Direct Payments:
A National Survey of Direct Payments Policy and Practice

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May 2007
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Published on behalf of the Direct Payments Survey group by:

Personal Social Services Research Unit
London School of Economics and Political Science
Houghton Street
London
WC2A 2AE

ISBN 978-0-85328-072-9

Printed copies of this report are available (in monochrome format), price £12 including post and packing within the UK, from:
The Administrator
Personal Social Services Research Unit
London School of Economics and Political Science
Houghton Street
London
WC2A 2AE

It is also available for download free of charge from the DPS web pages:
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rev. 001

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Executive Summary

Introduction (section 1)

Three research teams collaborated to carry out a UK-wide survey of direct payments. One team came from the Personal Social Services Research Unit at the London School of Economics; another from the Universities of Leeds, Edinburgh and Glasgow; and a third team from the Health and Social Care Advisory Service, the Foundation for People with Learning Disabilities at the Mental Health Foundation and the Health Services Management Centre at the University of Birmingham. This report summarises the findings.

Direct payments: client numbers and implementation (sections 2–3)

Direct payments were found to be provided most commonly to people with a physical disability or sensory impairment, compared to other groups, and least commonly to people with a mental health problem, but there was considerable variation across local authorities, underlining how some local authorities have risen to the challenge of implementing user-centred care through direct payments while others lag behind.

A small number of authorities developed forms of direct payments well in advance of the national legislation, but there was a significant gap between their early use and widespread implementation.

Almost all authorities had introduced direct payments before the statutory duty took effect in 2003.

Direct payments: expenditure, intensity and one-off payments (sections 4–6)

There were wide variations in the proportion of local community care budgets spent on direct payments, both between areas and across user groups. These were largely reflected in the strength in developments for different users groups, for instance, 15.5% of the budgets of English authorities for people with a physical disability was spent on direct payments, compared to 1.1% for people with a learning disability, 0.8% for older people and 0.4% for people with a mental health problem.

Expenditure growth between 2003/04 and 2004/05 was notable for all user groups and for most parts of England, but nonetheless modest given the policy emphasis on encouraging the use of direct payments by people with social care needs.

There were notable differences in the relative expenditure on direct payments across user groups; on average, expenditure on direct payments to people with a learning disability was *lower* than expenditure for mainstream services for this group, whereas the opposite is the case for people with a physical disability; there was no discernible overall pattern for elderly people and people with a mental health problem. These may relate to the effects of standardised direct payment rates across user groups.

Direct payments provided to older people, people with a learning disability and people with a physical disability tended to be of high intensity (or average size). For instance, three quarters of recipients with a physical disability in England received funding equivalent to over 10 hours of support per week (and nearly one-third received 31 hours per week).

Approximately three-quarters of local authorities in England and Scotland had made one-off direct payments in the preceding year, but there were wide regional variations in the numbers of such payments; these were most often made to assist the purchase of respite care or equipment, or to meet the set-up costs of longer-term direct payments.

More authorities had made one-off payments to people with a physical disability than to any other group, but such payments were most commonly made to user groups for which direct payments provision was otherwise very low, such as carers and people with a mental health problem.

Direct payments: payment rates (section 7)

Local authorities were found to pay similar rates to all user groups, with the exception of people with a learning disability who received higher core hourly rates; there was nonetheless considerable variation in rates across the UK, with lower rates paid by local authorities in Northern Ireland and Wales, compared to England and Scotland; there were also variations across England.

Average weekly rates for people with a learning disability, people with a physical disability and disabled children were all considerably *lower* than the average unit costs of residential care for these groups, whereas the average weekly live-in rates for older people and people with mental health problems were significantly *higher* than average unit costs for equivalent residential care.

The majority of local authorities included the cost of tax and national insurance in the hourly rate and these costs accounted for a sizeable proportion of that rate. Few local authorities included start-up costs in the hourly rates and about half included an element for contingencies. Just over half of all local authorities in England, however, provided ad hoc or periodic payments to cover start-up costs, contingencies or other costs, such as employers' liability insurance.

The majority of local authorities offered some flexibility in their hourly rates, usually responsive to need, but occasionally according to location, most commonly in rural areas; this was a potentially important factor in ensuring equitable access to direct payments.

Most local authorities stated that their hourly direct payment rates were lower than the average costs of preferred independent sector domiciliary care providers, as well as lower than the costs of in-house domiciliary care. Some authorities paid higher rates to service users who wished to pay an agency.

Local commissioning practices and care management policies (sections 8–9)

Approximately half of all English local authorities devolved budgets to care management teams for individual-level spot purchasing, with similar rates of budgetary devolution across client groups; although there were wide differences between regions, there did not appear to be any relationship between budgetary devolution and the take-up of direct payments.

Only a minority of authorities operated a generic budget for direct payments, and patterns in their use did not conform to take-up patterns.

The use of ring-fenced budgets for direct payments varied between user groups; they were most common for services for people with a physical disability and for older people.

Once a care package had been set up, varying practices were found both across user groups and across regions in the extent to which people were referred on to care management review teams. This was most common in the case of older people, and least common for people with mental health problems and parents of disabled children.

Few authorities indicated whether it was their policy for people receiving direct payments to remain the responsibility of the assessing care manager. We were therefore unable to assess any impact on staff workload due to increasing numbers of people taking up direct payments.

The provision of support to direct payments users (sections 10–11)

The commissioning of support services seems to be relatively underdeveloped in that many English local authorities (about two-fifths) did not tailor payments to support organisations to the volume of users supported, the type of service provided or the levels of support provided to individuals.

There was a fall in the level of funding of support services in the year of the survey, relative to the previous financial year, which might be due to the substitution of local funds by those from the Direct Payments Development Fund.

A range of funding sources were used by local authorities to fund support services; only a very small number of authorities charged users for support services.

Around two-thirds of local authorities in England stated that they would, in principle, facilitate access to an alternative support provider at the request of a service user. This appeared to be linked to local supply, as areas with more support organisations seemed to offer more choice. There was much lower inclination to fund alternative support providers, likely to be due to a sense of already funding support and brokerage costs via the hourly rates.

Factors aiding or hindering the implementation of direct payments (section 12)

A number of factors were seen as critical to aiding the implementation of direct payments in England, with a fair degree of consistency across authorities. Many of these factors concerned the local organisational infrastructure: an effective support scheme, staff training and support, local authority leadership and the provision of accessible information for potential recipients. Other factors included positive staff attitudes, demand for direct payments from service users and carers and national legislation, policy and guidance.

Three factors were cited as hindering progress: concern about managing direct payments amongst service users and carers, staff resistance to direct payments and difficulties regarding the supply of people to work as personal assistants.

Conclusions (section 13)

Despite the striking growth in the take-up of direct payments since the 1996 Community Care (Direct Payments) Act, the varied implementation across the UK and between service user groups raises questions about the impact of devolved governance on equity and social justice for people supported by social care services.

Data on the growth of direct payments and the timing of policy developments suggest that central government initiatives have had considerable impact on the implementation of direct payments, including the shift to mandatory duties, the provision of development funding in England, and the introduction of performance targets and indicators.

But there appear to be limits to the impact of central drivers. Low take-up by certain groups may be partly attributed to uncertainties among staff about their roles and responsibilities in the wake of local service reorganisation, workload pressures and a sense that direct payments are more demanding on care coordinators' time. Lack of knowledge and understanding of direct payments among care coordinators are also major factors.

A key issue is the extent to which some localities have risen to the challenges inherent in the provision of direct payments, including the imbalance between direct payments and institutional modes of social care practice, giving rise to questions about the underlying structure and organisation of services.

The substantial variation in the intensity of direct payment arrangements between localities is notable. The fact that a sizeable proportion of payments entail high-intensity packages may allay some of the initial fears from the independent living movement and others that direct payments would result in lower levels of support for disabled people, but poses further questions for policy makers and purchasers.

The key question is which users are obtaining the high intensity payments: if resources are being allocated equitably, they should be serving people with particularly complex support needs, but demand may be skewed because of perceptions about the burden of administrative responsibility, raising questions about how the service is promoted by care managers; yet again, the Independent Living Fund threshold may have had the effect of driving package sizes upwards.

A further issue is how levels of service intensity and expenditure might change as the direct payment client base grows; it may be that as the number of direct payment holders goes up, expenditure per capita will tend to fall, raising questions about equity of access and support over time.

The limited provision of one-off payments is surprising, as is the fact that larger numbers of such payments were provided to groups with few ongoing direct payments. The limited use for which such payments were made suggests that they are underused as a mechanism for enhancing social inclusion (such as through access to education and employment support schemes).

The marked variations in hourly direct payment rates, and in what is included in those rates, is an indication of local authority autonomy and is partly driven by

market forces, but there would appear to be more variation than can be explained by the latter.

Concerns have been expressed about the rates being generally too low to allow direct payment users a fair stake in the market and difficulties in recruiting personal assistants have been noted in a number of studies, as well as in this survey; there is relatively little information on salary levels for personal assistants, but flexibility and transparency are paramount in setting rates.

The wide variations in the levels of funding of support organisations will be explored in further work; the decrease in average funding found by the survey has potentially enormous implications for service users at a time when demand for such services is rising, as well as having implications for support organisations themselves.

The evidence of widespread growth in purchasing through direct payments inevitably raises questions about the future impact on mainstream service commissioning in some service areas, particularly for services for smaller client groups. As yet, there is little evidence that direct payments are transforming commissioning strategies, except in areas of the highest uptake where efforts are being made to negotiate with providers to offer services to direct payments users in lieu of a proportion of their block contract.

The similar patterns in responses from local authorities and support organisations regarding the factors assisting and hindering implementation deserve attention, particularly the stress on local organisational infrastructure; authorities could do more to counter staff resistance to direct payments.

1 Introduction

Direct payments give greater control to people assessed as needing social care or support and form a key part of the agenda for the developing social care system (Department of Health 2005, 2006). But they also raise many challenges – for the individuals holding the budgets, for the people they employ, their families and other unpaid carers, local authority staff and the organisations set up to support them. As more people take up the opportunity to purchase their own services, including employing their own personal assistants (PAs), so the commissioning, provision and regulating functions of social care agencies may need to change. This report describes how local authorities across the UK are responding to the practical challenges of policy change.

Data collected in two UK-wide surveys allow us to explore how the national policy of direct payments has been implemented locally. This report documents the main parameters of such implementation: the numbers of people receiving direct payments, the funding they receive, the support they are offered and the typical utilisation of this service. It also identifies the challenges that will need to be met if this policy is really to achieve the objective of enhanced individual choice to which so many people subscribe.

Policy context

Direct payments legislation was implemented in England, Scotland and Wales in April 1997 under the Community Care (Direct Payments) Act 1996, and a year later in Northern Ireland, for people between the ages of 18–65 assessed as requiring community care (Department of Health 1997; Northern Ireland 1996; Scottish Office 1997). The legislation followed from what were previously isolated practices in parts of England and Scotland of providing indirect payments to service users through a third party, such as a voluntary organisation, to purchase personal assistance. Subsequent changes to the legislation have opened up access to a wider user population (Department of Health 2003a; National Assembly for Wales 2000; Scottish Executive 2003; Great Britain Northern Ireland Assembly 2002). This now includes older people, 16 and 17 year olds, parents of disabled children and carers, with the exception of the latter in Scotland.

Throughout the UK, direct payments must now be offered to everyone assessed as needing social care, but take-up has been very slow, particularly in Wales and Northern Ireland (Riddell et al. 2005). There has been considerable growth in uptake in Scotland and England since 2003, but relative to the overall sum of people receiving community care services, numbers remain very low. In England 27,700 were in receipt of direct payments between April 2004 and March 2005 (Health and Social Care Information Centre 2006); in Scotland, the equivalent figure was estimated to be 1,483 people, while in Wales it was 853 and 248 in

Northern Ireland (Scottish Executive 2005; Social Services Improvement Agency, Wales 2006; Department of Health, Social Services and Public Safety 2006). Since implementation, the largest group of direct payment users has consistently been those with a physical disability.

In an effort to encourage take-up among a more diverse client base, funding was made available both to promote the use of direct payments and to develop support schemes, widely recognised to be central to their use (Hasler 2005; Pearson 2004a, 2004b; Scottish Executive 2003). The Direct Payments Development Fund (DPDF) made available £9 million, allocated between 90 different partnerships of local authorities and voluntary agencies in England, representing approximately three quarters of all local authorities (Department of Health 2004). Funds for the first round of successful bids were issued in September 2003, with the second round of funding a year later, at the time the survey was sent out.

In Scotland, funds were channelled through *Direct Payments Scotland* (DPS), a non-governmental organisation set up with funding from the Scottish Executive in 2001, with a remit to increase access to information on direct payments and help establish support organisations. Funding to support organisations themselves was not, however, made available until April 2005 (after the survey), when the Executive allocated an additional £1.8 million to be distributed among local authorities in recognition of the additional costs associated with maintaining support roles. DPS ceased operating in December 2005.

In Wales, limited monies of £4,000 have been given by the Welsh Assembly to develop publicity for direct payments by local authorities in 2005. In Northern Ireland, no funding has been available to boost direct payments implementation and all direct payments support has centred on the work of the Centre for Independent Living in Belfast (CIL). Whilst the CIL has received funds from individual health and social service trusts to undertake these roles, no additional monies have been made available through the Department of Health, Social Services and Public Safety.

This survey was conducted prior to the launch of individual budgets in thirteen pilot sites across England. Individual budgets bring together resources from a number of funding streams, including local authority adult social care budgets, community equipment, housing adaptations, housing-related support through the Supporting People programme, the Independent Living Fund and Access to Work from the Department for Work and Pensions. People holding individual budgets can choose from a variety of funding mechanisms, including direct payments, brokerage arrangements or directly commissioned services. The pilots are currently being evaluated (Glendinning et al. 2006; Knapp 2007). Although there are obvious differences, the implementation experiences relating to direct payments as described in this report are likely to have relevance for the wider use of individual budgets.

Survey aims

Despite the policy emphasis on promoting direct payments and supporting the development of support schemes, very little is known about the degrees or forms of support available, or about the accessibility of support schemes to different user groups. The two surveys were therefore designed to collect up-to-date information about the local implementation of direct payments. One questionnaire was sent to every local authority in England, Scotland, Wales and Northern Ireland, and another to organisations that support people receiving direct payments. The objectives of the surveys were to:

- describe how national policies for direct payments have been implemented locally;
- map the resources that support people receiving direct payments;
- assess the conditions needed to support the implementation of direct payments;
- explore variations in how direct payments are structured and the apparent consequences;
- examine variations in the costs of supporting people receiving direct payments and assess how they might be linked to the quality and scope of the support being provided;
- identify best practice in the provision of direct payments support; and
- examine the effects of local resources on both the levels of uptake and the funding received by individuals receiving direct payments.

This report is primarily concerned with the first and second of these survey objectives. The remainder will be addressed in subsequent papers.

Report structure

This report is structured as follows. After describing the design of the two surveys and the response rates, the report sets out the main results of the local authority survey. (The results of the questionnaire to support organisation are contained in a separate report.) These include the number of people receiving direct payments from each of the main service user groups (Section 2); the timing of when local authorities first implemented direct payments (Section 3), as well as budgetary expenditure on direct payments (Section 4). In addition, we report data on the intensity of the direct payments packages (Section 5). We then describe how direct payments are structured, in terms of the use of one-off payments (Section 6) and hourly payment rates (Section 7). The report then examines wider local authority practices and procedures that may affect the implementation of direct payments for different user groups (Sections 8 and 9). Regional differences in arrangements for support services are reviewed, in terms of both funding commitments and flexibility in access to services (Section 10 and 11). Finally, the views of those completing the local authority survey on the factors deemed to have aided and hindered the implementation of direct payments are presented (Section 12).

Results are described by country throughout the report. Where relevant, they are also described by region (using the Commission for Social Care Inspection's regional divisions), and by local authority administrative type (metropolitan district council; unitary authority; shire county council; London borough; Northern Irish health and social services trust; Scottish council area and Welsh unitary authority). We use the generic term 'authority' for all these entities. Results are also given by service user group, where applicable.

Survey design: a collaborative process

The direct payments survey combines the work of three multidisciplinary research teams currently involved in national studies of direct payments: a team from the Personal Social Services Research Unit (PSSRU) at the London School of Economics (LSE); a team from the Universities of Leeds, Edinburgh and Glasgow; and a team from the Health and Social Care Advisory Service (HASCAS), the Foundation for People with Learning Disabilities (FPLD) at the Mental Health Foundation and the Health Services Management Centre (HSMC) at the University of Birmingham. Their research activities were funded respectively by: the Department of Health; the Economic and Social Research

Council (ESRC) and the Modernisation of Adult Social Care Initiative (MASC) of the Department of Health. Further information on these projects is given in the Appendices (see Appendix II). We also append the two questionnaires used in our surveys (see Appendix I).

The content of the surveys reflects early analysis of data collected in interviews with a range of stakeholders as part of ongoing fieldwork and emerging findings on patterns of national variation (Fernández et al. 2007; Ridell et al. 2005), coupled with an awareness of the limitations of official data. The surveys are designed to address research questions on direct payments structure, policy, practice and support. Questions on factors affecting implementation derive from insights gained from an extensive literature review (6 2005).

The survey instruments were thus built on a combination of existing research and key policy and practice concerns. Their validity and applicability were confirmed by piloting the questionnaires. This involved working with existing fieldwork contacts, comprising three local authority direct payment leads and three support organisation coordinators. Each was sent a questionnaire by e-mail in early September 2004, with a request for their assistance with the pilot exercise. On agreement, each respondent was followed up by telephone to discuss the appropriateness of the questionnaire and any questions deemed to be difficult to answer. This proved helpful in compiling the final versions of the questionnaires.

Alongside the tick-box questions, opportunities for comment and further explanation were incorporated into the questionnaires to assist the interpretation of responses and provide some additional qualitative data. Where any data provided seemed unclear to the team, for instance by being difficult to interpret, the relevant respondent was contacted for a brief discussion.

Survey execution: tactics for targeting and follow-up

It was our aim that the surveys should be censuses, covering all local authorities in England, Scotland, Wales and all combined health and social services trusts in Northern Ireland, together with all support schemes operating in England, Scotland, Wales, and Northern Ireland.

Because existing knowledge is patchy, it was a significant task in itself to get the surveys underway. A database of contacts within local authorities needed to be established, including the contact details of all direct payment leads (or those in similar positions). At the same time, an up-to-date list of organisations providing support to direct payment service users was compiled.

Comparison of data on the organisations supporting people receiving direct payments (compiled from data from the National Centre for Independent Living on the existing support organisations prior to the DPDF funding) showed that, since the announcement of the DPDF bid, there had been approximately a 45% rise in the number of schemes associated with the implementation of direct payments and/or providing support to people receiving direct payment services. The term ‘scheme’ is used here to denote support provided by an organisation in one local authority area; where organisations run schemes that span more than one authority, either via a number of local branches or via staff situated in differing areas, these are counted as more than one such ‘scheme’. For simplicity, the term ‘support organisation’ is used to refer to any surveyed support schemes.

Data were sought on the support provided by each scheme in each local authority (or health and social services trust) area. If a single organisation operated schemes within a number of local authorities, respondents were requested to complete a

questionnaire for each. This was to enable us to distinguish the intensity of services provided in each area, which could vary because of different service level agreements and different levels of funding from the authorities. Administrative variations between authorities could also be noted, since direct payments policies and practices are governed locally, suggesting that the experience of implementing direct payments might differ across local authority areas. In addition, for the purposes of consistency and comparability, it was necessary that data be provided only at the local authority level.

Surveys were sent by post to the direct payment lead of each authority and the coordinator of each direct payment support scheme, with a covering letter (see Appendix II) and a freepost return envelope, in the last week of October 2004, with a request for them to be returned within three weeks. A website was set up, providing electronic access to the survey forms and publishing questions and answers on each of the surveys. By late November, approximately one third of the local authorities and one third of the support organisations had returned their questionnaires. The team then undertook telephone follow-ups of all non-respondents. In early 2005, a letter from the Department of Health was sent to non-respondents to encourage participation before the final cut-off date of 31 January 2005.

At the time of the survey, insufficient data on DPDF funded projects were available to discriminate between schemes providing formal support for people receiving direct payments (as described in the questionnaire) and schemes set up only to promote the local implementation of direct payments (and therefore not providing direct support to people receiving such payments). Where we did not receive a response, or where a respondent indicated that the questionnaire was not relevant, we contacted the scheme to request brief details of the project, including why they were not providing formal support services and whether they would be doing so in the future.

Response rates

Response rates were generally good, although there was considerable variation between regions for both surveys (see Table 1.1). The highest response rate for local authorities was among those in the North West region (91%), with the lowest among those in the South West (50%). The regional pattern from support organisations was strikingly different, with responses particularly high among organisations in the West Midlands (86%), Yorkshire and the Humber (80%) and Wales (76%). The lowest response was from organisations in the East Midlands (29%).

Table 1.1: Regional variance in the response rate between regions for the local authority survey and support organisation survey

	Number of local authorities (LA) in region (%)	LA response rate (%)	Number of support organisations (SO) in region (%)	SO response rate (%)
East	10	60	13	54
East Midlands	9	67	11	27
London	33	82	39	56
North East	12	58	14	50
North West	22	91	33	45
South East	19	68	27	63
South West	16	50	20	65
West Midlands	14	79	14	86
Yorkshire and the Humber	15	87	20	80
ENGLAND (total)	150	74	191	59
NORTHERN IRELAND	11	27	1	0
SCOTLAND	32	25	25	32
WALES	22	14	17	76

Within England, variations in response rates to both questionnaires are much less striking by local authority type as in Table 1.2. (Northern Ireland, Scotland and Wales each only have one type of local authority.)

Table 1.2: Variance in the response rate in England to the local authority survey and support organisation survey shown by local authority administrative type

	Number of authorities per local authority type	LA response rate per local authority type (%)	Number of support organisations per local authority type	SO response rate per local authority type (%)
Unitary authority	47	62	56	50
London borough	33	82	40	55
Shire county	34	71	47	66
Metropolitan district	36	83	48	63

In many English local authorities, more than one support organisation provides services to direct payment service users. Table 1.3 reveals regional variations in the ratio of support organisations to local authorities; it can be seen that all but one region has more support organisations than local authorities, with the highest concentration of support organisations being in the North West (an average of 1.5 support organisations to every local authority). There was much less variation in the average number of support organisations per authority across local authority types (see Table 1.4).

Table 1.3: Average number of support organisations per local authority

	Number of local authorities in region	Number of support organisations in region	Average number of support organisations per local authority
North West	22	33	1.50
South East	19	27	1.42
Yorkshire and the Humber	15	20	1.33
East	10	13	1.30
England (TOTAL)	150	191	1.27
South West	16	20	1.25
East Midlands	9	11	1.22
London	33	39	1.18
North East	12	14	1.17
West Midlands	14	14	1.00
Scotland	32	25	0.78
Wales	22	17	0.77
Northern Ireland	11	1	0.09

Table 1.4: Average number of support organisations per local authority for all English local authority administrative types

	Number of authorities per local authority type	Number of support organisations per local authority type	Average number of support organisations per local authority
Shire county	34	47	1.38
Metropolitan district	36	48	1.33
London borough	33	40	1.21
Unitary authority	47	56	1.19

There is no clear relationship between the response rate from support organisations and the number of such organisations per region. Given that the surveys were conducted separately, it is necessary to be cautious when linking response rates. Nonetheless, it is notable that the response rates from support organisations in the East Midlands and the North West were especially low, compared both to the average (for England) and to the response rate from local authorities in those regions. The low response of local authorities in the South West can also be compared to a higher than average response from support organisations in that region.

