**Table 2.1 Characteristics of the 13 pilot sites**

Site	Structure	High Black. Minority Ethnic pop'n (<10%)	Deprived area (top 50 LAs)	CSCI rating 2005	FACS eligibility threshold
1	London borough	Yes	Yes	*	Critical, substantial, (dropped moderate part way through pilot)
2	London borough	Yes		**	Critical, substantial, moderate
3	County			*	Critical, substantial, (possibly moderate)
4	County			*	Critical, substantial, moderate
5	County		Yes	*	Critical, substantial, moderate
6	County			**	Critical, substantial
7	Unitary			**	Critical, substantial
8	Metropolitan	Yes	Yes	*	Critical, substantial
9	Metropolitan	Yes	Yes	**	Critical, substantial
10	Unitary	Yes	Yes	**	Critical, substantial
11	Metropolitan			***	Critical, Substantial, (dropped moderate part way through pilot)
12	Metropolitan	Yes		**	Critical, substantial
13	Metropolitan		Yes	***	Critical, substantial

The characteristics of the 13 localities were examined in detail. Their size and demographic compositions varied significantly, with some of the pilot sites showing up to 30 per cent difference above or below the English mean in the proportions of their populations aged 65-plus.

At the time of selection, there were wide variations between the pilot sites in three indicators associated with the use of social care: deprivation; health-related need; and levels of informal care. Overall variations in levels of per capita expenditure on personal social services between the pilot sites were modest, but some sites had average per capita expenditure on mental health services significantly above the English average.

The unit costs of institutional and home care services varied considerably between sites, as did their relative use of in-house and independent service providers, but overall the pilot sites did not appear significantly different from the national averages on these measures. A majority of the pilot sites supported lower proportions of people with learning and/or physical disabilities in residential care than the English average, but a majority also had higher than average proportions of older people and people with mental health problems in residential care. A majority of the pilot sites provided home care to higher proportions of their populations, and more intensive home care packages, than the English average.

### 2.1.2 Previous experiences of self-directed support

Pilot sites' previous experience of offering self-directed support was a key contextual factor in their preparedness for implementing IBs. Two indicators were examined: whether sites were implementing the *In Control* programme for people with learning disabilities; and the relative take-up of direct payments (Table 2.2).

**Table 2.2 Pilot sites' previous experiences of self-directed support**

<i>Site</i>	<i>Direct payments (high/medium/low)</i>	<i>In Control (more ticks = early site = more experience)</i>
1	L	
2	M	√
3	H	√
4	M	√√√
5	L	
6	H	√√√
7	L	√
8	M	√√
9	H	
10	M	
11	M	√√√
12	H	
13	H	√



Although some pilot sites had lower than average take-up of direct payments, a majority provided direct payments to much greater proportions of their populations – particularly older people and people with mental health problems – than the English averages. Several sites also had significantly higher levels of spending on direct payments than the national average, particularly for people with mental health problems and learning disabilities.

In summary, there was wide variability between the 13 pilot sites but, overall, they did not appear to be significantly different from the English average on most indicators. The only respect in which they appeared to differ from the average was in the higher numbers of people receiving direct payments and the higher than average levels of direct payment expenditure per user, particularly for people with mental health problems and learning disabilities.

## **2.2 Reasons for bidding to pilot individual budgets**

The first round of interviews with the officers responsible for implementing IBs, conducted six to nine months after the pilot sites had been selected, revealed a keen commitment to developing personalisation in social care. Often this commitment took into account sites' previous positive experiences of implementing direct payments and *In Control*, and was reflected in common explanations that the IB Pilot was consistent with the authority's existing 'direction of travel'. Again this suggests the pilot sites may not have been entirely typical of all English local authorities, at least in their histories of and strategic commitments to personalisation. Alternatively the commitment expressed in these interviews may have reflected their early experiences of engagement with the IB pilots.

IB lead officers reported various reasons for wanting to pilot IBs. Common reasons included building upon their experiences of direct payments and/or *In Control*; creating better outcomes for service users; and consistency with the authority's existing or desired direction of travel.

### **2.2.1 Building upon direct payments**

IB lead officers in seven sites expressed concern over their relatively poor take-up of direct payments, either generally or among particular groups such as mental health service users or older people. Individual budgets were therefore perceived as an alternative way of increasing opportunities for choice and control. Officers also anticipated achieving improvements in performance indicators if increased opportunities for personalisation could be achieved through IBs.

Conversely, an already high take-up of direct payments, at least among certain groups of service users, encouraged other sites to bid for pilot status. Indeed, there was a clear relationship between high direct payment take-up among particular user groups and the inclusion of those groups in the local IB pilot – typically people with physical disabilities but also, in some sites, young people in transition from children's to adult services. Officers in such sites believed that their success in offering direct payments to these groups would facilitate implementation of IBs, which were perceived as the next logical development:

[with direct payments] all you're doing is offering people a nominal alternative to conventional packages of care and it doesn't really influence drastically the way in which care managers and/or the assessors carry out their assessments and it doesn't influence the way in which we allocate resources. So when individual budgets came along that really excited me and others in the department because it's, I think it really kind of allowed us an opportunity to tackle one of the things that we were decidedly uneasy about with, with direct payments.

(IB lead officer)

IBs were also expected to be more flexible than direct payments, requiring less rigid accounting structures and able to fund a broader range of support. Some IB lead officers hoped this flexibility would allow a wider range of user groups to benefit from opportunities for choice and control. Lead officers in three sites also saw IBs as offering the opportunity for a radical transformation of care management in a way that Direct payments had not; IBs were expected to facilitate a return to more traditional social work practice, focused on outcomes and support planning.

## **2.2.2 Building on experiences of *In Control***

Of the eight sites already working with *In Control*, six included people with learning disabilities in their IB Pilots. Most of those sites perceived IBs to be a natural progression from *In Control*. However, one IB lead officer subsequently reflected that the changes already made to implement *In Control* had been undervalued by the IB Pilot, which had attracted far greater political interest and support despite its smaller scale and shorter experimental phase:

... there'd been a lot of work around the *In Control* work and a lot of building blocks put in place that weren't necessarily, weren't that different but weren't completely in line with the individual budgets but there's a lot of, you know, a lot of investment. I think that did create tensions and difficulties because there was this momentum that was going on with *In Control* that had been going on for two years and suddenly there's this big wealth of, or this big surge of momentum for individual budgets that came in which seemed to take precedence over stuff that had gone before,

because of the, the importance, the national importance of the individual budgets.  
(IB lead officer)

Officers in some sites expressed uncertainty about how IBs would fit with *In Control*; in contrast other IB lead officers did not see IBs as necessarily compatible with their *In Control* programme:

... the *In Control* pilot had focused on people with very complex needs, a very small number, all of whom were known in the system so all of whom had quite detailed assessments, whereas the people that we're dealing with [with IBs], the sheer volume, the numbers that come through, the vast majority aren't known.  
(IB lead officer)

Officers without previous experience of *In Control* expressed slightly more anxiety about the impact of IBs on their staff, systems and structures, and were less clear about the nature of IBs than those who had.

### **2.2.3 Other reasons for becoming a pilot site**

Other reasons for bidding to pilot IBs included anticipated improvements in users' experiences of assessments, choice and control; and improved outcomes, including increased opportunities to move from or stay out of residential care. In nine sites, IBs were reported to be consistent with existing policies to improve the flexibility of support arrangements and modernise adult social care; piloting IBs was expected to make a significant contribution to the speed and extensiveness of this change. Although not a motivating factor, all sites noted that the DH implementation grant had been important in enabling them to bid to be a pilot site. This was particularly true for small authorities with less flexibility to release staff to lead the project.

## **2.3 User groups and funding streams**

The 13 pilot projects involved different groups of social care users and different combinations of funding streams, in addition to adult social care (Table 2.3).

**Table 2.3 Summary of each IB pilot project**

<i>Site</i>	<i>User groups</i>	<i>Funding streams *</i>
1	Physical/sensory impairment, learning disability	AtW, ILF, SP
2	Physical/sensory impairment, learning disability, older people	AtW, DFGs, ICES, ILF, SP
3	Mental health	AtW, ILF, SP
4	Older people	DFGs, ICES, ILF, SP
5	Physical disability, learning disability, mental health, older people	AtW, DFGs, ICES, ILF, SP
6	Physical disability, learning disability	AtW, DFGs (later in pilot), ICES, ILF, SP
7	Physical disability, learning disability, older people	AtW, ICES, ILF, SP
8	Physical disability, learning disability, mental health, older people	AtW, DFGs, ICES, ILF, SP
9	Older people	AtW, DFGs, ICES, ILF, SP
10	Physical disability, learning disability	AtW, DFGs, ICES, ILF, SP
11	Transitions, learning disability, older people	DFGs, ICES, ILF, SP
12	Transitions, physical disability, learning disability, mental health	AtW, DFGs (later in pilot), ICES, ILF, SP
13	Physical/sensory impairment, learning disability, mental health, older people	AtW, DFGs (later in pilot), ICES, ILF, SP

\* AtW = Access to Work; DFGs = Disabled Facilities Grant; ICES = Integrated Community Equipment Services; SP = Supporting People; ILF = Independent Living Fund.

### 2.3.1 User groups offered IBs

As noted above, common factors influencing decisions about the configuration of local IB pilots were previous (both positive and negative) experiences of direct payments or with *In Control* or person-centred planning. Some sites chose to build on existing successes with these approaches, particularly if they anticipated being able to adapt existing *In Control* or person-centred planning materials. Another reason for focusing the IB pilot on people with learning disabilities was that it would test how far IBs could facilitate a move away from care and task-oriented service provision.

In contrast, some sites chose to offer IBs to groups with little previous history of self-directed support, arguing that it was important to demonstrate that IBs could work for the most challenging groups. Thus some sites included mental health service users in their IB pilot, specifically because they were expected to be the hardest group to implement IBs for, as some mental health service users might find it difficult to

manage the responsibility of an IB, particularly when unwell. Sites offering IBs to older people hoped that IBs would be more attractive than direct payments had been, although it was recognised in one site that care manager attitudes and assumptions about the willingness of older people to accept IBs would need to be addressed. One site hoped to transfer its learning from *In Control* to older people.

Sites that planned from the start to pilot IBs with all service users were more likely to articulate an explicit future vision of modernisation and personalisation and argued that self-directed support opportunities should be available to everyone. Additional arguments for offering IBs to multiple user groups were that this was more likely to lead to sustainable change; that it would break down current differences in front-line practice; and that it would be easier to decommission some services and free up resources for IBs. Other sites were more cautious about their capacity to introduce IBs for multiple user groups and involve multiple teams of front-line staff.

Three sites focused their IB pilot, wholly or partly, on people undergoing major life changes, such as young people moving from education to employment, from parental or supervised homes to independent living; from hospital or rehabilitation back to the community; or from out-of-area placements back to the local authority.

### **2.3.2 Funding streams included in IBs**

Sites' decisions about the funding streams included in IBs were first of all shaped by their relevance to the user groups involved in each pilot. Other factors influencing decisions about funding streams included synergy with existing policies (for example, two sites included Access to Work because of local policy commitments to helping services users move into training and work); expectations of savings (for example some sites that included ICES did so because of expectations that speedy access to equipment could reduce needs for on-going support); and because of existing close relationships (for example with Supporting People which, in unitary authorities, was often part of the same directorate as adult social care). All 13 sites included the Independent Living Fund, either because of previous extensive take-up of this funding stream by social care service users, or because of a desire to increase take-up of ILF locally.

Sites also had reasons for not including particular funding streams. These concerned anticipated difficulties, such as the incompatibility of eligibility criteria (for example between Access to Work and adult social care); the problems of working with multiple district councils (in the case of DFGs); or a perception that a funding stream was not relevant to the user group being offered IBs (for example people with mental health problems who were unlikely to benefit from DFGs). Two sites restricted the number of funding streams included in their pilot because of anxieties about being over-ambitious.

## 2.4 Approaches to implementing IBs

Most sites intended to take an incremental approach to implementation, offering IBs to one user group at a time or within one team of care managers at a time. A few introduced IBs locality by locality. Many sites started by offering IBs to learning disabled people, expecting to be able to build on previous experiences of *In Control* or person-centred planning. Others started by piloting IBs with people with physical and sensory impairments because of the popularity of direct payments with this group. Most sites planned to offer IBs to both new and existing service users. Within any user group, sites variously intended to target specific groups of users, including those in residential placements and those dissatisfied with their current arrangements. Some intended to start with users with stable circumstances or with low or moderate needs, expecting that IBs would be easier to implement for them. However there was no overall pattern in sites' approaches to implementation.

### 2.4.1 Early preparations

Sites were encouraged<sup>1</sup> to adopt an incremental approach to implementation, prioritising those changes needed to offer small numbers of people an IB by June 2006, with a view to developing a fully fledged model thereafter. Incremental approaches included working with only one user group or one care management team and incorporating additional users and funding streams at a later date.

During the first four months of the pilot, up to the end of March 2006, sites were largely engaged in setting up implementation structures – project boards and linked stakeholder groups – and planning the processes needed to deliver IBs. Most worked on identifying the core tasks that needed to be accomplished in order to deliver the first IBs, with the development of a resource allocation system (RAS) a high priority. Some sites began early on to develop and test a system for allocating resources, while others were still considering different options. At this very early stage, the development of resource allocation systems was already regarded as the most challenging task. Most sites were considering adapting resource allocation methods developed by *In Control*, although concerns were expressed in some sites that these were too simplistic, particularly for people with fluctuating conditions; would not allow creative responses; or risked compromising authorities' statutory duties. Moreover, project managers were fully aware that early resource allocation systems would need to be adapted subsequently, when additional funding streams were aligned or integrated with IBs.

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<sup>1</sup> CSIP First Progress Report on the Implementation of the Individual Budget Pilot Programme, May 2006.

During the first four months of the pilots, problems were also already being reported in disaggregating social care resources from services that were jointly funded with other departments and organisations; in the exclusion of NHS continuing care; and in aligning Access to Work eligibility criteria with those for adult social care. Early reports from CSIP also drew attention to the barriers being experienced to integrating funding streams. Additional difficulties were reported in applying existing charging policies and practices to IBs, leading to concerns about levels of revenue that would be raised. Early problems were also experienced in releasing resources tied up in in-house services and block contracts that could be offered as IBs. The need for major changes in care manager activities and processes were already anticipated, as were new accountability and risk management processes.

Most sites established a number of 'work streams' to undertake clusters of related tasks, including resource allocation systems and assessment processes; support planning and brokerage arrangements; developing deployment options; and setting up monitoring, record keeping and recording systems. A few sites involved finance officers and/or communication specialists from the start.

#### **2.4.2 Actual implementation against initial plans**

Although sites had initially specified which user groups they intended to offer IBs to, most had extended the pilot to include additional user groups before the end of 2007 (these additional groups were not included in the RCT strand of the evaluation) (Table 2.4). Some IB lead officers reflected that, in retrospect, they would rather have offered IBs to all groups of adult social care users from the start. They had not anticipated the substantial additional work involved in adapting for other groups assessment documents and resource allocation systems that had been developed with one group. In contrast, others thought that a gradual, phased approach to implementation had enabled them to refine processes specifically for each user group and build on early learning.

**Table 2.4 Roll-out: Initial plans and actual roll- out**

<i>Site</i>	<i>Initial implementation plans</i>	<i>Actual implementation</i>
<b>1</b>	Original aim was to work with all four user groups (similar to previous work on direct payments). However, only people with PD and LD were included in the evaluation. Site offered IBs to existing users at the point of annual review, starting with PD. Later extended to OP, then MH.	Implemented IBs for people with PD and LD; then started working with OP and now working with MH. Worked well in PD as staff used to that way of working. LD has been an unexpectedly big drain on time. Expected OP teams to be most difficult as this is a new concept for them, but has proved to be much easier to get higher numbers of OP on IBs. In hindsight would prefer to have included PD and OP in the evaluation.
<b>2</b>	Planned to implement for LD, PD and OP across the site, working across teams.	Implemented for LD, PD and OP, but training care managers took longer than anticipated – they needed to be mentored and walked through the process by support planners.
<b>3</b>	For MH service users only within three localities. Could work with all people in residential then all people in the community, or work alternately with people in residential and people in the community. Need to release resources from residential care before spending them on supporting people to live in the community.	IBs implemented for MH in three localities, then extended to all localities. However, planned balance between people in residential care and people in the community not achieved: had to work fast to meet target numbers; was easier to offer IBs to people in the community; takes long time for somebody to move out of residential care. Site therefore had to balance numbers of residential and community-living IB users retrospectively; randomisation did not produce an equal split of people in residential care and people in the community.
<b>4</b>	For OP only within three localities (to keep the project manageable and so that other localities could act as comparison sites). Began by allowing care managers to select potential IB users then extended to all OP.	IBs offered to OP within the three localities then began to offer IBs in other localities towards the end of the Pilot in preparation for full roll-out. IBs are also being piloted with LD and PD under 65 (but not for the evaluation).
<b>5</b>	Implement for LD, PD, OP and MH in one locality, starting with OP; randomise new cases at point of referral on a particular day. Possibility of rolling out to other localities if target numbers are not met.	As planned. Introduced for all four user groups in one locality; started with older people as theirs was the first IB assessment document and RAS to be drafted. However, as care managers were not randomising enough cases and site risked missing its target numbers, it was decided to randomise all new and existing users.



<i>Site</i>	<i>Initial implementation plans</i>	<i>Actual implementation</i>
<b>6</b>	Aimed to offer IBs to LD and PD, targeting one or two teams in particular localities but may roll out to other teams if don't hit target numbers. Existing users only.	IBs implemented in LD and PD, existing users only. Started with group of LD; found implementation slower as existing service users had no great incentive to move quickly. Reorganisation meant that the site could not work with its preferred locality, thus worked with the most stable teams in the authority.
<b>7</b>	Intended to implement for PD, LD and OP, starting with LD. Randomise one in four new and existing cases.	Higher number of people than expected refused to partake in Pilot, partly due to concerns that IBs would lead to lower resources, therefore had to randomise more people, especially LD. Offered an IB to every new case, as more likely to accept an IB than existing users. Would have preferred to work only with new cases, but would have meant that the quota for PD was not reached (fewer new cases).
<b>8</b>	Implement for all user groups across the site; all new referrals and everybody else at the point of their annual review.	Implemented for all user groups across the site, including all new referrals and everybody else at annual review. Only exceptions have been emergency cases where care packages have to be put in place quickly. Hospital discharges go through six weeks reablement and during that time they go through the IB assessment, RAS and support planning processes. This involves assessing people as they recover, not while they are at their most unable.
<b>9</b>	To older people with dementia and to people with long-term neurological conditions (which would include most of the physical disability user group), renal patients and cancer patients across all teams.	Asked to work with older people for purposes of the evaluation so focus shifted from the more unusual user groups (long-term neurological conditions, cancer and renal patients) and these care managers had to stop obtaining consents. Opportunity for older people's services to take a lead role; however care managers working with other user groups continued to get consents. IBs offered to all older people (not just those with dementia); included LD within a few weeks of starting the Pilot. Would like to have worked with LD from the start as this group could really benefit from advocacy arrangements, support planning, and third party payments. Trialled extending IBs to MH late in the Pilot following a workshop about IBs and MH.

<i>Site</i>	<i>Initial implementation plans</i>	<i>Actual implementation</i>
<b>10</b>	Aim to implement with PSI (all teams) and LD (two teams) with both high and low level needs. Hoping to include new referrals and existing users, day services users, people in supported living, those who are looking for change.	Introduced for PSI (all teams) and LD (fewer teams). More difficult to introduce for LD as teams tend to be working with crisis situations; short-term focused; and higher staff turn-over thus higher training requirements. Not able to test IBs in the way they hoped owing to the demands of the evaluation and the fact that cases had to be randomised – thus not possible to pilot IBs with one group of people in supported living, for example. Need to do some early work with OP and MH prior to making a decision about future roll-out.
<b>11</b>	For young people in transition and older people moving from adult to older people's services across all user groups. Also offering IBs to anybody who requests one (not for the evaluation). Offering to all existing users, even those that were not due for review.	Offered to young people in transition and older people moving from adult to older people's services. But also advertised IBs more widely and had a significant number of additional people on IBs (not part of the evaluation).
<b>12</b>	For people aged 16-65 from LD, PD and MH who are known to the system who are in periods of transition, experiencing or about to experience a major life change.	Implemented as planned to people aged 16-65 from LD, PD and MH in periods of transition. More difficult within MH. Started off with pathfinder group of staff to work on getting the materials ready. Tactical decision to move away from 'IB champions' as aiming for general roll-out and broader cultural change.
<b>13</b>	Introduce IBs for PD, LD, MH and OP in all areas, starting with LD. Randomise cases at review and possibly also new referrals.	Introduced for all four user groups in all areas, but found it harder to engage with MH. Also extended to young people in transition as felt this group could particularly benefit from IBs rather than moving into traditional Adult Services.

Notes: PD= physical/sensory disability; LD= learning disability; OP=older people; MH=mental health service user; RAS= Resource Allocation System.

### **2.4.3 Experiences of implementation among different service user groups**

When interviewed towards the end of the pilots, IB lead officers thought that, as anticipated, implementation had been easiest for people with physical and/or sensory impairments; here, both users and their care managers were considered particularly receptive to self-directed support arrangements. In a few sites, implementation for people with learning disabilities had been more difficult than expected because it had required developing accessible information and assessment documentation; developing support plans with this group had also been more difficult and protracted than anticipated. In two sites it was reported that extending the pilot to older people

had been easier than expected and this prompted regrets that older people had not been included in these sites' pilots from the start. Widespread difficulties were reported in relation to people with mental health problems, because of the alleged paternalistic and protective attitudes of front-line staff and difficulties in working with NHS partners in what were often jointly funded and managed services (see also Chapter 14).

Regardless of their plans for the pilot projects, most sites planned to offer IBs to all their adult social care users eventually because of: the anticipated benefits for service users; the anticipated financial savings; and the need to reduce demand for traditional services to free up resources for IBs. In all cases, future plans were for a phased or incremental approach in order to: foster culture change among staff and service users; train care managers and other staff; decommission existing services to release further resources; work with providers to develop new services; and improve the alignment of funding streams.

#### **2.4.4 The roles of care managers in implementation**

The involvement of front-line care managers and team leaders in implementing IBs was highly variable across the 13 pilot sites. Team leaders were more likely to be involved in early planning and developmental activities, with care managers involved later in piloting new documentation or providing feedback from users on new processes:

... then when they started looking at the assessment tool, they actually came into the teams and we brought cases forward of existing cases, trying to test out how to apply it. And so the staff felt really positive about that, because it really made them feel very included.  
(Team leader, older people and physical disabilities)

Identifying 'champions' among care managers appeared to have benefits both in developing processes and in cascading knowledge and skills to colleagues:

... we formed what we called a Champion's Group, that was two people from each team. ... We discussed all the paperwork and because some paperwork didn't work for our service users ... we had to change a few formats. But we did it as a team and it was really good.  
(Care co-ordinator, learning disabilities)

What we currently do is have one individual, one care manager who has lead responsibility in relation to individualised budgets. They then share that information and knowledge with the rest of the team, and they become I suppose the guru of individualised budgets.  
(Team leader, learning disabilities)

There was widespread agreement across the pilot sites that the active involvement of front-line care management staff in developing new systems was key to successful implementation. This involvement helped to ensure that documentation and processes appropriate to specific user groups was developed and also made a major contribution to changing routine practice and culture. Thus many care managers expressed regret that they had not been more involved in implementation:

I think it would have been useful if maybe people on the ground had been involved right from the outset because then ... they might have been able to foresee some of the problems that they've come across and I think it might have helped in the communication stakes as well.  
(Care co-ordinator, physical disability team)

Factors that shaped care manager attitudes were, above all, the positive experiences of IB users and, to a lesser extent, strong leadership from senior managers or the IB implementation team:

In the instances where it's worked well for people and they're really happy. ... That makes me enthusiastic about it.  
(Care co-ordinator, learning disability team)

Conversely, barriers to positive care manager involvement included high workloads, poor information and training about IBs, and the lack of clarity about detailed processes as new systems were put into place:

Care managers really do see the benefits but don't feel able to put in much time when they have such high caseloads.  
(Care co-ordinator, adult services)

We needed to be informed about what was going on and, to tell you the truth, that's what made most people shy away from it.  
(Care co-ordinator, mental health services).

## **2.5 Overall reflections on implementation – successes and challenges**

### **2.5.1 Successes**

Regardless of the scope of pilots or their approaches to implementation, IB lead officers reported their most important successes as the positive impact on users' lives:

... seeing people who've had very, very traditional style support for a very long time, living much more independent lives than they had done.  
(IB lead officer)

People are actually living, not existing and they have stories that have changed the hearts and minds of not only the care managers but of the elected members.

(IB lead officer)

Such changes were evidenced by the range and quality of the support plans that some users had developed. In a small number of sites, benefits for carers of IB holders – mainly older people and people with learning disabilities – were highlighted.

A second cluster of achievements concerned the transformation of social care services including: the engagement of care managers in change processes; the development of support planning and brokerage services; renewed engagement with voluntary sector organisations through their membership of IB project boards or involvement in support planning; and to lesser degrees, increased equity between user groups and greater flexibility on the part of service providers. All of these changes were reported to be far more extensive than those generated by earlier experiences of direct payments and *In Control*.

## 2.5.2 Challenges

The costs and complexities of implementing IBs alongside traditional resource allocation systems and service provision were major challenges in all sites. Even sites that intended using the IB pilot to transform the whole of their adult social care provision recognised the need to operate parallel systems for significant transitional periods. Particular concern was expressed about the capacity to offer IBs while resources were still tied up in relatively long-term block contracts, especially in smaller authorities where overheads were proportionately greater.

Operating dual systems was also thought to inhibit change among front-line staff:

... whilst you're still carrying on and go the double running of the systems, it's very easy to lose people from – in terms of their buy-in, from people feeling it's more work and they're not quite sure where it's going.

(IB lead officer)

Most pilot sites reported major challenges in changing the attitudes and culture of care managers and other staff, regardless of which user groups were being offered IBs. However, particular resistance and aversion to risk was reported among some teams working with mental health service users and with older people.

Developing resource allocation systems was highly challenging – indeed, in several sites this was regarded as the single most difficult element of the pilot, regardless of whether sites had previous experience of *In Control*. Even by the end of the pilot in

late 2007, most IB lead officers either lacked confidence in the robustness of their RAS or argued that, on principle, it could not be used as a stand-alone tool:

If you move to a system that is rule-based and transparent, there is potentially more opportunity for challenge and therefore you have to be very confident in your system before you can roll it out and go public with it.

(IB lead officer)

I don't think you will ever get a RAS that is accurate enough to say this is an entitlement-based system ... I think it will only ever be indicative.

(IB lead officer)

Other widely reported difficulties included: managing change and perceived threats by in-house services; lack of time to work with external service providers to help them meet new demands; and the availability of appropriate support for IB users with mental health problems:

... a lot of people have got their individual budget, got their money in place, but haven't actually started new support because we haven't got the provider locally.

(IB lead officer)

Finally, all the IB lead officers drew attention to the frustration they had experienced in trying to integrate additional funding streams into IBs. Considerable amounts of time had been invested in this aspect of the pilots, but IB lead officers felt that appropriate support by central government had not been forthcoming:

Sites shouldn't have been left to struggle and waste so much time trying to integrate funding streams locally when national legislation meant that that was not possible.

(IB lead officer)

Sites' experiences of integrating or aligning other funding streams with adult social care are discussed in Chapter 8.

### **2.5.3 The impact of pilot status**

The pilot status of the IB projects had some significant impacts on the ways in which IBs were implemented in the pilot sites and these impacts, in turn, could influence the outcomes of IBs.

#### **2.5.3.1 National policy developments**

At the time of bidding to be an IB pilot, the longer-term direction of policy was unclear; sites therefore made the decision to pilot IBs in a context of some

uncertainty about the future. Although much of this uncertainty had been resolved by the time IB lead officers were interviewed towards the end of the pilot period, it had nevertheless had an impact on implementation, in particular allowing some staff to opt out of change:

Calling it a pilot was a real big mistake I think because. ... It gave people permission to think I can just get on with my work and I won't be affected by any of this.  
(IB lead officer)

Moreover, national policy announcements on the future of personalisation during the pilots were thought to have added to confusion and uncertainty about the status of the pilots:

... early on there was a kind of competing message which ran against people's understanding of what a pilot would normally be. ... The consensus here was that they were happy with something that would run on a small scale, experimentally, as a test pilot. ... And suddenly finding themselves in a position where actually this was the first stage of a major transformational programme, potentially.  
(IB lead officer)

Additional problems were reported because of the short timescale for implementing IBs and particularly the pressures to offer the first IBs before a robust RAS had been finalised. Several IB lead officers considered that a three-year pilot would have been more appropriate, given the major changes involved for users and staff alike:

I'm talking about the people out there, people's lives, getting on with their jobs and needing support, having challenges in life, you know. Two years to make that shift is not a very long time really for a lot of people and for staff to get up to speed and support them to do that.  
(IB lead officer)

Research and development activities commissioned by Department of Health, Care Services Improvement Partnership and other Government Departments during the pilots also prompted frustration at the additional demands on key personnel, although in some instances this had helped sites to clarify aspects of their own processes.

### **2.5.3.2 The IBSEN evaluation**

The IBSEN evaluation also affected implementation of IBs. With each user group, sites had to recruit a target quota of users to the evaluation; this requirement shaped local implementation activities and also created some difficulties. For example, new referrals were quickly discovered to be less likely to refuse the offer of an IB than existing service users and some sites therefore focused more on offering IBs to the former. The randomisation demanded by the evaluation also prevented one site trialling IBs with people in a supported living scheme. Another site was unable to

move as many people from residential to community-based settings using IBs as had been expected, because the length of time required to plan and implement this transition was difficult to accommodate within the timescale of the pilots and the evaluation. A third site claimed that, without the requirement to randomise, they would have offered an IB to every service user.

### **2.5.3.3 The role of CSIP**

Throughout the pilot project, sites received support individually and collectively from the Care Services Improvement Partnership. CSIP's programme of national conferences and regional workshops was well received, as was CSIP's capacity to raise local problems with relevant national organisations and policy makers. However, many IB lead officers were critical of the apparent close relationship between CSIP and *In Control* and the extent to which *In Control* approaches therefore shaped the implementation of IBs:

I think they've really missed a trick by focusing so clearly on *In Control*. There's more than one way to deliver personalisation and I think ... that because they had people with a level of expertise and a familiarity with *In Control*, the thinking was so blinkered.  
(IB lead officer)

I think it really stifled creativity. ... It would have been so much better to have given sites absolute freedom to start from scratch, a blank piece of paper and see what we came up with.  
(IB lead officer)

Particular concerns were expressed about the relatively limited evidence base underpinning *In Control's* approach to resource allocation; and about the fact that learning from *In Control* was not readily transferable to groups other than learning disabled people.



## **Chapter 3      The Evaluation Design**

### **3.1 Introduction**

This chapter summarises the design and implementation of the IB pilot evaluation. Detailed accounts of the methods used in the different strands of the evaluation including the design of the randomised controlled trial, theoretical frameworks adopted, sampling strategies used and approaches to data analysis are contained in the appendices.

### **3.2 Aims and objectives of the evaluation**

The overarching aims of the evaluation were to:

- Identify whether IBs offer a better way of supporting older people and other adults with social care needs, compared to conventional methods of funding, commissioning, and service delivery; and to assess the relative merits of the different models of IBs.

Specific aims were to:

- Describe the processes of implementing IBs, including identifying those factors that facilitate and inhibit implementation and the potential implications for sustainability and roll-out.
- Assess the effectiveness and cost-effectiveness of different models of implementing IBs for different groups of service users, compared to standard approaches to funding, commissioning and delivering services.
- Assess the experiences of IBs among different groups of service users and carers.
- Assess the wider consequences of IBs for adult social care and other services.

### **3.3 The context of the evaluation**

From the start, evaluating the pilots was recognised to be challenging. The pilots covered 13 local authorities, each with its own distinctive context and history, patterns of service funding, provision and delivery, and approaches to the implementation of IBs. In relation to the latter, the pilots also aimed to offer IBs to different user groups (and combinations thereof); to integrate different funding streams into local IBs; and to offer different options to users for deploying their IBs. All these factors are likely to affect the outcomes of IBs, including their acceptability to users; the implications for service commissioners and providers; and their wider

organisational and resource consequences. A simple research design was therefore unlikely to capture the complexity of the contexts, processes and outcomes involved.

Further, the research had multiple aims requiring different approaches. For example, to estimate the overall effect of IBs requires a form of quantitative impact assessment: are outcomes better for (which?) IB holders than those they would have achieved without the budget? Other research questions demanded a focus on the development and shaping of the different IB models that emerged, and collection of a broad range of perspectives of the processes being used.

For these reasons the evaluation adopted a multi-method approach drawing on the qualitative and quantitative research strengths of the five participating universities. In this report, quantitative data are broadly used to provide a numerical assessment of the impact of IBs on service users (or on care managers' time-use, in the workforce strand of research) and is interrogated using statistical techniques to assess whether findings are significant and can be relied upon. Qualitative data is used in two ways. First, it describes the mechanisms, contexts, processes and other factors that shaped the implementation of IBs. Secondly it offers important interpretive insights that help to understand and explain the quantitative findings<sup>2</sup>.

The strengths of these approaches are greatest in those sections where qualitative and quantitative methods are brought together. In our investigations of the impact of IBs on service users in particular (Chapter 6) we present a quantitative assessment of the impact of IBs on user outcomes, together with a qualitative understanding of why and how these effects come about.

The following section summarises the research design adopted.

## **3.4 Summary of evaluation design**

### **3.4.1 Randomised controlled trial**

The Department of Health, in discussion with HM Treasury, commissioned IBSEN to use the most robust evaluation design possible in assessing the costs and outcomes of IBs. We decided to adopt a Randomised Controlled Trial (RCT); within each site, potential users were randomised so the IB group all continued to receive standard social care support.

The problem with many evaluations that investigate the outcomes of those taking up an 'intervention' - and compared with not taking it up - is that they can create biased results due to 'selection effects'. This is because those selected for the intervention

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<sup>2</sup> Further detail of the combined strength of quantitative and qualitative data is found in Appendix A.

(either chosen by those implementing the pilot, or 'self-selected' if access is through individual choice) are usually people who:

- are more likely than average to benefit from the intervention being tested, and/or
- would achieve better outcomes than average anyway, even without the policy.

These biases tend to overstate the true effects of the policy being evaluated.

An RCT, by contrast, is able to mitigate this bias by randomly allocating service users to either an 'intervention' or 'comparison' group, and not permitting any selection by individual service users or others. This approach is therefore most able to compare 'like with like'.

Despite this strength, two unavoidable drawbacks remain. First, the evaluation could only allow IB holders (and comparison counterparts) six months from consent before outcome data was collected. A longer time period over which to assess the impact of IBs would have been highly desirable, especially since some of this period would be required to actually put the IB in place and commission new services. However, six months was the maximum that could be accommodated within the constraints of a two-year evaluation project.

Secondly, the trial cannot prevent inevitable 'pilot effects', whereby pilot initiatives are conducted in contexts that are not replicated in roll-out. These effects arise for a variety of reasons, including:

- The IB pilots received extra focus and attention - from national and local government and media, the general public, and other stakeholders - that may have motivated implementers more than would occur in roll-out<sup>3</sup>.
- The IB pilots have had to contend with many implementation barriers, from which lessons can be learned for roll-out.
- Each pilot LA voluntarily applied for pilot status and therefore may be different to other authorities that did not apply, especially in terms of relevant contextual factors, motivations and priorities.

Although these effects do not all work in the same direction, it is generally recognised that pilot effects tend to imply greater benefits from the intervention than subsequently observed in roll-out. Further discussion of how the findings should be interpreted – alongside other potential limitations - is reserved for concluding chapters.

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<sup>3</sup> Service users can also be influenced by the pilot nature of the intervention. In many drug trials it is possible to 'blind' the participant as to whether they are receiving the real drug or a placebo, which is of course not possible in a social care setting.

### **3.4.2 Implementing the RCT**

Twelve of the 13 pilot sites used a simple web-based tool to randomise potential IB users. The thirteenth site planned to offer IBs to people making major transitions in their service arrangements, so randomisation was not considered appropriate in this site. Each of the 12 randomising sites were given a target number of potential users who were to be randomised and from whom consent to enter the trial had to be obtained. Sites' target numbers were calculated according to the scope and anticipated scale of the pilot in their area. The size of each user group to be recruited to the study was calculated in order to yield adequate statistical power for the subsequent analysis. A total of 1,336 service users were to be recruited to the study; this was expected to yield a final 'achieved' sample (after drop-out and other attrition) of 1,000 people.

The RCT then required the following steps:

- Structured baseline data was collected by local authority staff about the circumstances and current support arrangements (including costs) of members of both groups.
- Members of the IB group were offered an IB, whilst members of the comparison group received standard services.
- For the IB group, information was obtained from local authorities on content and costs of the support plans that had been agreed.
- Members of both groups were asked to participate in an interview after six months by a specially trained interviewer using a structured interview schedule, to see how far their needs were being met and to obtain data on other indicators of health and well-being<sup>4</sup>.

### **3.4.3 In-depth examination of IB processes from users' perspectives**

The evaluation also conducted semi-structured interviews with sub-samples of people from each of the 13 pilot sites who had been randomised to the IB group, two to three months after being offered an IB. In all, 130 interviews were conducted. These interviews explored: service users' knowledge and expectations of IBs, compared to their previous support arrangements; their experiences of the IB assessment and support planning processes; the help they received with these; and their early impressions of using IBs.

Both the structured outcome interviews and the semi-structured interviews of users' early experiences covered all the main groups of service users being offered IBs and

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<sup>4</sup> The outcome measures used are introduced in Chapter 6 alongside the findings, and are described in more detail in Appendix C.

included people who needed support to take part in research interviews. Where a service user was not able to take part because of severe cognitive or communication impairment, even with support, an interview was conducted with a proxy - usually a family member or support worker - but every effort was made to involve the service users themselves.

#### **3.4.4 Pilot sites' experiences of implementing IBs**

The third strand of the evaluation covered: the organisational, cultural and professional changes experienced by local authorities, service providers and by partner agencies contributing funding streams to IBs; the challenges experienced; and how these could be overcome. This strand of the evaluation involved:

- Semi-structured interviews with IB project leads in all 13 sites near the beginning and towards the end of the pilots.
- Semi-structured interviews with other managers in the pilot sites who were responsible, respectively, for service commissioning and for developing Resource Allocation Systems (RAS); and with staff in organisations providing support planning and brokerage services in seven of the pilot sites. In addition, interviews with managers responsible for other funding streams contributing to IBs and with a sample of service providers were conducted in four of these sites.

#### **3.4.5 Workforce experiences, training and risk**

A final strand of research investigated the impact of IBs on the workforce, training and adult protection. Appendix B provides further detail of the methodology adopted, though briefly it involved:

- Interviews conducted with front-line care management staff and first-tier managers (along with one 'impromptu' discussion group with team managers in one site) in all 13 pilot sites about the impact on their workloads, job satisfaction and training needs.
- The collection of time diaries from front-line care managers.
- Interviews with training officers and with staff responsible for adult protection policies in the 13 pilot sites about the implications and impact of IBs.

Despite the broad range of experiences assessed, it should be noted that the evaluation team was not commissioned to include the views of central government departments or the CSIP implementation team, although the findings are set in the context of their activities, and the evaluation methods, processes and findings have been extensively discussed with them. Further, the impact of IBs on carers is not included here as this is the subject of a separate report to be published later in 2008.

## **3.5 Challenges in implementing the evaluation design**

Despite the careful planning of the evaluation design, its implementation was challenging and some modifications had to be made in the course of the evaluation.

### **3.5.1 RCTs in social care**

Randomised controlled trials are rare in social care and there were some local reservations about both the ethical and practical aspects of the design. For example, some service users who had been assigned to the comparison group were reported to have pressed their care manager for an IB immediately rather than in six months time. Some local authority staff were uncertain about the acceptability of withholding a form of support that might be better than current arrangements.

The research team attempted to address these issues through discussions with pilot site staff and clear written assurances and explanations were sent to each site. The assurances stressed the ethical clearances that the research had obtained (see below). Further, it was emphasised that, for members of the comparison group, opportunities to have an IB were only delayed, not denied; as soon as they had completed their outcome interview they could be offered an IB. For some sites, this phased approach was in any case consistent with their gradual implementation of the new initiative.

### **3.5.2 Delays to the implementation timetable**

The pilots took far longer than DH originally anticipated both to set up the very first IBs, and then to make progress in generating larger numbers of budget holders. This had substantial effects on the evaluation.

First, it meant that sites were under increasing pressure to achieve their target numbers of registered and randomised potential IB users by a deadline of 30 June 2007<sup>5</sup>. Rather than an evenly-spread collection of consents across 12-18 months, approximately two-thirds of the required consents were obtained between March and June 2007. The consequence was that the six-month outcome interviews were heavily concentrated in the latter months of that year.

Challenges in implementing IBs also meant that some people who had been randomised to the IB group also experienced delays in the assessment, resource allocation and support planning processes - compounding the problem noted above

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<sup>5</sup> This deadline was set to allow the six-month outcome interviews to be conducted before the end of December 2007.

of the short six-month window in which to observe outcomes. Consequently, a significant number did not have an IB agreed, or their new support arrangements in place, by the time their six-month outcome interview was carried out. Of those who did, some had only had an IB in place for a short period. More details are presented in the next chapter.

Other factors also reduced the number of people who had had experience of an IB by the time their six-month interview was conducted. Some people who had been randomised to the IB group subsequently chose to continue with their current services instead; some were withdrawn from the IB group by care managers as a result of major changes in their circumstances; and others had their IBs delayed due to ill health. Some people who had agreed support plans nevertheless experienced delays in setting up their new support arrangements, for example because of difficulties in recruiting personal assistants.

Finally, it is important to note that key features of implementation were being developed, modified and improved across the course of the pilot. Although most of the service user interviews took place towards the final few months of the pilot, the experiences of these users may differ from earlier interviewees by virtue of changes to implementation during the intervening months<sup>6</sup>. In the same vein the evaluation can only assess the IB pilots after two years of early developments, and cannot capture any developments in processes, structure or outcomes made since.

### **3.5.3 Demands on local authorities**

The evaluation depended throughout on significant levels of help and support from local authority staff in the 13 pilot sites. Sites were asked to supply data on the circumstances and service use of both IB and comparison group members. Care managers, first-tier managers and project leaders were all invited to be interviewed as part of the research programme. In addition, IBSEN contacted all care managers again before a service user was approached for a qualitative or six-month outcome interview, to check that there were no adverse changes in the user's circumstances (e.g. illness, hospitalisation) that would make contact inappropriate, and to check whether there were any safety issues to be taken into account in arranging the interview.

All of these demands were made at the same time as front-line staff in the pilot sites were themselves dealing with the challenges of new ways of working. In addition, sites were also asked to participate in other development activities commissioned outside of the IBSEN programme by CSIP and government departments.

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<sup>6</sup> Note that the very first tranche of service users from each pilot site were, nonetheless, excluded from the pilot whilst systems were particularly embryonic.

To assist with planning their contribution to the evaluation, each pilot site agreed with IBSEN a 'Research Timeline', establishing the timetable for each evaluation activity within the authority. Further, CSIP offered additional resource (in addition the financial support provided to each site by DH to support implementation) to each pilot site to assist with data collection, and in each site a named individual responsible for data collection was identified.

### **3.5.4 Policy changes**

A series of evolving policy decisions and directions accompanied the pilots. In October 2006 the Minister for Social Care, Ivan Lewis, announced that the pilots represented the future direction of social care. This changed the emphasis of the evaluation from one of testing if IBs work to assessing the different models of implementation for a future roll-out. It also proved harder from this point to convince pilot sites to maintain their engagement with the evaluation, as many then felt that the policy direction was a foregone conclusion.

The Department for Work and Pensions also commissioned a review of the Independent Living Fund in July 2006, which was published in March 2007. However, decisions on the many recommendations contained in the review were delayed pending the outcome of the pilots.

There were also local policy changes that affected the implementation of IBs and the evaluation. Some pilot sites decided during the course of the evaluation to extend IBs to other groups of service users than those originally targeted. Other pilot sites decided to adopt a 'total transformation' policy, involving the extension of personalised approaches to their entire adult social care service provision. There was a marked tightening of Fair Access to Care Services (FACS) eligibility criteria during the pilots in some authorities which led to some IB and comparison group members withdrawing from the evaluation as they were no longer eligible for local authority-funded adult social care.

## **3.6 Ethics and research governance approvals**

Care was taken in designing the evaluation to ensure that all participants, from service users to front-line practitioners, senior local authority managers and managers in external partner organisations, were given full information about the study; were aware of their right to refuse or withdraw from the study at any time; and were fully aware of the confidentiality with which all data would be treated. Consent to participate in the evaluation was obtained from all service users in both the IB and comparison groups before any baseline data about their circumstances and service use was collected for the evaluation, and then again at the interview.



All participants were assured that data obtained from or about them would be treated in absolute confidence. Recordings of interviews will be destroyed after the final report has been completed and accepted by the DH. All electronic data was held and transmitted in password-protected files; hard copy data was sent by Royal Mail Special Delivery; and other Data Protection safeguards were adhered to. All interviewers having direct contact with service users were carefully selected, trained, supervised and had recent, enhanced, Criminal Records Bureau checks.

Formal approvals to conduct the evaluation were obtained from:

- Research Committee of the (then) Association of Directors of Social Services.
- York Hospitals Trust NHS Multi-Site Research Ethics Committee (MREC).
- Research Governance Committees in each of the 13 pilot sites.

The evaluation was approved unconditionally by York MREC. However, each pilot site had different procedures and criteria for granting Research Governance approval and subjected the evaluation proposal to varying degrees of scrutiny. Negotiating ethical and research governance approvals proved to be very time consuming.

### **3.7 User and carer Advisory Group**

An Advisory Group of service users and carers was recruited through existing contacts and networks with which the research team had prior involvement. The Group comprised a variety of people with experiences of social care, including people with experiences of direct payments and of using other funding streams involved in the IB Pilots (e.g. Access to Work), and carers. They came from a mix of urban and rural settings and different age groups. The Group included older people, parents of adult children with complex disabilities, people with physical and visual impairments, people with mental health problems and carers. The Group met three times during the course of the evaluation and members were also consulted from time to time between meetings. The Advisory Group was consulted on some of the practical and ethical challenges encountered in implementing the evaluation design, including interview methods and communication styles; and on emerging findings from the evaluation.



## Chapter 4 The Sample of Service Users

### 4.1 Introduction

This chapter introduces the evaluation sample to inform interpretation and understanding of the analysis that follows in Chapters 5-7. The chapter is structured as follows:

- an account of how the sample was derived
- a description of the interview process
- the characteristics of the sample
- an analysis of potential bias in the sample, including:
  - How similar the IB and comparison groups are
  - Whether the overall sample is representative of the national population of social care users.

### 4.2 Background to the sample

This section describes how the sample was derived, including an outline of the randomisation, consent, sample attrition and interview processes.

#### 4.2.1 Randomisation, consent and attrition

From July 2006, 12<sup>7</sup> pilot sites began registering service users with the trial through a simple web-based portal that collected basic characteristics and randomly assigned service users to either the IB or comparison group. Up to June 2007 a total of 2,521 service users were approached by pilot sites to request their participation in the research; a total of 1,594 (63 per cent) agreed to take part.

For each person granting consent we requested that pilot sites complete 'baseline' data (either electronically or paper copy) and returned this to IBSEN. For those in the IB group additional information was returned relating to the details of their IB allocation and subsequent support plan.

In addition to details of service user characteristics and service use, the baseline data also contained name and contact details. However there were significant delays in returning baseline data to IBSEN, so that only 1,356 (of the 1,594 with consent) baseline forms were available to the interviewing team in sufficient time to complete

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<sup>7</sup> One site was excluded from the randomisation and therefore did not have quotas to reach as noted in Chapter 3.

all the six-month outcome interviews by the end of 2007. A further 129 service users were not subsequently approached (mostly because they became ineligible for services at a review, or because they had passed away) and 221 did not wish to, or could no longer (e.g. due to illness) take part in the research<sup>8</sup>.

A total of 1,006 outcome interviews were completed. However five service users were removed from the sample as they had not been randomly allocated and a further 42 records were excluded as they could not be matched to a randomisation record.

Therefore 959 service users constitute the total evaluation sample for the quantitative analysis.

#### **4.2.2 The six-month outcome interviews**

Outcome interviews were conducted with both IB and comparison group members asking a range of questions relating to their experiences of services and measures of social care outcomes. Most of the interviewing was conducted by a team of sessional interviewers recruited by the University of York and specially trained on using the questionnaires and on interviewing techniques. Of the 959 completed interviews for which we have sufficient baseline data for analysis, 871 (91 per cent) were conducted face-to-face with the remaining 88 (nine per cent) conducted by telephone.

In setting up face-to-face interviews, IBSEN sought to interview the service user directly wherever possible and offered them the option of being interviewed on their own or with support. When the service user was unable to supply information, or when they preferred not to take part directly in the study, the interviews were conducted through a proxy<sup>9</sup>. Seventy-six per cent of interviews were conducted wholly or partly with the service user, and the remaining 24 per cent conducted entirely through a proxy.

The research team aimed to interview service users six months after they gave consent (IB group), or after their most recent social care review (comparison group). However the significant delays identified in Chapter 3, together with service user preferences for dates (especially in summer months) and other logistical difficulties, meant that there was considerable randomisation in the time between recruitment to the study and the outcome interview (Figure 4.1<sup>10</sup>).

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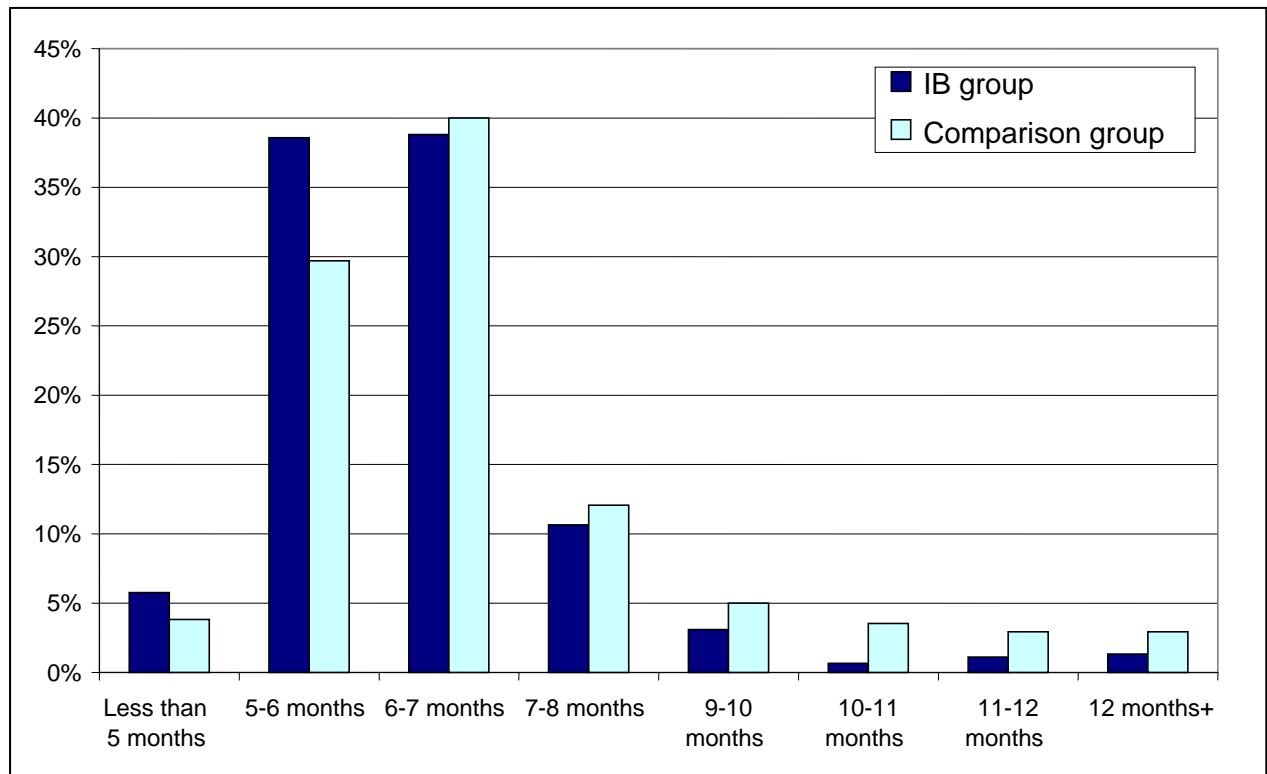
<sup>8</sup> More detail is presented in Appendix A.

<sup>9</sup> Proxy consent to the research was permitted where the care co-ordinator obtaining consent felt that the service user did not have capacity to consent.

<sup>10</sup> All ambiguous dates have been omitted from this figure.

In both groups the interviews were concentrated between five and seven months after giving consent, with an average of 6.2 months for the IB group and 6.7 for the comparison group. Comparison group interviews were more likely to be 'late' because of additional complications in one site which planned to roll out IBs quickly to all service users. In this site comparison group users were interviewed as soon as they gave consent (before they were offered an IB automatically in the site's roll-out), but this was often far longer than six months after their last review.

**Figure 4.1 Months elapsed between consent and interview**



### 4.3 An overview of the sample characteristics

#### 4.3.1 Randomisation outcome and primary user groups

As would be expected from a randomised process, the 959 service users are quite evenly distributed between the IB and comparison groups: 53 per cent (510) and 47 per cent (449) respectively.

Table 4.1 shows the spread of the sample across primary user groups. Mental health service users constitute only one in seven of the sample but this still represents a greater proportion than in the population of social care services users

as a whole, and only marginally less than the proportion of the quota<sup>11</sup> set for mental health (16 per cent).

**Table 4.1 Distribution of the sample between primary user groups**

	<i>Count</i>	<i>Percentage to total sample</i>
Physical disability	327	34
Older people	263	28
Learning disability	235	25
Mental health	131	14
<b>Total</b>	<b>956</b>	<b>101*</b>

Note: \*due to rounding.

#### 4.3.2 Age, gender and ethnicity

Table 4.2 combines information on age, gender and ethnicity. As expected, people with learning disabilities are the youngest, on average, of the working age groups. Women constituted the majority of older people and physically disabled service users, but a minority of learning disabled and mental health users.

Eight per cent of the sample were from Black and Minority Ethnic (BME) groups, with proportionately more amongst people with physical and learning disabilities. Across the sample as a whole Asian, Black and 'Other' ethnic groups amounted to approximately two per cent each, with people of mixed ethnic groups accounting for a further one per cent.

**Table 4.2 Average age, ethnicity and gender of the sample**

	<i>Mean age</i>	<i>Per cent female</i>	<i>Per cent BME</i>
Physical disability	54	63	10
Older people	81	66	5
Learning disability	34	42	11
Mental health	49	46	5
<b>Total</b>	<b>57</b>	<b>56</b>	<b>8</b>

<sup>11</sup> The quota system is explained in Chapter 3.

### 4.3.3 Household composition and informal carers

Three hundred and seventy-one (39 per cent) service users in the sample lived alone. Of the 587 (61 per cent) that lived with someone, 511 reported that a co-residing person was also their carer. Seven hundred and sixty-six (80 per cent) service users lived in a private household, 88 (9 per cent) in a sheltered/extra care setting and 14 (1.5 per cent) in a care home. For 90 people (9.4 per cent) this information was missing.

### 4.3.4 Activities of Daily Living (ADLs)

Data collected on the severity of need for the sample across 12 activities of daily living at baseline showed that approximately three-quarters of the sample needed regular help with shopping and housework and two-thirds needed help with cooking. A small minority of service users required assistance with feeding, and a little over a quarter needed regular help with toileting and washing their face/hands.

### 4.3.5 Previous social services support packages

We had information about the previous social services support package for 683 (71 per cent) of the whole sample, so less than a third of people in the study were new to social services. Overall, about a quarter of people had previously been receiving direct payments, and over two-fifths home care (Table 4.3).

**Table 4.3 Services received by those with a previous support package**

	<i>Count</i>	<i>Per cent</i>
Direct payment	177	26
Home care	294	43
Day care	51	7
Sheltered employment	8	1
Meals on wheels	11	1
Carer support services	79	12
Care home (with nursing)	5	<1
Care home (personal care only)	16	2
Breaks	65	10
Equipment	75	11
Childcare	7	1

Information was available about the total social services expenditure on previous packages for slightly more than half of the total sample. The average package cost £10,400pa but with a wide distribution spanning £100 to £72,500. Of those with a previous package receiving direct payments, the average annual cost was £10,300.

#### 4.3.6 Progress through the IB process at the time of the interview

The original evaluation design anticipated that all IB holders would be using their IB at the time of the six-month follow-up interview. However, IBs took significantly longer to be put in place than first anticipated.

Table 4.4 shows that around ten per cent of the IB group (52 service users) refused the offer of an IB (but still wished to take part in the research). Only 371 had reached the IB assessment stage, and only 280 had support plans in place. Just 231 - less than half of the 510 allocated into the IB group - had IB-funded support in place at the time of their outcome interview. The quantitative analysis to follow examines whether there are any differential effects associated with having a support plan for longer/shorter durations.

**Table 4.4 Stage of the IB process users reached at the time of interview**

	<i>Count</i>	<i>Percentage of total randomised to IB group</i>
<b>Total randomised into IB group</b>	<b>510</b>	<b>100</b>
(Agreed to IB)	(458)	(90)
Completed assessment <sup>12</sup>	371	73
Has support plan in place <sup>13</sup>	280	55
Has IB services in place	231	45

Of those with IB-funded support (231) at the time of the outcome interview, Table 4.5 shows the length of time this had been in place for at the time of the interview. Over half had been using their IB for over three months and a further quarter for at least a month.

<sup>12</sup> This is a proxy measure as this was recorded directly at interview. However, people who self-reported that they had not completed the assessment, and hence not yet been given an indicative budget, were not asked detailed IB questions. This number reflects the total people that were asked these subsequent IB questions.

<sup>13</sup> A further four IB 'refusers' returned support plans (presumably refusing to proceed only after the support plan was complete). These are excluded from this figure.



**Table 4.5 Length of time with IB funded support in place at the time of interview**

	<i>Count</i>	<i>Percentage</i>
Less than one month	24	10
Between one month and three months	58	25
More than three months	117	51
In place, but don't know how long	7	1.9
Not all in place yet	25	11
<b>Total</b>	<b>231</b>	

Of the IB refusers, there is some evidence that those who were previously aware of the level of funding (because they received direct payments) were more likely to refuse an IB, particularly those receiving higher levels of direct payments. This would fit with reports from authorities that people were turning down offers of IBs that led to a drop in the value of their direct payments or services.

#### 4.4 Representativeness and sources of bias

Understanding the composition of the sample is crucial in determining the validity of the subsequent analysis. Two features are of particular importance:

- Are the IB and comparison groups similar? For any attribution of effects to 'the intervention' to be reliable, the only difference between the IB and comparison groups should be the offer of the IB itself. If this condition is met, the sample can be considered 'internally valid'.
- Is the sample representative of the population of social care users? Even if the results are valid within our sample, can they be generalised to the population of social care users as a whole? If this condition is met, the sample will be 'externally valid'.

An understanding of both dimensions of potential bias is important to both the quantitative and qualitative investigations that follow this chapter.

##### 4.4.1 Are the IB and comparison groups similar?

Whilst randomisation should ensure that both groups have similar characteristics within the overall sample, some differences can occur. For example, if consent or sample attrition before the interview is more associated with (say) the IB group, and the characteristics of these people are not random, then our sample may be skewed.

Further, even carefully controlled clinical trials can find differences between ‘treatment’ and ‘control’ groups just by chance (Hoch *et al.*, 2002).

However, all tests conducted on a wide range of personal characteristics, service use and costs at baseline (including those characteristics detailed in section 4.3) found no significant differences between the IB and comparison groups, with the sole exceptions of prior receipt of carer support (where levels of service receipt were in any case very low in both groups) and whether the user posed a risk to others<sup>14</sup>.

#### 4.4.2 Representativeness of the sample

The previous section demonstrates that the IB and comparison groups appear to be similar in terms of key observed characteristics at baseline. A second and related question is whether the range of users in the study is representative of the population of social care services users in England.

There are several reasons why our sample may not be representative of the population of community (i.e. excluding those in residential care) social care service users as a whole. In particular this could be through pilot sites selecting or excluding specific types of service users to be put forward for the trial<sup>15</sup>. An unrepresentative sample may also result from non-response and sample attrition discussed above.

Informed by evidence of selection noted above, but limited by the available data<sup>16</sup>, we tested the representativeness of our sample against measures of:

- **Ethnicity** (because there was some evidence of targeting BME groups, but also some anecdotal policy concerns that take-up of IBs may be low among these groups). We found that Black and Minority ethnic groups are well represented in our sample; eight per cent of the IBSEN sample are from BME groups, compared to six per cent nationally, and five per cent of all service users within the pilot sites.
- **Previous use of direct payments** (because of evidence of sites wanting ‘quick wins’ and DP service users being likely to be the easiest to ‘convert’ to IBs). Twenty-six per cent of our sample (who had a previous care package) were using direct payments when recruited to the trial. This compares with just four per cent nationally. The main source of this difference is amongst physically disabled people, with 43 per cent having prior DP use compared to 13 per cent nationally.

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<sup>14</sup> Higher proportion in the comparison group,  $p=0.05$ ).

<sup>15</sup> Notwithstanding the discussion in Chapter 3, a form of selection is possible in this RCT in that all people put forward to the trial could, potentially, have been chosen before they are then randomised. Whilst most sites offered **all** (eligible) service users the option to be part of the trial (at the point of their annual review), there was nevertheless some evidence of selection.

<sup>16</sup> Discussed in Appendix A, alongside further details of the results of these tests.

- **Level of help needed with activities of daily living** (mixed evidence that very frail older people may have been excluded, but also that people needing high-cost packages were being targeted for inclusion in the trial while people needing only small packages (like equipment only) were being excluded). Older people in our sample were more likely to receive intensive home care: 36 per cent of our sample who received home care at the time of being recruited to the study received over ten hours of home care per week, compared with 26 per cent nationally; and were more likely to require assistance in five out of seven activities of daily living compared with national estimates.

The over-representation of direct payment users in our sample is particularly important, and can be hypothesised to have two effects on the results of the study. First, direct payment holders will be more used to the notion of controlling their own budget for support. They are arguably more likely to have positive attitudes towards, and may find it easier to manage, an IB. This will most likely make the transition to IBs quicker; indeed, people with prior use of direct payments were more likely to have had their IB in place at the point of their six-month outcome interview, and for a longer period of time. Secondly, given the similarities between direct payments and IBs, the relatively high proportion of direct payment users in our sample may result in smaller differences between the IB and comparison group in costs and outcomes that are attributable to IBs than may have been observed in a more representative sample.

To address this, the quantitative modelling of outcomes in Chapter 6 includes 'interactions' to explore if people with and without prior use of direct payments experienced different IB effects. This will allow us to provide evidence on how the effects of IBs on roll-out to the whole population of social care service users may be different from the sample in this evaluation. It may be, however, that some unobservable effects remain uncontrolled for in the analysis, such as a greater motivation for self-directed support or differences in personal aspirations within the study sample, that may not be true of the population as a whole.

## **4.5 The sub-sample of qualitative interviews**

As described in Chapter 3, the evaluation aimed to conduct semi-structured interviews with a subsample of 130 people from the IB group who had been offered an IB approximately two months earlier. The aim of these interviews was to explore experiences of (self-) assessment and support planning and, where appropriate, the early outcomes of using an IB, without incurring significant problems of recall. Appendix A sets out the sampling process in more detail.

Interviews were conducted across all 13 pilot sites with 32 people with physical disabilities and/or sensory impairments, 38 people with learning disabilities, 20 people with mental health problems, and 40 older people. The age distribution of interviewees demonstrates a good spread: 20 people aged 18-24 years, 66 people aged 25-59, 18 people aged 60-74 years, and 26 people aged 75 years and over. Seventeen interviewees within the qualitative study were reported to have had previous experience of direct payments and 21 to have had previous experience of *In Control*, though many of these had no knowledge of any self-directed support prior to being offered an IB.

However, at the two-month stage we did not interview as many people from BME communities as we intended. The aim had been to interview 90 White people; 20 Asian people; and 20 Black people. However, the 130 interviewees actually consisted of 118 White people, three Asian people, six Black people and three people defined as 'Other'.

## **Chapter 5      Who Got What**

### **5.1 Introduction**

A key principle of the IB arrangements across the pilot sites was to allow different streams of funding to be combined into a single budget, which individuals were then allowed to control. A range of ‘control options’ was available, including direct payments, the local authority, an independent agency or a combination of options. The aim was to provide transparency about resources, and to enable people to negotiate and purchase support in a way that best met their own desired outcomes.

In this chapter we describe the level and sources of funding of IBs, the content and management of support plans, and the degree to which individuals are taking advantage of the flexibility to spend their budget in innovative ways. We also compare these spending patterns with the type of support commonly purchased through an ‘ordinary’ direct payment system.

### **5.2 Method**

Most of the information about the level, sources and use of IBs was drawn from the support plan records, which were requested for all IB holders. In-depth interviews with a subsample of 130 people who had been offered an IB were also conducted to explore their first experiences of the new processes.

### **5.3 Size and sources of IBs<sup>17</sup>**

#### **5.3.1 Size of IBs**

Pilot local authorities supplied 285 support plan records with the total IB amount indicated. Over a third (38 per cent) of the support plan records were missing or unavailable for people who had accepted the offer of an IB. No significant differences were found between people for whom we had and those for whom we did not have a completed support plan record in terms of gender, user group or ADLs.

The average gross cost of an IB was about £11,450 (median £6,610; standard deviation £15,810; minimum £72; maximum £165,000)<sup>18</sup>. On average approximately

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<sup>17</sup> In presenting values we have rounded to the nearest £10.