None of the differences in response rates between local authorities and support organisations in England was as great as those in Wales. In Wales, 76% of support organisations returned their surveys, whereas only 14% of Welsh unitary authorities did so.

2 Implementation of Direct Payments Across the UK: client numbers

Introduction and overview

One of the most common issues raised in discussion of direct payments concerns the number of people receiving them. At the time of the survey both England and Scotland held national data collections providing annual or biannual snapshots of take-up, but in Northern Ireland and Wales there were no such routine collections. (Since this time the Local Government Data Unit for Wales and the Northern Ireland Statistics Office has made available systematic data on direct payments.) National data, where available, provide figures on the numbers of people in each of a number of service user groups in receipt of direct payments. In both absolute and relative terms, physically disabled people comprise the largest group. Some of the 'good practice' literature on direct payments helpfully complements these national statistics by describing examples of exceptional practice in a handful of local authorities. One aim of our survey, therefore, was to supplement existing statistics and descriptions, in particular to examine the pace, breadth and scale of implementation of direct payments. The first stage was to examine the patterns of uptake.

Key findings

- Generally, there are more people with physical disability or sensory impairment with direct payments than is the case for all other groups, but there was considerable variation across local authorities.
- The promotion of direct payments to people with a learning disability may have slowed down, amidst campaigns to promote access for other groups.
- The top five regions providing direct payments to people with a physical disability or sensory impairment were all associated with early forms of indirect payments to this group.
- The regional pattern of take-up of direct payments for older people mirrored that of people with a physical disability or sensory impairment, albeit on a lesser scale.
- The provision of direct payments to people with learning disabilities was strongest in the North West region, which also had high provision to carers of disabled children. Areas with some of the lowest uptake of direct payments to these groups included those which had above average take-up for the following user groups: physical disability or sensory impairment; older people and learning disabilities.
- There were fewer direct payments to people with mental health problems than to any other group. However, there were some examples of innovative practice, often among authorities from regions not having a long-standing history of the independent living movement or above-average take-up of direct payments. The same was true for carers, although different regions were involved.

The UK context

The disparities in uptake between user groups, as well as between countries within the UK, have been largely attributed to the staggered pace of policy implementation across user groups. As noted in section 1, the 1996 Act gave authorities the option to offer direct payments only to persons between the ages of 18 and 65 and in receipt of a community care assessment. This therefore provided access to such payments for adults with physical disabilities, adult mental health service users, and adults with learning difficulties. Changes in 2001 opened up access for older people, 16 and 17-year olds, parents of disabled children and carers (with the exception of Scotland where carers remain excluded from access to direct payments) (Department of Health 2003a). A mandatory duty to offer direct payments was introduced in England, Scotland and Northern Ireland in 2003, but not until November 2004 in Wales. Directives affecting all user groups were not officially implemented until March 2005, some six months after the completion of our survey.

The development of direct payments has also been promoted through financial support from the Department of Health, provided to around 68% of local authorities in England between 2003 and 2004. These funds were to support partnership enterprises between local authorities and voluntary sector agencies that had bid for funding. Such funding was intended to cover an 18-month period, starting either in September 2003 or September 2004 (Department of Health 2003b). However, this scale of financial support was limited to England (Pearson 2005).

English authorities have clearly led the way in terms of formal policy promotion, corresponding with a longer history of ground-level implementation (Pearson et al. 2005; Jolly 2004). There has been a longer history of disability activism in England, with greater pressures for independent living, including moves towards individual payments for personal assistance, compared to other areas of the UK (Barnes et al. 2000; Hasler et al. 1999). It is thought that such activism corresponds with patterns of provision, with some systems for indirect payments administered by local authorities having been introduced as early as the 1980s and early 1990s, largely to people with physical disabilities (Riddell et al. 2005). Such arrangements were particularly common in parts of the South and South East of England and in the Midlands.

In addition, while many English authorities have employed designated full-time direct payment coordinators, authorities in other parts of the UK have tended to employ people as direct payment leads but with only part of their time spent on this activity (Priestley 2005). This appears to be reflected in the response rates to our survey across the four countries of the UK, as well as in earlier efforts to obtain information on the take-up of such payments outside England (Jolly 2004).

Number of service users in receipt of direct payments within England, Scotland, Northern Ireland and Wales

Local authorities were asked to provide data on the number of people receiving direct payments in their authority by user group. The groups for which information was requested covered: older people; mental health service users; people with learning disabilities; people with a physical impairment, expressed in the survey as ‘physical disability’; people with a sensory impairment; disabled children; and carers.

The survey definition of people receiving direct payments included people receiving payments indirectly through pathways such as ‘circles of friends’ or through the support of trust mechanisms within the designated authority (or Health and Social Services Trust in Northern Ireland). People receiving monies from the Independent Living Fund (ILF) to direct their own services were

excluded. A number of authorities were able to provide only a combined figure for users with physical disabilities and sensory impairments, so for consistency this information is combined for all areas.

Table 2.1 displays the average numbers of people receiving direct payments by local authority in each of the four countries within the UK. Although the findings from Northern Ireland, Scotland and Wales cannot necessarily be considered fully representative, due to low response rates, they offer a reasonable base for analysing the dynamics of implementation of direct payments to the different user groups across the UK. It can be seen that the average number of people receiving direct payments was consistently higher for people with a physical disability or sensory impairment, and consistently lower for mental health service users.

Table 2.1: Average and maximum numbers of direct payments local authority, per user group within UK countries

		Older people	Mental health	Learning disabilities	Physical disability & sensory impairment	Disabled children	Carers
England	Average*	**16**	**1**	**11**	**47**	**8**	**1**
	Maximum	189	63	124	543	121	167
	Minimum	2	0	0	0	0	0
	Valid (N)	110	110	110	110	110	106
Northern Ireland	Average*	**8**	**0**	**1**	**15**	**0**	**0**
	Maximum	16	4	6	20	9	0
	Minimum	0	0	0	5	0	0
	Valid (N)	3	3	3	3	3	3
Scotland	Average*	**10**	**0**	**4**	**14**	**3**	**Not available in Scotland**
	Maximum	24	2	8	32	7	
	Minimum	1	0	1	5	0	
	Valid (N)	3	3	3	3	3	
Wales	Average*	**1**	**1**	**3**	**15**	**0**	**0**
	Maximum	2	2	4	21	2	0
	Minimum	0	0	0	6	0	0
	Valid (N)	3	3	3	3	3	3

* The figures present the median average instead of the mean due to the presence of outliers or extreme values.

It is widely recognised that mental health service users have the greatest difficulty of all user groups in accessing direct payments (Newbigging and Lowe 2005; Spandler and Vick 2004; Heslop 2001). From our data, it would appear that the statutory requirement to offer direct payments to this group made *no* substantial difference to the level of provision. Provision in Wales was no lower than elsewhere in the UK (except England where take-up was generally higher) despite that country being the last to impose a statutory duty on local authorities to offer direct payments to all user groups. (Although the survey data from Northern Ireland, Scotland and Wales were very limited, this picture is consistent with wider findings and feedback from local authority personnel from these countries; see Priestley 2006.) Moreover, provision across all four countries was almost non-existent, with only a few authorities in England making any payments to this group. Nonetheless, a few did so, suggesting that the barriers to implementing direct payments for them can be overcome. In contrast, the statutory duty to offer direct payments to older people did seem to make a difference, as the average number of people receiving such payments in Wales was significantly lower than in England, Northern Ireland and Scotland – confirmed by reports from authorities in these countries (Priestley 2005).

The provision of direct payments to disabled children and to carers was generally low, although in this regard authorities in England were more proactive than authorities (and trusts) elsewhere. Despite the general predominance of provision

of direct payments to people with a physical disability or sensory impairment in England, it is notable that some authorities provided no such payments at all. Indeed, direct payments to this group varied enormously across authorities in England, from none to 543.

Variability in the numbers of service users receiving direct payments in England

Table 2.1 depicts average numbers of people receiving direct payments by user group for local authorities. Focusing particularly on the dynamics of uptake in England (due to the low response rate for other countries in the survey), it is striking that, on average, the number of payments to older people has surpassed those to people with learning disabilities. This remains true after taking account of population size (see Table 2.2). Nonetheless, direct payments to older people accounted for only 0.6% and 0.7%, respectively, of older people in receipt of community care in the periods April 2003–March 2004, and April 2004–March 2005, respectively (see Tables 2.3 and 2.4).

Table 2.2: Average number of direct payments per local authority, per million inhabitants

	Valid (N)	Older people	Mental health	Learning disability	Physical disability and sensory impairment	Disabled children	Carers	ALL
England (regions)								
East	6	91	32	55	287	69	24	558
East Midlands	7	74	7	41	194	18	9	343
London	27	67	9	33	181	38	21	349
North East	9	44	11	42	149	35	4	285
North West	17	74	11	89	208	109	9	500
South East	14	90	19	42	238	39	27	455
South West	7	66	5	51	238	42	6	408
West Midlands	11	63	6	43	189	32	64	397
Yorkshire and the Humber	12	52	6	35	139	44	6	282
England (LA type)								
Unitary authority	29	82	10	51	231	42	28	444
London borough	27	67	9	33	181	38	21	349
Shire county	24	79	15	52	226	53	23	448
Metropolitan district	30	56	9	50	165	55	11	346
Northern Ireland	3	7	1	2	11	2	0	23
Scotland	8	21	1	8	36	7	0	73
Wales	3	1	1	2	12	1	0	17
England (regions)	110	71	12	48	205	50	20	406

Table 2.3: Proportion of total numbers of community care service users receiving direct payments, per user group, 2003–2004

	Older people (65+)[a]	Mental health (18–64)	Learning disability (18–64)	Physical disability (18–64)	Sensory impairment (18–64)	Disabled children and carers of disabled children	Carers
Number of direct payment users	5700[b]	400[b]	1,800[b]	6,800[b]	370[b]	Not known	Not known
Total number of service users for the client group	631,500[b]	105,000[b]	84,000[b]	96,000[b]	9,600[b]	Not known[c]	Not known
% service users receiving DP	**0.9%**	**0.4%**	**2.1%**	**7.1%**	**3.9%**	**Not known**	**Not known**

a Excluding people aged 65+ for the categories 'substance misuse' and 'vulnerable people'.

b Source: Health and Social Care Information Centre (2006a) Community Care Statistics 2004–2005: Referrals, Assessments and Packages of Care, for adults: Report of findings from the 2003–04 RAP collection – information for England for the period 1 April 2004 to 31 March 2005. Available at: http://www.ic.nhs.uk/pubs/commcare05adultengrepcssr/Final%20National%20Tables%202004_05.xls/file. Accessed 8 March 2006.

c 19,097 children received community care services. A further unknown number received care only from their parents who may or may not have received a direct payment as a carer of a disabled child (2004 figures). In the year ending 31 March 2004 out of 84,500 children looked after at any time during the year (excluding those who received short-term placements) only 13% of children were recorded as being looked

after because of their disability, amounting to 10,985 children. However, a further 10,400 children were looked after exclusively through short-term placements. Of these 78% were for reasons of the child's disability, amounting to 8,112 cases. In addition to these 10,400, an unknown number of children who were looked after by local authorities will have had a disability but this will not have been recorded as being the main or principal reason for them being looked after by social services. This means they cannot be identified from the data as having a disability.

Table 2.4: Proportion of total numbers of community care service users receiving direct payments, per user group, 2004–2005

	Older people (65+)[a]	Mental health (18–64)	Learning disability (18–64)	Physical disability (18–64)	Sensory impairment (18–64)	Disabled children and carers of disabled children	Carers
Number of direct payment users	7,180[b]	1,000[b]	3,300[b]	8,850[b]	650[b]	2757[b,c]	3185[d]
Total number of service users for the client group	967,900[b]	160,200[b]	92,000[b]	143,000[b]	13,900[b]	Not known	Not known
Per cent of service users receiving DP	0.7%	0.6%	3.6%	6.2%	4.7%	Not known	Not known

a Excluding people aged 65+ for the categories 'substance misuse' and 'vulnerable people'.

b Source: Health and Social Care Information Centre (2006a) Community Care Statistics 2004–2005: Referrals, Assessments and Packages of Care, for adults: Report of findings from the 2003–04 RAP collection – information for England for the period 1 April 2004 to 31 March 2005. Available at: http://www.ic.nhs.uk/pubs/commcare05adultengrepcssr/Final%20National%20Tables%202004_05.xls/file. Accessed 8th March 2006.

c Of which 492 were to disabled children aged 16–17, and 2265 were to carers (e.g. parents) of disabled children.

d Health and Social Care Information Centre (2006b) Personal Social Services Expenditure and Unit Costs: England 2004–2005.Detailed activity data by council 2004–2005. Available at: http://www.ic.nhs.uk/pubs/persocservexp2005/Detailed_activity_data_by_council _2004-05.xls/file. Accessed 8th March 2006.

Source: Education and Skills (2005) Children Looked After by Local Authorities, Year Ending 31 March 2004 (Internet only). Available at: http://www.dfes.gov.uk/rsgateway/DB/VOL/v000569/index.shtml. Accessed 4 February 2006.

The average number of direct payments made to parents (or carers) of disabled children was almost equivalent to those made to people with learning disabilities, as shown in Table 2.1. This is also the case when looking at uptake per million inhabitants (as shown in Table 2.2). Indeed, in a number of regions, uptake to disabled children per million inhabitants surpasses that of people with learning disabilities. This was unexpected given that parents of a disabled child (and disabled children aged 16–17) have been considered to be a highly marginalised group, for whom access to direct payments was thought to be poor. It would appear that the provision of direct payments to people with learning disabilities has (relatively speaking) slowed down, perhaps in response to high-profile campaigns on behalf of other groups. Relative to the total number of people with learning disabilities in receipt of community care services, people with learning disabilities still appear to comprise the second largest group for direct payments uptake (see Table 2.4), but comparison with proportional uptake for disabled children (aged 16–17) and carers of a disabled child is inhibited by a lack of a definitive number of potentially eligible clients. Statistics show only numbers of children looked after by authorities, whereas many families with disabled children that may be eligible for services (and thus direct payments) do not choose to use mainstream services. In the year ending 31 March 2004 there were 19,700 children being looked after by local authorities due to disability (Department for Education and Skills 2005), but there were an estimated 770,000 children in the UK using the 'widest survey definition'(Prime Minister's Strategy Unit 2005).

Regional patterns in people receiving direct payments per client group

It is important to adjust for differences in population base when comparing average numbers of direct payments by region or local authority type. When we adjust for population size we see that unitary authorities have the highest averages for the physical disability and sensory impairment group and older people (see Table 2.2). Shire counties also have high per capita numbers. Further research has found that take-up of direct payments among people with physical or learning disabilities is greater in areas with lower population densities (generally shire counties) indicating that rurality may be a factor, possibly because direct

payments have provided a solution where the provision of and access to services is difficult (Fernández et al. 2007). Regional patterns are important. In the following paragraphs we consider how patterns in provision of direct payments differ between user groups.

Direct payments to people with a physical disability or a sensory impairment

Table 2.2 shows that there is a striking variation in the average number of direct payments to people with a physical disability or sensory impairment (taken as a group), per million inhabitants by local authorities in different regions. Generally there is less variation in levels of provision between local authority types. The range in average number of direct payments per million inhabitants to this group was from 181 (London boroughs) to 231 (unitary authorities). The top five regions in terms of average numbers per million inhabitants were among those most closely identified with a history of activism around direct payments. These include (in this order): the East, the South East, the South West, the North West and the East Midlands. This correspondence is particularly notable for this user group. The lowest level of per capita provision was in the North East and the Yorkshire and Humber regions.

In terms of the absolute numbers of direct payments provided there was often a wide distinction between average practice and the practice of those local authorities with the most and least direct payment users within each region (see Table 2.1). This variance was greater for the physical disability and sensory impairment group than for any other. Although these variations partly relate to differences in the size of local authorities they clearly go beyond this. For example, although there were some exceptional levels of provision in the East and South East, local authorities from these regions also revealed some of the lowest minimum numbers of direct payments per authority. The only region in which there were consistently high numbers of people receiving direct payments across all authorities was the East Midlands.

Direct payments to older people

The average per capita number of older people receiving direct payments, by region, was found to correspond almost exactly to the pattern of take-up by people with a physical disability or sensory impairment, albeit on a different scale (see Figures 2.1 and 2.2). This relationship is confirmed by further research (see Fernández et al. 2007). Again, the region with the lowest level of provision was the

Figure 2.1: Average number of people with a physical disability or sensory impairment receiving DP per local authority per million inhabitants, by region

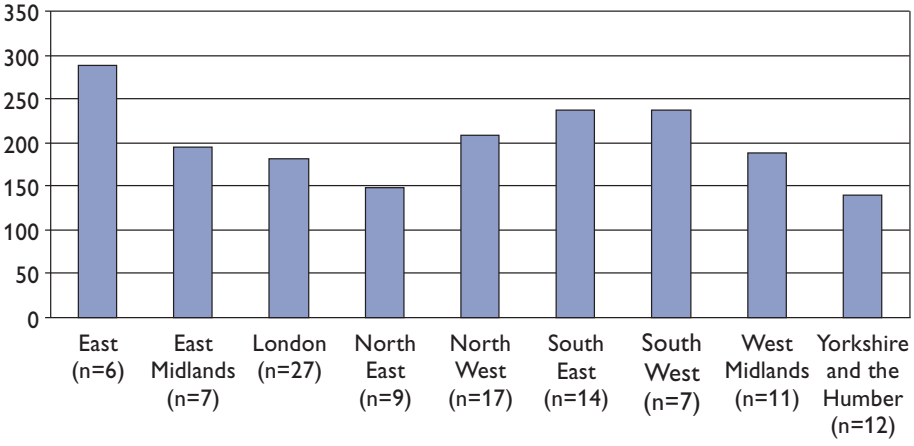
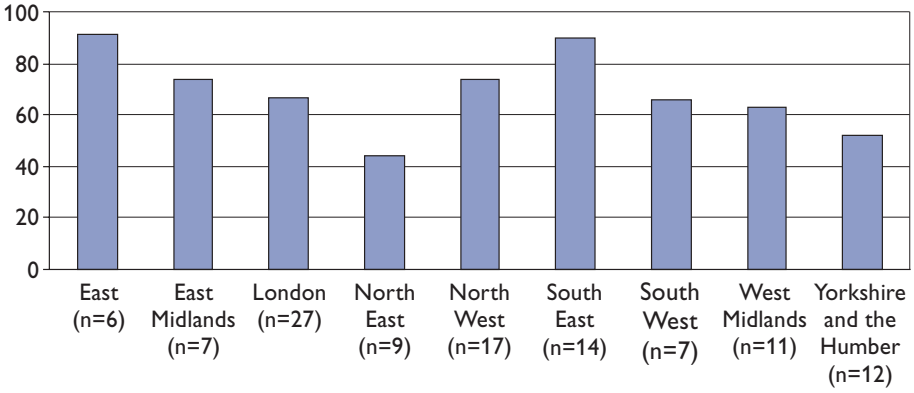


Figure 2.2: Average number of older people receiving DP per local authority per million inhabitants, by region

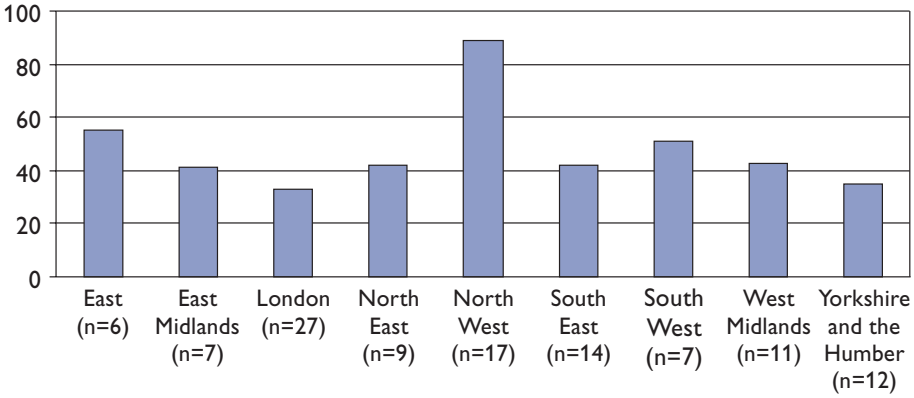


North East, and the highest provision was in the East. As with the physical disability and sensory impairment user group, there was less variation in the average number of direct payments to older people between authority types than between regions (see Table 2.2).

Direct payments to people with learning disabilities

The highest average number of people with learning disabilities receiving direct payments, per million inhabitants, was in the North West (see Figure 2.3). More surprisingly, the East and East Midlands did not show above average uptake per million inhabitants. This may suggest driving forces in the region that were specific to this user group. Possible explanations include varying histories of service redesign or varying pressures from local agencies working with people with learning disabilities. Interestingly, unlike the two user groups previously discussed, for people with learning disabilities uptake by metropolitan authorities was on a par with that of shire councils and unitary authorities, although the distinction between local authority types was less than it was for regions (Table 2.2). As with the previous user groups, the North East had the lowest per capita average number of recipients.

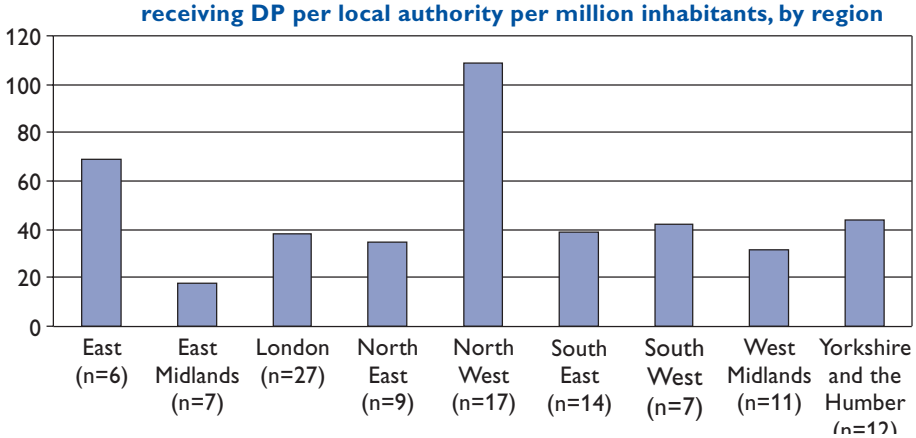
Figure 2.3: Average number of people with a learning disability receiving DP per local authority per million inhabitants, by region



Direct payments to the parents or carers of a disabled child

The regional pattern of direct payments to the parents (or carers) of a disabled child was most similar to the regional pattern for people with learning disabilities, as can be seen in Figure 2.4, but quite different from the patterns for people with a physical disability or sensory impairment and older people. Unexpectedly,

Figure 2.4: Average number of disabled children or parents of a disabled child receiving DP per local authority per million inhabitants, by region



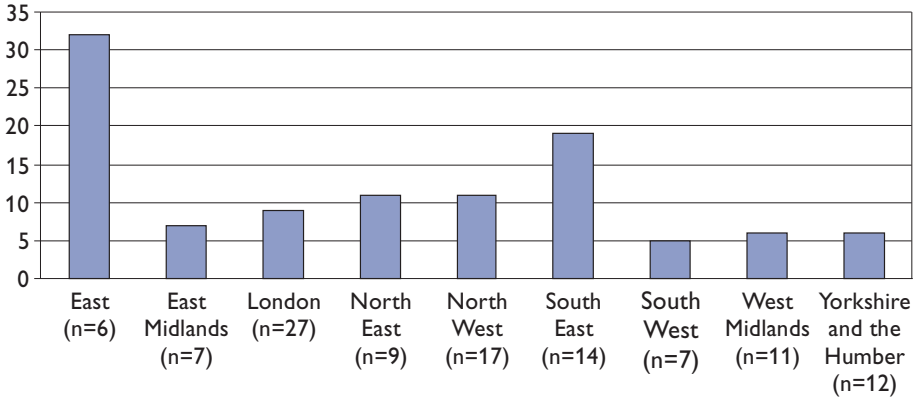
authorities in the East Midlands had fewest average direct payment recipients per million inhabitants, considerably lower than in the North East (which had an uptake of 35 per million inhabitants), which is generally associated with lower levels of uptake. The highest number of payments were found among authorities in the North West (109 per million inhabitants). Metropolitan district councils had a slightly higher uptake per million inhabitants for this group than other authority types, but there was much less variation between local authority types than between regions.

The similarity in regional patterns of payments to the parents (or carers) of disabled children and payments to people with learning disabilities is interesting, since provision to the latter may have tailed off. It may be that local authorities have now shifted their attention from one to the other. Local authorities suggest that the growth in uptake to disabled children is due to their popularity among children in transition aged 16–17, since direct payments help young adults maintain access to the same degree of personalised services that they probably became accustomed to as children and thus helps to smooth their transition between children's services and adult services. Nonetheless, between April 2004 and March 2005 only 492 young adults were receiving a direct payment (see Table 2.4).

Direct payments to mental health service users

The provision of direct payments to mental health service users was strikingly low. In absolute numbers this ranged by region from an average of one to four people per local authority (see Figure 2.5). This was the lowest for any user group, consistent with publicly available figures in England. A few authorities did make

Figure 2.5: Average number of mental health service users receiving DP per local authority per million inhabitants, by region

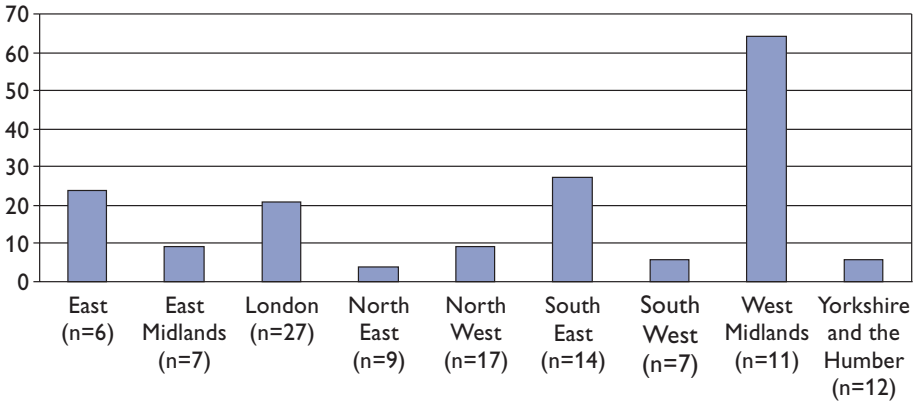


sizeable provision to this group, with one authority in the Eastern region providing direct payments to 63 mental health service users, and one authority in the North West providing 53 direct payments to this group. However, all but one region had at least one authority providing no payments – indeed almost one third of local authorities in England were making no payments to this group at the time of the survey (Murray-Neill 2006). Per million inhabitants, the average number of direct payments provided to mental health service users ranged from six in the West Midlands and the Yorkshire and Humber region to 32 in the East, with an average of 12 overall for England; but these averages mask the full extent of disparity in provision. It has been estimated that just 11 authorities were making over half the national total of direct payments provided in March 2005 (Murray-Neill 2006). Despite the concerns these disparities raise, the exceptional practice of some authorities does prove that access to direct payments in lieu of a mental health service can be significantly improved. However, there are questions to be asked regarding the low level of provision to this group, even by those authorities that have generally implemented direct payments to others.

Direct payments to carers

Carers present the most ambiguous case in patterns of uptake, with no conformity to the patterns of other groups, as can be seen in Figure 2.6. Although overall provision of direct payments was extremely low, there were some notable exceptions. In terms of absolute numbers, although four of the nine English regions recorded averages of zero, the maximum number of direct payments provided to carers from any one authority was 167 (in the West Midlands). Per million inhabitants, the average number of direct payments provided to carers ranged from four in the North East to 64 in the West Midlands with an average of 20 overall for England. The second highest average was considerably lower than that of the West Midlands (27 per million inhabitants), proving that uptake in the West Midlands was particularly high. This is interesting as the West Midlands has not generally been associated with more proactive developments in direct payments and may suggest that specific forces have driven the development of direct payments to carers as a group in this region. The three recorded averages above 20 were from the South East, the East and the East Midlands. The lowest number of direct payments to carers per million inhabitants was found in the South West and North East (6 and 4 per million inhabitants).

Figure 2.6: Average number of carers receiving DP per local authority per million inhabitants, by region



3 Implementation of Direct Payments Across the UK: earliest provision

Introduction and overview

In the previous section we noted some quite different patterns of take-up of direct payments for different user groups. We now turn to the related question of date of first implementation. We asked local authorities to tell us when they first provided a direct payment to each of the main user groups. This allows us to examine the spread of direct payments to each user group, for example, to establish whether proactive stances on the part of some local authorities towards some user groups appeared to carry through to other groups.

Key findings

- A handful of pioneering authorities developed forms of direct payments well in advance of the national direct payments legislation.
- There was a significant time gap between the first instances of direct payments and their widespread national implementation. However, almost all authorities had introduced direct payments before the statutory duty took effect in 2003.
- The East Midlands has an exceptional history of early implementation.
- There was more variation in the date of initiation for people with learning disabilities than for people with physical disabilities.
- Implementation of direct payments to people with a sensory impairment was considerably later than for the physical disability user group and significantly more variable.
- Direct payments for older people had been widely implemented before the statutory duty took effect (albeit with very low levels of take-up). The 2003 requirement has brought progress.
- Direct payments to disabled children (aged 16–17) and carers of disabled children were initiated relatively late. Despite this, they appear to have developed quickly.
- Payments to mental health service users were initiated earlier than would be expected given the extremely low levels of take-up today.
- Very few authorities appeared to have implemented direct payments to carers. The local authorities providing best access to carers were generally not the same authorities otherwise prominent in terms of direct payments provision to other groups.

Dates of first implementation of direct payments

Local authorities in England were the first within the UK to provide direct payments to all user groups, with at least one authority having provided direct payments to almost all user groups by 1998 (Table 3.1). All earliest dates of implementation were therefore both prior to the mandatory implementation of

direct payments in 2003, and prior to widespread policy promotion or financial support to develop direct payments. The results confirm the presence of early forms of direct payments in a number of authorities.

Table 3.1: Date of earliest recorded direct payment by per user group for any one local authority within each country in the UK

	Older people	Mental health	Learning disability	Physical disability	Sensory impairment	Disabled children	Carers
England	1990	1990	1993	1981	1989	1998	1998
Valid (N)	99	73	96	101	62	81	54
Northern Ireland	2003	–	2003	1997	–	2004	–
Valid (N)	2	–	2	3	–	1	–
Scotland	2002	2003	1997	1997	2003	2003	Not applicable
Valid (N)	6	2	7	7	1	6	–
Wales	2001	2002	2002	1997	–	–	–
Valid (N)	2	2	2	3	–	–	–

Payments to the physical disability user group were first made in 1981. Older people and mental health service users first accessed direct payments in 1990, while the learning disability user group first accessed a form of direct payments three years later. On average, however, the widespread introduction of direct payments occurred rather later (see Table 3.2). The more detailed figures in Table 3.3 give the year when a direct payment was first made to each user group.

Table 3.2: Average date of first recorded direct payment per user group for the UK

	Older people	Mental health	Learning disability	Physical disability	Sensory impairment	Disabled children	Carers
England	2001	2002	2001	1999	2001	2003	2002
Valid (N)	99	73	96	101	62	81	54
Northern Ireland	2002	–	2002	1998	–	Not applicable	–
Valid (N)	2	–	2	3	–	1	–
Scotland	2003	2003	2003	2003	Not applicable	2003	Not applicable
Valid (N)	6	2	7	7	1	6	–
Wales	2001	2002	2003	1999	–	–	–
Valid (N)	2	2	2	3	–	–	–

Not all English authorities were able to tell us when they had first provided direct payments. Low response rates were found in particular for mental health service users, people with sensory impairment, disabled children and carers. This underlines the findings discussed in Section 2 suggesting that some local authorities had not provided any direct payments to these user groups.

There was a low rate of return of questionnaires from other parts of the UK. Responses do, however, suggest that initial payments were also first made to the physical disability user group. Overall, direct payments appear to have been initiated much later than in England. For example, the average date at which a first payment was made to people from the physical disability user group in Scotland was 2003. As in England, the lack of data for a number of user groups suggests that direct payments had probably not been implemented by the time of the survey to many user groups. This hypothesis has been confirmed in other research (see Priestley 2005).

For none of the service user groups did we find any strong differences in date of implementation between authority types in England.

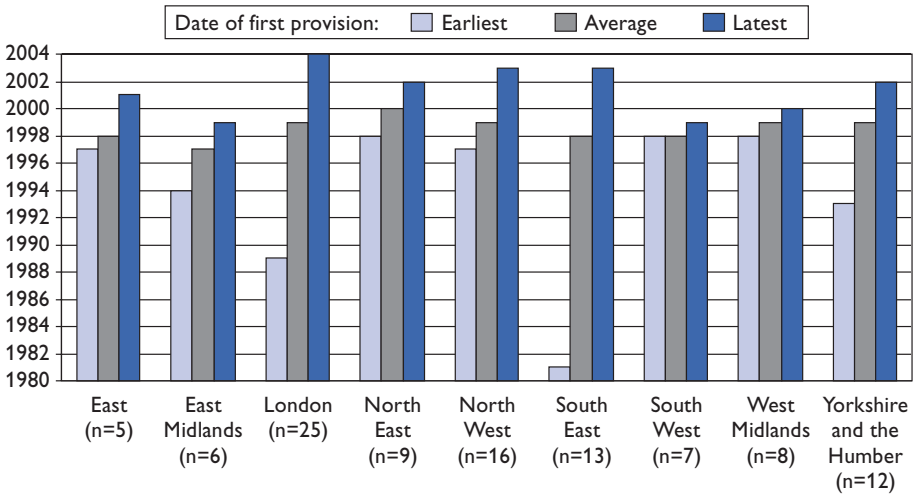
Table 3.3: Date of first introduction of direct payments, by user group

	Older people	Mental health	Learning disability	Physical disability	Sensory impairment	Disabled children	Carers
1980							
1981				1			
1982							
1983							
1984							
1985							
1986							
1987							
1988							
1989				1	1		
1990	1	1			1		
1991							
1992							
1993		1	1	1	1		
1994	1			2			
1995	1	1	1	1			
1996				3	1		
1997	1	2	4	15	3		
1998	1	4	5	25	6	1	1
1999	4	2	7	19	8		
2000	22	9	16	10	7	2	4
2001	24	4	21	12	5	11	4
2002	29	20	18	12	9	21	10
2003	17	10	20	8	8	21	15
2004	7	23	13	1	13	32	21
Total	108	77	106	109	62	88	55

People with physical disabilities

All but one of the regions in England first introduced direct payments to people with physical disabilities within one year of the 1998 legislation, which made direct payments legal for people between aged 18–65 (see Figure 3.1). The only exception was the North East region (average date 1999).

Figure 3.1: Timing of provision of direct payments to people with physical disabilities among regions in England



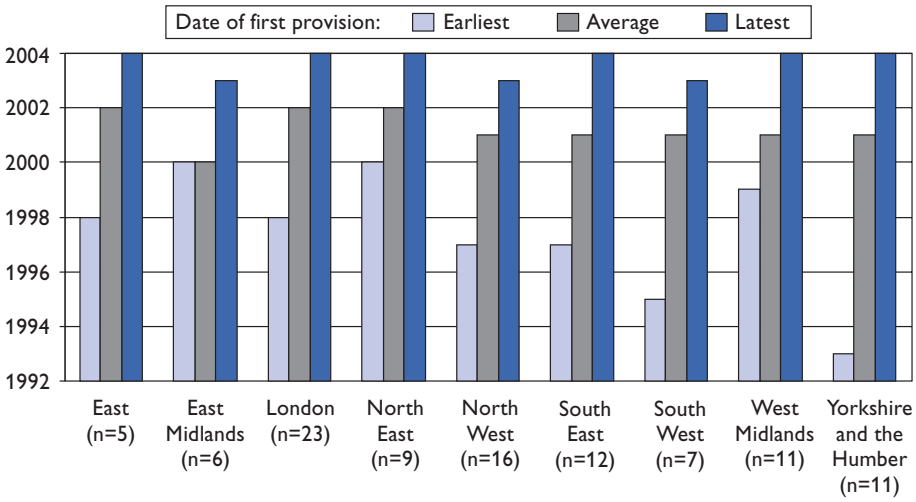
A majority of authorities in the East Midlands appear to have implemented direct payments for people with physical disabilities relatively early. This was the only region with an average date of initial payment predating the 1998 legislation (the first payment by a local authority in the East Midlands to this group was in 1994). First implementation for some other regions was earlier than had occurred in the East Midlands, but figures show far more variation in timing of implementation across those regions. An example of this is the South East, where an early form of direct payments was initiated in 1981 but where the regional average date for first providing direct payments to people with a physical disability was 1998. In London and in the Yorkshire & Humber region, similar patterns are seen. This suggests that the early initiation of direct payments by one (or more) authorities in these regions did not stimulate the development of direct payments in neighbouring local authorities, as may have occurred in the East Midlands.

Implementation of direct payments generally seems to have been later in the North East which notably also had lower per capita numbers of direct payments clients per million inhabitants from this group (and others).

People with learning disabilities

As was found for the physical disability group, some authorities introduced direct payments for people with learning disabilities prior to the 2003 legislation. In contrast, however, direct payments for people with learning disabilities were not generally started until the period 2000–2002. Many local authorities did not introduce direct payments for people with learning disabilities until 2004 (see Figure 3.2). Overall, the results therefore suggest a slower and more variable pace of implementation of direct payments for people with learning disabilities than for people with physical disabilities, and the regions identified as pioneers in relation to one group are different from the pioneers with the other group.

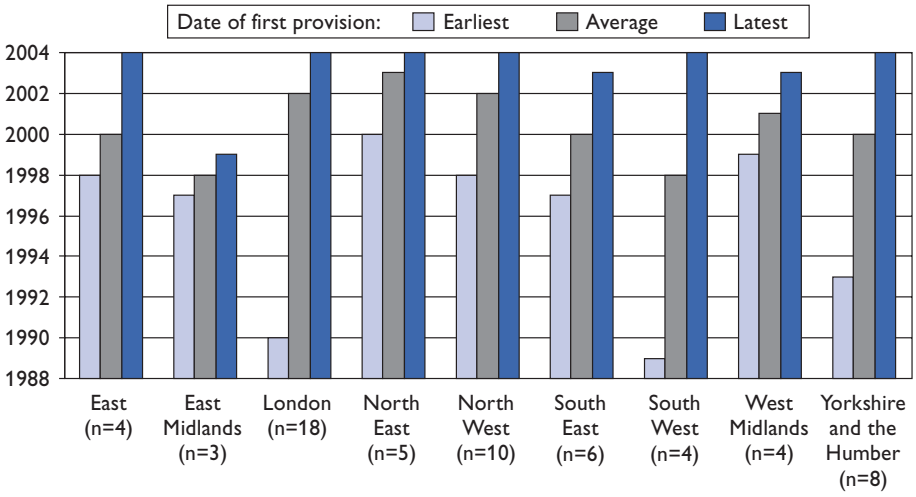
Figure 3.2: Timing of provision of direct payments to people with learning disabilities among regions in England



People with sensory impairments

At least one local authority in five out of the nine English regions initiated direct payments to people with sensory impairments prior to the implementation of the direct payments legislation (see Figure 3.3). The earliest was a local authority from the South West, which began providing the service in 1989. This contributed to the average date of initial payment for the South West being the earliest for all regions (1998), alongside the East Midlands.

Figure 3.3: Timing of provision of direct payments to sensory impairment users among regions in England



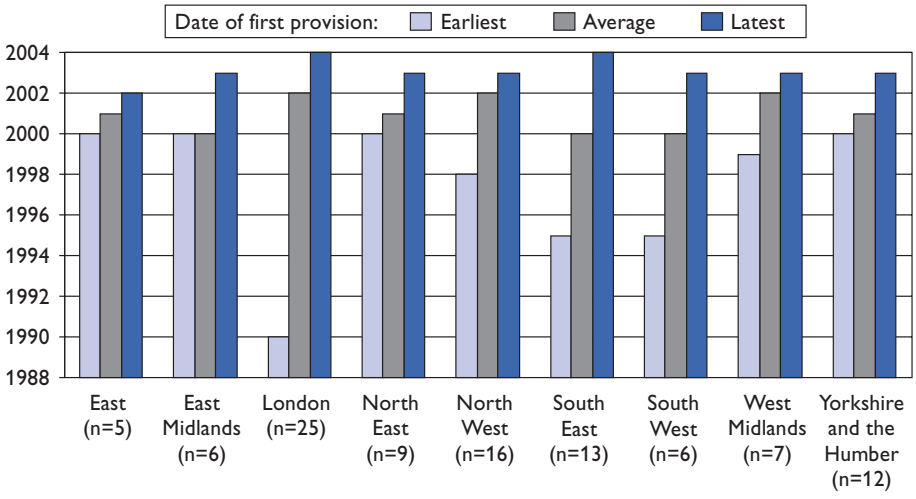
Overall, the typical date of first payment varied much more widely for this group than for the physically disabled group (see Table 3.2) and generally implementation was also later.

The East Midlands region includes a large number of pioneering local authorities in the provision of direct payments for people with sensory impairments. The last region to implement direct payments for this group was the North East, where numbers of people with direct payments are also low (see section 2).

Older people

The low take-up of direct payments by older people was the driving force behind the introduction of a statutory duty to offer direct payments to all eligible clients from 2003 onwards. From Figure 3.4 we can see that initiation of direct payments most commonly occurred between 2002 and 2004, suggesting that implementation to older people was fairly widespread before the imposition of a statutory duty, albeit with very low levels of take-up. However, the results also indicate that a number of local authorities began offering direct payments to older people during 2003, probably encouraged by central government.

Figure 3.4: Timing of provision of direct payments to older people among regions in England

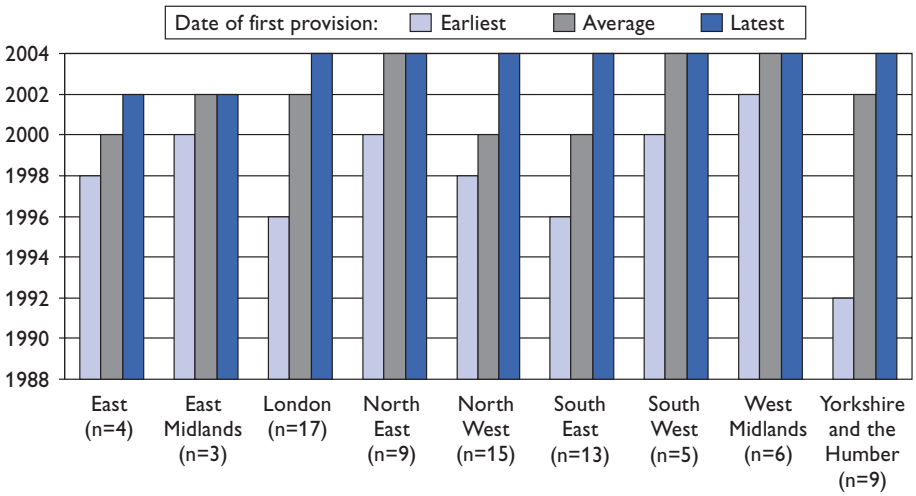


In a number of areas, the first recorded payment to older people was actually made before it became legal to offer direct payments to this group. The first older people to receive direct payments may have been physically disabled people who reached age 65.

Disabled children (aged 16–17) and carers of disabled children

The introduction of direct payments for disabled children and their carers occurred quite late, generally in the period 2002–2004 (see Figure 3.5). Subsequently, as we saw in section 2, per capita uptake has been relatively rapid.

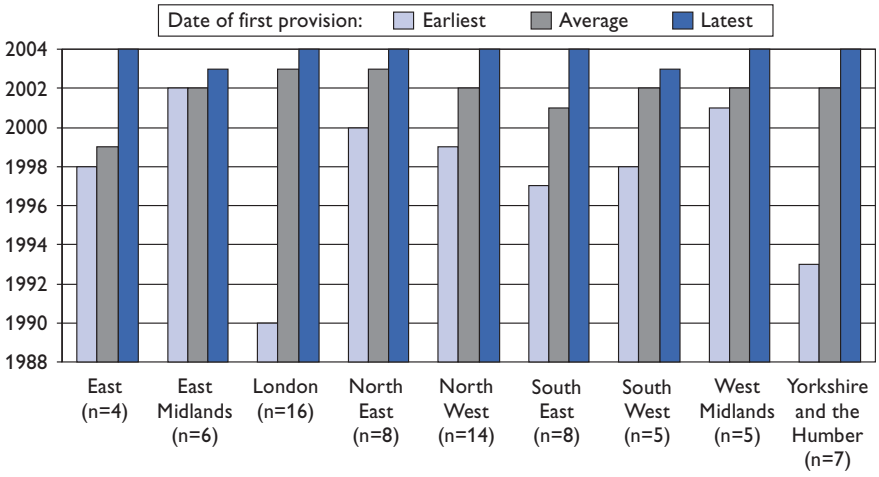
Figure 3.5: Timing of provision of direct payments to disabled children among regions in England



Mental health service users

Unlike the pattern for disabled children, the survey results suggest considerable variability in the date direct payments were first introduced for people with mental health problems. The earliest date noted by survey respondents was 1990 (see Table 3.3). This relatively early introduction contrasts with very low take-up levels for this group (see Section 2).

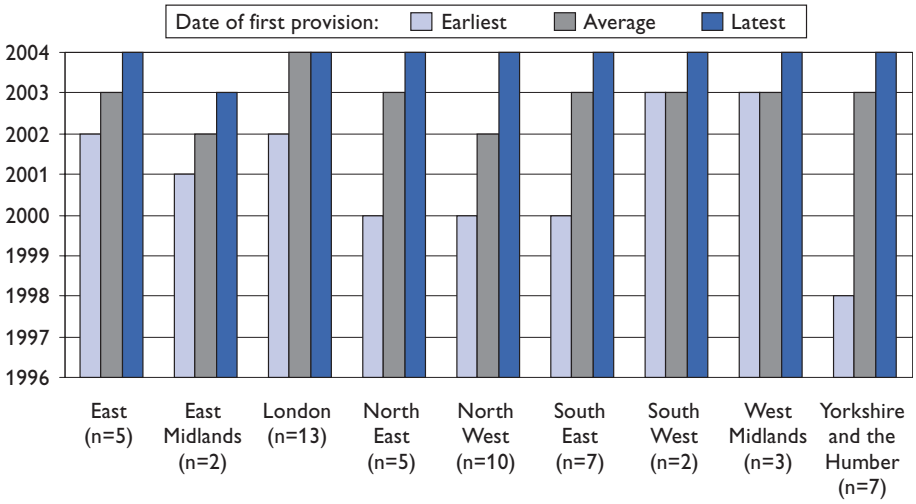
Figure 3.6: Timing of provision of direct payments to mental health service users among regions in England



Carers of adults

Very few authorities indicated the date when they first implemented direct payments for carers. It is most likely that this was generally due to the absence of direct payments to this group. In Section 2 we stated that it appeared that authorities providing best access to carers were generally not the local authorities with high levels of uptake for other user groups.