£11,760 was for annual recurrent funding (n=278; median £6,580; standard deviation £16,860)<sup>19</sup> and £1,260 for one-off payments (n=46; median £675; standard deviation £1,500).

The average gross value of IBs for people with learning disabilities was significantly higher (mean £18,610, p<.001) and had a higher amount of recurrent funding (mean £18,470; p< 0.01) when compared with the other three user groups (Table 5.1).

**Table 5.1 Average IB by service user group including mainstream and one-off payments**

	<i>IB Holders</i>			
	PD N=94	LD N=72	MH N=35	OP N=81
<b>Individual budget</b>				
Mean ***	£11,150	£18,610	£5,530	£7,860
Median	£6,550	£11,150	£4,860	£6,300
Standard deviation	£14,540	£24,140	£3,930	£6,030
Minimum	£72	£137	£140	£224
Maximum	£83,840	£165,000	£18,290	£27,410
<b>Recurrent annual</b>				
% (N)	100 (94)	100 (72)	88 (31)	96 (78)
Mean **	£11,780	£18,470	£5,270	£8,030
Median	£6,160	£11,150	£4,470	£6,350
Standard deviation	£17,350	£24,130	£4,060	£5,970
Minimum	£72	£137	£140	£200
Maximum	£108,680	£165,500	£18,290	£27,410
<b>One-off payment</b>				
% (N)	12 (12)	4 (3)	47 (16)	18 (14)
Mean	£1,220	£2,430	£1,740	£590
Median	£492	£3,084	£1,510	£280
Standard deviation	£2,060	£1,510	£1,400	£650
Minimum	£99	£700	£100	£15
Maximum	£7,420	£3,500	£4,500	£1,750

Note: Based on 285 support plan records.

Significance levels: \*\*\* p< 0.001; \*\*p< 0.01.

<sup>18</sup> Seven IBs contained only one-off payments. If we exclude the budgets containing only one-off payments, the average annual value of individual budgets is £11,600 (median £6,800).

<sup>19</sup> The recurrent annual funding included in the budget is slightly higher than the overall average because of the seven budgets that contain only one-off payments.

### 5.3.2 Funding streams

As would be expected, the majority of funding in IBs came from social services. Table 5.2 shows that, 282 (99 per cent) of the support plans contained information on social services expenditure (mean £9,980; median £6,320; standard deviation £13,910)<sup>20</sup>. Of the remaining streams, more people (31 in total; 11 per cent) got money from Supporting People (SP) than any other source, although the value of funding was highest from the Independent Living Fund (ILF) (mean £15,640; median £16,420, standard deviation £7,820). Only one budget included funding from Access to Work (AtW). Although possible in principle, no IBs included funding from the Disabled Facilities Grant (DFG). As explained later (Chapter 8) monies that would have been in ICES budgets were not usually identified as allocated at an individual level at the point of support planning, but two per cent of IBs (five people) were identified as including ICES funding. Four support plan records reported that additional funding came from the education service.

There was some variation in use of different funding streams across service user groups. Compared to other user groups, older services users with IBs were less likely to draw on funding from SP and people with a mental health problem more likely to do so (Table 5.2). Eligibility criteria would explain why these groups did not make use of ILF funds (although one older person was reported to use funding from this source).

The question arises whether this apparently limited use of the other funding streams represents an increase in take-up overall. We did not have a lot of information about the use of funding sources prior to the IB Project. Authorities participating in the pilot only supplied information about the use of funding sources other than social services for 20 per cent of people in the IB group and 28 per cent in the comparison group. However, the information available about these individuals revealed some indicators about take-up and an interesting pattern of integration (or non-integration) of funding streams.

In the group that accepted IBs, 25 people had been identified as previously receiving SP funding. We had information about the subsequent IB for 12 of these people: only five had the funding stream integrated into their budget, and for the other seven either the funding had ceased or the funding was treated separately. SP funding was obtained and integrated into the budget for another 25 people, leading to an overall increase in the rate of use of this funding stream. On the (admittedly strong) assumption that where SP had not been identified previously it was not being received, overall take-up rose among users of social services from about five per cent to 11 per cent. At the six-month interview point, 13 per cent (54) of people in the

<sup>20</sup> Three people were not receiving recurrent social care funding. One person was privately funding their services, one person was only receiving funding from the ICES and the third person was only receiving funding from the ILF.

comparison group identified that they had heard about SP, and 18 per cent (10) of this group reported that they were receiving SP funding. Again, we need to be cautious in our interpretation as people may not be aware of the source of support that they receive.

**Table 5.2 Description of funding streams**

	<i>Overall IB sample N=282</i>	<i>PD N=94</i>	<i>LD N=72</i>	<i>MH N=35</i>	<i>OP N=80</i>
<b>Social service expenditure</b>					
% (N)	99 (282)	99 (93)	100 (72)	100 (35)	99 (80)
Mean ***	£9,980	£8,730	£16,230	£4,600	£7,940
Median	£6,320	£5,920	£10,410	£4,140	£6,320
Standard deviation	£13,910	£9,500	£23,180	£3,530	£6,010
Minimum	£57	£72	£140	£140	£57
Maximum	£165,000	£50,570	£165,000	£18,290	£27,410
<b>Supporting People</b>					
% (N)	11 (31)	13 (12)	8 (7)	29 (11)	<1 (1)
Mean	£2,400	£2,760	£2,420	£2,190	-
Median	£1,260	£960	£960	£1,400	-
Standard deviation	£4,160	£6,140	£2,730	£2,280	-
Minimum	£135	£468	£680	£500	-
Maximum	£22,230	£22,230	£7,410	£8,250	-
<b>Independent Living Fund</b>					
% (N)	8 (22)	11 (10)	14 (10)	0	<1 (1)
Mean	£15,640	£19,160	£13,860	-	-
Median	£16,420	£18,210	£15,670	-	-
Standard deviation	£7,820	£8,200	£6,190	-	-
Minimum	£120	£9,030	£120	-	-
Maximum	£38,760	£38,758	£20,700	-	-

Note: Based on 285 support plan records.

For ILF there were 31 people in the sample who were offered IBs, but six people – representing a disproportionately high proportion of ILF users – refused the IB. We had information about the subsequent IB for 19 of the 25 people who had previously been identified as receiving ILF. Of these, 14 had the funding stream integrated into their budget. Again, in five instances either the ILF funding had ceased or the funding was treated separately. New ILF funding was integrated into the budget for just eight people in our sample. At six months, 42 per cent (138) of the comparison group reported that they had heard of ILF. Among this group, 26 per cent (36)



reported that they were receiving ILF funding, which suggests that there is no evidence of higher levels of uptake in the IB group.

As identified above, only one individual had AtW integrated into their IB. However, six people, one of whom turned down the IB, had previously received AtW funding. Support plan information was available about all five people – in four instances the funding had either ceased or (more likely) was not integrated into the IB. No new AtW funding was identified in our IB sample.

## 5.4 IB deployment mechanisms and support planning process

In the majority of cases the IB was managed as a direct payment. In about half the cases (51 per cent; 144 people) the IB was paid as a direct payment into a personal bank account, and for a further 16 per cent (45) the budget was paid into a joint bank account of the budget holder and/or another person. The local authority organised services for 20 per cent (58) of budget holders. Thirteen per cent (37) had the budget administered through an agent and in one instance the budget was administered through a Trust. Just four people had their services organised through an individual provider. Three per cent (eight) people had their budget organised through other means, including the involvement of other family members and third party accounts. Twelve per cent (33) of people had their budget deployed in a variety of ways, including combining direct payments and the management of some of the budget by the local authority.

The findings in Table 5.3 show that people with a mental health problem (71 per cent) or a physical disability (69 per cent) were significantly more likely to opt for the choice of having their IBs transferred into their personal bank account compared with either people with a learning disability (29 per cent) or older people (39 per cent;  $p < .001$ ). People with a learning disability were significantly more likely to opt for the choice of having their IB transferred into a joint bank account (33 per cent) compared with people with a physical disability (less than one per cent;  $p < .001$ ) or older people (16 per cent,  $p < .001$ ). Eighteen per cent of people with a mental health problem opted for this choice. Overall, older service users were less likely to opt for the choice of having their IB as a DP ( $p < .01$ ).

Among people with a mental health problem, 26 per cent of services were commissioned by the local authority, compared with 22 per cent for people with a learning disability, 18 per cent for those with a physical disability and 20 per cent of services for older people. The difference did not reach statistical significance.

**Table 5.3 Description of IB deployment mechanism by service user group**

<i>Deployment options</i>	<i>PD</i>	<i>LD</i>	<i>MH</i>	<i>OP</i>
	N=94 % (N)	N=72 % (N)	N=35 % (N)	N=81 % (N)
Personal bank account(s) of the IB person***	69 (65 )	29 (21)	71 (25)	38 (31)
Joint bank account(s) of the IB person and another person/people***	<1 (1)	33 (24)	17 (6)	17 (14)
Administered through an agent	15 (14)	15 (11)	6 (2)	12 (10)
Administered through a Trust	0	1% (1)	0	0
Local authority	18 (17)	22 (16)	26 (9)	20 (16)
Individual service provider	0	3% ( 2)	3% (1)	1% (1 )
Other	2 (2)	6 (4)	3 (1)	1 (1 )

\*\*\* significance level  $p < 0.001$ .

Note 1: Based on 285 support plan records.

Note 2: Percentages add to over 100 per cent as some people used more than one deployment option.

Table 5.4 shows the involvement of IB holders and the types of support on which people drew in the support planning process. IB holders themselves were most frequently cited as leading and/or involved in the support planning process. Only in five per cent of cases was the IB holder not identified as either leading or involved. After IB holders themselves, local authority care managers were the most frequently identified as leading or being involved. A local authority care manager played a role in 73 per cent of cases. Families were cited as taking the lead in about a third of cases. Overall independent brokers, advocates, providers or other agencies were identified in about a quarter of cases. Predominantly this was through the use of independent brokers: in nearly a fifth of cases these people or agencies were identified as taking a lead in the planning process. Local authorities were also asked to identify who agreed the support plan. Only 34 per cent of IB users were identified as agreeing the plan but this may reflect different processes across the pilot authorities. An official authorising manager was identified as agreeing the plan in 55 per cent of cases.

**Table 5.4 Support planning**

	<i>Role in support planning process (N=285)</i>	
	Leading (%)	Involved (%)
IB holder	55	40
Partner	10	11
Son/daughter	9	14
Parent	14	13
Other family member	3	9
Friend	1	3
Independent broker/ advocates	18	13
Provider	2	8
Local authority care manager	35	38
Non-local authority care manager	5	5

Note: Percentages add up to more than 100 per cent as more than one party could be identified in each role.

## 5.5 Support plans

When first introduced, direct payments were seen as an important step in promoting independence and choice, but they have been criticised for their limitations, particularly the restrictions on what people are allowed to purchase. In contrast, people receiving IBs can choose to receive local authority services or can receive their IB in the form of a direct payment that they use to purchase a whole array of services to meet their desired outcomes, including services beyond the normal conventions of social care. Given this flexibility, we might expect to see innovative use of IBs, particularly when people receive them as direct payments, as a high proportion of our sample have elected to do, but also when they prefer the budget to be managed by social services or another agency.

### 5.5.1 Expectations and plans

After meeting needs other than personal care and meeting needs in a more individualised way, being able to choose one's own carers or employ informal carers was the second most common expected advantage of an IB. For many, this would mean consistency of care: carers could develop specialist knowledge of the user's condition and/or preferences about how they like their needs to be met; and users could build good relationships with carers that would ease some of their discomfort around personal care tasks and help them to enjoy any social activities:

We can control how the money is spent – spend it on getting the right person to care for him the way we want him to be looked after – rather than getting an agency carer who doesn't really care but is doing it for a wage.

(Proxy of older person)

I could have the same person, develop a relationship with them and it would improve my quality of life because it would mean that I would be able to get out into the community, whereas that wasn't offered with the previous care package.

(Person with physical disability)

[I] will have one or two carers providing care rather than lots of different ones provided by previous care agency to cover care hours.

(Person with learning disability)

The ability to pay informal carers was also perceived as a potential benefit. Some service users thought that making small payments to family members would make them feel less of a burden:

It'd be nice to have a bit of cash to give 'em as a treat.

(Older person)

So it wasn't anything different, it'd just be a case of I'd be getting a bit of money. So I thought OK, that sounds, you know, better than doing it for nothing ... cos I thought I'd get paid, my mum would have some money there that I could use for like shopping, getting her around, like petrol, cos it's me that gets her everywhere. She has appointments, the hospital, got to pay for parking, things like that. So I thought that it would cover everything, and I thought right, that'd be great, I don't have to worry any more.

(Daughter of an older person)

It'll be nice to have someone come and not feel that she's a burden, you know, a burden on anyone, you know, it's, she can pay them to come and see her and have a chat and things like that.

(Carer of a person with physical disability)

The ability to employ one carer or to pay informal carers was perceived to be particularly beneficial for those who needed familiarity and routines, for example people with early onset dementia, autism or certain other mental health or learning difficulties. The opportunity to pay an informal carer was felt to be a major advantage of IBs for those who refused to be cared for by non-family members. For example, one BME carer reported that her mother depended on her 24 hours a day, seven days a week and would not let anybody else look after her. The carer felt that the IB would provide some recognition of her caring duties and could help her to organise more activities for her mother.

Some service users and/or their proxies expected IBs to be more flexible than direct payments. In particular, users anticipated being more in control of their IB compared with their direct payment; paying only for the hours that their carer actually worked (as opposed to carers charging the local authority for time that was not fully worked); the opportunity to use the IB to purchase items or activities for which direct payments could not be used, such as holidays or gardening; and the possibility of being more involved in their own care:

There are so many restrictions around care and what agency carers can or cannot do. You're not allowed to assess your own risk and make a choice and we were hoping that with an individual budget we'd be able to do that more.  
(Physical disability)

A small number of interviewees expected the IB would enable them to purchase more care or to 'save up' some of their IB so that they could use it for particular activities or at particular times, for example if an informal carer was taken ill or went on holiday. Perceptions of being 'better off' financially were strongest among those who had not previously received social services and who found themselves suddenly being offered a pot of money to be spent on meeting their own needs in the way that they felt best.

### 5.5.2 Patterns of expenditure

In order to provide an overall picture of the use of IBs, Table 5.5 shows the pattern of overall expenditure by client group and Table 5.6 compares the use of budgets by those who receive them as a direct payment with those where the budget was managed by the local authority or another agency. More detailed information about innovative ways in which people have used their payments is given in Tables 5.7 and 5.8.

Fifty-nine per cent (169) of people for whom we had the information used their budgets to purchase mainstream services<sup>21</sup>. The value of these services accounted for just under half the total budget: mean expenditure was £4,970, 44 per cent of the total average budget of £11,450. In line with the size of the overall budget, expenditure on mainstream services was significantly higher for people with a learning disability ( $p < 0.01$ ) compared with other groups (Table 5.5). People with mental health problems received a lower budget for mainstream services.

In terms of the types of mainstream services accessed, about a fifth of people receiving a DP purchased home care services, only two per cent opting for in-house

<sup>21</sup> Mainstream services included funding for employing a home care, meal services, equipment and adaptations, accommodation, planned short breaks and transport.

services, compared with nine per cent (nine people) of those who had a managed budget (see Table 5.6).

**Table 5.5 Use of IBs by service user group**

	<i>Individual budget holders</i>			
	PD N=94	LD N=72	MH N=35	OP N=81
<b>Mainstream services<sup>22</sup></b>				
% (N)	58 (55)	65 (47)	57 (21)	53 (44)
Mean **	£3,480	£7,500	£1,470	£5,970
Median	£720	£2,660	£1,190	£3,720
Standard deviation	£6,070	£11,510	£1,370	£5,350
Minimum	£26	£9	£140	£224
Maximum	£25,990	£56,120	£5,880	£18,720
<b>Personal assistance</b>				
% (N)	76 (71)	63 (45)	31 (11)	41 (33)
Mean	£9,430	£9,160	£3,660	£7,590
Median	£4,000	£4,680	£3,145	£5,240
Standard deviation	£14,840	£11,310	£3,430	£6,680
Minimum	£27	£48	£120	£720
Maximum	£76,680	£44,400	£13,090	£27,410
<b>Payment in kind<sup>23</sup></b>				
% (N)	5 (5)	3 (2)	0	<1 (1)
Mean	£340	£440	-	-
Median	£240	£437	-	-
Standard deviation	£240	£260	-	-
Minimum	£75	-	-	-
Maximum	£660	-	-	-
<b>Leisure activities</b>				
% (N)	43 (40)	42 (30)	65 (23)	15 (12)
Mean*	£1,490	£3,360	£1,020	£1,800
Median	£660	£1,150	£354	£1,040
Standard deviation	£2,300	£7,000	£1,390	£2,770
Minimum	£20	£6	£20	£260
Maximum	£11,870	£37,440	£5,200	£10,400

Note: Based on 285 support plan records.

Significance Level: \*\* p< 0.01; \* p< 0.05.

<sup>22</sup> Mainstream services included funding for home care, meal services, equipment and adaptations, accommodation, planned short breaks and transport.

<sup>23</sup> Payment in the form of goods or services, rather than cash.

The two-month interviews provided insight into the rationales behind staying with mainstream services. For some service users, particularly those with complex needs and those with relatively low-level needs, this decision was related to the size of the budget – they felt the amount of the IB was inadequate to cover any support over and above personal care. Some people felt that they had fought hard for the services they were currently receiving and therefore did not want to let these go; some others were hesitant or anxious about spending their IB on new services or different patterns of support; and some simply wanted, or needed, the security and continuity of care. Indeed, a number of service users stated that they had chosen to try an IB as they wanted to ‘keep the same carer’; others had accepted an IB as they feared losing their current carer and services if they refused.

However, even in the use of mainstream services, IBs allowed people to exercise a level of choice and control that they would not have been able to exercise under previous arrangements. Some of those interviewed at two months had ‘shopped around’ different care agencies to find a deal that best suited them. For some, this meant being able to have more hours of care by seeking cheaper options; for others it meant paying more per hour to obtain better quality care, even if this meant a reduction in the number of hours of care purchased. There were also examples of experimenting with new flexibilities. Typically, this involved ‘banking’ some of their hours of personal care – or the funds that would pay for this care – and asking carers to use some of that time to do some ‘extra little things’ such as helping with an extra bath or shower.

Table 5.6 shows that people who had an IB directly paid into an account were more likely to employ a personal assistant (PA) (64 per cent) compared with those who had a managed budget (47 per cent). High use of PAs is a finding we might expect as this is a common use of direct payments and, as we noted above, a quarter of our sample were in receipt of direct payments before moving on to an IB. However, it was clearly also a favoured option for those with a managed budget.

The use of PAs allowed people to undertake a much wider range of activities than otherwise would have been possible. For example, in the two-month interviews, a mother of a young physically disabled man commented that her son needs social care in the sense that he needed someone to take him out to do the normal things that young men do, such as going out ‘to clubs ‘til two in the morning’, not somebody to help him get up and to put him to bed. PAs were also a way of providing some freedom to carers. Another mother of a young man with learning disabilities identified that she would have more time for herself and this would benefit family relationships as a whole:

I’m gonna have some freedom, [service user is] gonna have some freedom as well, he gets tired of me and I get tired of him.  
(Carer of an IB user with learning disabilities)

Only two per cent of plans (eight people) identified using payments in kind, for example by taking someone out for a meal or to a show in repayment for their help. As might be expected, the level of expenditure associated with these payments in kind was low. Younger disabled adults were most likely to use their IB in this way (Table 5.5). None of the people with mental health problems in our sample, and only one older person in our sample, identified this option at the planning stage. Only in one instance was this type of payment included when the local authority or another agency managed the IB.

Overall, 37 per cent of support plans identified expenditure on leisure activities (mean £1,960; median £720; standard deviation £4,210). Older people were least likely to use their budgets in this way and people with mental health problems the most likely (Table 5.5). People with a learning disability spent significantly more on leisure activities (mean £3,360;  $p < 0.05$ ) compared with other client groups. This included one-off payments for a rock concert and football tickets and use of recurrent payments for Sky subscriptions, gym membership, going to the cinema and meals out.

Table 5.6 provides a more detailed breakdown of how people spent their budgets by deployment option. As we described above, plans were dominated by mainstream services and use of PAs. In addition to this recurrent expenditure, over 10 per cent of the sample used their budget for one-off items such as kitchen, bedroom, bathroom and mobility equipment and adaptations. Table 5.7 lists the types of items that were purchased. Less conventional purchases from one-off payments included: a caravan, new flooring, a mountain bike, carpet cleaning, skip hire, a snooker cue and a shed. Of the 112 support plan records that identified one-off payments, 36 reported purchasing mobility equipment/adaptations, covering convention purchases such as ramps, electric wheelchairs, bath lifts and bedroom equipment. Other one-off payments covered kitchen equipment (N=24), courses and computer equipment (N=9) and a whole array of single purchases (N=39) such as holidays, massages, flooring and gym equipment.

IB holders were able to use their budgets to go on holiday: Table 5.5 shows that overall a fifth of the sample used their IB for short breaks (average spending of £2,646 during the year). Nearly a quarter (24 per cent) of people who took short breaks received their IB as a DP compared with 15 per cent with a managed IB, although the mean expenditure for this activity was significantly higher for people with a managed IB (mean £5,460;  $p < 0.01$ ) compared with about £1,750 for people who received their IB as a direct payment. More personalised approaches to respite and short breaks were taken advantage of by IB holders compared with the more usual mainstream approach of using care homes.



**Table 5.6 Patterns of use of IBs comparing direct payments with managed budgets**

Service/type of expenditure	<i>Direct payments</i>		<i>Managed budgets</i>		<i>Overall</i>	
	% (N=189)	Mean annual expenditure	% (N=96)	Mean annual expenditure	% (N=285)	Mean annual expenditure
Personal assistant	64 (120)	£8,940	47 (46)	£7,420	59 (166)	£8,520
Home care (agency)	18 (34)	£7,140	30 (29)	£7,480	22 (63)	£7,290
Home care (in-house)	2 (4)	£1,350	9 (9)	£7,640	5 (13)	£5,700
Meal services	3 (5)	£1,070	2 (8)	£450	5 (13)	£690
Equipment – telecare	2 (4)	£160	2 (2)	£160	2 (6)	£160
Equipment – other	11 (21)	£1,070	8 (8)	£360	10 (29)	£870
Adaptations	3 (6)	£860	2 (2)	£100	3 (8)	£670
Leisure activities	43 (81)	£2,020	24 (24)	£1,750	37 (105)	£1,960
Planned short breaks**	24 (47)	£1,750	15 (15)	£5,460	22 (62)	£2,650
Child care	1 (2)	£1,850	0	-	1 (2)	£1,850
Health and dental services	2 (4)	£730	1 (1)	-	2 (5)	£900
Accommodation	1 (2)	£740	1 (1)	-	1 (3)	£830

Significance Level \*\*p< 0.01.

This flexibility was highly valued by those who were able to take advantage of it. For example, one interviewee at two months said that the ability to take her sister on holiday with her, as a carer, had 'changed my life completely. ... It's given me more say and I can do more' (Person with a physical disability).

At the time of the pilot, health expenditure was explicitly excluded from IBs. Certainly funding from the health service was not used, but there was some debate about whether IB holders could use their budgets to purchase health services. When asked to categorise expenditure in the support plan, only five people were identified as using their IBs for health services, with expenditure ranging from £280 in the year to £1,510. Analysis of the content of the plans (summarised in Tables 5.7 and 5.8) identified the use of private health care and alternative therapy in recurrent expenditure. Of course, much of the assistive technology equipment that people purchased could also be classified as health-related expenditure.

**Table 5.7 One-off payments reported in the support plan records**

<p><b>Kitchen equipment (N=24)</b>                      Cookers, microwaves, fridge freezers                      Washing machine/dishwashers</p> <p><b>Bedroom/bathroom equipment (N=14)</b>                      Beds/levers/sheets                      Shower stool/toilet seats                      Spa bath/bath lift</p> <p><b>Safety (N=4)</b>                      Fall detector/lifeline alarms/car harness</p> <p><b>Ramps and grab rails/mobility aids (N=22)</b>                      Ramps/rails/stair lift                      Mobility scooter/electric wheelchairs and accessories                      Chair raiser                      Adapted shoes</p>	<p><b>Courses and computer equipment (N=9)</b>                      Photography course                      Computer/laptop                      IT course                      Hygiene training                      Driving lessons</p> <p><b>Other 'one-off' payments (N=39)</b>                      House related, e.g. curtains/blinds, carpet cleaner                      Garden related e.g. landscaping, decking, shed                      Hobby related e.g. art materials, music keyboard, bikes, camera, football tickets, snooker cue                      Holiday related e.g. caravan, holiday for carer</p>
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Almost by definition it is difficult to classify and thus quantify the more innovative ways of using IBs. The list in Table 5.8 is drawn from both the plans and reports during the six-month interviews, and shows some of the other uses of recurrent expenditure classified under six domains: accommodation, managing support, transport, personal needs, employment and occupation, and health. For each domain, the Table gives some examples of the activities involved.

**Table 5.8 Additional services/expenditure identified in the support plan records and during the six-month interview**

<b>Accommodation (N=24)</b>	<b>Managing support (N=49)</b>
Cleaning service	Holiday and sickness cover
Decorating service	Insurance/PA insurance
Gardening service	Contingency payments
	Telephone costs
<b>Employment and occupation (N=16)</b>	<b>Transport (N=4)</b>
Going out: meals/the pub/day trips/cinema etc	Taxi service
Classes/arts and crafts	Petrol costs/ car cleaning
Gym membership/swimming	
Computer maintenance/internet access/games	<b>Health-related (N=3)</b>
Admission fees for service user and PA	Alternative therapy
	Private health care
	Massage for carer
<b>Personal needs (N=4)</b>	
Laundry needs	
Hairdresser	

In the two-month interviews, examples were given of using IBs to participate in family activities in quite modest ways but that nevertheless enabled people to feel that they were able to 'pay their way' and contribute financially to family activities or outings. This helped the person to feel less of a burden, as s/he could make a positive contribution. Typically, this involved simple things such as paying for the bus fares or treating family members to a meal out. In one more unusual case, an IB holder reported that he had used part of his IB to purchase a computer and was therefore able to play an active role in his son's business. This individual claimed that the IB 'gives you an interest in things to do [that] ... you couldn't do before you had an individual budget' (Person with physical disability).

## 5.6 Discussion

There were clear differences between service user groups in terms of levels, deployment, management and patterns of expenditure. To some extent these differences reflect the policies of the pilot authorities rather than the characteristics of the user groups themselves. Older people seemed less likely to use their budgets for leisure and in other innovative ways, possibly reflecting the lower level of budget received, and that they were less likely to manage for themselves through direct payments. Budgets for people with learning disabilities were highest and appeared to provide most scope for a wide range of uses, although this group still spent most

on mainstream services. Perhaps unsurprisingly, younger physically disabled adults appeared most likely to have personal control over their budget.

While clearly there were innovative ways of using budgets that were highly valued by those individuals, it seemed that these were relatively rarely reported in our sample. Most people made use of mainstream services and/or PAs, now quite common among direct payment users. However, there was evidence from the interviews at two months that people were taking advantage of the flexibility of budgets to reflect their personal preferences. We might expect, as confidence and experience grow, both among individuals themselves and those supporting them in planning, that more innovative approaches to care and support will increasingly be used.

Although an important aim of IBs was to integrate resources from a variety of funding streams, in our sample there was limited evidence of the use of non-social service funding streams and some indications that pre-existing funding sources were not being drawn into IBs. It did appear that SP funding was being used more as a consequence of IBs but, possibly due to implementation problems discussed elsewhere in this report, there was limited use of ILF and virtually no integration of AtW funding.

## Chapter 6 Outcomes

### 6.1 Introduction

A key objective of the IB pilot was to identify whether the approach improved outcomes for people by giving them greater control over the type of support they accessed and over the way that support was organised and delivered. The purpose of this chapter is to describe the outcomes for individuals, and particularly how they varied between groups<sup>24</sup>. Is there evidence that IBs lead to better outcomes? What other factors are associated with variation in outcomes?

### 6.2 Method

As described earlier in this report, the study was designed with the aim that there should be no systematic difference between those who were offered an IB and the comparison group who received conventionally arranged services. We sought to achieve this equivalence through randomisation. Throughout this chapter our primary aim is to compare these two groups of people (510 with IBs; 449 in the comparison group), based on standard intention-to-treat (ITT) principles. However, accepting an IB was optional, and some people allocated to that arm of the trial did decline to take up the opportunity. We therefore also looked at a third group of people, a subgroup of those offered an IB: these are the people who accepted an IB (458 people). This so-called *IB-accepted group* included people whether or not they had a total budget value reported on the support plan record, as well as some who were still working through the support planning process, and some whose services were not in place by the end of the evaluation period (i.e. at the six-month interview point).

The analysis explored whether, due to missing outcome data, the samples used in the outcome analyses differed significantly in terms of baseline characteristics from the overall study sample. The results indicate that, relative to the overall study sample, the samples used for the different outcomes analyses had somewhat lower proportions of users from the comparison group, lower proportions with signs of cognitive impairment, and lower proportions in the critical FAC need group. Also, the samples used in the outcomes analyses contained greater proportions of users with physical disabilities and of users living alone at baseline than the overall study sample. However, only the difference in the proportion of PD users was statistically significant at the 95 per cent confidence level.

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<sup>24</sup> Clearly outcomes for carers are also very important but this is the subject of further work.

While the in-depth interviews conducted with 130 IB holders two months after they had been offered an IB were not intended to establish outcomes, they did provide us with information about what people expected from their IBS. We draw on these data to provide context and further insight into the experience and impact of IBs.

### **6.2.1 Outcome measures**

In order to identify the impact of IB on outcomes, we used a randomised controlled trial design, which is the best approach for making like-with-like comparisons between the new and the current care support arrangements. We compared people on a variety of measures designed to reflect the intentions of IBs. We sought to capture some over-arching aspects of well-being by using well-validated global indicators, and also to use measures that picked up key areas of people's lives that are specifically relevant to social care. Appendix C describes the indicators in more detail.

As far as possible, these measures reflected individuals' own perceptions of their lives and their well-being, but in a number of cases we needed to rely on proxy views when people were unable fully to communicate. In Chapter 4 we identified that proxy interviews were conducted in 24 per cent of cases. In addition, people sometimes had others with them during the interview who might respond on their behalf if there were problems in communicating or understanding an individual question. Proxy respondents of this kind do not always respond in the way that the individual would when reporting on the types of subjective issues covered in our outcome measures – particularly self-perceived health and quality of life. However, excluding all proxy respondents considerably reduces the sample size, particularly for people with learning disabilities. In the results presented in the tables below we include proxy respondents and, where significant differences are reported, identify the impact of excluding these proxies. Appendix C provides more detail about numbers of proxy respondents.

One important effect of the process of identifying resources available and giving IB holders control over the support planning process could be to increase their sense of what it was possible to achieve: to increase their aspirations. In the six-month interviews we asked people who had accepted the offer of an IB whether their views had changed on what could be achieved in their lives.

Global measures of well-being used in the evaluation included the widely used 12-item version of the General Health Questionnaire (GHQ-12), (Goldberg, 1992) and a single quality of life question using a seven-point scale (Bowling, 1995). We report what we found using the GHQ-12 in two ways. The first provides a continuous variable reflecting psychological well-being, and is obtained by summing scores on the 12 items (which run from 0 to 3, with higher scores indicating worse conditions).

The second way to use the GHQ-12 scores each item as 0 or 1, sums them, and then calculates the proportion of people with a total score of 4 or higher, which is conventionally interpreted as indicating that they are at risk of psychological ill-health.

The Adult Social Care Outcome Toolkit (ASCOT) is a developing approach that seeks to identify the specific aspects of people's lives that are addressed by social care interventions (Netten *et al.*, 2006). The measure is applicable across all user groups. It has seven domains, ranging from basic areas of need such as personal care and food and nutrition, to more aspirational aspects such as social participation and involvement and control over daily life. For each domain, respondents were asked to indicate which of three options best describes their situation, reflecting: no needs, low-level needs and high-level needs. For example, one domain asked them to choose between: I feel in control of my daily life; I have some control over my daily life but not enough; I have no control over my daily life. Full details are in Appendix C. Responses were then weighted and summed to reflect the relative importance of each domain and level of need, drawing on previous work on population preferences (Burge *et al.*, 2006).

While better health was not a core objective of the pilot programme, we need to check whether there was any difference in health status. Self-perceived health has been found in previous work (Ferraro, 1980) to be a reliable predictor of objective health, and has been found to be closely associated with overall well-being (e.g. Palmore and Luikart, 1972).

The process of care can play an important part in people's lives. We asked both about people's overall satisfaction with their support and about specific aspects of quality that previous studies have identified as important. Measures of satisfaction and quality of care were based on quality indicators derived from the extensions to national User Experience Surveys for older home care service users and younger adults (Jones *et al.*, 2007; Malley *et al.*, 2006).

## 6.2.2 Analyses of responses

We begin by reporting the degree to which the IB process changed people's views on what could be achieved. We then compare the IB and comparison groups on each of our outcome indicators, and also examine how outcomes varied for the different user groups using parametric statistical tests<sup>25</sup>. Remember that we did not collect data using these outcome-measuring tools at baseline, but because the randomisation

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<sup>25</sup> A chi-square test of association was used to explore the relationship between two discrete variables (for example, between the IB and comparison groups on the dichotomous GHQ-12 indicator). When the outcome measure was based on a Likert scale (e.g. running from one to seven), a t-test was used to explore mean differences between groups (for example, quality of life and satisfaction). ANOVA analyses were used when describing overall differences between user groups.

process produced equally matched groups of individuals, we can assess relative outcomes between the IB and comparison groups by looking at the ratings on these various scales at the six-month follow-up point. If IBs are better for people than conventional support arrangements, then we would expect to find that people in the IB group reported significantly higher levels of well-being, fewer needs in the social care domains, and higher levels of satisfaction and quality.

However, in making these comparisons and interpreting the results, it is important to remember that some people declined an IB, and for many others there were delays in implementation, with the result that less than half (45 per cent) of those who accepted an IB actually had a support plan in place at six months. Even those with a support plan had often not had it for long: only 36 per cent had the arrangements in place for more than a month. The primary purpose of the randomised trial was to evaluate the policy, and so it is correct to look for differences between the IB and comparison groups as randomised. But it is also unrealistic to expect much in the way of an impact on outcomes given the implementation difficulties.

We highlighted earlier the potential problems raised by the use of proxy responses when analysing outcomes. Allowing for factors such as whether people accepted IBs and whether the support plan was actually in place, adds further complications in ensuring that we are making valid comparisons. We sought to adjust for these complications through our choice of statistical analysis. Thus, in addition to simple comparisons between the IB and comparison group, we used multiple regression<sup>26</sup> to control for the impact of whether proxies were involved in answering the outcome questions, take-up of IBs, whether the support plan was in place and other relevant factors on our conclusions. These other relevant factors included baseline characteristics and the level of support received by individuals (as indicated by the cost of the support package).

### **6.3 Aspirations**

We start by considering the views of IB recipients of the support planning and financial arrangements, and whether the experience had made them re-evaluate what could be achieved in their lives. These views necessarily come only from those people who accepted the offer of an IB. We used a simple seven-point satisfaction scale (see Table 6.1). Just under half the sample reported that they were extremely or very satisfied with the support planning process (47 per cent) and with the financial arrangements (49 per cent).

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<sup>26</sup> The estimation used was ordinary least squares for modelling ASCOT and GHQ scores, as well as indicators of quality of life and satisfaction with services. The appropriateness of the model specifications, and particularly of the distributional assumptions was confirmed using standard tests. Control over daily life was modelled using an ordered logit model.



**Table 6.1 Overall satisfaction with the support planning process and financial arrangements**

	<i>Satisfaction with support planning process</i> N=323 (%)	<i>Satisfaction with financial arrangements</i> N=268 (%)
Extremely satisfied	13	19
Very satisfied	34	30
Quite satisfied	29	30
Neither satisfied not dissatisfied	8	10
Quite dissatisfied	4	6
Very dissatisfied	3	2
Extremely dissatisfied	4	4
Unaware of the planning process	5	Not applicable

Note: The percentages do not add up to 100 due to rounding.

The process did appear to have an impact on people's aspirations. Table 6.2 shows that 47 per cent of people who had accepted the offer of an IB reported that their view of what could be achieved in their lives had changed a lot and 19 per cent reported that it had changed a little. A third reported that their view had not changed at all. Older people were significantly less likely than other user groups to report that the process had changed their view on what could be achieved.

**Table 6.2 Aspirations of people accepting the offer of an IB**

	<i>IB-accepted group (all user groups)</i> N=302 (%)	<i>PD</i> N=97 (%)	<i>LD</i> N=70 (%)	<i>MH</i> N=46 (%)	<i>OP</i> N=89 (%)
Has the IB process changed your view on what can be achieved in your life?***					
A lot	47	55	54	44	33
A little	20	21	14	29	17
Not at all	34	25	31	27	49

Note: Significance Level: \*\*\* $p < 0.01$ .

People who reported that the IB process had a big impact on their view of what could be achieved in their lives were more likely to be either extremely or very satisfied with

the support planning process (chi-square  $p < 0.001$ ) and the financial arrangements (chi-square  $p < 0.001$ ). In both instances, 65 per cent of those whose aspirations had increased a lot reported being either extremely or very satisfied, compared with 36 per cent of people who reported that their views had only changed 'a little' or 'not at all'.

The interviews at two months provided us with some insight into the nature of these higher aspirations. Most commonly, they related to being able to meet needs other than personal care; and to meet those needs in a more individualised way:

That's all they recognise, just your personal care, being washed and, and all that and the end of, you know, and other things are so much more important to your wellbeing, it's very frustrating when you can't do these things and you've got to sit and look at them, you know, building up around you, that's not good for you at all. It drags you down even further.  
(Older person)

I can choose my own respite facilities and check them out first to make sure they meet my needs as a disabled ... person. I can control where I go and pay for it with the IB money. You are the best judge of your own needs, not a social worker.  
(Physical disability)

IBs were thought to mark recognition that older and disabled people want, and are entitled to, a quality of life over and above that of being clean, fed and watered. The possibility of using an IB to pay for social activities thus proved particularly appealing to many service users. Greater independence, choice and control were also mentioned as potential advantages of IBs.

## 6.4 Global outcome measures

Tables 6.3 and 6.4 bring together our findings using the measures of quality of life, well-being and social care outcomes at six months for all those randomised to the IB group and to the comparison group.

Overall current levels of met need measured by the ASCOT score appear slightly higher among people in the IB group (Table 6.3). However, at this global level there were no statistically significant differences. In these analyses, there are lower numbers of observations for which we have composite scores because when any one question is not answered then we cannot compute the total score<sup>27</sup>.

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<sup>27</sup> In the multivariate analyses in section 6.7 we have imputed for missing items.

**Table 6.3 Quality of life, well-being and met needs**

	<i>IB group</i>	<i>Comparison group</i>
<b>Quality of life</b>	N=504	N=439
So good, it could not be better	3%	3%
Very good	15%	18%
Good	27%	28%
Alright	38%	31%
Bad	8%	9%
Very bad	7%	7%
So bad, it could not be worse	2%	5%
<b>GHQ-12</b>	N=448	N=380
Mean score <sup>1</sup> (sd)	13.83 (6.74)	13.80 (6.85)
Percentage <sup>2</sup> scoring 4+	36%	33%
<b>ASCOT<sup>3</sup></b>	N=457	N=385
Current needs mean score (sd)	3.55 (0.79)	3.48 (0.89)
<b>Self-perceived health</b>	N=507	N=446
Very good	12%	16%
Good	23%	24%
Fair	37%	35%
Bad	20%	16%
Very bad	8%	10%

<sup>1</sup> GHQ item scoring 0-3, higher GHQ scores indicate poorer outcomes.

<sup>2</sup> Using GHQ 12 item scoring 0-1.

<sup>3</sup> Higher scores indicate lower levels of need.

Analysing the results for individual service user groups, we converted the individual questions into scores for the purposes of comparison, with higher scores reflecting poorer levels of quality of life or self-perceived health. There were some significant differences between user groups in the six-month scores on the various instruments used (Table 6.4). These are interesting, but we cannot interpret them as indicating that *outcomes* are better or worse for one service user group (say older people) compared to another (say, people with learning disabilities) because we cannot assume equivalence at baseline<sup>28</sup>.

- Mental health service users reported the poorest overall quality of life ( $p < 0.001$ ), the highest scores on the GHQ-12 scale indicating *poorer* psychological well-being, and not surprisingly were more likely to fall into the at-risk category for psychological ill health.
- Forty-five per cent of older people in the IB group also scored above the threshold for psychological ill-health.

<sup>28</sup> The randomisation is between IB and conventional services, not between user groups.

- In the IB group, younger disabled people rated their quality of life to be worse than did people in the other user groups ( $p < 0.001$ ).
- In both the IB and comparison groups, people with mental health problems had greater current social care needs than other groups (indicated by a lower mean ASCOT current need score), while people with learning disabilities reported lower current needs ( $p < 0.001$ ).
- Self-perceived health was worst among physical disabled people and older people ( $p < 0.001$ ).

The key question was if there were differences in outcomes between the IB and comparison groups **within** each of the four main service user groups. For people with a mental health problem, self-reported quality of life was significantly higher for those in the IB group than for those in the comparison group ( $p < 0.05$ ). For older people, those in the IB group reported significantly lower well-being on the GHQ-12 than the comparison group ( $p < 0.05$ ). There were no other significant differences between the IB and comparison groups.

In some instances the lack of significant effects may well be due to the low number of observations. The exclusion of proxy responses exacerbates the problem. The number of people with mental health problems for whom we have reported quality of life drops from 129 to 102. While the exclusion of proxies has minimal impact on the size of the reported difference in quality of life, this difference ceases to be statistically significant, suggesting that this is a result of the reduction in number of observations rather than the impact of proxy views. For older people and GHQ, the exclusion of proxies reduces the number of observations from 236 to 169. This much larger proportionate fall has an impact on the size of the difference which becomes non-significant (36 compared with 31 per cent scoring 4+, see Appendix C). There was a slightly higher proportion of proxy responses in the IB group (31 per cent compared with 26 per cent in the comparison group) but overall it is more likely that the difference is a result of responses to the questions by the proxies than the prevalence of proxies in the two groups.

We identified above that the basis for the outcome evaluation is a like-with-like comparison between the IB and conventionally supported groups, with differences driven by the impact of IBs in the former, but that we might expect more differences to emerge if we compared just those who **accepted** an IB with those in the comparison group. In practice, one, rather puzzling, additional result was found; this was for people with learning disabilities. Self-perceived health appeared to be significantly lower among those who accepted IBs compared with the comparison group ( $p < .05$ ). In this comparison we include responses from proxies (of whom there were a substantial proportion in this user group), and exclusion of these does make the result non-significant. Nevertheless, as in our other results, the direction and size of effect was equivalent for proxies and self-report service users.

**Table 6.4 Quality of life, well-being and met needs, by user group, for the IB and comparison groups (CG)**

	<i>User Groups</i>			
	PD Mean (sd)	LD Mean (sd)	MH Mean (sd)	OP Mean (sd)
<b>Quality of life<sup>1</sup></b>				
Number of respondents – IB	178	118	65	140
Number of respondents – CG	146	110	64	119
IB group	3.93	2.99	3.78	3.71
Comparison group	3.83	2.92	4.31*	3.70
<b>GHQ-12 mean score<sup>2</sup></b>				
Number of respondents – IB	164	96	56	129
Number of respondents – CG	134	82	57	107
IB group	14.73	10.25	15.68	14.63
Comparison group	15.01	9.59	18.05	13.24
<b>GHQ-12 % scoring 4+<sup>3</sup></b>				
IB group	40% (65)	15% (14)	46% (26)	45% (58)
Comparison group	40%(53)	7% (6)	60% (34)	29% (31)*
<b>ASCOT<sup>4</sup></b>				
Number of respondents – IB	169	106	54	126
Number of respondents - CG	138	93	57	97
IB group	3.53	3.80	3.16	3.53
Comparison group	3.39	3.81	2.97	3.57
<b>Self-perceived health<sup>4</sup></b>				
Number of respondents –IB	179	118	66	141
Number of respondents –CG	146	115	65	120
IB group	3.15	2.14	2.89	3.20
Comparison group	3.15	1.97	3.03	3.01

Significance level: \*  $p < 0.05$ .

<sup>1</sup> GHQ item scoring 0-3, higher GHQ scores indicate poorer outcomes.

<sup>2</sup> Using GHQ-12 item scoring 0-1.

<sup>3</sup> Higher scores indicate lower levels of need.

<sup>4</sup> Higher scores indicate worse self-perceived health.

The negative findings reported above raise questions. Lower self-reported health among people with learning disabilities who accepted the IB suggests either those who refused IBs had significantly better health initially or IBs had a detrimental effect

on people's perceptions of their health. There is no clear reason for either of these interpretations and no other evidence from other aspects of the evaluation to support either of them. In view of this puzzling result, further analysis was carried out to explore the impact of IBs on the health of service users. In particular, further modelling investigated the existence of differences in the levels of physical ability between users in the IB and comparison groups, controlling for baseline characteristics (results are shown in Appendix C).

Overall the results did not show lower physical ability among IB users. In fact, the statistical analysis for all users, including cases where responses were provided by proxies, indicated significantly better physical ability among IB users. This effect became non-significant when proxy responses were excluded from the analysis sample, or when the model was fitted exclusively for people with learning disabilities.

There is some evidence to help us interpret the finding of lower level of well-being among older people in the IB group, however. In the two-month interviews, concerns about managing the budget were more frequently expressed by older people, people with learning difficulties and their respective informal carers. Most notably for older people, three types of experience emerged: those who did not want anything different; those who were anxious but could see some potential benefits; and those embracing the potential for choice and control over their own support.

In the first group, service users and families take on an IB, without the desire for change, choice or control being the key motivation. There was a clear lack of engagement on their part. The 'decision' to take up an IB seemed to be just accepting whatever the social worker said. In these cases, either nothing changed at all (the social worker administered a 'virtual budget') or nothing changed in the care given, but the user/family had the responsibility of the paperwork, which was often seen as an extra burden:

Carers are all laid on for me at the moment and I haven't got the time and I haven't got the brain really to work out financial details or anything like that, and I'm quite happy with the arrangement I've got.  
(Older person)

At six months people in the IB group who had previous social care packages were asked what changes they had made or were planning to make as a result of the IB. Nearly a third of respondents (31 per cent) said that they had made or planned no changes. Among older people the proportion was nearly two-fifths (39 per cent), although this difference was not statistically significant.

The second group was the largest in the small two-month interview sample. This group would normally say that IBs are not for people who are not organised, determined and have family support available. They experienced the administration

as stressful. 'What if I overspend?' 'I don't want to owe people money.' 'What if I don't fill the form in right?' 'What if there is no money left?' 'What if they cut my budget?' 'I can't recruit anyone!'

Several interviewees at two months feared that relationships with directly employed carers could break down, leaving users and/or carers to dismiss the paid carer, face threats of legal action, and possibly be left for a period without a paid carer. This was contrasted with situations in which a relationship with an agency carer broke down, where the agency could send a replacement carer straight away. Direct employment of carers through an IB was anticipated to carry more responsibility and risk for the user.

Other service users and carers felt able to cope but simply did not want to take on the extra work and responsibility:

I understand you have got to start keeping records and you'd have to have receipts and I've done that all my life and don't want to start that again.  
(Older person)

There were also a few examples of older people rejecting the idea of spending £350 on an agency to manage payroll and paperwork, because it 'seems so much money to waste' (older person).

However, even in this 'anxious' group it seemed that there were positive changes happening to the patterns of support. People valued 'Being able to go to church, having someone come in to make the bed and prepare vegetables for me'. There were also some examples of people getting used to the administration, with it becoming less daunting after a while.

The third group were those service users and their families that were able to handle the finances in a stress-free way. Among older people these may be quite a rare breed: examples included people who had previous experiences of being a treasurer for an organisation, managing their previous direct payment successfully and having relatives in relevant professions ('My son is an accountant'). This group was fully engaged with the importance of choice and control, and prepared to challenge decisions made for them (such as a support planner choosing an expensive agency, social services seeking to dictate). The benefits to this group were clear, even without having lots of extra resources to spend.

## 6.5 Social care outcome domains

ASCOT is designed to pick up on those aspects of life that are particularly the focus of social care interventions. Responses for each of the seven ASCOT domains can

be compared for people in the IB group and those in the comparison group. There are few statistically significant differences (Table 6.5). People in the IB group were significantly more likely to report that they felt in control of their daily lives (48 per cent,  $p < 0.05$ ) compared with those in the comparison group (41 per cent).

**Table 6.5 ASCOT outcome domains for all service user groups combined**

	<i>IB group</i>	<i>Comparison group</i>	<i>Overall</i>
	% (N)	% (N)	% (N)
<b>Personal care/comfort</b>			
No needs	82 (408)	78 (334)	80 (742)
Low needs	15 (75)	19 (80)	17 (155)
High needs	2 (12)	4 (15)	3 (27)
<b>Social participation and involvement</b>			
No needs	35 (169)	38 (159)	36 (328)
Low needs	43 (207)	39 (159)	41 (366)
High needs	22 (106)	24 (101)	23 (207)
<b>Control over daily life*</b>			
No needs	48 (235)	41 (179)	45 (414)
Low needs	43 (212)	44 (194)	44 (406)
High needs	9 (46)	15 (64)	12 (110)
<b>Meals and nutrition</b>			
No needs	74 (363)	67 (291)	71 (654)
Low needs	21 (102)	26 (112)	23 (214)
High needs	5 (26)	7 (30)	6 (56)
<b>Safety</b>			
No needs	47 (232)	45 (195)	46 (427)
Low needs	43 (212)	43 (184)	43 (396)
High needs	10 (49)	12 (51)	11 (100)
<b>Accommodation cleanliness and comfort</b>			
No needs	87 (429)	83 (106)	85 (793)
Low needs	11 (56)	15 (65)	13 (121)
High needs	2 (9)	2 (9)	2 (18)
<b>Occupation and employment</b>			
No needs	45 (219)	46 (195)	45 (414)
Low needs	41 (198)	42 (177)	41 (375)
High needs	14 (70)	13 (54)	14 (124)

Note: \* Significance level:  $p < 0.05$ .

Tables 6.6 to 6.9 show the same comparisons on the ASCOT measures, but now for each user group in turn. While there were some differences between the IB and comparison groups for younger physically disabled people (Table 6.6), none of them reached statistical significance.



**Table 6.6 ASCOT outcome domains for younger physically disabled people**

	<i>IB group</i>	<i>Comparison group</i>	<i>Overall group</i>
	% (N)	% (N)	% (N)
<b>Personal care/comfort</b>			
No needs	84 (148)	77 (111)	81 (259)
Low needs	15 (26)	19 (27)	17 (53)
High needs	2 (3)	4 (6)	3 (9)
<b>Social participation and involvement</b>			
No needs	29 (51)	35 (50)	32 (101)
Low needs	46 (80)	43 (61)	44 (141)
High needs	25 (44)	22 (32)	24 (76)
<b>Control over daily life</b>			
No needs	51 (91)	44 (65)	48 (156)
Low needs	43 (76)	44 (64)	43 (140)
High needs	6 (11)	12 (18)	9 (29)
<b>Meals and nutrition</b>			
No needs	73 (129)	62 (90)	68 (219)
Low needs	22 (38)	30 (44)	25 (82)
High needs	6 (10)	8 (12)	7 (22)
<b>Safety</b>			
No needs	42 (73)	36 (52)	39 (125)
Low needs	49 (87)	51 (74)	50 (161)
High needs	9 (16)	14 (20)	11 (36)
<b>Accommodation cleanliness and comfort</b>			
No needs	84 (149)	82 (121)	83 (270)
Low needs	15 (26)	14 (21)	15 (47)
High needs	2 (3)	3 (5)	3 (8)
<b>Occupation and employment</b>			
No needs	47 (82)	47 (67)	47 (149)
Low needs	40 (70)	38 (55)	39 (125)
High needs	13 (23)	15 (22)	14 (45)

The results reported in Table 6.7 suggest that people with learning disabilities in the IB group were more likely than those in the comparison group to feel they had control over their daily lives ( $p=0.054$ ). Once those who refused the IB were excluded, this difference grew, with 47 per cent reporting no needs and nine per cent reporting high needs ( $p < 0.05$ ). On a less positive note, people with learning disabilities who had accepted the offer of an IB and their proxies were significantly less likely to report that the IB holder was fully occupied in activities of his or her own choice (45 per cent,  $p < 0.05$ ). However, this may reflect the proxy perspective and/or the type of individual who needed a proxy respondent. When we exclude proxy responses, service users who had accepted the offer of an IB were **more** likely to report that they

were fully occupied in activities of their own choice (69 per cent; n=18)<sup>29</sup> although this difference did not reach statistical significance.

**Table 6.7 ASCOT outcome domains for people with learning disabilities**

	<i>IB group</i>	<i>Comparison group</i>	<i>Overall</i>
	% (N)	% (N)	% (N)
<b>Personal care/comfort</b>			
No needs	89 (103)	90 (95)	89 (198)
Low needs	8 (9)	9 (9)	8 (18)
High needs	3 (4)	2 (2)	3 (6)
<b>Social participation and involvement</b>			
No needs	50 (57)	58 (59)	54 (116)
Low needs	40 (46)	29 (30)	35 (76)
High needs	10 (11)	13 (13)	11 (24)
<b>Control over daily life</b>			
No needs	46 (52) <sup>1</sup>	35 (38)	41 (90)
Low needs	44 (49)	46 (50)	45 (99)
High needs	10 (11)	20 (22)	15 (33)
<b>Meals and nutrition</b>			
No needs	77 (89)	79 (85)	78 (174)
Low needs	20 (23)	20 (22)	20 (45)
High needs	3 (3)	<1 (1)	2 (4)
<b>Safety</b>			
No needs	59 (68)	57 (60)	58 (128)
Low needs	32 (37)	31 (33)	32 (70)
High needs	9 (10)	11 (12)	10 (22)
<b>Accommodation cleanliness and comfort</b>			
No needs	96 (110)	93 (102)	94 (212)
Low needs	4 (5)	7 (8)	6 (13)
High needs	0	0	0
<b>Occupation and employment</b>			
No needs	51 (6)	61 (66)	56 (126)
Low needs	40 (47)	38 (41)	39 (88)
High needs	9 (10)	2 (2)	5 (12)

<sup>1</sup> The difference between the IB group and the comparison group was approaching significance (p=0.054).

There were no statistically significant differences between the IB and comparison groups for people with mental health problems (Table 6.8), but the small sample size limited our ability to detect differences. Nor were there any statistically significant differences between older people in the IB and comparison groups (Table 6.9).

<sup>29</sup> Due to the small sample size, any firm conclusions need to be made with caution.

**Table 6.8 ASCOT outcome domains for people with a mental health problem**

	<i>IB group</i>	<i>Comparison group</i>	<i>Overall</i>
	% (N)	% (N)	% (N)
<b>Personal care/comfort</b>			
No needs	62 (38)	58 (37)	60 (75)
Low needs	31 (19)	34 (22)	33 (41)
High needs	7 (4)	8 (5)	7 (9)
<b>Social participation and involvement</b>			
No needs	22 (13)	12 (8)	17 (21)
Low needs	44 (26)	48 (31)	46 (57)
High needs	34 (20)	40 (26)	37 (46)
<b>Control over daily life</b>			
No needs	49 (30)	41 (26)	45 (56)
Low needs	44 (27)	52 (33)	48 (60)
High needs	7 (4)	8 (5)	7 (9)
<b>Meals and nutrition</b>			
No needs	70 (42)	52 (33)	61 (75)
Low needs	17 (10)	31 (20)	24 (30)
High needs	13 (8)	17 (11)	15 (19)
<b>Safety</b>			
No needs	35 (21)	31 (20)	33 (41)
Low needs	52 (31)	52 (34)	52 (65)
High needs	13 (8)	17 (11)	15 (19)
<b>Accommodation cleanliness and comfort</b>			
No needs	66 (40)	56 (37)	61 (77)
Low needs	26 (16)	40 (26)	33 (42)
High needs	8 (5)	3 (2)	6 (7)
<b>Occupation and employment</b>			
No needs	41 (24)	25 (15)	33 (39)
Low needs	41 (24)	58 (34)	49 (58)
High needs	19 (11)	17 (10)	18 (21)

**Table 6.9 ASCOT outcome domains for older people**

	<i>IB group</i>	<i>Comparison group</i>	<i>Overall</i>
	% (N)	% (N)	% (N)
<b>Personal care/comfort</b>			
No needs	84 (116)	79 (91)	82 (207)
Low needs	15 (21)	19 (22)	17 (43)
High needs	<1 (1)	2 (2)	1 (3)
<b>Social participation and involvement</b>			
No needs	36 (47)	39 (42)	37 (89)
Low needs	41 (53)	34 (37)	38 (90)
High needs	24 (31)	28 (30)	25 (61)
<b>Control over daily life</b>			
No needs	42 (59)	43 (50)	43 (109)
Low needs	43 (60)	41 (47)	42 (107)
High needs	14 (20)	16 (19)	15 (39)
<b>Meals and nutrition</b>			
No needs	74 (101)	72 (83)	73 (184)
Low needs	22 (30)	23 (26)	22 (56)
High needs	4 (5)	5 (6)	4 (11)
<b>Safety</b>			
No needs	50 (69)	55 (63)	52 (132)
Low needs	40 (55)	38 (43)	39 (98)
High needs	11 (15)	7 (8)	9 (23)
<b>Accommodation cleanliness and comfort</b>			
No needs	93 (127)	90 (104)	91 (231)
Low needs	7 (9)	9 (10)	8 (19)
High needs	<1 (1)	2 (2)	1 (3)
<b>Occupation and employment</b>			
No needs	38 (51)	41 (47)	40 (98)
Low needs	43 (57)	41 (47)	42 (104)
High needs	19 (26)	18 (20)	19 (46)

## 6.6 Satisfaction and quality of care or support

We might expect that when people take more responsibility for organising their own support they would report higher levels of satisfaction with that support. For people in the IB group, satisfaction referred to help paid for by the IB, while for the majority of people in the comparison group this question referred to help commissioned by social services. We found that 49 per cent of people in the IB group and 43 per cent of people in the comparison group were either extremely or very satisfied with help they received (Table 6.10). Using a chi-square test this difference was statistically significant ( $p=.05$ ). When this indicator was converted to a satisfaction score, a t-test showed people in the IB group to be clearly significantly more satisfied ( $p < 0.05$ ).

When proxies were excluded this result became non-significant but the direction of difference remained the same.

Again partly as a result of lower sample numbers, differences between IB and comparison groups were not significant for the separate user groups, with the exception of younger physically disabled people ( $p < 0.01$ ).

**Table 6.10 Satisfaction with help paid for from IB or from social services**

	<i>IB group</i> <i>N=478</i> (%)	<i>Comparison group</i> <i>N=431</i> (%)
Extremely satisfied	15	15
Very satisfied	34	28
Quite satisfied	30	28
Neutral	11	14
Fairly dissatisfied	5	7
Very dissatisfied	3	4
Extremely dissatisfied	3	5

Table 6.11 shows the proportion of each sample that gave the highest quality rating to each of a number of aspects of care or support (based on a four-point scale). High quality ratings were given slightly more often by people in the IB group than in the comparison group, notably with respect to care workers<sup>30</sup> tailoring the way they do things to the individual's preferences rather than their own. When these items were summed into a composite quality indicator, an overall significant difference between the IB and comparison group was not found. However, younger physically disabled people in the IB group were significantly more likely to report higher quality (mean 4.91;  $p < 0.05$ ) than those in the comparison group (mean 4.14).

<sup>30</sup> When asking the question, interviewers replaced 'care workers' with the term most appropriate to the individual's circumstances (e.g. personal assistant or support worker).

**Table 6.11 Quality of care or support**

	<i>IB group</i> % (N)	<i>Comparison group</i> % (N)
My care workers always come at times that suit me	59 (200)	57 (172)
My care workers are never in a rush	58 (202)	54 (164)
My care workers are always arrive on time	40 (136)	35 (103)
My care workers always do things that I want done	64 (222)	59 (177)
My care workers never do things in their own way	46 (156)	39 (114)
I always see the same care worker	53 (188)	49 (154)
I am always kept informed about changes	53 (182)	53 (161)
My care workers always treat me with respect	80 (288)	77 (238)

## 6.7 Variations in outcome

As we identified above, we used statistical models to explore the implications of the receipt of an IB, allow for the impact of proxy informants and to explore a series of additional potential influences on outcomes. These influences included measures of baseline needs and other characteristics, as well as some operational measures such as the level of support received (as indicated by the cost of the support package), whether or not an IB user had their support plan in place at the time of the interview, and whether proxies were involved in answering the outcome questions.

We also examined whether the high proportion of direct payment (DP) users in the comparison group influenced the effect associated with IBs, given the similarities in commissioning processes between these two types of self-directed support. In fact, we did **not** find any evidence suggesting the differential effect of IBs was affected by the use of direct payments among the comparison group. Equally, the results did **not** suggest differences in the levels of outcomes achieved for new referrals compared with current service users.

The results of the five series of econometric analyses are described here. In each case we report the regression equation that best fitted the data, taking into account statistical significance, various diagnostic tests of model specification and interpretation. These equations show the influences of the included factors after taking into account the effects of all included variables<sup>31</sup>.

<sup>31</sup> Tests of interaction were also conducted (e.g. IB effects by user group for each outcome domain, interactions with pilot site models etc.) but none were found to be significant.

### 6.7.1 Social care outcomes (ASCOT)

The factors associated with variations between individuals in the levels of social care outcome (ASCOT) are shown in Table 6.12. As we saw in Tables 6.5 to 6.9 above, the ASCOT outcome indicator reflects level of need along seven dimensions: personal care/comfort; social participation and involvement; control over daily life; meals and nutrition; safety; accommodation cleanliness and comfort; and occupation and employment. Levels of need in each domain are aggregated in such a way as to reflect the relative importance attached to the different dimensions by the general population (see further details in Appendix C).

Not surprisingly, the results suggest that social care outcomes are significantly affected by physical and health problems. Hence, other than the ability to transfer from and to bed and chairs, greater ability to undertake ADL tasks improves users' social care outcomes<sup>32</sup>. Evidence of cognitive impairment reduces social care outcomes significantly. Perhaps a reflection of lower levels of disability, people in part-time or full employment enjoy higher levels of these social care outcomes.

There are also significant differences in scores on ASCOT between user groups. People with mental health problems had significantly lower scores (indicating higher levels of need), and people with learning disabilities had higher scores (lower needs), other things being equal. These differences between user groups may capture differences in intensity or type of disability, and may also reflect differences in the perception and attitudes towards the questions in the ASCOT instrument. Scores were also found to increase with age.

In terms of the effect of services, higher levels of services (as measured by weekly expenditure on support) led to improvements in outcomes ( $p < .10$ ), but the marginal effect is reduced as the intensity of provision increases<sup>33</sup>.

People in the IB group appeared to benefit from significantly better social care outcomes, other things being equal ( $p < .05$ ). The size of the effect, however, was no longer significant at the ten per cent level if we did not control for the fact that some IB users did not have a support plan in place by the time of the interview and in particular for the fact that in some cases user proxies were involved in answering the outcome questions. In other words, and perhaps not surprisingly, IBs were

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<sup>32</sup> When other factors are not included in the model, and particularly when the dummy variable identifying the learning disability user group is omitted, the effect of ability with ADL tasks is significant for all indicators of ability.

<sup>33</sup> Similar patterns of decreasing marginal effects of services on social care outcomes have been found for instance in Davies and Fernández (2000).

associated with better ASCOT scores only among IB users whose support plan had been **implemented** by the time of the interview<sup>34</sup>.

**Table 6.12 Production function for social care outcome (ASCOT)<sup>1</sup>**

	<i>Coefficient</i>	<i>P</i>
IB group	0.158	0.03
Count of abilities undertaking ADL activities (squared)	2.5E-04	0.04
Ability to transfer from and to bed /chair independently	-0.121	0.01
Learning disabilities user group	0.622	0.00
Mental health problems user group	-0.305	0.00
Individual is employed	0.499	0.00
Evidence of cognitive impairment	-0.174	0.02
Age	0.005	0.00
Weekly expenditure on support	3.4E-04	0.05
Weekly expenditure on support (squared)	-1.4E-07	0.16
Proxy involved in answering outcome questions	-0.027	0.02
Support plan not yet agreed	-0.102	0.20
Constant	3.248	0.00

<sup>1</sup> Model estimated using ordinary least squares. Positive effects denote improvements in the outcome. R<sup>2</sup>=0.09.

### 6.7.2 Control over daily life

Given its central relevance to the objectives of IBs, we separately analysed the outcome dimension in ASCOT that measures ‘control over daily life’ (Table 6.13). As found in the model looking at overall ASCOT scores, physical disability (problems with ADL activities), evidence of cognitive impairment and age were all found to affect significantly the level of control over daily life. In addition, people in the learning and physical disability groups reported higher levels of control over daily life, and users living with their partner reported lower levels of control.

In contrast with the patterns found for the overall ASCOT indicator, levels of service expenditure were **not** found to increase the feeling of control over daily living among individuals. Importantly, however, users with IBs reported significantly higher levels of control over daily life, other things being equal. As for the previous outcome

<sup>34</sup> A priori, one could expect outcomes to improve in the same way for the rest of the people with IBs once the support plan was implemented. However, it could be that in some cases the reason why support plans were not implemented was linked to complications in the application of the IB model. There are always likely to be some people who decline to take up an IB. The two results in this chapter – one for the intention-to-treat sample, and the other now suggested by the coefficient in the regression equation for having a support plan in place – probably span what would be expected in the wider and longer-term context.



indicator, the model controlled for the involvement of proxy responses, and for cases where the support plan was not yet agreed by the time the interview took place.