Figure 3.7: Timing of provision of direct payments to carers among regions in England



4 Implementation of Direct Payments Across the UK: expenditure on direct payments packages

Introduction and overview

Despite the national policy emphasis on direct payments, roll out across the country has been described as disappointing (Glasby and Littlechild 2002; Spandler 2004). Expenditure on direct payments has attracted interest for a variety of reasons, not only because it provides an indication of activity. Central government has been interested in potential savings through reabsorption of unspent funds (at the end of the financial year) from service users who have effectively met their needs but not required all their direct payment funds. On the other hand, some local authorities argue that direct payments cost them more than mainstream services (Rankin 2005).

The survey sought to clarify what proportion of each local authority's total budget for community care had been spent on direct payments, looking at each service user group in turn. The survey asked for information for two financial years, 2003/04 and 2004/05. In addition we requested information on the proportion of service users in each group who were receiving a direct payment at the time of the survey to compare this to the proportion of the identified social care expenditure for each group spent on direct payments. Cross-national comparisons were precluded by the low response rates in Scotland, Wales and Northern Irelandd, and so we present only the results for England.

Key findings

- For all English authorities that provided these figures, 15.5% of the community care budget for people with physical disabilities was spent on direct payments, which was considerably larger than the equivalent proportions for older people (0.8%), people with learning disabilities (1.1%) and mental health service users (0.4%).
- Wide variations were discovered across the country in this expenditure proportion. For some user groups there was a fourfold difference between the lowest and highest spending regions (in terms of budgetary proportions). For all service user groups the greatest proportionate expenditure was by local authorities in the West Midlands.
- Expenditure growth between 2003/04 and 2004/05 was noticeable for all service user groups and for most parts of England, but actually still quite modest given the policy emphasis on making direct payments available to more people with social care needs.
- The proportion of the community care budget spent on direct payments can be compared to the proportion of service users in each group who received a direct payment. Some interesting differences emerge, suggesting that – on average across the country – expenditure on direct payments to people with a learning disability is *lower* than the average expenditure for mainstream services for this group. In contrast, expenditure on direct payments for the

physical disability group is *higher* than the average expenditure for mainstream services. For the other two user groups there is no discernible overall pattern.

Expenditure on direct payments to people with a physical disability

The proportion of the 2003/04 community care budget allocated to the support of people with a physical disability that was spent on direct payments averaged 10.5% in England, but had grown to 15.5% by the following year (see Table 4.1). (This is an unweighted average – it shows the mean of all the proportions across those authorities that responded to this question in the survey. Larger authorities are not given greater weight in the analyses.) However, there was wide variation across the country. For example, at a regional level in 2003/04, the proportion was as low as 5.8% in the North East, with a high of 20.8% in the West Midlands. The next year, the range extended from 8.7% to 33.6% (with the same regions being at the two extremes).

Table 4.1: Budgetary expenditure on direct payments to people with a physical disability and proportion of service users with a physical disability receiving direct payments, by region

		Proportion of the total community care budget spent on direct payments		Proportion of service users receiving direct payments (as at October 2004)
		2004/05	2003/04	
East		27.0	20.0	9.2
	Valid (N)	5	5	4
East Midlands		10.4	13.0	17.4
	Valid (N)	5	6	2
London		13.9	9.0	8.4
	Valid (N)	21	18	17
North East		15.8	16.2	1.7
	Valid (N)	6	6	5
North West		8.7	5.8	9.9
	Valid (N)	13	13	12
South East		17.7	17.4	12.6
	Valid (N)	12	12	10
South West		25.2	21.7	9.2
	Valid (N)	5	5	5
West Midlands		33.6	20.8	11.5
	Valid (N)	7	6	5
Yorkshire and the Humber		11.5	8.1	3.9
	Valid (N)	8	5	7
ENGLAND		15.5	10.5	9.2
	Valid (N)	82	76	67

Unitary authorities tended to devote higher proportions of their social care budgets for people with physical disabilities to direct payments (20.8% in 2004/05), almost double the allocation in metropolitan boroughs (10.8%) (Table 4.2).

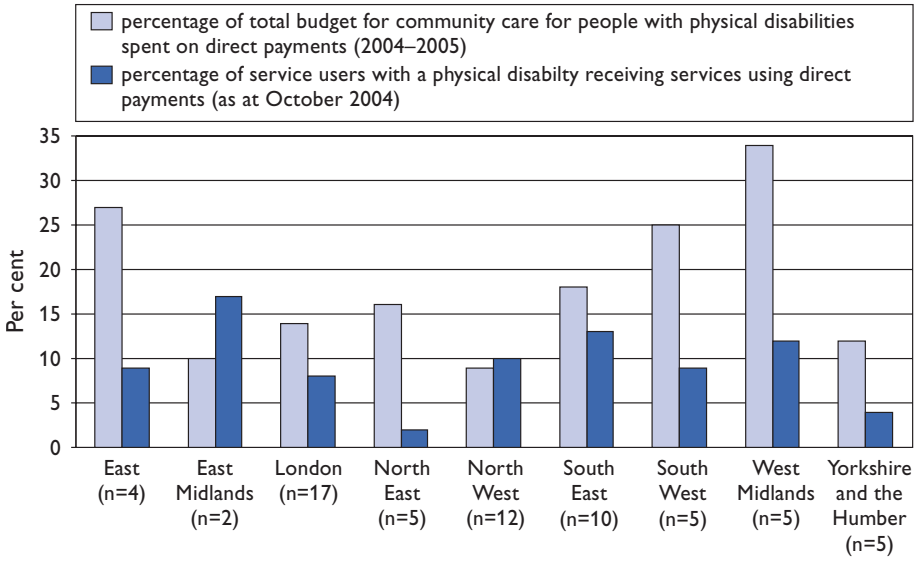
The average proportion of the community care budget devoted to direct payments thus grew by 5 percentage points for England as a whole, as well as in all but two of the regions. The exceptions were the North East and the East Midlands. The most marked growth was in the West Midlands (13 percentage points) from what was already a relatively high base. There is little difference in the pattern of growth of budget expenditure by authority type, ranging from 1 to 5 percentage points (Table 4.2).

Table 4.2: Budgetary expenditure on direct payments to people with a physical disability and proportion of service users with a physical disability receiving direct payments, by local authority type

		Proportion of the total community care budget spent on direct payments		Proportion of service users receiving direct payments (as at October 2004)
		2004/05	2003/04	
Unitary authorities		20.8%	17.8%	8.4%
	Valid (N)	21	22	18
London boroughs		13.9%	9.0%	8.4%
	Valid (N)	21	18	17
Shire counties		15.8%	14.7%	10.0%
	Valid (N)	20	19	14
Metropolitan district councils		10.8%	7.4%	9.5%
	Valid (N)	20	17	18

The proportion of the identified social care expenditure for people with physical disabilities that goes in direct payments can be compared to the proportion of service users in this group who were receiving a direct payment at the time of the survey (October 2004). The final column in Tables 4.1 and 4.2 gives the latter figure. For example, for England as a whole, an average across authorities of 15.5% of the budget went on direct payments in 2004/05 while only 9.2% of all people with physical disabilities supported by social services were in receipt of direct payments. This may be because direct payments are offered to people needing more intensive packages of support than the average person with a physical disability. If so, this would be expected to be reflected in the intensity of direct payment packages provided to people with a physical disability (see Section 5). This same pattern – a higher proportionate expenditure than the proportion of people in receipt of direct payments – is also found for each authority type (see Table 4.2) and for six of the regions, while the reverse pattern is observed in Eastern, London and North Western regions (Table 4.1). Figure 4.1 illustrates this pattern.

Figure 4.1: Percentage of budget spend and percentage of people using direct payments by English region: physical disabilities



Expenditure on direct payments to older people

As expected, proportional expenditure on direct payments to older people was much lower than for the physical disability group. One reason, of course, is that they have been available for older people for a shorter period. Previous studies have commented on the slow take-up by older people, and direct payments were made to only 0.6% and 0.7% of older people in receipt of community care in the

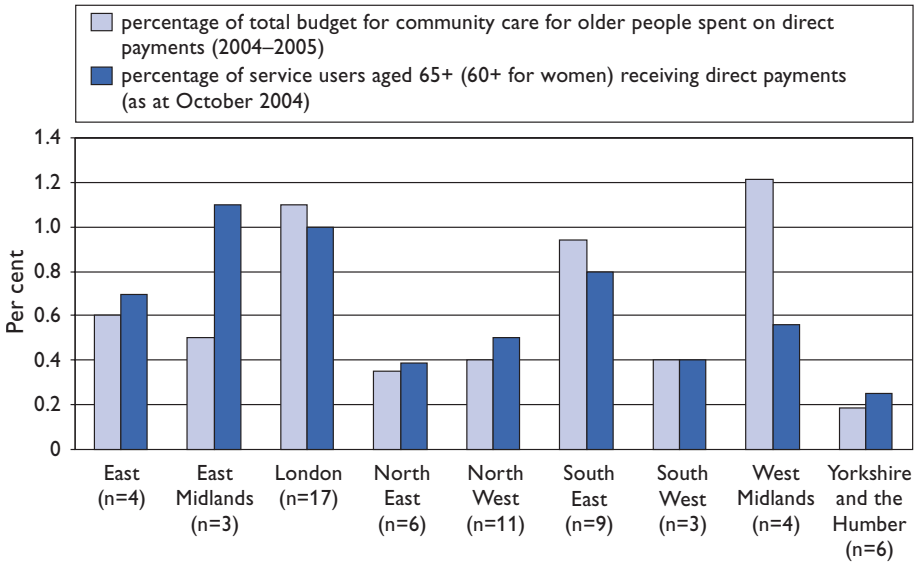
years ending March 2004, and March 2005 (see Section 2). The main barriers to greater uptake suggested by other commentators have been: poorly informed care managers, lack of direct payments support services, lack of enthusiasm among local authorities (Clark et al. 2003), poor public information, overly complicated monitoring systems and difficulties with associated responsibilities. Older people in particular feel less able to use direct payments without sufficient support services, including access to a payroll service (CSCI 2004).

The survey showed just how low was expenditure on direct payments for older people – less than 1% of total identified community care expenditure in 2004/05 for this user group when averaged across all responding English authorities, and as low as 0.2% in the Yorkshire and Humber region (Table 4.2). The region with the highest average was West Midlands (but still only 1.2%). Nevertheless, the budget proportion had grown between 2003/04 and 2004/05 (more than doubling for England as a whole), and was more rapid than for people with physical disabilities, although obviously this was from a very low base. Only in the Yorkshire and Humber region did there appear to have been a decline in the budget proportion between the two years for this user group (whereas there was growth in the budget allocation for all other user groups in this region).

When looking at the figures averaged by authority type, the 2004/05 proportion was highest for London boroughs, which also saw the fastest growth rate (Table 4.4).

Unlike the pattern we found for people with physical disabilities, the proportion of community care expenditure on older people that went on direct payments was generally very similar to the proportion of direct payment recipients within the overall user group (see Figure 4.2). For example, direct payments accounted for 0.8% of community care expenditure for the average English authority while – again on average across all English authorities for which we have data – the proportion of older people receiving direct payments was 0.5%. There was some regional variation, but not a great deal of disparity.

Figure 4.2: Percentage of budget spend and percentage of people using direct payments by English region: older people



The final columns of Tables 4.3 and 4.4 show the low proportions of older people in receipt of direct payments who have mild to moderate dementia. The average across English authorities was 0.1%. We did not ask for data on the proportion of expenditure on people with severe dementia as it was anticipated that direct

payments would not have been available to these clients given the requirement of informed consent to access a direct payment.

Table 4.3: Budgetary expenditure on direct payments to older people and proportion of service users aged 65 plus receiving direct payments, by local authority type

		Proportion of the total community care budget spent on direct payments		Percentage of older service users (men aged 65+ and women aged 60+) receiving direct payments (as at October 2004)	Percentage of older people receiving direct payments who have mild or moderate dementia
		2004/05	2003/04		
East		0.60%	0.43%	0.7%	2.55%
	Valid (N)	4	4	5	4
East Midlands		0.50%	0.41%	1.1%	0.03%
	Valid (N)	5	6	3	2
London		1.10%	0.42%	1.0%	0.04%
	Valid (N)	21	17	19	11
North East		0.35%	0.17%	0.4%	0.11%
	Valid (N)	6	6	4	4
North West		0.40%	0.24%	0.5%	0.75%
	Valid (N)	13	13	11	8
South East		0.94%	0.45%	0.8%	0.05%
	Valid (N)	10	10	9	4
South West		0.40%	0.24%	0.4%	0%
	Valid (N)	5	5	3	2
West Midlands		1.21%	0.59%	0.6%	0%
	Valid (N)	7	7	4	1
Yorkshire and the Humber		0.19%	0.39%	0.3%	0.46%
	Valid (N)	8	6	7	3
ENGLAND		0.77%	0.32%	0.5%	0.10%
	Valid (N)	79	74	65	39

Table 4.4: Budgetary expenditure on direct payments to older people and proportion of service users aged 65 plus receiving direct payments, by local authority type

		Proportion of the total community care budget spent on direct payments		Percentage of older service users (men aged 65+ and women aged 60+) receiving direct payments (as at October 2004)	Percentage of older people receiving direct payments who have mild or moderate dementia
		2004/05	2003/04		
Unitary authorities		0.68%	0.34%	0.7%	0.10%
	Valid (N)	20	21	18	11
London boroughs		1.10%	0.42%	1.0%	0.04%
	Valid (N)	21	17	19	11
Shire counties		0.64%	0.39%	0.5%	0.40%
	Valid (N)	18	17	13	8
Metropolitan district councils		0.31%	0.24%	0.4%	0%
	Valid (N)	20	19	15	9

Expenditure on direct payments to people with learning disabilities

The proportional expenditure on direct payments to people with learning disabilities was in some cases as low as it was for older people (see Tables 4.5 and 4.6). The national average for England was only 1.1% in 2004/05 (although this represented a doubling in the proportion in the previous year). We found the highest proportion in the West Midlands (3.6%) and the lowest in the South East (0.5%). There was little difference by authority type. Growth in proportional

expenditure was highest in the West Midlands (from 0.8% in 2003/04 to 3.6% in 2004/05) and also high in the North East. Moreover, every region registered a growth in proportional expenditure over the two years. Growth was noticeable in unitary authorities (Table 4.6).

Table 4.5: Budgetary expenditure on direct payments to people with a learning disability and proportion of service users with a learning disability receiving direct payments, by local authority type

		Proportion of the total community care budget spent on direct payments		Percentage of service users receiving direct payments (as at October 2004)
		2004/05	2003/04	
East		0.65%	0.26%	1.9%
	Valid (N)	5	5	4
East Midlands		0.80%	0.28%	4.5%
	Valid (N)	5	6	2
London		0.91%	0.54%	1.7%
	Valid (N)	21	20	17
North East		1.50%	0.61%	1.8%
	Valid (N)	6	6	5
North West		1.6%	1.20%	4.5%
	Valid (N)	13	13	11
South East		0.47%	0.31%	1.9%
	Valid (N)	11	11	9
South West		1.40%	1.10%	2.0%
	Valid (N)	5	5	4
West Midlands		3.58%	0.80%	3.0%
	Valid (N)	6	5	5
Yorkshire and the Humber		0.94%	0.70%	2.1%
	Valid (N)	7	5	7
ENGLAND		1.10%	0.50%	2.1%
	Valid (N)	79	76	64

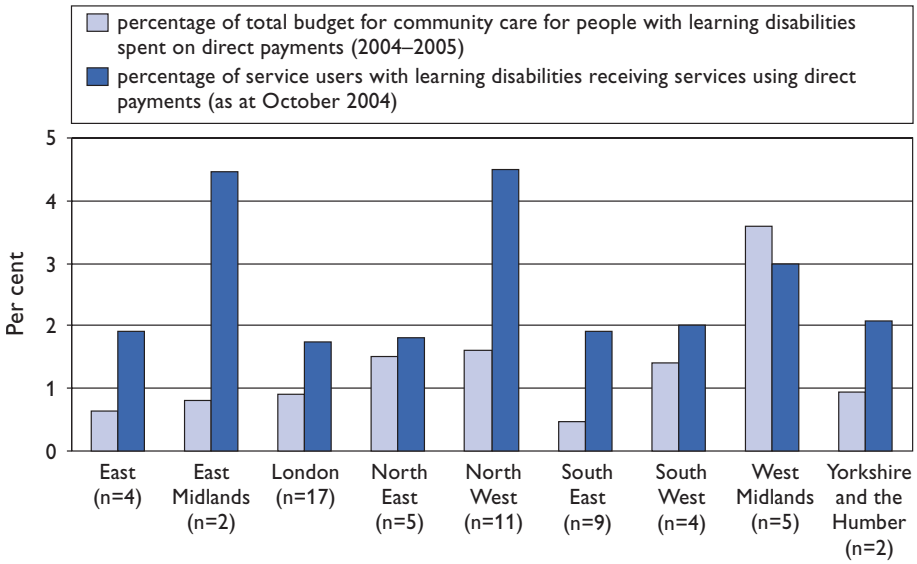
Table 4.6: Budgetary expenditure on direct payments to people with a learning disability and proportion of service users with a learning disability receiving direct payments, by local authority type

		Proportion of the total community care budget spent on direct payments		Proportion of service users receiving direct payments (as at October 2004)
		2004/05	2003/04	
Unitary authorities		1.40%	0.33%	1.9%
	Valid (N)	19	20	16
London boroughs		0.91%	0.54%	1.7%
	Valid (N)	21	20	17
Shire counties		1.30%	0.50%	2.7%
	Valid (N)	20	19	14
Metropolitan district councils		1.34%	0.70%	3.1%
	Valid (N)	19	17	17

In contrast to the pattern for people with a physical disability, generally the proportion of the community care budget spent on direct payments for people with learning disabilities was *lower* than the proportion of direct payment recipients within the overall user group (see Figure 4.3). For England as a whole, direct payments accounted for 1.1% of expenditure in 2004/05, but 2.1% of people with learning disabilities were receiving direct payments. This pattern was particularly noticeable in the East Midlands, the North West, and the South East. One reason could be that direct payments are offered to, or taken up by people in the learning disability user group who have less than the average level of support

needs, although the results that we will present in Section 5 suggest that in fact learning disability clients receiving direct payments tend to receive intensive packages of care (similar to people with physical disabilities). This may indicate that direct payments rates do not fully reflect the costs of mainstream services for people with learning disabilities (see Curtis and Netten 2004).

Figure 4.3: Percentage of budget spend and percentage of people using direct payments by English region: learning disability



Expenditure on direct payments to mental health service users

As we saw in Section 2, very few people with mental health problems who are in contact with social care services are receiving direct payments. 'Numbers receiving such payments have increased, but slowly and from a very low base' (Robbins 2004 p.2). In fact just 11 authorities accounted for more than half the national total of direct payments provided in March 2005 (Murray-Neill 2006).'Studies have shown that inadequate leadership, a lack of awareness about and promotion of direct payments, and staff concerns about people's ability to manage payments have hindered greater take-up' (Office of the Deputy Prime Minister 2004 p.43). A report funded by the National Institute for Mental Health in England suggested further reasons, including emphasis in the 1996 Community Care (Direct Payments) Act on the needs of people with physical disabilities, the tendency for people with mental health problems to have contact with the NHS rather than with social services, tough eligibility criteria, and difficulties that people may have managing money when they are ill (Spandler and Vick 2004).

In terms of expenditure, and averaging across England as a whole, only 0.4% of community care budgets in 2004/05 for this client group went on direct payments. This was, however, an improvement on the average of 0.1% in 2003/04 (Tables 4.7 and 4.8). There was a great deal of variation in this proportion – from barely above zero in London to approximately 1% in the West Midlands and Yorkshire & the Humber regions. This is in keeping with findings on uptake of direct payments to mental health service users (see Section 2).

Comparing the expenditure and user group proportions (the first and third columns of figures in Tables 4.7 and 4.8) reveals a great deal of similarity. For England as a whole, the 0.4% of the budget spent on direct payments matches the 0.4% of mental health service users receiving them. There are some regional variations, but the proportions are generally too low for us to draw meaningful conclusions.

Table 4.7: Budgetary expenditure on direct payments to mental health service users and proportion of mental health service users service users receiving direct payments, by region

		Proportion of the total community care budget spent on direct payments		Proportion of service users receiving direct payments (as at October 2004)
		2004/05	2003/04	
East		0.50%	0.63%	1.00%
	Valid (N)	4	4	3
East Midlands		0.45%	0.30%	3.70%
	Valid (N)	4	5	2
London		0.01%	0%	0.10%
	Valid (N)	15	16	15
North East		0.29%	0.45%	0.50%
	Valid (N)	6	6	5
North West		0.53%	0.18%	0.50%
	Valid (N)	13	13	11
South East		0.20%	0.06%	0.85%
	Valid (N)	11	11	10
South West		0.05%	0.18%	0.06%
	Valid (N)	5	5	2
West Midlands		1.02%	1.03%	0.28%
	Valid (N)	6	2	5
Yorkshire and the Humber		1.03%	0.03%	0.12%
	Valid (N)	5	2	4
ENGLAND		0.41%	0.13%	0.40%
	Valid (N)	69	68	57

Table 4.8: Budgetary expenditure on direct payments to mental health service users and proportion of mental health service users service users receiving direct payments, by local authority type

		Proportion of the total community care budget spent on direct payments		Proportion of service users receiving direct payments (as at October 2004)
		2004/05	2003/04	
Unitary authorities		0.29%	0.20%	0.44%
	Valid (N)	20	21	16
London boroughs		0.01%	0%	0.10%
	Valid (N)	15	16	15
Shire counties		0.56%	0.35%	0.88%
	Valid (N)	16	16	12
Metropolitan district councils		0.69%	0%	0.34%
	Valid (N)	18	15	14

5 Intensity of Direct Payments Care Packages

Introduction and overview

An important indicator of the implementation of direct payments is 'intensity' – the average amount received by service users with direct payments. The average amount of direct payment has been a somewhat neglected topic in the research literature (which has mostly been concerned with take-up, which we described in Section 2). This has implications in terms of measures of performance given that a local authority with, for example, relatively high numbers of people receiving direct payments may have a high proportion of its provision in low-intensity packages of care, with a lower overall investment than one with fewer numbers but higher intensity packages. Moreover, understanding the intensity of direct payment services provides an indication of demand. Getting the mix and intensity of services right is an important factor in how well social care services perform overall (Wanless 2006) In our survey questionnaire for local authorities we therefore asked about the intensity of each of their direct payment care packages provided to people from four key service user groups including people with physical disabilities; older people; people with learning disabilities and mental health service users.

Key findings

- The intensity or average size of direct payments has been studied less often than the take-up rate but tells us a lot about policy implementation. Once again, there is enormous variation between and within service user groups and parts of the country.
- Almost a third of direct payment recipients with physical disabilities in England received funding equivalent to over 31 hours of support per week, and three-quarters received intensive care packages according to the Department of Health definition (over ten hours per week). The intensity of care packages for physically disabled people is perhaps even greater outside England.
- For older people, the proportion of care packages exceeding ten hours per week in England is significantly above the national figure for home care packages (70% versus 26%). But there were fewer very intensive care packages allocated to older people than to physically disabled people.
- A majority of direct payments packages for people with learning disabilities provide high levels of inputs: in England, for instance, 68% and 24% of packages provided over ten and 31 hours per week of care, respectively.
- Average intensity of direct payments to mental health service users is significantly less than for the other service user groups: fewer than half provided over ten hours per week of care.

People with physical disabilities

A significant proportion of people with physical disabilities who receive direct payments were getting very high levels of inputs. In England, for instance, 29% of users received over 31 hours per week of service (see Table 5.1). These and other figures reported in this section are averaged after weighting for the number of direct payments users in each area and user group. Using the Department of Health's definition (over ten hour per week of care), approximately 75% of users of direct payments would be classified as receiving intensive care packages. This contrasts with a national figure (for all client groups) in 2004 of 26% of intensive home care packages in England (Health and Social Care Information Centre 2006).