**Table 6.13 Production function for extent to which user feels in control over daily life<sup>1</sup>**

	<i>Coefficient</i>	<i>P.</i>
IB group	0.537	0.00
Count of abilities undertaking ADL activities (squared)	0.001	0.00
Evidence of cognitive impairment	-0.656	0.00
Lives with partner	-0.709	0.00
Age	0.009	0.05
Learning disabilities user group	0.716	0.01
Physical disabilities user group	0.444	0.02
Weekly expenditure on support	-1.1E-04	0.66
Proxy involved in answering outcome questions	-0.706	0.00
Support plan not yet agreed	-0.235	0.22

<sup>1</sup> Model estimated using ordered logit. Positive effects denote improvements in the outcome. Pseudo  $R^2=0.08$ .

### 6.7.3 General Health Questionnaire (GHQ)

Table 6.14 reports the results of the model predicting variations in GHQ scores (using a 0/1 coding). Given that GHQ is coded as a negative outcome indicator, negative coefficients in the table actually denote **improvements** in psychological well-being.

Ability to undertake ADL activities and age were again found to be important influences. However, the nature of the effects is different. Among individuals aged up to 48 years old, greater age was associated with lower psychological well-being, but after age 48, the association is reversed and older individuals enjoy **better** psychological well-being. This U-shaped effect of age on well-being has been identified in studies of general populations (Blanchflower and Oswald, 2004).

The effect of physical disability is also non-linear. Among the 42 per cent least able individuals (people scoring below 23 on the ADL scale), higher levels of ability are associated with lower levels of psychological well-being. For more able people (as rated on the ADL scale), greater ability to carry out the activities of daily living are associated with better psychological well-being. As found in the previous statistical analyses for other outcome indicators, people in the learning disability group report better well-being, and people with mental health problems lower well-being.

Higher levels of formal support, as indicated by the weekly expenditure on services and support, were associated with significantly better psychological well-being ( $p < .01$ ). The effect of IBs on psychological well-being, although positive, is not close to being statistically significant even at the ten per cent confidence level.

**Table 6.14 Production function for GHQ score (using 0-1 coding)<sup>1</sup>**

	<i>Coefficient</i>	<i>P</i>
IB group	-0.164	0.64
Count of abilities undertaking ADL activities	0.323	0.02
Count of abilities undertaking ADL activities (squared)	-0.007	0.01
Learning disabilities user group	-2.567	0.00
Mental health problems user group	1.306	0.01
Age	0.066	0.08
Age (squared)	-0.001	0.03
Weekly expenditure on support	-0.001	0.01
Support plan not yet agreed	0.131	0.73
Proxy involved in answering outcome questions	-0.009	0.78
Constant	0.328	0.88

<sup>1</sup> Model estimated using ordinary least squares. Positive effects denote improvements in the outcome.  $R^2=0.13$ .

#### 6.7.4 Quality of life

People in full-time or part-time education and employment, and individuals able to leave their home on their own appear to report significantly higher quality of life (Table 6.15). While these effects reflect differences in levels of functional ability, they are also likely to indicate the importance for quality of life of enjoying regular social contacts and of having the opportunity to undertake activities outside the home.

As was the case in all the previous outcome analyses reported above, people in the learning disabilities group exhibit better self-rated quality of life, other things being equal. Older people also report better quality of life.

In terms of the effect of services and support, the level of weekly expenditure on support appears to contribute significantly to a higher self-reported quality of life. However, as found in the social care outcome model (in Table 6.12), the marginal effect of services and support appears to decrease as greater levels of support are provided. Other things being equal, quality of life did not appear to differ between people assigned to the IB and comparison groups.

**Table 6.15 Production function for quality of life**

	<i>Coefficient</i>	<i>P</i>
Individual budget group	0.006	0.96
Student	0.550	0.00
Ability to move outdoors independently	0.112	0.05
Employed	0.545	0.04
Learning disabilities user group	0.971	0.00
Age (squared)	5.8E-05	0.01
Weekly expenditure on support	8.5E-04	0.00
Weekly expenditure on support (squared)	-5.0E-07	0.00
Proxy involved in answering outcome question	-0.236	0.03
Declined to take up individual budget	-0.099	0.64
Support plan not yet agreed	0.008	0.95
Constant	-4.391	0.00

Note: Model estimated using ordinary least squares. Positive effects denote improvements in the outcome.  $R^2=0.12$ .

### 6.7.5 Satisfaction

Although almost all of the variation in observed satisfaction levels remains unexplained by the statistical model, the results reported in Table 6.16 identify a number of important influences. Older people appear to express higher satisfaction levels. Being able to move indoors independently, benefiting from informal support and being white are also all associated with higher satisfaction.

Even though the results suggest a positive relationship between service and support levels and satisfaction, the effect was not significant at the ten per cent confidence level. However, users with IBs report significantly higher levels of satisfaction ( $p<.01$ ) after we have taken into account the effects of other factors. It is important to note, however, that the overall level of explanatory power of the model is very low, so we are not talking about a major impact for any of these factors on levels of satisfaction.

**Table 6.16 Production function for satisfaction**

	<i>Coefficient</i>	<i>P</i>
IB group	0.350	0.01
Age (squared)	0.007	0.01
Has informal carer	0.199	0.08
Ability to move indoors independently	0.148	0.04
White	0.380	0.06
Weekly expenditure on support	1.9E-04	0.28
Declined to take up individual budget	0.203	0.41
Support plan not yet agreed	-0.298	0.04
Proxy involved in answering question	-0.143	0.21
Constant	-4.140	0.00

Note: Model estimated using ordinary least squares. Positive effects denote improvements in the outcome.  $R^2=0.03$ .

## 6.8 Interpreting the outcome findings

Clearly, it is important to interpret the results presented here carefully. Earlier chapters have identified that the RCT design worked well in terms of the random and equivalent allocation of people to the IB and comparison groups. However, delays in implementation and in the IB process had knock-on effects for what we could identify in terms of outcomes six months after people had agreed to participate. On top of this, missing data reduced the number of people for whom composite measures were available, and if we exclude proxy responses the numbers fall even further. As we identified above, some differences between user groups may reflect differences in perceptions and attitudes rather than underlying differences in needs, well-being or satisfaction. However, differences in the instrument scores between user groups to some extent reflect what we would expect. Similarly, the GHQ measure was developed to screen for mental health problems and appears most sensitive to change for this group.

A key finding was that of higher levels of control expressed by members of the IB group, which is of particular relevance given the objectives of IBs. Given our caveats about expected effects (in view of the short follow-up duration, the delays in putting support plans in place and so on), this suggests that this particular finding must be an important one. While in most instances not statistically significant (which is not surprising given the limited level of actual implementation), the **direction** of effects in other domains of social care outcomes was generally encouraging.

The areas of social care outcome where there were some apparent negative effects for IBs were in the domains of social participation and involvement and occupation for some user groups. There are important considerations here. For the most part

these 'negative' differences were not statistically significant. It was only in the domain of occupation and for people with learning disabilities where there appeared to be a significant difference. But this difference not only disappeared once proxy responses were excluded, in fact it appeared to reverse. The sample size is so small that we must be careful in our interpretation, but as we discussed above, the 'proxy effect' may reflect differences in perceptions between the proxy and the service user, and/or differences in the types of individuals who needed a proxy respondent.

A very important message for rolling out IBs for older people is that they may have a negative impact on psychological well-being, at least in the ways these new arrangements were introduced and implemented during the pilot. The results suggest that while lower levels of well-being or higher anxiety levels might be slightly more prevalent among those older people able to respond in the interview, higher levels of anxiety appear to have been systematically attributed to more vulnerable older people who had IBs **by their proxy respondents**. We cannot distinguish whether this is due to the concerns of more vulnerable older people, less able to respond on their own behalf, or of their relatives (the most frequent proxy).

This finding may be partly a cohort effect, but clearly has implications for the pursuit of a 'personalisation' policy built on IBs or something like them. The effect on older people does not appear to be associated with social care outcomes, although it is noticeable that this group did not appear to experience the higher level of control with IBs reported by younger age groups. The findings during the two-month interviews suggested that this may be associated with the process of both planning and managing their own support – substantiating the views of some providers and care workers that we describe in later chapters. This is an aspect of care that is also likely to be of concern to carers and something it will be important to investigate further in the study of carer outcomes.



## Chapter 7      Costs and Cost Effectiveness

### 7.1 Introduction

A key question to be answered by the Individual Budgets pilot concerned cost-neutrality: was it possible to introduce IBs and so to improve choice and control without increasing the overall cost of the care system? This led us to ask whether IBs cost more or less than conventional arrangements, and how the costs compared across different service user groups. A second key question concerned cost-effectiveness: what was the balance between outcomes experienced by IB holders and the costs of achieving them, and how did that balance compare with conventional support arrangements?

In this chapter we draw together the evidence about the costs of social care, health care and support planning and management, and compare estimated costs for the IB and comparison group. We then undertake a statistical exploration of the relationships between needs, other characteristics of individuals and costs, and – crucially – the impact of IBs on these relationships. In the final section, we set out the findings from a series of cost-effectiveness analyses.

### 7.2 Method

We drew on information provided by local authorities on the costs of IB support plans and unit costs of mainstream services. Information about service use, including health services and use of funding streams other than social care, by those people not in receipt of IBs was collected at the six-month interview. We describe the approach to estimating costs in detail in Appendix A.

As we identified in Chapter 6, while the main comparison is between the IB and comparison group, there are a number of factors that ideally we want to take into account when making comparisons, and it is important to understand the relationship between costs, factors affecting need for support and outcomes. We address this complication through multivariate analyses, exploring both factors associated with variations overall and within the IB and comparison groups.

The cost-effectiveness analyses compute the mean difference in each outcome measure (such as the ASCOT) and divide it by the mean difference in costs to obtain a ratio. Simulations are made with the IBSEN data in order to consider whether these ratios are likely to be interpreted as indicating that IBs would be seen as cost-effective. That is, they ask whether a policy built on individual budgets is likely to achieve better user outcomes at a cost that is worth paying.

### 7.3 Social care costs

In reporting the value and content of IBs in Chapter 5 we used reported annual figures, including one-off payments. When drawing comparisons with people receiving standard care packages we focus on recurrent expenditure and use weekly costs drawing on the content of the support plan records to ensure that as far as possible we are comparing like with like<sup>35</sup>.

In total, 268 support plan records contained all the information about the funding allocated to particular services/activities. Differences between the total costs of support received by the comparison group and those offered an IB were small and not statistically significant: the average value of funding within IBs across all user groups was £279 per week compared with £296 in the comparison group.

Table 7.1 shows how the value of the packages and IBs varied between client groups, reflecting the pattern of overall budgets as reported in Chapter 5<sup>36</sup>.

**Table 7.1 Social care costs**

	<i>N</i>	<i>Overall weekly cost</i>
<b>Overall</b>		
IB group	268	£279
Comparison Group	250	£296
<b>Learning disability</b>		
IB group	70	£359
Comparison Group	63	£390
<b>Mental Health</b>		
IB group	35	£149
Comparison Group	33	£152
<b>Older people</b>		
IB group	73	£228
Comparison Group	66	£227
<b>Physical disability</b>		
IB group	90	£310
Comparison Group	88	£334

<sup>35</sup> It is difficult to reach firm conclusions as we cannot be sure whether hidden costs have been included in the expenditure for IBs. Moreover, we are costing social care for the comparison group using self-reported data and therefore there is always a possibility of reporting error. People in the IB sample who only received a visit from their local authority social worker/care manager have been omitted from the analysis.

<sup>36</sup> While the pattern is the same across user groups, the adjustments used to convert IBs to weekly package costs reported in Appendix A mean that the annual budgets and weekly amounts do not correspond exactly.



Table 7.2 gives the breakdown of costs: the weekly cost of home care in the comparison group was significantly higher (mean £70, with 51 per cent not receiving the service) compared with the IB-accepted group (mean £37, with 72 per cent not receiving the service). There were some significant differences between the groups: the weekly cost of employing a PA was higher in the IB-accepted group; the amount of ILF funding was higher in the comparison group<sup>37</sup>; and local authority social worker/care manager weekly cost was higher in the IB group.

**Table 7.2 Breakdown of costs (per week)**

	<i>IB group</i>	<i>Comparison group</i>
<b>All user groups</b>	<b>N=268</b>	<b>N=250</b>
Home care	£37	£70***
Meals service	£1	£1
Personal assistant	£100	£52***
Supporting People	£2	£4
Integrated Community Equipment	£18	£19
Independent Living Fund	£8	£30***
Social worker/care manager	£18	£11
<b>Older people</b>	<b>N=73</b>	<b>N=66</b>
Home care	£57	£90*
Meals service	£2	£2
Personal assistant	£66	£31*
Supporting People	£1	£1
Integrated Community Equipment	£29	£26
Independent Living Fund	£0	£0
Social worker/care manager	£16	£10
<b>Young adults with physical disabilities</b>	<b>N=90</b>	<b>N=88</b>
Home care	£24	£82***
Meal service	£1	£1
Personal assistant	£144	£73**
Supporting People	£1	£1
Integrated Community Equipment	£26	£29
Independent Living Fund	£14	£39**
Social worker/care manager	£16	£8***
<b>People with learning disabilities</b>	<b>N=70</b>	<b>N=63</b>
Home care	£48	£65
Meal service	£0	£0
Personal assistant	£112	£58*
Supporting People	£5	£7
Equipment	£3	£3
Independent Living Fund	£11	£66***
Social worker/care manager	£20	£10

<sup>37</sup> Funding from ILF, Supporting People and Integrated Community Equipment was added to the value of the IB when it was missing in the support plan record but baseline data was showing that the person was receiving the funding. For people in the comparison group, funding was included in the weekly cost of the package when it was indicated in the baseline data collection instrument or during the six month interview that the person received the funding.

	<i>IB group</i>	<i>Comparison group</i>
<b>People with mental health problems</b>	<b>N=35</b>	<b>N=33</b>
Home care	£5	£7
Meal service	£0	£0
Personal assistant	£39	£24
Supporting People	£3	£8
Equipment	£6	£6
Independent Living Fund	£0	£7
Social worker/care manager	£24	£25

Note: Significance level \*  $p < 0.05$ ; \*\*  $p < 0.01$ ; \*\*\*  $p < 0.001$ .

## 7.4 Health care costs

Summary data on the use of health care services and associated costs are given in Table 7.3. The mean health cost for the IB group was significantly higher (mean cost £83 per week;  $p < 0.05$ ) than for people in the comparison group (mean cost £59 per week). The significant difference between the two groups was partly associated with more in-patient stays among the IB group (mean cost £33 per week) compared with the comparison group (mean cost £19 per week), although the significant difference remained when hospital costs were removed from the equation.

The extent to which health service use and cost differed across service user groups is shown in Table 7.4. On average, there was a significantly higher health cost per week among older people (mean £107;  $p < 0.001$ ) compared with people with a physical disability (mean £76), people with a learning disability (mean £23), and people with a mental health problem (mean £76).

**Table 7.3 Health service use and costs by intervention groups**

<i>Health resource</i>	<i>IB group</i>	<i>Comparison group</i>
<b>Day Hospital in the last month</b>		
Mean number of visits to day hospital	0.28	0.26
Mean cost (£)	£40	£37
Mean cost per week	£10	£9
<b>Nurse in the last month</b>		
Mean number of times (at home and elsewhere) *	2	2
Mean cost (£)	£128	£98
Mean cost per week	£32	£24
<b>Therapist in the last 3 months</b>		
Mean number of times (combined at home and elsewhere)	1	1
Mean cost (£)	£37	£30
Mean cost per week	£3	£3

<i>Health resource</i>	<i>IB group</i>	<i>Comparison group</i>
<b>GP in the last 3 months</b>		
Mean number of times (combined at home and elsewhere)	2	1
Mean cost (£)	£55	£50
Mean cost per week	£5	£4
<b>A&amp;E department in the last 3 months</b>		
Mean number of times	0.21	0.18
Mean cost (£)	£7	£6
Mean cost per week	<£1	<£1
<b>Chiropodist in the last 3 months</b>		
Mean number of times (combined at home and elsewhere)	0.57	0.53
Mean cost (£)	£8	£7
Mean cost per week	£1	£1
<b>In patient service in the last 6 months</b>		
Mean number of days in hospital *	3.47	2.03
Mean cost (£)*	£797	£468
Mean cost per week*	£33	£19

Note: Significance level \* $p < 0.05$ .

**Table 7.4 Health service use and costs by service user group**

	<i>Service user group</i>			
	PD	LD	MH	OP
<b>Day Hospital in the last month</b>				
Mean number of visits to day hospital**	0.32	0.05	0.21	0.38
Mean cost (£)**	£45	£7	£31	£54
Mean cost per week**	£11	£2	£8	£14
<b>Nurse in the last month</b>				
Mean number of times (at home and elsewhere)**	1.75	0.79	1.60	1.91
Mean cost (£)**	£130	£53	£107	£142
Mean cost per week**	£33	£13	£27	£36
<b>Therapist in the last 3 months</b>				
Mean number of times (combined at home and elsewhere)**	1.44	0.80	0.70	0.74
Mean cost (£)**	£49	£27	£22	£25
Mean cost per week**	£4	£2	£2	£2
<b>GP in the last 3 months</b>				
Mean number of times (combined at home and elsewhere)***	1.79	0.90	1.47	1.60
Mean cost (£)***	£64	£29	£49	£61
Mean cost per week***	£5	£2	£4	£5
<b>A&amp;E department in the last 3 months</b>				
Mean number of times*	0.22	0.09	0.24	0.23
Mean cost (£)*	£7	£3	£8	£7
Mean cost per week*	<£1	<£1	<£1	<£1

	<i>Service user group</i>			
	PD	LD	MH	OP
<b>Chiropodist in the last 3 months</b>				
Mean number of times (combined at home and elsewhere)***	0.58	0.33	0.16	0.90
Mean cost (£)***	£8	£4	£2	£13
Mean cost per week***	<£1	<£1	<£1	£1
<b>In patient service in the last 6 months</b>				
Mean number of times ***	2.45	0.32	3.79	5.33
Mean cost (£)***	£567	£74	£861	£1231
Mean cost per week***	£24	£3	£36	£51

Note: Significance level \*p<0.05; \*\* p<0.01; \*\*\*p< 0.001.

## 7.5 Care and support planning and management

It was clear that, at the time of the fieldwork, local authorities were still learning and experimenting with care and support planning processes. They were also maintaining dual systems, making it hard to distinguish the longer-term comparative costs of the proposed new and conventional systems. (We conjecture – from the evidence in this study and elsewhere – about some of the possible longer-term impacts in Chapter 15.) Here we draw together information from both the evaluation and other sources to discuss the cost implications for care and support management and planning.

There are four different aspects of care and support planning and management:

- assessment (including self assessment)
- planning
- putting plans in place (including support brokerage)
- ongoing management.

Each of these might be conducted with a greater or lesser degree of involvement by a care manager, other worker in the local authority or outside agencies.

In our IB sample very few people had identified funding for support planning and support brokerage. Two people (one with a learning disability and one with mental health problems) received an average of £864 funding for support planning, while nine people received on average £292 for support brokerage. No older people were identified as having funding for support planning.

Evidence that we set out later (Chapter 12) strongly suggests that, rather than reducing their role, care managers were spending more time in all aspects of assessment and planning with IB holders compared with normal practice. There

were significant differences with increased time spent in assessment documentation and support planning. This could be an underestimate of the additional time since the comparison was between care managers with some (not all) IB holders on their caseloads and those with no IB holders. Hence any 'IB effect' could be diluted by the numbers of care managers with only a few IB holders on their caseloads. (The mean was 2.7 IB cases. Eighty-five per cent had four or fewer IB cases at the time of the data collection.) This was reinforced by evidence from the six-month interviews in which respondents were asked how many times they saw a local authority social worker or care manager in the previous three months. People in the IB group reported that they had seen a local authority social worker or care managers more frequently (Table 7.5). While this might be due to ongoing support and management of care, it is more likely that this reflects the fact that support plans were taking considerable time to put into place. The average care management cost for the IB group was significantly higher (mean £18 per week) compared with an average of £11 per week for the comparison group ( $p < 0.001$ ).

**Table 7.5 Care management**

	<i>IB group</i>	<i>Comparison group</i>
<b>Care management time</b>		
Mean number of visits***	1.66	0.98
Mean cost ***	£217	£128
Mean cost per week ***	£18	£11

Note: Significance level \*\*\* $p < 0.001$ .

In terms of ongoing management, most frequently (in over 40 per cent of instances) a member of the family was identified as managing the support. Only in about a fifth of cases was the IB holder identified as managing their own support. Care managers were identified in this role 27 per cent of the time, primarily through the local authority (in 21 per cent of cases). In 14 per cent of the plans, providers were identified as managing the support.

Later chapters will describe how pilot authorities varied in the degree to which they involved external organisations in support planning and brokerage. These arrangements were not well established during the main fieldwork period so it was not feasible to identify the costs of such arrangements on a consistent basis. IBs themselves rarely included an identified cost for this support. Only in 31 cases was the cost of payroll support included in the IB (mean £320; standard deviation £194). Despite the widespread use of direct payments, the costs of support for these were only included in the budget in seven instances (mean £2,218 standard deviation £194). This was much higher than average levels of support costs identified in previous research: a national study identified average expenditure by support organisations as £981 per person (uprated to 2007/08 prices) (Davey *et al.*, 2007).

Such payments were more frequently identified in our IB sample for younger physically disabled adults and people with learning disabilities.

A previous study calculated that care managers working with older people took an average of 10 hours 20 minutes to complete assessments, support planning and setting up packages (Davies and Fernández, 2000), costing £364 at 2007/08 prices. Work with other client groups tends to identify annual or weekly costs of involvement of care managers. Up-rated to 2007/08 prices, the costs of care management of people with mental health problems and learning disabilities from earlier research are very similar to the reported costs of the IB group: £18 and £19 per week respectively (Felce *et al.*, 2007; Byford *et al.*, 2000)<sup>38</sup>.

In light of uncertainty, we have not attempted here to identify comprehensive costs but to identify those elements of cost for which we have sound evidence. Even if we were able to reflect the actual costs of the care and support management and planning during the pilot, it is unlikely that this would be a true reflection of the costs of the process even now in light of the learning that the pilot authorities have undergone.

As identified elsewhere in this report, the nature of the pilot and the evaluation will have had an impact on the process of implementation and the costs of that implementation. Some of the pressures reported have been about the pace of implementation. However, the evidence about care management costs suggests that there would be significant additional set-up costs to those identified in Appendix B. Even if the costs of new cases are no higher than they would have been under the standard care system, if IBs are to be introduced universally there will be the costs of supporting people already in receipt of services through the IB process.

## 7.6 Predictors and sources of cost variation

In addition to contrasting average levels of support in the comparison and IB groups, we used multivariate regression techniques to:

- a) control more effectively for the effect on the allocation of resources of potential differences in baseline characteristics of users in the comparison and IB groups, and
- b) investigate in greater detail the nature of the interactions between needs, costs and outcomes, and some indicators of care processes.

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<sup>38</sup> We are not aware of any sources of evidence on the care management costs of adults (aged under 65) with physical or sensory impairments.

Table 7.6 summarises the results of this examination – called an expenditure function – of the impact of the baseline characteristics of individuals in the comparison and IB groups on the cost of their subsequent support. Overall, the results indicate that the allocation of services responds to a wide range of needs-related factors, including physical disability, mental health problems, informal support and broader socio-economic characteristics.

As we would expect, ability in activities of daily living was found to be negatively associated with the cost of the support package. A variable indicating that the care manager perceived the service user as having some degree of cognitive impairment was associated with higher costs. Interestingly, this effect is found over and above the indirect effect of cognitive impairment on costs through their impact on ADL problems. The fact that service users who are in employment receive statistically significantly fewer resources is likely to be related to lower average intensity of mental or physical problems among individuals able to maintain a professional activity.

**Table 7.6 Baseline individual characteristics predicting levels of support service expenditure**

	<i>Coef.</i>	<i>P.</i>
Individual budget group	-0.103	0.24
Count of lack of problems with ADL activities	-0.155	0.00
Count of lack of problems with ADL activities (squared)	0.002	0.00
Evidence of cognitive impairment	0.191	0.03
Mental health user group	-0.562	0.00
Age of service user	-0.009	0.00
Principal carer living in the household	-0.222	0.01
Service user is employed	-0.669	0.01
Service user is white	0.420	0.01
User refused Individual Budget	1.033	0.08
Support plan not in place by time of interview	0.299	0.05
Constant	8.101	0.00

Note: Model estimated as a GLM model, with a logarithmic link function and a Gamma variance function. Pseudo-R<sup>2</sup> = 11.5%.

Other things being equal, mental health service users appeared to receive lower levels of support. This finding could be explained by the fact that much support for mental health service users is funded and provided by health care services, which are outside the range of support accounted for in the expenditure explored in this analysis. However, overall health care expenditure in this group was no higher than for other user groups (see section 7.4).

Interestingly, even when the degree of physical disability was controlled for through the ADL ability indicator in the regression equation, the age of the service user appeared to be very significantly related to the cost of the support package. Older service users tended to receive significantly lower levels of resources. Ethnicity also appeared to be associated with resource use<sup>39</sup>.

The intensity of service provision depends in part on whether individuals are supported by informal caregivers, particularly on whether informal carers and service users live in the same household. Co-residence between users and informal caregivers has often been associated with very significant levels of informal support in previous research.

Of central importance to the present evaluation, Table 7.6 suggests that, once confounding factors are accounted for, IB holders tended to use fewer resources than users in the comparison group<sup>40</sup>. However, the differences between the costs of individuals in the two groups do not appear to be statistically significant at the ten per cent level. The fact that the analysis could not identify significant interaction effects between the receipt of IBs and baseline characteristics of service users, suggests that the allocation of resources for comparison and IB cases is broadly comparable.

Two indicators were included in the model in order to adjust for the fact that some people in the IB group did not have a support plan fully in place by the time of the six-month interview, and the fact that a number of people declined to receive an IB and opted instead to receive a standard care package. That people who declined an IB received on average significantly higher levels of resources is explained by the fact that, in most such cases, individuals turned down IBs precisely in order to avoid a reduction in the support package they received.

We looked for evidence of differences in expenditure levels between current and newly referred service users. After controlling for individual characteristics, the analysis suggests that newly referred cases received significantly higher levels of resources, equivalent to approximately £80 per week of extra support ( $p < .05$ ). Although this effect hints at the preferential treatment of new 'cases', it could also reflect the need to give particular support to people who are new to the care system because of their lack of experience in dealing with social care services.

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<sup>39</sup> Note that the demographic pattern of the population across England and the focus on different user groups by different pilot authorities mean that older and non-white groups are more heavily clustered in some localities than others. It is not possible to say whether the effects are associated with local authority policies or other individual factors before any definite conclusions can be drawn.

<sup>40</sup> On average, the model predicts that the support package of a case with the average characteristics in the sample with an IB would cost approximately £29 less than for an identical case in the comparison group. However, this difference is not found to be statistically significant.



We also explored differences in the factors explaining the size of the care packages of people with IBs and with standard support packages by statistically modelling the two groups independently (Tables 7.8 and 7.9). The results suggested that fewer factors affected the size of the IB packages compared with standard packages. In particular, IBs appeared to focus resources on a narrower range of ADL activities, and did not seem to increase significantly with levels of cognitive impairment once physical disability was taken into account. Other things being equal, the size of the support package was greater the younger the age of the user in both IB and comparison groups, with a slightly stronger age effect in the IB group (see Figure 7.1). Overall, it was slightly easier to explain the size of IB packages with the indicators available (see Figure 7.2)<sup>41</sup>.

**Table 7.7 Cost of care package among IB users**

	<i>Coeff.</i>	<i>P&gt;t</i>
Able to use toilet independently	-0.237	0.003
Able to feed self independently	-0.198	0.028
Informal carer living with user	-0.161	0.156
Mental health group	-0.621	0.000
Age of user (squared)	<0.000	0.000
Constant	7.030	0.000

Pseudo-R<sup>2</sup> = 22 per cent.

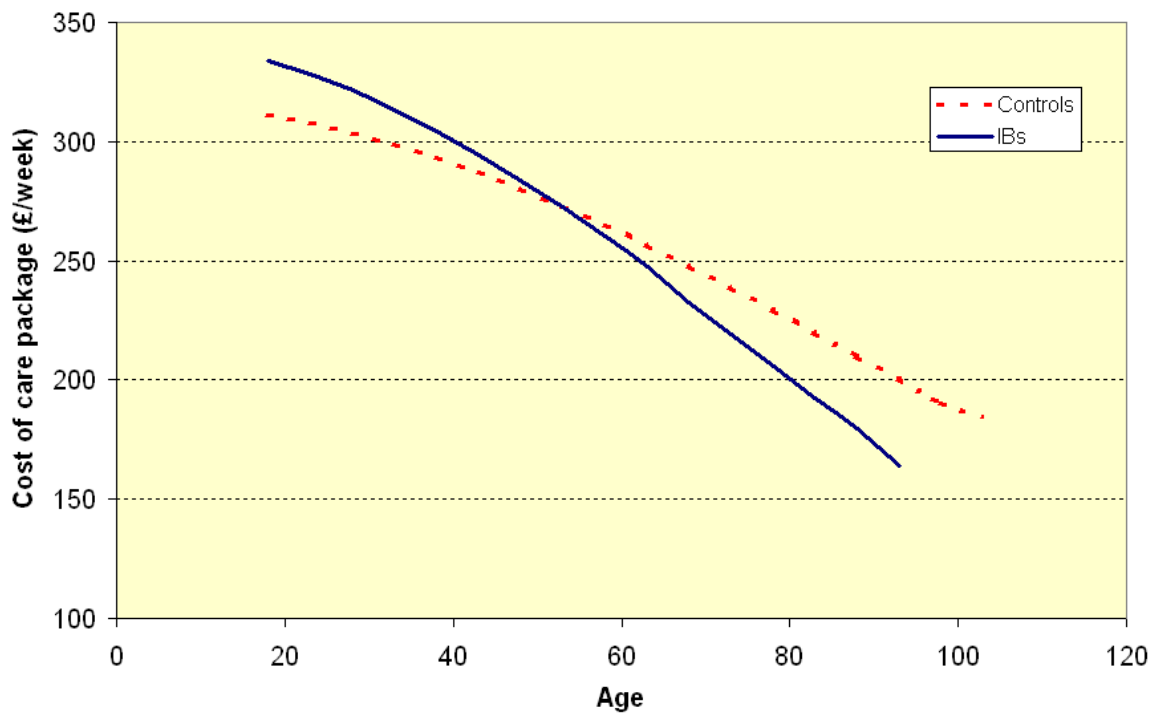
**Table 7.8 Factors predicting package costs among control group**

	<i>Coeff.</i>	<i>P&gt;t</i>
Count of lack of problems with ADLs	-0.153	0.004
Count of lack of problems with ADLs (squared)	0.002	0.034
Informal carer living with user	-0.144	0.201
Mental health group	-0.621	0.002
Age of user (squared)	<0.000	0.014
Evidence of cognitive impairment	0.348	0.002
_cons	8.084	0.000

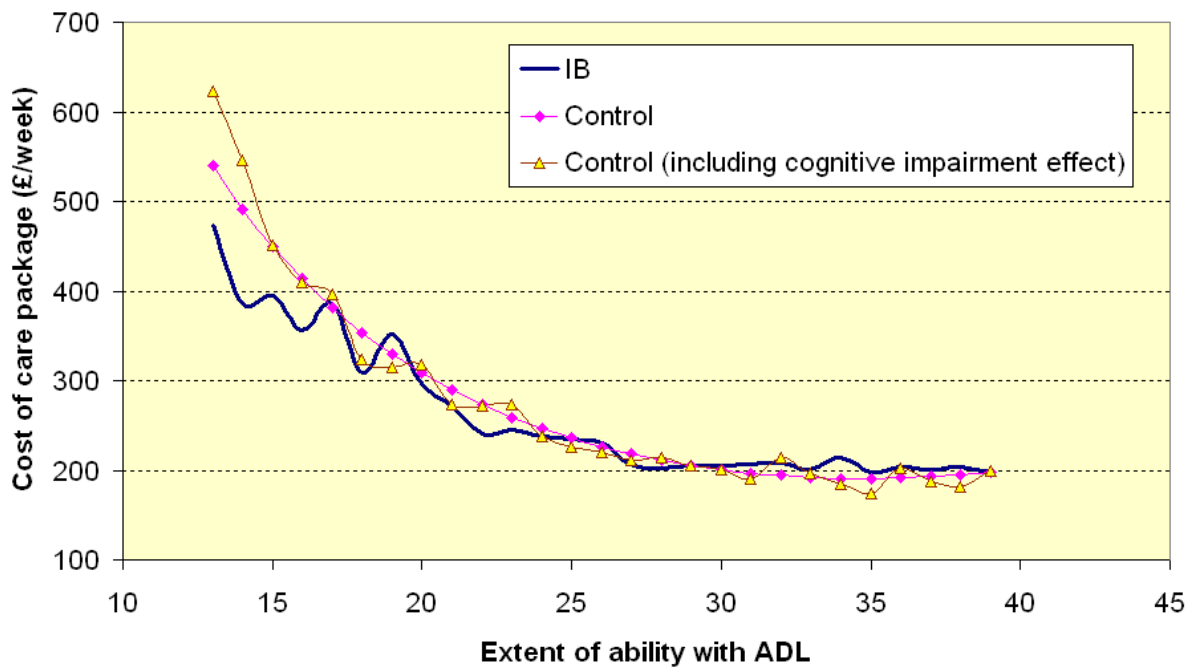
Pseudo-R<sup>2</sup> = 16 per cent.

<sup>41</sup> The IB model yielded a pseudo-R<sup>2</sup> of 22 per cent, compared to 16 per cent for the standard support model.

**Figure 7.1 Effect of changes in age on care package among controls and IBs (average case in sample)**



**Figure 7.2 Effect of changes in ability with ADLs on care package among controls and IBs (average case in sample)**



## 7.7 Cost-effectiveness analyses

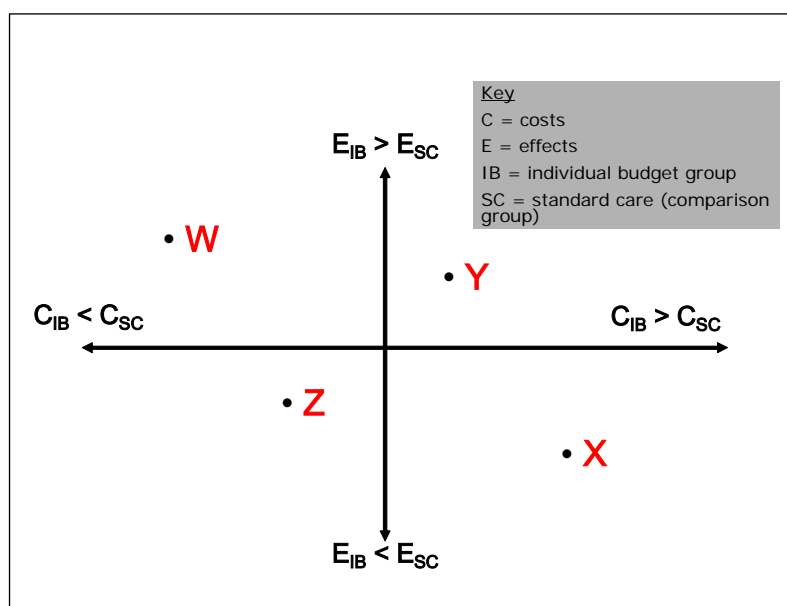
In considering the policy of personalisation – in this case as operationalised through IBs – decision makers are primarily interested in effectiveness: does the policy work in terms of improving user choice and control, quality of life, and met needs? Closely following behind is a second question: is it cost-effective? That is, does the policy achieve its aims (in terms of user outcomes) at a cost that is worth paying?

### 7.7.1 Calculating and visualising cost-effectiveness ratios

The cost-effectiveness evaluation within IBSEN examined the mean differences in outcomes over the six-month follow-up period between people randomly allocated to the IB group and those allocated to the comparison group, and compared them with the mean difference in costs between IB and comparison groups. A ratio of cost difference to outcome difference is computed – the so-called incremental cost-effectiveness ratio (or ICER) – for each outcome in turn. In fact, we concentrate here on two outcomes: the total ASCOT score and the GHQ-12 score (using the 0-1 coding of responses).

A common visual representation of the estimated cost-effectiveness ratio is to use a quadrant diagram (Figure 7.3). The horizontal axis measures the difference in costs: on the right of the axis, costs for the IB group are greater than costs for the comparison group; and on the left, IB costs are less than comparison group costs. The vertical axis measures the difference in outcomes: towards the top, outcomes for the IB group are better than outcomes for the comparison group; towards the bottom, outcomes for the IB group are worse.

**Figure 7.3 The cost-effectiveness plane**



The four quadrants therefore represent different results from the cost-effectiveness analysis:

- If the estimated ratio is in the north-west quadrant then the IB group has better outcomes and lower costs, and the implication would be that IBs were more cost-effective than standard support arrangements. So, for example, if the estimated ratio was point W on Figure 7.3, then this would indicate greater cost-effectiveness for IBs.
- In the south-east quadrant, the IB group has worse outcomes and higher costs relative to the comparison group. (In the figure, the point marked X is an example.) Standard arrangements would appear to be cost-effective.
- In the north-east quadrant, however, the conclusion would be that the IB group had better outcomes but also higher costs. Point Y is an example. It would then not be immediately obvious whether the extra costs associated with achieving these better outcomes are worth paying. That is, it is not clear with this finding from a study whether the IB policy would be seen as cost-effective.
- Finally, in the south-west quadrant (such as point Z), the conclusion to draw would be that the IB group had worse outcomes than the comparison group, but had lower costs. Again, it would not be obvious what cost-effectiveness conclusion to reach. The cost reduction that would follow from introducing IBs might look attractive to some decision makers, but it would only be achieved by leaving service users with worse outcomes.

The scenarios set out in the third and fourth bullets (and illustrated by points Y and Z) demonstrate well the issue that cost-effectiveness analysis aims to address: what is the trade-off between higher costs and better outcomes? There is no simple or definitive answer, for it depends fundamentally on what amount a decision maker is prepared to pay for better outcomes. This is why the discussion of the results below will necessarily have to use phrases such as 'appears to be cost-effective'. In health economics contexts it has been suggested that an estimated ICER is compared with some externally generated benchmark. There has been very little discussion of this issue in social care contexts, although the Wanless Inquiry approached the allocation problem in this way, and the ASCOT tool could in due course be used for this kind of benchmarking exercise<sup>42</sup>. One way to formalise this examination of whether the outcomes are worth the higher cost is to construct cost-effectiveness acceptability curves, although we do not report them here.

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<sup>42</sup> The approach adopted by NICE for health technologies is to use a benchmark of £30,000 per quality-adjusted life year (QALY) to indicate, approximately, whether a health technology looks cost-effective to the NHS. If a new technology, such as a new drug, can produce on average one additional QALY at a cost of less than £30,000 then it is likely to be seen as cost-effective and will probably be recommended for use in the NHS. If, on the other hand, it costs more than this benchmark amount to produce each additional QALY, then the technology will probably not get recommended – as happened when NICE looked at the dementia drugs in 2006.

In any empirical research study, quantitative or qualitative, there is uncertainty about the findings. In this case we can express this uncertainty in two ways, first by reporting the confidence intervals around the estimated cost and outcome differences. Secondly, we generated scatter plots of simulated cost-effectiveness ratios by using repeat sampling (3,000 repetitions) from the dataset and bootstrapping. We explain the interpretation of these scatter plots below.

### 7.7.2 The estimated cost-effectiveness ratios

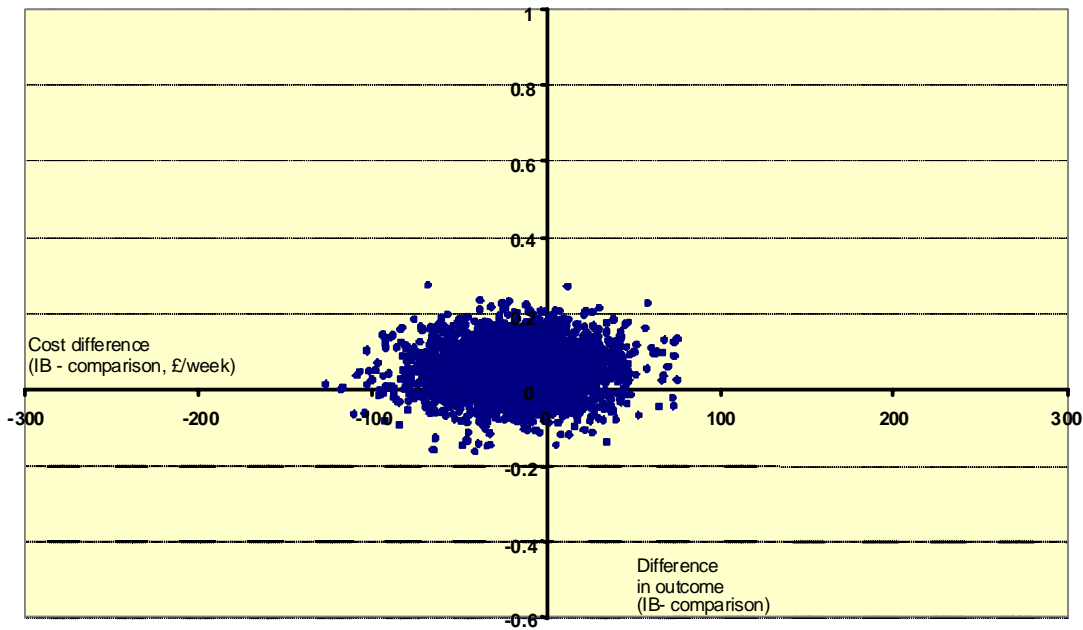
The average incremental cost-effectiveness ratios are given in Table 7.9, together with bootstrapped estimates of standard errors and normal distribution-based confidence intervals. Two outcomes are included: the overall ASCOT social care outcomes measure and the GHQ-12, scored using the 0-1 method. Normally a higher score on the GHQ indicates worse psychological well-being but to simplify matters and to make it consistent with the scoring of ASCOT, we have reversed the scoring for the purposes of calculating the cost-effectiveness ratios.

What do the figures in Table 7.9 tell us? For the full sample (all user groups combined), the IB group is slightly less costly than the comparison group (so the difference in cost is negative), the score on ASCOT is slightly higher for the IB group (so the difference is positive), and the score on the GHQ is slightly lower (indicating better psychological well-being) for the IB group (so the difference is now negative). The mean ICER using the ASCOT measure would be located in the north-west quadrant of our cost-effectiveness plane (like point W in Figure 7.3): on average across all user groups combined, individual budgets look to be cost-effective, although the mean value (-£222) is small and not statistically significant from zero (as shown in Table 7.9 by the wide confidence interval that spans zero). When we look at the mean ICER using the GHQ measure, however, there is a different story. The cost difference is of course the same (IB has slightly lower costs) but now the outcome measure favours the comparison group: the difference is very small but negative, suggesting that the comparison group had very slightly better psychological well-being. In this case, the cost-effectiveness ratio is equal to 250, which means that it was costing £250 to achieve an additional one-point gain in psychological well-being (measured with the GHQ) for the comparison group. Or it means that IBs could be used and would save money, but would leave users with slightly poorer outcomes.

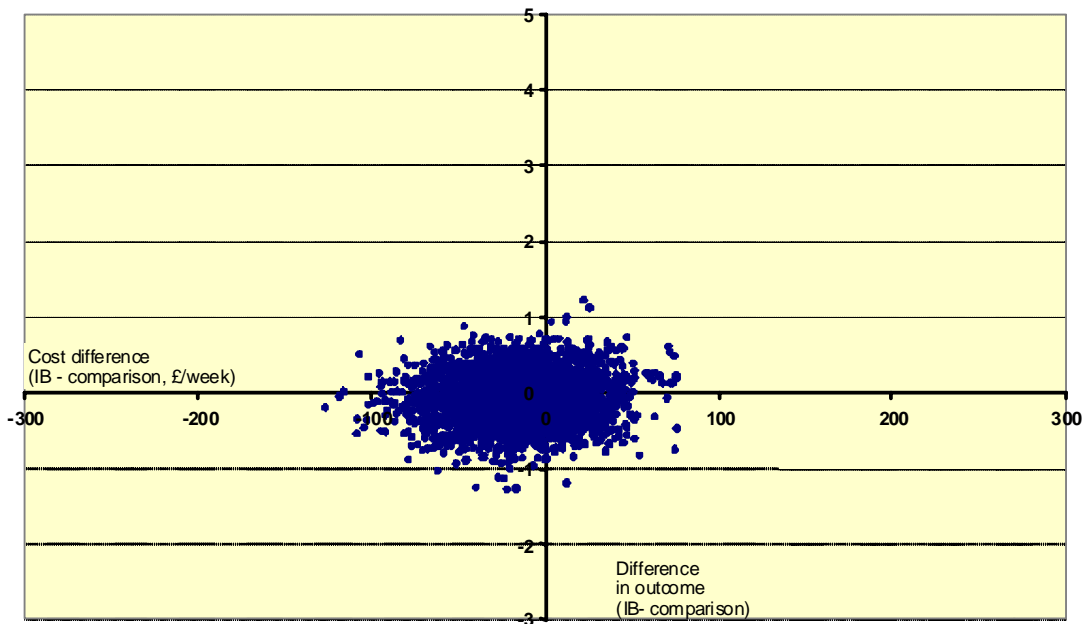
However, before jumping to conclusions we need to look at the variability and hence uncertainty in the sample, and here the scatter plots help us. Figure 7.4 shows the scatter plot of simulated cost-effectiveness ratios for the ASCOT measure and the estimated costs, again for the full sample. The plot shows that most of the simulated ICERs are in the north-west quadrant, although not very far from the origin, which suggests that individual budgets appear to be marginally more cost-effective than

conventionally arranged support. The scatter plot for the GHQ for the full sample (Figure 7.5) shows that there really is very little to choose between the IB and comparison arrangements as most of the simulated ICERs are bunched around the origin (no cost difference, no outcome difference). It is difficult to interpret a plot such as this one, and the cost-effectiveness acceptability curves that we will estimate later will show the information here a little more clearly, but they will not change the result.

**Figure 7.4 Incremental cost-effectiveness ratio for observed ASCOT: all user groups**



**Figure 7.5 Incremental cost-effectiveness ratio for observed GHQ-01: all user groups**



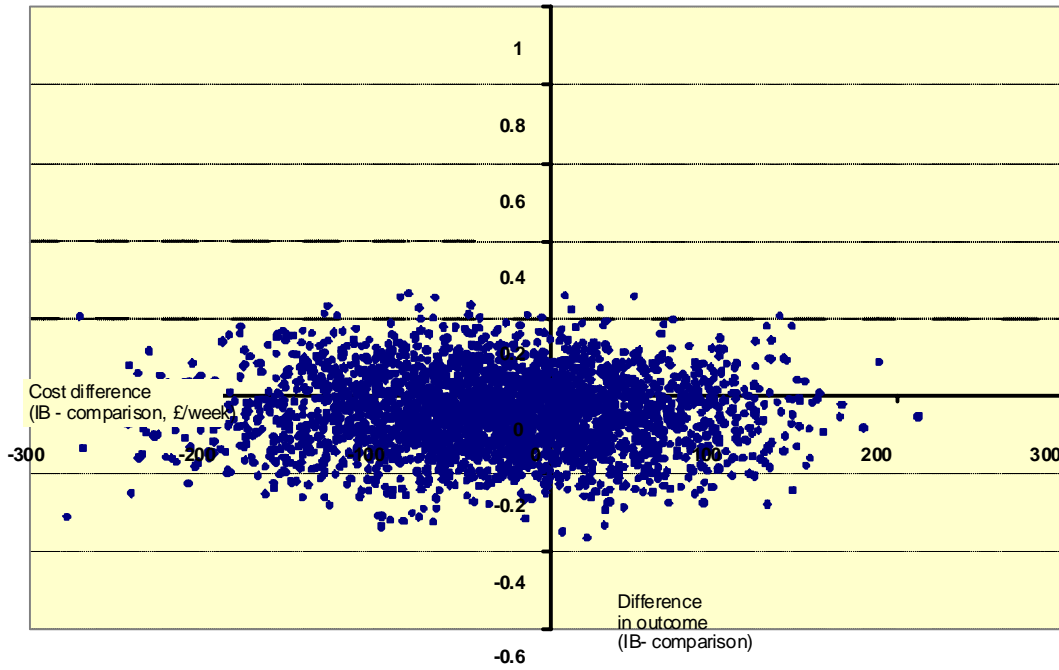
**Table 7.9 Estimated incremental cost-effectiveness ratios**

	<i>Mean</i>	<i>Bootstrap std error</i>	<i>Normal-based 95% confidence interval</i>	
<b>All sample members</b>				
Difference in cost (IB – Comparison group)	-16	29	-73	41
Difference in ASCOT score (IB – Comp)	0.07	0.06	-0.05	0.19
Cost per incremental change in ASCOT	-222	29850	-58727	58282
Difference in GHQ score (IB – Comp)	-0.07	0.32	-0.56	0.69
Cost per incremental change in GHQ	250	3627	-6858	7359
<b>People with learning disabilities</b>				
Cost per incremental change in ASCOT	42937	36743	-29077	114951
Cost per incremental change in GHQ	56	1516	-2915	3027
<b>People with learning disabilities, excluding those without a support plan in place</b>				
Cost per incremental change in ASCOT	-1690	169189	-333295	329915
Cost per incremental change in GHQ	-142.	6978	-13536	13820
<b>People with mental health problems</b>				
Cost per incremental change in ASCOT	-14	4826	-9473	9445
Cost per incremental change in GHQ	-3	509	-1001	995
<b>Older people</b>				
Cost per incremental change in ASCOT	-61	101635	-199262	199141
Cost per incremental change in GHQ	-2	1105	-2166	2161
<b>Younger physically disabled people</b>				
Cost per incremental change in ASCOT	-214	18963	-37382	36954
Cost per incremental change in GHQ	-107	2816	-5625	5412

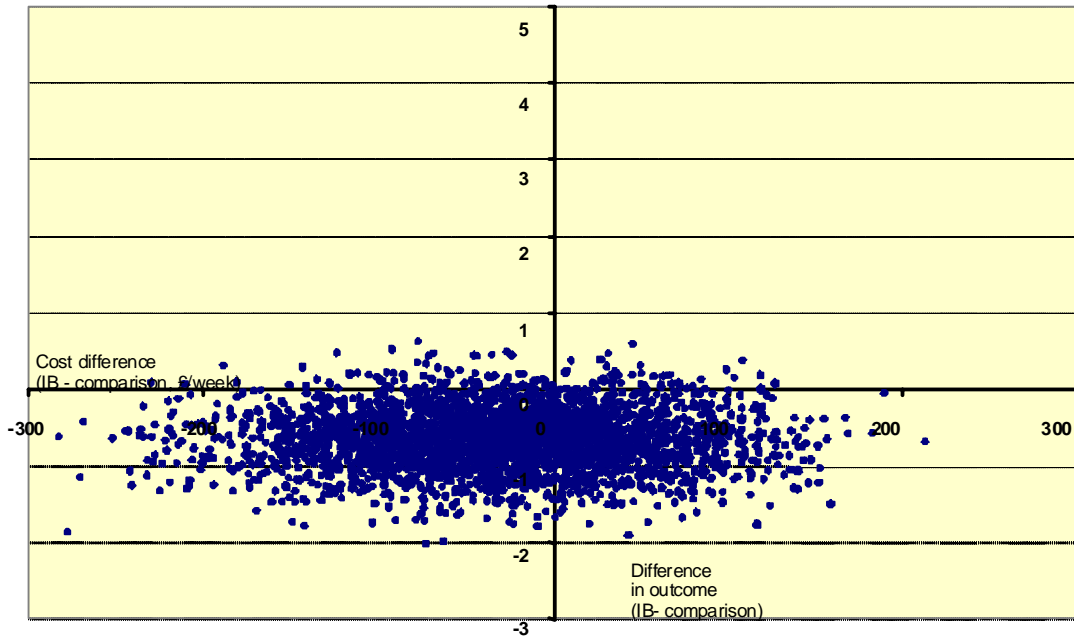
We followed the same approach for each of the separate user groups in turn: the mean values of the cost-effectiveness ratios are reported in Table 7.6, and the scatter plots are illustrated. We have carried out two additional cost-effectiveness analyses and associated scatter plots for the learning disability group, after excluding those people without a support plan in place. These are also reported in Table 7.6. The remaining scatter plots are shown Figures 7.6 to 7.15. What do they tell us?

For people with learning disabilities, the ICER for ASCOT is very high, but this is driven by the fact that the cost difference between the groups is almost zero. The scatter plot (Figure 7.6) shows a wide variance and no evidence of relative cost-effectiveness for either IBs or standard arrangements. Using the GHQ to measure outcome, the ratio and scatter plot (Figure 7.7) suggest that IBs might be slightly less cost-effective than standard arrangements, but the difference is not statistically significant. When we narrow the sample by excluding people who did not have a support plan in place, we find that the IB group is slightly less costly and the ICER for ASCOT now appears to favour the IB option, although for the GHQ, the comparison group arrangement certainly looks more cost-effective (Figures 7.8 and 7.9).

**Figure 7.6 Incremental cost-effectiveness ratio for observed ASCOT: people with learning disabilities**

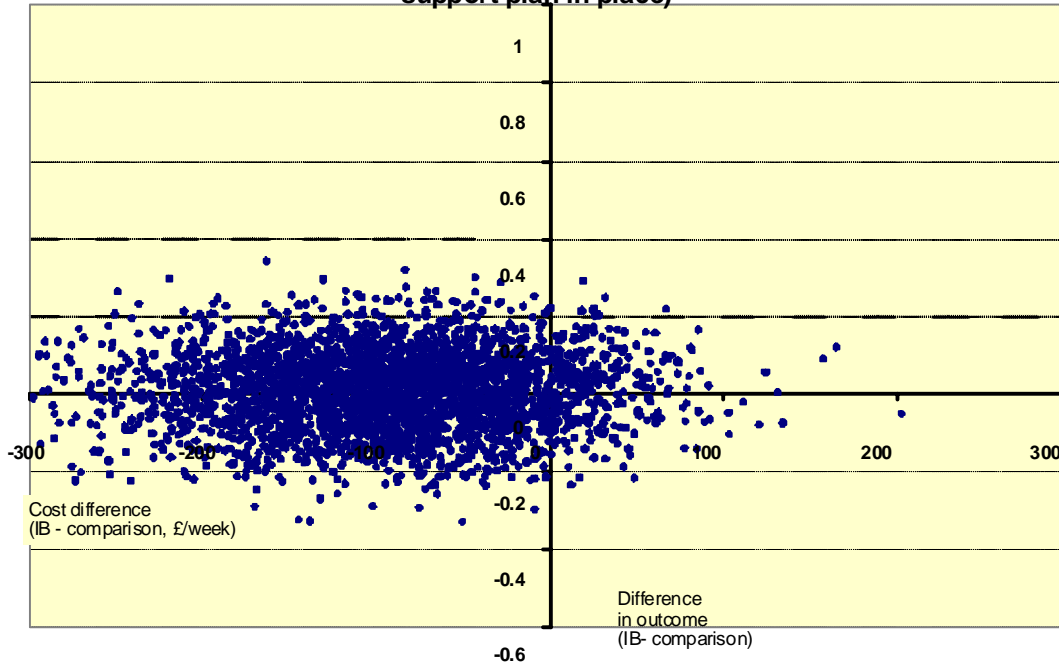


**Figure 7.7 Incremental cost-effectiveness ratio for observed GHQ-01: people with learning disabilities**

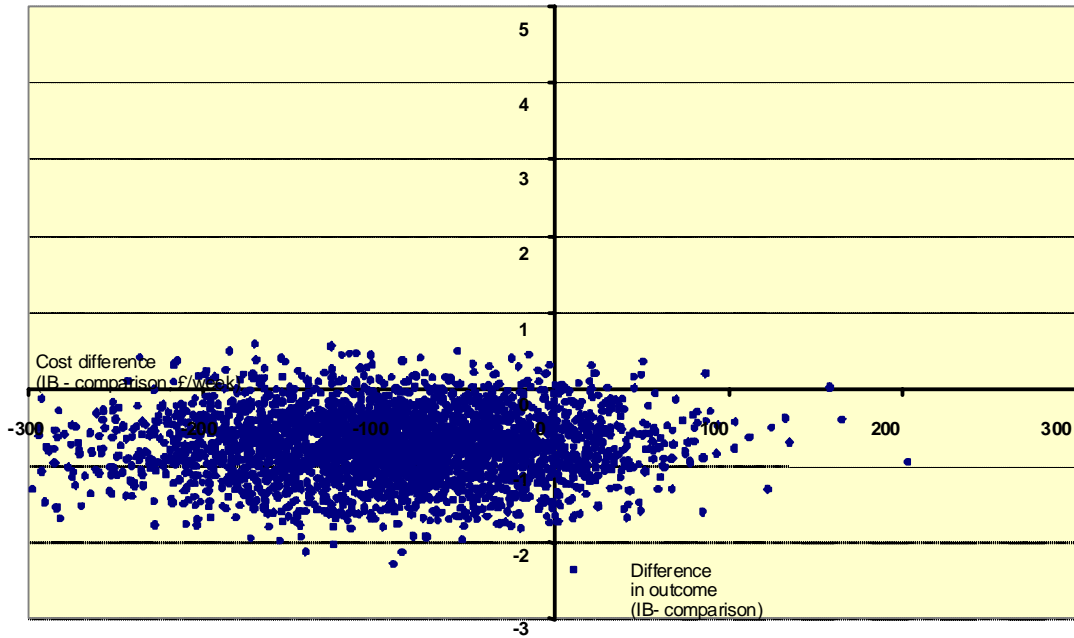




**Figure 7.8 Incremental cost-effectiveness ratio for observed ASCOT: people with learning disabilities (excluding individuals without a support plan in place)**

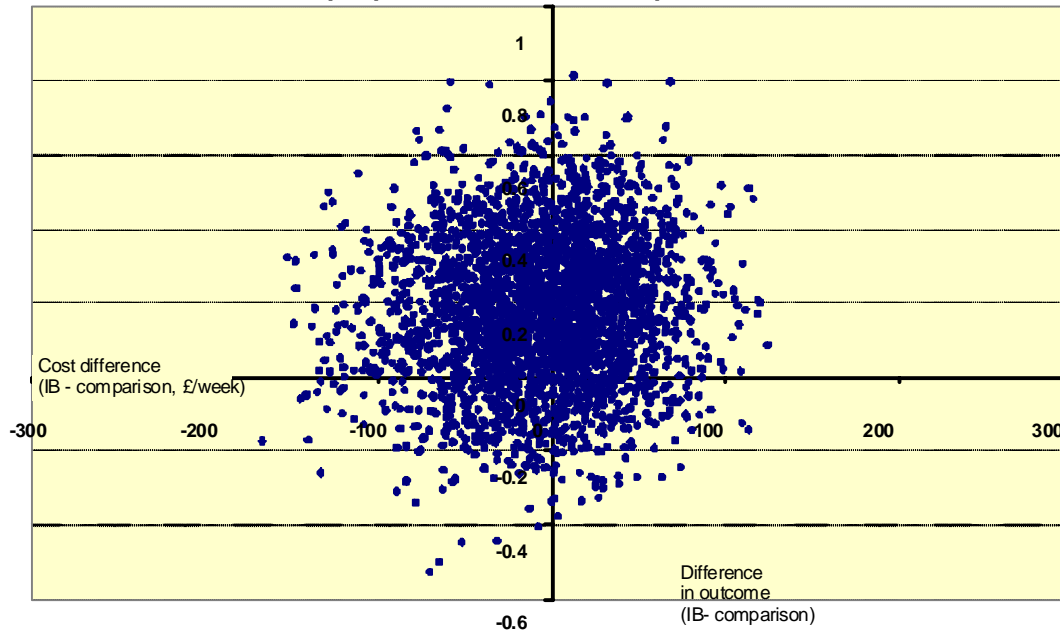


**Figure 7.9 Incremental cost-effectiveness ratio for observed GHQ-01: people with learning disabilities (excluding individuals without a support plan in place)**

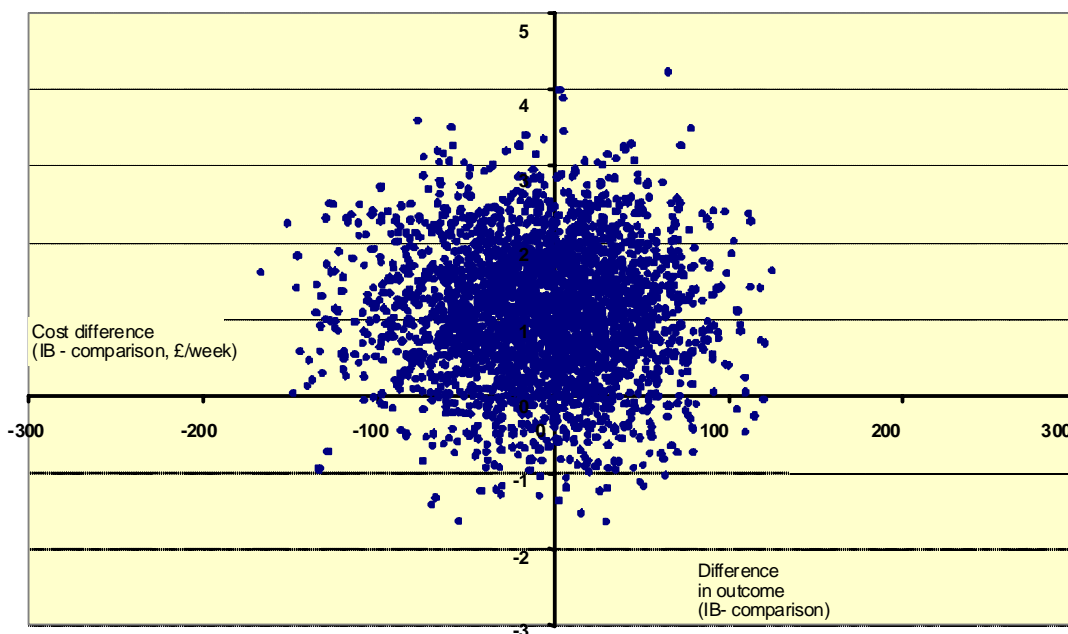


For mental health service users, IBs look more cost-effective than standard arrangements on both the ASCOT and GHQ. Both mean ratios are negative, although small in size relative to the estimated standard errors, and the scatter plots (Figures 7.10 and 7.11) suggest better outcomes at roughly an equivalent cost. This would be seen as indicating cost-effectiveness.

**Figure 7.10 Incremental cost-effectiveness ratio for observed ASCOT: people with mental health problems**

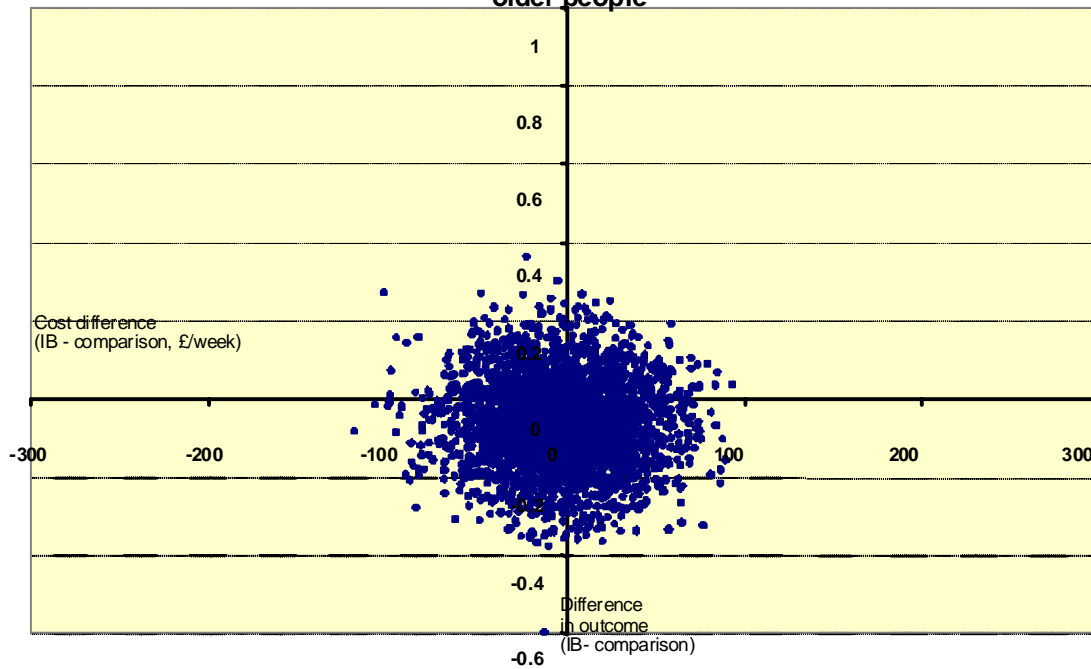


**Figure 7.11 Incremental cost-effectiveness ratio for observed GHQ-01: people with mental health problems**

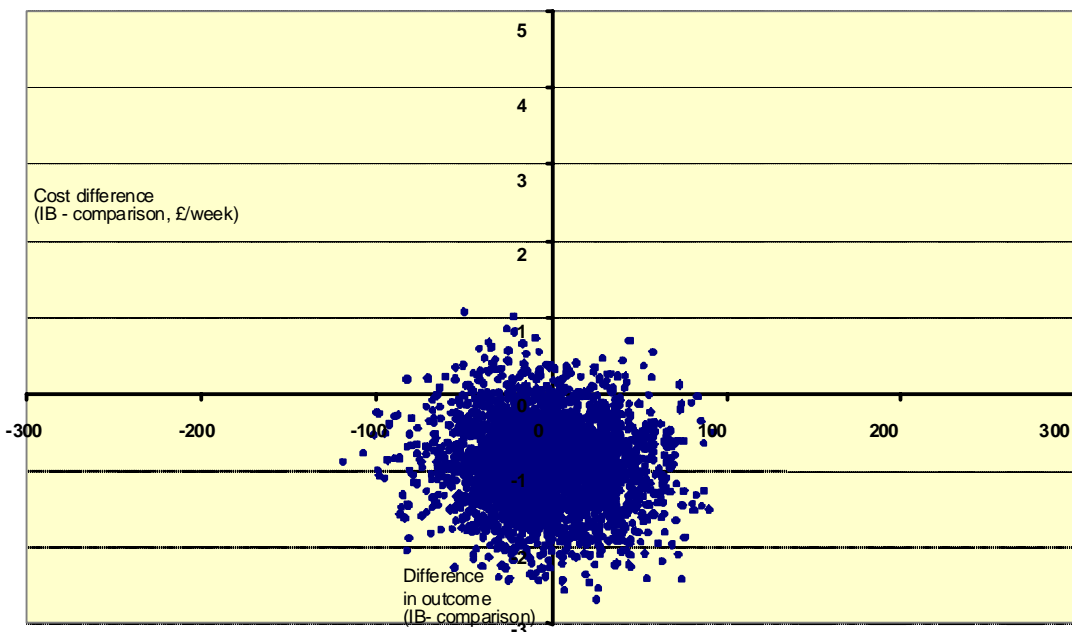


For older people there is no sign of comparative cost-effectiveness on the ASCOT, and on the GHQ the IB option looks marginally less cost-effective than standard arrangements (Table 7.6 and Figures 7.12 and 7.13).

**Figure 7.12 Incremental cost-effectiveness ratio for observed ASCOT: older people**

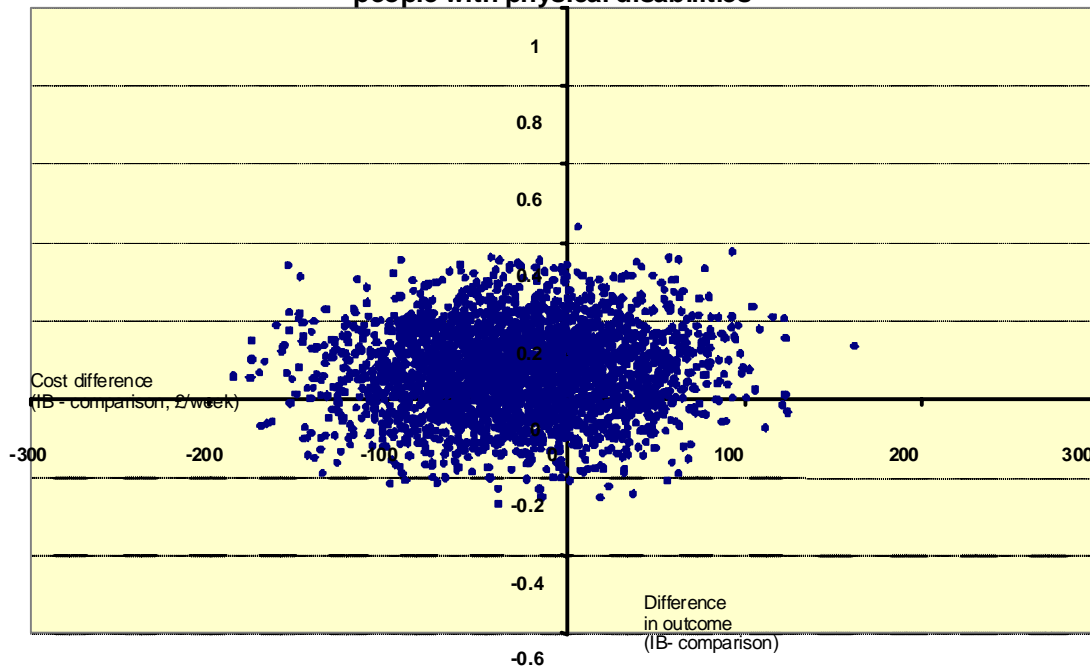


**Figure 7.13 Incremental cost-effectiveness ratio for observed GHQ-01: older people**

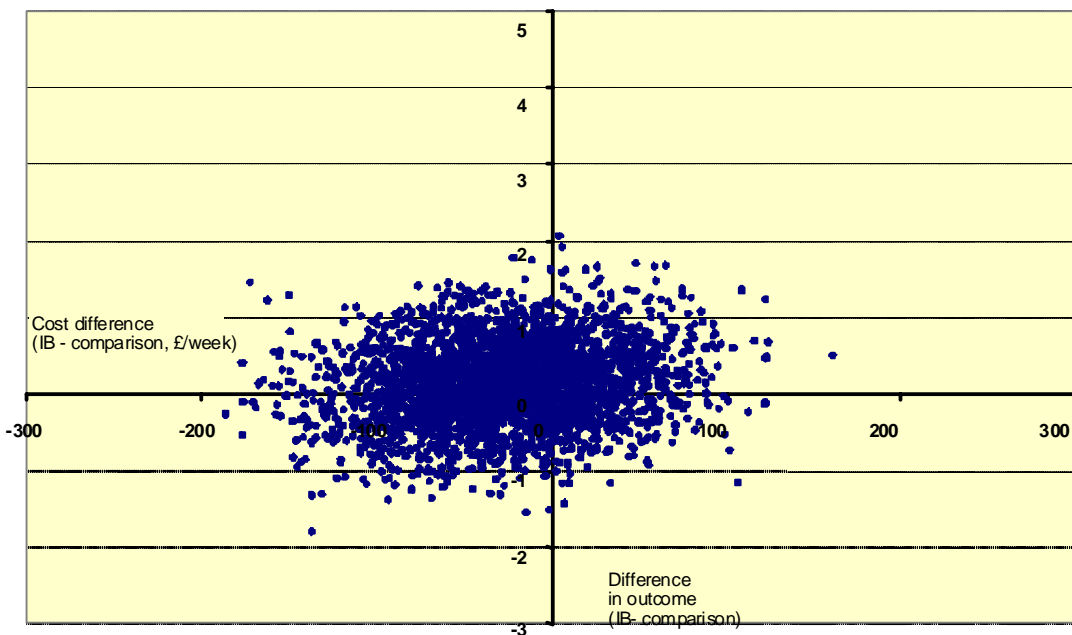


For younger physically disabled people, there appear to be small cost-effectiveness advantages for IB over standard support arrangements, more so on the ASCOT than on the GHQ (Table 7.6 and Figures 7.14 and 7.15).

**Figure 7.14 Incremental cost-effectiveness ratio for observed ASCOT:  
people with physical disabilities**



**Figure 7.15 Incremental cost-effectiveness ratio for observed GHQ-01:  
people with physical disabilities**



What do we conclude from these cost-effectiveness analyses? Given the short follow-up for people allocated to the IB group and the delays in actual implementation – at the time of interview, some people did not have their support plans in place and for many others they had only been set up relatively recently – the findings are broadly encouraging for the new arrangements:

- Across *all user groups combined* there is some evidence that IBs are more cost-effective in achieving overall social care outcomes, but no advantage in relation to psychological well-being.
- For *people with learning disabilities*, there is a cost-effectiveness advantage in terms of social care outcomes but only really when we exclude people without support plans in place from the analysis. In other words, the *potential* is there to achieve cost-effectiveness, but implementation delays in the pilot sites meant that we did not observe this during the evaluation period. When looking at the psychological well-being outcome, standard care arrangements look slightly more cost-effective than IBs.
- Cost-effectiveness evidence in support of IBs is strongest for *mental health service users*, on both the outcome measures examined here.
- For *older people*, there is no sign of a cost-effectiveness advantage for either IBs or standard support arrangements using the social care outcomes measure. Using the GHQ outcome measure, standard arrangements look marginally more cost-effective.
- There appear to be a small cost-effectiveness advantage for IB over standard support arrangements for younger physically disabled people using either of the outcome measures.

## 7.8 Discussion

As we emphasised above, we must be cautious in our comparisons of costs as there are many uncertainties in the way that costs and expenditure have been reported, particularly for the IB group. Our presentation of the costs is necessarily not comprehensive as we have not been able to include the costs to and for carers, or their associated outcomes. Ongoing work by some members of the IBSEN team will later be able to shed light on these impacts, but for the moment this remains an omission that needs to be borne in mind in interpreting the outcomes.

Overall the picture would suggest similar levels of social care package costs for the IB and comparison groups, which is what we would expect given the bases of the resource allocation systems used to identify or guide the size of the IBs. Health care costs appeared to be higher in the IB group, possibly reflecting more intense focus and involvement of professionals and others in the planning process for these

individuals, resulting in better identification of unmet health needs and access to health care.

Some previous commentaries on self-directed support have suggested that, with the greater involvement of individuals and their families, there might be reduced costs of the care and support planning and management process. While individuals and their families were clearly involved in the processes of care and support planning and management in the IB group, we could find no evidence of cost saving. Indeed, the indications were, at least in this pilot stage, that there were increased costs in terms of care management time. Whether this situation would persist in the longer term is a different question, and one to which we return in Chapter 15. It clearly has implications for local authorities planning the pace at which they would want to implement IBs into mainstream practice.

Our statistical interrogations of the expenditure variations between individuals revealed some interesting associations. Among other things, they suggested that where a support plan was not yet in place, costs were higher, which could be interpreted as indicating that the full (individual) operationalisation of an IB could bring costs down in the longer term. Alternatively, this could reflect more complex cases taking longer to be implemented.

Are the outcome gains that we charted in Chapter 6, modest as they are, worth the cost of achieving them? The findings are (cautiously) encouraging for the introduction of IBs. This is particularly the case for people with mental health problems, and probably also for younger physically disabled people. When we look at the results for people with learning disabilities, IBs appear to be more cost-effective once we take into account that a number of people in the sample had been randomised to the IB group but not actually had a support plan set up by the time of the follow-up interview. As far as older people are concerned however, there is no evidence of cost-effectiveness from this pilot.

These outcome and cost-effectiveness findings very clearly emphasise the need for *properly evaluated* innovations in social care. A number of observers expressed concerns about the ethical implications of, as they saw it, withholding IBs from comparison group members. Our results imply that it is important *not* to assume in the absence of evidence that such interventions are necessarily a 'good thing' for everybody. There was no robust UK evidence on the effectiveness of IBs prior to this study, and our results now show why an evaluation design of this kind was needed.

## Chapter 8      Integrating Funding Streams With Adult Social Care

### 8.1 Introduction

The original proposal for individual budgets, in the Cabinet Office Strategy Unit's report *Improving the Life Chances of Disabled People* (PM's Strategy Unit, 2005), suggested that IBs should bring together local authority resources for community care; integrated community equipment and housing adaptations budgets; the Independent Living Fund (ILF); Access to Work (AtW); and the Family Fund for disabled children. The inclusion of these funding streams was restated in the 2005 DH Green Paper *Independence, Well-being and Choice* (DH, 2005). A third policy statement *Opportunity Age*, setting out a UK-wide strategy for an ageing society (HM Government, 2005), additionally suggested the inclusion of housing support and permissive powers to allow 'other discretionary services in individual budgets, for example leisure and transport services provided by local councils (HM Government, 2005: 52).

The potential of integrating multiple funding streams into a single personalised budget was one of the distinctive features of IBs. This set IBs apart from both Direct payments and *In Control*, both of which involve local authority adult social care funding only. Underpinning the proposal were expectations that assessments and eligibility criteria could be integrated, or at least aligned, in order to cut down the number of assessments that disabled and older people have to undergo. The original proposals for IBs did not prescribe the sectoral or organisational base for IBs and, early in the Pilot Projects, questions were raised about whether IBs could be awarded to people who were not eligible for adult social care but were entitled to resources from one or more other funding streams. However, the location of the IB Pilot Projects within adult social care determined by default that this was to be the organisational gateway to IBs; consequently the integration of multiple funding streams became a question of their integration or alignment with processes located within adult social care.

Also implicit in the original proposals for IBs was the assumption that, once integrated into a single individual budget, the resources from the different funding streams to which an individual was eligible could be used flexibly to meet whatever needs and priorities the IB holder considered important to maintain independence and social inclusion. Such flexibility was explicit in earlier measures allowing pooled budgets between NHS and local authorities; under Section 31 of the Health Act 1999, such pooled resources lose their distinctive health or local authority identity and can be spent in whatever ways are appropriate to meet jointly agreed goals (Glendinning *et al.*, 2003).

The key questions relating to the integration of additional funding streams concerned the extent to which eligibility criteria and assessment processes could be integrated, or at least aligned, in order to reduce duplicative assessments for disabled and older people; the degree of flexibility with which particular funding streams could be used within an IB; and where responsibilities lay for audit and review. Here the evaluation was particularly interested in where responsibilities lay for assessing whether the goals and objectives attached to particular funding streams had been met, once resources had been integrated within IBs that were organised and delivered through adult social care. Additional questions concerned the perceived benefits and drawbacks – from the perspectives of adult social care services and of IB holders – of integrating particular funding streams; the viability of funding streams if some resources were top-sliced and transferred to adult social care; and equity between those who received resources from a particular funding stream through an IB and those who did not.

The evidence reported in this chapter is taken from interviews with IB lead officers in all 13 pilot sites and from interviews with funding stream leads in the four ‘in-depth’ case study sites. Experiences of each funding stream are dealt with separately; the chapter concludes with reflections from the IB lead officers about other funding streams that could be considered for inclusion with IBs, and an overview of users’ understanding and experience of aligned or integrated funding streams.

## **8.2 Overview**

Support for the integration or alignment of most funding streams, was in principle, positive and the integration of Supporting People funding was generally felt to have been the biggest success. However, the majority of IB and funding stream leads whom we interviewed were disappointed at the slow progress with integration of other funding streams despite often significant local investment in understanding how the different funding streams operated and how integration may be achieved.

### **8.2.1 Common benefits from attempts to align/integrate funding streams**

#### ***8.2.1.1 Awareness-raising of other funding streams***

Most IB lead officers reported that attempts at integration or alignment had at least raised understanding and awareness of the various funding streams among front-line staff, and led to an increase in applications to other funding streams (particularly the ILF) and/or to more discussion with users around, for example, employment issues (with greater awareness of Access to Work).



### **8.2.1.2 New or improved working relationships**

Several IB lead officers reported that, through the IB pilot, they had instigated, renewed or improved their personal or their department's professional relationships with other funding streams. IB and funding stream leaders reported a greater understanding of the aims, rules, regulations, eligibility criteria, responsibilities and procedures within adult social care and the other funding streams, with teams giving presentations to one another in some sites. This greater understanding and improved working relationship was reported to be beneficial to both front-line staff and to service users, whether IB holders or not.

### **8.2.1.3 Co-location of teams**

IB lead officers in pilot sites in which those responsible for other funding streams were located in the same building, or particularly within the same Directorate, as adult social care, reported feeling better placed to co-ordinate integration or alignment:

Also the fact that four of the income streams are ... managed by the same Director has got to have made things easier, because we've just found a way round the problems, whereas I suppose if housing had been separate from social care then we might have had a battle on our hands with the Director of Housing but it's one and the same Director so it hasn't, that hasn't been a problem either ...

(IB lead officer, metropolitan district)

## **8.2.2 Common challenges with integrating and/or aligning funding streams**

### **8.2.2.1 Legislative barriers and restrictions on how resources could be used**

Most IB lead officers and funding stream leaders representing Access to Work, Disabled Facilities Grants and the Independent Living Fund agreed that these three funding streams in particular were difficult to include within Individual Budgets since national legislation effectively prohibited integration at local level:

But actually, the reason they're not aligned is that they're all governed by separate Government bodies with their own rules and regulations.

(IB lead officer, county council)

Consequently, there was little flexibility in what monies from those funding streams could be used for. So, for example, if an IB holder could make efficiency savings in the support that they received to maintain their employment, any monies left over from their AtW entitlement could not be used to purchase other types of support as the money was ring-fenced for employment-related support. Similarly, monies from a DFG are only paid out upon proof of receipt and specific adaptations being carried out to particular specifications; any cost saving secured by the IB holder could not be used to purchase further adaptations or other types of support. And ILF monies can

only be spent on personal care and domestic assistance. Such rigidities are a result of existing legislation and could not be overcome by IB teams and funding stream leaders at local level.

#### **8.2.2.2 Accountability to individual funding streams**

IB holders remained directly accountable to each contributory funding stream for the resources that they received, with the exception of ICES and Supporting People in some sites. These barriers were considered incompatible with the IB principles of transparency and flexibility. Parallel and sometimes conflicting monitoring and review arrangements were also problematic and prohibited the streamlining of review processes for the individual IB holder.

#### **8.2.2.3 Concerns over destabilising the market**

In theory, increased consumer choice and the power of the markets ought to ensure that providers who are more flexible and responsive to consumer demands prosper while those that do not provide as good a service fail. However, Supporting People and ICES lead officers, in particular, expressed concerns over the possibility that IBs could destabilise the market. IB and SP lead officers relayed concerns from providers of supported living services around planning staffing and income levels if some resources were top-sliced for IBs and IB holders chose to take those resources elsewhere. SP lead officers were particularly concerned about the potential loss of accommodation-based services and the impact on those service users who were not part of the IB pilot or those who were unable or unwilling to consider moving to a different provider. ICES lead officers were concerned about destabilising existing community equipment services for similar reasons.

#### **8.2.2.4 Budgetary implications of the expected increase in demand**

IB and funding stream lead officers all reported some expectation that demand for, or applications to, all funding streams would increase as awareness of the funding streams increased and as individuals who had not previously approached or accepted social care services would do so, some of whom would be eligible for resources from other funding streams. Despite the budgetary implications of any such increase, this could mean that more older and disabled people have greater access to more resources that could help to support them in more personalised ways.

#### **8.2.2.5 Social care as the gateway to other funding streams**

IB lead officers expressed concern that the potential integration of funding streams could lead to social care becoming the gateway for all older and disabled people to access resources from those other funding streams, including those individuals who are ineligible for adult social care. This raised issues around capacity and the additional costs to adult social care of undertaking assessments for a wider population. For example, in relation to AtW, one IB lead officer commented:

... most people who get Access to Work aren't eligible for our services and I don't think we would want to take on the overheads of doing assessments for all those people unless we got a lot more money for doing it. So I think there would have to be some agreement about funds transferring between agencies to do that really.  
(IB lead officer, unitary authority)

These issues presented practical difficulties, but were also felt by interviewees to challenge the very principles of transparency and flexibility that sites and the government were aiming to achieve. Some of the reported difficulties may be 'pilot effects', i.e. restrictions on radical change in the context of an initiative that may not have been carried forward.

### **8.3 Supporting People**

Supporting People (SP) operates under the auspices of the Department for Communities and Local Government (CLG). SP funds support services that aim to 'provid[e] a better quality of life for vulnerable people to live more independently and maintain their tenancies' (Office of the Deputy Prime Minister, 2004) by meeting their housing-related needs. SP funds may be directed to block contracts with housing providers and/or may be available to individuals to purchase the housing-related support that they require. During the IB pilot project, pilot sites were granted permission to use one per cent, later increased to ten per cent, of the Supporting People budget in IBs, although one site was granted Ministerial approval to include up to 40 per cent of the SP budget in their IB pilot.

Of all the funding streams, the 13 pilot sites had had most success in integrating SP funding and associated assessment, resource allocation and review processes into individual budgets. SP was also widely identified as the most relevant to IBs and thus the most important funding stream to include in IBs; some IB lead officers described the integration of SP as integral to the success of IBs. However, some sites still experienced difficulties relating to the aims, objectives and local contexts of SP services; and additional difficulties were experienced by two-tier authorities who had to work with multiple district council housing authorities. Some problems encountered with integrating SP into IBs may have reflected specific local arrangements, as none were reported by more than one or two pilot sites.

Twelve pilot sites had intended to include SP within their IB Pilot Project from the start, and the thirteenth had brought SP in during the course of the Pilot. In most of the pilot sites a tranche of SP funding had been top-sliced or ring-fenced and included within the budget for adult social care and therefore was included within the local authority's RAS. Typically, IB lead officers worked with SP lead officers to develop a price per point that was inclusive of SP.

The extent to which assessments for SP had been integrated into IB assessments varied, but again a majority of sites reported significant moves towards integration or alignment of assessment processes. Where SP monies were included in the RAS a separate SP assessment was generally not required.

Alternatively, some sites were working to a recharge system whereby the IB was paid from the social care budget and those elements that related to housing support were later charged to the SP budget. Particularly where SP funding had not been top-sliced and transferred to IBs, the IB assessment included trigger questions that signalled a potential need for housing-related support. These cases, and any relevant information from the IB assessment, would then be passed to SP for a more detailed assessment and decision relating to SP funding:

It's not integrated, it's aligned, because basically the funding has to be approved by the Supporting People manager.  
(IB leader, unitary authority)

Top-slicing SP resources and transferring these to IBs also involved a transfer of responsibility for how those resources are spent. However, some accountability to SP was usually also retained:

I have to report to Supporting People quarterly, they just invite me to do a, [an overview] and a sort of submission saying 'We've allocated this amount of money and on occasions it's been spent in this way'. So no, it doesn't get lost in the pool of things.  
(IB leader, London borough)

Whether or not processes had been aligned or funding streams integrated, SP usually required some involvement in agreeing IB support plans and reviewing outcomes, although these often appeared to involve only 'light touch' oversight:

They sample some of the [support] plans when we've got Supporting People so, you know, clearly they want to make sure that it's spent on housing-related support.  
(IB leader, metropolitan district)

Indeed, one or two sites hoped that eventually responsibility for monitoring the use of SP funding within an IB could be transferred to adult social care.

### 8.3.1 Factors supporting a move toward integration

#### 8.3.1.1 *Close working relationships*

The most common factor reported to help the integration of SP was the close or co-location of managerial responsibilities for SP and adult social care. This was much more likely in unitary local authorities, where SP and adult social care services might be located within the same local authority directorate; where a senior member of the IB Pilot Project team could be the designated budget holder for any transferred SP resources; where adult social care and SP were already jointly commissioning supported living services; and where simple proximity facilitated communication:

It was easier because Supporting People is based within this building, within social services, as opposed to housing.  
(IB lead officer, metropolitan district)

Some IB lead officers were very positive about the relaxed and co-operative approach of SP colleagues; again this may have been at least partly a result of close managerial and operational linkages within many unitary authorities. In one pilot site, the SP lead officer was a member of the IB Project Board.

#### 8.3.1.2 *Overlapping aims and objectives*

Several IB lead officers attributed their relative success in including SP in IBs to the fact that, in many of the pilot sites, the aims and objectives of the programme were very similar to those of adult social care, as were its operational processes. In both these respects, SP was very different from the other funding streams included within IBs.

### 8.3.2 Barriers to integration

#### 8.3.2.1 *Diverse target/user groups between adult social care and SP*

A small number of sites reported that there was only a marginal overlap between those people who were eligible for resources from Supporting People and adult social care. This was more or less of a problem for pilot sites depending on the user groups that were being offered IBs and targeted for SP support respectively:

... the ground root problem is that we've assumed that Supporting People – the interests of the Supporting People funding stream, is pretty much close to ours, but actually it's not. They're dealing with ... ex-offenders, care leavers, people with a history of homelessness ... and that's their bulk clientele, people recovering from, you know, mental illness placements, that sort of thing, who don't actually overlap with our long-term care people to the same extent at all.  
(IB lead officer, county council)

Linked to these differences in target user groups was the expectation that SP funding to any individual would gradually reduce as greater independence was achieved; this was not necessarily the case with IB holders who may need longer-term support. Sites that were offering IBs to only a limited number of user groups were more likely to report difficulties in securing ring-fenced or top-sliced SP funding. This was because of concerns to retain sufficient resources within the SP budget to fund housing-related support for people who were not likely to receive this through their IB.

#### **8.3.2.2 Diverse eligibility criteria**

In some sites, different eligibility criteria for SP and adult social care, as determined by local FACS thresholds, created difficulties as many individuals eligible for SP were not eligible for social care and thus could not be offered a social care IB. A small number of IB lead officers and SP lead officers reported that a separate RAS had or was being developed that focused solely on SP funding, with the possibility of producing SP-only IBs in the future. Another site noted that the opportunities to do this were restricted by the care management costs of conducting assessments and calculating entitlements to funding streams outside adult social care.

#### **8.3.2.3 Block contracts and the risks of double-funding**

A couple of sites reported a lack of available local SP resources because these were currently tied up in contracts with supported living providers or in individual tenancy arrangements:

Supporting People commissions and arranges its services on an aggregated basis and the money is allocated ... Supporting People has gone down the road of getting contracts in place with providers ...  
(IB lead officer, unitary authority)

IB and SP lead officers were therefore concerned that, in the short-to-medium term, this could result in expensive double-funding.

#### **8.3.2.4 Budgetary uncertainty**

Finally, uncertainties over the local and national budget allocations for SP were reported as having restricted the flexibility of this funding stream and the ability to commit resources to the IB Pilot Projects.

### **8.3.3 Issues for the future**

#### **8.3.3.1 Charging**

Some SP lead officers expressed concerns that the integration of SP within IBs could result in some service users being charged for short-term support services that were previously not chargeable under SP. Indeed, one SP lead officer stated that, under

IBs, all short-term services had been relabelled as long-term and thus were potentially chargeable.

### **8.3.3.2 Crisis services**

A number of SP lead officers were also concerned that the move towards Individual Budgets and away from block contracts could potentially result in the dismantling of traditional short-term services for people in crisis, for example those seeking to escape domestic violence. It was hoped that CLG would safeguard the provision of such safety net services.

## **8.4 Access to Work**

Access to Work (AtW) is a resource delivered by the Department for Work and Pensions (DWP) through Jobcentre Plus and is open to those who are already in paid employment, self-employed, and those who are about to start paid work whose disability or health needs means that they require assistance to undertake parts of their job<sup>43</sup>. Access to Work monies may be used to pay towards the costs of equipment that is needed at work, adapting premises to meet needs, paying for a support worker, and/or contributing towards the cost of getting to and from work for those who cannot use public transport. Employers are required to contribute toward the costs of equipment and adaptations for disabled people who have been in their employment for a minimum period of six weeks<sup>44</sup>. Access to Work effectively funds personalised services and equipment and thus had the potential to fit well with Individual Budgets. However, very few of those eligible for Access to Work funding were reported to also be eligible for social care funding and thus the amount of work required to attempt the integration, or even the alignment, of Access to Work with adult social care was disproportionate to the number of people who could potentially benefit.

Initially, it was intended to integrate Access to Work with adult social care in the IB pilots. This would have entailed combining assessments and top-slicing the AtW budget by working out an average amount of funding per person; asking pilots to provide an estimate of the numbers of people they expected to be eligible for AtW (based on historic data); and then paying the money to the local authority retrospectively on a per capita basis, up to the maximum amount agreed. Access to Work and a number of the pilot sites reported that they had put significant efforts into understanding one another's regulations and procedures and working out the finer

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<sup>43</sup> Job Centre Plus, *Access to Work*, Available online at: [http://www.jobcentreplus.gov.uk/JCP/Customers/outofworkhelplookingforwork/Getting\\_job\\_ready/Programmes\\_to\\_get\\_you\\_ready/Dev\\_014875.xml.html](http://www.jobcentreplus.gov.uk/JCP/Customers/outofworkhelplookingforwork/Getting_job_ready/Programmes_to_get_you_ready/Dev_014875.xml.html).

<sup>44</sup> Directgov, *Access to Work – practical help at work*, Available online at: [http://www.direct.gov.uk/en/DisabledPeople/Employmentsupport/WorkSchemesAndProgrammes/DG\\_4000347](http://www.direct.gov.uk/en/DisabledPeople/Employmentsupport/WorkSchemesAndProgrammes/DG_4000347).

details of integration. However, during the course of the pilot, Ministers decided to approve alignment rather than full integration, partly owing to the risk that the local authority may reach its quota of Access to Work funds and potentially have to turn down AtW applications from other IB holders, with negative consequences for any such individuals (Waters and Duffy, 2007).

Instead, DWP decided to focus on aligning AtW with Individual Budgets. This meant that AtW monies would not be top-sliced; AtW would retain responsibility for managing their own funds; assessments would not be combined (although there would be a move towards collecting information only once and sharing relevant information); individuals would be encouraged to be more involved in the assessment (to increase their choice and control); the review process would be co-ordinated with adult social care; existing support arrangements would be utilised; and there would be closer working between the care manager and the AtW case manager.

Several IB lead officers voiced frustration at having spent considerable time and effort trying to understand AtW protocols; organising workshops and staff training; trying to negotiate service agreements; working on integrating employment-related questions into their IB assessment processes; and negotiating a top-slicing of the AtW budget, when ultimately the funding streams was not going to be integrated. Most IB lead officers reported that they had been given no explanation as to why DWP had decided not to proceed with attempts to integrate AtW. Some thought that the time and resources involved in working on the integration of AtW was disproportionate to the numbers of people who could potentially benefit from this funding stream. A number of officers also stated that the new goal of aligning rather than integrating AtW was not only less interesting but also meant that the time and energy invested would yield even smaller gains.

Of the 11 pilot sites that initially chose to work with AtW, only two reported actually succeeding in including AtW funding into an IB. The possibility had been explored but not taken up by one person in a third pilot site, while an IB holder in a fourth site had already been in receipt of AtW funding before being offered an IB. In none of the other sites had anyone had AtW funding included in their IB or even started to explore this possibility.

Nevertheless, several pilot sites had included trigger questions for AtW in their IB assessment documentation; this would prompt a separate specialist assessment undertaken by an AtW assessor. The failure to integrate AtW into IBs meant that most sites had not had to consider whether IB reviews should also include reviews of AtW funding against relevant outcomes.



### 8.4.1 The benefits of linking adult social care with employment support

Despite the difficulties experienced with AtW, a number of IB lead officers reported positive spin-offs from the closer contact created by the Pilot Projects. Five officers commented that the inclusion of AtW had raised their awareness of this funding stream; they had in turn encouraged care managers to explore training and employment needs (where appropriate) when conducting assessments. A number of lead officers reported that they had been asked to pilot new publicity materials for AtW *Is work right for you?* One IB lead officer commented that the AtW service appeared to have little experience of working with mental health service users. Staff in this site were particularly interested in helping to promote AtW among mental health service users and thereby help to extend knowledge and expertise within the AtW programme.

According to one IB lead officer, DWP had agreed that a Disability Employment Advisor could attend support planning training sessions in order to understand more about IBs and the potential contribution of AtW funding to the Pilot Projects. Another IB lead officer praised DWP's decision to amend the regulations around AtW such that people needing personal assistance at work no longer needed to go through a tendering process and recruit another person, but could employ the same person who provided their support out of work (if appropriate).

IB lead officers had a number of suggestions about how to (further) improve the links between adult social care and employment support services. One interviewee suggested that a job brokerage service to help people access sources of support to get back into work would have been more appropriate to include within IBs than AtW. Other IB lead officers suggested other employment-related resources that would have been more relevant; WorkStep and Work Preparation programmes were felt to be particularly appropriate, as they offer work preparation and training and could thus act as stepping stones towards eventually being eligible for AtW. Another officer suggested that more use could be made of AtW if IBs were used to support people to enter employment and gradually build up to 16 hours per week, at which point the service user would become eligible for AtW funding. Finally, one interviewee proposed that AtW resources should be completely transferred to local authorities, with the amount allocated to each LA determined by the numbers of disabled people within the authority engaged in employment and engaged in training and voluntary/community work, as this figure would be an indicator of the number of individuals potentially eligible for AtW resources in the future.

## **8.4.2 Barriers to aligning/integrating Access to Work**

### **8.4.2.1 Eligibility criteria**

IB lead officers were aware that owing to local FACS eligibility thresholds for social care funding few social care users would be in employment and thus eligible for both social care and AtW funding. Indeed, several lead officers questioned the rationale for including this particular funding stream in the IB Pilot Projects:

I suppose the big issue about Access to Work was, I think it's only five or ten per cent of people who get Access to Work also get social care funding. So, the real question is why was it put in in the first place?  
(IB lead officer, unitary authority)

There was also confusion over AtW eligibility criteria. Most IB lead officers understood that someone needed to be in employment for a minimum of 16 hours a week to qualify. However, one lead officer reported having been told in the latter stages of the IB Pilot that people working less than 16 hours per week could also be considered for funding.

### **8.4.2.2 Employer contributions**

Another obstacle to integration was thought to be the multiple sources of AtW funding:

... a lot of the funding actually comes from the employer anyway, it doesn't come from the government agency. So how on earth do you put that in a RAS because it's often a tripartite agreement?  
(IB lead officer, unitary authority)

### **8.4.2.3 Inability to target particular groups through the evaluation**

Two IB lead officers expressed frustration that the design of the Pilot Projects and the evaluation had restricted opportunities to experiment with working with different funding streams, including AtW. For example, one lead officer argued that sites would have had greater incentives to work with AtW if they had been able to explicitly target IBs on individuals who were already in employment and eligible for both social care and AtW support, as this would have justified the effort involved in aligning or integrating processes.

The small number of IB holders potentially eligible for AtW funding during the pilots effectively meant that sites were not able to test out the new alignment processes.

## 8.5 Disabled Facilities Grants

Disabled Facilities Grants (DFGs) are a capital funding stream administered by housing authorities under the auspices of the Department of Communities and Local Government (CLG), and are used to finance adaptations to the properties of older and disabled people to enable them to access necessary parts of the house and remain in their own homes rather than move into institutional care. Eight pilot sites aimed to include DFGs from the start of their IB Pilot Projects and two more included these later on.

Sites that had included DFGs within the IB pilot had only managed to align, not integrate, assessment processes. IB and DFG lead officers argued that the conditions attached to DFGs, waiting lists for DFGs, and the complexity of OT assessments for major adaptations, meant that it was not possible to top-slice any of the DFG budget and integrate this within IBs. Alignment had simply been achieved via including a trigger question relating to DFGs within the main IB assessment and through passporting some of the service user's details to the DFG team. Recipients of DFGs remained accountable to DFG for how their grant was used.

### 8.5.1 Potential benefits of integration

#### ***8.5.1.1 Avoiding delays and reducing longer-term costs***

Some IB lead officers were initially optimistic that the inclusion of DFGs within individual budgets could speed up assessments and ultimately the installation of adaptations. There were also potential gains to be made to the adult social care budget as the earlier installation of adaptations could reduce some on-going adult social care support costs or prevent an individual from moving into residential care:

It's looking for the win/win situation. If you've got somebody with a degenerative condition and wants to stay at home, but their bathroom's upstairs, without the bathroom downstairs which may cost £30,000, that won't even keep them in a Nursing Home for a year. One, they don't want to be there, and two, they're going to probably be there for what, 30 years. (IB project team member, metropolitan district)

A small number of sites had decided to meet the costs of adaptations up front from the adult social care budget in order to reduce on-going support costs. In one site the adaptation needed to be 'rubber-stamped' with an occupational therapy (OT) assessment; another site reported costing up simple adaptations and including this sum in the IB. A third site did not include DFGs within the IB but again funded adaptations up front. The latter two sites operated a 'recharge' model, where adult social care initially met the cost of an adaptation and then charged this amount to DFG, rather than wait for an OT assessment and the allocation of resources from

DFG. Other sites were more cautious, especially without a guarantee that social care would eventually be 'refunded', for example if the person died or made a significant recovery. One IB lead officer reported securing funds to meet the cost of adaptations by setting charges against adapted properties such that (part of) the costs of the adaptation could be claimed back if the property was to be sold. However, the possibility of setting charges against a property was not supported by a number of other IB lead officers.

## **8.5.2 Barriers to integration**

### **8.5.2.1 Legislative barriers**

Several IB lead officers commented on a perceived lack of commitment to change at national level, arguing that it was not possible to integrate DFGs into IBs without a change in primary legislation:

... it looks as though it's going to take primary changes in legislation and regulation, if we're going to make any headway there at all. I personally don't see how that can be done within my lifetime, but, you know, unless and until legislation changes absolutely radically [then integration cannot happen].

(IB lead officer, county council)

This perceived lack of commitment to supporting the integration or alignment of DFGs within IBs led some sites to abandon local efforts with this funding stream.

### **8.5.2.2 Type of authority**

IB Pilot Projects' experiences of DFGs were also affected by the type of authority, with particular challenges experienced in two-tier authorities where DFGs might be managed and implemented differently between district councils.

### **8.5.2.3 Specialist assessment**

IB lead officers in three sites argued that the complexity of assessments for DFGs meant that it would be difficult, if not impossible, to integrate these with IB assessments as care managers would not have the necessary skills to undertake the assessments or act upon the results. Several possible solutions were suggested: care managers could be specially trained to undertake DFG assessments; care managers and occupational therapists could be jointly trained so either professional could undertake an integrated assessment for IB and DFG; or care managers could carry out assessments for small pieces of equipment and simple adaptations, while anything more complex would be referred for a specialist Occupational Therapy (OT) assessment (as is currently the case). However, some IB lead officers commented that integrated IB and DFG assessments would increase the length, complexity and costs of IB assessments as they would require a home visit and this would prove particularly problematic in sites that were trying to move towards self-assessment.

#### **8.5.2.4 Inability to 'personalise' adaptations**

One IB lead officer disputed the extent to which DFGs were possible to 'personalise':

... that's the whole issue really, is that they can't do it, anything other than spend it on what it's intended for and that's why you can't really amalgamate it very easily.

(IB lead officer, county council)

Several IB lead officers commented that they could not see how including a DFG within an IB could benefit service users. It was argued that there are very few flexibilities within DFGs, as the money can only be used to pay for an agreed adaptation. Integration would therefore mean DFG monies being ring-fenced within an IB for a particular adaptation, thus reducing opportunities for flexibility, choice and control.

#### **8.5.2.5 Stresses of managing a DFG**

Some IB and DFG lead officers could not understand why an older person or someone who was physically or mentally frail would want to take responsibility for tendering for builders and project managing the construction of, for example, a ground floor extension:

I mean, the general view from the DFG team and ours is, because of the complexity of builders and all the rest of it, that it's highly unlikely that anybody would want the cash and would want to sort it out for themselves. You've got all these things going around in your life that's complicated enough, why would you want to take on responsibilities of negotiating with builders?

(IB lead officer, all user groups, metropolitan district)

#### **8.5.2.6 Timescales**

The timescales for planning and carrying out major adaptations and triggering the release of DFG funds were reportedly incompatible with those for setting up an IB and for meeting the evaluation targets. For example, several IB lead officers argued that social care support usually needed to be put in place immediately, whereas installing stair lifts or building ground-floor extensions were much longer-term projects. Moreover, DFG resources are only released where there is evidence that appropriate work is taking place. Thus, not only did most IB lead officers consider that the integration of DFGs was neither possible nor desirable; some also felt that there was not time within the IB Pilot to see through a case where attempts at integration had been made.

### 8.5.3 The DFG Review

Since the pilot, and in response to Bristol University's evaluation of the DFG, DCLG has amended some of the regulations around the DFG<sup>45</sup>. The changes ought to make it easier for DFGs to be included within IBs. In particular:

- Removing the ring-fence around DFGs and broadening the scope of what DFGs can be used for will enable DFGs to be aligned with other funding streams, such as adult social care, tele-care and equipment services more broadly.
- Removing the need for individuals in receipt of certain social security benefits to undergo further financial assessments will reduce duplication and potentially speed up the processing of applications for DFGs.
- The increase in the global DFG budget and the increase in the amount available to an individual from £25,000 to £30,000 may speed up the rate at which DFGs are granted.

## 8.6 Independent Living Fund

The Independent Living Fund (ILF) operates under the auspices of the Department for Work and Pensions (DWP) and is governed by its Trust Deeds and a board of Trustees. The ILF is a national resource 'dedicated to the financial support of disabled people to enable them to choose to live in the community rather than in residential care'<sup>46</sup>. The ILF can effectively 'top-up' the funding available from the local authority, but in so doing it can also challenge local authority spending decisions. Individuals may apply to the ILF if they meet certain criteria<sup>47</sup>. During the life of the IB pilot, disabled adults could apply to the ILF if, *inter alia*, they received services or direct payments of at least £10,400 per annum (at least £200 per week) from their local social services department. Since April 2008 this threshold has increased from £10,400 to £16,640 per annum (£320 per week). Successful applicants receive funds directly into a bank account. ILF monies must be used 'to purchase care from an agency or pay the wages of a privately employed Personal Assistant (PA)'<sup>48</sup>.

In principle, the ILF appears to be a natural contributor to Individual Budgets owing to its holistic approach and 'its strong commitment to independence and greater choice

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<sup>45</sup> Department for Communities and Local Government (Feb 2008) Disabled Facilities Grant – The Package of Changes to Modernise the Programme, CLG.

<sup>46</sup> ILF *What is the ILF?* [http://www.ilf.org.uk/about\\_the\\_ilf/what/index.html](http://www.ilf.org.uk/about_the_ilf/what/index.html).

<sup>47</sup> ILF *Eligibility – who can apply?* [http://www.ilf.org.uk/making\\_an\\_application/eligibility/index.html](http://www.ilf.org.uk/making_an_application/eligibility/index.html).

<sup>48</sup> ILF *What is the ILF?* [http://www.ilf.org.uk/about\\_the\\_ilf/what/index.html](http://www.ilf.org.uk/about_the_ilf/what/index.html).

and control for disabled people<sup>49</sup>. However, in practice the constraints of the Trust Deeds meant that integration with social care during the life of the Pilot was not possible; instead, the ILF and the pilot sites attempted to align and fast-track some of their processes.

All 13 pilot sites opted to include ILF funding within their IB Pilot Projects: some had extensive experience of working with the ILF; others saw the IB pilot as an opportunity to increase take-up, particularly among direct payment users.

### **8.6.1 Steps toward alignment**

The ILF reported that it had set up a dedicated team to work on applications from (potential) IB holders to ensure a faster turnaround time and thus work within local authorities' timescales for calculating indicative IBs and producing support plans. The ILF reported that applicants from IB pilot sites were tending to submit the required financial information alongside their application, which speeded up the process. This was felt to be associated with the greater awareness of ILF rules, regulations and process within the pilot sites. A small number of IB lead officers reported experience of fast-tracking by the ILF. However, most did not and remained frustrated at the time taken for an ILF application to be turned around. It is not possible to determine whether this was due to delays by the ILF or due to sites (or individual care managers within sites) having little experience of supporting applications to the ILF and not submitting the necessary paperwork required by the ILF.

### **8.6.2 Barriers to alignment**

#### ***8.6.2.1 Legislative barriers and restrictions on how funds could be spent***

Most IB lead officers reported feeling deeply frustrated at the restrictions surrounding ILF funding, in particular that (a) only that portion of adult social care monies spent on personal care counted towards the £200 per week threshold for the ILF; and that ILF monies had to be spent wholly on personal care and domestic assistance and could not, for example, be used towards purchasing pieces of equipment or support for social inclusion (e.g. leisure activities). This restriction on the use of ILF funds was upheld by the ILF Pilot Protocol Part 2 (CSIP, 2006a). Such restrictions significantly reduced the flexibility of how an IB could be used in more creative ways:

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<sup>49</sup> Independent Living Funds (2006) *Pilot Protocol Version 1*, Strategic Policy Directorate, Independent Living Funds, Nottingham, March 2006.  
[http://networks.csip.org.uk/\\_library/Resources/Personalisation/Personalisation\\_advice/ILF\\_Protocol\\_1\\_March\\_2006.pdf](http://networks.csip.org.uk/_library/Resources/Personalisation/Personalisation_advice/ILF_Protocol_1_March_2006.pdf).

... it doesn't sit with self-directed support. Its lack of flexibility, even if you, you know, you're in the case where you still have to spend the first 200 quid on personal care, you're still taking that £200 worth of flexibility away. (IB lead officer, county council)

Although IB holders may be able to choose who provides their personal care and when this care is delivered, there will be no flexibility over the type of support that can be purchased if the local authority contribution is close to the £200 threshold amount<sup>50</sup>, as all monies would have to be spent on personal care.

### **8.6.2.2 Inability to include ILF monies within the RAS**

No site had managed to include ILF resources in its RAS, even on a recharge basis, as there was no way of guaranteeing that the ILF would make a contribution to an IB or what the level of that contribution might be. IB lead officers in several sites reported second-guessing what the outcome of an ILF application might be when calculating an indicative IB allocation, but sites differed as to how far they were willing to honour an indicative IB that included a predicted ILF contribution. Most IB lead officers and senior managers argued that if the IB assessment had identified a need then the local authority had a duty to meet that need, although this did not necessarily involve funding the entire ILF shortfall. However, the lack of certainty about the ILF contribution to an IB was considered incompatible with the transparency at the heart of the IB process.

Resource Allocation Systems developed by the pilot sites focused on local authority funding streams (social care, ICES, Supporting People) and were not developed in consultation with the ILF. The ILF reported difficulties in working with different RAS models across the pilot sites and advocated a consistent national approach to resource allocation should IBs be mainstreamed<sup>51</sup>.

### **8.6.2.3 Support planning**

In some sites service users were asked to devise two support plans, one that included a 'guesstimate' of a potential ILF contribution and one that did not. This created extra work for older and disabled people and their families, advocates, care managers and others involved in support planning; added to the costs of care management and support planning; and risked raising user expectations that could not be met if the ILF application proved unsuccessful or if the ILF contribution was significantly lower than expected.

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<sup>50</sup> Independent Living Funds (2006) *ILF Pilot Protocol Part 2*, Independent Living Funds, Nottingham, October 2006  
[http://icn.csip.org.uk/\\_library/Resources/Personalisation/Personalisation\\_advice/ILF\\_Protocol\\_2\\_October\\_06.pdf](http://icn.csip.org.uk/_library/Resources/Personalisation/Personalisation_advice/ILF_Protocol_2_October_06.pdf).

<sup>51</sup> Independent Living Funds (2006) *Pilot Protocol Version 1*, Strategic Policy Directorate, Independent Living Funds, Nottingham, March 2006.  
[http://networks.csip.org.uk/\\_library/Resources/Personalisation/Personalisation\\_advice/ILF\\_Protocol\\_1\\_March\\_2006.pdf](http://networks.csip.org.uk/_library/Resources/Personalisation/Personalisation_advice/ILF_Protocol_1_March_2006.pdf)



#### **8.6.2.4 *Separate financial assessment and review arrangements***

During the life of the pilot the ILF and the local authority each conducted separate financial assessments of service users to ascertain eligibility for funding and to assess users' financial contributions. Removing or reducing the unnecessary duplication of assessment was one of the aims of Individual Budgets and IB lead officers reported that such ongoing duplication contradicted the spirit of IBs. However, a single financial assessment was felt to be challenging as divergent regulations and charging policies meant that the ILF required more information than the local authority needed or could legally collect (for example, the ILF takes partners' income into account but the local authority does not). A combined assessment was deemed possible by the ILF but this would have to be undertaken by the ILF (in accordance with their Trust Deeds) and local authorities would need to confirm the legalities of handing over responsibility for their assessments.

The ILF and local authority also carry out separate reviews. This was a further source of frustration for IB lead officers as separate reviewing arrangements again flew in the face of streamlining assessment and review. A small number of IB lead officers argued that the ILF could make efficiency savings if it worked more closely with local authorities, for example by removing restrictions on how ILF funds are spent or by unifying review arrangements, as local authority reviews of IBs already cover the entire funding package, including the use and continuing applicability of resources from other funding streams. The ILF reported to have considered a synchronised review process but this again proved difficult to implement as one of the functions of the ILF was reportedly to challenge local authorities. IB holders therefore remained directly accountable to the ILF for how they spent the ILF element of their budget which meant that IB holders were subject to multiple monitoring requirements. IB lead officers were also critical of the ILF's financial monitoring arrangements, which reportedly continue to require receipt-level monitoring; this was considered incompatible with the greater flexibility of IBs.

#### **8.6.3 Rising applications to the ILF**

Despite the challenges of aligning the ILF and IB processes, the inclusion of ILF in the IB Pilot Projects increased local awareness of the ILF and significant increases in ILF applications were reported from several sites and indeed from the ILF itself. Maximising the uptake of resources from other funding streams, particularly from the ILF, was reported to be a significant factor in several sites' plans for achieving cost-neutrality in the IB pilots. While the increase in applications to the ILF could result in more disabled people receiving additional funds to which they are entitled and thus potentially increasing the amount of support they could purchase, there were concerns over the extent to which this increase was financially sustainable and might lead to tighter eligibility criteria. Following the rise in applications during the life of the IB pilot, the ILF amended its criteria for applications from April 2008 (see above).

#### **8.6.4 ILF Review**

An independent review of the ILF was commissioned by DWP in 2006. The review (Henwood and Hudson, 2007) recommended the integration of application, assessment and review processes between the ILF and partner agencies – including the local authority – with the medium term goal of ‘full integration with Individual Budgets’. In addition, the review was critical of the continuing restrictions on how ILF monies must be spent, arguing that such restrictions ‘do not sit comfortably with the new spirit of independent living that is being encouraged in the wake of the Improving Life Chances report from the PM’s Strategy Unit’ (p. iv). As indicated above, these findings are supported by the results of the IB pilot evaluation.

### **8.7 Integrated Community Equipment Services**

Local Integrated Community Equipment Services (ICES) is resourced from baseline social care and NHS primary care trust budgets and as such is not a separate ‘funding stream’. ICES provides health and social care equipment to those with long or short term needs to enable them to remain living in the community (CSIP, 2006b). Examples include hoists and raised toilet seats. LAs and PCTs allocate an amount of baseline social care funding to either an in house (statutory), private or voluntary sector provider depending upon local needs and priorities. Equipment is effectively on loan to the user and is provided free of charge, including the costs associated with installation and maintenance.

Ten sites planned to include ICES from the start of their IB Pilot Project and an eleventh site started to include ICES during the course of the Pilot. No site had top-sliced its ICES budget to include within IBs; this was deemed largely unnecessary given that the ICES budget was already funded from within the adult social care budget:

Essentially, whilst it’s in different budgets it’s essentially all our money really ... so, it’s not as if we’re getting the money from anywhere else, it was our money to start with.  
(IB lead officer, London borough)

Nevertheless three sites had explicitly included resources for equipment within their RAS. One site had received significant support and advice from their local OT team:

... they did some quite detailed modelling, looking at the costs of equipment, the provision that they were doing, and came up with a set of questions that linked to, kind of, price points ...  
(IB lead officer, London borough)

In the second site, simple pieces of equipment had been costed and once needs had been identified during the assessment process these costs were simply included in the IB, with the cost later being recharged to ICES. Theoretically, this would be possible without IBs, however the possibility was reportedly conceived as the IB team attempted to integrate ICES resources. In the third site, individuals who were assessed as in need of equipment could either receive the item from the equipment store or an appropriate sum of money could be included within their IB.

A number of other sites argued that they could not incorporate ICES resources into the RAS as this could create complexities with charging (equipment cannot be charged for); it was too complex; or wouldn't be worthwhile. The alternative to including ICES within the RAS was to fund equipment purchased with an IB from the adult social care budget and subsequently recharge it to ICES. Important considerations here were speed; the potential savings to the adult social care budget if equipment could reduce the need for on-going personal care; and user preference:

... there's a lot of work going on, and a lot of people choosing to take elements of their community care grant and spend it on equipment, because they feel it's more secure and less intrusive [than carers going into the house], and I think that's a major issue for people.  
(IB lead officer, metropolitan district)

IB lead officers in four sites reported that their IB assessment documents included a question that would trigger a separate assessment for equipment; once an OT had carried out this assessment, the notional cost of the equipment could be added to an individual's IB.

## **8.7.1 Advantages of including ICES within individual budgets**

### **8.7.1.1 Increased choice**

In principle the inclusion of community equipment within IBs was thought to offer older and disabled people and their families the opportunity to consider more flexible solutions to assessed needs and to choose from a greater range of equipment than was traditionally available from health or social services' equipment stores.

### **8.7.1.2 Bespoke items of equipment**

Lead officers for IBs and for ICES thought that including ICES within IBs could be particularly beneficial for disabled children and younger adults who may want bespoke pieces of equipment, or for people with sensory impairments who might prefer equipment in a different colour or texture. Moreover, specialist equipment that was not bulk-purchased was no cheaper if supplied through ICES than if purchased on the open market. Indeed, one site already offered direct payments for non-stock items of equipment and this protocol was extended to individual budgets.

### **8.7.1.3 Avoiding delays**

In some sites, delays arose around assessment and delivery of equipment; it was argued that including funding for equipment within an IB and recharging this to ICES was an efficient use of resources:

... our equipment budget was traditionally always overspent. People had to wait a long time to get access to it, and what's happened is some people have been kept prisoner for things like ramps for 300 quid.  
(IB lead officer, metropolitan district)

In two sites, social workers had received Trusted Assessor training so they were able to assess for, and order, minor pieces of equipment that could be included in the IB if the user did not want the item(s) to be supplied and fitted through ICES. This was thought to speed up the process of obtaining equipment; reduce demands on OTs; reduce the cost of unnecessary OT assessments; and cut down on assessments for users. Other IB lead officers argued that service users and carers were often best placed to know what small pieces of equipment would make their lives easier and these did not need a specialist OT assessment, an argument also put forward by an interviewee from a service user organisation. Reducing OTs' involvement in such assessments could help to reduce waiting times for specialist OT assessments.

## **8.7.2 Barriers to integration**

However, most of the 11 IB lead officers who had included ICES in their local IB pilots argued that, although ICES was one of the easier budgets to work with, integration would have few benefits for service users typically because of the time and effort involved in sourcing one's own equipment:

... the equipment that you're going to buy yourself isn't always that much better. It's a lot more difficult to get hold of. You've got to do the research for yourself, all of that sort of stuff. It's much easier to get the local authority on with it and we're not bad at it either.  
(IB lead officer, metropolitan district)

### **8.7.2.1 Specialist assessments and workforce issues**

Most IB and ICES lead managers argued that integrating ICES assessments within IB assessments undermined OTs' specialist skills and risked users receiving no, or inappropriate, advice. There were concerns over the potential health and safety risks of inappropriate, poorly fitted or wrongly used equipment, risks that could be avoided if an OT was involved. ICES managers also argued that OTs can offer a fuller assessment of an individual's needs and determine if additional pieces of equipment, or advice might be beneficial. They also pointed to the expertise of staff working in equipment stores and their ability to offer advice or respond to user queries. Any expectation that care co-ordinators could or should undertake assessments for

equipment, or sign off support plans that include pieces of equipment where an OT has not been involved, would necessitate significant training. Support brokers who may be involved with the purchasing of items of equipment may also require training.

### **8.7.2.2 Costs and budgets**

ICES were able to bulk purchase standard pieces of equipment at very low cost and both IB and ICES managers argued that users would not be able to buy individual items from suppliers at such low prices. Indeed, this could undermine the cost-neutrality of IBs:

If we buy 1,000, you know, raised toilet seats, and they cost [£1] each, you know. If somebody wants a [direct payment] then we as a – strictly speaking, we as the local authority are obliged to fund them at a rate which enables them to get something at least of the quality that we would supply. Now if we say ‘Well, it’s cost us [£1], so that’s what we’ll give you’, they actually can’t go to the High Street and get one for [£1]. They’ve got to spend 15 quid. So somebody, you know, legally we could be under pressure to pay people for market price, despite the fact that it’s very much more cost effective for us to [supply equipment ourselves].  
(IB lead officer, county council)

Moreover, one IB lead officer reported that equipment suppliers were not always willing to release information on the costs of different items of equipment to individual purchasers because this information was commercially sensitive.

In two sites, ICES resources were committed to block contracts, so any funding for equipment that was integrated into an IB would equate to double-funding and be financially unsustainable. One of these sites was developing notional costs for equipment in order to determine how much of their ICES budget they might need to free up from block contracts in the future.

The joint (with NHS) management of ICES services could be problematic. The typical example reported by some interviewees was the issue of ‘health’ or ‘social care’ wheelchairs (each to be used for different purposes). However, other sites reported no problems in using a Section 31 pooled budget to fund equipment as part of an IB.

### **8.7.2.3 Fitting, delivery and maintenance**

Equipment provided by ICES is fitted and maintained for service users at no cost, whereas equipment purchased privately could require private installation and maintenance. ICES stores were typically able to deliver stock items within seven days, irrespective of where the user lived; while some IB lead officers argued that people who live in rural areas would be hard pressed to find a shop or online supplier who delivered any more quickly. Moreover, those needing equipment were often ‘vulnerable, you know, disabled, elderly’ and thus would not want to shop around for

equipment that the local authority could provide, fit quickly and maintain free of charge:

... for people to buy a piece of equipment, if that's what they identify they need, they're not really going to want to go and buy one down the road that's three times more expensive and doesn't come with maintenance and cover and all the rest of it.  
(IB lead officer, county council)

Further, a number of IB lead officers argued that as OT assessments were conducted promptly in urgent cases, integrating ICES into IBs could actually slow down delivery of essential equipment:

... if you need a zimmer frame, you need it now. If you need a bar to get you in and out of the bath, you need it now. Why bother aligning/integrating assessments? ICES assess before IB assess because that need is pressing, so, you know, you just do it.  
(IB lead officer, county council)

## **8.8 Service users' awareness of non-social care funding streams**

One hundred and thirty service users and their proxies were interviewed across all 13 pilot sites approximately two months after the initial offer of an IB. Of those interviewed, just over one-third (44 cases) had an IB in place, although not all were actually using the IB, for example they may have been in the early stages of recruiting a PA. Service users and proxy interviewees reported very low awareness of which funding streams were included in their IB assessment, and which funding streams were actually contributing to their IB. Only nine of the 130 people interviewed in-depth had any such understanding. Of these nine users (or their proxies), one mental health service user simply stated that funding streams had not been discussed; another mental health service user thought that their funding came from the mental health service budget; one older person and one person with a physical disability (from different sites) said they thought that only social care monies were included; one person with physical disabilities and one with learning disabilities (also from different sites) thought that their budgets consisted of money from social care and health; another older person stated that s/he 'was surprised at the lack of medical input into the assessment'; another older person knew that different funding streams had contributed to her/his IB but could not remember which they were; and a further older person stated s/he was initially unclear about the involvement of different funding streams but later worked out that ILF had not been included. Interviewees reporting no knowledge of the different funding streams came from six sites, including two 'total transformation' sites offering IBs to all adult social care service users.

This lack of awareness suggests that the partial integration or alignment of assessments for non-social care resources within the IB assessment may not be wholly transparent. Moreover, the lack of understanding or awareness over the source of the money suggests that service users and their carers may not be clear about the restrictions on how monies from particular funding streams can be used. Further, few people reported a reduction in the number of assessments they had experienced. Given the limited progress made with integrating the funding streams, this observation is not surprising. Nevertheless, most interviewees commented that they did not care where the money came from so long as they received it.

## **8.9 Including additional funding streams within IBs**

A number of IB lead officers reported that attempts to integrate funding streams had been the most challenging aspect of the pilot. However, IB lead officers in a number of sites reported that other funding streams had been involved in the pilot. Where local authorities operated pooled budgets with NHS partners, IB lead officers reported that they had effectively included NHS Continuing Care funding in IBs (see Chapter 14). One site claimed to have incorporated DWP Social Fund resources into its Pilot Project; another had started to include Learning and Skills Council (LSC) funding; and one had combined its Carers' budget within the global adult social care budget.

All IB lead officers and senior managers were supportive of the principles of integrating funding streams and most suggested additional resource streams that could potentially be included within IBs. These included disability benefits, resources to support education, training and labour market activity, transport, and some NHS funding.

### **8.9.1 Disability benefits**

Three IB lead officers argued that disability benefits should be integrated with IBs. Although the political difficulties of such a radical overhaul were acknowledged, these IB lead officers argued that an overhaul could maximise benefit take-up, streamline assessments and simplify charging policies.

### **8.9.2 Resources to support education, training, and labour market activity**

IB lead officers in six sites suggested that LSC resources should be included in IBs and, indeed, were disappointed that these had not been included in the pilot. These officers came from sites that were offering IBs to a range of different user groups. Some argued that LSC funding would be particularly relevant where IBs were offered

to young people in transition; others argued that older and disabled people could also benefit from access to adult learning and lifelong education:

... if you're looking at a broader spectrum of interests, I mean, if your general point is, you know, the aim is to encourage sort of, full social inclusion in, you know, all aspects of community life, then education, leisure, learning, training are all part of that work.  
(IB lead officer, county council)

The three sites offering IBs to a single user group only (older people or mental health service users) all argued for including resources from local authority education budgets, for similar reasons. One IB lead officer commented that some service users already used direct payments to purchase education and reported that this had proven successful. The advantage of using a direct payment or IB to pay for education was that individuals need not be limited by their geographical catchment area, and could choose where they wanted to go and what they wanted to learn.

Further, three sites argued for the inclusion of employment-related resources other than AtW and in particular recommended the Work Step programme:

... because our RAS is around people with substantial and critical needs, the majority aren't actually in work yet, and we're thinking about it, and it might be that something like a Work Step programme is the right budget to pool because more people would have access to training and other things to get them ready for work, and then hand them over to Access to Work at a later date. ...  
(IB lead officer, metropolitan district)

### **8.9.3 Transport**

IB lead officers in three sites argued that transport should be included as a funding stream within IBs. One site reported that the local transport executive was keen to be involved; others stated that transport had proven a thorny issue during the development, and testing of the RAS and subsequent discussions around choice and control as costing units of transport was particularly challenging.

### **8.9.4 NHS funding**

IB lead officers from all 13 pilot sites expressed frustration that NHS resources could not be included in individual budgets. Despite concerns that the integration of health and social care monies could be particularly challenging, many IB lead officers



argued that in the longer term IBs and wider personalisation policies would require the inclusion of at least some NHS resources (see Chapter 14 for further details).

## 8.10 Conclusions

IB lead officers reported having spent considerable time and effort working to integrate or align other funding streams with adult social care, through combined or integrated assessments, the sharing of information, negotiating the top-slicing and pooling of resources, or attempting to set up joint review arrangements. Overall, IB lead officers supported the principle of alignment and/or integration and a majority felt that this had been a relative success for Supporting People and Integrated Community Equipment Services. However, there was disappointment among IB lead officers that the Pilot Projects had not been able to make more progress with integrating the other three funding streams:

... that, to me, is one of the most disappointing things, is, have we really made that much difference? How much have we improved service users' experience of assessment? We hardly have at all, 'cause although it's an integrated assessment for minor equipment and housing-related support, the major problem that people have always experienced, and will continue to experience, is that the Access to Work and the ILF processes are completely alien and completely different, and their rulebook is, you know, they don't give out money in the same way.  
(IB lead officer, metropolitan district)

IB lead officers reported their frustration that integration had been limited by a perceived lack of commitment and/or over-cautiousness at national level (although it had always been intended that IBs would be delivered within existing legal frameworks). Eligibility criteria for adult social care did not fully overlap with that for the other funding streams; assessment processes and review arrangements had only been integrated or aligned (in some sites) for SP and ICES; and most IB lead officers reported little, if any, flexibility in how monies from non-social care funding streams could be used by an IB holder. Some IB lead officers argued that the limited coverage and short-term nature of the IB Pilot Projects may have inhibited central government's willingness to amend the legal and governance restrictions that inhibited closer integration at local levels.



## **Chapter 9      Eligibility, Assessment and Resource Allocation**

### **9.1 Introduction**

This chapter explores the implications of Individual Budgets for the care management processes of ascertaining eligibility for services and assessment, and describes the pilot sites' experiences of developing and implementing systems for allocating resources to IB users. The perspectives of IB project lead officers, voluntary and community sector (VCS) representatives, care co-ordinators and team managers are reflected in this chapter. Such perspectives must be considered as part of the context of implementation, rather than a direct evaluation of the ideas underlying the policy. Respondents' views and beliefs will have influenced all aspects of the processes through which IBs are delivered and therefore will have impacted on outcomes. How IB lead officers understood and presented the change will also have been a critical part of how front-line workers approached this new way of working. Support planning and brokerage are covered in Chapter 10 and monitoring, review and risks in Chapter 11; the overall impact on the workforce is addressed in Chapter 12. Taken together, these four chapters give a comprehensive view of the perspectives of a range of stakeholders on the basic processes involved in implementing Individual Budgets at an individual level.

### **9.2 Impact of the Pilot**

The interviews were undertaken during a period in which care co-ordinators (this term includes care managers, some of whom are social workers) were being asked to take a very different approach to their work and were under pressure to meet the quotas for the evaluation. These factors may have impacted on who was offered an IB. Two general issues were raised by many of these respondents. First, there was a very strong sense that all aspects of IB practice were evolving throughout the pilot period, which meant that the descriptions of the approaches taken were subject to change. Secondly, being involved in the pilot was seen by many care co-ordinators both as opportunity to learn and be creative as well as a source of uncertainty and confusion, making negotiating the system 'a bit like wading through a swamp with Wellingtons' (Care co-ordinator, adult services). Such feelings were exacerbated by the need to work with two systems, as most sites had necessarily implemented IBs alongside existing care management processes. This team manager neatly summed up both of these perspectives:

I think for us, and I don't know about the other teams, but I think for us at the moment because it's a pilot and I suppose you're learning all the time from a pilot and evolving all the time. We get very confused as a team because one, we think we got our head round it, a process. And then we'll ring the self-support team and somehow it's changed.  
(Team manager, disabled people)

## 9.3 Eligibility for Individual Budgets

This section explores the impact of Individual Budgets on pilot authorities' approaches to, and staff and service users' views of, eligibility.

### 9.3.1 Changes in Fair Access to Care Services (FACS) eligibility criteria

Councils are required to use the FACS criteria since 2003 (DH, 2003). Four bands of eligibility were set out in the *Fair Access to Care Services: Guidance on Eligibility Criteria*, (DH, 2003): critical, substantial, moderate and low. Establishing a person's eligibility for social care services has previously been found to present problems in terms of the variability of judgement and the degree of confusion over the interaction with NHS criteria (Cestari *et al.*, 2006); both of these issues were mentioned as continuing problems by care co-ordinators in this study.

Across the life of the IB Pilot, eight sites kept their FACS eligibility criteria unchanged at substantial and critical levels; three sites retained moderate, substantial and critical; and two sites dropped moderate. As a consequence of their early experience, and broader budgetary concerns, care co-ordinators and team leaders across a number of sites had been instructed to tighten up on FACS and to check that potential or existing service users were FACS eligible before setting up an IB or providing conventional services. Conversely, a small number of care co-ordinators from sites in which there had been no such changes, indicated that thresholds were lower. However, this may well have been another reflection of the impact of the Pilot and particularly the challenge for sites to reach the research quotas.