Table 5.1: Average intensity of direct payment packages (hours) for people with physical disabilities

	Valid (N)	Hours per week						
		0–5 (%)	6–10 (%)	11–15 (%)	16–20 (%)	21–25 (%)	26–30 (%)	31+ (%)
England: regions								
East	6	13	19	16	11	8	7	26
East Midlands	4	3	11	13	8	13	14	37
London	25	12	15	13	12	11	8	29
North East	8	7	16	11	7	18	12	29
North West	14	10	18	16	11	15	11	19
South East	10	9	14	13	10	12	8	33
South West	5	13	20	20	13	10	9	16
West Midlands	6	4	9	6	6	8	10	58
Yorkshire and the Humber	11	7	13	13	11	13	13	31
England: LA type								
Unitary authority	24	7	15	13	11	12	12	31
London borough	25	12	15	13	12	11	8	29
Shire county	16	10	17	16	11	11	9	27
Metropolitan district	24	9	14	12	10	12	12	31
Northern Ireland	2	7	7	10	10	3	3	60
Scotland	4	13	8	4	4	12	8	52
Wales	3	5	0	10	2	12	19	52
England	89	10	16	14	11	11	10	29
Total	98	10	15	14	10	11	10	30

The large percentage of packages provided for over 31 hours per week of service may relate to the threshold that must be met in order to gain access to ILF support. (In order to receive funds from the Independent Living Fund packages a local authority must already be paying costs of more than £200 per week towards a service user's package.) The contrastingly lower proportion of packages falling between 21–25 and 26–30 hours per week may suggest that the ILF threshold has had the effect of driving package sizes upwards to the 31+ hours per week mark.

At the regional level, local authorities in the West Midlands provided the most intensive care packages, with 88% and 58% of direct payment users in receipt of more than ten and 31 hours per week of care, respectively. In contrast, the least intensive packages appeared to be provided in the South West and Eastern regions, where only 68% of care packages exceeded ten hours per week of input. Both regions were distinctive with respect to direct payments implementation for other reasons: the East had the highest per capita uptake (see Section 2), whereas the South West provided remarkably high hourly rates (see Section 7).

There were very small differences in the intensity of provision of care packages across local authority types (Table 5.1).

As we have noted in other sections, the low response rate to the survey achieved outside England makes it difficult to compare patterns across countries. It seems, however, that the average intensity of direct payment packages was even higher outside England, with more than half of the packages for physically disabled people in Northern Ireland, Scotland and Wales providing in excess of 31 hours per week of care inputs.

Older people

The distribution of direct payments packages for older people in England by levels of intensity was broadly similar to that for physically disabled people. The proportion of care packages exceeding ten hours per week in England was again significantly above the national figure for home care packages (70% versus 26%) (Health and Social Care Information Centre 2006).

However, compared to the patterns for physically disabled people, there were fewer very intensive care packages allocated (providing over 31 hours per week), than for people with physical disabilities, as shown in Table 5.2. This finding may reflect the fact the ILF is not available to people aged 65 plus. Only clients that were receiving ILF before the changes to the scheme in 1993 were given the right to retain their ILF after the age of 65 (Department for Work and Pensions 2001). Although there were fewer very intensive care packages (over 31 hours per week), overall the packages provided to older people were predominantly intensive according to the Department of Health criteria. On average across England 70% of direct payment packages to older people were above the threshold of over ten hours of service per week – this was only slightly below the average for services provided to

Table 5.2: Average intensity of direct payment packages (hours) for older people

		Hours per week						
	Valid (N)	0–5 (%)	6–10 (%)	11–15 (%)	16–20 (%)	21–25 (%)	26–30 (%)	31+ (%)
England: regions								
East	6	9	20	20	14	8	5	24
East Midlands	4	7	18	22	11	11	8	24
London	25	15	14	16	13	13	10	19
North East	8	6	18	16	2	32	6	20
North West	14	11	16	23	15	9	9	15
South East	10	14	18	12	13	13	7	23
South West	5	9	22	18	12	10	14	14
West Midlands	6	4	12	12	19	8	26	20
Yorkshire and the Humber	11	10	29	14	9	9	10	20
England: LA type								
Unitary authority	24	10	18	18	11	12	8	23
London borough	25	15	14	16	13	13	10	19
Shire county	16	10	19	19	12	10	9	21
Metropolitan district	24	8	23	15	14	10	12	18
Northern Ireland	2	42	21	8	4	0	4	21
Scotland	3	0	6	9	9	28	19	28
Wales	2	0	0	33	0	0	33	33
England	89	11	19	17	12	11	10	20
Total	96	11	18	17	12	11	10	20

people with a physical disability. This is surprising as, in general, community care packages are more intensive for disabled people aged under 65 than for social care users aged 65 or older. This may suggest that older people receiving direct payments tend to be those with particularly complex support needs.

Regionally, the most and least intensive packages of care were provided in the West Midlands (85%) and Yorkshire and the Humber regions (62%), respectively. There was no significant difference in the intensity of direct payments across local authority types.

With the usual caveat of having a low response rate, the pattern of intensity of direct payments for older people outside of England is variable. In Northern Ireland, the majority of packages provided fewer than ten hours per week of care, whereas in Scotland and Wales the majority included at least 21 hours of inputs.

People with learning disabilities

As we have already noted for physically disabled people and older people, the patterns for people with learning disabilities confirmed that a majority of direct payments packages provided were for high level inputs (see Table 5.3). In England, for instance, 68% and 24% of packages provided over ten and 31 hours per week of care, respectively.

In part due to the lower numbers of recipients of direct payments with learning disabilities (as discussed in Section 2), there was greater variability in the patterns of provision across regions, authority types and countries.

Table 5.3: Average intensity of direct payment packages (hours) for people with learning disabilities

		Hours per week						
	Valid (N)	0–5 (%)	6–10 (%)	11–15 (%)	16–20 (%)	21–25 (%)	26–30 (%)	31+ (%)
England: regions								
East	5	13	15	12	6	6	11	36
East Midlands	5	6	9	20	11	14	9	31
London	22	14	20	22	16	6	4	18
North East	7	11	19	19	9	4	16	22
North West	14	9	27	21	15	9	7	13
South East	10	16	22	11	9	8	5	28
South West	4	16	12	8	3	8	25	28
West Midlands	6	3	12	8	3	8	10	57
Yorkshire and the Humber	9	21	23	15	12	9	3	17
England: LA type								
Unitary authority	21	13	29	17	9	7	5	20
London borough	22	14	20	22	16	6	4	18
Shire county	17	13	15	16	7	8	12	29
Metropolitan district	22	11	21	14	16	9	9	20
Northern Ireland	1	17	17	17	0	0	33	17
Scotland	4	8	33	17	0	0	8	33
Wales	2	71	14	0	14	0	0	0
England	82	13	19	16	11	8	9	24
Total	89	13	19	16	11	8	9	24

On average, the most intensive care packages for people with learning disabilities were provided to recipients in the Eastern and West Midlands regions, where 85% of care packages included over ten hours of care per week.

Mental health service users

The average intensity of direct payments to mental health service users was significantly lower than for the other three main service user groups distinguished in our survey (see Table 5.4). For instance, in England, only 10% of direct payments to mental health service users were for over 31 hours of inputs per week, against 29%, 20% and 29% (respectively) for people with learning disabilities, older people and physically disabled people. The provision of packages classified by Department of Health criteria as intensive was also much lower. On average, in England, less than half of direct payments for mental health service users were for over ten hours per week of care, again a considerably lower proportion than for the other client groups. These findings are consistent with the fact that care packages tend to be smaller for this user group.

Table 5.4: Average intensity of direct payment packages (hours) mental health service users

		Hours per week						
	Valid (N)	0–5 (%)	6–10 (%)	11–15 (%)	16–20 (%)	21–25 (%)	26–30 (%)	31+ (%)
England: regions								
East	3	35	27	14	1	8	8	7
East Midlands	5	13	13	27	0	13	7	27
London	17	15	35	22	8	5	5	10
North East	6	20	13	17	27	6	0	17
North West	12	33	26	8	12	7	2	12
South East	9	21	37	5	16	0	11	11
South West	5	33	0	30	0	12	12	12
West Midlands	5	18	27	0	0	0	36	18
Yorkshire and the Humber	5	35	9	33	19	0	5	0
England: LA type								
Unitary authority	15	25	9	20	22	12	4	9
London borough	17	15	35	22	8	5	5	10
Shire county	20	32	26	14	4	7	9	10
Metropolitan district	15	34	23	12	10	3	8	10
Northern Ireland	0	–	–	–	–	–	–	–
Scotland	2	0	0	100	0	0	0	0
Wales	2	25	0	25	0	0	0	50
England	67	29	25	15	8	6	8	10
Total	71	29	24	15	8	6	7	10

There was considerable variability in the intensity of direct payments across regions and authority types. This is likely to be due in part to the very low total number of direct payments for mental health service users. We noted previously in Section 2 that only a few local authorities were very active in providing direct payments to mental health service users. According to our results, unitary authorities appear to provide the most intensive direct payment packages, with 66% of them providing over ten hours per week of care.

The response rates for countries other than England prevent any intra-UK country comparative analysis of intensity of direct payments for mental health service users.

6 One-off Direct Payments

Introduction and overview

A key limitation of routinely collected data on direct payments is that they do not distinguish between those provided on an ongoing basis and those provided on a one-off basis. In England, the Department of Health recommends the provision of direct payments on a non-recurrent or one-off basis for short-term needs (Department of Health 2003c). Examples include payments to parents to arrange short-term breaks for their disabled children (through alternative providers) and similarly to families providing care for elderly parents for respite breaks. The survey sought to establish the extent to which local authorities were making one-off payments and, where they did so, for what kinds of assessed need. In addition, there was a concern to learn whether one-off payments were used more frequently for particular groups of service users.

Key findings

- Approximately three-quarters of local authorities in England and Scotland had made one-off direct payments in the preceding year.
- In England, there were wide regional variations in the provision of one-off payments with such payments offered in large volumes by only a minority of local authorities, with the rest providing very small numbers of payments.
- More local authorities had made one-off payments to people with a physical disability than to any other group. However, a greater volume of one-off payments was made to user groups for which direct payments provision was very low, particularly carers and people with mental health problems.
- Although there were higher average numbers of one-off payments made by local authorities from the East and West Midlands, overall provision was patchy and inconsistent. In particular, very few of the local authorities that provided high numbers of one-off payments to one user group repeated this pattern for other user groups.
- One-off payments were most often made to purchase respite care and equipment, or to meet the set-up costs of arrangements for longer-term direct payments.
- Very few local authorities offered one-off payments to enable access to education or employment as a means of promoting social inclusion.

Access and availability of data on one-off payments

The survey asked local authorities to state the number of one-off payments (if any) provided to each service user group in the preceding year (October 2003 to September 2004), and to indicate the range of purposes for which they had been made. The majority of those indicating that they had provided one-off payments

were able to specify the exact numbers provided per user group. Nonetheless, full information on one-off direct payments does not seem to be always accessible at local level. For instance, four authorities reported data on the number of one-off payments provided, but not the purposes for which they had been made; in addition, 12 authorities provided information on the uses for which one-off payments had been made, but not the actual numbers of payments provided. Since a response to either question indicated that one-off payments had been provided to at least one user group, we took it as an indication of provision of one-off payments during the period, as shown in Tables 6.1, 6.2 and 6.3.

Table 6.1: Percentage of local authorities in countries within the UK indicating provision of one-off payments

	Valid (N)	Number of local authorities indicating provision of one-off payments	% providing one-off payments
England	110	82	75
Northern Ireland	3	3	100
Scotland	8	6	75
Wales	3	1	33

Table 6.2: Percentage of local authorities within regions in England indicating provision of one-off payments

	Valid (N)	Number of local authorities indicating provision of one-off payments	% providing one-off payments
East	6	4	67
East Midlands	7	6	86
London	27	18	67
North East	9	5	56
North West	17	15	88
South East	14	10	71
South West	7	4	57
West Midlands	11	10	91
Yorkshire and the Humber	12	10	83

Table 6.3: Percentage of local authorities in England of each local authority type indicating provision of one-off payments

	Valid (N)	Number of local authorities indicating provision of one-off payments	% providing one-off payments
Unitary authority	29	19	66
London borough	27	18	67
Shire county	24	18	75
Metropolitan district	30	27	90

Provision of one-off payments

It appeared that three-quarters of local authorities in England and Scotland provided one-off payments to some service users. (Regrettably, few local authorities from Northern Ireland or Wales responded, so that little information can be provided here on their arrangements.) Within England, there was considerable variation in provision. As shown in Table 6.2, only 56% of local authorities in the North East reported having made one-off payments, compared to 91% of those in the West Midlands. Less variation was apparent across administrative types, although a higher proportion of metropolitan authorities provided one-off payments (see Table 6.3). This may be due solely to the high

number of such authorities in theYorkshire and Humber and West Midlands regions.

Among those local authorities in England supplying information on the number of one-off payments provided, more reported making such payments to people with a physical disability than to any other service user group, reflecting general patterns of implementation, as indicated in Table 6.4. Also consistent with general patterns of direct payments uptake, more local authorities made one-off payments to older people and people with a learning disability than to service users with a sensory impairment or a mental health problem.

Table 6.4: Numbers of one-off payments provided by local authorities to service user groups in England

	Older people	Mental health	Learning disability	Physical disability	Sensory impairment	Disabled children	Carers
Valid (N)	33	17	39	49	7	20	26
Minimum	1	1	1	1	1	1	1
Median	3	3	2	3	1	3	6
Maximum	35	30	34	58	2	12	445
Sum	161	106	142	432	9	73	1593

Although the numbers of local authorities involved in providing direct payments reflected the pattern of implementation of direct payments across service user groups, the actual volume of one-off payments to different groups suggests a preference for making one-off payments to those user groups receiving lower levels of direct payment (Table 6.4). For example much larger volumes of one-off payments were made to carers and mental health service users than might be expected, given the average number receiving direct payments from these client groups (see Box 6.1). Conversely, fewer one-off payments were made to people with a physical disability than might be expected. People with a sensory impairment received the lowest number of one-off payments.

Regionally, above-average volumes of one-off payments were found in the East and West Midlands (see Table 6.5). Both regions provided more one-off payments to mental heath service users and older people. In the Eastern region, one-off payments were also particularly common to carers and people with physical disabilities. The maximum number of one-off payments made by any authority was however made by a London authority, to carers (445). The next highest volume (but considerably lower) was to people with a physical disability (58). The maximum number of one-off payments provided by any authority to people with a learning disability (34), older people (35) and people with a mental health problem (30) were fairly similar.

Box 6.1: Volumes of one-off payments made per user group versus average direct payment client numbers in England

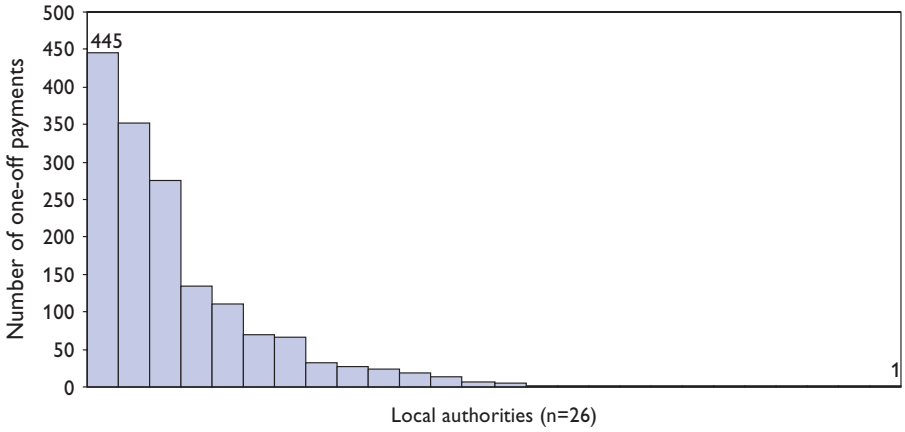
- **Carers** – only one direct payment client on average per local authority compared to a total of 1593 one-off payments provided to carers
- **Mental health service users** – only one direct payment client on average per local authority versus a total of 106 one-off payments made to this group
- **Learning disability** – 11 direct payment clients on average per local authority versus 142 one-off payments made to this group
- **Disabled children** – eight direct payment clients on average per local authority compared to a total 73 one-off payments made to this group
- **Older people** – 16 direct payment clients on average per local authority versus 161 one-off payments made to this group
- **Physical disability and sensory impairment** – 47 direct payment clients on average per local authority versus a total of 432 one-off payments made to people with a physical disability and only nine one-off payments made to people with a sensory impairment

Table 6.5: Average (median) numbers of one-off payments provided to service user groups by local authorities in regions of England

	Older people	Mental health	Learning disability	Physical disability	Sensory impair-ment	Disabled children	Carers
East	10	17	7	36	–	1	65
Valid (N)	2	2	3	2	0	3	2
East Midlands	1	–	4	6	1	3	12
Valid (N)	3	0	2	3	1	1	2
London	3	1	1	2	–	6	5
Valid (N)	5	4	7	5	0	2	5
North East	6	2	1	1	1	6	–
Valid (N)	3	2	3	5	1	1	0
North West	9	14	1	3	2	2	14
Valid (N)	3	1	7	9	1	4	7
South East	3	1	3	6	1	4	1
Valid (N)	7	3	6	7	1	5	2
South West	2	5	10	4	–	–	1
Valid (N)	2	1	1	3	0	0	2
West Midlands	7	7	5	2	1	2	134
Valid (N)	4	2	3	8	1	3	4
Yorkshire and the Humber	3	7	2	3	2	1	2
Valid (N)	4	2	7	7	2	1	2

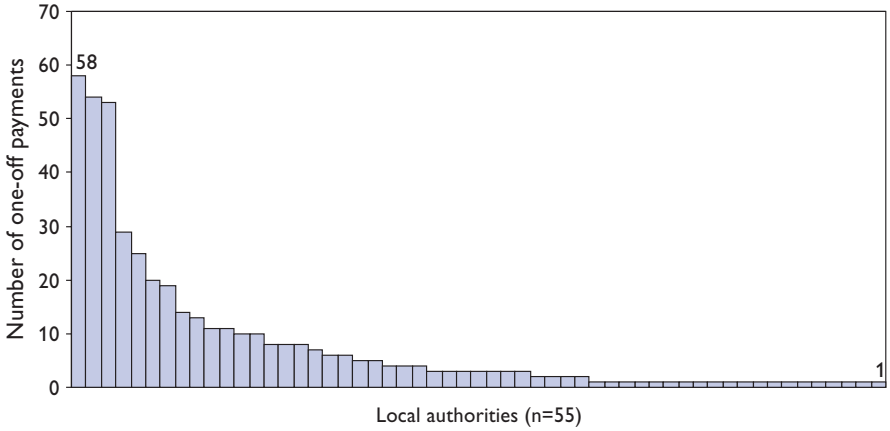
The distinction between large volumes of payments by a few authorities and the low volumes generally provided was particularly acute for carers and people with physical disabilities, as shown in Figures 6.1 and 6.2. Furthermore, despite exceptional levels of practice in some cases, a total of only 26 local authorities across England reported providing one-off payments to carers. No local authority from the North East reported making any such payment to this group. The overall level of involvement of local authorities from the East and the West Midlands in the provision of one-off payments to carers was also very low (only six authorities made payments out of a possible 23) despite very high numbers of one-off payments having been provided by a handful of local authorities from these regions (see Table 6.7).

Figure 6.1: Reported one-off payments to carers by local authorities in England



Across all user groups, local authorities in the West Midlands made the most one-off payments, but the average number of payments in this region was lower for people with a physical disability and mental health service users than in the East region. Authorities in the North West also made, on average, high numbers of payments to mental health service users. On the whole, the volume of one-off payments between authorities was very uneven.

Figure 6.2: Reported numbers of one-off payments made to people with physical disabilities by local authorities in England



There was little variation in average numbers of one-off payments by local authority type (see Table 6.6).

Table 6.6: Average numbers of one-off payments provided to service user groups by local authorities of different type in England

	Older people	Mental health	Learning disability	Physical disability	Sensory impairment	Disabled children	Carers
Unitary authorities	1	15	1	4	2	2	14
Valid (N)	21	17	20	23	16	18	19
London boroughs	3	1	1	2	–	6	5
Valid (N)	5	4	7	5	–	2	5
Shire counties	7	5	3	7	1	5	19
Valid (N)	12	6	12	14	2	6	5
Metropolitan district councils	4	3	2	3	1	1	2
Valid (N)	9	5	14	18	2	5	9

We contacted a handful of the authorities that had made high numbers of one-off payments to carers to determine the reasons for this. In most of these authorities, exceptional practice appeared to reflect generally well-developed services for carers and proactive strategies for developing support to caregivers. One-off direct payments for carers were seen as a mechanism for offering greater flexibility, choice and autonomy. Two such authorities had initially set up a pilot programme to examine the benefits of one-off payments to informal carers. After successful results these had been extended and had provided one-off payments to carers for a wide variety of uses in accordance with the guidance on providing direct payments to carers (Department of Health 2004). These included: short breaks for the carer or the person they cared for; personal assistance and practical support within the home; sitting services; social, education and leisure activities; transport costs; equipment; counselling; house maintenance; and complementary therapies such as relaxation, stress management and holistic therapies.

In contrast to this, one of the local authorities noted as having made exceptional numbers of one-off payments to carers was found to have provided only payments for short-term respite breaks in lieu of a voucher system. There are a number of problems with this. First and foremost, these payments should not have been classified as a direct payment to a carer. According to the DH guidance, carers are not currently entitled to a direct payment to purchase services to meet the assessed needs of the person they care for (other than those with parental responsibility caring for children). This illustrates the potential gap between direct payment policies and principles and the organisation of mainstream services.

Respite is often funded through a budget for carers and as such viewed as a service for 'carers'. This would suggest that the control is in the hands of the carer, although in practice arrangements are agreed in conjunction with the carer and service user. Direct payments guidance provides a clearer distinction between services. Services for a carer include only those of which the carer is in direct receipt, thus respite (where the service user receives the care) could not be administered as a direct payment to a carer. If respite is required and direct payments is felt to be the best route, but the service user is unable to manage the direct payment alone, intensive support options should be explored to enable them to do so (which may include management by the family).

Even if these payments had been counted as payments to the service user, it remains questionable whether they should have been counted as one-off direct payments as they did not provide access to a broader range of services than would have otherwise been available. Furthermore, it appeared that some other authorities were involved in similar practice but did not define it as one-off direct payments. These discrepancies have implications for monitoring provision of one-off payments to carers.

Use of one-off payments

Table 6.7 illustrates the range of purposes for which one-off payments were provided. Overall, they were most frequently given to purchase respite care, including holiday care, short breaks and support for a family holiday, as well as various forms of sitting service, such as night-sitting and a sleep-in service. Although it is likely that the majority of such payments were aimed at carers, one local authority reported payments for 'alternative respite for a mental health service user and learning disabled service user' and another indicated that one-off payments were being used for 'monthly day trips'.

One-off payments for general equipment were also common. Although most local authorities did not specify the type of equipment for which payments were made, examples given included payments for domestic appliances, furniture or carpets, an allotment shed, a 'light box' and 'a guitar to enable a service user to join a band'.

In addition, four authorities reported one-off payments for communication equipment, such as a video phone or mobile phone, and five had made one-off payments for aids and adaptations, including the purchase or repair of mobility or hearing equipment, and a dog to assist a disabled person.