Despite the fact that the piloting of IBs appeared to have had minor impact on FACS eligibility thresholds, it raised a number of related issues. First, among sites that had raised or tightened up their FACS eligibility criteria prior to or during the life of the Pilot, there were concerns that service users would 'blame' cuts in their packages on the IBs. Secondly, several IB lead officers reported that some care co-ordinators either did not understand FACS or had not been operating within FACS criteria. They argued that care co-ordinators needed to focus on eligibility for support rather than be caught up in a concept of 'FACS eligible services'. Indeed, the FACS criteria were also mentioned by care co-ordinators in relation to limitations on assessment

more generally and in terms of the kinds of needs that could be considered in support planning, in addition to simply establishing eligibility for services. Thirdly, FACS appeared to present particular problems for sites working with older people or mental health service users. For older people, this concern was based on the fact that IBs had a more visible focus on social inclusion, both in terms of the domains of the assessments and in the support planning process, which was felt to be a potential pressure on budgets. In terms of mental health services, two sites had experienced problems in relation to implementing FACS, with which mental health staff were much less familiar than other social care practitioners.

### **9.3.2 Suitability for Individual Budgets**

Many care co-ordinators reported taking extra factors into account when deciding whether to offer IBs. This was not described in terms of eligibility, but more as suitability for IBs, views about which varied considerably. Four main issues were raised by many care co-ordinators; some of these suggest they were not making a fundamental distinction between IBs and direct payments (DPs). First, several care co-ordinators stressed the importance and complexity of explaining to service users and their families where there were communication problems how the new process worked:

The only difficulty I've come up against is actually explaining to people with a limited understanding of what it's all about, to actually explain it to them and the slight difficulty I have is when I explain to people that this would give them a cost that went with their care package.  
(Care co-ordinator, learning disabilities)

Secondly, the ability of service users or their networks to manage budgets or to understand the process was seen by a small number of care co-ordinators as a key element of their suitability to be offered individual budgets:

Well I think we've got to take into account that we have some families who we know historically do not manage money as well.  
(Team manager, learning disabilities)

Thirdly, offering IBs to existing, longstanding service users could present particular problems as some of these individuals might find it more difficult to take advantage of the choice, which could be stressful:

Because it's a completely different way of working. You say, 'OK then what's important to you at the moment?' It's like hey, you know, 'what are you on about?' they sort of can't believe it. I had one and he was like, 'I can't believe this'. It was quite a positive experience for him but initially the first visit he was quite thrown by it.  
(Care co-ordinator physical disabilities)

Finally, an individual's first contact with adult services is often during a period of crisis, which makes it harder for them to make informed choices about their care needs. This was identified as an issue by several care co-ordinators and IB lead officers:

It's really hard to offer it straight away, because I mean, sort of people that I deal with are really going through crisis, do you know, and it's really difficult to start talking about money and how it's coming.  
(Care co-ordinator, learning disabilities)

#### **9.4 Service users' initial understanding of Individual Budgets**

This section describes how and where service users interviewed first heard about IBs and their initial understanding of them.

The most common source of information about IBs was reported to be social services (62 cases), which is to be expected, as most sites were offering IBs to existing service users at the point of review or to new referrals at the point of first contact. However, service users reported obtaining initial information from a wide variety of sources, including other agencies, informal contacts and local and national publicity (e.g. after 'seeing Dame Denise Platt talking about IB pilots on TV'). In some cases IBs were suggested 'as a way of employing a friend or relative as a carer' or as 'a way of keeping the same carer' and thus ensuring continuity of care. In other instances IBs were suggested as a possible solution where particular services were closing down; where an individual's situation was changing; or where individuals were not happy with existing services.

People using services and carers were asked what they understood about individual budgets when they first heard of the scheme. Of the 99 interviewees who answered this question, 27 people stated that they did not understand anything about what an IB was or what it would mean for them; 37 felt that they had a little understanding; 27 felt that they had a reasonable understanding of IBs; and eight people reported feeling that they had a good understanding of IBs.

Interviewees who reported no understanding of IBs tended to be from 12 pilot sites. The thirteenth site offered a relatively robust system of advice and support from support planners/brokers and all the users and carers interviewed from this site

expressed a reasonable or good early understanding of IBs. This site was piloting IBs with two user groups for the purposes of the evaluation.

The 64 people using services and carers who reported little understanding of IBs included individuals from each user group (including people in transition). These respondents were uncertain about what or who IBs were for; what it meant to be in control of an IB; what the money could and could not be spent on; as well as a general lack of understanding about the whole concept. Some felt that the information they had received was confusing and a small number of users and carers felt that their lack of understanding about IBs was mirrored by the professionals with whom they were in contact:

Well I didn't understand it at all because I felt they [care co-ordinator] didn't seem to know either.  
(Mental health service user)

Those who had a vague early understanding of IBs tended to be aware of the broad concept, stating, for example, that an IB is 'for an individual to say what that individual will need' (older person); 'IBs are a lot more flexible than direct payments, with IBs you are in charge of your money as well as your care' (person with a physical disability). Only eight people clearly understood from the start the concept of IBs, the practical aspects of how an IB might work and what IBs could be used for:

... we did understand that it would be a pot of money that included not only care monies, others like for wheelchairs and so on that we, we'd be able to really spend as we wished, providing our needs were being satisfied, whatever our assessed need was we could choose how that would happen.  
(Person with physical disability)

Of these eight interviewees, four had a physical disability, two were older people (or their carers), and two were the carers of people with learning disabilities. Three of these eight interviewees were from one pilot site that was offering IBs to all user groups and the other five were from five different sites.

## **9.5 Assessment**

Assessment has been reported separately from resource allocation for the purposes of this report, although these processes are conceptually and practically linked. Resource Allocation Systems (RAS) incorporate assessment tools and processes as well as the method of translating information gathered into resources. Any references to RASs in this section relate to the tools and processes rather than the methods of allocating resources.

### 9.5.1 Assessment processes

The introduction of IBs, complete with a focus on 'self-assessment' and outcomes, signals a potentially significant shift in assessment processes and practices in adult social care, as suggested by this IB lead officer:

If you're going to do away with a system that assesses needs by listing the jobs you're going to do, that instead focuses on people's life experience, you know, it's a whole different approach to assessment.  
(IB lead officer)

Overall, care co-ordinators' views varied on the extent to which assessment practice changed for IBs and the nature of these changes. For some, the new approach meant 'Turning it [care management practice] on its head', whereas for others it was seen as a more gradual development of practice.

Seven sites explicitly stated that they were running IB assessments in parallel with traditional community care assessments for new referrals (existing service users should have had a community care assessment previously). Continued use of the community care assessment was felt to be important for a number of reasons. First, it incorporates a risk assessment and thus can highlight issues around risk and adult protection that might not be picked up by the IB assessment alone. Secondly, it highlights issues around carers and their needs. Increasingly, IB assessments were including questions around informal care and informal carers' desires or abilities to continue providing care; however in many sites work around informal carers and IBs was still in its infancy. Thirdly, some sites felt that individuals should be supported through a thorough needs assessment, as they wanted to be sure that they were in receipt of all relevant care and benefits. Fourthly, a number of sites stated that the community care assessment upheld the skill and professionalism of social workers, which they felt was at risk of being eroded with the introduction of self- or assisted self-assessments.

Data collected from community care assessments could be used as a check on the information collected from the IB assessment, according to some IB lead officers. This could then feed into the development of the IB assessment and ultimately could give staff enough confidence so as to avoid duplication. Several sites were already working on merging the community care and IB assessment documents to streamline the process and reduce the time taken to assess. This was felt to be particularly important if or when IBs were rolled out.

One site did not consider that it had developed a distinct IB assessment; instead, all service users went through the same community care assessment but those to be given an IB were then 'put through' the RAS. Another site had developed an outcomes-focused assessment based on the Social Policy Research Unit outcomes



framework (Glendinning *et al.*, 2008). The assessment identifies high-level outcomes (for example, 'getting a job') and then lower-level outcomes that will help an individual to reach those goals (for example, help with getting up in the morning, the ability to use public transport).

### **9.5.2 Self-assessment**

Whilst the concept of self-assessment was introduced separately from Individual Budgets and is being piloted separately (Challis *et al.*, 2006), it became a main part of several sites' approach to assessment for IBs. Mediated or supported self-assessment featured as part of the process in 11 sites. In four of these, some service users completed a purely self-assessment. Self-assessment was considered by sites as an indication that people's views were taken seriously and as having the potential to generate positive discussions about needs and outcomes. IB lead officers in all 11 sites reported that most of these assessments also involved an element of support or checking by care co-ordinators. In contrast, two sites had not set up any self-assessment process and reported that the assessment process was care co-ordinator led, but was a collaborative endeavour, in which service users and carers were fully involved.

Most IB lead officers felt that some degree of professional assessment was necessary in addition to self-assessment. Having both views was believed to produce a more accurate assessment of needs and offered an opportunity for useful dialogue between the service user and care coordinator. Further, a small number of care co-ordinators and team managers had more serious doubts about the value of self-assessments and reported that it was often necessary to assess needs independently of service users, in order to establish 'what people's needs were as well what their own perception of what their needs were' (Team manager, physical disabilities).

Many care co-ordinators also reported that self-assessment usually involved some additional input from family members, friends or other professionals, who were seen by many as providing essential support, for example where service users could not fully understand the range of potential options. The types of individuals or organisations to whom service users could turn for support differed between pilot sites and, to a lesser degree, between user groups within the same site, but generally included family members, friends, advocates, voluntary organisations, brokers, support planners, peers, user and carer groups/organisations, in addition to care co-ordinators. Older people, people with learning disabilities or with severe and enduring mental health needs, were all specifically identified by IB lead officers as needing different kinds of support, which related to their social networks, overall mental health or level of understanding:

Our default position is that people can do this for themselves. However, we are very much aware, particularly in older people's services, there may need to be care manager involvement especially as increasingly families don't live near the older person. So there's thus nobody to help them; they're more isolated. Some older people prefer supported self-assessment. In mental health, people can self-assess but this can cause anxiety around paperwork and so the care co-ordinator follows it up to make sure they're okay with it.

(IB lead officer)

### **9.5.3 Integrating information**

Several care co-ordinators and team managers identified integrating the information from different processes and tools as an important aspect of assessment, which had been made more complex by the introduction of IBs. Information from community care and self-assessments needed to be integrated with information already known about the service user as well as the views of providers and other professionals. Integrating the information from multidisciplinary assessments was mentioned by a small number of care co-ordinators as an added complexity, but potentially providing further valuable information. Through combining and reconciling information, final agreements were generated, as illustrated in the following comment:

So whilst you've got the initial information about the self-assessment questionnaire, you would then go through and establish whether or not it was felt, based on the information that had been provided in the Community Care Assessment, the Care Plan and any other information, whether or not you would agree with, or what the final agreement was, really. Because you'd have your view, the worker's view and then the final agreement.

(Team manager, learning disabilities)

### **9.5.4 Degree of engagement with service users and carers**

One important dimension to the difference in assessment practice with IBs was the extent to which care co-ordinators' assessments went beyond establishing the resource allocation. Assessments more restricted to informing resource allocations were described by care co-ordinators as more superficial and involving less engagement with service users and carers:

With the IB questions, it was just like 'I need considerable support. I need a lot of support'. It wasn't actually going into exactly what that support entailed.

(Care co-ordinator, learning disabilities)

However where assessments went beyond gathering the information necessary for resource allocation, IB assessments were perceived by a number of care co-ordinators to gather more in-depth information, involving greater engagement:

So I think instead of looking at the needs now, we would be looking at future goals and achievements. So we are not just looking at the here and now, again we are looking at further into the future and I think that's really important, particularly for children in the transition process.  
(Care co-ordinator, children's services)

### **9.5.5 The inclusion of carers in the IB assessment**

The extent to which carers and carers' issues were included within the assessment process differed between sites and indeed developed over the course of the Pilot. Some sites did not include questions about carers in the IB assessment, choosing instead to stick with the traditional carers' assessment. Other sites decided to include questions around informal carers since the presence or absence of informal carers had some influence over the amount of formal care or support a service user was deemed to require, and thus could have a significant bearing on the service user's resource allocation.

Where informal carers were included in the IB assessment, some sites incorporated a carer's self-assessment into the main service user's self-assessment document. Other sites felt, or were advised, that this was inappropriate: informal carers may feel unable to answer questions about their ability to cope honestly in the knowledge that the person they care for would see their responses, and thus the carer's self-assessment was separate from the main IB assessment document.

### **9.5.6 Tendency to over- or under-estimate need**

A number of sites had experience of older people, and people with mental health problems in particular, under-assessing their own needs; in part this was felt to be a consequence of older people having low expectations, or people with mental health problems being in denial about their needs, or not perceiving their actions or behaviours to be anything unusual. In contrast, people with physical disabilities, sensory impairments or learning disabilities were felt to be more likely to over-assess their needs. This may come from a longer history of campaigning for greater rights, choice and control, particularly among physically disabled people, or from working with person-centred planning in learning disabilities. Confusion could also arise from differing interpretations of carers' roles or from carers' and service users' conflicting assessments, rendering the interpretation of the self-assessment problematic.

In contrast, several IB lead officers reported that care co-ordinators tended to over-assess people's needs; and that there was a culture of care co-ordinators trying to get the 'best deals' for the people they worked with, particularly perhaps for those who were the most difficult cases and/or were the most likely to complain. The IB model was expected to restrict care co-ordinators from over-assessing, or to seek to offer certain individuals more, due to the apparent greater transparency of the assessment and resource allocation system. The RAS was considered by some to be much more objective as systems were in place for each decision to be justified and the path from assessment to allocation was expected to be more transparent.

## **9.6 Resource allocation systems**

This section describes the development of RAS and outlines how they were perceived to be operating in practice. Respondents' views of the perceived consequences for service users and carers and implications for adult social care departments more generally are also given in this section.

### **9.6.1 Principles of resource allocation**

In essence, resource allocation involves translating information about the needs and outcomes identified into a budget (often termed an indicative budget). One of the key characteristics of IBs is that information is made available to service users, their families and networks, about the amount of resources available for support planning. Nine sites were using a RAS questionnaire at the time of interviews with IB lead officers (May to November 2007), which calculated IBs using information from care co-ordinator-only, care co-ordinator-supported or self-assessments. How such translation was achieved varied across sites, with degrees of reliance on a direct application of a funding formula; however, ensuring the appropriateness of the sums identified was seen as a central part of the process by care co-ordinators, team managers and IB lead officers, a form of quality assurance. However, one site approached resource allocation differently, employing outcome-focused assessments: three others were using a variety of outcome-focused methods (see next section).

In some sites, where care co-ordinators had knowledge of the RAS process and were directly involved in calculations, this involved a purely mathematical process or an awareness that, at its most simple, 'points make prizes'. In these cases, the clarity of the process or ease of use of the systems was sometimes applauded:

You identify what the needs are and you tick the boxes that actually say where those needs are met and it's quite specific. That identifies what the

budget is at the end of it, which is done on a spreadsheet. From a practical point of view, it's a very easy tool to use.  
(Care co-ordinator, older people)

Others believed that a purely mechanical approach to resource allocation was too simplistic to be able to differentiate between the complexity of different people's needs and that there was a need to interpret the material:

And there's not really a right answer, the way it's worded. So when you actually fill the form in with a person and you're reading all these answers but they can only pick one per section. And you just then say, 'Well none of them really'. But you know if you put 'none applicable' on it then this person's not going to get any points. And no service.  
(Care co-ordinator, older people)

In some sites the process was seen by care co-ordinators as more iterative, or involving a degree of interpretation using other assessment information, negotiation, discretion or even 'tweaking':

It's only used as a guide; it is only a tool at the end of the day. So, we usually have a chat with the team manager or chat with each other and see perhaps we haven't put something in the right way or maybe we could have done this better. So, I'm not saying we don't tweak it because we do. We do tweak it. Sometimes they are just not tweakable, so you'd be lying, so I can't do that.  
(Care co-ordinator, older people)

In the majority of cases (even those relying more heavily on formulae), a panel of senior managers was involved in either determining or signing-off the indicative amount. The role of this panel ranged from calculating themselves the amount of the IB, based on the care co-ordinator's assessment, user self-assessment and other information; to agreeing (or not) to the care co-ordinator's own calculations. In a smaller number of areas, these decisions were made at the level of the team manager or the service manager which was usually reflected the organisational level at which the care budget was held.

Most sites reported that their RAS underwent continual evolution over the period of the pilot, which was aimed at making them more sensitive to the variety and complexity of service users' needs, which suggests that the level of interpretation involved could either increase or decrease as systems developed. Along with other evolving elements, these changing systems created further uncertainty and were reported to result in disputes, frustration and delays in the system:

We think it's just going to be rubber-stamped. But it doesn't. And when it gets returned, it really does annoy you, because then you've got to go back, go back through it again and think, 'Where did I go wrong?' And it might be questions where you've had problems with the wording.  
(Care co-ordinator, learning disabilities)

### **9.6.2 Alternative approaches to resource allocation**

One of the pilot sites did not intend to develop an RAS that derived IB allocations on the basis of assessment information. Instead they concentrated their efforts on developing an outcomes-focused approach to assessment and support planning, based on the Social Policy Research Unit outcomes framework (Glendinning *et al.*, 2008). Crucially, in this site, costs were calculated after assessments had taken place and support plans devised. Although latterly persuaded into developing a RAS, upon which they admitted spending significant resources, it was never used during the pilot, being finalised too late in the process. In this site, and the one other where a RAS was not being used to calculate indicative amounts of support funding at the time of these interviews, most care co-ordinators seemed happy with the process.

Three other sites were also exploring variants of outcomes-focused assessment, although not at the expense of an upfront allocation of resources. In one, allocations were made on the basis of the number of hours of personal care predicted to meet each level of need. Towards the end of the Pilot another site moved towards an outcomes-focused RAS which resulted in a shorter, less complicated assessment. This site felt that their outcomes-focused RAS worked better and that the revised system was a more economical use of people's time:

It's really how purist we want to be in terms of the model, I think, because what is the most economic use of people's time that's going to produce the same outcomes really? Do I need to fill out 21 page documents really, you know, when we can perhaps get the outcomes in a much swifter way?  
(IB lead officer)

A third site was considering amending their IB assessment form so that the outcomes were laid out at the start of the document and the rest of the assessment form was used 'simply as a device to measure how much we can invest in doing something about that'. This was felt to be a more workable format, because starting with outcomes would focus on positives rather than deficits. There was also a perception that such approaches would facilitate reviewing.

### 9.6.3 Matching resources with needs

Care co-ordinators' views on the match between resource allocation and needs varied considerably; with some thinking there was a good match, others that levels were systematically too low and some that they tended to be overgenerous. This mirrored the views of some IB lead officers who reported particular problems getting the RAS to fit for a particular user group, typically older people. However, several IB lead officers expressed their frustration that there had been no clear pattern in the indicative allocations provided by the RAS:

That it's just not fitting for everybody, you know. If it was, like I say if it was consistently over or under that would be much easier to deal with. It's not even great problems between user groups because again we could do that separately.  
(IB lead officer)

Particular aspects of individuals' needs were perceived by care co-ordinators and their managers to be poorly accounted for in the process (although there was evidence from team managers that some of these factors were beginning to be incorporated in the RAS questionnaire). These included 24 hour care or night-time care; specialist services or agency care (where unit costs may be higher); informal care (where there was a need for clarity about how this could influence the indicative amount); when two carers are needed; rural location or isolation; and the needs of different user groups.

### 9.6.4 Variations in resource allocation to different user groups

Of the sites that were developing a RAS for multiple service user groups, most had or were working towards producing a single RAS assessment form across all service areas. In a small number of cases, this had not been the original intention but, following encouragement from the Department of Health, they had changed their approach midway:

Why the Department of Health didn't say from day one, one questionnaire, because we wasted a lot of time doing four questionnaires, four exercises on 100 clients, with 40 staff, ten from each service area, as a desktop exercise.  
(IB lead officer)

One site was still working with different domains for different service user groups within their RAS assessment. Other sites continued with multiple assessment approaches, although some had a core assessment with 'bolt-ons' to reflect particular issues, in respect of risk for example:

We have core domains across all user groups and then bolt-ons. We were going to have one form across all user groups but some domains won't be applicable so you only complete the set of questions relevant to your user group. There are also issues around terminology, for example around risk within LD and risk within PD, and they're viewed very differently.  
(IB lead officer)

More variable than the assessment forms was whether or not individual sites had adopted a single 'price per point' for all user groups or if they retained a different level of funding against assessed need in different service areas. Some lead officers felt very strongly that to achieve equity between the different user groups, a single price per point was a necessity:

I felt very strongly that having one questionnaire doesn't make it equitable, but if you and I fill a questionnaire in ... and you've got a learning disability, and I've got a physical disability ... to fill the same form in, and both score the same points, and then you get more than me, because you're unable, I just can't square in my head.  
(IB lead officer)

However, others believed that with existing budgetary limitations, achieving a single price-per-point was unworkable in the short term at least.

### **9.6.5 Service users' understanding of budget calculations**

Where interviewees had already been told the indicative or actual amount of their IB, they were asked if they understood how the sum had been calculated. Responses were varied. Over half of those who responded stated that they did not know how the amount of their IB had been calculated. A number of interviewees had received a letter from the local authority informing them of the amount of their IB, but this often did not explain how the sum had been calculated:

No, I just got a letter telling me what the amount was. I don't know how they reached that decision.  
(Mental health service user)

However, in some cases service users reported that the letter from the local authority had included details of how their IB had been calculated:

... it was all laid out on a sheet for me of how much I was getting for what and it was quite clear.  
(Service user with physical disability)



Several interviewees were aware that the level of the IB was determined by a points system, but none really knew how this operated:

No, apparently it is done on a points system but I have not seen this ... it shouldn't be hidden in some Town Hall desk.  
(Older person)

A number of interviewees related the amount of their IB to their 'hours of care', suggesting that the assessment and resource allocation processes retained a focus on hours rather than money. Others said that the calculation of their budget had been explained to them by the care manager, although some found the explanation difficult to understand.

## 9.7 Discussion

Eligibility, in the main had not been influenced by the introduction of IBs. However, the issues identified in relation to suitability suggested that IBs were not being conceptualised as fundamentally different from direct payments, because in order to be seen as suitable, characteristics that made people suitable for direct payments were often quoted when choosing who should be offered IBs. This is not a reflection on personalisation, nor on care co-ordinators' abilities to take on new ideas; it is more likely to be a reflection both of the early stage of implementation, and in practice the limited range of ways of deploying individual budgets which were often akin to a direct payment. As such it possibly reflects a stage of development in terms of thinking, and awareness of this possibility may facilitate future implementation of personalised approaches.

Many of the issues about assessment outlined in this chapter reflect some of the general questions about personalisation, in terms of the roles of professionals and how to support people whose needs include assistance with decision making and understanding their own situations. Practice in the midst of a pilot is bound to be different from a 'steady state' situation, but the research has unearthed genuine dilemmas about who should lead assessment and how to overcome conflicts between service users, carers and professionals about what are relevant and important needs to address or outcomes to pursue. If assessments are focused mainly on informing resource allocation, rather than exploring in depth the kinds of outcomes and choices important to the person, this perhaps creates a different slant. This is important for the future of social work, in terms of where these professionals are employed and how they interact with people using services and their carers.

Allocating resources transparently was one of the major changes involved in implementing IBs and was the subject of strong guidance from the DH. Sites approached this in very different ways, which raised two issues. The first was how to

develop an approach that reflects people's different needs effectively and produces an equitable distribution of resources. This is not simply a technical issue: political and ethical questions about the level of public support provided for different kinds of lifestyles, and what represents good quality of life for whom at different points in the life course, need to be addressed through consultation and further research.

More technically, debate continues about the merits of a mathematical or 'points make prizes' approach to resource allocation. Opinion was split between welcoming the clarity this gives (where calculation criteria were transparent) and questioning whether such an approach can reflect individual differences, which would imply a continuing role for professional judgement and interpretation. Again, further research is required to establish an appropriate balance and combination of these approaches.

# Chapter 10 Support Planning and Brokerage

## 10.1 Introduction

This chapter presents a range of perspectives on support planning and brokerage. It draws on semi-structured interviews with:

- Service users
- Carers
- Care co-ordinators/Care Managers
- Team managers
- IB lead officers
- Voluntary and Community Sector representatives.

## 10.2 Support planning

Support planning refers to the process of deciding how to use individual budget allocations to help achieve outcomes identified through assessments and other needs' identification processes. In care management practice, this equates most closely to 'care planning'.

### 10.2.1 Care co-ordinators' roles

Exploring options and co-ordination were the main tasks mentioned by many care co-ordinators, involving working with service users to help them identify and prioritise important and realistic goals, and to identify the kinds of support needed in order to reach them:

Trying to pull it all together and being clear about what the outcomes are, who can do what and agreeing that, you know, negotiating with people which bits they can do, which bits they could sign up to and what's the time framework.

(Care co-ordinator, physical disabilities)

In addition to exploring options and co-ordination, several care co-ordinators described their role in terms of building confidence or empowering service users and carers to think more broadly about their lives, and make the best use of the IB to help meet their goals:

And plus the fact, I mean if the client feels confident, if somebody goes out and speaks to them and they've obviously got background knowledge or whatever, and they've got to get that support from somebody else who's confident in that, then that's when you've got to instil more confidence in the service user or the carers or whatever.  
(Care co-ordinator, adult services)

However, a few care co-ordinators also described the need to be directive with some service users and their families if they lacked confidence; it was also necessary to ensure that plans were realistic and safe in terms of the goals set. Contingency planning to allow for matters such as personal assistants (PAs) taking holidays or sick leave was seen as crucial by several care co-ordinators and team managers, especially for people with fluctuating conditions. Devising support plans that could help people through difficult periods was given more emphasis, partly as a result of the extra freedom offered by IBs to use money differently:

And so I think, I suppose, my concern is that overall in terms of the sort of way of thinking for the future, those bits, you know if you're gonna be doing much more of that sort of way of working, that needs to be looked as an overall cost.  
(Team manager, adult services)

Some service users and carers reported that the care co-ordinator or support planner did not seem to have much knowledge of IBs or of any restrictions on how the budget could be spent. This criticism tended to apply more to care co-ordinators than to specialist support planners.

### **10.2.2 Dedicated in-house support planners and brokers**

Several sites had employed or redeployed staff to work exclusively on support planning, which meant that other care co-ordinators had little familiarity with IBs. The degree of division of roles varied; sometimes the arrangements were set up mainly for the Pilot, to help 'kick start' the implementation of IBs and provide back up for care co-ordinators who only undertook some support planning. Other sites had formally separated assessment from support planning. Typically in these latter sites, the care co-ordinator would undertake the assessment and resource allocation (by whatever means that had been arranged) and the support planner/broker would work out a plan and possibly arrange services. Support planners tended to have more time-limited involvement with service users than care co-ordinators, who would be given responsibility for cases at the point of the initial review. While this was a separate role, much liaison was reported between local authority employed support planners and care co-ordinators, as described by one care co-ordinator, for whom this was clearly a supportive arrangement:

Initially I think they'd [the support planner] gone with me on a joint visit for me to introduce the person to them. And then they explained the nitty-gritties of how IB will work and what their role will be, and the fact that they'll come at some point in time to carry out the, or to, to do the support plan. Which they do usually, later on, as part of the process. So yeah, I think it would be from day one really, their input. And then they've gone through the process in a, a sense with, with us.  
(Care Co-ordinator, Physical Disabilities)

Two care co-ordinators were less happy with this arrangement, feeling that it was difficult to pick up cases when the support planner withdrew. A further two care co-ordinators felt that having separate support planners could be confusing and disjointed for service users and carers, as it introduced an extra professional into the process. This issue of continuity in the care management process has been highlighted as important, particularly for more vulnerable service users (Challis *et al.*, 1995, 2002).

Service users and carers frequently reported that specialist support planners had focused on the individual and offered a personal touch that built up a bond between planner and user. Others reported that not only did their support planning lead to a successful programme of care but the process was enjoyable too:

We made a plan together with my broker. I quite enjoyed doing it because we did it together. I did some drawings and pictures of what I wanted to do and found it very interesting.  
(Service user with a learning disability)

Another prominent feature of successful support planners was their availability, either on the telephone, by email or face-to-face, to address quickly any problems care co-ordinators experienced. In contrast, service users and carers who had help from a specialist support planner or broker appeared to wait longer for an appointment to see the planner or broker, compared to those helped by their care co-ordinator. This experience may reflect the relatively small number of specialist support planning organisations within the IB Pilot Projects. A small number of individuals expressed concern that, in some sites, specialist support planners were actually employed by the local authority, although similar concern was not raised about care co-ordinators who helped with support planning:

The support planning team is paid for and funded by the local authority and it's a conflict of interest. They will focus on financial issues of affordability and not be person-centred.  
(Carer of a person with learning disabilities)

### **10.2.3 Service users', carers' and others' involvement in support planning**

Service users and carers were always involved in support planning and a small number of care co-ordinators reported that some service users and carers had taken on this process on their own, with care co-ordinators providing 'minimal advice and guidance' (Team Manager, Adults). Service users and carers who had worked on the support plan alone, or with family and friends, reported greater problems obtaining information about the costs of services and about recruiting personal assistants or selecting a care agency. More usually, care co-ordinators, specialist support planners or friends and family helped in writing the support plan.

In addition to service users and carers, advocates, other professionals - occupational therapists, social care workers (e.g. support workers), and private organisations (who tended to be more involved in brokerage and supporting employment) - could all contribute to support planning.

Several care co-ordinators indicated that service users and their families' choices should determine who would take on support planning, brokerage and support with employing PAs and how much support was required:

One family I had was really very ... competent and very articulate and said, fine, yeah, we get this completely and we can do this. They really didn't want that much help at all. ... On other occasions, I've sort of helped a family get together and make sure we've got the right bits and the support plan.

(Care co-ordinator, older people)

Furthermore, many IB lead officers and voluntary organisation representatives indicated that making available a choice of who helped people develop support plans and purchase the support desired was a main aim of the changes planned:

We'd want to be able to say to people, 'There's a variety of options and if you don't like the Department', which some people won't do clearly, 'There are some independent sector (staff) or there are people outside your own team, your Social Work Team'.

(IB lead officer, round two)

However, most service users and carers reported that they did not have a choice of who helped them to devise their support plan, and this role tended to be automatically assumed by their care co-ordinator or social worker. The majority of service users and carers were happy to work with their care co-ordinator as they felt that s/he already had a relatively good understanding of their situation and would advocate on behalf of the user and 'fight their corner' in any disputes over the level of the IB.

### 10.2.4 Systems, tools and recording

Methods of recording support plans varied across sites and between teams within sites. Examples were given of support planning templates that were followed more or less rigorously, which focused on asking the person about their lives and goals and how they could meet them. However the information in support plans could be recorded in a variety of different formats, incorporating photographs, for example, or simply notes of an interview with the care co-ordinator. Information about the support plan often needed to be translated before being entered into local authority computer systems, which care co-ordinators reported as being one of their roles. Some care co-ordinators also reported needing to write in distinctly different styles in order to produce a record of the plan that would be meaningful both for providers and service users and carers:

... it's about wording things in a way that services can actually understand it, you know, if it's a big outcome and in fact simplifying it, putting it in a simple way, because if you don't they won't be able to understand it if it's in a social work language, that's a skill in itself.  
(Care co-ordinator, physical disabilities)

Service users and carers across all user groups and all pilot sites considered that the volume and complexity of paperwork involved with support planning were demanding:

About quarter of the way through it I began to feel 'Oh I wish I hadn't bothered'. So much paperwork, it was beginning to addle me brain!  
(Older service user)

This was felt to be particularly problematic for the parents of people with learning disabilities who took on the bulk of support planning on top of their existing care responsibilities. Those who had help from support planners found this assistance invaluable, as the support planner would often work with the service user and carer to find out what they would like to have in a plan and would go away, write up the plan and take it back to be agreed or amended.

Seven service users reported that the level of their indicative IB allocation changed during the support planning process, causing confusion and frustration. Users reported either that there was no explanation as to why this had happened, or that such explanation was not clear. This uncertainty led to some loss of faith in IBs, the care co-ordinator or the support planner; it caused particular anxieties for mental health service users:

The final budget still isn't decided so I have had to plan what to spend my budget on whilst not knowing what I'll get ... I've just done three pages of what I might do, but then I might not be able to ... I don't like it when things are so uncertain. This has happened now, so we move on to the next uncertain thing, then another and so on and it gets confusing and I don't like that.

(Mental health service user)

Further, in some sites service users were asked to write two support plans, one that was based on the indicative allocation of social care funding and another in case they were successful in being awarded additional funding from another funding stream (typically the ILF). Not only did this slow the process down, it also led to confusion and frustration among some users.

Most service users who offered an opinion (15 in total) felt that support planning was too slow. Often this was linked to the approval process but other reasons included the length of time an individual had to wait for an appointment to see a support planner (three months); delays due to staff shortages within social services (four months); delays when social workers left and users did not know who to contact about their support plan; and, in one case, a support plan that was reported to have been lost by social services. Several users expressed frustration that they were not kept abreast of developments. A number of users were also concerned that the PAs they had lined up to provide their support would find alternative work because of the delays in approving the support plan. However, delays are also known in traditional social care services and may in part have been due to the uncertainties of implementing the pilot (see Chapter 9).

### **10.2.5 Flexibilities and boundaries**

One of the most important reported benefits of IBs was the ability to meet needs differently and the freedom to focus on broader areas in terms of the outcomes and goals set out in plans. However, some limits were usually placed on the content of support plans, although there was some confusion and variability about the boundaries of what was acceptable. One key debate concerned whether money allocated on the strength of personal care or social support needs that reached the FACS criteria could be used to pay for different kinds of support. For example, a team manager described a situation in which someone with what was accepted as a 'need' for personal care chose to struggle over that aspect of life, in order to have other things provided. This was seen as a legitimate and realistic way of spending the budget:



He is a very proud man and doesn't want personal care. What he wants is other things, so that, when he is up and dressed and tired out, somebody will be there to do other things for him like, [keep] a house tidy. That is a legitimate way to spend their budget.  
(Team manager, physical disabilities)

A further dilemma was identified by several care co-ordinators and team managers over whether, and what kinds of, material goods, such as computers or equipment, like satellite navigation (sat nav) systems for cars, IBs could legitimately be used to purchase.

But for me about being confident driving around wasn't, that wasn't even essential because (inaudible) the care. So you wouldn't spend it on a sat nav. But in another case it might be that the sat nav did meet that need.  
(Team manager, physical disabilities)

Having realistic and relevant goals and being able to show that the support plan could help to meet them were seen as important by many care co-ordinators. However, several care co-ordinators gave examples of carers estimating their ability to provide support, and also of service users who wanted their carers to provide personal care to free up resources for social and leisure support. Again this illustrated the complexities of defining the boundaries of social care.

Whether family members could be paid to provide care was another boundary issue. Apart from the standard regulations of direct payments, that carers can usually only be paid if they do not live with the service user, paying family members was seen by a small number of care co-ordinators and team managers to create complexities in terms of eligibility and power relationships:

Do I actually do the assessment and say, well, this person is entitled to an individual budget because they want to actually to pay the family member, or do I actually put FACS into place and say, if the family member is providing the service then they are not eligible?  
(Care manager, older people)

### 10.2.6 Agreeing plans

After support plans have been devised, they have to be formally accepted or 'signed off' by the social services department, in a similar way to the process of agreeing resource allocations described in Chapter 9. Team managers or assistant team managers in some teams were able to sign off plans, whereas in other sites, support plans had to be submitted to a panel of senior managers. In addition to signing off plans, a small number of care co-ordinators said that team managers were also monitoring or guiding what could go into plans, and questioning why certain services were not being used:

When you take the support plans to the managers they can tend to make sort of value judgements on, 'Well I don't think this'll suit them' and at one point 'cos we wanted to do a befriender, the manager said, 'Well you know we've got a befriending service at the moment, why can't they use that?'  
(Care co-ordinator, mental health)

Several care co-ordinators gave accounts of what they saw as inconsistent decisions being made by panels about component elements of plans, which created conflicts with service users and carers and between members of teams. A small number of service users and carers felt that such difficulties had undermined opportunities for choice and control. Where plans had been sent back to the user to be revised, the reasoning was sometimes seen as difficult to understand:

We had such a palaver about how to word it. On the plan we put down 'befriender' and when we tried to get it signed off higher up it got rejected because of that. So we all got back together and changed the word to 'companion'. All that added an extra 4-5 days of our time.  
(Mental health service user)

In some areas, service users were able to change support plans without notification, whereas in others, all changes had to be agreed by panel. For example, one care co-ordinator indicated that service users were given a great deal of freedom to make changes:

In theory they should let us know about that, in practice, I mean, there's nothing there that we've given them to tell that they must tell us.  
(Care co-ordinator, learning disabilities)

### **10.3 Brokerage (arranging services)**

Brokerage, in this context, refers to identifying resources, services, or individual staff; and making arrangements to provide the support planned, although some respondents suggested there was a lack of clarity in this distinction.

#### **10.3.1 Costing services**

Costing services and other provision to meet goals identified in support plans is a key initial step in the process of brokerage. Unit costs were seen to be more important, as a result of service users and carers being more aware of money available to pay for support and having more choice about providers. Examples were given by several care co-ordinators and team managers of service users choosing more of less expensive services than may have been accessed through a traditional route as a result of this increased transparency. In mental health there was the further

complexity of the 'free at the point of delivery', and potentially substitutable, services provided by the NHS:

Well basically, you know, all of a sudden, you know people can buy their own agency (staff) or whatever. Now, I've got like support workers, some are Social Services and some are health. So you wouldn't pay for a health worker, would you?

(Team manager, mental health)

Several service users and carers who were putting services in place reported difficulties setting wage rates for personal assistants whom they were hoping to hire themselves. Individuals were torn between setting a wage high enough to attract 'good quality' workers, but low enough so that they could afford enough hours of support. These interviewees found it particularly difficult to work out wage rates when they realised they also had to allow for other costs such as holiday pay, sick pay, tax and national insurance contributions. However, the majority of these interviewees had help with such costings from direct payment support services, support planners/brokers and informal contacts such as accountants, family and friends. Notably, interviewees who had previous experience of direct payments reported finding it easier to find out how much different support arrangements cost and how to spend their IB.

Several service users and carers reported that the common currency when discussing support arrangements with their care co-ordinator or support planner remained the number of hours of help, as opposed to the actual financial cost. For some this seemed to be an easier basis on which to work, as it enabled them to calculate how many hours of care they could afford out of their IB. However, others found the focus on hours difficult, especially if they were seeking to purchase support other than personal care or a personal assistant:

I kept saying 'Stop looking at it in hours 'cos it don't mean nowt to me, I want money, I want to see what there is to spend'.

(Carer of a person with a learning disability)

### **10.3.2 Information about costs**

Where users opted to use agency care workers, some were offered information about the costs of different agencies from a care co-ordinator, support planner/broker or voluntary organisation. In many cases however, care co-ordinators suggested which care agency a service user should use, typically the agency that the user was currently with. Nevertheless some users took it upon themselves to ring around different agencies and ask for prices:

I had said to [support planner] 'Well, God, that's not very much left to have a gardener' and she said 'Well that's how it's been worked out'. But of course then I realised and appreciated that ... the company I'd been put into, the agency, was about the dearest there is in [council district] ... so I thought, right, well I can do this cheaper myself so ... I went to a smaller, cheaper and far superior agency.

(Older person)

Several service users and carers felt that there was too little information available to them to make decisions about which agencies to work with. Some felt that the local authority should provide more information. Others had undertaken their own research, but felt that this would be too difficult for some people:

You've got to be determined, some people couldn't manage it. I've been through the Yellow Pages, the Thomson Directory, to get this off the ground.

(Older person)

Where information was available, users and carers were able to compare the approximate costs of agency staff against directly employed PAs and thus be in a better position to balance costs against the level of responsibility they were prepared to undertake:

I was given good guidelines by [social worker] and [broker] on the average cost of, per hour, of an agency compared to hiring them myself personally and I did lose a few hours doing it the way that I've done it, but reasoned that it was easier than having to deal with employer liability insurance and all the rest of it.

(Person with a physical disability)

### **10.3.3 Roles of external agencies**

Dedicated support planners and brokers employed by the local authority, service users, informal carers, and voluntary and private organisations were all reported as taking on the role of arranging services, in addition to care co-ordinators. At a minimum level, external organisations managed technical issues of employing PAs such as payroll; in other situations such organisations undertook the whole process of identifying and liaising with potential provider agencies or recruiting and managing individual staff. The question of who would be ultimately responsible for dealing with conflicts and crises, when different organisations were involved in putting services in place, was raised as a potential dilemma by a small number of care co-ordinators. The following quote gives a good impression of the variety of possible approaches which were used to put services in place:

We, depending on who's going to be providing the services, usually it's a person that the service user knows. I've not had anybody where they've said; 'Well I don't know anybody to do that for me. So can you actually go and find somebody for me?' If it was a case that that's what they said, then obviously I would, [name of local organisation] or another organisation that help out with the finances and, and finding a PA, and things like that for service user.

(Care co-ordinator, physical disabilities)

Many care co-ordinators, IB lead officers and voluntary and community sector representatives described a changing situation with regards to formal arrangements with external organisations, and reported that different approaches were being attempted. Using external agencies (which were mainly, though not exclusively, from the voluntary sector) for support planning seemed to several care co-ordinators and IB lead officers to be more complex than for brokerage or support with payroll issues, which are perhaps less personal aspects:

The brokerage bit feels far better because you're actually trading the skill in, accountancy or payroll, you know, something, or you're actually managing money on behalf of the person. I think the support planning bit is something that is a little bit too personal at the minute.

(IB lead officer, round two)

Several IB lead officers and voluntary organisation representatives reported that local Centres for Independent Living (CILs) or other user-led organisations were being considered as potential hosts for, or providers of, support planning or brokerage services. One other site had seconded their in-house support planners to the CIL. Such organisations were thought by these respondents to be particularly appropriate because of the link with the disability movement; their positive image and closer links to service users and carers; and their more independent position in relation to the local authority:

It sounds much better to ring somebody and say, you know, 'I work for the Centre for Independent Living; I'd like to talk to you about individual budgets' rather than 'I work for Social Services'. So it's proving, it's, it's going down quite well.

(Voluntary organisation representative)

A small number of IB lead officers and voluntary organisation representatives raised the possibility that organisations that provided services, particularly those in the private sector, might be faced with a conflict of interest if they are also involved in support planning and particularly brokerage, which involves making decisions about particular providers. These concerns echo the calls for a split between purchasing and providing that were influential in driving social care policy and practice in the early 1990s, and the role conflicts of case managers in the Japanese social insurance system:

I mean, I think that's part of your reviewing process, so if someone – yeah, say, for instance, the broker they choose is [Name of organisation], and the next thing you find out they're spending the bulk of their money on [The same organisation's services], I think that's where we need to be very careful.

(IB lead officer, round two)

Ensuring the quality of external support planners more generally was felt to be a key issue by several IB lead officers and voluntary organisation representatives, who also questioned whether there were as yet enough good quality support planners in the voluntary and private sectors:

But yeah, we've got to be very wary that there'll be lots of people ready to pick this thing up and may not be as good. But, you know, hopefully users will get some, sort of, benchmarking advice about who's good, bad or ugly.

(IB lead officer, round two)

In the three sites where plans to implement external support planning had been developed, approaches to quality mainly involved the usual checks on the acceptability of support plans produced. However a small number of IB lead officers and voluntary organisation representatives discussed the possibility of setting up some sort of accreditation for support planning:

They [local voluntary organisation providing support planning] chose to set ... an accredited standard for delivery, so it chose what that would be, and you could only join if your organisation was like that.

(IB lead officer, round two)

#### **10.3.4 Funding and contracting external support planning and brokerage**

How to fund externally commissioned support planning and brokerage was a subject of much debate among IB lead officers and voluntary organisation representatives. In two sites, consortia of voluntary organisations were being set up and were bidding for Department of Health Social Enterprise funding, in order to help develop the infrastructure for support planning and brokerage. One of the main issues with external organisations contracting was whether to set up a block contract for a certain number of service users to be supported with support planning or brokerage, or to pay a fee-per-service-user, which was felt to be more flexible but possibly less attractive for providers.

The main challenge, mentioned by many IB lead officers and voluntary organisation representatives, was deciding how to fund independent organisations to undertake the work; re-engineering care management was felt by several respondents to be a means to resolve this issue. A lack of clarity about what is involved in support planning and brokerage was felt by a small number of respondents also to have

inhibited the involvement of independent sector organisations. This IB lead officer described the approach taken in one site, which was fairly typical of the kinds of development work being undertaken:

The steps are that we've had some, sort of, groundwork discussions with a range of local Voluntary and Community Organisations, and have invited people to say whether they want to undertake some of this work for a modest payment, you know, just to reimburse them for their efforts really, on a, sort of, 'suck it and see' basis. We've got 15 responses, which will be shortlisted to a group that we will then work more comprehensively with to offer some training and briefing on the sort of thing we expect people would want.

(IB lead officer, round two)

### 10.3.5 Who pays for external support planning and brokerage

In almost all sites, the arrangements during the pilot period were that support planning was not charged out of the IB allocation, even in the three sites which had made arrangements with voluntary organisations to provide some support planning. However two IB lead officers reported that service users were paying for independent brokers, or for support with employment issues such as payroll. However, whether support planning and brokerage should be charged out of service users' IB allocations was debated by respondents in many sites. Continuing to fund external support planning and brokerage out of adult social care budgets was felt to be a simpler, but possibly expensive, route. Two options for service users to pay for support planning from their IB allocations were outlined by many respondents: either identifying a 'ring fenced' amount in the resource allocation, which could only be used to pay for support planning or brokerage; or adding a sum to all IB allocations which could be used by service users as they wished. One or two respondents noted that this would involve identifying unit costs for support planning and brokerage, and that the approach would require a way of assessing how much to allocate for support planning for individuals with different needs or for those and with informal networks that could take on different levels of responsibility. Further, having a ring-fenced amount to pay for support planning out of the IB allocation was felt by some to produce inequities for people who were able, or whose families or informal networks were able, to do most if not all of this themselves. The following quote, from an IB lead officer, sums up these issues:

Yeah, I mean, there's a range of models whereby we could say, 'Here's x amount of pounds', but then if they get thousands of people coming through their door, obviously it's not going to be enough money. So do we give people, you know, do we pay per head or do we say to the individual, 'This is your Budget, you can choose to pay'. We, sort of thought for those people who would lack capacity or don't have anybody in the world to support them to write their own plans or help them direct their own

support, for those people should we pay for it? And for those people who choose to have a broker, but who are well able to do it, because we spoke to somebody who's very articulate, very able to write down what they wanted?

(IB lead officer, round two)

## 10.4 Discussion

One of the key elements of personalisation is the hope that service users and carers are enabled to use public money to support themselves in new ways and to create greater flexibility in the care and support system. However, this creates a dilemma. If a person can do without an element of the personal support they have been assessed as needing in order to free up money to spend elsewhere, can they still be seen as needing the personal care? Clearly an element of judgement is involved in resolving such dilemmas, but it points to a mismatch between the concepts underlying eligibility criteria and assessment practice, which focuses very tightly on clearly defined needs; and a personalised approach, which, in contrast, focuses on supporting quality of life and achieving a set of outcomes.

A further aspect of this discrepancy arises from the original policy intention of merging several different funding streams into a single IB, which would further have enabled people to go beyond traditional social care boundaries. Limiting IBs to social care funding requires further thinking in terms of identifying what social care is for and for which activities should be prioritised. This requires a re-examination of assessment practice in particular, and the role of policy directives such as FACS.

These findings have highlighted an increased role for service users and carers in developing support plans and putting them in place, and for other workers, often based in the voluntary sector, in providing advocacy and brokerage to support this process. This suggests the possibility of an abbreviated support planning process (in terms of input from local authority staff) for many service users alongside longer-term intervention models offering greater continuity of support for certain individuals who present higher levels of need or risk.



# Chapter 11 Risk and Risk Management

## 11.1 Introduction

This chapter gives an account of the different types of risks associated with IBs from the perspective of Adult Protection (AP) lead officers, care co-ordinators and team managers; examples of actual referrals to the adult protection service in the context of IBs; and the policies and procedures developed by sites for managing risk, including routine monitoring and review processes. Whilst the benefits of Individual Budgets (real and anticipated) were universally recognised by this group of respondents, fears of a potential negative impact on risk were regularly voiced. Moreover, by early 2008, AP lead officers were gaining insights into the realities of the pros and cons of the system as a result of their experiences over the past 12 months. The findings presented in this chapter are based on semi-structured interviews conducted with 14 AP lead officers<sup>52</sup>, 48 care co-ordinators and 43 team managers from across the 13 pilot sites.

## 11.2 Perceived risks associated with Individual Budgets

### 11.2.1 Positive risk-taking

A number of interviewees recognised that there was a need to transfer more responsibility for taking risks to the individual, and that 'positive risk-taking' was part of the philosophy of IBs where previously there was a tendency for service users to be 'wrapped up in cotton wool'. But this was also seen as a difficult culture shift for care co-ordinators to make and there were tensions in relation to safeguarding vulnerable adults:

We're having to undo many years of people's rigid thinking in terms of service users about, 'I know what's best for you'. And I think that has existed in psychiatry for a long time. And I've heard psychiatrists say, 'But I know what's best for you. I know what you need'. But they don't. It's an arrogant statement. We actually need to point out to service users, 'Maybe the reason we don't want you to do that is because you could get hurt, and we can see it'. But again, it's about risk learning. You know, it's positive risk taking. And we're not good at that. And so that's fear for us. (Care co-ordinator, mental health)

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<sup>52</sup> Findings from the interviews with adult protection personnel have previously been published in the *British Journal of Social Work* (Manthorpe *et al.*, 2008b).

### **11.2.2 Risks associated with managing budgets and employing personal assistants (PAs)**

Often the expectation was that IBs would take the form of a direct payment and concerns were expressed about this. To the extent that for some service users the IB could take the form of a more flexible care-managed budget (Challis *et al.*, 1995, 2002) some of these concerns could be addressed.

There were concerns amongst interviewees that money given to some service users as an IB could be spent inappropriately, for example on services or commodities not directly meeting their needs, leaving no funds available to provide fundamental personal or social care<sup>53</sup>. More commonly, however, care co-ordinators, team managers and adult protection leaders alike expressed concerns that service users or their families would not have the ability to manage the finances made available to them. In either situation the worry was not only that the service user would not receive the care they required but also that the local authority would be left to 'pick up the pieces' and either top up payments or provide extra services.

Another worry for respondents was that for those electing to employ their own PAs, service users and their families may not have the knowledge or ability to employ a suitable person or to be good employers. In particular, the complexities of employment law, ensuring that employees were paid, ensuring that employees were not exploited and that they had the necessary training to undertake personal care tasks in a safe and effective way were all raised as concerns:

We are not aware of the system in place if the service user is employing the PAs, and if someone else advises them about moving and handling training and PAYE, if National Insurance or the Income Tax is not paid, or the insurance is not sorted by the service users, the local authority is not responsible for that, as far as I know.  
(Team manager, physical disabilities)

The relationship between employer and employee was seen as potentially vulnerable from each party's perspective:

I think the downside for carers and service users is that they can all be exploited and carers can exploit service users, and service users can exploit carers. Do service users get ripped off by the people that they are employing? Are they able to deal with the problems of employing people that aren't up to what they should be providing? So I think there is a whole spectrum of good to bad.  
(Care co-ordinator, learning disabilities)

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<sup>53</sup> Also mentioned by providers. See Chapter 7.

For AP lead officers there was a perceived danger that people using IB- purchased services could become isolated and that the power of the collective voice on commissioning, shaping, developing and regulating services might be lost. Services might be stripped of an accessible pool of staff. There were also dangers that people employed under the new arrangements might lose entitlements over sickness and pension benefits.

A further risk, which interviewees perceived to be associated with service users employing their own PA, was where the care arrangement arrangements broke down. There was still a lack of clarity over who should be responsible in that situation and what the role of the local authority was:

If there's a problem they can't just ring us up and say, 'Sort it'. Because if they're actually employing the person, they've got to sort that out with whoever it is that's supporting them to employ that person. If it's a problem with one of our own commissioned services we may say, 'Okay. Well we need to investigate that or stop that service and we'll put another one in from nine o'clock tomorrow morning'. So I see that as a risk which could be a risk around needs not being met.  
(Team manager, learning disabilities)

### 11.2.3 Financial abuse

In addition to the potential for service users and/or their families to spend IBs inappropriately, some care co-ordinators and team managers also believed that there was an increased risk of the wilful misuse of money:

I know service users, the ones I know, are pretty genuine, but I know, having words with social workers, there's people out there that aren't as honest. And it's how you monitor that bit of money going in. And how it's spent. I haven't had any problems yet, touch wood, but saying that I had a problem with a direct payment user that we're looking into who's using it to pay off debts that he got into.  
(Care co-ordinator, physical disabilities & older people)

Furthermore, a larger number of interviewees had anecdotal evidence of users of direct payments and possibly IBs being subject to financial abuse from family members or paid carers:

You know, we've had even close family taking money from people if they've got access to a direct payment or an IB account.  
(Care co-ordinator, physical disabilities)

And also we identified within the last four months about three or four cases where the PAs financially abused the service users.  
(Team manager, physical disabilities)

#### 11.2.4 Neglect and physical and emotional abuse

Although not questioned specifically on issues of risk, care co-ordinators regularly voiced their concerns during interviews about the risk of neglect and physical or emotional abuse that could be associated with IBs:

I mean they're vulnerable to start with. And I think if we've got someone on a twelve month review and they're left out there in a community that doesn't fully appreciate them, you know, the level of vulnerability is going to be sky high.

(Care co-ordinator, physical disabilities)

With no clear monitoring systems yet in place (see below), many worried that they might be abandoning already vulnerable people into the hands of unscrupulous employees or family members:

I know that a traditional care plan might be pretty rigid to people but for some people that can be a good thing because there is an element of monitoring. You know that there's somebody that's always going to be there to oversee and make sure that the risk of abuse is reduced. But it's like, 'There's your money; off you go' at the moment.

(Care co-ordinator, physical disabilities)

The potential for IBs to destabilise family relationships and even exacerbate domestic abuse situations was also raised by AP lead officers, explicitly linked to similar concerns about direct payments:

I think a more general point, both around direct payments and by implication IB as well, [is] in those situations where a service user employs a friend or family member ... you are talking about relationships that go beyond, 'I pay you', personal relationships. And I think we may have to consider that phenomena like domestic abuse could play a part in choosing to pay a family member. The danger doing this job is that you have a fairly jaundiced view of humanity really.

(AP lead officer, round two)

Several AP lead officers were also concerned that people out to abuse the system would target and exploit IB recipients. In one authority there were apparently already signs that this was happening:

The real risk is that they will be targeted and groomed by people who abuse vulnerable adults. There is a bit of local evidence that some people who've abused children have moved over to abuse vulnerable adults.

(AP lead officer, round two)

### 11.2.5 Adult protection referrals

At the time of the first round of interviews (early 2007) no AP lead officer had received or been aware of an IB referral to the adult protection service, although in some authorities the AP lead officers might not necessarily have known because service managers would have dealt with such cases appropriately at an early stage, without recourse to the AP lead officer.

However, in the second round interviews (early 2008), examples were cited of financial abuse, financial irregularities, concerns about the criminal record of the carer (fraud), deception regarding levels of need, allegations of rape and personal assistants ignoring court injunctions preventing family visits. The care worker, whether family or friend was often, although not in every case, dismissed. In one instance, regarding financial manoeuvres to avoid loss of welfare benefits, the family asked to be relieved of responsibilities for managing the IB. Many of these cases prompted the authorities to look at their reporting policies, risk assessment procedures and monitoring and review arrangements.

Problems encountered in these investigations (which were also reported in round one interviews in relation to AP referrals involving people using direct payments) related to gathering evidence; establishing how far a person using services was colluding in the abuse; and the grooming and other tactics of care workers. Service users were reported to be scared to complain lest they lose their services or because of problems with mental health, cognitive impairment, emotional abuse or inappropriate pressure by the alleged abuser.

## 11.3 Managing risk

### 11.3.1 Links between existing adult protection policies and Individual Budgets

The interviews with AP lead officers enabled exploration of existing adult protection or safeguarding policies and practices regarding consumer-directed support in England, such as direct payments and *In Control*, and examined whether these policies were compatible with IBs. In both rounds of interviews, most AP lead officers referred to their local authority's existing multi-agency AP policies as the umbrella procedure to cover all forms of abuse among vulnerable adults, not just abuse related to statutory or social services. Whilst generic policies were the norm, one AP lead officer stated in the second round of interviews that the different service areas were using them differently.

Whilst AP policies were in place everywhere, fine-tuning in respect of IB issues was either in the early stages of development, or had not yet started at the time of the first interviews. However by the second round of interviews, AP lead officers reported a

number of general and specific developments. It was frequently mentioned that policies were under review and that changes in staff or service configuration were likely to bring further safeguarding improvements into the IB service.

In one site institutional abuse had been added to the standard list (physical, emotional, financial, sexual, neglect, and discriminatory abuse) in the authority's policy in the hope that such an extension would reduce risks as the AP lead officer explained:

We've added institutional abuse and what that constitutes [is] where someone buys a service from another agency. I know it involves all of those, but it's highlighted ... to show up poor institutional practices that everyone's just come to accept.  
(AP lead officer, round one)

Another AP lead officer (in round one) registered concern that the IB implementation had been developed apparently without adequate thought having been given to risk, particularly of financial abuse. However in two instances the participants suggested that specific responses to the perceived increased risks associated with IBs should be mentioned in AP policies when they were next reviewed:

I've raised concerns about the way in which we're making sure we have the safeguards in place, in the way we do for direct payments. I'm asking about identifying risk factors in abuse, the way in which it could be included in the support plan. I think all abuse across the board, finance as a particular issue. ... Within the AP procedures, they don't mention IB. When the POVA (Protection of Vulnerable Adults List) procedures are rewritten they will talk explicitly about IBs. A self-assessment questionnaire is part of that.  
(AP lead officer, round one)

Future policy development plans identified by AP lead officers included firming up AP policies and ensuring they are regularly reviewed: in one case an additional internal policy had been developed to link with the existing AP policy document; in another, identifying some of the safeguards that social workers and care managers would have to follow was under consideration; and establishing clear links between AP and IB systems.

### **11.3.2 Procedures for minimising risk**

Team managers were asked how they were adapting their approaches to managing risk in the context of IBs. Risk assessments to identify areas of existing risk were generally undertaken during the initial assessment process and a number of participants referred to specific approaches to address risk at different points in the process. In some authorities, a section in the support planning documentation had

been put aside for individuals to consider strategies for dealing with risk, for example, contingency planning should care arrangements break down. Virtual or internally managed budgets were suggested for use in cases where there was any concern with the direct management of IB funds. However, some interviewees had concerns that if the system placed excessive reliance upon self-assessment using RAS documentation, assessments of risk would suffer.

For cases of identified risk, some authorities had established or were considering using Risk Enablement Panels to assess the risks of implementing an IB. In situations where these had been used, they had been considered by care co-ordinators to be an invaluable support:

I've been to the risk panel with one of mine, which I found useful really because it takes the pressure off, when you're saying 'no' to somebody, it takes the pressure off, it's not you saying it personally.  
(Care co-ordinator, physical disabilities)

However, in this authority according to AP lead officers, the criteria for meeting the panel's risk aversion threshold were still in the process of being worked out.

Although there appeared to be safeguards in place for dealing with identified risk and protecting vulnerable adults, many authorities did not seem to have clear mechanisms for monitoring and identifying risk once support packages were in place. Some were reliant on annual review systems. Others felt that the responsibility for risk had been transferred away from the local authority and was now more in the hands of the service user and their family. It was clear there was a tension between how far individuals were allowed to take risks and where the authority had to retain responsibility for protecting vulnerable adults:

People have raised concerns, 'Is that what's happening? Is the risk being transferred to the service user?' Equally, people here said, 'What business is it of yours? We are entitled to take risks'. You are patronising if you say you want to watch how you spend this money. There is a tension. But clearly, it is public money. The council has a reputation and duty to monitor safeguarding issues. I still think the buck stops with us if we ... it will be harder to monitor.  
(Team manager, older people)

More widely, changes had been made in several of the authorities in response to actual instances of abuse. Publicity and dissemination of information to service users and personal assistants featured in many of the responses. One area had set up a group to examine how information should be circulated and was using the local free newspaper as an outlet. Several authorities had produced leaflets to help service users recognise abuse and to advise them of the appropriate contact points:

... service users are given information on safeguarding issues – if the service user wishes to use a personal assistant the PA is given information on safeguarding vulnerable adults in a leaflet.  
(AP lead officer, round two)

Training for service users and involving service users in policy development were additional aspects of the changes that were mentioned in a couple of the interviews. As one AP lead officer stated:

The IB team are setting up training for service users. We are setting up user groups to advise on the policies and we are going to other service users' training on policy and categories of abuse: I even touched on statistics that abuse is highest in your own home. I didn't want to scare, but to reassure processes are in place and how to access the services. Even if they come to us we clearly signpost them, we have to follow it through ...  
(AP lead officer, round two)

One authority had a policy, procedure and practice guide in place which worked towards tailoring processes to the individual and the particular circumstances. This had apparently enabled the authority to act in the case of a person in receipt of self-directed funding who had not previously been categorised as vulnerable. Another authority had changed its procedures to ensure that every complaint was logged and followed through. A third authority had implemented a pilot project to streamline risk assessments and bring those relating to IB into an integrated service. The pilot was given the task of making recommendations about how to respond to safeguarding incidents, and to support staff in informing service users about abuse.

Additional ways to safeguard people in receipt of direct payments were in existence and their extension to IBs was being considered by participants' social services authorities. Further actions were identified by AP lead officers in both rounds of interviews. These included: incorporating IBs in adult protection training; developing audit trails; improving complaints procedures for people being cared for by family members; 'beefing up' advocacy services to support people in decision-making; multi-agency training and public awareness training to ensure people were aware of what counted as abuse; identifying any risk factors for abuse and how these could be recognised in an individual's support plan; and preparing a guide for social workers about co-working issues, protection and risk management.

### **11.3.3 Ongoing support with employment, monitoring and review**

Care co-ordinators and their team managers were questioned about monitoring, review and ongoing support processes developed by sites which, along with ensuring that existing support packages remained adequate and appropriate after services



had been put in place, were an important way of minimising and managing risk. This aspect of the IB process was least well developed at the time of the interviews, particularly in those sites which we visited in the spring and early summer of 2007, when fewer IBs had been set up. Given our experience in interviewing service users for the outcome part of the study, even in the sites visited in the autumn of 2007 it is likely that relatively few IB cases would have reached this stage. Therefore some of the comments made by care co-ordinators and team managers are likely to be based on modest direct experience.

### **11.3.3.1 Ongoing support with employment**

Support for employing PAs varied: it was often a matter of identifying other sources of support, such as brokers, or voluntary organisations to undertake this work with service users, although responding to emergencies was still seen by some as the role of the care co-ordinator:

So the care co-ordinators were always involved in supporting people. Putting them in emergency practicing care because their PAs were leaving every five minutes. So [name of voluntary organisation] could re-advertise for more.  
(Team manager, physical disabilities)

Critically, there was no means of enforcing checks on care workers' possible criminal records through the Criminal Record Bureau (CRB) or whether workers were on the Protection of Vulnerable Adults (POVA) List. Therefore a person with a criminal or blemished career record could apply for a job to support an isolated, vulnerable individual. The availability of CRB checks for individuals wishing to employ their own PAs appeared to vary between sites. Where available, service users could choose not to go down this path and might be deterred from doing so because of the hassle and expense (there was a lack of clarity amongst care co-ordinators over whether the cost of CRB checks would be covered by authorities or would have to be taken account of in a person's IB). However, in one authority, ways of enabling service users to access CRB checks free of charge was under consideration and in two of the authorities this had been implemented, according to AP lead officers. Again, many of these issues were similar to those experienced in the implementation of direct payments.

The AP lead officer in one site also indicated that they were preparing an information pack for service users about CRB checks and the POVA List to ensure they were fully informed. They also intended to ensure that it was distributed to service users who were considering taking up IBs. In another authority, they were considering using dedicated support brokers to assist individuals with their employment responsibilities, CRB checks and POVA List. A further site was planning to establish a local system of registration for unregulated workers, which would be recognised by the national safeguarding unit.

### **11.3.3.2 Monitoring**

According to AP lead officers, several authorities had instituted increased monitoring where vulnerability was a cause for concern. However, many care co-ordinators reported that they knew of no new monitoring systems and that the approach to monitoring IBs was essentially the same as for traditional services. Care co-ordinators played a flexible role in monitoring cases. This was dependent on the individual situation of service users, the role of family members and what kind of input was desired. Monitoring involved visits and telephone calls to check how the person was and whether arrangements were working. This was essential in the first few weeks, in order to be able to make changes quickly if necessary. The frequency, duration of visits and how long such work continued varied, although many care co-ordinators described how such involvement would cease after between six weeks and six months, when cases tended to be closed to the original worker, but remained open to the team.

One AP lead officer maintained that there had been misconceptions in their department about social workers' responsibilities around direct payments which had transferred to the IB context:

We have a long history here of DPs, there's a feeling around DPs you can't touch them, you set them up and then you can't touch them. We're just beginning to understand the position of adult protection with DPs.  
(AP lead officer, round one)

Another AP lead officer in the first round of interviews indicated that in respect of the local *In Control* and IB schemes, their local authority relied on the people supporting a person to use services to identify any abuse and not its own monitoring systems:

There's no audit for *In Control* as far as I'm aware – we will be reliant on someone supporting the person to identify abuse. We know our families and their support networks – you know other people are monitoring the situation well.  
(AP lead officer, round one)

However, several care co-ordinators feared that there would not be sufficient ongoing monitoring information derived from agencies, workers and families with IBs, unlike formerly where providers had a contract with, and therefore more accountability to, the local authority. This issue was also raised as one likely to make the process of reviewing potentially more difficult. One consequence of this, identified by several care co-ordinators and team managers, was to place a greater onus on family members and service users to identify when things were going wrong, and either make changes themselves or to ask for help. These participants felt this would increase the risk of harm and make it more likely that service users would not receive the right kinds and level of support:

If somebody is receiving an individual budget and then paying Fred up the road to actually provide them with the care that they need as is their want, will Fred come back to us and say, this person is not managing any more and needs more care or we don't know.  
(Care co-ordinator, older people)

A small number of care co-ordinators and team managers reported being responsible, to different extents, for monitoring how the IB money was being used, which was seen to be an added task for IBs. Care co-ordinators who commented on this recognised the need for the task, but tended to be slightly uneasy about their role. This was also a key theme for nine IB lead officers (eight in the round one and two in the round two interviews), who identified a slight relaxation of financial monitoring, although this was described by some as involving ongoing negotiations with finance departments. Two IB lead officers also mentioned a policy of clawing back unspent portions of the IB, which suggests further tension over the issue of financial management.

### **11.3.3.3 Review**

While little evidence emerged of major changes to reviewing practice possibly due to the timing of the fieldwork, changes in emphasis were noted by some participants. Reviewing IB cases was said by IB lead officers, care co-ordinators and team managers to have a slightly different focus, given the more fluid nature of the support plans as described above. Several IB lead officers described this as being 'light touch'. One of the clearest messages, mentioned by eight IB lead officers in rounds one and two, representing ten different sites, was that reviews were becoming more outcome-focused. In other words, reviews were aiming to identify the extent to which the support plan was helping achieve the outcomes set out in the support plan, as opposed to checking the needs against the hours of service required. Several care co-ordinators and team managers also reported that reviews were focused more on outcomes and the way that the support plan was operating and supporting the service user in the intended way, rather than on the delivery or quality of services as such.

Balancing a review of how well the support plan was helping to achieve outcomes identified at the assessment (the general purpose of the review) against re-examining the resources allocated in the IB, was seen by a small number of care co-ordinators and team managers as a new dimension to the reviewing function. Four IB lead officers indicated that reviews always involved a reallocation of resources, and four indicated that this was undertaken only when there were significant changes.

A small number of care co-ordinators and team managers indicated that care co-ordinators were playing more of a role in reviews than they would normally do because of the difficulty of reviewing officers taking on this role during the pilot project. However this was presented very much as a temporary situation. One team

manager noted that a similar approach had been taken when direct payments had first been introduced.

Care co-ordinators and team managers in half of the sites indicated that reviewing teams or officers took over responsibility for cases after support plans had been set up and the initial review or reviews had been completed. However, reviewing teams were mentioned by only two IB lead officers. Care co-ordinators and internal support planners, finance officers, voluntary organisations such as Age Concern, independent support planner/brokers and advocates were identified by IB lead officers from many sites as contributing to the review process. Two sites mentioned that a self-review process was being developed, and three said that reviews by telephone were already considered or were being considered as an option in stable cases.

## Chapter 12 Impact on In-house Staff

### 12.1 Introduction

This chapter deals with the impact that IBs had and might have in future on front-line staff. It is based on interviews with care co-ordinators, team managers and training and development personnel, together with structured data from care co-ordinators including a diary of time use; the experiences of front-line staff working in the pilot are examined in terms of the impacts on their use of time, professional roles and responsibilities; and the training and support requirements associated with the implementation of IBs.

### 12.2 Analysis of care co-ordinators' time use

This section of the report examines the ways in which care co-ordinators spend their time during the working week and asks whether the new processes involved in implementing IBs have any impact upon the length of time spent on different aspects of their work. Data were available from both qualitative interviews with care co-ordinators and team managers, and a quantitative diary study of care co-ordinators' time use from which evidence could be obtained regarding the impact of IBs on care co-ordinators' working patterns.

It is important to note that the care co-ordinators completing the diary study had mixed caseloads. The numbers of IB users on the caseloads of those in the 'Some IB users' group (n=123) varied from one to 16 (mean 2.7; mode 1) with 85 per cent having four or fewer IB cases (Tables 12.1 to 12.4). This is in the context of total active caseloads of between three and 52 (mean 22; mode 25). Moreover, we were cautioned by some respondents that during the week of recording, the diaries might not capture any of their time spent in relation to this small number of IB users. Thus, the differences between the figures for this group and those for the 'No IB users' group in Tables 12.1 to 12.4 do not represent the true difference in time spent on IB cases compared to non-IB cases. *Any differences are therefore, of necessity, likely to be a gross underestimation.*

The diary study recorded an average of 38.5 hours per care co-ordinator per week for those with some IB users on their caseloads and 37.0 hours per care co-ordinator per week for those with no IB users on their caseloads. This difference was not significant. However, it was clear from the qualitative interviews that many care co-ordinators believed that their involvement in the IB Pilots was putting an additional strain on their workload. Part of this was thought to have been due to authorities 'running two systems at once,' and partly it was due to getting to grips with new

processes. However, care co-ordinators believed that this was at the expense of other service users, creating a backlog of work, and that it could ultimately lead to more ‘fire fighting’ as unmonitored service users slipped into crisis:

Last week I spent three of my days on individual budgets alone. Which is having an impact now on the other work which I’m not able to process because of the constant doings of the IB. So everything’s having a knock on effect. Things are just not getting done. I am working longer hours.  
(Care co-ordinator, older people)

### 12.2.1 Direct vs. indirect work

The balance between office-based work and time spent in direct contact with service users has been of longstanding concern for social workers and care co-ordinators. Most care co-ordinators believed that IBs would lead to more time being spent with service users, in particular around support planning activities. However others, in particular in sites where the care management role had been fragmented, believed that care co-ordinators had less opportunity to spend time with clients than previously.

**Table 12.1 Mean weekly hours (% working week) spent by care co-ordinators in direct contact with service users and carers**

<i>Activity type</i>	<i>Task category (task number)</i>	<i>Some IB users (N=117)</i>	<i>No IB users (N=82)</i>	<i>Sig.*</i>
Direct contact with service user	Interview with service user (2)	1.0 (2.8)	1.3 (3.6)	ns
	Complete assessment documents with service user (3)	0.5 (1.2)	0.2 (0.7)	p=0.005
	Carry out financial assessment (4)	0.1 (0.3)	0.2 (0.5)	ns
	Counsel service user (6)	0.9 (2.2)	1.1 (2.8)	ns
	Discuss care options (7)	0.8 (2.1)	0.5 (1.6)	p=0.007
	Accompany service user on appointments or visits (8)	0.5 (1.3)	0.3 (0.7)	ns
	Add further information to assessment by telephone contact with user (9)	0.4 (1.1)	0.3 (0.8)	ns
	Review care package in person (10)	1.5 (3.8)	1.9 (5.2)	ns
<b>Total</b>	Review care package by telephone (11)	<b>6.1 (15.5)</b>	<b>6.2 (17.1)</b>	<b>ns</b>
Direct contact with carer	Gather assessment information from carer (13)	0.3 (0.9)	0.3 (0.9)	ns
	Assess carer’s own needs (14)	0.3 (0.8)	0.1 (0.3)	p=0.015
	Provide advice support to carer (15)	0.7 (1.8)	0.5 (1.3)	ns
<b>Total</b>		<b>1.3 (3.5)</b>	<b>0.9 (2.5)</b>	<b>ns</b>

Note: \* t-test comparing mean weekly hours spent on task by care co-ordinators with some IB users on their caseloads vs. those with no IB users.

The diary study demonstrated that approximately six hours of care co-ordinators' time per week (16 and 17 per cent of their working week; Table 12.1) was spent in direct contact with the service user. Although this overall figure was not significantly affected by whether or not the care coordinator had any IB users on their caseload, those who did, spent significantly more time completing assessment documents with service users and discussing care or support options.

Interestingly, although the increase in the overall time spent by IB care co-ordinators in direct contact with carers did not reach significance, they did spend significantly more time assessing carers' own needs (Table 12.1). This finding is consistent with views expressed by care co-ordinators during interviews that IBs were of benefit to family members and other informal carers in view of the fact that they gave more opportunity to acknowledge the role played by carers (Chapter 6).

**Table 12.2 Mean weekly hours (% working week) spent by care co-ordinators in contact with services related to the service user or carer**

<i>Task category</i>	<i>Some IB users (N=117)</i>	<i>No IB users (N=82)</i>	<i>Sig.*</i>
Information exchange – multidisciplinary team (17)	1.1 (2.8)	1.2 (3.2)	ns
Gather information prior to assessment (1)	0.7 (1.8)	0.6 (1.8)	ns
Gather assessment information from health services staff (18)	0.4 (1.0)	0.3 (0.9)	ns
Gather assessment information from other agencies (19)	0.5 (1.4)	0.4 (1.2)	ns
Gather information from existing user records (20)	1.1 (3.0)	1.1 (2.9)	ns
Complete benefit forms for user (5)	0.1 (0.4)	0.1 (0.3)	ns
Complete assessment documentation back in office (21)	4.1 (10.3)	3.6 (9.7)	ns
Other office-based paperwork related to caseload (22)	3.5 (9.4)	3.2 (8.8)	ns
Discuss cases in supervision with manager (23)	0.7 (2.0)	0.8 (2.2)	ns
Negotiate and arrange social services for service user (24)	1.2 (3.0)	0.8 (2.3)	ns
Negotiate and arrange health services for service user (25)	0.3 (0.8)	0.3 (1.0)	ns
Monitor social service provision (26)	0.4 (1.1)	0.4 (1.2)	ns
Monitor health service provision (27)	0.1 (0.4)	0.3 (0.8)	ns
Review care package in conjunction with other agencies (28)	0.6 (1.5)	0.5 (1.4)	ns
<b>Total</b>	<b>15.0 (38.9)</b>	<b>13.9 (37.9)</b>	<b>ns</b>

Note: \* t-test comparing mean weekly hours spent on task by care co-ordinators with some IB users on their caseloads vs. those with no IB users.

There was no significant change in the amount of time spent by care co-ordinators with IB cases in contact with services related to the service user or carer (Table

12.2). Indeed, none of the measurements of time spent on the individual tasks within this activity type showed any significant change. Bearing in mind the caveats above, there is some suggestion that slightly more time was spent on 'completing assessment documentation back in the office' and on 'negotiating and arranging social services for the service user' with IBs but these small increases were not significant. The completion of assessment documentation and other deskwork were sometimes perceived by care co-ordinators to be time consuming when questioned in interviews. Certainly few claimed that there was any less paperwork involved though, in most sites the extent of this extra work was not emphasised as strongly nor as frequently as other demands on care co-ordinators' time.

Unsurprisingly, perhaps, care co-ordinators working with IB users spent on average an extra hour per week on training activities (Table 12.3). The diary study data demonstrated no other significant differences in the time care co-ordinators spent on organisational activities unrelated to individual service users.

**Table 12.3 Mean weekly hours (% working week) spent by care co-ordinators on social services organisational activities**

<i>Task category</i>	<i>Some IB users (N=117)</i>	<i>No IB users (N=82)</i>	<i>Sig.*</i>
Administration and reading of departmental documents (30)	2.2 (5.8)	2.4 (6.2)	ns
Team meetings (31)	1.2 (3.2)	1.4 (4.0)	ns
Developing new services/changing existing services (32)	0.6 (1.7)	0.4 (1.1)	ns
Training (33)	2.1 (5.3)	1.1 (3.3)	p=0.042
Dealing with telephone enquiries (34)	2.4 (6.6)	2.0 (5.3)	ns
Filing, faxing, photocopying (35)	0.9 (2.3)	1.0 (3.0)	ns
Miscellaneous, e.g. checking mail, feeding back information (38)	0.6 (1.6)	0.9 (2.3)	ns
Lunch/breaks (36)	2.3 (5.8)	2.3 (6.1)	ns
<b>Total</b>	<b>12.4 (32.5)</b>	<b>11.5 (31.3)</b>	<b>ns</b>

Note: \* t-test comparing mean weekly hours spent on task by care co-ordinators with some IB users on their caseloads vs. those with no IB users.

### 12.2.2 The Individual Budgets process

An alternative way of examining care co-ordinators' time use is to group tasks by the different core tasks of the care management/individual budgets process (assessment, care/support planning, monitoring and review, etc.). In this respect, the data presented in Table 12.4 demonstrate that, for care co-ordinators working with IB users, care planning and arranging services for the service user took up a significantly greater part of their working week than for care co-ordinators with no IB



users on their caseloads. Although assessment activities as a whole also took approximately an hour longer in the IB group, this finding did not reach statistical significance. These increases in time use appear to be at the expense of time spent on monitoring and review activities. However, the difference in time spent on the latter between the two groups was not significant.

**Table 12.4 Mean weekly hours (% working week) spent by care co-ordinators on different aspects of care management**

<i>Group of activities (task numbers<sup>1</sup>)</i>	<i>Some IB users (N=117)</i>	<i>No IB users (N=82)</i>	<i>Sig.*</i>
Assessment (1,2,3,4,9,13,14,18,19,20,21)	9.4 (24.6)	8.5 (23.5)	ns
Care planning and arranging services (5,7,8,24,25)	3.0 (7.6)	2.1 (6.0)	p=0.009
Monitoring and review (10,11,26,27,28)	3.0 (7.5)	3.6 (9.6)	ns
Support and counselling (6,15)	1.5 (3.9)	1.6 (4.1)	ns
Administrative tasks (4,5,21,22,30,35,38)	11.6 (30.2)	11.4 (31.0)	ns
Interface with health services (18,25,27,28 <sup>2</sup> )	1.4 (3.7)	1.5 (4.1)	ns

Notes: <sup>1</sup> N.B. some overlap; <sup>2</sup> not strictly health ('other' agencies); \*t-test comparing mean weekly hours spent on task by care co-ordinators with some IB users on their caseloads vs. those with no IB users.

These findings from the diary study very much reflect the perceptions of care co-ordinators interviewed for the evaluation. Despite the fact that dedicated support planners were available in some pilot sites, support planning was most frequently cited as an aspect of care management which was taking up more time than previously. Most of those providing estimates of how long a care plan would traditionally take to draw up suggested between half an hour and an hour of their time. For support planning in the context of IBs, estimates ranged from six hours to three full working days, depending upon the complexity of the individual's needs. This would involve usually two to three visits and another hour for writing it up. However, in cases where service users and their families could take on this role, or support planners were available, the time needed by care co-ordinators for support planning would be minimised.

In the case of assessment, most care co-ordinators believed that IB processes were more time-consuming than care management assessments. Some believed 'it's like doubling your work' with estimates ranging from half a day's work to a whole day's visit plus time to write it up. Again, this could be dependent upon the complexity of the case and/or cognitive ability of the service user, but a common complaint was that the assessment process included a degree of duplication (Chapter 9):

There's a lot more repetitive stuff going on. Somebody, I don't know who it is, believes that you can go out, meet a new client, introduce yourself, explain the whole philosophy of IBs, explain brokerage, explain service

development then complete a community care assessment, complete a carer's assessment, complete a financial assessment, complete an RAS assessment, a consent form and do all that in one visit, it's just impossible, people are so overwhelmed with the whole process, it's so unfamiliar.  
(Care co-ordinator, learning disabilities)

Mixed views were expressed by IB lead officers about differences in the time needed for assessment, with factors such as service users taking longer to think about and answer some questions, or the need to make several visits to the service user being thought to increase the time taken. This perhaps suggests that the difference in time spent on assessment may be influenced by the approaches taken at different sites. Opportunities for improved use of self-assessment and streamlining the assessment process were suggested as ways in which the assessment activities might be shortened, albeit with the important caveats noted earlier about self-assessment.

## **12.3 Changing the face of care management and social work**

This section looks at what the introduction of IBs meant for front-line professionals – the social workers, nurses and other professionals responsible for care co-ordination activities – in terms of their professional roles and how they were feeling about their jobs. In addition, a quantitative measure of how care co-ordinators felt about different aspects of their job and of overall job satisfaction was taken to assess the impact of IBs on those.

### **12.3.1 Changing roles of care co-ordinators**

For a small number of care co-ordinators, particularly from learning disability and physical disability services where direct payments and person-centred planning had become more widespread, the introduction of IBs had not led to a significant alteration in their professional roles:

No, I wouldn't say [my role has changed] because you still want the same outcome don't you and that's just to get somebody's needs met, so I think people have always worked with people in a person-centred way, it's just the administration side of it really, but the way that you talk to people and interact with people, I don't think there's been any changes there.  
(Care co-ordinator, physical disabilities)

However, for many others, IBs were 'turning on its head' the role of care co-ordinators and social workers. The focus on outcomes as opposed to needs, and starting the process from individuals' priorities, were often lauded as important changes to how they worked and a huge change in culture for them as professionals:

I think the service user has a lot more control instead of having decisions made for them. They are at the centre of the process. OK, you would look at each person's individual needs before, but the social worker would have more power, more control. I think perhaps that's what certain colleagues might be struggling with.  
(Care co-ordinator, children's services)

There was a distinct split in respondents' perceptions of the role of social work in IBs. Some had seen care management as an erosion of core social work values and skills which IBs were now giving care co-ordinators an opportunity to rekindle:

They've had to rediscover traditional social work core skills. So in direct working with individuals they've had to go back to looking at things like transactional analysis, motivational interviewing, those kinds of skills which are actually negotiation and mediation. Because they are actually forming relationships with people and working with them in a much more meaningful way, and it gets them to focus on why they're doing what they're doing, which I think through care management we kind of lost.  
(Team manager, physical disabilities)

In direct contrast to this, others saw IBs as a further erosion of social work skills:

I just feel like I'm doing an office job most of the time now. You know, when you train to be a social worker, you get trained in counselling techniques and different therapeutic approaches. What I do is go out with a tick box form and read it out to somebody and then get somebody to come back to tell me how much money they are allowed and that's not a social worker. It's getting worse and worse.  
(Care co-ordinator, older people)

Some were concerned about the fragmentation of their roles as care co-ordinators with the separation of assessment and support planning through the use of self-assessment and independent support planners. Care co-ordinators were concerned about the impact this would have on the continuity of care for the service users and increase the number of people they would have going in and setting up services. But they were also frustrated by what this would mean for their own roles in that it might cause confusion and conflict between the different professionals involved and also, in the words of one social worker, 'take away the most interesting bit'.

The perceived impact IBs were having on the relationships between care co-ordinators and service users varied widely between respondents. For some, by allowing service users and their families to engage more fully in the process, relationships were becoming more positive. For others, however, relationships had been seen to diminish, either because of delays in the process leading to expectations not being met, or because of care co-ordinators taking a step back in

the process and not having the same opportunities to develop good relationships. Other interviewees were more ambivalent:

It's got potential for allowing you to become more involved in people's issues, rather than being reactive. It gives you the potential to start to do some preventative work. It has the ability to move us completely into a tick box culture. And, once you've ticked a load of boxes, to forget about people. It has the potential for going either way.  
(Team manager, learning disabilities)

In some pilot sites, it was recognised that the ultimate role of the care coordinator would depend very much upon an individual's needs and abilities and the support they had from others. However, others could foresee the ultimate demise of social work and care management:

And the social work, well, it may end up that the legalities of it basically reduce it to its assessment function, which is a legal obligation that we, that the department's having to fulfil, but the rest of it doesn't have to be the social work role at all.  
(Care co-ordinator, review team)

Such stark differences in the characterisation of the impact of IBs on social work practice and the future of care management may have been influenced by the widely varying approaches across sites.

From the perspective of IB lead officers and senior management, most pilot sites reported difficulties in engaging and changing practice among care managers, and some reported that care managers were increasingly accepting of the concepts and practice of self-directed support and outcomes. One IB lead officer commented that the social work students who had been on placement with the local authority during the pilot period appeared to have grasped the concept of self-directed support. IB lead officers in other pilot sites expressed their hope that future training for social workers and occupational therapists would include the principles of personalisation and self-directed support and IBs within that.

### **12.3.2 Care co-ordinator's work environments and job satisfaction**

The Karasek Job Content Questionnaire (Karasek, 1979) was used to measure different aspects of care co-ordinators' views of their work environment and to assess whether working with IB users had had any impact upon these. In addition, overall job satisfaction was measured using a seven-point 'delighted – terrible' scale where higher scores are related with increasing *dis*-satisfaction.

The absence of many significant differences in the Karasek sub-scales between the two groups of workers (Table 12.5) is not surprising. The influences on care co-ordinators' perceptions of their working environment are multiple and much wider than just the introduction of IBs. These include their professional training, the wider organisational culture, roles and responsibilities and other current changes in social care policy and organisation including job evaluations and changes to worker registration requirements. One would expect that social support (the sum of co-worker support and supervisor support) would remain unaffected by the introduction of IBs given no major changes in team composition or membership. Decision latitude (the sum of skill discretion and decision authority) would similarly be more dependent upon existing roles and organisational structures than IBs themselves.

**Table 12.5 Karasek indicators<sup>+</sup>**

<i>Karasek sub-scales</i>	<i>Some IB users</i> (N=116 to 121)	<i>No IB users</i> (N=80 to 85)	<i>Sig.*</i>
Skill discretion	36.3	36.3	ns
Decision authority	33.4	33.6	ns
Decision latitude	69.5	69.8	ns
Psychological job demands	37.1	36.2	ns
Co-worker support	13.0	13.1	ns
Supervisor support	12.0	12.5	ns
Social support	25.0	25.5	ns
Job insecurity	-4.0	-4.5	ns
Customer relations	12.7	12.0	p=0.023
Self-identity through work	17.9	18.2	ns

Note: \* t-test comparing mean value from responses of care co-ordinators with some IB users on their caseloads vs. those with no IB users. <sup>+</sup> Details of the scales are presented in Appendix A.

There was a one point increase in psychological job demands in the IB group. Although this was not a statistically significant finding, it is consistent with the increased workload and pressure involved in implementing IBs described during interviews with care co-ordinators.

The one statistically significant finding from the Karasek data was in relation to the customer relationships sub-scale. This scale measures workers' perceptions of different aspects of their relationships with service users, for example, the influence they have on each other; their knowledge of their clients as individuals; and the degree of hostility or abuse they are subject to from service users. A small increase in this score was measured for care co-ordinators working with IB users indicating an overall perceived improvement in customer relationships. This not only represents a potential benefit of working with IBs but also indicates the importance of the service user in care co-ordinators judgements about their work environment. The potential benefits of IBs for service users identified by care co-ordinators (Chapter 6) appeared

to be influencing their orientation to service users. However, overall job satisfaction was no greater for those working with IB users (mean job satisfaction score 3.37 for those with some IB users vs. 3.19 for those with no IB users, n.s.). So, although care co-ordinators derive personal benefit from seeing an improvement in individual service users' circumstances, this may not be sufficient to measurably overcome any dissatisfaction associated with other aspects of working with IBs.

## **12.4 Training and support<sup>54</sup>**

Training and development personnel (and some IB lead officers) were asked about aspects of the training and support available to care co-ordinators implementing IBs in the pilot sites at an early stage and again towards the end of the pilot. Care co-ordinators and team managers were also asked to provide information regarding the extent of their involvement in training activities; their views of that training; other support mechanisms available; and what training and support was still required.

### **12.4.1 Resources available for training**

At the time of the first round of interviews with training and development personnel (November 2006), budgets for IB-related training had been allocated by 12 of the 13 pilot sites. Interviewees from ten sites were able to specify the amount of cash resource allocated. For four sites it was set between £2,000 and £5,000. The highest available budget specified was £100k although this was to support a broad programme of organisational development to deliver the cultural change needed for IBs. Moreover, in this locality the investment was seen as 'front-end' until the new processes were in place; in other areas where budgets were lower, there was often a recognition that training costs would substantially increase should IBs be rolled out more widely.

Over and above the money made available, it was recognised that a substantial non-cash resource in terms of staff time had been necessary in relation to training. Although one site believed that a proactive approach to securing funding and careful prioritisation ensured that training needs could be met, in many cases the budget allocated for training was considered to be insufficient for what was needed at the time of the first round of interviews. Thus it was suggested in some sites that training needs were only met through additional commitment from the staff involved in planning and delivering that training.

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<sup>54</sup> Findings from the interviews with training and development personnel have previously been reported to the Department of Health in November 2006 and have been published in the *British Journal of Social Work* (Manthorpe *et al.*, 2008a).

### 12.4.2 Organised training activities

Training and development personnel were asked to describe the training activities they had organised. At both round one and two interviews, respondents reported that these were wider than simply the training of front-line workers on the concepts and processes involved in implementing IBs. Often, communication and awareness raising events and activities for the wider authority and/or partner organisations (other local authorities, health agencies, providers, voluntary sector, personal assistants and service users) were considered to be within the training umbrella. This generally reflected a recognition of the need for a significant cultural shift for individual IBs to be successfully implemented. By the second round of interviews, IBs were being integrated into the mainstream workforce development work. For example, NVQ awards were closely tied in with the IB programme in more than half of the authorities. There was one clear reference to links with post qualifying arrangements in social work and in several cases contact was being (or had already been) made with regard to IB teaching on the new social work degree course.

Training for managers, both first tier and more senior, was recognised as an important activity in many although not all of the pilot sites. This involved not only awareness raising but also training in the processes involved and their monitoring, and training in change management. This was designed to provide the top-down endorsement of IBs, to ensure the necessary support of front-line workers in delivering the new systems and again in an attempt to influence the culture of the wider organisation. Two training managers from different sites in the first round of interviews highlighted the need to involve managers as key to ensuring that IBs are viewed as a 'lasting change' and not 'just another pilot'.

Training and communication activities aimed at service users and other stakeholders were afforded nearly the same priority as those for staff. For example, training for service users about why they should choose to receive IBs was being undertaken in one authority; another was expressly engaging with providers to consider the likely effects of IBs on traditional services once service users started choosing alternative ways of meeting their needs. An additional purpose of the training activities devised by some pilot sites was to assist in the development and implementation of the Pilot Programme. For example, in one authority, joint training events with staff and service users had been used to feed into the development of the assessment process, and other events with service users acted as a way to build up capacity to develop a peer support network for other service users. Training service users in peer support was being organised at the time of the first round interviews by four of the 13 pilot sites. In a small number of sites training was also arranged for voluntary organisations about providing brokerage services.

The extent of training activities could sometimes be seen to relate to the size of the Pilot in terms of the number of user groups involved. However, the impression given

by interviews with training and development personnel was that the underlying determinant was whether the implementation of IBs was viewed as a pilot, where roll-out would very much depend upon its success or otherwise, or an inevitability, where efforts were already being made to incorporate IBs and their core principles and processes into the wider organisational culture and practice. This has implications for the future roll-out of IBs inasmuch as wholesale change will require a much greater investment in training activities than had occurred in some of the pilot sites at this time.

### 12.4.3 Opportunities and barriers to training

Although not designed specifically to explore the opportunities and barriers to training for IBs, the first round interviews with training and development personnel raised some pertinent considerations. There was a recognition that front-line staff, in particular care co-ordinators, may consider IBs as a threat. Thus a view was expressed that training ‘mustn’t give the impression that everything they’ve done up to now is worthless’. The importance of clarifying and defining care co-ordinators new roles either alongside or before training was recognised to prevent the ‘alienation’ of this group of staff. In addition to this perceived potential threat to professional roles, a pervading cynicism about new initiatives – ‘not *more* change!’ – was suggested as a barrier to the success of training. However, as we outlined earlier in this chapter, some care co-ordinators felt they were going back to their social work roots – ‘this is what I trained to be a social worker for’.

The timing of training was also suggested as necessary to its success. Some interviewees suggested that training had to occur early enough in the process to pave the way for the necessary changes, yet not before the finer details regarding implementation had been worked out. This could lead not only to difficulties in answering the questions posed by training participants but also to the situation where, as the Pilot evolved, the training could soon become outdated. The question was posed as to whether training should be implemented before or combined with systems change – ‘a chicken and egg situation’.

Common to many sites was the wider context of organisational change demanded by other policy initiatives. As well as influencing care co-ordinators’ attitudes to change, organisational restructuring could also cast doubts over continuity of training personnel, the availability of future funding for training, and the possibility of future roll-out of the Pilot. However, opportunities could also arise from the wider policy and organisational context. Training for IBs was sometimes packaged along with training supporting a drive towards a more outcomes-focused approach to services; on empowering service users; regarding the adoption of new information systems; in relation to the White Paper, *Our Health Our Care Our Say* (DH, 2006); or the implementation of the 2005 Mental Capacity Act. This wider focus could sometimes



be seen as an additional way of securing money for IB training. The backing of senior management and directors was highlighted by some as key to the success of developing a successful training programme, as was involvement of training and development departments from an early stage.

#### **12.4.4 Care co-ordinators' and team managers' access to training and support**

Although most care co-ordinators and team managers had access to both formal and informal training activities, a number of care co-ordinators reported that they had not received any training before setting up their first IB with a service user. Others thought that the formal training events they had attended had not helped them to fulfil their roles with confidence. Sometimes, the training was seen as patronising to care co-ordinators. Others thought that it was too ideological, unrealistic and did not mirror their own experiences of working with their particular user group:

We had two sessions, and I must say that I found, I didn't attend the second one because I found the first one so patronising and so unrelated to what we actually do.

(Care co-ordinator, mental health)

A common complaint was that whilst the formal training went into the background of IBs and the philosophy behind them, it did not go into the detail of the processes of setting them up, leaving care co-ordinators unequipped to perform these tasks. However, other respondents thought that these introductory sessions were 'enlightening' and had opened them up to the potentials of IBs.

The types of informal training that were available varied from site to site and included visits by the IB team or development officer to team meetings to introduce new paperwork or to work through processes or current problems, and also team meetings initiated by team managers to share experiences and to explain particular features of IBs. This informal, hands-on training and support, offered by managers and IB teams, tended to attract more praise than the more formal events:

And certainly the joint work or the briefings that have taken place around IBs have actually been spot on because they've been done by the IB worker. So they have a very grounded knowledge and experience of doing it on a day-to-day basis. And therefore impart that knowledge to the rest of the care managers.

(Team manager, learning disabilities)

Other common support mechanisms, which were generally welcomed by care co-ordinators and team managers, included: peer support groups; the identification of champions in each team; and an IB team able and willing to respond to queries and

offer one-to-one support to care co-ordinators. Support was also available to care co-ordinators from dedicated brokers in those sites where they had been employed:

The IB team workers are fabulous. I sat on the phone, for an hour with somebody going through things and, you know, they are really, really good.

(Care co-ordinator, older people)

Conversely, in some areas where care co-ordinators appeared to be really struggling, the support offered by IB teams had been more inconsistent:

All we need is somebody to say, 'Oh yes you can do that; no you can't.' We ring up; there's nobody in ... and that's been the main criticism that the teams have had that you haven't got a communication channel to ask for advice, so you tend to make it up as you go along, because you need to respond quickly so you make a decision and keep your fingers crossed.

(Care co-ordinator, learning disabilities)

#### **12.4.5 Support from team managers**

The impact that IBs were having upon the perceived workload of care co-ordinators was something that many were struggling with. Some care co-ordinators expressed a wish for their team managers to address the issue of caseload size in supervision and in a small number of cases this was indeed raised during supervision. However, given existing caseload pressures and the likelihood that all staff would be moving to working with IBs, without the additional staffing thought to be necessary by some respondents, it was difficult for respondents to envisage how this would be managed.

Pressures upon staff supervision were noted by some managers as a result of IBs. Some addressed these through existing formal supervision sessions or team supervision. Others saw a need for increased informal supervision with individual workers involved in the Pilot. Often the need was for care co-ordinators to work through individual cases. Alternatively, a clarification or explanation of processes was required. Sometimes supervision identified a need for additional training. However, both team managers and their staff sometimes recognised that the managers themselves were struggling with the new ideas and processes as much as the care co-ordinators. This had implications for the support available to care co-ordinators. Additional resources called upon by some team managers included the input of senior practitioners or assistant managers and the peer support available through team meetings and champions.

### 12.4.6 Additional training needs identified by care co-ordinators, team managers and training personnel

Many care co-ordinators felt confident enough in their own skills and abilities to take on the evolving roles expected of them through IBs. However others were less comfortable. Many felt strongly that they were working with service users before they fully understood what IBs were, or how to implement the processes involved, and lacked the knowledge to be able to respond to individuals' questions:

And I think there was just an expectation across the board that people would understand what it was about. And they don't. You know, even coming out of two days of training, scratching their heads. What do I do? So although the philosophy and everything else was explained and how to support somebody to write a support plan there was no. ... So everybody was confused basically about where to go and what to do and so we sort of went into a pilot with very little information and very little knowledge.  
(Care co-ordinator, physical disabilities)

A number of areas for further training were identified by care co-ordinators and team managers. Specific areas identified included: assessment; support planning; brokerage; knowledge of services; practical aspects of IBs including employing staff and managing finances; the financial aspects of support planning; and managing risk. Another suggestion was for training around how to manage an IB in-house to offer flexibility of the system to service users. One care co-ordinator suggested that having a 'dry run' session for care co-ordinators to go through the entire process from start to finish before they implemented it in practice may help to avoid some mistakes along the way which may adversely affect the service user:

What would have been actually really good, probably, is a day where you could actually practice doing an assessment and going through the process. The first one I did was held up for three months. And eventually, someone came back to me and said, 'Oh, you haven't got the financial agreement form signed'. Nobody told me to do that. I didn't know anything about it.  
(Care co-ordinator, older people)

Some respondents felt that more training from a professional or theoretical perspective would be of value. A specific focus on outcomes-focused practice was mentioned as was training in motivational skills and empowerment.

Continued support from the IB team or other specialists (e.g. brokers) past the period of the Pilot was also desired. In particular one-to-one support and/or joint visits were considered invaluable:

Maybe what needs to happen is we either shadow the support planners or they shadow us and actually give us training on the job? I don't think I

could actually go and sit in a lecture and somebody saying, you could do this, this and this. Every situation is different. I think I probably would have benefited from actually seeing it happen in real life.  
(Care co-ordinator, transitions)

A number of care co-ordinators and managers looked further into the future in terms of training requirements and the implications of IBs rolling out further than the Pilots. Some recognised the need for the sites themselves, and authorities more widely, to learn the lessons from the Pilots which tended to be very much an evolving process. Training would therefore be needed on the 'final product'. In relation to this, others suggested a need for 'refresher courses' to reinforce skills learned in practice, to update practitioners and also to try to rally those still reluctant to engage with the process. Induction courses would be required for new staff and, eventually, IB training integrated into mainstream training programmes.

#### **12.4.7 Future training plans**

In the majority of sites, plans for the forthcoming year (2008) were expressly embedded in the broader workforce development strategy and personalisation agenda. Several authorities were expanding their training or workforce development departments to take account of increased expectations relating to IB and other areas of work. Much of the training activities already offered would be repeated in the forthcoming year, subject to review and modification following feedback from manager and practitioner forums and the outcomes for service users. Publicity about training, employment law and responsibilities, and how to manage finance were identified as areas either being considered or being acted upon. Whilst some authorities had already developed links with Mental Capacity Act training, in some cases this was still to be incorporated. Links with adult protection training in some areas needed to be developed.

# Chapter 13 The Experiences of Providers and Commissioning Managers

## 13.1 Introduction

This chapter reports provider and commissioning manager perspectives on the pilot, and is structured around four main themes:

- a brief account of the methodology
- a description of the context and early experiences of the pilots, as viewed by commissioning managers and providers
- an account of the actual and anticipated impact of IBs on providers
- a discussion about the future role of the local authority in market development.

In each section, provider and commissioning manager views are presented together to enable comparison and contrasts between different perspectives.

## 13.2 Methodology

This strand of the evaluation forms part of the broader 'in-depth' explorations of implementation within a subsample of sites. Full details of the in-depth study, in addition to a fuller account of how providers were selected and recruited to the study, are described in Appendix B.

In summary, face-to-face, semi-structured interviews were conducted with 16 managers<sup>55</sup> of social care providers (spread across the four 'core' pilot sites) during November and December 2007; and seven commissioning managers (one in each of the four 'core' sites and three 'peripheral' sites) during the summer of 2007.

Most (13 of 16) providers were delivering services to IB holders at the time of the interview: five providers had up to five IB holders; a further six had up to 20; and two had even more. Providers interviewed included a range of for-profit and not-for-profit organisations, covering the full range of adult service user groups, and supplying a variety of different (non-residential) services. Both in-house and independent providers are included.

To help interpret the findings of this chapter, a number of important points should be considered. First, we chose providers that were reported to have the most

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<sup>55</sup> These, most usually, were the managers responsible for delivering care out of a single office, and so for large agencies these were the branch managers for that locality. We use the term 'providers' to refer to the views of managers we spoke to.

experience of IBs to generate findings most closely associated with an ‘up and running’ scheme, but they cannot be considered as representative of the views of all providers either in the pilot sites or more generally. Secondly, the small number of interviewees means that this cannot be considered a comprehensive assessment. Finally, some providers seemed to conflate IBs with *In Control*, in sites where these initiatives operated in tandem.

### **13.3 The early experiences of providers and commissioning managers**

Providers first learned about IBs through one of three mechanisms: by being asked by the IB team to conduct developmental work (e.g. calculating unit costs, or supporting a very early IB holder); by attending seminars/meetings; or by proactively seeking advice from social services.

The first reactions from all the providers were positive, with comments such as IBs being ‘heaven sent’. Providers had many initial questions about IBs, though the potential for the financial abuse of IBs was the most prevalent. The providers we interviewed reported that many others were less keen on IBs, however.

Providers commonly found that the information and support initially given by LAs was poor. There were several reports of social workers giving out incorrect and inconsistent information to service users. In one authority, providers felt that they were not effectively consulted on the change process. One said: ‘it’s never felt like a partnership. It’s always felt like a heavy-handed direction’.

In contrast, several commissioning managers we interviewed reported significant difficulty in engaging providers, even those attending their briefings. One reported that:

A lot of our smaller providers don’t seem to have the slightest understanding of what IBs are or the impact that it can have. I’ve presented at probably three or four provider forums now. I present it and there are no comments, so I then explain it again and there are no comments, and I don’t understand why the providers don’t have a hundred questions about it. Somehow it doesn’t seem to be registering.

Commissioning managers typically attributed this to one of two reasons: providers expecting that the pilots would not lead to a significant change in their activities; and/or distraction caused by other simultaneous commissioning activities (e.g. re-tendering exercises).

## 13.4 The impact of IBs on providers

Our interviews investigated the impact of IBs - both experienced and expected - on service demand, delivery, and providers' organisational features.

### 13.4.1 New market conditions

#### **13.4.1.1 IBs as a threat to current service levels?**

One hypothesis we sought to test was that IBs may affect homecare provider client numbers as IBs expand the opportunities for employing PAs as an alternative option. This was borne out to some extent by the interviews, with several providers reporting examples of clients leaving their service to be supported by a PA as a consequence of IBs. However most of the providers we interviewed were not too concerned about losing clients in the long run.

One commissioning manager commented that IBs had highlighted how 'hideously expensive' in-house services were and anticipated that demand for their services would fall away 'because it costs three times more to get in-house so why on earth would they want to'. Some pilot sites intended to switch their in-house home care provision towards reablement care in the future. Of two day care providers<sup>56</sup> in our sample, neither experienced nor feared a reduction in their client base through IBs<sup>57</sup>.

#### **13.4.1.2 IBs as an opportunity for new business?**

We also asked if IBs had generated new opportunities for expanding business or branching into new service areas since with IBs, purchasing choices are made by individuals who may have different preferences to local authorities. There were already examples of this happening.

One day centre provider had wanted to open a domiciliary care service but - prior to IBs - felt that they would not win a contract from the local authority because the provider's higher-quality service cost too much. However the provider felt that IB holders (as purchasers) would demand their proposed service, because the additional quality was worth the money. The manager successfully opened the new service after using the IB pilot to convince the organisation's Board.

Some providers also reported that they had succeeded in increasing their client base at the expense of less flexible agencies, with one saying that they had already trebled their business amongst people wanting smaller packages of care.

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<sup>56</sup> One independent and one in-house.

<sup>57</sup> Though note that Poll *et al.* (2006) found a fall in day centre demand following the early phases of *In Control*.

Both providers and commissioners identified examples of new opportunities to offer services to recruit and manage the administrative aspects of employing a PA. This could work well for providers because they had expertise in recruitment and payroll administration of care staff; the marginal costs of expanding this would be relatively low; and the provider could also provide a covering option for holidays/sickness.

Opportunities were not restricted to personal care providers, and there were some examples of particularly innovative uses of IBs:

- One local authority had decided to close a drama group it ran, but a provider in the area felt it would be popular amongst IB holders. The provider therefore took over the drama group as a not-for-profit venture and has attracted a number of IB holders to it.
- A provider had developed close links with the local Learning and Skills Council to develop an educationally-focused service involving local colleges (though this was still in early days at the time of the interview).
- A commissioning manager reported that one provider had started to establish links with telecare and meals-on-wheels organisations, with a view to sub-contracting part of potential IB packages to these partner organisations.

It is important to note, however, that in our sample providers were typically those already closely aligned with the principles of IBs, and some of the competitive gains mentioned above would come at the expense of other providers. One commissioning manager reported that providers he had spoken to were worried about losing large volumes of business.

#### **13.4.2 Are providers being asked for existing care to be delivered in new ways?**

A mixed picture was portrayed of how IBs had impacted upon the care given to **existing** service users, when they were given an IB.

##### ***13.4.2.1 Where IBs had little or no effect on the provision of care***

Some IBs appeared to providers to simply be ‘conversions’ of previous care packages: such as direct payments now simply being called IBs, or ‘virtual budgets’ where a local authority continues to manage the money and support. In such cases, providers could not detect any change in user behaviour or expectations; these just involved an administrative exercise. One provider said:

It was just a matter of changing our information on our computer to highlight that they were individual budget holders, and change the address to where we sent the invoice ... their care hasn't changed in any way.



Another reason for IBs having no impact on the provision of care occurred where service users had wanted to spend their IB in new and exciting ways but found that they could not afford this, without sacrificing their personal care, because of a low RAS allocation. One provider argued that this problem was compounded by local authority workers raising expectations of what they could get *before* the RAS allocation was known.

This is how they seem to be selling it. It's the computers, the aromatherapy, hair extensions ... that seems to be at the top and then support right at the bottom. Now, for a lot of these people it's the support that maintains those other things ... [IB user] was promised the earth with the individual budget. 'Oh you could have aromatherapy, you can have your hair done, you can have your nails done'. And it turned out she got half the support she'd already got.

Another provider commented that the IB does not offer 'real choice' if IB holders must sacrifice personal care to be able to go out and do new things because the RAS is not sufficient. In such cases this provider felt that people 'are being backed into a corner'.

#### **13.4.2.2 *Where IBs have led to new demands***

There was, however, evidence on a modest scale of existing service users demanding new types of care from their providers. These new demands were concentrated among home care providers, and most commonly included cleaning and domestic assistance, transport, shopping and sitting/company.

Home care providers reported that the practice of banking hours was now commonly experienced, whereby users receive fewer hours of support over the course of several weeks to 'save-up' for a special activity. Examples included enabling an agency carer to take them Christmas shopping, or for trips to the beach, and in another example it allowed a carer to assist a blind client with baking. There were also reports of more frequent demands for short-notice care, with users asking for more or less support on the same day.

Where these demands were, or would be, quite new to the organisation, providers had to decide whether to meet them. The following two examples illustrate the divergent thinking:

We've got a guy whose main companion is his dog, but he can't get out and walk the dog. So he's assessed to having four half hour calls a day so we go in [and] walk his dog for him ... he thinks that he can use the service to do that and ... who are we to argue if that's what he wants, it's [his] choice, isn't it?

I still wouldn't provide a different service. I mean, at the end of the day this is about the care ... obviously there will be things that you would have to explain [to IB holders], 'I'm really sorry ... if you want your loft cleared out, well then you're going to have to get somebody that can do that task'. I'm not going to change my goalposts.

### **13.4.3 Workforce issues**

We found only isolated examples of IBs affecting the organisation of the workforce, such as by agencies recruiting staff to work on particular IB packages. Based on their experiences of IB use to date, we therefore asked providers to consider what issues might arise in the future in a larger-scale IB system.

#### **13.4.3.1 *The impact on rostering***

One common concern for the future amongst providers was that meeting the demand for short-notice and unplanned care in a larger IB system would require a considerable change in the organisation of staffing. One said:

We'd have to work totally different to how we're working now. We'd have to completely change the rostering system. I worry that the service users will sit there and say 'Actually, I think I'd like to go here' and just make the call to the agency and think that it's going to happen just like that. 'Oh don't send anyone today; I don't want her after all' ... this is a totally different, almost alien way of working.

One provider with a longer experience of trying to meet these expectations found that trying to please everyone would require a three-fold increase in their workforce. The common view amongst providers was, therefore, that it was important to have a clear understanding with service users at the very beginning about both what the user requires, but also what the provider is able to meet.

#### **13.4.3.2 *Managing boundaries in mental health services***

We interviewed two specialist mental health care providers that provided personal support to clients, and both argued that some of the freedoms and choices associated with IBs might, paradoxically, slow the journey to independence.

Their workers were trained to challenge some decisions and motivate people to help take more control over their life. One explained that where an individual gets behind on paying their bills or cleaning their house because 'they don't feel up to it' then the worker will support and encourage that person to take action. Because this approach is sometimes not welcomed in the short term by users there was a concern that IB holders may resist this type of support to their long-term detriment.

Further, both providers currently had clear professional boundaries between client and worker, and also rotated staff deliberately to prevent over-dependence on individual supporters. However, these providers felt that IBs would blur that distinction by encouraging a caring relationship more akin to friendship.

### **13.4.3.3 Forward planning**

Providers voiced concern that the prospect of a commissioning system without local authority contracts (already being phased-out in one site, and being proposed in a second) could adversely affect forward planning, especially for providers whose current contracts currently span several years.

One provider at the time of the interview guaranteed to train new recruits to NVQ level three; this was achievable because their LA block contracts allowed them to look three to five years ahead and plan their staffing needs. However because of the time it takes to train staff, and being unable to forecast demand more than a few months down the line, this would become difficult without contracts. The provider therefore expected it would have to end this guarantee to new employees as IBs are rolled-out.

### **13.4.3.4 Recruitment and retention of staff**

Providers gave mixed perspectives on whether IBs would hinder or benefit recruitment and retention. We found that five of the providers offering personal care services had experience of losing staff to become PAs as a consequence of IBs, and one commissioning manager also reported that it was happening in their authority. Conversely, one provider reported that IBs might **improve** their agency's recruitment and retention by providing a more rewarding job, by enabling staff to build up a better rapport with clients because their roles are less focused just on providing routine personal care.

## **13.4.4 Administrative issues**

### **13.4.4.1 Non-payment, invoicing and pricing**

There were reports of IB holders not paying the bills for their care. The example of the unbalanced promotion of IBs above led to the service user spending all his IB without leaving enough spare to pay for the personal support he received, leaving the provider out of pocket. Another provider explained that some non-payment was simply inevitable and something that needed to be planned for, saying: 'if you run a shop you accept that five per cent of your products get nicked ... and therefore you build that in'. However most providers felt that non-payment in a larger IB system would be relatively small scale and mostly resolvable.

With regards to individual invoicing, it was widely expected (both by providers and commissioners) that this would be an additional burden on some providers. One commissioning manager said:

The administration costs will be terrible and, and therefore that part of the charge will be much higher because [currently] they provide care for a hundred people and then they just bill as one invoice to the Council. [With IBs] that'll be a hundred different invoices chasing payment ... a nightmare from their point of view.

One provider with a large number of IB holders had just recruited a Finance Director specifically to lead this task, and expected the 'backroom' team would have to grow substantially as IBs were rolled out.

#### **13.4.4.2 Marketing**

We got conflicting views from commissioners and providers as to whether providers would have to market themselves differently. Providers, on the whole, reported that they did not expect that they would have to do anything different: those that already undertook formal advertising would continue to do so, and others were happy to rely on word of mouth. This was not, however, the experience of some commissioning managers we spoke to. Commissioning managers more often felt that marketing was a common issue raised in their discussions with providers and expected this to be an important area of work in the future.

### **13.5 The role of the local authority in commissioning**

This section is devoted to understanding what commissioning managers and providers perceive as being the future market development role for a local authority with IBs.

#### **13.5.1 Promoting efficiency**

Interviews with commissioning managers and providers asked about any potential conflicts between an individualised system of purchasing care and LA efficiency policies. Two conflicting messages can be drawn from the responses:

- The foundation of IBs is the principle that people directing their own budget will ensure it meets their needs in the best possible way - which must be good for efficiency .
- But devolved budgets to service users could reduce the potential for cost savings that were previously exercised through the use of market power and bulk purchasing.

Reconciling this conflict was the focus of attention for several commissioning managers who were looking at future arrangements<sup>58</sup>. One LA proposed to maintain the efficiency of a block system through the control of the **preferred provider list** that would be promoted to IB holders. Under this system, only providers offering volume discounts and winning a competitive tender would be allowed on the list. Whilst IB holders retain the option of choosing another provider, and there are no contractual guarantees for providers, it is likely that being on the preferred list would ensure a large market share.

However providers in this area argued that volume discounts could only be achieved through standardising services and reducing transaction costs. Therefore 'preferred providers' would be forced into delivering the kinds of standardised, inflexible services so criticised by advocates of self-directed support. In addition, providers argued that many of the administrative aspects of moving to an IB system incur **additional** costs for providers (e.g. invoicing and administration).

### **13.5.2 Promoting standards and 'policing the system'**

Despite the arguments just outlined, providers did tend to agree that a preferred provider list would be beneficial to service users in making their choices, though some argued that access to that list should be based on meeting quality standards alone. Most providers argued that local authorities must have a policing role to protect vulnerable adults, as well as accounting for the use of tax-payers money. Linked closely to this was a general frustration that PAs continue to be unregulated, with some providers and one commissioning manager reporting instances of PAs delivering low and dangerous standards of care. At a very basic level, almost all providers argued that the local authority should ensure that all PAs are CRB checked. Others discussed the importance of ensuring a minimum level of training in personal care.

### **13.5.3 Informing providers of user choices and preferences**

Every commissioning manager spoke of the importance of supplying providers with information, or 'intelligence', on which to plan their services. The providers also supported this principle, and other sources have also emphasised the need for this role (OPM, 2007; Tyson, 2007; CSCI, 2006). There is evidence that progress is being made on this front, with one commissioning manager reporting that they are able to share detailed collective support plan information with providers.

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<sup>58</sup> Also discussed at the OPM workshop (OPM, 2007: 13).

Most commissioning managers saw this role developing to form a website providing information both to providers and to IB users about available services. One went further, wishing to develop a 'commissioning hub' for providers containing updated support plan data, consultation about proposals, bulletin boards and discussion zones - 'a very interactive space'.

#### **13.5.4 Supporting providers through change**

All commissioning managers reported their involvement in leading providers in the transition towards IBs, beginning with briefing and consultation.

Their experiences so far also indicated that more detailed advice had been given to providers, such as on marketing, unit cost calculations, charging/fee policies and risk assessment<sup>59</sup>. These activities were summed up by one commissioning manager by saying 'I think Local Authorities should be much more creative in how they help providers'.

One commissioning manager reported giving providers transitional grants if IB holders had left their service, to cushion the effects and avoid jeopardising the services the provider delivered to others. In this case the commissioning manager said that it had been 'a very fine balance and it's taken a lot of negotiation'.

#### **13.5.5 Supporting informed decision making by IB holders**

There were examples of new roles emerging for commissioning managers as IBs developed, with one example from a local authority where a consortium of 15 IB holders decided that they wished to group-purchase a single contract of care. The commissioning manager assisted with the tendering and navigation of legal concerns relating to this venture, whilst the service users remained in control of their choice of provider.

Both commissioning managers and providers saw a critical role in assisting users in becoming effective and informed purchasers of care, through a system of brokerage<sup>60</sup> encompassing:

- service users to have a choice of independent brokers
- web-based 'menus' from which users could purchase services on-line
- shared customer feedback that goes beyond traditional care

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<sup>59</sup> Also mentioned as desirable in the workshops hosted by OPM (2007).

<sup>60</sup> A more general discussion of brokerage services is found in Chapter 10.

- an extension of services to include obtaining references and CRB checks from prospective personal assistants.

Most commissioning managers proposed that all these should also be available to private paying service users.





## Chapter 14 Individual Budgets and the NHS

This chapter describes the experiences of implementing IBs in the context of local strategic, financial and operational relationships with NHS partners and services. It draws on the interviews carried out with the lead officers responsible for implementing IBs in each of the 13 pilot sites during summer 2006 and again during autumn 2007. It therefore captures both expectations about the relationships between the IB Pilot Projects and, subsequently, officers' actual experiences of these relationships.

First, the relevant policy context is outlined. The histories of organisational relationships in the 13 pilot sites between adult social care services and NHS partners are described, as are their specific experiences of collaboration over the funding and implementation of direct payments and In Control. The paper then documents two specific areas of difficulty highlighted by IB lead officers: the implementation of IBs in the context of integrated local arrangements for funding and/or delivering services for specific user groups, particularly mental health service users; and the boundaries between IBs and NHS funded continuing health care. The chapter concludes with IB lead officers' reflections on the overall impact of IBs on relationships with local NHS partners and their priorities for extending IBs to include some elements of NHS funding or services.

### 14.1 Background

#### 14.1.1 Policy

Relationships between NHS and social care services have a long and problematic history. Since 1997 encouragement has been given to collaboration between the two sectors (Hudson, 1999), sometimes underpinned by substantial amounts of ring-fenced funding. Of particular significance were measures introduced by the Health Act 1999. Relevant sections of this legislation were:

- *Section 29 Expanded Funding Transfers from the NHS to Local Authority.* This expanded the range of functions for which the NHS can transfer resources to a local authority. NHS bodies can fund any function of a local authority that can be linked to public health provision or the role of the NHS. Funding transfers contribute to specific services that the receiving authority agrees to provide; NHS bodies need to be satisfied that the payment is likely to secure a more effective use of public funds than the deployment of an equivalent amount on its own services. This clause enables the NHS to transfer resources to the local authority for the provision of specific services or for individual service users.

- *Section 31 New 'Flexibilities'*. These allow NHS organisations and local authority services to pool budgets (with the pooled resources losing their distinctive 'health' and 'social' identities); delegate commissioning responsibilities to a single lead organisation that takes on the commissioning of specified services on behalf of both sectors; and/or integrate both health and local authority services (including assessment and care planning functions) within a single management structure.

The Section 31 flexibilities have been used (singly or in combination) in many areas of adult services, particularly mental health, learning disabilities and some elements of older people's services. They have been extensively used to create Integrated Community Equipment Services (ICES). Where commissioning responsibilities are not delegated to a single lead organisation, joint commissioning arrangements between local authorities and Primary Care Trusts (PCTs) are likely to have been established to ensure collaboration.

#### **14.1.2 Practice issues**

Despite these developments, some areas of difficulty between NHS and local authorities remain. One such problem has been arrangements for funding and providing services for people with high long-term health and social care needs but who are nevertheless able, with appropriate support, to live independently in the community (Lewis, 2001; Glendinning and Means, 2004). Successive guidelines have aimed to establish clear boundaries to the responsibilities of the NHS for funding continuing care and ensure their equitable application across England (DH, 2007).

A second area of difficulty has arisen in relation to the funding of direct payments (Direct payments) for people with very complex or continuing health care needs. The 1996 legislation introducing direct payments was linked to the statutory duties of local authorities and made no mention of the potential for NHS funding to be delivered in the form of direct payments. Nevertheless, in some localities Section 29 of the Health Act 1999 has been used to enable the NHS to transfer resources to a local authority that are then paid to an individual in the form of direct payments (Glendinning *et al.*, 2000a). Even without NHS contributions, some direct payment users are likely to receive help, treatments or support through their direct payment that fall within their definitions of 'health' care (Glendinning *et al.*, 2000b).

#### **14.1.3 Individual budgets and health**

The IB Pilot Projects were explicitly tasked by Department of Health to exclude NHS resources in the funding streams included in IBs. However, during the course of the Pilots, personalisation gradually achieved a higher profile across public sector

policies. In particular, interest has been expressed in exploring the potential of individual budgets to deliver more personalised health care (Milburn, 2007; Le Grand, 2007; Alakeson, 2007; Leadbeater *et al.*, 2008). Further debate was prompted by the interim report of the NHS review conducted by Lord Darzi, which again recommended the extension of the IB approach to some areas of health care. The issue is currently (2008) actively being pursued by a team from the Cabinet Office.

## 14.2 Relationships between adult social care and NHS partners in the IB Pilot Project sites

### 14.2.1 Service partnerships

In the first round of interviews, IB lead officers described the histories of their local authority relationships with NHS partners. All had joint commissioning arrangements for at least some of their adult services. However, some had much more extensive partnership arrangements in place - including pooled budgets, lead commissioning and integrated provider structures - for at least some groups of users who were to be offered IBs:

... We had, and still have, Section 31 arrangements for the Learning Disability Service ... as lead commissioner we had a pooled budget and integrated provision. ... We also have an arrangement with [NHS Trust] to deliver mental health services on behalf of the local authority and the PCT.

*Interviewee 1:* We have a lead commissioning arrangement, Section 31, so we have a commissioning board that oversees the health and social care budgets.

*Interviewee 2:* Well, we have a few joint appointments.

*Interviewee 3:* We've got a number of Section 28 agreements in both directions around small pieces of work but generally we haven't got big large-scale things, apart from in learning disabilities.

*Interviewee 2:* Our two PCT host partners [for lead commissioning arrangements] have always been signed up to *In Control* and a lot of the learning disabilities development fund money that comes through health, comes into the social care economy, has gone on to fund *In Control*.

Partnership arrangements were more extensive and deeply embedded in those sites where the local authority had a long history of co-terminosity with the local PCT and where the latter had not experienced recent reconfigurations. The following two quotations, the first from a unitary authority, the second from a large rural county, illustrate the contrasting contexts:

We actually have a Section 31 agreement on mental health, which is around integrated service provision ... and that's been around for years and years and years. ... We had a proper full pooled budget for the ICES ... and we have a pooled budget for the learning disability development fund ... and ... a number of posts that are jointly funded partnership posts and associated other roles that we put together. Like we've got a joint commissioning manager. ... There's the learning disability partnership board, the mental health partnership board, there's an older people's partnership board and the children's one, and then the most recent one was physical and sensory impairment.

Officially we have joint commissioning but ... it's actually in reality parallel commissioning. We don't have a pooled budget. ... Although we're, we're just now tentatively looking at perhaps a pooled budget around care home with nursing provision.

In 12 of the pilot sites, partnership arrangements were specific to particular service user groups, so their implications for the implementation of IBs largely depended on whether these groups were to be offered IBs. The thirteenth site had long-established pooled budget and delegated lead commissioning arrangements with the PCT across all areas of adult services. However, all sites anticipated from the outset that introducing IBs would have both strategic and operational implications for relationships with their NHS partners. For example, where services were delivered through an integrated service provider, this would involve implementing change through another organisation. Different approaches were anticipated to the use of social care resources in IBs where these were already committed to pooled budgets:

We've got more pooled budgets with, obviously, learning disabilities, so some of those pooled budgets will be used in individual budgets.

... mental health is a pooled budget, so obviously they [NHS] have quite a high involvement with that group and obviously that poses its own problem then, about splitting out what's health and what is social care.

When you're working in the LD, LD budget, which is about – I don't know, 60:40 adult social care:health, so I mean that's a lot of money that's excluded from the individual budget. ... When we did our planning day, we put health in there and it's something we were very, very keen to do because the disabled people's movement is so keen to do it ...

#### **14.2.2 NHS partners and direct payments**

In the first round of interviews with IB lead officers, around half reported informal arrangements with their local PCT so that NHS resources could be contributed to the funding of direct payments. These arrangements arose in two sets of circumstances.

First, some people with very complex needs received jointly funded packages of support which were deployed by the local authority in the form of a direct payment:

We know from our direct payments history that there are a lot of very large care packages with a historical Section 28A payment which have worked really, really well through direct payments and they've been running for eight years some of them, maybe nine.

Secondly, in some sites people in receipt of a direct payment whose condition deteriorated so that they became eligible for fully funded NHS continuing health care could continue to receive that support as a direct payment:

We've got a very good working relationship with our PCT and ... we've got a number of direct payments where we'd set up the direct payment; the person's health had deteriorated; we'd persuaded our PCT colleagues that they should accept full financial responsibility, but where we really didn't want to take away from the individual or from the families concerned that flexibility around having a direct payment and where the PCT has agreed.

They [PCT] are quite happy to let people use continuing care money as a direct payment if they pay it to us and we pay it back out.

In another site, user trust arrangements had been deployed to enable NHS continuing care funding to be received as a direct payment, as 'health can pay the trust but they can't pay us and they can't pay the individual'.

### **14.3 The impact of IBs on existing NHS partnership arrangements**

IB lead officers were virtually unanimous in expressing disappointment that the IB pilots excluded all NHS funding. Phrases like 'missed opportunity' were repeated by many of the IB lead officers in the initial round of interviews:

I mean, to be honest one of the big disappointments for Individual Budgets for, for us in learning disabilities was that it excluded the health economy and it was just about the social care economy.

It seems we're very much about health and social care and then there's this big barrier. It's all about choice and control until it comes to health. ... If we're talking about the service user or the patient journey it's like, you know, stop-start, stop-start, because – whereas if health was just in there, it just seems the whole thing would be smoother.

The IB lead officer in the latter site also pointed to the contradictions between continuing obligations to carry out the Single Assessment Process and a greater role for self-assessment: 'We're [either] trusting your assessment of yourself or we're not.

Why are we then going to do a massive assessment to assess your needs when you've already told us what your needs are?'

Given this disappointment, there were a number of ways in which pilot sites had managed the impact of IBs on their NHS partnership arrangements.

### **14.3.1 Maintaining previous operational arrangements**

Despite the exclusion of NHS resources from IBs, sites nevertheless attempted to maintain their existing arrangements with NHS partners. For example, one site hoped to maintain a holistic approach to assessment:

We've certainly agreed that we don't drop our health needs assessment element. ... The *In Control* model tends to make the allocation, that's it, end of assessment. Well, we don't think that's good enough. You've actually got to make sure you've got a holistic assessment, your health colleagues are on board ... especially with older people. ... The support plan's got to be comprehensive, it's got to take on board what health is putting in.

Other sites intended to use their Section 31 pooled budget arrangements to include NHS continuing care funding in IBs:

What we've been told is 'No, it's not in the guidance', but obviously if you've got a way around it because you've already sought those permissions, or you've already got them because of your pooled arrangements then it's not an issue.

Indeed, two sites had already included NHS funding in one or two IBs by the time the first interviews with the IB lead officers were conducted during summer 2006:

We already have health making a sort of – we have an individual budget with health, adult social care and ILF funding and ICES, so health are involved.

By the time of the second round of interviews with IB lead officers towards the end of 2007, another site had adapted the self-assessment documentation so that health needs and appropriate resources could be identified:

When we're completing the self-assessment we might also identify some health needs in there. ... If that person actually hits so many things and it might become very clear up front and early on that they're [eligible for] fully funded continuing health care, in which case they may follow another route or they may be – have some contributions from continuing care ...

but the bottom line is that health are still contributing to the outcomes in that person's plan.

In all, four sites reported having been able to maintain at least some elements of their earlier joint arrangements for people with very complex needs in order to offer IBs funded wholly or partly from NHS resources:

In effect we've been offering, through what we call a recharge, we've been offering direct payments for health in [site] for several years, so in effect we've just paralleled that process. So ... there will be several people in there who have health money within their individual budget because it's recharged. If it's for someone with a learning disability it might be spent on the additional support they need to manage their risky behaviour.

### **14.3.2 NHS continuing care funding and individual budgets**

There were widespread and strongly held views that NHS continuing care was particularly appropriate for inclusion in IBs, particularly for existing direct payment users who risked losing their existing personalised support arrangements if their condition deteriorated to the extent that they became eligible for continuing care funding:

I think there's been a missed opportunity for things like continuing health care. ... For me continuing health care is so individualised that it would fit beautifully into this model. ... Is it not an individualised budget already? It can only be spent on the person.

We've got a number of direct payments where we'd set up the direct payment, the person's health had deteriorated, we'd persuaded our PCT colleagues that they should accept full financial responsibility for the package but we really didn't want to take away from the individual or from the families concerned that flexibility. ... It's going to be frustrating I think not to be able to offer some of those individuals full flexibility of an individual budget really.

One or two sites did report including NHS continuing care funding within an IB:

We've got some people who've got their individual budget and have continuing care contributing to it.

One site had included a trigger question relating to NHS continuing care eligibility in the IB self-assessment in order to identify those potentially eligible, 'because not only should we be encouraging them to do that but we might be charging them for something that they could get for free. And there's the whole issue of restitutions'.

However, difficulties arose during the course of the IB Pilot Projects with the publication of new national guidelines on NHS continuing health care eligibility. These state that 'NHS services cannot be provided as part of an Individual Budget or through Direct Payments. ... This means that when an individual begins to receive NHS Continuing Healthcare they may experience a loss of control over their care which they had previously exercised through Direct Payments or similar' (DH, 2007: para 77). Thus in at least four sites previous informal arrangements, where PCT partners had agreed NHS funding could be transferred to the local authority and continue to be delivered through a direct payment, had been terminated and this also affected IBs:

Continuing health care, that's another group of people where we're really, really struggling ... those people who have previously enjoyed direct payments have got to sack all their [personal assistant] staff because they've got more ill.

In one site, a PCT review following the publication of the new guidelines had pronounced such arrangements to be illegal:

... We were appalled at the way it was carried out. They [PCT] decided that they were going to employ their own care manager, broker. Those service users were previously getting a direct payment until – the direct payment now stops. 'We're not going to fund it, instead you're going to have a conventional service,' and the only provider they're going to use is a provider that ... is no longer used by the local authority because they're rubbish. ... Our PCT will not consider any longer joint-funded packages of care.

In another site, the PCT had reluctantly agreed to continue an IB indirect payment arrangement for someone who had very complex needs that were being met very effectively by a specially trained team of personal assistants. One site anticipated that restrictions on the deployment of NHS continuing care funding would deter potentially eligible people from applying for NHS continuing care funding if they risked losing the flexibility of their IB:

Up till [new continuing care framework came into effect] we had quite a flexible arrangement with our PCT and if someone had a DP then ... we would go on administering the DP and the PCT just reimbursed it. ... It worked very well, but now we can't do that. So there's going to be quite a disincentive for people on direct payments and IBs to actually consent to a continuing health care assessment.