Table 6.7: Range of purposes for which one-off payments provided, by country

	England	Northern Ireland	Scotland	Wales	Total	%
Respite	59	2	3	0	64	32
General equipment	34	0	0	0	34	17
Start-up and administrative costs	22	0	0	1	23	11
Leisure	16	1	1	0	18	9
Transport	13	0	0	0	13	6
Personal assistants/ support costs	9	1	1	0	11	5
Additional costs	7	1	0	2	10	5
Therapeutic	8	0	0	0	8	4
Childcare	3	1	2	0	6	3
Aids and adaptations	4	1	0	0	5	2
Education	5	0	0	0	5	2
Communication equipment	4	0	0	0	4	2
Employment	1	0	0	0	1	>1
Total	185	7	7	3	202	99

Twenty-three authorities reported that they provided one-off payments for costs associated with setting up a direct payment, serving as an alternative to the mechanisms for funding set-up costs described in Section 7. Some of the specific purposes mentioned included payments for Criminal Record Bureau (CRB) and Protection of Vulnerable Adult (POVA) checks, employer liability insurance, recruitment costs and annual expenses. One local authority indicated the payment of start-up costs equal to two weeks payment to ensure cash flow in the account and 'payment for a training course for a PA working with a disabled child'. A further ten local authorities made payments for 'additional costs', for instance to cover 'back-dated money due', additional hours or bank holiday costs, a temporary increase in hours or variation in a care package and to 'cover a delay in ILF funding'. In addition, payments were reported for personal assistant or support costs, such as covering a PA's maternity leave, paying for an outreach worker, supporting a client's return home from hospital, paying for care outside of the authority and paying for palliative care management.

From their inception, direct payments had been envisaged as a means of promoting independence and aiding social inclusion by offering opportunities for rehabilitation, education, leisure and employment (Department of Health 2003c). Of these, one-off payments were most frequently mentioned in relation to leisure activities (16). Examples cited included: gym membership, classes in pottery, flower arranging, painting and taekwondo and access to community services, including paying for an outreach worker to support a service user to attend salsa classes.

Few local authorities reported the provision of one-off direct payments to enable service users or carers to access education or employment, although several mentioned payment of college fees or assistance to attend an educational course. Only one authority had made a one-off payment to support a young disabled person to undertake work experience.

A small number of local authorities had made one-off payments for therapeutic purposes, for instance to purchase holistic and complementary therapies, such as aromatherapy, massage and relaxation. A very small number also provided such payments to assist with childcare, including play schemes, extra support during school holidays and emergency child support.

Lastly, seven local authorities made one-off payments for transport costs and another six reported one-off payments for driving lessons.

In general, there was little difference in the purposes for which local authorities provided one-off payments across administrative types (see Table 6.8). Metropolitan districts reported slightly greater provision for respite care, and shire counties reported slightly greater provision for general equipment. Although based on limited data, the findings suggest that London boroughs used one-off payments more frequently as a mechanism for providing start-up and administrative costs and less frequently for leisure, compared with other types of local authority. In contrast, shire counties and metropolitan districts indicated the use of one-off payments more frequently for transport.

Table 6.8: Range of purposes for which one-off payments provided, by local authority type

	Unitary authority	London borough	Shire county	Metropolitan district	Total
Respite	13	14	12	20	59
General equipment	9	6	12	7	34
Start-up and administrative costs	4	9	3	6	22
Leisure	5	1	6	4	16
Personal assistants/ support costs	2	0	5	2	9
Transport	2	0	6	5	13
Additional costs	2	2	3	0	7
Therapeutic	1	2	1	4	8
Childcare	2	0	1	0	3
Aids and adaptations	1	1	1	1	4
Education	1	1	2	1	5
Communication equipment	2	0	2	0	4
Employment	0	0	0	1	1
Total	44	36	54	51	185

7 Direct Payment Rates

Introduction and overview

What levels of direct payments are offered by local authorities, and what factors are taken into account when setting rates? According to practice guidance in England, the level at which a direct payment is set should equal the authority's estimate of a '*reasonable*' cost of lawfully securing the provision required, to fulfil the needs for which the direct payment service relates (Department of Health 2003c). Although there is no requirement that direct payments be based on an hourly rate, in practice they are often so calculated, with a fixed (or contingent) hourly rate provided for a certain number of hours per week.

The survey requested data on *average* hourly rates for all service user groups. Over 80% of the English local authorities returning a questionnaire were able to provide data on their daily direct payment rates, suggesting that most of them structure their provision around set rates. Only four of the authorities not answering this question stated explicitly that this was because their payment rates varied for individual service users.

The most significant rate for those receiving direct payments is the 'daily rate' (see Box 7.1), often with variations in rate for evenings, weekends and bank holidays. For simplicity, these four are jointly referred to here as the 'core' rates. Local authorities tend to favour this approach, with prescribed rates for evenings, weekends and bank holidays. In some cases, however, the daily rate is set at a higher level, with the assumption that it is sufficient to allow a proportion of the funding to be used to pay for care during unsocial hours.

Box 7.1: Hourly direct payment rates

The amount of a direct payment paid to a service user will usually be equal to the number of care hours required per week multiplied by the relevant hourly rate. The core variations are as follows:

- Daily rate – for care required between 8am and 7pm
- Evening rate – for care required after 7pm
- Weekend rate – for care after 7pm Friday and until 7am Monday
- Bank holiday rate – for care required on bank holidays

Further variations may include a sleepover rate, sleep-disturbance rate and a live-in rate.

The question of what is a 'reasonable' amount to pay for any given set of care needs is a complex question. It is especially difficult to answer given the novelty of direct payments and the fact that the mechanisms for purchasing care with such payments necessarily differ from those for established mainstream social care. Very little is known about how these relate in practice. In addition, it remains unclear how direct payment service users secure services as individual purchasers and what factors influence their ability to do so. Local authorities are therefore

reliant on feedback obtained from service users through monitoring, to assess whether the sum paid to individuals is reasonable, given their circumstances.

There are a number of benefits to providing a standardised rate, including greater transparency across the authority and swifter decisions on payments. Standardised rates also provide a benchmark for everyone concerned, including prospective users, prospective employees and other service providers who might seek to enter the local direct payments market. On the other hand, tightly fixed rates that do not accommodate variations in need, or other factors affecting the cost of securing services, may disadvantage some service users and create barriers to access. A critical feature is therefore the degree of flexibility in their provision, as discussed below.

Key findings

- Local authorities were found to pay similar rates to all user groups served, with the exception of people with a learning disability who received higher core hourly rates.
- Although payment rates were consistent across user groups, there was considerable variation in these rates across the UK. Rates paid by local authorities in Northern Ireland and Wales were markedly lower than in England and Scotland. The former also appeared to offer little compensation for unsocial hours.
- There were further variations throughout England. Above-average rates were paid in London and the South East, as may be expected given above-average labour costs in these areas. More surprisingly, local authorities from the South West were found to pay the highest regional rate.
- A North/South divide in payment rates was apparent, but comparison between neighbouring regions in the north suggests that the picture of regional disparities was complex. Metropolitan authorities were found on average to offer hourly rates 11% lower than the English norm.
- For care required at night, local authorities prefer to pay a nightly (rather than an hourly) rate. Similarly, weekly rates were also paid as they provide better value of money for local authorities than paying the hourly rate for the number of hours within a week.
- Average weekly rates for people with a learning disability, people with a physical disability and disabled children were all considerably *lower* than the average unit costs of residential care for these groups. In contrast, the average weekly live-in rates for older people and people with mental health problems were significantly *higher* than average unit costs for equivalent residential care.
- The majority of local authorities included the cost of tax and national insurance in the hourly rate. These costs account for a sizeable proportion of the hourly rate. Lower rates paid by authorities in some English regions may be related to non-inclusion of these items in their hourly rates.
- After deductions for tax and national insurance, a direct payment user with a physical disability can afford to pay on average £6.08 per hour. Rates of pay that can be provided are highly contingent upon the level of hours worked by a personal assistant.
- Few local authorities include start-up costs in the hourly rates and around 50% include an element for contingencies within the hourly rates. However, just over half of all local authorities in England provide ad hoc or periodic payments on top of the hourly rates, which may pay for start-up costs, contingencies or other costs such as employer's liability insurance.
- The flexibility with which hourly rates are applied is a potentially important factor in ensuring equitable access to direct payments. The majority of local authorities offer some flexibility in their hourly rates, usually responsive to need, but occasionally according to location, most commonly in authorities in rural areas.

- Most local authorities stated that their hourly direct payment rates were lower than the average costs of preferred independent sector domiciliary care providers as well as lower than the costs of in-house domiciliary care. Some authorities pay higher rates to service users who wish to pay an agency.

Hourly direct payment rates

It had been our expectation that there would be differences in the rates provided to different service user groups, reflecting differences in the average unit costs of their services. However, few differences were found in the core direct payment rates to each of the seven service user groups across the UK (see Tables 7.1, 7.2, 7.3 and 7.4), although the rates for standard services varied between user groups (as well as between service type and setting). Little information was provided on direct payment rates in Scotland, Wales or Northern Ireland, but the data suggest that direct payment rates in Scotland are on a par with England, while the rates in Northern Ireland and Wales are markedly lower and with little apparent compensation for people requiring care during unsocial hours.

Table 7.1: Core average hourly direct payment rates – England

	Older people	Mental health	Learning disability	Physical disability	Sensory impairment	Disabled children	Carers	All
Day	£8.70	£8.81	£9.63	£8.69	£8.76	£8.77	£8.71	£8.87
Valid (N)	100	97	94	95	86	81	75	N/A
Evening	£9.02	£8.97	£9.11	£9.04	£9.10	£9.06	£9.15	£9.06
Valid (N)	84	81	78	80	73	70	65	N/A
Weekend	£9.47	£9.34	£9.52	£9.43	£9.46	£9.33	£9.44	£9.43
Valid (N)	86	83	81	83	73	71	67	N/A
Bank holiday	£10.47	£10.38	£10.43	£10.43	£10.55	£10.50	£10.46	£10.46
Valid (N)	73	73	69	71	64	64	58	N/A

Table 7.2: Core average hourly direct payment rates – Northern Ireland (Northern Irish Health & Social Services Trust)

	Older people	Mental health	Learning disability	Physical disability	Sensory impairment	Disabled children	Carers	All
Day	£7.76	£7.90	£7.90	£7.45	£7.90	£7.90	£7.90	£7.82
Valid (N)	2	1	1	2	1	1	1	N/A
Evening	£7.76	£7.90	£7.90	£7.45	£7.90	£7.90	£7.90	£7.82
Valid (N)	2	1	1	2	1	1	1	N/A
Weekend	£7.76	£7.90	£7.90	£7.45	£7.90	£7.90	£7.90	£7.82
Valid (N)	2	1	1	2	1	1	1	N/A
Bank holiday	£7.76	£7.90	£7.90	£7.45	£7.90	£7.90	£7.90	£9.10
Valid (N)	2	1	1	2	1	1	1	N/A

Table 7.3: Core average hourly direct payment rates – Scottish council areas

	Older people	Mental health	Learning disability	Physical disability	Sensory impairment	Disabled children	Carers	All
Day	£8.96	£10.21	£9.87	£9.36	£9.57	£10.21	–	£9.70
Valid (N)	6	4	5	5	4	4		N/A
Evening	£8.96	£10.21	£9.87	£9.36	£9.57	£10.21	–	£9.70
Valid (N)	6	4	5	5	4	4		N/A
Weekend	£9.22	£10.66	£10.12	£9.48	£9.81	£10.66	–	£9.99
Valid (N)	4	3	4	4	3	3		N/A
Bank holiday	£9.22	£10.66	£10.12	£9.48	£9.81	£10.66	–	£13.49

Table 7.4: Core average hourly direct payment rates – Wales (Welsh unitary authorities)

	Older people	Mental health	Learning disability	Physical disability	Sensory impairment	Disabled children	Carers	All
Day	£7.05	£7.05	£5.95	£5.95	£7.05	£7.05	£7.05	£6.74
Valid (N)	3	3	3	3	3	3	3	N/A
Evening	£6.70	£7.05	£6.50	£6.50	£6.70	£6.70	£6.70	£6.69
Valid (N)	2	2	2	2	2	2	2	N/A
Weekend	£8.32	£8.32	£6.81	6.81	8.32	£8.32	£8.32	£7.89
Valid (N)	3	3	3	3	3	3	3	N/A
Bank holiday	£6.81	£6.81	£6.81	£6.81	£6.81	£6.81	£6.81	£7.81
Valid (N)	1	1	1	1	1	1	1	N/A

In England the average daily rate for all user groups, excluding people with learning disabilities, was £8.87. The evening rate was £9.06 (approximately 2% higher than the daily rate) and the average weekend rate was £9.43 (6% higher than the daily rate). The average daily rate for people with learning difficulties was higher at £9.63. Across England, there was relatively little variation in day, evening and weekend rates for each service user group, as revealed by low standard deviations.

Higher rates were paid for bank holidays for all service user groups. In England, these were, on average, £10.46 per hour (18% higher than the daily rate) and they varied much more than any other rates (in England, the range was £4.12 to £25). Although there was some variation by region and local authority type, each area showed roughly the same degree of variation, suggesting that bank holiday rates were much less homogenous than daily, evening and weekend rates.

Variations were found in average hourly rates between types of local authority (Table 7.6). London boroughs paid the highest rates in England, not surprisingly given the above-average unit costs for social care services in London boroughs (Curtis and Netten 2004). In shire counties, however, where higher unit costs might arise because of rurality (McCann et al. 2005), core direct payment rates were close to the English average. English unitary authorities also offered rates very close to the English average. Only metropolitan district councils paid lower than average rates for daily, weekend, evening and bank holiday time periods. For instance, their average daily rate of £7.70 was 13% lower than the average English rate. There were also slight differences between local authority types in the extent to which users were compensated for care needs occurring during unsocial hours, with shire counties paying the lowest compensation, compared to their daily rates. There was little variance within each local authority type, aside from bank holiday rates previously described.

Table 7.5 shows that there were also regional variations in payment rates, again with very little variance within each region. Above-average rates were found in the South East, consistent with the costs of providing services in this region (Curtis and Netten 2004). The South West appeared to have the highest average daily rate at £10.30, but this should be treated with caution as there was a small response rate from this region and only a small number provided data on their rates. Although direct payment rates appeared to reflect a North–South divide, the discrepancy between the neighbouring North East and North West regions indicates that the picture of regional disparities was somewhat more complex than this simple characterisation seems to suggest. Higher rates to clients with learning disabilities were not linked to any particular region or type of local authority, but were found consistently across all local authorities in England.

Table 7.5: Average core direct payments rates in England for all service user groups, by regional location

	Daily	Evening	Weekend	Bank holiday
South West	£10.30	£10.54	£10.54	£10.30
Valid (N)	4	4	4	3
London	£9.75	£9.87	£10.41	£12.09
Valid (N)	24	20	20	17
South East	£9.07	£9.88	£10.25	£11.51
Valid (N)	12	11	12	10
East	£8.96	£9.06	£9.91	£11.68
Valid (N)	6	5	5	5
North East	£8.95	£8.70	£8.70	£8.70
Valid (N)	9	6	6	6
East Midlands	£8.33	£8.56	£9.24	£7.95
Valid (N)	6	5	6	5
West Midlands	£8.25	£8.15	£8.35	£8.81
Valid (N)	8	5	7	3
North West	£7.68	£8.39	£8.66	£10.30
Valid (N)	16	15	15	14
Yorkshire and the Humber	£7.57	£7.92	£7.95	£8.86
Valid (N)	10	9	8	8

Table 7.6: Average core direct payments rates within England for all service user groups, by local authority administrative type

	Daily	Evening	Weekend	Bank holiday
London borough	£9.70	£9.87	£10.41	£12.00
Valid (N)	24	20	20	17
Shire county	£8.96	£9.06	£9.46	£9.50
Valid (N)	17	15	16	15
Unitary authority	£8.77	£9.36	£9.55	£10.40
Valid (N)	29	24	26	21
Metropolitan district	£7.70	£8.05	£8.43	£10.10
Valid (N)	25	21	21	18

Hourly direct payment rates for support at night or for a 24-hour period

The survey also asked about any other rates provided, including sleepover, sleep disturbance and live-in rates. Some authorities did not respond to such questions (or marked them 'not applicable'), so there is less information here, as shown in Table 7.7. This seemed to suggest that some local authorities do not have experience of providing for clients during these time periods. The most data obtained pertain to older people and people with physical disabilities, whereas few data were offered for disabled children, reflecting general patterns of take-up of direct payments. Too few data were provided to note regional patterns (see Table 7.8).

Nonetheless, the findings are of some interest. First, about three-quarters (75%) of local authorities preferred to pay a nightly rate for a 'sleepover' or 'sleep disturbance', rather than an hourly rate, presumably to contain costs Fewer local authorities detailed sleep disturbance rates – on average only around half of those that responded. The ratio of the provision of nightly to hourly sleep disturbance rates in England was around 50:50. The use of a nightly rate was particularly common in shire counties (83%), also offering generous rates, as seen in Table 7.9. London boroughs tended to pay the lowest nightly sleepover or sleep disturbance rates, surprisingly given that they paid above average core rates.

Table 7.7: Non-core DP rates by service user group in England

	Older people	Mental health	Learning disability	Physical disability	Sensory impairment	Disabled children	Carers
Sleepover – hourly	£8.29	£8.34	£8.42	£8.18	£8.69	£8.77	£8.42
Valid (N)	21	19	21	22	18	20	18
Sleepover – nightly	£40.87	£40.19	£40.51	£40.51	£39.75	£339.79	£338.21
Valid (N)	52	49	51	51	45	39	36
Sleep disturbance – hourly	£9.01	£9.29	£9.22	£9.18	£9.34	£9.35	£9.29
Valid (N)	25	23	23	24	22	22	21
Sleep disturbance – daily	£63.74	£63.84	£62.87	£65.12	£63.19	£64.57	£62.84
Valid (N)	24	21	24	24	20	15	14
Live-In – hourly	£8.09	£8.42	£8.45	£7.96	£8.33	£8.62	£7.84
Valid (N)	17	17	16	19	15	13	13
Live-In – weekly	£537.74	£533.94	£546.78	£553.62	£565.40	£574.20	£604.58
Valid (N)	14	11	14	15	11	8	7

Table 7.8: Average non-core direct payments rates for older people in England, by regional location

	Sleepover, hourly	Sleepover, nightly	Sleep disturbance, hourly	Sleep disturbance, daily	Live-in, hourly	Live-in, weekly
East	£6.65	£39.87	£9.83	£62.38	£6.55	£543.29
Valid (N)	3	2	3	1	3	2
East Midlands	£6.23	£48.55	£8.56	£74.07	£8.54	£754.00
Valid (N)	2	3	4	1	2	1
London	£8.98	£37.76	£10.19	£57.63	£7.53	£595.47
Valid (N)	4	12	5	5	3	6
North East	£8.24	£45.17	£8.79	£56.67	£8.79	–
Valid (N)	2	5	2	2	2	0
North West	£6.59	£39.37	£6.59	£58.22	–	£474.5
Valid (N)	1	11	1	7	0	2
South East	£9.32	£41.03	£9.32	£66.38	£8.65	£439.65
Valid (N)	4	6	4	2	3	2
South West	£10.88	£47.45	£13.05	£72.40	£9.00	–
Valid (N)	2	3	1	3	2	0
West Midlands	£7.70	£34.40	£7.70	£83.56	–	£286.66
Valid (N)	1	4	1	2	0	1
Yorkshire and the Humber	£8.06	£43.62	£7.10	£67.19	£8.35	–
Valid (N)	2	6	4	1	2	0

Table 7.9: Average non-core direct payments rates for older people in England by local authority administrative type

	Sleepover, hourly	Sleepover, nightly	Sleep disturbance, hourly	Sleep disturbance, daily	Live-in, hourly	Live-in, weekly
Unitary authority	£8.21	£42.76	£9.13	£64.38	£8.35	£510.17
Valid (N)	10	12	9	5	5	4
London borough	£8.98	£37.76	£10.19	£57.63	£7.53	£595.47
Valid (N)	4	12	5	5	3	6
Shire county	£8.24	£45.84	£9.26	£62.77	£8.02	£482.94
Valid (N)	5	10	7	6	8	2
Metropolitan district	£7.51	£40.83	£6.82	£67.88	£9.00	£474.50
Valid (N)	2	18	4	8	1	2

Only about a quarter of local authorities provided data on live-in rates, possibly reflecting low levels of provision for this purpose. Rates varied considerably. Weekly live-in rates seem to be better value for a local authority compared with mainstream residential care, dependent on the rates for residential care for each

group. As Table 7.10 shows, the lowest average unit costs for private residential care are for mental health service users. Curtis and Netten (2004) reported the latter to be £234 per week in 2003/04, roughly £300 lower than the average weekly direct payments rate for people with mental health problems. The average unit costs of residential care provided by the independent sector for older people are also comparatively low, compared to other service user groups. In consequence, the average weekly live-in direct payments rate is £193 per week higher than comparative residential care costs. In contrast, weekly live-in rates for people with learning disabilities, and disabled children, are all considerably lower than the average unit costs of residential care for these groups. Although these comparisons are crude, the best-value regime does require that local authorities make comparisons of the costs of providing a direct payment with the costs of alternative mainstream services. In England, the Department of Health (2003) argues that where a direct payment represents worse value on the basis of cost alone, it may nonetheless be considered cost-effective if the outcomes for the service user are greater than those from the alterative service.

Table 7.10: Comparison of average weekly direct payment rates per user group to average weekly private residential care costs per service user group in England

	Older people	Mental health	Learning disability	Physical disability	Sensory impairment	Disabled children	Carers
Average weekly live-in direct payment rate	£538	£534	£547	£554	£565	£574	£605
Valid (N)	14	11	14	15	11	8	7
Weekly private sector residential care rate[a]	£345	£234	£979	£631	No information available	£2,033[b]	No information available

a Source: Curtis and Netten (2004)
b Non-statutory community home

Inclusion of employment costs in the direct payments rates

An important question for interpreting observed variations in core rates between regions and local authority administrative types is whether these differences can be explained by their coverage, that is, the extent to which they were designed to cover all employment costs.

The rates of pay that service users can afford with their direct payments will vary significantly. The most significant deductions are tax and national insurance (NI), which vary considerably according to hours of employment. An service user in England receiving the average daily rate of £8.87, who employed a personal assistant for a full 37-hour week, would have sufficient funds to pay £6.08 per hour (minus deductions for tax, NI and 20 days per annum holiday allowance), as illustrated in Table 7.11. This is only marginally lower than the average wage for home care workers, roughly £6.20 (£7.10 in London and £5.90 outside London) (Curtis and Netten 2004).

Table 7.12 provides data on average hours of care per week received by direct payments service users, based on a study of direct payment packages in one local authority in the South West. The sensitivity of tax and NI contributions to hours of care worked is illustrated in Table 7.13, which sets out potential rates of pay for a personal assistant meeting the care needs of one service user receiving an average package of care. It can be seen that service users receiving an average care package would be able to offer salaries either above, or closely in line with, the average wage for home care workers. Service users receiving more intensive care would need to offer lower rates of pay, unless they each employed a number of care workers for only a small number of hours per week.

Table 7.11: Potential hourly rates of pay after statutory deductions based upon average hourly direct payment rates in England

	Day	Evening	Weekend	Bank holiday
Hourly rate	£8.87	£9.06	£9.43	£10.46
Yearly salary	£17,066	£17,431	£18,143	£20,125
Tax allowance	£5,035	£5,035	£5,035	£5,035
Band A tax	£209	£209	£209	£209
Band B tax	£2,601	£2,267	£2,838	£2,860
Total tax	£2,810	£2,476	£3,047	£3,069
Total NI	£1,877	£1,917	£1,996	£2,214
Holiday pay	£1,313	£1,341	£1,396	£1,548
Total lost	£6,000	£5,735	£6,438	£6,831
New salary	£11,066	£11,697	£11,705	£13,294
Hourly rate of pay	£6.08	£6.43	£6.43	£7.30

Note: Calculations are based on a personal assistant working a 37–hour week. Four weeks' holiday pay is applied as per European Working Time Directives (Department of Trade & Industry, 2003). Yearly salaries for weekends and bank holidays are notional given that only a limited number of hours per year can be worked at these pay rates.