One interviewee pointed out that although the new guidelines encouraged the personalised commissioning of NHS-funded continuing health care services, this:



... is bunkum really, 'cause actually you know, it's the person being in control that's the thing that matters. You can't commission, if you're commissioning for somebody, the whole point of Direct payments and whatever is that they commission themselves.

### 14.3.3 IBs and mental health services

A second major area of difficulty was experienced by those sites offering IBs to people with mental health problems. Typically, mental health service funding and provision were closely integrated, with mental health needs and outcomes widely perceived to be indivisible into 'health' and 'social' care elements.

Pooled budgets and integrated services created challenges in identifying which resources could and could not be included in the money available for IBs and allocated through a RAS:

... the demarcation between care management and care service provision is often not that clear, and also you get sort of strange wrinkles in the system where you've got people whose mental health needs are quite high and they're managed by their care co-ordinator or the outreach team or whatever, with lots of visits. ... We're trying to work out whether we can include support workers who are employed by the Health Service ... or whether we're gonna count support workers in terms of those employed by the social services.

This site could not offer IBs to people in jointly funded residential care placements as the exclusion of NHS resources meant that 'the full cost would then fall on social services and that would not be cost-effective for us'. Consequently only a small proportion of the total mental health service budget, covering existing spot purchasing of day care and other services, was available for IBs. Another site came to a provisional working agreement with NHS colleagues over a jointly-funded mental health service - 'if it's treatment it's health and everything else is social care' - but recognised that this might not be a sustainable arrangement in the longer term. A third site which began offering IBs to mental health service users during the course of the pilot agreed with its PCT that the latter would transfer resources from a joint funded mental health service to the local authority if the latter could specify the likely number of users of the service who would take up an IB. However, the impact of this agreement was restricted because much of the local authority's funding was used to commission day services from which only a limited level of resources could be withdrawn in the short term. Lead officers in a fourth site with extensive pooled budget arrangements pointed to the different accounting procedures in the jointly funded mental health services that created problems in identifying the resources available for IBs:

I need to understand the costs of inpatient treatment, 'cos that's gonna be one of the [outcome] measures for mental health service users. Has an individual budget reduced the period of home-based treatment or inpatient admission? ... Our local authority council bit of the budget pays for some of the ... day centre and then you've got another bit of the services [which] is funded by the PCT on a different financial report.

Further difficulties were reported in at least two sites in implementing IBs through jointly-funded mental health service staff who were not employed by the local authority:

... it's an integrated mental health service, so what we're doing is quite a radical shift in terms of social care policy being delivered by a health service and that certainly had its tensions in terms of we don't have direct operational management responsibility for the people we're asking to deliver this.

In one of these sites, IB lead officers had had to work closely with front line NHS staff:

I suppose in some ways you picked off the people at the bottom you know, relatively - some of them relatively - quickly. They got it and that's good, you know, they thought it was a good idea and the people at the top were saying 'Oh yes, we're signed up and we're committed'. And it was classic, the gap in the middle; but they're the ones who'd actually make it happen, that effectively had to sign off plans in order to get the money moving through, because it was their money.

Implementing IBs in jointly-funded and/or operationally integrated mental health services also prompted anxieties of cost-shunting. Excluding NHS resources from IBs meant that the costs of supporting someone with a mental health problem through an IB fell entirely on the adult social care budget, rather than being shared through a jointly-funded service:

These people would probably have had a, you know, at least once a month, probably once a fortnight, a CPN coming in. ... Our problem is that we can't actually cost those services with people who've been going to an acute day hospital, they just haven't been using social care services. There were mental health support workers, employed by health, going in.

Problems of cost-shunting were accentuated where users had previously chosen not to use conventional mental health services, but were using an IB because this was a more attractive option. Moreover, opting for an IB could mean a user becoming subject to means-tested charges, in contrast to the support that was previously available free of charge by an integrated mental health service provided through an NHS Trust: '... you can see why there ends up being confusion out there and they [users] get quite het up by that. ... It is a nonsense'. Risks of cost-shunting were also

anticipated if IBs were extended to mental health service users currently in residential care 'where there are a lot of health top-ups, and if we were taking someone out of residential care that health top-up would disappear and we'd be carrying the entire cost'.

#### 14.3.4 Maintaining the health-social care distinction in the use of IBs

Earlier research (Glendinning *et al.*, 2000a) found that direct payment users with complex needs often asked PAs to undertake health-related tasks – physiotherapy, footcare, medication, catheter and tissue care – as part of daily personal care routines. Lead officers in several sites reported similar difficulties in maintaining a clear distinction between health and social care in how IBs were used:

*Interviewer:* To your knowledge are individual budgets being used to purchase health equipment or services such as chiropody, physio, complementary therapies, those sorts of things?

*Officer 1:* Not generally, I think we've sort of built into our guidance that we wouldn't sign off support plans where that is the case. There are those kinds of slightly debatable – aromatherapy, sports therapy ...

*Officer 2:* We've had one signed off where the person wants to use some of the money for acupuncture.

*Officer 1:* Acupuncture yea, yea. So, complementary therapies probably and massage ...

*Officer 3:* ... things like gym membership and you know, that sort of thing where maybe health should be providing physiotherapy and I think we've accepted that.

... if you look at what needs people want, you know, if they're gonna want physiotherapy, they're gonna want aromatherapy ... and strictly we can't put that in an Individual Budget ... but some of those kinds of low level health services are critical to people's well-being.

Officers in this latter site tried to ensure that IBs were not used for items that could be funded from other sources, although the only opportunity to exercise this scrutiny was in signing off the support plan; there were no mechanisms to prevent IBs subsequently being used to purchase services that could, in principle, be provided free of charge through the NHS. However, officers in another site were less concerned about ensuring that IBs were used only for social and not health-related care, arguing that it was the outcome for the user that was important:

None of us live in a silo, I don't mind if somebody wants to use the allocation they have as long as they can meet their needs overall. ... We've got people who go dancing or shooting, it actually keeps their mental health at a level where they feel relaxed, they feel comfortable,

people will buy equipment that helps them feel relaxed and comfortable, they can have Reiki ...

However IB lead officers recognised that this flexible approach raised a number of wider policy issues. First, it risked using local authority social care resources for services and support that were normally NHS responsibilities; where the outcomes were also primarily health-related; and where at least some of the benefits, in terms of reduced service use, would accrue to the NHS:

*Officer 1:* I think it [IBs] works incredibly well in mental health but there are real challenges around the costs, money and whose ...

*Officer 2:* ... and whose money yeah, 'cos you say, I think if you take the whole mental health economy, then it [IBs] probably is far more cost-effective.

Such concerns were particularly marked in sites offering IBs to people with mental health problems, where better user outcomes were sometimes reported from IBs than from conventional NHS mental health services, but where the NHS was unable to contribute funding towards achieving those outcomes:

The chap [whose IB was paying for a photography course] was having two days a week in [voluntary sector] day service and three days in an acute hospital funded by health. ... His [IB] was about £4,000. ... But actually the saving, you know, I don't know how much those days at an acute day hospital costs but I suspect it's more than £4,000 a year.

A second concern over the use of IBs to fund arrangements that included elements of both health and social care support was that the full amount of the IB became liable for means-tested charges. This had implications both for users and for the local authority's recovery of some of its social care budget from user charges:

If you charge the whole of that person's package it probably wouldn't be fair.

Charging is the big elephant in the room, isn't it? I mean, you still have to separate out which element is social care and which element is health care, because we can't afford to say 'You can have it for nothing'.

A third area of difficulty raised by IB lead officers concerned responsibilities for training and risk management in respect of personal assistants employed through IBs to carry out health-related tasks:

We already offer NVQ2 to PAs anyway and we already have a basic training programme for personal assistants, but one of the things that we need to deal with, I think, is for people who've got a joint package. We've got some people who've got their Individual Budget and have Continuing

Care [sic] contributing to it and some of those PAs need training in relation to meeting the individual's health needs and who should pay for that?

Our concern is that – we've had this with direct payments – we've had PAs doing tasks that frankly are really health tasks and there's some concern about safety ... it's the issues around what's safe.

## **14.4 Individual budgets – the impact on wider collaborative relationships**

In the second round of interviews, IB lead officers were asked about the actual impact of IBs on collaborative relationships with NHS partners. Their responses were sharply contrasting.

### **14.4.1 Positive impacts and implications**

Some IB lead officers reported considerable initial interest from PCT colleagues and, once IBs began to be put in place, collaboration between staff at operational levels as well. These experiences were more likely (but by no means exclusively) to be reported in sites with co-terminous and stable PCTs and with established patterns of referral and collaboration between health and social care professionals at all levels:

The NHS has been very, very supportive of the concept, absolutely. From medics to lots of different people ... in fact, quite a few referrals for IBs have come from community matrons. So that's quite good really there, you know, the way it should work.

We've had lots of people from joint commissioning and PCTs on board and they've come to some of the meetings that we've had. ... The lady who's got the lead for long-term conditions in [PCT], she's been on board and kept informed of what's going on, she goes away, cascades that information.

Some IB lead officers who reported broadly positive impacts described how the IB pilot had highlighted previously implicit cultural differences between the two sectors and thereby prompted new dialogue:

I think one of the most interesting conversations over the next six to twelve months is going to be with health you know. They are in major change mode. ... What is interesting is how that actually begins to help our conversation with health along, you know, what is a care pathway. Because fundamentally most doctors and most nurses work on the basis of 'I diagnose and then I prescribe.' Well we don't ... and insofar as they are there at all, we're moving away from them with Individual Budgets,

which is. ... 'This is what the money might be, how do we ensure that you actually get what you want and what way would you like that money?' ... So I think we are in for some interesting conversations ...

Indeed, the changes involved in implementing IBs were reported to have generated new imperatives for collaborative engagement:

It makes buy-in more important, the idea that we do have to be working together as partners. ... You can't do it as an individual organisation.

Some lead officers reported their NHS partners were particularly interested in learning from the IB pilot projects in order to extend personalisation across both sectors:

NHS have been very very supportive, very prepared to learn; really really keen on how they can develop the whole personalisation approach within health as well. ... It's got the PCT really excited about all of this and now we know it's got them working together, and social services and the PCT have worked together to establish a new vision based upon what we've been doing. ... We've got a new programme board set up ... that's got all the senior bods on there, providers and commissioning directors and commissioners and lots of different people and we've got a programme plan and a workstream ... because we're wanting to try and introduce the concept of self-directed support across health and social care. This is a big thing for health.

Other IB lead officers confirmed the potential of the IB experience to stimulate cultural changes among NHS partners:

I think it's a massive culture change both in terms of social care and in terms of health and what we've done is we've worked with our health colleagues. For our sins we [senior adult social care officers] also sit on the Continuing Healthcare panel ... I think the change in culture, the change in the way they do things is getting much closer to an In Control model ... they've really moved, in the way they think about their community support.

#### **14.4.2 Difficult relationships with NHS partners**

In contrast, four IB lead officers reported major difficulties in engaging NHS colleagues. Three were in counties with (until April 2007) multiple PCT partners, so some of these difficulties were attributed to the organisational turbulence surrounding the recent wave of PCT re-configurations:

We have a joint commissioning strategy, but only the social care half of it's written [laughs] – all of this is because the PCTs have been in such flux.

We've got acute hospitals being threatened with closure, we've got [several] to one PCTs coming, we've got practice-based commissioning beginning sort of to emerge and we want to have a more integrated front door!

Sectoral differences in performance management, managerial priorities and organisational targets were cited as creating further barriers:

It's always been difficult to get PCTs involved in social care initiatives potentially and I think this is still seen primarily as a social care initiative ... obviously they're very much into meeting their national service framework targets and if this doesn't help that, if they can't see the link, they won't get involved, to be honest.

*Interviewee 1:* I think it was the fact that actually, the Trust had different priorities.

In the latter site, IB lead officers reflected that it would have been helpful to have obtained a clear commitment from the Chief Executive of the NHS Trust at the start of the Pilot Project, not just to collaboration at a senior level but also to encouraging the involvement of middle managers and front line staff: 'They're far more interested in meeting their (Key Performance Indicators) KPIs for health and if there are other things to do they're way below that. ... If you deal with roll-out, it needs to have some muscle behind it.'

## **14.5 Extending personalisation to the NHS – beyond the IB pilot projects**

When interviewed towards the end of the Pilot Project, IB lead officers were unanimous in advocating the extension of the IB approach to at least some NHS funding and services. This was not surprising, given the initial disappointment at the exclusion of NHS resources from the IB pilots and given the actual experiences of implementation. Arguments for extending IBs to NHS resources were similar to those expressed earlier.

### **14.5.1 The indivisibility of health and social care**

Several officers pointed again to the indivisibility of health and social-care related outcomes; a holistic approach was wholly compatible with the principles underpinning IBs:

I don't see how you could roll out personalisation without including health, I really don't. 'Oh, this is really holistic and it's about your entire life – oh, apart from your health needs'. It's just crazy and it goes against the entire principle of self-directed support.

We're fudging it because at the end of the day we've got joint services. ... Why create a system that we're fudging ... when the whole philosophy around this thing is about being open and transparent?

Moreover, commitment to a holistic approach was considered essential to the future of local partnerships:

If we're going to move towards any form of integration of our services with our health partners, then that funding issue is always going to stand in the way so it's got to be sorted and we've got to have some clear guidance about whether we will ever have PCT money as an IB funding stream.

There have been issues about what should be health funding and what should be social care funding ... the danger is that we each go off at a tangent and what we're trying to do is to be working more together.

More generally, opportunities to collaborate with NHS partners on IBs was thought to maximise the benefits of personalisation:

If a lot more could be done with health, I think in terms of cost neutrality and in terms of outcome, so much more could be achieved.

#### **14.5.2 NHS continuing care and nursing care**

IB lead officers argued that IBs should be extended to include NHS funding for continuing health care, long-term conditions and the funding contributions for people in nursing home care:

... it would be just absolutely lovely to have access to free nursing care and continuing care monies to actually use that to buy all of the support, to have someone have nursing care in their own home. ... For some people it could really improve their lives markedly and they wouldn't be sitting in big nursing homes. People at end of life care and things like that, having access to health funds very quickly that we could use in a very flexible way.

I would suggest that you need to make sure there is provision for somebody to have the option [of a personalised budget] if they have a long-term condition.



However it was pointed out that many people with long-term conditions experience fluctuations in the amount of medical care they need and this could require frequent reassessments.

### 14.5.3 IBs and mental health

Sites offering IBs to mental health service users all argued strongly for the inclusion of NHS resources in IBs:

If you want individual budgets to work in mental health, it's got to be combined health and social care funding and you can't go in there and say 'We're just going to do it for social care'. ... It's not going to work in reality on the ground.

Two sets of reasons underpinned these arguments. First, IBs for people with mental health problems were implemented in the context of local joint or lead commissioning, pooled budgets and/or integrated providers. These sites had all struggled with the challenge of identifying resources, needs and outcomes that could be addressed through social care IBs alone:

You've got ST and R workers – support time and recovery workers in mental health ... somebody tell me what they're supposed to do that's different from what a personal assistant could do and help somebody on the road to recovery? ... There is more and more confusion in mental health.

The other argument for extending IBs in mental health services related to widespread perceptions of cost-shunting: the fact that, in contrast to previous joint-funded services, IBs for people with mental health problems were wholly funded by adult social care, while at least some of the benefits of IBs were experienced by the NHS in terms of reduced health service use:

... it's costing social care more but is it costing health less, is the big [question]? ... Mental health needs don't fit neatly into health or social care, do they?

Do I think they [DH] will like the outcomes from the pilots? No I don't. I think they'll see that there's the potential for quite a large increase in the spend because we're actually picking up a lot of the tab at the moment. I think that one needs real thought – very important in mental health.

#### **14.5.4 Other priorities for including NHS resources in IBs**

Officers also drew attention to other NHS-funded services where users might benefit from a personalisation approach. These included wheelchairs which ‘could be voucher based’; and nursing care:

... some people who buy nursing care for a couple of weeks because, you know, their daughter is going away on holiday, I think some people would prefer to have ... 24 hour care in their own home rather than the person go to a nursing home.

I think people would like to purchase their own chiropody services and I think people would like to purchase some of their own district nursing services.

#### **14.5.5 Bringing NHS resources into IBs – implementation issues**

As noted above, in some sites existing close relationships between local authorities and PCTs had helped to develop PCT interest in the IB pilot experience. Conversely, some IB lead officers were aware of NHS policy initiatives that could offer opportunities to extend personalisation. These included models of chronic disease management that involved individualised funding held by a care manager; and links with the Expert Patient Programme as part of wider discussions about using resources to prevent acute illness episodes. Two IB lead officers thought there was potential to contribute the experiences of personalisation to practice-based commissioning, not least ‘because unless we get in at this stage they’ll become entrenched in what they’re doing’. In this respect, several IB lead officers were disappointed that their bid for pilot site status had only required signing off by the local authority and not the local PCT:

I think probably earlier on, what we’d have had to get is sign-up from the Chief Exec of the Trust at that point, not just sign-up from the Director of Social Services – and, actually, not just sign-up but also an instruction from that level down ...

These IB lead officers thought that strong leadership from DH would be needed to encourage NHS colleagues to develop a commitment to personalisation and its full implementation:

I really would like to see health taking proper ownership. ... They are far more conservative than local authorities.

It would be much easier if we had the Department of Health saying there was flexibility here [with nursing home funding] so we wouldn’t have to jump through these hoops really.

## 14.6 Conclusions

Interviews with IB lead officers in the early and latter stages of the pilots uncovered strategic and operational difficulties with the boundaries between social care IBs and NHS resources and services. These arose in the context of concerted efforts over the past decade to overcome the historical 'Berlin Wall' between health and social care and the widespread development in the 13 pilot sites, as elsewhere, of extensive joint arrangements for commissioning, funding and delivering services. In this context, restricting IBs to social care funding only was widely perceived to be unhelpful and potentially contradictory to previous policy pressures. One of the requirements for successful partnership is the identification and agreement of common goals (Hudson and Hardy, 2002). As the implementation of IBs and the associated cultural transformation only involved social care partners, this risked undermining existing good relationships.

The exclusion of NHS resources from IBs also created practical problems. Pooled budgets and integrated services had to be disaggregated in order to identify the resources that could be put into the RAS and allocated as IBs. This was particularly problematic where substantial volumes of resources were invested in specialised mental health posts and all sites offering IBs to mental health service users reported major difficulties from the exclusion of NHS funding. Moreover, in mental health services, in particular, health and social care needs and outcomes were widely viewed as indistinguishable; the exclusion of NHS resources led to renewed anxieties about the use of social care funding to achieve outcomes that had potential resource benefits for the NHS – precisely the kinds of anxieties that the 1999 Health Act flexibilities had sought to remove.

Practical problems also arose in relation to NHS Continuing Healthcare and the joint funding of support packages for people with very complex health and social care needs. Most pilot sites had negotiated informal arrangements with their local PCTs so that jointly-funded support packages could be received in the form of a direct payment. The exclusion of NHS resources from IBs, coupled with the publication of new guidance on NHS Continuing Care in 2007, seriously threatened these arrangements. There were particular concerns about the loss of personalised support by people who received an IB in the form of a direct payment but became eligible for NHS Continuing Healthcare funding; and anxieties that others might be deterred from applying for NHS continuing care because of this – another potential source of cost-shunting.

These two areas of NHS funding, for mental health services and continuing health care, were widely considered to be high priorities for inclusion in IBs. Indeed, most IB pilot site lead officers considered they offered greater opportunities for developing integrated, personalised funding arrangements than some of the other funding streams that had actually been included in the pilot projects.

By the time of their second interviews, IB lead officers were aware of the recommendations in the interim Darzi report for introducing personal budgets in the NHS and most welcomed this initiative, not least because they promised a closer alignment in broad policy goals as both sectors experiment with personalised approaches. The experiences of the social care IB Pilots suggests that, in these localities at least, the social care IB Pilot Projects should form the basis for introducing personalised approaches to NHS funding.

## **Chapter 15    The IB Pilots – Achievements, Challenges and Longer-term Perspectives**

This chapter discusses the main conclusions of the evaluation; those features of the pilots that contributed to these findings; and the implications for the longer-term roll-out of personalisation.

### **15.1 Strengths of the evaluation**

#### **15.1.1 Evaluation challenges**

Evaluating the IB pilot projects was challenging. The evaluation addressed multiple research questions encompassing the development, implementation and outcomes of a radically different approach to allocating resources and delivering social care. The evaluation extended across 13 localities, each of which had a distinctive organisational and cultural context and approach to managing change. Within these, each IB pilot focused on different groups of service users (and combinations thereof); involved different funding streams (and combinations thereof); and offered users a range of options for deploying IBs. Each of these factors was likely to affect answers to the key research questions:

- Do IBs offer a better way of supporting older people and adults with social care needs, compared to conventional methods of funding, commissioning and service delivery?
- What are the relative merits and problems of different models of IBs for different groups of service users?
- What are the impacts of IBs on the workforce involved; and what factors facilitated or constrained implementation of the policy?

#### **15.1.2 A multi-method evaluation**

Given the complexity of the evaluation task, a multi-method evaluation was designed. A randomised controlled trial examined the costs, outcomes and cost-effectiveness of IBs, compared to conventional methods of service delivery. The absence of significant differences between the IB and control groups at the point at which randomisation occurred means that differences in outcomes observed subsequently can be attributed with confidence to the impact of IBs. The trial was complemented by in-depth interviews with subsamples of people from the across the range of user groups who had been offered IBs. These interviews examined users' early knowledge and expectations of IBs and their experiences of assessment, resource

allocation and support planning. Repeated semi-structured interviews were conducted with a wide range of senior managers and others involved in implementing IBs in the pilot sites. The experiences of front-line care co-ordinators involved in piloting IBs were also examined; these interviews and other data covered issues such as workloads, job satisfaction, training needs and the management of risk. They provide a unique perspective on the front-line implementation of this new approach to social care. The evaluation also extended beyond adult social care and included the experiences of aligning or integrating other funding streams into IBs and the implications of IBs based in social care on NHS collaborations and joint or integrated service delivery.

### **15.1.3 Strengths of the evaluation**

The evaluation is the most extensive and rigorous English study to date of the implementation of personalised approaches to social care and of the impacts of this on individual service users, adult social care practitioners, commissioning and service provision. Two particular strengths can be highlighted. First, an unusually wide range of sources and types of data have been combined in different ways to illuminate, inform and explain each other. Thus, for example, quantitative statistical data on user outcomes can in part be interpreted and explained through the qualitative data derived from interviews with users or with front-line care co-ordinators. Similarly, the experiences of managers responsible for implementing IBs can be corroborated by, for example, the views of managers responsible for other funding streams or the perspectives of care co-ordinators involved in support planning. This triangulation of different data sources adds immeasurably to both the robustness of the evaluation findings and to the interpretation and understanding of those findings.

Secondly, the evaluation covered implementation processes as well as outcomes. It followed longitudinally what happened in the local implementation of a new national policy; and it did this from the perspectives of managers, front-line staff and service users. Certainly, this longitudinal perspective was not very long: the whole evaluation lasted only two years; implementation in some sites was much slower than expected; and IB arrangements continue to evolve beyond the end of the pilot period. However, this strand of the evaluation provides a wealth of insights that will be invaluable in informing the wholesale roll-out of personalisation across adult social care.

## **15.2 The implications of the IB pilot projects for the evaluation outcomes**

Despite the robustness of the evaluation design, there were nevertheless some distinctive features of the IB pilot projects that are likely to have influenced the findings of the evaluation. The design of the evaluation itself also imposed some constraints on implementation and, hence, on the outcomes for individual service users. However, the multiple methods used in the evaluation means that these features and their potential impacts can be identified, and their possible impacts on the findings of the evaluation discussed with a relatively high level of certainty.

### **15.2.1 The pilot sites**

Only 13 sites took part in the pilot projects. Sites appeared reasonably representative of English adult social care authorities but, from their previous involvement with *In Control* and relatively high levels of direct payment take-up, appeared to have a strong commitment to personalisation. Senior officers and most care co-ordinators and team managers expressed enthusiasm for the principles of IBs – user empowerment, choice and control – even if that enthusiasm was not always easily turned into operational practice. They were backed up by a dedicated national implementation team. And they may have been motivated by the spotlight of a high-profile national pilot and evaluation and the opportunities it presented. Such commitment was probably strengthened by their involvement in a pioneering experimental programme. Bidding to pilot a high profile initiative, with on-going support from CSIP, was likely to create high levels of motivation and commitment to change, particularly among senior managers. These features may be less prominent in a national programme of personalisation

### **15.2.2 Time constraints**

The requirement to implement IBs within a short timescale meant that processes evolved rapidly during the course of the evaluation. At least some outcomes may therefore reflect early implementation experiences that would not necessarily be replicated in an evaluation of a mature, steady-state IB system. For example, some members of the IB group still did not have an IB in place by the time of their outcome interview and, of those who did, this had been only for a relatively short time. Different outcomes might be anticipated once initial anxieties and teething problems have been overcome and users have developed confidence after several years' experience of enjoying an IB, although developing individually tailored support plans may inevitably remain a more time-consuming process.

Both DH and the evaluation design required the pilot sites to achieve target numbers of people who were offered IBs within a timescale that was more challenging than some sites might otherwise have wished. These pressures may have encouraged some sites to recruit people to the evaluation who were thought to need less encouragement to participate or less preparation to take responsibility for an IB. For example, some sites were particularly active in recruiting to the IB pilot: people who were already receiving direct payments; new referrals who had no existing support arrangements to compare with; or those who were dissatisfied with existing arrangements. Other sites avoided offering IBs, in the first instance at least, to people with very complex needs or who already had stable support arrangements with which they were satisfied. There were high numbers of direct payment users in the comparison group, thus potentially reducing differences in outcomes between the two groups. Without these selection biases, greater (positive or negative) impacts of IBs might have been observed. Nevertheless, the evaluation also revealed the advantages and challenges of these 'targeting' strategies and the consequences for rolling out IBs beyond the initial pilot phase.

The pressures on sites to implement IBs and meet target numbers within a relatively short timescale also contributed to widespread early reliance on established deployment options - particularly direct payments and care-managed 'virtual budgets' - that differed little from previous arrangements.

### **15.2.3 The effects of uncertainty and change**

The developmental nature of the IB pilots meant that high levels of uncertainty were reported by both senior and front-line staff, at least during the initial stages of the pilots. In some sites, the level of uncertainty reflected ambitions to achieve a wider 'transformation' of social care across the authority. Working in times of change and uncertainty is likely to impact on the choices made by individuals offered IBs as well as affecting the quality of interactions with front-line staff. These factors could well have counteracted the benefits of novelty and enthusiasm derived from taking part in a high-profile pilot and thus restrict generalisation from the evaluation. Nevertheless, although there will have been much collective learning from the experiences of the pilot sites, there will inevitably be some uncertainty during any wider implementation of personal budgets.

Because they were in the national spotlight, because of the uncertainties associated with major processes of change and because new systems for monitoring and review were only gradually put in place, care managers were sometimes reluctant to give IB users as much freedom as they might have done. Further they were constrained by concerns about their 'duty of care' and the need sometimes to safeguard adults in vulnerable situations. Other sources of caution arose when IBs were used to purchase support from untrained or unchecked staff; over the use of IBs to purchase



health-related services such as complementary therapies; and over concerns about the legitimate and acceptable boundaries of 'social care' expenditure.

Care managers also invested extra time in assessment and support planning, adding to the overall costs of IBs. With time, experience, improvements in support planning and brokerage services, and the development of robust monitoring and review arrangements, front-line staff and users may in future become more confident about using IBs flexibly and imaginatively. Such changes might lead to more marked differences in support arrangements, costs and outcomes.

Indeed, risk management was a very important element of sites' approaches to implementation. This affected their approaches to resource allocation and also led to high support and monitoring costs. Such caution is also likely to characterise the introduction of personal budgets more widely. In the longer term, as staff and users become more confident and competent with new systems, they may require less support and be willing to experiment with new deployment options. All these factors may lead to greater measurable benefits in future.

#### **15.2.4 Additional funding streams**

One of the most challenging aspects of the IB pilots was the requirement to integrate or align other funding streams along with resources from adult social care. Despite considerable efforts by the pilot sites, little progress was made with this because of continuing legal or administrative restrictions which local sites found difficult to circumvent. Only in some sites was some funding from Supporting People included in the global budget to be allocated through the RAS. This very limited success almost certainly also affected user outcomes; it is not unreasonable to expect that, if multiple funding streams had been pooled at an individual level and deployed flexibly according to users' individual priorities, greater benefits might have been apparent.

Widespread difficulties were also reported because of the requirement that IBs were not to include NHS resources. Again, some potential opportunities for flexibility in the deployment of resources according to individual priorities and preferences were reduced, particularly when IB users became eligible for fully funded NHS continuing care.

#### **15.2.5 Changes in patterns of support**

Given the time it often took to put IBs in place, the period between recruitment to the evaluation and outcome follow-up was short. Of those with an IB in place by the six month outcome interview, many had had this only for a short time – greater positive or negative impacts may be seen over a longer period. The two-year evaluation also

limited evidence of other longer-term implications of IBs, such as the emergence of demands for types of support that are very different from conventional services. IB holders did begin to use a wide range of different services and types of support; the use of IBs for one-off purchases of special and ordinary everyday equipment was particularly interesting. Nevertheless, the volume was relatively small compared with the continued use of conventional services. It is not possible to anticipate how far demands for new or different services will increase over time as users become more confident. It was also not possible during the evaluation to assess how far service providers will be able to adapt and change in the longer term in response to changes in user demand. Reported developments so far were relatively small scale and providers also anticipated being exposed to new risks. One major unanswered question is whether the economies of scale currently achieved through large local authority contracts can be sustained by individual IB purchases; this will have major implications for user-level benefits and outcomes.

### **15.3 Explaining outcomes for different groups of service users**

There were encouraging indications of the impact of IBs on individuals' lives, particularly the fact that those receiving IBs felt more in control of their lives than the comparison group. However, only limited gains were observed overall and these varied by user group. Here we discuss the possible reasons for these differences, as they have major implications for the roll-out of personalisation.

The contexts in which IBs were offered, the attributes of individuals, the levels of resources and the interactions between these factors, varied between user groups.

#### **15.3.1 People with mental health problems**

The most positive outcomes in overall well-being were found among mental health service users. People with mental health needs who are eligible for social care are a heterogeneous group, varying by diagnosis, the severity of their problems and wider circumstances. The evaluation suggests that IBs offered a greater range and flexibility of support arrangements than were available for this group through standard services. However, although some increase in demand for social care IBs was reported, mental health service users nevertheless remained a relatively small proportion of all IB users, just as they remain under-represented in the use of direct payments. These small numbers and a lack of detail about individual characteristics make it difficult to generalise to the wider population about which groups of people with mental health needs are particularly likely to benefit from IBs.

### **15.3.2 People with physical and sensory impairments**

For working age people with physical or sensory impairments, IBs had positive effects on all dimensions of social care outcomes, although these did not reach statistical significance. As already demonstrated by their take-up of direct payments, this group has most experience of and enthusiasm for taking control of their support arrangements. Active peer-support networks, again often developed around direct payments, provide opportunities for shared learning. Moreover, the levels of resources allocated through IBs to working age people with physical or sensory impairments were relatively high, particularly compared to older people. People with physical or sensory impairments were also more likely to be able to access additional funding streams such as the ILF. It is therefore likely that these more extensive allocations of resources offered greater flexibility and more opportunity for innovative approaches to addressing support needs.

### **15.3.3 People with learning disabilities**

Mixed outcomes were found for people with learning disabilities. If IBs allowed reductions in expensive care packages (a stated aim of some sites) then negative impacts on mental well-being might be anticipated, at least in the short term. People with learning disabilities and their carers were thought to find IB processes stressful and this stress may have been exacerbated by the length of time it took to put an IB in place; more people with learning disabilities than other user groups did not have an IB in place by the outcome interview and hence had had no opportunity to experience any countervailing benefits. On the other hand, learning disabled people in both the IB and control groups had more social care resources allocated to leisure or social participation activities than other user groups and this was likely to contribute to higher levels of well-being in both groups. Both groups may also have experienced previous policies of normalisation and person-centred planning (DH, 2001) that would reduce the impact of any additional benefits of IBs.

The impact of IBs on the domain of 'occupation' differed depending on whether responses to our outcome questions came from service users themselves or their proxies. This finding may just reflect differing perspectives. Alternatively, it is possible that less disabled service users who were themselves able to take part in the interviews were also better equipped to take advantage of the flexibility that IBs allowed; they could communicate, plan and get involved in the types of activity that they found most rewarding. Additionally, if those with more profound or complex needs found problems in accessing traditional service arrangements, then – in the absence of alternatives – they might have reported reduced levels of met need in the 'occupation' domain.

### 15.3.4 Older people

The results of the evaluation also raise questions about the benefits of IBs for older people and how these can be maximised. Concerns expressed by CSIP (CSIP, 2007a, 2007b), care co-ordinators, IB lead officers and providers alike about how older people would cope with the responsibility of an IB were supported by the lower levels of well-being among older IB holders than the comparison group, as measured in the outcome interviews. This suggests that the anxiety and stress about potential changes to their established support arrangements reported by some older people in the qualitative interviews continued to moderate any potential gains from the increased transparency, control and flexibility offered by IBs.

Evidence from the different strands of the evaluation suggests that older people often approach services at a time of crisis when they feel vulnerable or unwell and find decision-making difficult. The evaluation indicates that a potentially substantial proportion of older people may experience taking responsibility for their own support as a burden rather than as leading to improved control. Older people satisfied with their current care arrangements – particularly when this involved an established relationship with a current care worker – were reported to be reluctant to change, so differences in outcome would be minimal. Other attributes of older people, that have been shown to act as barriers to take-up of direct payments, are also likely to affect their responses to IBs.

Older people's support plans reflected high levels of need for personal care rather than domains such as occupation and social participation, restricting the scope for improvements in wider well-being. The fact that older people received smaller average levels of IBs compared to younger adults was also likely to have limited their opportunities for flexibility and innovation.

The particular challenges of implementing IBs with older people make the care co-ordinator role notably demanding. At least in the early stages of the pilots, care co-ordinators were less experienced and less confident in developing more innovative and creative support plans with older people. Organisational arrangements to support the flexible deployment of care-managed 'virtual budgets' were generally not in place; changes to existing local authority contracts with providers that might facilitate greater flexibility for care managed 'virtual budget' holders had not been negotiated; and there was a lack of access to alternative deployment options and services that could bring greater flexibility and control without the well-documented drawbacks.

## **15.4 Factors affecting costs – longer-term issues**

### **15.4.1 Resource allocation systems**

Resource allocation systems have fundamental implications for the costs and outcomes of IBs. In all sites the development of a robust system was a long-term, iterative process and in most sites was still on-going at the end of the evaluation period. Because of constraints on the evaluation design, we were not able to compare levels of IBs or their outcomes between those sites that used a RAS adapted from *In Control* and the pilot site that developed an outcomes-focused assessment and resource allocation system.

The levels of IBs awarded through the RAS during the evaluation period and the consequent implications for efficiency, cost-neutrality and user benefits may be different in a mature IB system. The level at which local authorities pitch their RAS and revise this in successive years will have major bearings on whether IBs are cost-saving, cost-neutral or more expensive in the longer term. Over time, with experience, discussion and negotiation following representation by individuals, advocacy groups and elected members, the algorithms used to allocate resources through a RAS will undoubtedly be subject to change. This will mean changes to the absolute and relative allocations of resources to different groups of individuals. How these changes will affect future comparative costs and outcomes of IBs is impossible to guess.

Costs will also be affected by whether IB users can negotiate higher level IBs than their RAS allocation in order to match existing direct payment levels, as was reported in several pilot sites, or whether currently high support costs can be pegged and protected during a transitional period. The impression was sometimes created that no one was allowed to be a loser, although this may have been partly a function of the pressures of IB pilot status and the evaluation. Whether such negotiations will be permissible or indeed affordable in the future remains an open question.

### **15.4.2 Demand and the impact on social care budgets**

Increased demand on social care budgets, particularly by mental health service users, was reported and this is also likely to increase costs. More generally, major challenges were experienced by pilot sites offering IBs to groups of users who were hitherto served by jointly-funded services. It was not easy to disaggregate social care resources from these services; IBs were allocated from social care resources, but at least some of the benefits of IBs were reported to be experienced by NHS partners, for example in the form of reduced day and in-patient hospital use.

### **15.4.3 Additional funding streams**

Only limited progress was made with integrating additional funding streams during the pilots. Nevertheless, expectations that additional resources to support IB users would be available - for example from Supporting People or the Independent Living Fund - were factored into sites approaches to cost-neutrality. Further developments in integrating funding streams depend on central government policy decisions. In the longer-term, these decisions will affect: the overall level of resources to be allocated through IBs; global management costs, if assessment, allocation and audit processes can be integrated; and potential efficiencies in how resources are used at individual levels.

### **15.4.4 Set-up costs and economies of scope**

The set-up costs for pilot sites were not inconsiderable and any wider roll-out of IBs will need substantial investment in areas such as training, assessment tools and support planning systems, monitoring and review arrangements, and IT systems that can administer and audit payments. As more people hold IBs, these relatively fixed costs could be spread more thinly over a larger number of IB holders, leading to potential economies of scope. Administrative processes for allocating resources for IBs, for assessing, monitoring and review could also become more efficient over time. However, there is no evidence from the evaluation of immediate or dramatic reductions in care management and other 'transaction' costs in the short term. Indeed, the costs of implementation experienced by sites were considerable.

### **15.4.5 Wider market changes and the impact on costs**

IBs are likely to precipitate changes in the wider care market that will influence costs in the longer term. For example, a number of people interviewed during the evaluation anticipated that the supply price for personal assistants could rise as demand for them increases. Moreover, there is a major tension between the economies of scale that flow from negotiating high-volume, low price block contracts with providers and the supply of individualised services. IB users do not have the same purchasing power as a local authority commissioner. A number of alternatives were suggested by local authority managers and providers that might preserve the financial advantages of block purchasing, while at the same time giving IB users greater freedom to use the service, organisation or person of their choice. If these are not widely employed or prove to be unsustainable, then the costs of IB-purchased services may rise and the benefits of IBs correspondingly reduce.

This trend is likely to be exacerbated if providers face falling demand and lose economies of scale; a day centre that is still chosen by some people but which is only

half full will become correspondingly more expensive or unsustainable. The protection offered by existing contracts meant that few such problems were experienced during the evaluation. Such effects could be counteracted if the range of services offered by existing provider organisations expanded; for example, a domiciliary care provider that begins offering Individual Service Fund management of IBs might expect to incur relatively marginal increases in costs.

#### **15.4.6 Running parallel support systems**

The final major factor affecting costs is the need to run two systems almost in parallel, one based on IBs and one that continues to be organised around conventional assessment, care management and local authority commissioned services. In the pilots, an individual could decline to take responsibility for their IB and continue to receive services commissioned by the local authority. This option will also be available to users of social care personal budgets as these are rolled out across England. It is not possible to predict how many people will want or need their local authority to manage their personal budget and commission services on their behalf, so these parallel systems will therefore continue for the foreseeable future, along with their associated costs.





## Chapter 16 Recommendations for Policy, Practice and Research

In December 2007 the Department of Health announced plans for the transformation of adult social care into a service characterised by person-centred planning, self-directed support and personal budgets for everyone eligible for publicly funded adult social care (HM Government, 2007). The aim is to create an outcome-focused, whole system approach to service planning, commissioning and delivery. In relation to personal budgets, it is expected that everyone receiving adult social care should know the level of resources available to them and should be offered choice over how those resources are used.

Despite these more recent developments, the evaluation of the IB pilots has highlighted a number of issues that require further attention. Indeed, addressing these issues will be important in achieving the ambitions for transformation.

### 16.1 Policy issues

#### 16.1.1 Integrating funding streams

The integration of resources from different funding streams was a key – arguably the most radical – feature of the proposals to pilot IBs. The Prime Minister's Strategy Unit report *Improving the Life Chances of Disabled People* (2005) highlighted the barriers to independent living that arise from fragmented and silo-based approaches that make it difficult to take a comprehensive and cost-effective approach to meeting disabled people's needs. The report recommended that different sources of funding should be brought together in individual budgets; these could include community care resources, and social services expenditure on equipment and minor adaptations; the Independent Living Funds, Disabled Facilities Grant, Family Fund and Access to Work. Individual budgets should be accessed through a simplified resource allocation system, including 'one stop' assessment and information provision; be portable between different local authority areas; and be accompanied by a single national charging policy.

The integration of additional funding streams into IBs based in adult social care was widely regarded in the pilot sites as the most exciting and innovative element of the pilot projects. However it was also the element which probably proved the most problematic and frustrating, to IB lead officers and funding stream leaders alike. Only in respect of Supporting People (SP) funding was significant progress made, to the extent of integrating (some) SP resources into the IB allocations and aligning or integrating assessment and review arrangements. Progress with integrating SP was

greater in unitary and metropolitan authorities, where adult social care and housing-based support services tended to share the same management structures. Even so, some concerns were expressed about the viability of the remaining SP-funded services for people not eligible for IBs (as assessed on social care eligibility criteria) if the top-slicing of SP resources for IBs led to disinvestment in standard SP services. This is an issue which will require careful monitoring, particularly for its impact on the development of preventive services, which is another strand of the personalisation policy agenda.

Progress was also made with integrating ICES resources into IBs, not least in part because ICES is funded from baseline adult social care (and NHS) resources. Moreover, sites found ways of managing the apparently contradictory pressures of conducting specialist assessments where these were needed, in the context of wider use of self-assessment processes. However, both IB and ICES funding stream leaders were concerned that it could be difficult to pass on the benefits of volume discounts on the bulk purchase of standard items of equipment to individual IB holders. The evaluation found that a substantial proportion of people used their IB to buy equipment or fund minor adaptations; moreover, IB lead officers argued that the timely provision of equipment could enhance independence and reduce needs for on-going social care support. All these considerations suggest that tackling any remaining barriers to the integration of ICES within IBs is a high priority that may have both budgetary and user-level benefits.

In respect of the other funding streams to be included in IBs, little progress was made with top-slicing budgets; harmonising eligibility criteria, assessment, decision-making and review processes; and aligning or devolving accountabilities for how resources were used. Some IB lead officers and funding stream lead officers regarded particular funding streams as inappropriate for integration (for example DFGs which, as a lump-sum payment, could not easily be integrated with an on-going IB payment) – in many ways analogous to capital and revenue budgets respectively. Integration of other funding streams such as Access to Work was hampered by differences in eligibility criteria and potentially eligible populations. The greatest frustrations were experienced with ILF. Despite similarities in target groups and linked eligibility criteria, the Fund's Trust deed prevented changes to ILF assessment processes, decision-making on applications and monitoring and review arrangements during the course of the pilot projects. A further barrier was the continuing requirement that all ILF funding had to be spent on personal and domestic care, which significantly reduced flexibility and creativity in how an IB could be used. In some sites the inability to integrate ILF affected the global IB budget and had implications for sites' cost-neutrality; with individual prospective IB holders it meant that, despite improvements in the speed of ILF decision-making, clarity about the level of indicative IBs was impossible.

The inclusion of Access to Work funding within IBs was not successful. Nevertheless, IB lead officers and front-line staff appreciated the attention they had been encouraged to give to training, work preparation and employment issues in their assessment and support planning activities. This suggests there is scope to explore how adult social care services and the various training and work preparation programmes funded and sponsored by the Department for Work and Pensions could work more closely together.

Many of the difficulties in integrating funding streams were attributed to legislative and administrative barriers that required action by central government. It was not clear within the IB sites how far these barriers reflected the pilot status of the projects – whether central government departments were awaiting evidence on the outcomes of the pilots before making the necessary changes. The decision to postpone action on the ILF following the independent review conducted during the period of the pilot certainly reflected this position (Henwood and Hudson, 2007). However, following the completion of the pilots, these issues now require urgent clarification and action in the context of a national commitment to personalisation. If IBs are to include other funding streams, over and above adult social care, then co-ordination and leadership will be needed from relevant government departments to remove current barriers to integration. From the evidence of the evaluation, the highest priorities for such measures are SP, ICES and ILF.

Decisions are also needed about the inclusion of NHS resources in IBs, particularly given the longstanding policy emphasis – reflected in current funding and service delivery arrangements in the pilot sites – on improving collaborative activities between the two sectors. It was widely believed in the pilot sites that the exclusion of all NHS resources from IBs was a ‘missed opportunity’. One high priority for policy attention is the status of NHS continuing health care funding, particularly for people with established support arrangements funded through direct payments (and now also through IBs or personal budgets) who become eligible for continuing care. The IB pilots also demonstrated both the difficulties and the potential benefits of delivering social care IBs to people with mental health problems. Resources were committed in jointly-funded and jointly-managed services; IBs were funded from social care alone; but the NHS was nevertheless expected to experience savings in the form of reduced service use. The attractiveness of IBs compared to conventional provision for mental health service users was also thought to increase demand, thus exacerbating these problems for social care budgets.

Including these (and possibly other) NHS funding streams in IBs was widely regarded as potentially important in increasing the benefits of personalisation. Moreover, as NHS personal budget pilot projects are currently (autumn 2008) being planned (DH, 2007b), it will be important that these build on the experiences of the social care pilots.

### **16.1.2 Resource allocation systems and principles**

The original policy proposals for IBs made no recommendations about how resources were to be allocated to IB holders, other than that this should be simplified (Prime Minister's Strategy Unit, 2005). Resource allocation systems (RAS) adapted from *In Control* were helpful in many sites. However, they were also controversial; there was no consensus among either senior officers or front-line staff about the appropriateness of a RAS-type approach compared with assessment processes where professional judgement and discretion play greater roles, or with the outcomes-focused approaches adopted to a greater or lesser extent in a few pilot sites. The inappropriateness or inadequacy of existing processes for allocating resources were not self-evident to local authority staff; any systematic errors in the RAS were seen to threaten the resource neutrality of IBs; and front-line staff had to manage difficult situations where indicative IBs were lower than existing direct payment awards.

The more transparent allocation of resources to people with highly variable sets of needs also brought into sharper focus the issues of equity that underlie any process of resource allocation. RAS processes led to some redistribution of resources between people within user groups. The evaluation showed that there did appear to have been some redistribution in favour of people with smaller previous care packages; some service users appreciated that their IB assessment and resource allocation covered their social and recreational as well as personal care needs. However, the evaluation also showed continuing major differences in the average levels of IBs received by different groups of users, such as people with learning disabilities and older people. If more progress had been made with integrating additional funding streams, it is possible that these differences would have been even greater, reflecting the differences in eligibility and 'target' groups of the various funding streams.

Given that transparency about resource allocation is fundamental to personalisation, the principles underpinning resource allocation systems and their desired outcomes need debate at national level. This debate should extend to consider the relative merits of alternative methods of resource allocation, including those currently used to award direct payments and the outcomes-focused approach used in one of the pilot sites. This debate could usefully contribute to the strategic review of adult social care and support (HM Government, 2008) and the Green Paper planned for 2009.

### **16.1.3 Fair Access to Care Services and charging policies**

There were debates within pilot sites about the operation of Fair Access to Care Services (FACS) eligibility criteria, in the context of increasing opportunities for self-assessment as part of the IB pilots. FACS eligibility criteria were also inevitably

poorly aligned with some of the funding streams that were to be included in IBs. It could be helpful to extend the review of FACS being conducted during 2008-9 by the Commission for Social Care Inspection to cover these emerging issues and prevent new problems arising as personalisation is rolled out across adult social care.

Many sites also reported difficulties with existing charging policies, particularly when IB users opted for mixed deployment options that included, for example, some local authority-commissioned direct service provision and some support purchased with a direct payment. Charging policies are also likely to need review as personalisation is extended, and particularly so if current principles are revised following the 2008 consultation and forthcoming Green Paper on the future funding of adult social care and support.

#### **16.1.4 The legitimate 'boundaries' of adult social care**

IBs raised important questions for senior managers, front-line care co-ordinators and IB holders alike about the role and legitimate boundaries of publicly-funded adult social care provision. Both conventional assessment and the (often mediated) self-assessment processes developed during the IB pilots focused on risk and need, a focus that has arguably been sharpened by the recent history of tight funding constraints. Thus, both social care staff and users may have become accustomed to social care provision that prioritises meeting personal care needs and avoiding crisis.

In contrast, the IB pilots encouraged resources to be used in new and creative ways that focus on goals, outcomes and inclusion. In principle, IB holders were able to use their social care resources to undertake ordinary social activities and purchase ordinary commercial services – uses that were sometimes far from traditional. As many as two-thirds of mental health service users used IBs for leisure and recreation activities, such as gym membership and cinema trips. Such practices could challenge both professional and public perceptions of what constitutes the legitimate use of public resources. Thus care managers reported considerable uncertainty about their roles in relation to some of the choices made by IB holders. IB holders were also unclear about what was and was not legitimate for their IB to be spent on; indeed, they reported that greater transparency about the resources available to them was only of value if it was accompanied by clear guidance for what they could (and could not) use those resources. The increasingly strong policy focus on independent living and outcomes-focused services prioritises social inclusion; indeed, it is argued that people dependent on publicly-funded support arrangements should have the same choices and rights to enjoy the same range of services and amenities as those who pay for their own support (HM Government, 2007). It will be vitally important for these changing perceptions to be clarified, endorsed and legitimated in public and policy debates, otherwise some of the opportunities for creativity in using IBs may be reduced.

## **16.2 Issues for practice**

### **16.2.1 Managing change**

The 13 pilot sites had all bid for pilot status and, by the time the first interviews were conducted with IB lead officers a year later, all saw themselves as enthusiastic champions of personalisation. These distinctive attitudes mean that 'crossing the chasm' between the 'early adopters' and the 'mass market' (Leadbetter and Gallagher, 2008) in rolling out personalisation is likely to be challenging. Nevertheless, although most IB pilots started gradually, most had extended IBs to other user groups by the end of the pilot. Their experiences therefore illustrate many of the key factors for success.

Clear, comprehensive and sustained information, training and on-going mentoring for staff at all levels were perceived to be vital. Ring-fenced resources for training will be needed if IBs or personal budgets are introduced gradually alongside existing patterns of assessment and care management over a transitional period, otherwise it may be difficult to divert funding from established training programmes. Training and capacity-building with external brokerage and support organisations, including those run by user and carer groups, are also essential.

The experience of the pilots identified some benefits of an implementation strategy that aimed to introduce IBs for all groups of service users right from the start; lead officers reported delays and repetition in adapting processes and documentation that had been developed for one group so that they could be used with others. Nevertheless IB lead officers also argued the case for introducing change gradually. One strategy for managing change that was endorsed was to designate a champion or expert within each care management team who could promote new ways of working and answer queries from colleagues.

Many care managers who took part in the evaluation argued that they should have been involved in developing assessment and support planning tools; this involvement would have improved their understanding of IBs and enabled them to feel more 'ownership' of the changes they were being asked to make in their professional practice. Other factors identified by local authority staff interviewed in the evaluation as facilitating change are not unique to the introduction of personalisation. Like other change management processes, key success factors included active support from the most senior managers and decision makers in the organisation, together with an implementation team that was enthusiastic, able to problem-solve and to bring in other people - IT staff, finance officers, expertise from voluntary and independent sector organisations - as and when required.

### 16.2.2 Proportionate controls

Concerns about financial and individual risks for IB users were widespread. Front-line staff voiced concerns about poorer quality services, misuse of resources, financial abuse, neglect and harm; about the level of responsibility that should sit with vulnerable adults; and about the lack of Criminal Records Bureau checks on people employed by IB holders. Although there was little evidence during the evaluation of the actual incidence of increased risk, it is possible that these concerns may have inhibited creativity on the part of front-line staff.

Monitoring and review systems developed for conventional service delivery arrangements need adapting to focus more on whether an individual is being supported in the way intended (rather than on the delivery or quality of services); to look at a broader range of outcomes; and perhaps to review resource allocation in the light of how well outcomes are being achieved. Additional changes could include reviewing and resourcing Adult Safeguarding policies and capacity; regular reviews of how IBs are being spent against the outcomes achieved; incorporating risk assessments into support plans; better guidance for care managers and better information for IB holders. Such measures are likely to increase the confidence of front-line staff and IB holders alike; encourage greater creativity; and enhance the potential benefits of IBs.

### 16.2.3 Alternative deployment methods

Although perhaps inhibited by the pressures of the pilots, relatively little use was made of new options for deploying IBs; most people opted for direct payments to employ a personal assistant or made use of care-managed 'virtual budgets'. Working age people with physical and sensory impairments were more likely to opt for direct payments while older people were more likely to use care-managed 'virtual budgets'. Very few used agency or trust arrangements or individual service provider accounts. It is likely that these preferences at least partly reflected the views of front-line staff about the appropriateness of different deployment options for different user groups; they may also reflect the very early stages of developing alternate deployment options.

Given the apparent preference of a substantial proportion of IB holders for care manager-held 'virtual budgets', particularly in the early stages of IBs, it is important that these can also be used flexibly and creatively (Challis *et al.*, 2002) so that opportunities for choice and control are widely available regardless of the preferred deployment option. This will require reviews of local authority commissioning and contracting arrangements and of processes and procedures for the use of internal resources. A clear position on the 'boundaries' of social care will also help give care managers 'permission' to work more creatively. For example, many local authorities

are developing outcomes-focused commissioning approaches to home care and day care services (Glendinning *et al.*, 2008) and these also need to be linked to the roll-out of personalisation. Other deployment options, such as provider-managed individual service funds, third party and trust arrangements also need further development and evaluation, so that their relative advantages and drawbacks for different groups of IB users can be assessed and communicated to front-line social care staff.

#### **16.2.4 Culture change**

Implementing IBs required shifts in the culture, roles and responsibilities of existing adult social care staff, whether professional, administrative or hands-on carers. As with direct payments, front-line social care staff played a key role in introducing people to IBs and helping them through unfamiliar and potentially stressful changes. Intensive staff support and extensive training and communication activities, supported by levels of ring-fenced funding, can assist in this process.

In particular, taking advantage of the new opportunities offered by IBs to exercise choice and control requires new skills in support planning and brokerage. These skills might be located within local government or with external organisations; if the latter, clear liaison and accountability arrangements are also needed. Improvements in all these activities need to be accompanied by an emphasis on the principle of transparency, so that far more people are aware of the level of resources allocated to them and how these have been determined.

#### **16.2.5 Local market development**

There was little evidence during the pilots that IBs had had an immediate impact on the numbers of local provider agencies. Nevertheless, providers anticipated higher transaction costs as they managed more individual accounts and also expected to be more directly exposed to new risks of non-payment. Providers already reported that workforce supply constraints created difficulties in responding to new demands from IB holders for flexible, one-off help at short notice. Other providers had experienced some staff losses as care staff left for private employment by IB holders. Similarly, difficulties were reported by some IB users in finding people to employ as personal assistants. However, on balance, providers were still largely protected by existing contracts, although some had begun to develop new services.

Major challenges will arise as existing contracts with providers come up for renewal, and local authorities will need to work carefully with providers to ensure that new contracts can support new patterns of user demand while at the same time protecting providers from excessive – and ultimately destabilising – risk.



Managing local markets to provide individualised services will be a major challenge in the future. A high priority activity for local authorities will be informing IB-holding purchasers about the services that are available and provider organisations about what services are wanted. This will demand a more interactive and cyclical strategy rather than a top-down, commissioner-driven approach. Other important roles for local authorities will include maintaining standards, with providers particularly concerned about the expanding supply of unregulated personal assistants.

## **16.3 Research priorities**

### **16.3.1 Longer-term impacts and outcomes**

Both ethical and practical considerations limited to six months the time that could elapse between obtaining consent from service users to participate in the evaluation and the outcome interviews. Coupled with delays in some sites in calculating indicative IBs and signing off support plans, this meant that many IB holders in the evaluation only had a very short period of time to experience their IBs before the outcome interview. Longer-term follow-up of the benefits and drawbacks of different approaches to IBs is therefore an urgent priority. A further priority for research is the more detailed examination of the relative benefits and drawbacks of IBs for different groups of service users, in order to understand why IBs appear to lead to fewer benefits for some groups and how these problems can be overcome. In particular, research is needed to find out whether, as front-line staff and IB holders become more confident in managing IBs, there are changes in the preferred options for deploying IBs. Such longer-term changes could have significant implications for the costs of IBs and for local provider markets.

The evaluation was also unable to cover the effectiveness of new monitoring and review processes established for IBs. These are likely to encompass the continuing appropriateness, over time, of the level at which IBs were initially set; how overspending and underspending are managed; the actual incidence of risk, including financial abuse, and how this is tackled; and the negotiation of changes to support plans that, over time, cease to meet identified needs. Given the considerable uncertainties and qualifications attached to the IBSEN findings on the costs of IBs, other longer-term research is needed into whether IBs remain cost-neutral over time and how resource allocation systems can adapt to changes in local authority, adult social care budgets.

The evaluation measured the differences in the resources allocated to the IB and comparison groups, and between different groups of IB users. However, as noted above, the resource allocation systems developed by the pilot sites were not based on any explicit principles, despite the fact that some redistribution of resources within and between user groups was likely to result. As IB sites develop and implement

their systems of allocating resources, such redistribution across groups is likely to become more marked. Research is therefore needed on the impacts of different resource allocation approaches, including outcomes-focused approaches, to assess their adequacy; their respective redistributive and equity implications; and their longer-term sustainability. Also crucial is an investigation of whether differences in the cost of IBs reflect real differences in needs, goals and desired outcomes between groups. Coupling this research endeavour with debates suggested above about the boundaries and role of adult social care will provide the evidence base for more effective and equitable services.

### **16.3.2 The wider social care market**

Given the relatively small impact on existing patterns of service provision, even in sites with extensive IB pilots, longer-term research is needed into the dynamics of local social care markets as personalised approaches are rolled out. The need for this research will become even more acute as existing contracts between local authorities and service providers come due for renegotiation. At that point, changing patterns of demand – in terms of both volume and types of services – may impact more visibly on provider stability.

As existing block contracts are replaced by individual purchasing, service unit costs are also likely to change; providers may also be increasingly exposed to new risks such as non-payment and late payment. Again, the impact on the costs and sustainability of IBs will need investigation.

Research will also be needed into the impact of personalisation on the wider care labour market. There were indications during the IB evaluation that delays in putting some IBs into place arose because of difficulties in recruiting personal assistants. Research will be required into the scale and patterns of care-labour market shortages and the effectiveness of new recruitment, training and retention initiatives. Similarly, research will also be needed into the quality and supply of care agency staff if IB holders continue to request greater flexibility through, for example, banking hours and requesting care workers at short notice; and if providers are no longer able to afford guarantees of minimum hours, holiday and sick pay, training and career development to their staff.

### **16.3.3 The role of carers**

A small-scale linked study of the impact of IBs on carers will be completed in autumn 2008. However, more extensive research is needed into the activities of local authorities in aligning policies, budgets and services for carers with the roll-out of personalisation. How is the unpaid help of carers treated in assessing needs and

allocating resources for IBs? What are the consequences for carers, for disabled and older people and for the relationships between them of different approaches to assessing carers contributions? How compatible are different approaches with local authorities' statutory duties regarding assessments? To what extent might it be desirable to integrate resources for carers' services into IB resource allocation systems and conduct single, integrated assessments of the needs of disabled and older people and their carers? How far are carers involved in managing the IB of the person they care for and what is the impact of this new responsibility (Rosenthal *et al.*, 2007)?

This was an aspect of IBs that prompted concern among some care managers; it is also a subject of considerable academic debate (Ungerson and Yeandle, 2007). Research is needed into the impact of paying carers through IBs on care-giving relationships, on the quality of care, on the social inclusion of carers, on household incomes and on the immediate and longer-term economic independence of carers.



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## **Appendix A Methodological Frameworks**

This Appendix summarises the different theoretical frameworks and analytical approaches used in the evaluation; describes the implementation of the Randomised Controlled Trial (RCT); outlines the approach to analysing qualitative data; and discusses the sample of service users.

### **A.1 Theoretical frameworks**

The aim of the IBSEN study is to evaluate qualitatively and quantitatively the costs and benefits of Individual Budgets (IBs) for a wide range of service users, and to describe - assess where possible - the merits of different approaches to implementation. As highlighted in Chapter 3 the approach taken draws on a number of key theoretical foundations, which are presented in more detail below.

#### **A.1.1 Realistic evaluation**

The research design has been informed by the concept of 'realistic evaluation' (Pawson and Tilley, 1997). This approach involves a stratified view of social processes requiring multiple levels of explanation of causal patterns (Julnes *et al.*, 1998). Pawson and Tilly (1997) propose a framework based on the assumption that the impact of any intervention is highly influenced by the contexts surrounding its implementation. The role of evaluation is to explain outcomes through an exploration of contexts and the identification of mechanisms. Advocates of the realist approach argue that evaluations of pilot initiatives that ignore these contexts, and the mechanisms through which they influence the outcomes of the pilot, will not lead to results that can sensibly inform wider roll-out or transfer to other settings.

Within the IB pilot, the diversity of the 13 sites, the client groups, and their different approaches to implementing IBs drew attention to the different contexts and processes within which IBs were being implemented. While the design adopted was not a pure Realistic Evaluation, it did seek to frame the results in these different contexts to ensure they could inform a wider implementation in other settings after the pilot. The approach taken in this study placed slightly more emphasis on identifying any differences IBs had made in terms of outcomes for people using services, partly because of the complexity and scale of the RCT outcome study. Further, the differences between sites and the range of approaches created a very complex set of contexts and mechanisms to explore.

However, the central quantitative assessment of impact – through the RCT – is analysed together with qualitative interviews of service users to seek to understand the mechanisms by which IB have an effect (or if not, why not, and for whom). The interviews with IB lead officers, front-line staff and other stakeholders also investigate the different implementation mechanisms, and also provide a better understanding of the behaviours, motivations and history within the pilot sites. Together, this blend of approaches aims to maximise the usefulness of the research in informing roll-out and follows the broader interpretation of a realistic approach to evaluation advocated by Julnes *et al.* (1998). The use of qualitative data within the research more generally is discussed below.

### **A.1.2 Production of welfare framework**

Beyond the framework influencing the overall design of the research, we also require an analytical approach to addressing the key research questions. What data do we need to collect, and how should we analyse them? Primarily the research uses the well-established ‘production of welfare’ framework (Davies and Knapp, 1981).

This framework established a model of relationships between resource inputs (staffing, capital, other service costs) and local context (staff attitudes, client characteristics etc) determining a set of service provision (outputs) that ultimately impact on service users’ well-being (outcomes) (Challis *et al.*, 2006). This model establishes a mechanism for investigating how different models of service delivery, resource use (and costs) and contextual factors can influence service user outcomes. This model provides the structure for the collection and interpretation of outcome, service use and cost data in order to address questions of relative effectiveness and cost-effectiveness.

## **A.2 The RCT**

### **A.2.1 The application of the RCT**

Randomisation was conducted through a web-based portal that collected basic characteristics (e.g. date of birth, gender, service user group) and a unique local authority identifier. After local authority staff entered basic demographic details and an identifying number (which was not identifiable to the researchers), the service user was immediately randomised to either the IB or comparison group through the website. At this point, local authorities sought consent from service users to take part in the evaluation and could either offer an IB, or offer standard services as normal. Outcome interviews took place six months later.

A different process was required in one site. This pilot aimed routinely to offer IBs to **all** current users of adult social care as their annual service review was carried out. Here the evaluation team arranged to conduct outcome interviews with comparison group users six months following their *previous* review. A similar process was adopted for one user group in another site at the start of the pilot.

Pilot sites were each asked to reach a quota of service users who would be counted if they had been randomised and had given consent to take part in the evaluation. These quotas were calculated so that from across all the 12 randomising pilot sites (one LA was excluded because they were offering IBs to young people undergoing a major transition from child to adult services) and allowing for some attrition and drop-out, the evaluation could interview 1,000 service users in total.

In meeting these quotas a total of 3,743 service users were randomised between July 2006 and June 2007. This total is significantly more than the number of people approached for consent to the trial (2,521). One reason for this may be the lags between randomisation, gaining consent, and then reporting back to the IB team: meaning users were still randomised even after quotas had been reached (or could have been reached from people randomised up to that point). There is no evidence that over-randomisation was deliberately conducted to allow care managers to then select people to get consent from (and still meet their quotas).

There were 72 exclusions from the randomisation process. Most of these were permitted according to an exclusion criteria we set out in advance. In addition to 'transitions', exclusions from the randomisation processes were also allowed if a service user was terminally ill or if they lived with someone who had already been randomised (in which case the service user was allocated into the same group as the first resident of the household, and still approached for consent). Six of the 72 exclusions were early IB holders<sup>61</sup> that were entered in error. A further four requests for exclusions were denied as falling outside the agreed exclusion principles.

As highlighted in Chapter 4, the success of the randomisation was tested to see if there were significant differences between the IB and comparison groups across a wide range of variables (a successful randomisation should ensure there are no such differences). Tests of differences across 41 variables encompassing a range of personal characteristics, needs and service use found no significant differences at the five per cent level, save for whether the user poses a risk to self or others (higher proportion in comparison group,  $p=0.05$ ), and prior receipt of carer support.

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<sup>61</sup> Each local authority introduced IBs for a small group of service users at an early stage (before evaluation processes were established) to test processes and to meet a request from DH. These were excluded from randomisation.

### **A.2.2 Intention to treat**

It is helpful to introduce also a key analytical concept – the ‘Intention to Treat’ (ITT) approach – that is used to define the ‘treatment’ and ‘comparison’ groups used in parts of the RCT analysis in Chapters 5 and 6. An ITT approach means that in the analysis, membership of the comparison and treatment groups was strictly defined by the outcome of the randomisation, regardless of whether individuals allocated to the IB group refused to receive an IB and opted instead for a standard support package.

The implications of adopting an ITT analysis strategy are important. The ITT approach prevents the analysis from yielding an overly optimistic view of the impact of IBs on outcomes (Hollis and Campbell, 1999: 53-4). It could be argued that the reason why some individuals opt out of receiving an IB was that they expected standard packages to be a better alternative for them. Treating such individuals as part of the comparison group would fail to reflect that, for those people, the outcomes of IBs were not expected to be better than those of standard support packages. In other words, selecting out of the IB group all the ‘refusers’ would leave in the IB group only those individuals keen to receive IBs, those for whom a priori expectations were that IBs would be equally good, if not better, than standard care packages.

In addition, by maintaining the composition of the IB and comparison groups as defined by the randomisation, ITT ensures the comparability of the two groups, and therefore the integrity of the randomisation process. Further, it is likely that if IBs were rolled out more widely there would also be service users outside the pilots that would also opt to remain with standard services (and potentially bias the extent to which our findings could be generalised to wider roll-out). However, adopting an ITT approach means that the average estimates (for instance of costs or outcomes) for the IB group included some individuals receiving standard packages of care, and that not all users with standard care packages were included in the calculation of estimates for the comparison group.

### **A.3 Using qualitative data**

The research report includes findings from both quantitative and qualitative sources, but the application of results from the latter forms of data are sometimes misunderstood. How is qualitative data used in the IBSEN report, and what weight should be attached to it?

The analysis of the qualitative interviews is not intended to be strictly representative of all views; it is not the result of a survey of a statistically drawn sample of IB lead officers, care co-ordinators, team managers and service users. Rather, it is an indication of the range of potential perspectives on the various aspects of the pilots that we were investigating. Such an analysis does not therefore rely heavily on the



numbers of people giving a certain view. Instead, it purposively selects a range of respondents to cover the potential range of different experiences and perspectives. Moreover, it aims to reach the point of 'data saturation' (i.e. when analysis of each successive interview stops producing any new findings) and therefore is strongly indicative that the full range of views has been captured. As such, these qualitative findings represent far more than mere anecdotal reports: they give an indication of the perceptions of structure and relationships, including causal relationships, which can be considered as the context or framework within which the outcomes for service users were created. Where the sample was unable to reach this saturation of views (e.g. due to the breadth and complexity of the topic, or due to a small sample size) this is clearly indicated within the relevant chapter.

Qualitative data is used in two ways in the report. First of all it provides an illumination and potential explanation of the outcome findings, by showing how participants with different perspectives regarded their experiences and their interpretations of the policies, practices and goals of the pilots. For example, explanations of differences between the outcomes for older people and younger disabled people, are given more weight by reference to the possible range of understandings and meanings of care co-ordinators. The qualitative element has also generated themes which fed into the quantitative analysis. Taken together, the two elements provide stronger evidence supporting different courses of action.

Secondly, as well as complementing the RCT analysis, the qualitative data have important implications at the micro level, upon which the hoped-for macro changes in practice depend. For front-line workers an interpretation of the understanding and stories of the different actors in the setting, can help to develop reflective and reflexive practice. In order to promote more choice and independence for people, workers who have been trained and expected to work in certain ways for much of their working lives will need to reflect on the different kinds of interactions with service users and with their managers or employers. An interpretation of the experiences and understanding expressed by the different groups of participants will be a valuable aid to developing such an approach.

Managers responsible for initiating and implementing change also need to have an understanding of how different parties interpret the changes and ways in which they are managed. By presenting interpretations of the range and nature of individual experiences, we will provide valuable insights for managers considering how to go about making changes. Again, the value of this analysis lies not in the numbers of people expressing views, but in the extent to which this resonates with the experiences of participants and readers (Rolfe, 2006).

Thus we are presenting two very different kinds of data, which have value both separately and when considered together. We discuss possible links between these kinds of findings in the Chapter 16. For example, the differences between groups in

terms of outcomes are hard to interpret. By adding our interpretation of the range of possible understandings and meanings, we can draw out more useful messages from both sets of findings. Integrating qualitative and quantitative data produces more than just the sum of both parts.

## **A.4 Response and representativeness**

### **A.4.1 Response and sample attrition**

Up to the end of June 2007 a total of 2,521 service users were approached by pilot sites to request their participation in the research; a total of 1,594 (63 per cent) agreed to take part and baseline records containing (among other data) contact details subsequently returned to IBSEN. We have little evidence to explain the reasons for non-consent, except for comments by IB lead officers that mental health service users were more likely to be anxious about participating in the research (and the prospect of an IB more generally). This was also reflected in the final numbers of interviews undertaken with people with mental health problems.

As explained in the main body of the report, there were significant delays in returning baseline data (which held name and address details) to the evaluation team (mostly caused by delays in achieving consents). As a consequence IBSEN had contact details for just 1,394<sup>62</sup> people in sufficient time to be interviewed (out of the 1,594 giving consent). Of the 1,394 a further 129 service users were not approached for the following reasons:

- they no longer received social services support (n=62)
- service user had passed away (n=40)
- incorrect contact details (n=18)
- user moved out of area (n=9).

Of the remaining 1,265 service users, a further 221 did not complete a six-month interview. The reasons given were:

- they no longer wished to take part (n=154<sup>63</sup>)
- they were too ill, hospitalised or in crisis at the time of the approach (n=59)
- the interview began, but was incomplete (n=8)
- no reason given/recorded (n=38).

This yielded a total of 1,006 achieved interviews, or 40 per cent of the 2,521 people originally approached to take part. A further 47 were also removed post-interview

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<sup>62</sup> Not all data was returned to IBSEN in time for the whole sample to be approached for interview.

<sup>63</sup> Includes 34 people who we approached and who wanted to take part, but could not do so before IBSEN finished interviewing.

because we could not validate the randomisation group: **resulting in a final sample of 959 users.**

#### A.4.2 Analysis of representativeness

Chapter 4 presents the general conclusions of the analysis of representativeness. This section presents the findings in more detail.

We compare differences between the IBSEN sample and national averages for a limited number of variables, where reliable data exists. We use the Department of Health's data for analysis of ethnicity, direct payment use, and intensity of homecare use<sup>64</sup>. A more limited analysis is also attempted comparing measures of need in the British Household Panel Survey of 2006.

##### A.4.2.1 Results

*Ethnicity:* The IBSEN sample comprises 8.1 per cent BME service users, which is significantly higher than the national average (5.8 per cent) and even higher than the average for the 12 selected pilot sites (4.6 per cent)<sup>65</sup>. This is consistent with reports that BME groups were targeted by some sites. Looking at differences between sub-groups (Table A.1) finds significantly fewer BME groups among mental health service users than would be expected in a representative population.

**Table A.1 Proportion of BME service users by primary client group**

	% BME in IBSEN sample	% BME in England	Sig (95%)
Physical disability	9.8	9.4	n/s
Older people	5.0	3.7	n/s
Learning disability	11.1	8.3	n/s
Mental health	4.7	12.1	√
<b>Total</b>	<b>8.1</b>	<b>4.0</b>	√

*Direct payment use:* As compared to four per cent in England as a whole, 26 per cent of the evaluation sample had direct payments. Investigating at a sub-group level (Table A.2), all groups except older people show significantly higher user of direct payments. The difference is largest amongst service users with physical disabilities. Investigating our sample within each site (not shown) shows that in one site 66 per

<sup>64</sup> All Information Centre data is taken from Community Care Statistics 2006-07: Referrals, Assessments and Packages of Care for Adults, England, except for the intensity of home care use which is derived from Community Care Statistics 2007: Home Help/Care Services for adults, England. Available from [www.ic.nhs.uk/statistics-and-data-collections/socialcare](http://www.ic.nhs.uk/statistics-and-data-collections/socialcare).

<sup>65</sup> Where comparisons are made with the 12 pilot sites, this represents totals for all service users within those pilot sites.

cent of service users with physical disabilities had a direct payment at baseline, yet in some other sites the proportions were more representative.

**Table A.2 Proportion of service users with direct payments by primary client group**

	<i>% with direct payments (IBSEN)</i>	<i>% with direct payments (England)</i>	<i>Sig (95%)</i>
Physical disability	43.4	12.7	√
Older people	4.2	2.1	n/s
Learning disability	21.3	7.3	√
Mental health	20.3	1.6	√
<b>Total</b>	<b>25.9</b>	<b>5.8</b>	√

*Intensity of home care use:* There is evidence that the IBSEN sample has significantly higher *intensity* of service use, as one possible measure of the overall service need of the sample. Table A.3 shows the proportion of all homecare users who receive more than ten hours of care per week, by user group<sup>66</sup>. The IBSEN sample of homecare users received significantly higher intensity of care, in particular amongst older people (the only sub-group with a statistically significant difference in intensity).

**Table A.3 Proportion of service users receiving intensive homecare, by primary user group**

	<i>% intensive homecare (IBSEN)</i>	<i>% intensive homecare (England)</i>	<i>Sig (95%)</i>
Physical disability	33.6	30.0	n/s
Older people	35.9	25.6	√
Learning disability	42.6	45.4	n/s
Mental health	11.1	14.3	n/s
<b>Total</b>	<b>35.0</b>	<b>27.0</b>	√

*Activities of daily living:* The IBSEN sample can also be compared with other nationally representative surveys to investigate more formal measures of need: Activities of Daily Living (ADL) – though the Department of Health does not collect data on this variable. However a cautious comparison can be made between the IBSEN sample and the British Household Panel Survey (BHPS)<sup>67</sup>. Restricting the

<sup>66</sup> Note some limitations to the comparison: first, that national data is only available at a household-level (whereas our sample is individual); and secondly, national data adds the stipulation that 'intensive' homecare is ten hours or more AND including six or more separate visits (although the impact of the latter issue will be very small).

<sup>67</sup> The BHPS data used is taken from Wave 15, conducted in 2006, and is taken from the UK Data Archive. Just six domains of ADL are comparable with the IBSEN data, and note that in the BHPS it is not possible to distinguish just people receiving social services support with these ADLs, as distinct from health care support.

analysis to *just older people in receipt of homecare*, a comparison is made between six ADL domains presented below. Comparing proportions of the samples unable to conduct each activity on their own we find the IBSEN sample has significantly greater needs in four of the six domains. A significant finding is also found testing the difference between ADL scores on these domains.

**Table A.4 Proportion of older people in receipt of homecare unable to undertake selected ADLs or mobility**

	% Unable to do on own (IBSEN)	% Unable to do on own (BHPS, 2006)	Sig (95%)
Walking up stairs	58.6	57.0	n/s
Walking down road	77.4	56.2	√
Getting around indoors	17.4	5.0	n/s
Getting in/out of bed	27.7	13.5	√
Have a bath/shower	64.2	32.0	√
Getting dressed	48.5	13.8	√

#### A.4.3 The sub-sample of 130 service users offered an IB

The original research design proposed interviews with a sub sample of 130 people who had been randomised to the IB group about two months after recruitment to the study and collection of baseline data. It was intended to select the 130 interviewees ensuring a good range of characteristics, using data returned to IBSEN from the pilot sites to select service users. However delays in the return of data meant that this was rarely possible. Nevertheless, a wide range of characteristics from across all 13 pilot sites were achieved in the final sample, which comprised:

- 32 people with physical disabilities and/or sensory impairments, 38 people with learning disabilities, 20 people with mental health problems, and 40 older people.
- 20 people aged 18-24 years, 66 people aged 25-59, 18 people aged 60-74 years, and 26 people aged 75 years and over.
- 118 White people, three Asian people, six Black people and three people defined as 'Other'.
- 17 interviewees were reported to have had previous experience of Direct payments and 21 to have had previous experience of *In Control*<sup>68</sup>.

There was often uncertainty about the funding streams, deployment options, and even stage of the IB process the users had reached, and therefore this information is not reported. Although aiming for interviews at two months from initial consent, the delayed implementation often meant that this could be longer and three to four

<sup>68</sup> However when interviewed, a number of these interviewees appeared to have no knowledge or experience of any self-directed support prior to being offered an IB.

months was more common. Finally, the delayed data returns also caused interviews to be concentrated towards the end of the pilot.

## Appendix B In-depth Implementation and Workforce

This appendix outlines the methodologies adopted for the in-depth implementation and workforce strands of the evaluation, and an outline of how qualitative data is used within the research.

### B.1 In-depth implementation

An important strand of the evaluation included a detailed investigation of the processes of implementing IBs, and the different perspectives of a wide range of stakeholders. This element of the study was undertaken using semi-structured interviews with a much wider range of stakeholders in seven of the pilot sites.

#### B.1.1 Selecting the in-depth sites

Resource and time constraints meant it was not possible to conduct this in-depth investigation in all 13 pilot sites; instead it was originally proposed to focus on four sites, to be selected on the basis of information obtained from a first round of interviews with senior managers responsible for IB implementation in each site. However, these interviews revealed a wide diversity of local contexts and approaches to implementation (see Chapter 3). It would not have been possible to capture this diversity through in-depth case studies in just four sites. It was therefore decided to examine *some* of the key issues central to the evaluation in seven sites, while investigating **all** of these issues in just four.

In the four 'core' sites, every key aspect of the implementation and impact of IBs was investigated. Specifically:

- The development and impact of the RAS.
- Arrangements for support planning and brokerage.
- Commissioning and managing change in patterns of service provision.
- The responses of provider organisations.
- Experiences of aligning assessments and integrating resources from different funding streams.
- The involvement of user and carer organisations in the IB Pilot Project.

Four 'core' sites were selected that reflected the full range of local authority types and sizes involved in the pilots; different approaches to implementing IBs; and local features of theoretical interest, such as relationships with local NHS partners.

In a further three 'peripheral' sites, only the development of the resource allocation system, support planning and brokerage arrangements, and implications for commissioning and service providers were investigated. These three sites were selected because of unique features of theoretical interest, including the nature of the resource allocation system being developed in the site and the user groups being offered IBs.

The outcome of these selection processes meant that, between them the seven in-depth sites covered a range of geographical regions (south, Midlands and north of England); predominantly urban and rural areas; high and low proportions of people from black and minority ethnic (BME) communities; type of local authority and star ratings; user groups being offered IBs; and previous experiences of *In Control* and direct payments.

Sections B.1.2 to B.1.5 describe the key themes of the in-depth research in more detail, as well as describing how, and with whom, we conducted the interviews.

### **B.1.2 Resource Allocation System and support planning/brokerage**

Two waves of interviews were conducted with IB lead managers in each of the seven sites, the first in March/April 2007 and the second in November 2007. Both sets of interviews covered recent experiences of developing resource allocation systems and setting up support planning and brokerage arrangements. This two-stage approach aimed to track the development of these arrangements, the problems encountered and how these were resolved. Conducting only one interview in each site would have risked failing to capture the richness and complexity of implementation experiences. Between the two waves of interviews with IB lead officers, additional interviews were conducted with individuals responsible for developing local support planning and brokerage services, including dedicated in-house support planners, and representatives of voluntary and private organisations that were considering or were in the process of setting up support planning services. These individuals were identified by the IB lead managers.

### **B.1.3 Commissioning and service provision**

We asked local authorities in the four nominated 'core' sites to identify a range of providers that have had most exposure to individual budgets, alongside some basic characteristics such as the type of services they provided; client groups served; whether they were for/not for profit; size; and the extent of their involvement in IBs. We were given the details of 29 providers in total, approaching 17 providers to achieve 16 interviews as intended. Table B.1 below summarises the characteristics of the achieved sample.



**Table B.1 Provider sample**

<i>Provider characteristic</i>	<i>Categories</i>	<i>No. of providers</i>
Provider type	For profit	8
	Not for profit	7
	In house	1
Primary user group served	Older people	9
	Physical/sensory impairment	2
	Learning disability	3
	Mental health	2
Services provided*	Personal care	12
	Day services	5
	Supported living	10
	Advocacy and support	5
	PA recruitment	4
Provider size	Small (0-500 hrs of service p/w)	4
	Medium (501-1500)	4
	Large (1501 +)	6
	Don't know	2
IB numbers	None	3
	1-5	5
	6-20	6
	21+	2
Experience of non-LA purchased services (more than one response per provider possible)	Direct payments (excl IB)	9
	Private funded clients	5

In all seven in-depth sites, interviews were conducted during the second half of 2007 with managers responsible for commissioning adult services.

#### **B.1.4 Funding streams**

The experiences of integrating additional funding streams into IBs were explored in interviews in the four 'core' in-depth sites. Interviews were conducted with managers from SP in four sites; managers of ICES and DFG in three sites; and the link person for AtW in one site. Interviews were also conducted with managers from the ILF and AtW. These interviews were conducted towards the end of 2007, when sites were likely to have had opportunities to identify difficulties associated with integrating additional funding streams and to have developed ways of resolving these.

### **B.1.5 User and carer organisations**

The involvement of user and carer organisations is central to major transformations in adult social care such as the piloting of IBs. Interviews with IB lead managers in the four 'core' sites explored the role of user and carer organisations in the implementation process. These were complemented by interviews with 13 user and carer organisations in the four core sites about their perceptions of their involvement and their views on the impact and outcomes of IBs for users and carers.

## **B.2 Workforce**

There were three broad areas of study in relation to the workforce – the processes of assessment and care co-ordination; the emergence of different models of care co-ordination and their impacts on service users; and patterns of time use and activity by care managers and other front-line social care staff.

This section details the methodology adopted for this strand of the research, which involved interviews with:

- Workforce development, training officers and/or IB lead officers from each pilot site.
- Adult protection leads from each site.
- Care co-ordinators and their team managers.

In addition, we undertook a structured diary and questionnaire study of care co-ordinators.

### **B.2.1 Training interviews**

Two rounds of interviews were also undertaken with training and development managers and/or the IB lead officer from each of the 13 sites, to investigate the training implications of implementing IBs in pilot sites. Early in the life of the pilots (October-November 2006), 18 telephone interviews were conducted across all 13 pilot sites. Six IB lead officers, 11 training and development managers and one consultant occupational therapist involved in training participated.

The aim of the second round of interviews was to find out how the different pilots had developed over the year and whether any significant issues had emerged. These interviews were undertaken approximately one year after the first round, between December 2007 and February 2008. Training officers were contacted first by email and then by a follow up telephone call. The interview schedule was sent to participants before the interview to facilitate the session. Nine people were

interviewed from seven local authorities, though one was abandoned as it became clear they no longer had a remit for training. Four participants described their roles as heading workforce development, whilst the remaining four were more clearly aligned with that of training or operational manager. Five of the eight people with training responsibilities said that their jobs had changed in the last 12 months and one stated that his role was 'about to' do so. Two of the training leads were new in post.

### **B.2.2 Adult protection interviews**

This aspect of data collection aimed to elicit the approach to adult safeguarding taken in the pilot sites and to explore any issues raised by the pilots about adult protection and safeguarding. Again, two rounds of interviews were involved, with respondents who were expected to be aware of the impact on adult protection policies and practice of the pilot experiences. Contacts within each of the 13 pilot local authorities identified the member of staff who was responsible for adult protection or safeguarding who could be approached for interview about risk and protection issues arising from the introduction of IBs. The participants occupied slightly differently named positions and roles in each of the 13 social services authorities but in all 13 sites, the local authority was the lead agency responsible for adult protection services in their localities. The first round of 13 interviews were undertaken by telephone and took place at the start of 2007 using a semi-structured interview guide.

The aim of the second interviews was to find out how the different pilots had developed over the year and whether any significant issues had emerged. With this in mind, the interview schedule of the first round of interviews was amended to take account of the temporal change. A draft was devised and further modified following consultations within the research team. Following final agreement, Adult Protection lead officers were approached first by email and a follow-up telephone call. The interview schedule was sent to participants prior to the interview to facilitate the interview process. The interviews lasted from just over half an hour to an hour and a half and took place during January and February 2008. Two interviews were conducted in one area because adult protection responsibilities were found to be located in two roles. Thus 14 interviews in the 13 pilot sites were conducted in the second round of the evaluation.

### **B.2.3 Interviews with care co-ordinators and team managers**

An important element of the Individual Budgets evaluation involved examining the impact of this initiative on the care co-ordinators employed by local authorities and on the management of their teams. The aim of these interviews was to investigate how,

by whom, in what ways, at what level and with what effects the core tasks of care co-ordination are performed for different service users.

Four care co-ordinators were selected for interview from 12 of the 13 pilot sites (one site was excluded from this part of the evaluation, having too few front-line practitioners involved with IBs at this stage). In addition, between two and four team managers were invited to participate from each of these 12 sites. Altogether, 48 care co-ordinators (including one local authority-employed broker) were interviewed, together with 43 team managers. These represented all the main user groups (learning disabilities, older people, people with mental health problems and people with physical disabilities) from each of the 12 pilot sites involved. Interviews were conducted in six pilot sites between May and July 2007 and the remainder between September and December 2007.

The interviews with care co-ordinators were conducted face-to-face and those with team managers by telephone. In both instances semi-structured interview guides were used. For the purposes of this report, transcripts were coded until data saturation point was reached, i.e. no further codes were being generated. Thus the findings reported here are from 40 care co-ordinator interviews and 28 team manager interviews, randomly selected from across all 12 pilot sites; these represent 75 per cent of all interviews conducted. A final analysis was conducted using the coded data from these 68 transcripts.

#### **B.2.4 Diary and questionnaire study of care co-ordinators**

The aim of this part of the evaluation was to examine the impact of the new arrangements on care managers' time use; and to find out how care managers viewed their work environment, with a focus on the impact of delivering IBs. .

A booklet was produced containing a short questionnaire to elicit background information regarding respondents (age, gender, qualifications/years qualified, years with current employer, location, team type/size, service user group, caseload size, casemix); a single item question on job satisfaction using a seven point (delighted-terrible) scale (Andrews and Withey, 1974); a version of Karasek's Job Content Questionnaire (Karasek, 1979) modified by the research team; and a structured diary study tool developed at PSSRU Manchester and successfully used in previous studies (Weinberg *et al.*, 2003; Jacobs *et al.*, 2006b). Care co-ordinators were invited to complete this booklet either directly by researchers or via their team managers; instructions for completing the different sections were fully explained and opportunities given for questions and clarification. Pre-paid envelopes were provided to return the diaries directly to the research team. Six pilot sites participated in this aspect of the study during May to July 2007 and a further six were asked to participate during September to December 2007.

The Karasek Job Content Questionnaire provides standardised sub-scale ratings of decision latitude (discretion), psychological job demands and social support in the workplace. Additional sub-scales used in this evaluation included those measuring job insecurity, customer relationships and self-identity through work. Respondents were asked to select one response for each of 40 statements which most closely corresponded to their own view of how they felt about that statement. In most instances, this was on a four point (strongly agree-strongly disagree) Likert scale.

For the diary study, care co-ordinators were asked to complete a structured diary of work activities at the end of each working day for a period of one week. Forty-one job-related activities were identified within six broad areas of care managers' working lives.

The diary schedule was divided into half-hour time slots from 8.30am to 6.30pm and was printed with the list of activities alongside for ease of reference. Participants were invited to insert on the schedule the appropriate code for the activity in which they had been predominantly engaged for each half-hour period.

The intention was to invite **all** care co-ordinators from **all** the teams involved in **all** the IB Pilot Project sites to complete the diaries and questionnaires, together with a selection of teams **not** involved in the Pilot Projects. In total, 851 booklets were distributed to teams in 12 pilot sites. This elicited 249 usable responses (total response rate 29 per cent) with responses from individual sites ranging from 13 to 58 per cent. This sample consisted of 22 (9 per cent) care co-ordinators from teams not involved in any pilot work, 64 (26 per cent) from teams involved in the pilot but without any IB cases themselves and 121 (49 per cent) with IB cases on their caseloads. Forty-one cases (16 per cent) had missing data regarding the numbers of IB cases on their caseloads. Further details regarding the sample are presented in Table B.2. Although there were some small differences between the two groups, none of these reached significance.

**Table B.2 Characteristics of care co-ordinators participating in the diary/questionnaire study**

	<i>Some IB users (N=123)</i>	<i>No IB users (N=85)</i>
Age (mean)	42.2	44.6
Gender (% Female)	72.6	76.2
% Qualified Social Workers	54.1	56.1
% Full-time	81.3	77.4
Service area (% working with):		
Older people	47.2	56.5
Physical disabilities	41.5	31.8
Learning disabilities	39.0	30.6
Mental health	27.6	34.1
Size of active caseload (mean)	22.2	20.7
Total number hours worked (mean)	38.5	37.0



## **Appendix C Collecting Data from Users and Local Authorities**

This appendix reports the approach to data collection, from both pilot sites and through interviews with service users.

### **C.1 Baseline, support plan and six-month data collection**

There were three sources of data on needs resources and outcomes: baseline returns, support plans and six-month interviews. Information about service use and needs were collected both at baseline from local authorities and at six months from the individuals and their carers in the comparison group. For the IB group support plan data, including the costs of different elements of the plan, were collected once the plans were in place. As described above, the RCT design was intended to ensure comparable groups so group differences in outcomes six months on could be ascribed to differences in the experiences of the groups in terms of intervention.

#### **C.1.1 Baseline data**

At baseline, administrative information (whether a new case, client group, FACS) was collected together with basic demographic information (ethnicity, age, gender and so on), and information about current circumstances (household composition, receipt of benefits, employment status, activities of daily living, presence of carer and so on). Information was also requested about current levels of support including details about current social services packages of care and receipt of support from other funding streams: Supporting People, Independent Living Funding, health services, Access to Work and education.

#### **C.1.2 Support plans**

For individual budget holders, sites were asked to complete a support plan record designed to capture the content of the agreed plan. The support plan record was divided into four sections that covered:

- Total levels and contributions from different funding streams, amount of the budget intended for recurrent annual and one-off payments, funding for support planning and support brokerage, the proportion of the budget the individual was expected to contribute if this was included.

- The formal organisation of the budget in terms of who held the budget and who was involved in the support planning and managing the support.
- Areas of outcome that the plan addressed: the aim was to identify the IB holder's perspective primarily, but there was space for the care manager/social worker to identify any other objectives or any reservations about the aspirations of the IB holder.
- Activities included in the support plan, the budget per year and the frequency of activity: this section also asked whether the services were commissioned by the budget-holder/nominated person or by the local authority.

### **C.1.3 Interviews at six months**

In the six-month interviews items were asked in the same order for every respondent and interviewers were trained to follow the same instructions in each interview. The timing of the interview was guided by the needs of the respondent but generally it lasted between 1-1½ hours. Show cards were designed to aid the hearing and visually impaired particularly but were also used to guide the interview.

The questionnaire included structured items about service receipt for the comparison group and more open-ended items about use of budgets for the IB group. Piloting had identified that a more structured approach to self-report for the IB group led to over-long interviews. For both groups the same information was collected about their use of health services and activities of daily living. A number of outcome indicators and instruments were included covering psychological well-being, self perceived health, social care outcomes, quality of life and indicators of satisfaction and quality of care:

- *Psychological well-being*

The psychological well-being of service users was measured by the 12-item version of the General Health Questionnaire (Goldberg, 1992). This scale comprises of 12 items that explore whether respondents have experienced a particular symptom or behaviour over the past few weeks. Each item is rated on a four-point scale (less than usual, no more than usual, rather more than usual, or much more than usual). There are two scoring methods; the Likert scoring scale (0 to 3) which generates a total score ranging from 0 to 36, with higher scores indicating worse conditions; and the bi-modal (0 to 1) scoring style that indicates the likely presence of psychological distress according to a designated cut-off score of 4 or more. The GHQ-12 has been extensively used in national studies including British Household Panel Survey and the Health Survey for England providing the scope for comparative analysis in the future. In our sample Cronbach's Alpha for the scale was 0.92 demonstrating that it had good internal reliability.



- *Self Perceived Health*

A person's perception of his/her own health has been found to be a reliable predictor of objective health. Specifically, self-rated health has been found to predict functional decline (Ferraro, 1980), chronic disease (Shadbolt, 1997) and even mortality (Idler and Benyamini, 1997). The perceived health question was based on the five point scale suggested by Robine and colleagues (2003) as part of a European project on health indicators. This question asks respondents to rate their health in general according to five categories ranging from 'Very good' to 'Very bad'.

- *Perceived quality of life*

The quality of life item was developed as part of a project funded under the ESRC Growing Older Research Programme (Bowling *et al.*, 2002). This item was measured using a seven-point scale, with categories ranging from 'So good, it could not be better' to 'So bad, it could not be worse' (Bowling, 1995).

- *Social care outcomes*

The Adult Social Care Outcomes Toolkit (ASCOT) is a preference weighted indicator that reflects need for help and outcome gain from services across seven domains ranging from basic areas of need such as personal care and food and nutrition to social participation and involvement and control over daily life. The questions asked respondents to choose from a series of three deteriorating situations, which of the options best describes their situation. In this way the question aims to capture no needs, low level needs and high level needs. Table C.1 below shows the responses actually used in the interview. Using the same format, respondents were asked to best describe their in the absence of services or the support purchased through the IB. Rather than assuming that each domain and level is of equivalent importance the measure is weighted using population-based preferences (see Burge *et al.*, 2006). Outcomes can be reported in terms of both current levels (a score ranging from 0 to 4.57) and a difference measure that reflects the difference between expected needs in the absence of services and current levels. Initial examination of this difference outcome measure suggested that some IB respondents may be thinking about their previous experience of mainstream services when identifying expected needs, rather than their needs with no help at all from social services. Further work could adjust for this but was not possible to incorporate in this report. In our sample Cronbach's Alpha for the scale was 0.74 demonstrating that it had good internal reliability.

**Table C.1 Options provided for each domain to reflect each need level**

<i>Domain</i>	<i>Need level</i>	<i>Description</i>
Control	No	I feel in control of my daily life
	Low	I have some control over my daily life but not enough
	High	I have no control over my daily life
Safety	No	I have no worries about my personal safety
	Low	I have some worries about my personal safety
	High	I am extremely worried about my personal safety
Personal care	No	I would always feel clean and would be able to wear what I want
	Low	I would occasionally feel less clean than I would like or would not be able to wear what I want
	High	I would feel much less clean than I would like, with poor personal hygiene
Accommodation <sup>1</sup>	No	My home is clean and comfortable as I'd like it to be My home is as clean and comfortable as it can be
	Low	My home could be more clean and comfortable than it is
	High	My home is not at all clean or comfortable
Food and nutrition	No	I am able to eat the meals I like when I want
	Low	I can't always eat the meals I like when I want to, but I don't think there is a risk to my health
	High	I can't always eat the meals I like when I want to, and I think there is a risk to my health
Social participation	No	I have a good social life
	Low	I have a social life but sometimes I feel lonely
	High	I feel socially isolated and often feel lonely
Occupation <sup>1</sup>	No	I am fully occupied in activities of my choice
	Low	I am occupied but not in activities of my choice I don't have enough to do to keep me occupied
	High	I have nothing much to do and am usually bored

<sup>1</sup> Four levels were presented to respondents in each of these domains but reduced to three as shown here for the purpose of scoring the measure.

- *Satisfaction and quality of services*

Measures of satisfaction and quality of care were based on quality indicators derived from the extensions to national User Experience Surveys for older home care service users and younger adults (Jones *et al.*, 2007; Malley *et al.*, 2006). In our sample Cronbach's Alpha for the quality of care scale was 0.80 demonstrating that it had good internal reliability.

## C.2 The impact of proxy responses on outcomes

As reported in Chapter 4, 24 per cent of the interviews at six months were conducted with proxy respondents. Table C.2 shows that proxy respondents were more much likely to be interviewed if people had learning disabilities, and the proportion of proxy interviews tended to be slightly higher in the IB group than in the comparison group. In addition, some respondents were interviewed with another person, usually their informal carer, who on occasion might help the individual or respond for them on a particular item if there was some difficulty in communication or understanding.

**Table C.2 Proportion of proxy interviews by user group**

	<i>Overall sample</i>		Overall (%)
	IB group (%)	Comparison group (%)	
Physical disability	12	10	15
Learning disability	40	44	44
Mental health	18	11	8
Older people	31	26	33

Table C.3 compares the responses for each of the outcome measures for the sample as a whole, including and excluding the proxy responses. For composite measures (e.g. GHQ-12 and ASCOT) only total proxy interviews were excluded. For single item outcome measures, responses were excluded when it was reported that a full proxy interview was carried out or when the proxy assisted the service user in answering the question.

In Chapter 6 we identified a number of associations between outcomes and IBs which ceased to be statistically significant once proxies were excluded. In the sample as a whole the proportion who reported feeling in control of their daily lives was 48 per cent in the IB group (n=493) and 41 per cent in the comparison group (n=437). Excluding proxies the proportion who reported feeling in control was 55 per cent in the IB group (n=287) and 49 per cent in the comparison group (n=299).

When proxies were excluded from the sample of people with mental health problems the proportion reporting that their quality of life was good or better was 35 per cent in the IB group (n=65) and 27 per cent in the comparison group (n=64) when proxies were included, and 32 per cent in the IB group (n=49) and 24 per cent in the comparison group (n=53) when proxies were excluded.

The proportion of older people reported to have a GHQ-12 score of 4+ was 45 per cent in the IB group (n=129) and 29 per cent in the comparison group (n=107) when

proxies were included. It was 36 per cent in the IB group (n=89) and 31 per cent in the comparison group (n=80) when proxies were excluded.

**Table C.3 The impact of proxy responses on outcomes**

	<i>Overall sample</i>		<i>Excluding proxy responses</i>	
	IB group	Comparison group	IB group	Comparison group
<b>Quality of life</b>	<b>N=504</b>	<b>N=439</b>	<b>N= 308</b>	<b>N=302</b>
So good, it could not be better	3%	3%	3%	4%
Very good	15%	18%	15%	15%
Good	27%	28%	24%	24%
Alright	38%	31%	41%	36%
Bad	8%	9%	8%	11%
Very bad	7%	7%	7%	6%
So bad, it could not be worse	2%	5%	3%	5%
<b>GHQ-12</b>	<b>N=448</b>	<b>N=380</b>	<b>N=344</b>	<b>N=300</b>
Mean score <sup>1</sup> (sd)	13.83 (6.74)	13.80 (6.85)	13.73 (6.90)	14.26 (7.19)
Percentage <sup>2</sup> scoring 4+	36%	33%	37%	37%
<b>ASCOT<sup>3</sup></b>	<b>N=457</b>	<b>N=385</b>	<b>N=341</b>	<b>N=304</b>
Current needs mean score (sd)	3.55 (0.79)	3.48 (0.89)	3.62 (0.78)	3.49 (0.93)
<b>Self-perceived health</b>	<b>N=507</b>	<b>N=446</b>	<b>N=311</b>	<b>N=317</b>
Very good	12%	16%	12%	15%
Good	23%	24%	21%	19%
Fair	37%	35%	35%	38%
Bad	20%	16%	23%	19%
Very bad	8%	10%	9%	10%
<b>Satisfaction of services</b>	<b>N=478</b>	<b>N=431</b>	<b>N=268</b>	<b>N=288</b>
Extremely satisfied	15%	15%	16%	15%
Very satisfied	34%	28%	35%	31%
Quite satisfied	30%	28%	27%	25%
Neutral	11%	14%	13%	14%
Fairly dissatisfied	5%	7%	3%	6%
Very dissatisfied	3%	4%	2%	5%
Extremely dissatisfied	3%	5%	4%	5%

<sup>1</sup> GHQ item scoring 0-3, higher GHQ scores indicate poorer outcomes.

<sup>2</sup> Using GHQ-12 item scoring 0-1.

<sup>3</sup> Higher scores indicate lower levels of need.

### C.3 Difficulties with ADL activities

The analysis explored further the impact of IBs on the health of service users by examining differences in the levels of physical disability between users in the IB and comparison groups, controlling for baseline characteristics. The aim of this analysis was to examine whether the finding of worse self-perceived health among IB users, and in particular among people with learning disabilities, was corroborated in terms of decline in physical ability as indicated by the number of difficulties with ADL tasks (which is highly correlated with the indicator of self-perceived health).

The results reported in the Table C.4 do not show worse physical disability among IB users. In fact, the statistical analysis for all users, including cases where responses were provided by proxies, indicates significantly better physical ability among IB users. This effect becomes not significant when proxy responses are excluded from the analysis sample, or when the model is fitted exclusively for people with learning disabilities.

**Table C.4** Number of difficulties with activities of daily living

	<i>All user groups</i>				<i>People with learning disabilities</i>			
	All responses		No proxy responses		All responses		No proxy responses	
	Coeff.	P	Coeff.	P	Coeff.	P	Coeff.	P
ADLs at baseline	0.22	0.00	0.21	0.00	-0.26	0.00	-0.30	0.00
Learning disabled user	-1.66	0.00	-2.25	0.00				
Mental health user	-1.58	0.00	-1.70	0.00				
User is employed	-1.00	0.02	-0.76	0.14	-0.80	0.17	-0.59	0.42
Living alone	-0.36	0.03	-0.18	0.37	-0.36	0.34	-0.05	0.92
IB user	-0.31	0.04	-0.21	0.30	-0.40	0.16	0.53	0.41
Package cost	0.0004	0.12	0.0002	0.57	0.0007	0.05	0.003	0.01
Proxy response	0.51	0.00			0.85	0.02		
Constant	10.89	0.00	10.72	0.00	9.78	0.00	9.59	0.00
Observations	801		479		199		48	

Model estimated using OLS, with multiply imputed data.

### C.4 Cost estimation

Cost estimation is rarely straightforward but there are particular challenges in the evaluation of IBs. In our estimates we want to ensure as far as possible that we are comprehensive and compare like with like.

There were two principal sources of data: local authorities and individuals and their carers. Ideally information is collected from both sources as both have problems associated with them. In the case of local authorities, previous experience had

shown that we could not rely on all authorities being able to identify the components or full costs of packages for all cases. In this evaluation there was the additional problem that authorities were already overburdened as a result of the demands of the evaluation as described earlier in the report. Interviews with individuals, the approach most frequently used in evaluations, have the advantage that the data collection is more directly within the control of the evaluators. However, there may be problems of recall in terms of identifying all the components or details about amounts, frequency of contacts or number of hours. In this evaluation we drew on each source with the aim of making the best use of each.

At baseline we asked local authorities for the components of and expenditure on packages for those already in receipt of services as we were not interviewing individuals and their carers. While there was a substantial level of missing data authorities were able to provide sufficient data to provide a good picture of the costs of packages prior to the introduction of IBs.

As identified in Appendix A, we had intended to collect information about service use in a structured way as part of the six-month interview for both IB holders and the comparison group. This was done for the comparison group but did not prove practical for the IB group so we drew on the support plan record described in Appendix A. The support plan record identified what individuals were planning to spend their budget on and the amount. Information about health service use and contacts with local authority social workers was not expected to be included in the budget and information was therefore obtained from the six-month interview. The open-ended questions asked of IB holders about their support plan can be analysed at a later date but for the purposes here did not generate information that could be used for the cost analysis.

For comparative purposes we needed to eliminate costing associated with support planning and support brokerage. The IB total cost was estimated by summing the total funding of services and support identified on the support plan record. We included funding in the total IB for the following activities: personal assistance, home care (through registered agency), home care (through in-house), telecare equipment, other equipment, other one-off purchases, leisure activities, transport, accommodation, planned short breaks, payment in lieu of services, direct payment support, payroll support, child care, health and dental services, meal services and all other services that were reported on the support plan record. For providing a cost for services rather than the total individual budget, we omitted funding for payroll support and direct payment support.

Information about service use supplied by individuals and their proxies in the comparison group at six months provided us with the overall pattern of resource use. In order to compare like with like it was important to reflect unit costs in the same areas as these would best reflect what IB holders would be able to purchase with

their budgets. The pilot authorities were asked to provide unit costs for all services used by people in the comparison group in their area. Each unit cost was multiplied by the appropriate frequency of use and summed to produce an overall social care cost for each member of the comparison group.

The social care resources identified along with the unit costs supplied by the pilot local authorities are listed in Table C.5. To provide a comparison, data from the PSS EX1 2006-2007 and from Curtis (2007) where necessary were inflated<sup>69</sup> to 2007/2008 prices. This table shows the variation in unit costs between local authorities which will have an impact on the calculated social care cost for people who had not been offered an IB.

For health services each service user was asked about contacts with their GP, health visitor, district nurse, occupational therapist, chiropodist; day hospitals, accident and emergency units and inpatient hospital stays.

National unit costs were used for these services (Curtis, 2007) inflated to 2007/2008 prices. The service resources identified along with their unit costs are listed in Table C.6.

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<sup>69</sup> The PSS inflator was used which was 3.6 per cent for converting 2006/2007 prices to 2007/2008.

**Table C.5 Average social care costs**

<i>Social care resource</i>	<i>Average unit cost (supplied by pilot sites) 2007/2008</i>	<i>National average - PSS EX1 (2006-07)</i>	<i>Other sources</i>
Home care			
Mean	£15.54	£17.70	
Minimum	£10.50		
Maximum	£21.68		
Day centre per attendance			
Mean	£39.75		£28.14 <sup>70</sup>
Minimum	£24.72		
Maximum	£56.00		
Lunch club per session			
Mean	£2.76 <sup>71</sup>		
Minimum			
Maximum			
Meals on wheels (per meal)			
Mean	£4.62	£3.50	
Minimum	£3.20		
Maximum	£5.25		
Supported employment service			
Mean	£12.99 <sup>72</sup>		
Minimum			
Maximum			
Average gross weekly expenditure on supporting adults in residential and nursing care <sup>73</sup>			
Kensington – Learning disability		£910	
Essex – Physical disability		£893	
Oldham – Older		£403	
Oldham – Learning disability		£383	
Norfolk – Mental health		£486	
Lincolnshire - Older		£415	
West Sussex - Older		£788	
Bath – Learning disability		£864	
Bath – Physical disability		£918	
Gateshead – Physical disability		£726	
Gateshead - Older		£402	

<sup>70</sup> Data from Curtis (2007).

<sup>71</sup> Only one local authority supplied a figure.

<sup>72</sup> Only one local authority supplied a figure.

<sup>73</sup> The PSS EX1 2006-07 data was inflated by 3.6 per cent to reflect 2007-2008 expenditure.



**Table C.6 Summary of main service resources and unit costs**

<i>Service resource</i>	<i>Unit cost 2007/2008</i>
Day Hospital per visit	£142 <sup>74</sup>
District nurse, health visitor or other kind of nurse <sup>75</sup>	
Home	£77 <sup>76</sup>
Clinic	£55 <sup>77</sup>
Home and clinic	£68 <sup>78</sup>
Occupation therapist, physiotherapist, speech therapist or any other kind of therapist <sup>79</sup>	
Home	£38 <sup>80</sup>
Clinic	£29 <sup>81</sup>
Home and clinic	£36 <sup>82</sup>
Local authority social worker <sup>83</sup>	£131
General Practitioner	
Surgery	£31 <sup>84</sup>
Home	£50 <sup>85</sup>
Hospital accident and emergency department	£32 <sup>86</sup>
Chiropodist	
Home	£17 <sup>87</sup>
Clinic	£9 <sup>88</sup>
Home and clinic	£19 <sup>89</sup>
Inpatient service – per bed day	£231 <sup>90</sup>

<sup>74</sup> General inpatient cost – weighted average of all day care attendances in a hospital.

<sup>75</sup> Based on an average unit cost between a community nurse (including a district nursing sister and district nurse) and health visitor.

<sup>76</sup> Based on an hour spent on home visit.

<sup>77</sup> Based on an hour of clinic contact.

<sup>78</sup> Based on an hour of client contact.

<sup>79</sup> Based on an average unit cost between a hospital physiotherapist, community physiotherapist, community occupational therapist and a community speech and language therapist.

<sup>80</sup> Based on an hour spent on home visit.

<sup>81</sup> Based on an hour of clinic contact.

<sup>82</sup> Based on an hour of client contact.

<sup>83</sup> Based on an hour of face to face contact.

<sup>84</sup> Based a clinic consultation lasting 11.7 minutes including direct care staff costs.

<sup>85</sup> Based on a home visit lasting 11.7 minutes including 12 minutes for travel and direct care staff costs.

<sup>86</sup> Based on an average between cost of walk-in, follow attendance and non 24 hour A&E department.

<sup>87</sup> Based on a home visit.

<sup>88</sup> Based on a clinic visit.

<sup>89</sup> Based on an hour with the chiropodist.

<sup>90</sup> Based on the weighted average of all patient rehabilitation stays excluding patients with brain injuries.



## Appendix D Estimating the Set-up Costs of Individual Budgets

### Introduction

The introduction of IBs represents a major cultural shift in the organisation and provision of social care. Clearly this will require additional resources to ensure that systems are in place that reflect local needs and circumstances as well as the overarching aims of the initiative. It is important, therefore, that the introduction of IBs is adequately resourced or there is a risk that either IBs will not be introduced effectively or potentially damaging opportunity costs will be incurred elsewhere in the organisations involved.

We would expect the set-up costs of introducing IBs to vary. Some organisations will be further along the process towards self-directed support, having already been involved with *In Control* pilots. Even within such authorities there will be variations in the degree to which the thinking about self-directed support is reflected in parts of the organisation dealing with other client groups. Some authorities will have information and administrative systems more easily adapted to the needs of IBs than others, and of course we might expect geographical location (with higher costs associated with London and the South East) and scale and complexity of the organisation to have an impact. Costs will also depend on the approach adopted, whether authorities attempt to address all or a selected number of client groups and/or teams or geographical locations in the first instance. They will also depend on the degree to which external agencies and processes to support direct payment arrangements are already in place and are seen as adequate for the requirements of supporting IBs.

Estimating set-up costs from the early stages of pilots is problematic as the costs actually incurred rarely reflect the resource implications of rolling out a previously piloted intervention into mainstream practice. Moreover, costs incurred are often heavily influenced by resources available. In this instance the pilot authorities received funding of £200,000 for the first year, with further funding of £150,000 for the second year of implementation. In the invitation to authorities to become pilot areas it was made clear that ongoing care costs were expected to be cost neutral overall.

In spite of the problems of estimating set-up costs, it is important that information is available to those responsible for ensuring adequate funding for any future roll-out of this important innovation. Those best placed to provide these estimates are those who are actively involved in the process. Our pilot areas reflect the full range of factors that we expect to affect set-up costs, although there are clearly a wide range of factors expected to cause variation and only a limited number of pilot areas. This

chapter describes the results of a consultation with the pilot areas on their experience and best estimates of the cost of the set-up process.

We start by describing the approach we adopted to estimating set-up costs, describe the results for the first year of implementation, speculate on likely subsequent set-up costs and briefly report on authorities' views about the longer-term cost implications of IBs. Throughout it is important to be clear that there are heavy caveats to all our estimates. We have identified the range of factors that might affect costs, the limited number of cases that we can draw on and, as will become clear below, the need to make a number of assumptions.

## **D.1 Method**

All 13 pilot sites were asked to take part in an interview designed to obtain their best estimates of the resources required in order to implement individual budgets. After the interview, an Excel spreadsheet was sent to each pilot site, requesting the relevant cost data. It had been anticipated that we might also explore implementation costs with agencies responsible for other funding streams. However, it was too early in the process to identify such costs. At the time of the fieldwork most of the activities by these agencies were likely to be focused on issues raised by national policies around assessment, eligibility and flexibilities.

### **D.1.1 Initial assumptions**

It was made clear in the interview that we wanted to explore how much a local authority (similar to the interviewees' own authority) would need in order to adapt, design and introduce the process to fit in with local systems, excluding the costs associated with being a pilot site. The following assumptions were made in an attempt to avoid the inclusion of costs arising from the initial obstacles present in the piloting stage.

- Finance streams, administration, national policy and principles are in place, including charging and health funding.
- Legal issues regarding employment by individuals using public funds are resolved (IR and DTI regulations).
- Information requirements by Department of Health/Department for Communities and Local Government are known.
- Recommendations about local information requirements are available.

The pilot sites have received (and continue to receive) a considerable level of support from CSIP in the implementation process. While a lot of this reflects the specific requirements of the pilot, there are more general types of support in local

implementation that respondents may have assumed would be available for authorities initiating individual budgets in the future. While the costs of such support were beyond the scope of this exercise, we asked whether the authorities were assuming such support from CSIP or other external agencies.

As we identified above, costs will depend on the approach authorities adopted, for example whether they initially introduced individual budgets to all client groups, all geographic areas and so on. In addition to identifying what approach the authority had used in practice we asked whether, given their experience, they would still introduce individual budgets in the same way. Necessarily, their estimates reflected their experiences in terms of the overall broad approach. However, we asked them to reflect the results of their experience rather than actual costs incurred. So, for example, where they felt that they had not adequately resourced an activity, to identify what they now felt would be an appropriate level of resources.

### **D.1.2 Set-up costs**

Local authorities were asked first to describe the overarching project management structure required to implement individual budgets. The following information was requested:

- number of people and proportion of their time
- grade and spinal point that these posts should be costed at
- length of time the posts/time would be required (for example, six months, one year, two years)
- where available, the cost of overheads to staff time (for example, human resource and finance departmental costs)
- direct expenditure identified (for example, expenditure on IT equipment, training or contracting tasks out).

These overall management costs covered a variety of activities, the extent depending on local organisational arrangements. In order to ensure that we had fully covered all set-up costs, authorities were asked to identify any additional resources that would be required to:

- design systems (for example, assessment, resource allocation, support planning, review, financial administration and information system set up)
- train the workforce (for example, initial training/involvement in design)
- develop support planning/brokerage (for example, peer support, developing a private/voluntary sector role and developing marketing materials for in-house services)
- manage the market (for example, development of a procurement and commissioning strategy, contract renegotiation, transitional arrangements).

They were then asked if they had identified any further activities or resource requirements.

### **D.1.3 Ongoing costs**

While a requirement of the pilot was that the cost of care packages was to be at least cost neutral overall, there might be additional associated organisational costs or indeed savings in the long term. It was too early for authorities to identify such implications, but given the importance of the issue and their unique position in facing the practical issues of implementation, they were relatively well placed to speculate about the ongoing cost implications. We asked whether they anticipated additional costs or savings in the areas of:

- overheads/administration
- workforce development
- support planning/brokerage
- market management
- care management/social work time.

## **D.2 Results**

Information was collected from 12 of the 13 pilot sites. As described above, we asked authorities to provide their best estimates based on a number of assumptions, including how, given hindsight, they would approach the implementation of IBs. However, pilot sites were still relatively early on in the process of implementation so, while estimates of the early costs were probably reasonably accurate they had limited information about the resource implications of later activities, for example market management and likely costs in the second year of implementation.

Four of the 12 sites reported that if they were to introduce individual budgets again, they would adopt the same overall approach. They also reported the level of resources they had used in practice or were currently in their budget where the activity was yet to be undertaken. The remaining sites were more speculative, with four sites identifying the need for additional resources earlier on in the process than they had been able to put in place in practice.

In terms of client groups, all the sites that were introducing IBs across all client groups reported that they would do the same again. Four of the pilot sites that were introducing IBs across a limited number of client groups, felt that due to the dramatic cultural shift required, it would be more efficient to address all client groups, although some made the exception of mental health because of the particular challenges

presented by that group. While in hindsight this group of authorities indicated the possibility of introducing IBs across all client groups, the cost estimates were based on their actual experiences rather than what it would cost if a different approach was adopted locally.

CSIP was very active in providing support to all sites during the pilot process and an overwhelming majority of pilot sites were assuming a supportive role from them in mainstream implementation. One site identified potential additional costs to the Pilots of requests for information and support from local authorities currently outside the pilot process, such as sharing assessment forms and support plans. This authority suggested that CSIP could play a role in reducing this burden, perhaps through secondment or employment of staff from the current pilot sites and making clear to other authorities that this was a more appropriate source than directly approaching the pilot sites themselves.

### **D.2.1 Overall costs**

As we identified above, there were a variety of organisational arrangements, with some authorities employing dedicated staff to undertake a wide range of activities and others allocating these activities over a range of individuals and organisations. As a result it is not easy to identify the separate costs of activities necessary for the implementation of IBs. We start by describing the overall estimates and the basis for these and then identify the level of costs incurred for specific activities where this information was available. We report the mean, median and range throughout as there are a low number of observations and the data were often skewed.

Authorities used two different approaches to estimate the cost of introducing IBs. Seven of the pilot sites considered that a dedicated overarching project management team was required and reported annual costs of these dedicated staff, while five pilot sites reported hours spent on individual budget implementation by a range of current staff<sup>91</sup>. It was unclear whether additional workers were employed to undertake tasks that these staff would otherwise have undertaken.

All pilot sites reported that at least one year was required to introduce IBs. While four authorities felt that at least two years would be required, others were less clear about what resources would be required after the first year when it came to mainstream implementation. This is not surprising given the fact that they were not yet into the second year of implementation and the need to make assumptions about lessons

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<sup>91</sup> Two authorities identified that they had a dedicated project management team and also made use of existing resources. One authority indicated that the dedicated project team actually implemented Individual Budgets while the other authority indicated the use of a high proportion of existing resources. In the first case, the authority was included in the 'Dedicated management team' group, while in the second case, the authority was included in the 'Own resources' group.

learnt from the piloting process. As a result we focus here on estimates for the first year's cost. Below we discuss a possible basis for estimating set-up costs required for the second year.

While every attempt was made to exclude the costs associated with being a pilot site from those necessary for the implementation process, it was not always clear from the information provided. For example, while there clearly will be some travel costs within authorities, in the Pilots such expenses may be dominated by national and regional meetings associated with the pilot process. Taking the strictest definition, excluding all expenses that might be at least in part associated with the pilot process, in the first year the estimated cost of implementation ranged from £128,470 to £486,460, with a mean of £286,630 (median £267,710). When these 'uncertain' costs were included, the average cost was in practice not much higher: a mean of £291,120 (median £270,100, ranging from £143,290 to £486,460). Due to two authorities reporting much higher costs and some authorities reporting lower costs, the analysis was repeated with the four most extreme authorities removed. The estimated average cost was £272,340 when all expenses that might be associated with the pilot process were removed, compared to £275,340 when all costs were included.

Unsurprisingly, the costs reported were dominated by the costs of salaries and associated on-costs (National Insurance and superannuation). The average overhead cost, supplied by three authorities, was seven per cent of salary and on-costs, so this value was assumed for all authorities. As described below, some authorities identified substantial budgets or expenditure for commissioning other organisations or consultants to undertake specific tasks such as developing systems or setting up support planning and brokerage arrangements. Training costs excluded the opportunity costs of the time of those being trained but included the costs of the trainer and direct expenses. Only a couple of authorities separately identified the costs of room hire; and the opportunity cost of using rooms already available to the authority was not included. Other expenditure included PCs and IT equipment<sup>92</sup>.

Those authorities reporting the lowest costs were more likely to have identified the use of existing staff time, with relatively low levels of expenditure for commissioning additional inputs from elsewhere (see Table D.1). Among pilot sites that made use of existing resources, the average set-up cost was £219,690 (median £195,050) compared with £334,450 (median £312,730) among sites with a dedicated team. While we would expect there to be a genuine range in expected costs, in a situation where authorities are required to speculate, there is always the concern that those reporting the lowest costs may reflect a lack of information about the full cost implications of the process. The highest costs were associated with the use of more

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<sup>92</sup> For our purposes here we included all expenditure on equipment in the first year rather than annuitising or depreciating the value over the expected life of the equipment.



senior staff, the use of three ILF officers and high estimates for specific tasks such as developing brokerage services. It was interesting to note that in validating the upper estimates one authority came back with even *higher* estimates as a result of their actual experience (in this instance of the costs of developing the resource allocation system).

**Table D.1 Overall set-up costs**

	<i>Minimum set-up cost</i>	<i>Average set-up cost (excluding costs incurred as a result of the pilot process)</i>	<i>Maximum set-up cost</i>
All pilot sites	£128,470	£286,630 <sup>93</sup> (Median = £267,710)	£486,460
<i>Project management</i>			
Dedicated team	£222,950	£334,450 (Median = £312,730)	£486,460
Own resources	£128,470	£219,690 (Median = £195,050)	£345,910

## D.2.2 Project management team

The structure of the project management team varied considerably across the 12 authorities. Five authorities had one overarching team, while seven had a number of distinct management teams. While the structure of the project management team varied, three core activities covered were consistently identified:

- strategy development
- partnership development (other LA departments, voluntary sector, other funders)
- setting up user involvement processes.

Average costs of the management teams are not very meaningful however, as authorities varied considerably on the degree to which these teams were involved in these and the other implementation activities. Particularly where there were dedicated teams, they were likely to get involved in a wider range of activities. Once the cost of the project management team was taken into account, authorities using existing resources rather than a dedicated team were on average more likely to report the need for further expenditure (£107,390 (median £83,200) compared with £92,925 (median £86,630) respectively). Four areas were identified as requiring

<sup>93</sup> Two authorities have not responded to queries regarding their cost information and therefore this figure may be amended.

additional resources: development of systems, workforce development, development of support planning and brokerage, and market management.

### **D.2.3 Development of systems**

As we identified above, some authorities will have administrative systems that are more easily adapted to the needs of implementing IBs than others. Some development would be undertaken by the project management team but often additional costs were being incurred over and above the project management resource. Eleven of the 12 pilot sites reported average costs of £42,594 (median £24,970), with estimates ranging from £5,000 to £148,880, to adapt and develop their local systems. Of this, £24,240 was reported as required for the development of the assessment and resource allocation process by seven of the authorities. One authority reported that they would need £93,020 for setting up new information systems locally, which included recruitment of a full-time information systems officer, consultancy time from a software company and to purchase a software licence. Another authority reported the recruitment of a resource officer to design systems at a cost of £33,180.

Among pilot sites that used a dedicated team, it was reported that on average an additional £32,560 (median £13,310; minimum £5000; maximum £133,760) would be required to develop systems, compared with £54,640 (median £36,500; minimum £15,000; maximum £148,880) among pilot sites making use of existing resources.

### **D.2.4 Workforce development**

As IBs are a new way of allocating money to meet the needs of service users, the workforce will need to be trained in many aspects of the process. In order to ensure ownership and a genuine change in culture, such training will need to go beyond simple training sessions and workshops. For example, care managers could be involved in the development of the resource allocation system, with those involved earlier in the process providing support to other care managers becoming involved later on. Development officers could provide a general resource for those coming up against practical problems of implementation, in addition to providing training in assessment and resource allocation processes. The level of training and development required at individual, team, area, and authority levels will depend on the degree to which care managers are outcome-led in the support that they provide and their appraisal of support plans and the review process. Such training and development was part of the remit of the management team in some areas, but pilot sites also reported the need for specific additional resources. On average it was estimated among ten authorities, that an additional £13,100 (median £10,660 with

estimates ranging from £918 to £35,800) would be needed to meet the training needs of the workforce.

### **D.2.5 Support planning and brokerage**

An important element of IBs is the facility for individuals and their families to draw on their own resources or other agencies rather than use local authority care managers in the support planning process. For example, support brokers can offer essential help and support to service users in planning and finding the appropriate services. In order to ensure that such sources of support were available, seven pilot sites reported that on average £51,710 (median £47,000) would be required to set up support planning and brokerage arrangements, with estimates ranging from £20,000 to £80,000. As it was still very early within the pilot process, these estimates were usually based on funds already set aside for this area rather than based on actual experience. Peer support was also seen to be an important aspect of this process in a few authorities, with an average estimated cost in the first year of £5,470<sup>94</sup>.

### **D.2.6 Market management**

The implementation of IBs may well result in additional costs being incurred by local authorities in terms of renegotiating contracts with service providers and making necessary arrangements for the transitional process. However, due to the early stage within the pilot process, only two pilot sites reported that additional resources would be required for market management in terms of contract renegotiation and transitional arrangements. One authority reported that an additional £10,440 would be required for market management. Of this, it was reported that £5,120 would be required for contract renegotiation and £5,320 for transitional arrangements. The other authority reported that a contracts officer would be required at a cost of £1,030.

### **D.2.7 Variation in set-up costs**

There are many factors that could influence costs associated with implementing IBs. We would expect that size, type and location of authority would be influential, but due to the small number of pilot sites and variety of approaches being adopted, it was not possible to separate out such effects. However, there were scale effects in terms of the number of client groups that authorities were addressing and their target number of IB holders to be achieved during the pilot period.

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<sup>94</sup> This includes interventions which in Jacob's *et al.*'s (2006a) report titled 'Training for Individual Budgets: Early findings' are reported as training as they include an element of workforce development.

Table D.2 shows that the average set-up cost among authorities implementing IBs within two or fewer client groups was £276,080 (median £283,060) rising to £297,180 (median £266,350) when IBs were introduced across three or more client groups. Eleven of the 12 pilot sites interviewed were asked by the evaluation team to register a specific number of eligible service users within their specific client groups, half of which were to be allocated IBs. The target number was driven by the evaluation and associated with the number and type of client groups<sup>95</sup>. Table D.2 shows that for pilot sites who were asked to identify less than the average of 56 IB holders for the evaluation, the average set-up cost was £266,110 (median £238,170) compared with £318,440 (median £312,730), among sites who were asked to identify more than 56 IB holders.

Another potential cause of variation was the degree to which authorities already had moved towards a culture of supporting self-directed support. We would expect those authorities that had been *In Control* pilots and were most active in promoting direct payments to be more advanced in this area. In practice such authorities tended to estimate higher rather than lower costs of setting up IBs, suggesting that rather than a saving such authorities were possibly more able to identify the full resource implications of what was required.

**Table D.2 Variations in set-up costs**

	<i>Minimum set-up cost</i>	<i>Average set-up cost (excluding costs incurred as a result of the pilot process)</i>	<i>Maximum set-up cost</i>
<b>Number of client groups</b>			
2 or less	£128,470	£276,080 (Median = £283,060)	£467,610
3 or more	£195,050	£297,180 (Median = £266,350)	£486,460
<b>Number of service users required for the evaluation</b>			
Below average <sup>1</sup>	£128,470	£266,110 (Median = £238,170)	£467,610
Above average	£195,050	£318,440 (Median = £312,730)	£486,460

<sup>1</sup> Average number of IB holders per authority was 56.

<sup>95</sup> Local authorities who were addressing either transitions or service users suffering from a rare medical condition were not asked to reach a target number and therefore were not included in the analysis.

### **D.3 Additional costs for the second year**

Necessarily, there are limitations on the data that could be collected at this stage in the implementation. Clearly in many instances local authorities had to be speculative, particularly over how long the set-up period would last. As we identified above, some authorities identified at least a two year set-up period but others felt only one year would be needed. However, we would anticipate that it would take longer than one year to put in place all the support systems and to role IBs out to all, or all eligible, clients and they will need to run dual systems during this period. While our estimates are speculative we can draw on the data provided about the initial set-up period and information about the roles and activities that authorities have identified as critical to the implementation process.

We are assuming that additional resources for the set up process will only be required for one further year, although some authorities may well take longer to fully implement IBs. We anticipate that a project leader would continue to be needed to oversee the process at an average cost of £54,840. The project leader's responsibilities would involve the monitoring of the implementation progress and ongoing development of the resource allocation system, liaising with other agencies, supporting external brokerage arrangements, helping to manage the transition of resources from internal care management to external support, and advising on the transitional implications for market management. During the transition period, local authorities will need to maintain dual administration and financial accounting systems. We assume that this would require a part-time finance officer and part-time administrative support at an approximate cost of £30,000. In total this would suggest that local authorities would need approximately £84,840 to implement Individual Budgets within the second year of the process<sup>96</sup>.

As we identified above, we have focused on the costs incurred by local authorities. Theoretically, it would be expected that there will be further costs incurred by other funding organisations and it is clear that authorities were assuming support from CSIP in the introduction of IBs. These organisations will be best placed to provide estimates about their potential costs and the distribution of these costs over time.

### **D.4 Ongoing costs or savings**

We have concentrated on the set-up costs, however clearly there will be ongoing costs and cost reductions as a direct impact of introducing IBs. It is still early within the pilot process, so all views were very speculative. Five authorities reported that they anticipated a cost reduction in terms of assessment and support planning as a result of introducing IBs. When people either self-manage support planning or go to

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<sup>96</sup> Assumptions for the second year have not been verified and therefore could be amended.

external agencies there is at least theoretically less demand on care managers' time but will take some time before such 'savings' could be realised in practice. Moreover, while there may be some savings to the public purse as a result of families undertaking support planning, costs will continue to be incurred by care managers and other agencies where support is required.

Two authorities suggested that they were anticipating a cost reduction in terms of financial administration. While one authority suggested that the introduction of IBs would probably be cost neutral, a further authority suggested that the process may be more expensive. Five authorities suggested that they anticipated additional ongoing costs associated with monitoring and auditing of accounts.

## **D.5 Conclusion**

Clearly the estimated costs presented here are very speculative. The pilot authorities have been extremely helpful in providing their best estimates under difficult circumstances. While they are in the best position to estimate the costs, they were still in the midst of the process and were having to make assumptions in addition to simply not having undertaken some of the tasks yet. Their activities and understanding will have moved on since we undertook the fieldwork. With the limited number of authorities and wide range of approaches and arrangements, it was difficult to identify clear patterns in terms of factors affecting set-up costs.

It does appear that there is a scale effect in terms of the numbers of client groups and numbers of IBs that authorities are aiming to provide in the pilot period. Among the authorities there appears to be a level of agreement that addressing more client groups rather than less in the early stages would be more efficient, or at least more effective, as there is learning across groups. Table D.2 shows that at least in the short term, this method was more costly. However, what we are not able to observe (and will not be able to within the time-frame of the Pilot) are the knock-on costs of *not* addressing all client groups initially. However, the full evaluation should be able to shed some light on the effectiveness of alternative strategies within the time-frame of the Pilot.

# Evaluation of the Individual Budgets Pilot Programme

## Final Report

### About the evaluation

Individual budgets (IBs) were piloted as a new way of providing support for older and disabled adults and people with mental health problems eligible for publicly funded social care.

The Department of Health set up IB pilot projects in 13 English local authorities, running from November 2005 to December 2007, and commissioned a national evaluation.

This evaluation is the first robust UK study of the implementation and impact of personalisation approaches in social care.

### The research network

The Individual Budgets Evaluation Network (IBSEN) team who conducted this research are from:

**Social Policy Research Unit**, University of York

**Social Care Workforce Research Unit**, King's College London

**Personal Social Services Research Unit**, University of Kent

**Personal Social Services Research Unit**, University of Manchester

**Personal Social Services Research Unit**, London School of Economics

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