Table 7.12: Average weighted number of hours of care per week required by direct payments service users

Service User Group	Weighted hours of care per week
Older people	18.79
Mental health	3.00
Learning disability	37.40
Physical disability	23.29
Sensory impairment	Not known
Disabled children	3.67
Carers	Not known

Source: Illingworth 2004

Table 7.13: Potential rates of pay based on average weighted package size per service user group

	Older people	Mental health	Learning disability	Physical disability	Disabled Children
Average weighted hours of care per service user per week	18.79	3	37.4	23.29	3.67
Hourly direct payment rate (day)	£8.70	£8.81	£9.63	£8.69	£8.77
Weekly pay (gross)	£163.47	£26.43	£360.16	£202.39	£32.19
Monthly salary (gross)	£708.38	£114.53	£1,560.70	£877.02	£139.47
Yearly salary (gross)	£8,501	£1,374	£18,728	£10,524	£1,674
Tax allowance	£5,035	£5,035	£5,035	£5,035	£5,035
Band A tax	£209	£0	£209	£209	£0
Band B tax	£716	£0	£2,967	£1,162	£0
Total tax	£925	£0	£3,176	£1,371	£0
Employees monthly NI contributions	£33	£0	£73	£52	£0
Employers monthly NI contributions	£39	£0	£1,030	£61	£0
Annual holiday pay entitlement	£343	£0	£1,513	£526	£0
Total lost (in contributions)	£1,341	£0	£5,792	£2,010	£0
New salary	£7,160	£1,374	£12,937	£8,514	£1,674
Hourly rate of pay	£7.38	£8.88	£6.70	£7.08	£8.84

Note: Other sources of employment always need to be considered when calculating required statutory contributions. Hence different rates would apply to any care workers who work for a number of direct payment service users, or have alternative employment.

Little is known about the employment of personal assistants by those using direct payments. Research by Clark et al. (2004) suggests that older people prefer to have more than one personal assistant so that the employment level of each one falls below the threshold for tax and NI contributions, thus enabling the payment of a higher hourly rate and a reduced administrative burden. In that study, service users had relatively low-level needs, generally requiring only a few hours of care

per week. Such an arrangement may be much less attractive for service users requiring substantial care, because of the implications for continuity of care, recruitment, training and day-to-day staff management. Nonetheless, it is likely that personal assistants working for people using direct payments may be prepared to accept part-time positions, given that 50% of the workforce within mainstream social care provision work part time (Roche and Rankin 2004).

The survey inquired about the extent to which any of the following items were included in the daily rates:

- Tax
- National insurance
- Holiday pay
- Sickness pay
- Start-up costs
- Contingency funds
- Support costs

Tax and national insurance contributions

Tables 7.14, 7.15 and 7.16 show that the majority of local authorities included an element for tax and NI contributions, with some variations between different parts of the UK and across England. For example, only 50% of Scottish authorities stated that their rates include tax. Data from a few Welsh authorities suggest that fewer made explicit allowance for tax and NI in their direct payment rates. Within England, the Yorkshire and Humber region and the West and East Midlands regions provided the exception, with approximately one quarter of local authorities stating that their hourly rates did not include tax. The non-inclusion of these items may partly explain why these regions had hourly rates below the English average.

Table 7.14: Items included in the direct payments hourly rate of local authorities in England, by region

		Tax	National insurance	Holiday pay	Sickness pay	Start-up costs	Contingency funds	Support costs	Other
	Valid (N)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
England	110	88%	96%	86%	78%	19%	46%	25%	24%
Northern Ireland	3	100%	100%	100%	67%	0%	0%	0%	0%
Scotland	8	50%	100%	100%	75%	13%	75%	13%	25%
Wales	3	67%	67%	67%	67%	0%	33%	23%	0%

Table 7.15: Items included in the direct payments hourly rate of local authorities in England, by region

		Tax	National insurance	Holiday pay	Sickness pay	Start-up costs	Contingency funds	Support costs	Other
	Valid (N)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
East	6	100%	100%	100%	83%	33%	67%	17%	33%
East Midlands	7	71%	100%	86%	86%	29%	57%	29%	57%
London	27	93%	100%	89%	81%	15%	52%	26%	19%
North East	9	100%	100%	100%	100%	11%	78%	11%	44%
North West	17	100%	100%	71%	59%	18%	29%	35%	24%
South East	14	86%	93%	86%	86%	36%	43%	50%	7%
South West	7	100%	100%	100%	100%	0%	57%	14%	29%
West Midlands	11	73%	91%	91%	64%	9%	18%	0%	27%
Yorkshire and the Humber	12	67%	75%	75%	67%	25%	42%	17%	8%

Table 7.16: Items included in the direct payments hourly rate of local authorities in England, by local authority type

		Tax	National Insurance	Holiday pay	Sickness pay	Start-up costs	Contingency funds	Support costs	Other
	Valid (N)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Unitary authorities	29	93%	97%	90%	93%	24%	55%	24%	14%
London boroughs	27	93%	100%	89%	81%	15%	52%	26%	19%
Shire counties	24	92%	100%	92%	79%	25%	58%	33%	42%
Metropolitan district councils	30	77%	87%	77%	60%	13%	23%	17%	23%

Holiday pay

After tax and NI, the highest 'extra' call on pay rates is holiday pay. Employers are required by law to provide four weeks paid holiday per year (pro rata for part-time staff) (Department of Trade and Industry 2003). Support schemes generally advise service users on how to set aside appropriate funds for holiday pay. Based on the average daily hourly rate, a person with a full-time personal assistant would need to set aside £1,313 per year for holiday pay (see Table 7.11). The regions with the most local authorities *not* including holiday pay in the hourly direct payment rates were Yorkshire and the Humber and the North West (see Table 7.15).

Sickness pay

Sickness pay was found to be universally included in direct payments rates in only one region, the North East. Employers are required to pay only the first seven days of statutory sick pay and are able to claim this back afterwards. Statutory sick pay is set at £68 per week and is payable only to employees earning above an average of £82 a week, before tax and NI (Department for Work and Pensions 2005).

As was found for holiday pay, the regions with the lowest inclusion of sickness pay in the hourly direct payment rates by local authorities were those with the lowest average hourly rates: the North West, the West Midlands and Yorkshire and the Humber (see Table 7.15).

Start-up costs

It has long been argued by proponents of direct payments and independent living that reimbursing start-up costs is key to helping service users feel able to switch to using direct payments (Hasler et al. 1999). Setting the hourly rate at a level deemed sufficient to include these costs is one mechanism but is unlikely to be particularly effective, as the designated resources would not be readily available at the actual time needed but spread across payments for an indefinite period of time.

Few local authorities were found to include start-up costs in their regular direct payment rate: 19% in England, 13% in Scotland and none in Wales or Northern Ireland (see Tables 7.14 to 7.16). This may suggest some recognition of this problem. Those local authorities which tended to include start-up costs in the hourly rate were in the South East and the East, both of which offered above-average hourly rates. However, none of the local authorities in the South West included start-up costs in the hourly rate. Each of these regions has a history of association with the Independent Living campaign and, as such, more likely to have a history of user involvement in policy and practice.

On the other hand, local authorities were asked if any employment costs *not* funded through the hourly rate were funded by periodic or ad hoc payments. Although a positive response to this question does not necessarily indicate that start-up costs were actually paid by this means, the provision of such payments was found to be widespread, as shown in Tables 7.17, 7.18 and 7.19. This may imply that the majority of local authorities were providing for start-up costs through ad hoc payments.

Table 7.17: Are extra payments provided on a periodic or ad hoc basis to supplement the hourly direct payment rates? Responses by country

	Yes		No		It depends	
	Valid (N)	%	Valid (N)	%	Valid (N)	%
England	59	56	19	18	27	26
Northern Ireland	2	100				
Scotland	6	75	2	25		
Wales	3	100				

Table 7.18: Are extra payments provided on a periodic or ad hoc basis to supplement the hourly direct payment rates? Responses by local authority administrative type

	Yes		No		It depends	
	Valid (N)	%	Valid (N)	%	Valid (N)	%
East	2	33	1	17	3	50
East Midlands	3	43	2	29	2	29
London	11	44	6	24	8	32
North East	5	56	1	11	3	33
North West	11	65	4	23	2	12
South East	8	61	1	8	4	31
South West	4	57	1	14	2	29
West Midlands	6	67	2	22	1	11
Yorkshire and the Humber	9	75	1	8	2	17

Table 7.19: Are extra payments provided on a periodic or ad hoc basis to supplement the hourly direct payment rates? Responses by local authority administrative type

	Yes		No		It depends	
	Valid (N)	%	Valid (N)	%	Valid (N)	%
Unitary authority	15	52	6	21	8	28
London borough	11	44	6	24	8	32
Shire county	15	65	1	4	7	30
Metropolitan district	18	64	6	21	4	14

Contingency funds

Contingency funds represent a limited sum set aside for unexpected needs, often periods when slightly higher levels of care are required. This may be because a service user is unwell; because a carer is unavailable to provide the usual input of care for a short period of time; or because a person requires more care to accommodate an unusual event, such as needing to attend a family funeral. In some cases, local authorities may allow a contingency fund to be spent on employing a PA for longer hours to allow a service user to go on holiday.

The survey asked local authorities whether contingency funds were included in their hourly rates, although not for information on the uses to which they might be put. Around 50% of English authorities stated that contingency funds were included in their hourly rate (Table 7.14). There was considerable regional variation; the inclusion of contingency funds was least common in the West

Midlands and the North West, both areas also having below average hourly direct payment rates (Table 7.15). Such a practice was also less common in metropolitan district councils, the type of local authority in England with the lowest average hourly direct payment rates (see Table 7.16).

As with start-up costs, contingency funds may be provided by other means, as ad hoc payments. This would allow payments to be focused on individual need, but may reduce perceived independence from the local authority as each ad hoc payment would need to be separately requested. The service user would also then be reliant on local authority responsiveness to provide the funds in a timely manner. If included in the hourly rate, the contingency fund would need to be slowly built up over time. Those receiving higher direct payments would get proportionately more resources to divert to a contingency fund, compensating for higher needs.

Support costs

The survey also asked if hourly rates included an allowance to finance support and brokerage costs associated with direct payments. A policy of providing service users with funds to pay the costs of any support needed with their direct payment provides greater choice and flexibility for the user, since the resources need not be spent on buying support from the local organisation supplying direct payments support. Service users may prefer to purchase support and brokerage from an organisation that meets cultural and language needs, or from a third party which they choose to be involved with the management of their direct payments.

It would appear that funding service users directly for support needs was very uncommon: only one quarter of local authorities in England (and roughly the same in Wales) indicated that they did so. Fewer did so in Scotland and none in Northern Ireland as shown in Table 7.11. There were quite considerable regional variations, with 50% of authorities from the South East providing such support, compared to none in the West Midlands (see Table 7.12). This, coupled with a greater level of inclusion of start-up costs, may account for the above average core hourly rates found in the South East. There did not appear to be much variation in responses by local authority type (Table 7.16).

Choice and flexibility in obtaining support with managing a direct payment may be provided by other means other than through the hourly rate. Local authorities that did not offer such choice through this means tended to do so through other means (as discussed in Section 11).

Further or miscellaneous employment costs

Local authorities were asked if any other items were included in their hourly direct payment rates. Across England and Scotland, about one quarter of local authorities stated that they include other items in the hourly rate, particularly common for those in shire counties and authorities in the East Midlands and North East regions (see Tables 7.14 to 7.16). The most frequently cited item (12 authorities) was ‘book-keeping, administration and/or payroll costs’, mainly by London boroughs (five) and Shire counties (five). This is one type of support and brokerage that service users may obtain from a direct payments support organisation. Equally, assistance may be obtained by recruiting someone to take on these roles. As with support costs generally, directing these resources to service users would arguably enhance their choice as to how they meet their needs.

The second most cited item was employment liability insurance, noted by seven local authorities. Only four within England stated that their hourly rates include funding for training costs. This finding echoes Flynn’s (2005) evaluation of the

emerging role of personal assistants which concludes that, 'In the experience of personal assistants, "learning while earning" is not yet endorsed, prioritised, funded or embedded, nationally, regionally or locally' (p.5).

Provision of ad hoc or periodic payments independent of direct payment hourly rates

An alternative mechanism for funding costs related to direct payments is through ad hoc payments, useful for funding start-up costs as well as for payments related to a specific fixed cost, such as employer's liability insurance. An ad hoc payment can ensure that funds are available when needed at the correct amount and can also help to avoid any confusion regarding the objective of the resources. This may suit some service users, depending on their desired level of control over resources. The provision of periodic or ad hoc payments was found to be widespread, either as a standard, or dependent upon circumstances (Tables 7.14, 7.15 and 7.16). It was particularly common in Scotland, Wales and Northern Ireland, where the provision of direct payments was less common than in England. There was also some regional variation; such payments were most common in authorities in Yorkshire and the Humber (75%) and lowest in the East (33%).

Ad hoc payments might also be a suitable mechanism for funding specific times of unexpected increased need, although the processes through which such payments were organised would need to be sufficiently straightforward to enable service users to benefit when such a payment is most needed.

Flexibility and variation in hourly direct payment rates

The extent to which the hourly rate for direct payments is designed to include any of the above items clearly affects the net resources available to pay a personal assistant or social care agency. The adequacy of such resources will depend on individual factors. In setting direct payment rates, local authorities should ideally try to distinguish between the factors governing the costs of the services *they* commission and those influencing the costs of securing care as a direct payments service user. The interaction between a direct payments service user and their provider(s) of care may differ quite distinctly from mainstream social care as shown by Leece (2005), but it is unclear what impact this has on the deployment of resources and the ability to secure services to meet needs. Given the extent of individual responsibility involved in securing care through direct payments, it is likely that the deployment of resources is likely to vary with individual circumstances.

Tightly fixed standard direct payment rates that do not accommodate variations in needs or other factors affecting the cost of services may disadvantage some service users and create barriers to access. The flexibility with which hourly rates are applied is therefore an important factor in understanding how local authorities create access to direct payments for those whose care may be more costly than average.

The survey asked local authorities if any variations were available in the hourly rates on the basis of:

- Level of complexity of need of the service user;
- Location of the service user;
- Local labour market prices;
- Any other factors.

Results are shown in Tables 7.20, 7.21 and 7.22.

Table 7.20: Flexibility in local authorities' hourly direct payments rate by the following factors within the United Kingdom

		Level and complexity of need	Location of the service user	Local labour market prices	Other factors
	Valid (N)	Yes	Yes	Yes	Yes
England	106	72%	24%	26%	30%
Northern Ireland	3	100%	0%	33%	0%
Scotland	8	88%	25%	0%	25%
Wales	3	0%	0%	33%	33%

Table 7.21: Flexibility in local authorities' hourly direct payments rate by the following factors, summarised by region in England

		Level and complexity of need	Location of the service user	Local labour market prices	Other factors
	Valid (N)	Yes	Yes	Yes	Yes
East	6	67%	33%	17%	33%
East Midlands	7	57%	14%	23%	43%
London	26	77%	4%	23%	35%
North East	9	67%	11%	11%	44%
North West	16	76%	19%	13%	6%
South East	13	62%	46%	54%	31%
South West	7	71%	43%	71%	43%
West Midlands	9	78%	22%	0%	22%
Yorkshire and the Humber	12	75%	50%	33%	25%

Table 7.22: Flexibility in local authorities' hourly direct payments rate by the following factors, summarised by local authority type in England

		Level and complexity of need	Location of the service user	Local labour market prices	Other factors
	Valid (N)	Yes	Yes	Yes	Yes
Unitary authority	28	62%	18%	18%	32%
London borough	26	77%	4%	23%	35%
Shire county	23	65%	52%	48%	39%
Metropolitan district	28	82%	25%	18%	14%

Level and complexity of need

Within mainstream social care, the level and complexity of need affect the level of resources required to pay for an individual's care. Reasons for high costs include: a small client base; highly differentiated needs within the client group; specialist needs, particularly those requiring a greater level of technical expertise; and the need for more than one care worker. In principle, the same considerations are likely to affect those paying for their care using direct payments. The survey asked if local authorities accounted for variations in level and complexity of need by allowing hourly rates to vary.

The majority of local authorities in England, Scotland and Northern Ireland offered some flexibility in hourly direct payment rates on the basis of complexity of need, although no Welsh local authorities did so, despite the fact that their hourly rates appear to be the lowest in the UK.

Local authorities were also asked to describe how they varied hourly rates in response to the level and complexity of needs. Some responded in terms of the level of decision-making required, for instance that variations could be made only in *exceptional* cases with senior management approval. Generally, however, comments suggested flexible policies towards those with specialist needs. One

local authority stated that the flat rate could be varied, 'with any concessionary rate agreed between the care manager and the service user'.

The majority of comments (23) indicated that the provision of a higher rate was standard for specific client groups. Specialist rates for people with learning disabilities were particularly common, in approximately half the cases to meet the needs of people with challenging behaviour. Specialist rates for people with a sensory impairment were the next common, cited by eight authorities. This marries with patterns of resourcing mainstream services for people with a learning disability, where costs are scaled according to level of need (Curtis and Netten 2004). A recent study by Knapp et al. (2005) found that approximately one third of the variation in costs of residential care for people with intellectual disability and challenging behaviour could be explained by need-related factors.

Higher rates could also be used for people with specialist or complex needs, noted by 17 authorities, with such decisions typically taken on an individual basis. Variations in rates were also available where a specialist s*ervice* was seen to be required, also noted by 17 local authorities.

A small number of authorities noted that higher rates might be offered if additional funding were to be available for health needs. This was understandably a marginal practice, given the statement from the Department of Health in England in February 2005 concerning the use of direct payments for health needs:

> direct payments made under the Health and Social Care Act 2001 relate only to certain local authority social services. This means that where an individual has an identified health need which falls to the NHS, that part of any 'care' package cannot be delivered as a direct payment within the meaning of the legislation, including where a local authority is acting under a partnership arrangement pursuant to section 31 of the Health Act 1999.

Location of the service user

Rurality tends to be associated with higher costs of care for mainstream services, due to both the distance that care workers must travel to reach clients and the lower concentration of clients in rural areas. Unless a care worker can be found in the very immediate vicinity, there is no reason to suggest that users of direct payments would not equally require greater resources to secure needed care in a rural area.

Broadly consistent with such considerations, our results show that shire counties most often indicated that they enabled variations in average hourly rates to compensate for a service user's location. According to comments received, this is particularly the case where the individual's location makes recruitment difficult. Indeed, the regions with authorities most often willing to vary rates were those with high proportions of shire counties. In contrast, only 4% of London boroughs offered rate variations on the basis of a service user's location. Outside England, only a quarter of Scottish authorities offered variations according to location, where again rurality is an issue for many authorities. Yet despite similar potential problems in Wales and Northern Ireland, none of their authorities offered rate variation according to a service user's location. This compounds the general picture of a low level of resources provided to direct payment service users in Wales and Northern Ireland.

Local labour market prices

Differences in local labour market conditions may lead to considerable variation in the costs of employing a personal assistant. For example, a tight local labour

market may tend to be associated with higher levels of remuneration to induce the desired supply, affecting both traditional modes of provision and the context of direct payments. One study in the South West found up to 27% variation in the prices of domiciliary care in one local authority (Illingworth 2004).

The survey results show considerable variance in the willingness of local authorities to consider this as a factor requiring variation in the resources supplied to individual service users. In England, this willingness appeared to be most frequently associated with shire counties, as well as some London boroughs.

Other factors

Approximately one third of all authorities in England and Wales noted some other reasons to vary their hourly rates. A key one was the wish of a service user to use a social care agency, suggesting that direct payment rates are often acknowledged to be below market value for social care. A number of local authorities gave indications of their special agency rates, which varied by region: £14.00 (London), £13.50 (South East), £12.00 (East) and £9.00 (East Midlands and North East). One local authority stated that their agency rate was based on their contract prices with social care providers.

One factor notable in its general absence was consideration of flexible rates to account for the impact of requiring multiple short visits. In mainstream services, a service provider may charge proportionately higher prices for shorter visits than longer ones. An exception to this was a unitary local authority in the South East that provided different direct payment rates for 15, 30 and 60 minute units of care.

Comparative value of direct payments hourly rates for older people

A key question with respect to direct payments is whether the set hourly rate is perceived to represent good value, compared with the cost of local authority mainstream services. As a means of obtaining some relevant information, we asked local authorities to compare their direct payments rates for older people with their average local rates for preferred independent sector domiciliary care for older people as well as with their rates for in-house domiciliary care. As shown in Tables 7.23, 7.24 and 7.25, the results suggest that direct payment rates tend to be pitched at below the 'going rate' for care. The majority of local authorities in England and Northern Ireland – and all authorities in Scotland and Wales – stated that their direct payments rates were lower than the average costs of preferred independent sector providers of domiciliary care.

Table 7.23: Local authorities' comparisons of their hourly direct payments rates to: A) the hourly cost of in-house domiciliary care, and B) the average hourly cost of preferred independent sector providers of domiciliary care. Responses by region

		Lower		Higher		The same	
		Valid (N)	%	Valid (N)	%	Valid (N)	%
England	In-house domiciliary care	72	77	7	8	14	15
	Preferred independent sector providers of domiciliary care	68	69	4	4	26	27
Northern Ireland	In-house domiciliary care			2	67	1	33
	Preferred independent sector providers of domiciliary care	2	67			1	33
Scotland	In-house domiciliary care	4	50	1	13	3	38
	Preferred independent sector providers of domiciliary care	4	100				
Wales	In-house domiciliary care	2	100				
	Preferred independent sector providers of domiciliary care	2	100				

Table 7.24: Local authorities' comparisons of their hourly direct payments rates to: A) the hourly cost of in-house domiciliary care, and B) the average hourly cost of preferred independent sector providers of domiciliary care. Responses by region

		Lower		Higher		The same	
		Valid (N)	%	Valid (N)	%	Valid (N)	%
East	In-house domiciliary care	5	100				
	Preferred independent sector providers of domiciliary care	5	100				
East Midlands	In-house domiciliary care	5	83			1	17
	Preferred independent sector providers of domiciliary care	6	100				
London	In-house domiciliary care	12	57	2	10	7	33
	Preferred independent sector providers of domiciliary care	18	72	2	8	5	20
North East	In-house domiciliary care	6	75	1	13	1	13
	Preferred independent sector providers of domiciliary care	2	29	1	14	4	57
North West	In-house domiciliary care	11	79			3	21
	Preferred independent sector providers of domiciliary care	10	63			6	38
South East	In-house domiciliary care	11	79	2	14	1	7
	Preferred independent sector providers of domiciliary care	12	92			1	8
South West	In-house domiciliary care	5	83	1	17		
	Preferred independent sector providers of domiciliary care	4	57	1	14	2	29
West Midlands	In-house domiciliary care	8	100				
	Preferred independent sector providers of domiciliary care	7	78			2	22
Yorkshire and the Humber	In-house domiciliary care	9	82	1	9	1	9
	Preferred independent sector providers of domiciliary care	4	40				

Table 7.25: Local authorities' comparisons of their hourly direct payments rates to: A) the hourly cost of in-house domiciliary care, and B) the average hourly cost of preferred independent sector providers of domiciliary care. Responses by local authority type

		Lower		Higher		The same	
		Valid (N)	%	Valid (N)	%	Valid (N)	%
Unitary authority	In-house domiciliary care	23	85	2	7	2	7
	Preferred independent sector providers of domiciliary care	19	68	1	4	8	29
London borough	In-house domiciliary care	12	57	2	9	7	33
	Preferred independent sector providers of domiciliary care	18	72	2	8	5	20
Shire county	In-house domiciliary care	15	79	1	5	3	16
	Preferred independent sector providers of domiciliary care	16	80			4	20
Metropolitan district	In-house domiciliary care	22	85	2	8	2	8
	Preferred independent sector providers of domiciliary care	15	60	1	4	9	36

The fact that direct payment rates tend to be below the 'going rate' for contracted care may affect the ability of older people to secure care using direct payments, given that unit costs for social care for this group tend to be among the lowest of all groups. It is also unclear whether individual purchasers would be able to secure care on a par with prices negotiated by local authorities if seeking care from independent sector providers rather than from personal assistants.

The picture was similar with respect to in-house domiciliary care costs, with the exception that all three Northern Ireland authorities that stated that their direct payment rate was either higher or the same as local costs of in-house domiciliary care.

Retention of surplus direct payment funds

Finally, the survey asked about the extent to which direct payment service users could retain any funds accumulated in the course of a year. Relatively few local authorities responded to this question; of those that did, we found considerable variation in the responses, from none to all the accumulated funds, as shown in

Table 7.26. The average in England was 17%; the regions with authorities above this average were the North West (30%), the East (30%) and the South East (26%). The averages for Northern Ireland and Scotland appeared to be higher, although very few data were presented from these regions.

Table 7.26: Percentage of accumulated funds a direct payment service user is entitled to retain at the end of the financial year (from any service user group). Results for the United Kingdom

	Valid (N)	Minimum	Mean	Maximum
England	71	0	17	100
Northern Ireland	2	0	50	100
Scotland	3	10	25	50
Wales	1	2	2	2

8 Local Commissioning Practices

Introduction and overview

The purpose of this section is to outline the commissioning arrangements that local authorities have in place which in turn may have a bearing on direct payment implementation. Since the community care reforms of the 1990s, local authorities have developed a variety of approaches to commissioning and managing the developing mixed economy of welfare (Knapp and Wistow 1998). These have implications for the types of contracts awarded, the level at which purchasing and providing functions are separated, and the extent to which budgets are devolved (Forder et al. 2002). A range of contract types are now used in social care, with associated advantages and risks. Contract types include: 'block contracts' which guarantee a level of revenue regardless of whether a service is used; 'spot contracts' which are arranged on an individual client basis such that reimbursement is made if the client uses the service; 'call-off contracts' where care managers can call off services from a contract where a price band has been set prior to purchase; and 'cost and volume contracts' which combine block and price-by-case arrangements. While spot purchasing offers greater flexibility than other contract types, higher costs can be incurred (Forder et al. 2004; Knapp et al. 2001).

Given the small number of community care packages provided through direct payments at the time of the survey, we did not expect to find that direct payments would have had any impact on commissioning practices. Therefore the questions posed were designed to establish the commissioning context within which direct payments are provided.

Key findings

- Approximately half of all English local authorities devolved budgets to care management teams for individual-level spot purchasing, with similar rates of budgetary devolution reported across client groups. Wide differences were found between regions but very little difference between local authority types. Despite extensive regional variations in devolution of budgets there did not appear to be any relationship between patterns of budgetary devolution and the take-up of direct payments. In terms of overall levels of spot purchasing (whether at a devolved level or not), local authorities reported purchasing the majority of services on a spot-contract basis. The lowest levels of spot purchasing were for services for older people (60% in England).
- Shire counties reported notably lower levels of spot purchasing.
- Only a minority of authorities operated a generic budget for direct payments and patterns in the use of a generic budget did not conform to take-up patterns.

- The use of ring-fenced budgets for direct payments (where funds are ring-fenced from the core budget of each client group) varied between service user groups.
- Ring-fenced budgets were most typical for services for people with a physical disability and services for older people. Such budgets were less common for user groups with lower levels of direct payment users, although they were relatively popular for mental health services. The latter suggests an attempt by local authorities to kick-start implementation of direct payments in this field but may also be due to the need to extract funds from pooled health and social care budgets in order to provide direct payments to mental health service users.About half of all English local authorities had neither a generic budget for direct payments users nor ring-fenced funds for direct payments.

Extent of budgetary devolution

Budget inflexibility has been cited as a barrier to direct payment implementation, particularly in circumstances where resources are tied up in block contracting arrangements (Spandler and Vick 2004; Direct Payments Scotland 2003; Witcher et al. 2000). We were therefore interested to explore the extent to which local authority budgets were devolved for spot purchasing to care managers and/or social work team managers. In general, it might be assumed that a higher level of spot purchasing for individual service users would offer greater flexibility in the system which, in turn, would support take-up of direct payments. Research in Scotland, however, has suggested that care managers can create barriers to direct payments take-up because of concerns about handing over control of their devolved budgets (Direct Payments Scotland 2003).

In England, approximately half of all local authorities devolved budgets to care management teams for individual-level spot purchasing. The frequency with which they did so was fairly similar across client groups, although the practice was most often reported for services for older people and people with a physical disability (where take-up of direct payments is highest), and least often reported for services for disabled children and carers (see Tables 8.1 and 8.2). Despite regional variations in budgetary devolution there did not appear to be any relationship between patterns of budgetary devolution and patterns of direct payments uptake. The highest proportion of local authorities reporting budgetary devolution for spot purchasing was in Eastern region (see Table 8.1). In the North East, spot purchasing was also relatively common.

Table 8.1: Average percentage of local authorities among each English region devolving budgets to care managers/team managers for individual level spot purchasing for each care group

	Valid (N)	Mental health	Older people	Physical disability	Learning disability	Sensory impairment	Disabled children	Carers	Total Average
East	6	67%	83%	83%	67%	83%	50%	67%	71%
East Midlands	7	43%	43%	43%	43%	43%	43%	43%	43%
London	27	44%	48%	48%	41%	41%	37%	37%	42%
North East	9	56%	56%	56%	56%	56%	67%	44%	56%
North West	15	60%	67%	67%	67%	67%	47%	53%	60%
South East	13	46%	46%	46%	46%	46%	46%	38%	46%
South West	6	33%	50%	50%	17%	50%	33%	50%	40%
West Midlands	10	50%	60%	60%	60%	50%	40%	40%	51%
Yorkshire and the Humber	12	42%	50%	50%	42%	42%	50%	33%	44%
ENGLAND	105	49%	54%	54%	49%	50%	45%	43%	49%

Budgetary devolution for spot purchasing showed less variability by type of authority (see Table 8.2). More authorities reported devolving budgets for older

people and physical disability services than for disabled children's or carers' services.

Table 8.2: Average percentage of local authorities of different types devolving budgets to care managers/team managers for individual level spot purchasing for each care group

	Valid (N)	Mental health	Older people	Physical disability	Learning disability	Sensory impairment	Disabled children	Carers
Unitary authority	27	48%	52%	52%	44%	48%	37%	37%
London borough	27	44%	48%	48%	41%	41%	37%	37%
Shire county	23	48%	61%	61%	52%	61%	48%	57%
Metropolitan district	28	54%	57%	57%	57%	54%	57%	43%

Extent of spot purchasing

The survey asked for the approximate percentage of community care packages for each user group purchased using spot contracts (but not including direct payments). Less than a third of authorities were able to provide this information.

A mapping of the development of the mixed economy of care in the early 1990s, based on detailed research with 25 English local authorities, found that all purchasing was done on a spot basis, 80% of which was operated through budgetary devolution to either a care manager or team manager (Wistow et al. 1996). Given what we know today about the consequences of different contract mechanisms (Forder et al. 2004; Netten et al. 2005), it was striking that the survey findings suggest that large proportions of community care packages were still purchased on a spot basis (see Table 8.3). This was unexpected as other research has found considerable concern among local authorities about the potential impact of direct payments on block contracts (Priestley 2005).

Table 8.3: Average* percentage of community care packages purchased as a spot purchase (not including direct payments) among different care groups in England

	Mental health	Older people	Physical disability	Learning disability	Sensory impairment	Disabled children	Carers
	80%	60%	85%	75%	85%	100%	95%
Valid (N)	29	28	27	25	22	19	17

* Median used as average

Although the tendency was to spot-purchase most community care packages, there were nevertheless wide variations in the rates reported (from 0% to 100%) and differences between user groups (see Table 8.3). There was also variation by authority type (Table 8.4). Across all user groups, shire counties were less likely to use spot purchasing than other types of authority.

Table 8.4: Average* percentage of community care packages purchased as a spot purchase (not including direct payments) among different care groups by local authority type

	Mental health	Older people	Physical disability	Learning disability	Sensory impairment	Disabled children	Carers
Unitary authority	100%	73%	90%	99%	88%	100%	100%
Valid (N)	8	8	8	7	8	6	7
London borough	70%	65%	95%	94%	100%	88%	100%
Valid (N)	5	5	4	4	3	4	2
Shire county	56%	40%	52%	30%	70%	64%	40%
Valid (N)	8	7	7	6	4	4	3
Metropolitan district	70%	70%	70%	70%	80%	95%	50%
Valid (N)	8	8	8	8	7	5	5

* Median used as average

The response level from Northern Ireland, Scotland and Wales to the questions on extent of budgetary devolution and extent of spot purchasing was too low to determine any patterns.

Budgetary arrangements for direct payments

A generic budget for all direct payment users may be established on the basis of existing uptake and increased in line with estimated demand. From responses to the survey questionnaire it is clear that some authorities favour this approach on the basis that it helps to increase transparency of direct payment funding.

Just under one third (29%) of local authorities in England operate a generic budget for direct payment users (Table 8.5). Regionally the extent to which this was the case varied quite considerably (see Table 8.6). Shire counties utilised generic budgets least often (Table 8.7).

Table 8.5: Percentage of authorities reporting a generic budget for direct payment users – all countries

	Valid (N)	%
England	100	29
Northern Ireland	3	0
Scotland	8	63
Wales	2	50

Table 8.6: Percentage of authorities reporting a generic budget for direct payment users by region

	Valid (N)	%
East	5	0
East Midlands	5	80
London	27	30
North East	9	33
North West	17	12
South East	12	8
South West	5	20
West Midlands	10	40
Yorkshire and the Humber	10	60

Table 8.7: Percentage of authorities reporting a generic budget for direct payment users by local authority administrative type

	Valid (N)	%
Unitary authority	26	38
London borough	27	30
Shire county	20	15
Metropolitan district	27	30

If there was not a generic budget, local authorities were asked to state if funding for direct payments was ring-fenced from core budgets. It has been suggested previously that ring-fencing can facilitate access to direct payments (Spandler and Vick 2004; Witcher et al. 2000). However, while ring-fenced funds for direct payments may help to kick-start implementation, there is still a longer-term need for commissioning strategies which are sufficiently flexible to respond to significant increases in direct payments uptake (Vick 2005). Indeed, some local authorities report problems when ring-fenced funds are used up but further demands are being made. Furthermore, there is some evidence that ring-fenced budgets tend to occur in a context where there is broader political resistance to direct payments coupled with concerns regarding the implications of funding

direct payments on mainstream services. This leads to funding from additional budgets rather than from centralised service allocations (Priestley 2005).

The proportion of local authorities that had chosen to ring-fence budgets for direct payments from core budgets varied by user group (see Table 8.8). Local authorities most often ring-fenced funds for services for older people and people with a physical disability, for which the greatest number of users are generally found. A third of local authorities had this arrangement. Fewer ring-fenced budgets were in place for user groups with lower levels of direct payment users. In this context levels of ring-fenced budgets for direct payments to mental health service users were comparatively high (with the exceptions of the North East, South West and Yorkshire and the Humber). One interpretation could be that ring-fenced budgets are intended to help kick-start implementation of direct payments in this underserved field. Another interpretation might be the need to separate budgets from pooled health and social care funds which cannot be spent on direct payments.

Table 8.8: Percentage of local authorities within England reporting that funds for direct payments are ring-fenced from core funds for each client group

	Valid (N)	Mental health	Older people	Physical disability	Learning disability	Sensory impairment	Disabled children	Carers
East	5	60%	60%	60%	60%	40%	40%	20%
East Midlands	1	100%	100%	100%	100%	100%	100%	100%
London	20	20%	25%	25%	20%	15%	15%	10%
North East	9	0%	17%	33%	33%	0%	17%	17%
North West	15	27%	33%	20%	20%	13%	14%	13%
South East	11	27%	45%	45%	36%	27%	36%	18%
South West	4	0%	50%	50%	25%	0%	0%	0%
West Midlands	6	33%	50%	50%	40%	17%	0%	33%
Yorkshire and the Humber	5	0%	0%	20%	0%	0%	20%	20%
ENGLAND	73	23%	34%	34%	28%	16%	19%	16%

As noted earlier, shire counties were the least likely of authority types in England to have a generic budget for all direct payments. We can now see that shire counties were most likely to have ring-fenced funds (Table 8.9). Half the shire counties ring-fenced funds for direct payments within their budgets for older people and physically disabled people, 41% within learning disability budgets, and a third for mental health services. With the exception of two care groups (older people and carers), metropolitan districts least often reported ring-fencing budgets.

Table 8.9: Percentage of local authorities reporting that funds are ring-fenced from core funds from each client group

	Valid (N)	Mental health	Older people	Physical disability	Learning disability	Sensory impairment	Disabled children	Carers
Unitary authority	17	24%	35%	41%	35%	18%	29%	18%
London borough	20	20%	25%	25%	20%	15%	15%	10%
Shire county	17*	35%	53%	53%	41%	24%	31%	24%
Metropolitan district	19	16%	26%	21%	17%	11%	5%	16%

* The valid (N) for disabled children's services was 16 rather than 17.

Once again the response to these questions from parts of the UK other than England was limited. In Scotland, 63% of councils reported having a generic budget for direct payments users. No responding trusts from Northern Ireland indicated operating a generic budget for direct payment users, nor ring-fenced funds for direct payments.

Finally, Table 8.10 shows the proportion of English local authorities that had neither a generic budget for direct payments nor ring-fenced funds from core budgets. Although there were variations between client groups, taken overall the results suggest that for each client group roughly half of all responding local authorities had neither a generic budget for direct payments nor ring-fencing arrangements.

Table 8.10: Percentage of English local authorities reporting that neither have a generic budget for direct payments, nor do they ring-fence funds for direct payments for each client group

	Mental health	Older people	Physical disability	Learning disability	Sensory impairment	Disabled children	Carers
	56%	48%	48%	52%	61%	58%	62%
Valid (N)	100	100	100	100	100	100	100

9 Care Management Policies and Procedures

Introduction and overview

While most studies of the implementation of direct payments have highlighted the pivotal role played by care managers in helping people access direct payments, these professionals have also been identified as a potentially hindering factor (Dawson 2000a; Evans and Carmichael 2002; Clark et al. 2003; 6 2004). Lack of awareness among those local authority staff in a position to promote the use of direct payments, combined with staff concerns about issues of consent, control and management of direct payments, have been implicated as factors contributing to local authorities' reluctance to embrace direct payments, particularly for certain groups of users (Ridley and Jones 2002; Dawson 2000a; Evans and Carmichael 2002). Comparatively less attention has been paid to the contribution of care management policies and procedures to the development of direct payments. Nonetheless, it has been suggested that the care management policies and procedures developed over the past 15 years are not fit for the purpose of supporting direct payments (Payne 2000). Moreover, care management has been seen as part of a systemic failure to establish necessary systems to help people access direct payments (Scope 2003).

Generally, understanding is hampered by a lack of information on local arrangements for assessment and care management within community care support services, including those purchased through direct payments. The survey therefore sought to gather information on the degree of continuity of care management arrangements across care groups.

Key findings

- Once a care package had been set up, it was most common for older people to be passed on to care management review teams, while clients with mental health problems and disabled children were least often passed to review teams.
- There was extensive regional variation in the practice of referring clients on to review teams, with no apparent correspondence with known patterns of take up of direct payments. Moreover, there was little differentiation in this practice between local authority types.
- Few authorities indicated whether it was their policy for people receiving direct payments to remain the responsibility of the assessing care manager or to be passed on to review teams after the establishment of a care package. This made it impossible to determine whether there was an impact on staff workload due to increasing numbers of people taking up direct payments, where care managers retained responsibility for them.
- Over half of all local authorities reported that social work assistants were able to assess older people, people with a physical disability and those with a sensory impairment for direct payments. This practice was more often reported by shire counties.

Care management policies and procedures and access to direct payments

Although there is no clear evidence to suggest that the care management policies and procedures developed over the past 15 years are *not* fit for the purpose of supporting direct payments, there have been various calls to widen discussion on this issue. This can be seen in emphasis placed by the Green Paper *Independence, Well-being and Choice* on 'opening up a debate about risk management and achieving the right balance between protecting individuals and enabling them to manage their own risks' (Department of Health 2005c, p.10).

In principle, there can be conflicts for staff between performance targets which emphasise the speed with which assessments and care packages are set up, and a wish to be responsive to the needs of individual clients, which may be exacerbated in the case of efforts to develop arrangements for direct payments. Ongoing fieldwork suggests that arrangements for direct payments can take longer to set up than arrangements for the use of mainstream services. The SCIE best practice guide to direct payments states that an assessment for direct payments 'may well require several sessions to complete. In addition it may be a complex situation requiring the support of advocates, family members, interpreters, and staff from a support service, as well as the service user and care manager.' (Lewis 2005, p.32) Although the guide also asserts that this process should not be any different from completing a traditional needs-led assessment, delays may indeed occur in setting up a direct payments package that are distinct from those likely to occur in the process of organising a traditional care package, including difficulties in setting up a bank account or in recruiting a personal assistant.

This assertion that the two sets of processes should take similar amounts of time fails to recognise that there tend to be three types of assessment in practice: administrative assessment, for the provision of information and advice or a simple service; coordinating assessment, for the provision of a single service or a range of straightforward services, appropriate for the majority of users; and intensive assessment, for users with more complex needs or changing needs, requiring the allocation of a designated care manager (Social Services Inspectorate 1997).

It is also important to consider the extent to which local authorities have shaped care management policies and procedures to assist the implementation of direct payments and, in particular, whether these support or hinder developments. There is some evidence to suggest that there may be variations across care groups in the way care management arrangements have been adapted in response to the implementation of direct payments. For example, in some instances where people with mental health problems have substituted a personal assistant employed via direct payments for care support arranged through a multi-disciplinary team, more regular reviews by care managers have been instituted to ensure that mental health needs are routinely checked (Ridley and Jones 2003). In contrast, it has been suggested that older people using direct payments receive less personalised attention from a named care manager than before (Clark et al. 2003).

Other relationships are even more complex, such as those between managers and professional social work staff and those between needs assessment staff and care managers in delivering direct payments (6 2004). To date, research in this area has been particularly underdeveloped.

Local arrangements for care management

In order to establish the extent of continuity within care management arrangements, the survey asked whether service users were typically referred on from the assessing care manager to a review team, once a care package had been established and was considered to be stable. The extent to which continuity of care management is provided has potential implications for ongoing care planning

processes for people receiving direct payments. Moreover, pressure to pass cases on to a review team within a set period can potentially conflict with a drive to promote direct payments.

As shown in Table 9.1, within English local authorities, the arrangement of passing on clients from their assessing care manager to a review team was most often reported in the case of services for older people (46%), perhaps reflecting the tendency for this group to require relatively straightforward packages of care. By comparison, just over a tenth of authorities reported such a practice within their mental health services or those for disabled children, possibly indicative either of the way these services are organised, or of the need for active or intensive care management for these groups. In the case of people with learning disabilities, on average 22% of clients were passed on to a review team, whereas the equivalent proportion for people with a physical disability was 33%.

Table 9.1: Percentage of authorities where service users are passed from their assessing care manager onto a review team(s) once a care package is established, responses from local authorities in England

	Mental health	Older people	Physically disability	Learning disability	Sensory impairment	Disabled children	Carers
Valid (N) 105	13%	46%	33%	22%	25%	12%	17%

Table 9.2 shows that there was extensive regional variation in the practice of passing clients onto a review team, but little difference across local authority types (see Table 9.3). Although there were distinctions between regions, patterns differed both across regions and within them by user group. The use of review teams was markedly more common in some regions for certain user groups, but regional patterns did not seem to correspond to any patterns relating to the take-up of direct payments.

Table 9.2: Percentage of authorities where service users are passed from their assessing care manager onto a review team(s) once a care package is established by region in England

	Valid (N)	Mental health	Older people	Physical disability	Learning disability	Sensory impairment	Disabled children	Carers
East	6	0%	17%	17%	0%	17%	0%	17%
East Midlands	7	43%	43%	29%	43%	43%	29%	14%
London	25	8%	52%	36%	12%	20%	16%	20%
North East	9	33%	56%	56%	56%	44%	11%	44%
North West	16	13%	44%	31%	25%	31%	13%	19%
South East	14	14%	50%	36%	21%	14%	7%	14%
South West	7	14%	29%	29%	29%	14%	0%	0%
West Midlands	10	10%	70%	40%	20%	30%	20%	20%
Yorkshire and the Humber	11	0%	27%	18%	9%	18%	9%	0%

Table 9.3: Percentage of authorities where service users are passed from their assessing care manager onto a review team(s) once a care package is established by local authority type in England

	Valid (N)	Mental health	Older people	Physical disability	Learning disability	Sensory impairment	Disabled children	Carers
Unitary authority	28	14%	43%	36%	25%	25%	14%	21%
London borough	25	8%	52%	36%	12%	20%	16%	20%
Shire counties	24	13%	42%	25%	25%	21%	13%	8%
Metropolitan district	28	18%	46%	36%	25%	32%	7%	18%

Supplementary questions were asked of those local authorities stating that service users were typically passed on from the assessing care manager to a review team once a care package had been established. These included the ratio of care

managers to social work assistants within the review teams, and the average number of weeks for the transition between services. Regrettably, the response rate to these questions was low and the responses have not been analysed here. It must be assumed that this information is not available at local level.

Lastly, we were interested to know whether direct payment service users tend to be passed onto the review team (as with the majority of cases), or if an exception was taken for direct payment service users. Such an arrangement would place the procedures for people receiving direct payments on a par with those for people receiving complex packages, who also tend to be retained by the initial care manager. Earlier fieldwork had determined that some local authorities adopt such a policy to ensure continuity of care for direct payment clients, particularly where care managers play the principal role in monitoring the use of funds, or where direct payment clients are viewed as being open to greater risk than people using mainstream services. Where local authorities operate such a policy, it is likely to result in improved monitoring of the welfare of direct payment recipients, but at the cost of increased case loads for assessing care managers. This, in turn, may create a potential disincentive to increase numbers of direct payments.

Regrettably, very few authorities responded to this question: only 5% with respect to care management for disabled children and, at the highest, 9% with respect to services for older people. Of those that did respond, only a small proportion indicated that service users remained continuously the responsibility of the assessing care manager (see Table 9.4). This was slightly higher in services for people with mental health problems, for people with a physical disability and for older people, compared with other care groups. This may suggest greater concern about the vulnerability of these groups, but the response rate is too low to draw any conclusions. It is therefore not possible to determine the impact on staff workload of an increasing use of direct payments.

Table 9.4: Percentage of authorities where service users remain continuously the responsibility of the assessing care manager – responses from English local authorities

	Mental health	Older people	Physically disability	Learning disability	Sensory impairment	Disabled children	Carers
	21%	7%	15%	15%	7%	0%	11%
Valid (N)	14	14	13	13	14	7	9

Access to direct payments through social work assistants

The survey also asked local authorities whether social work assistants were permitted to assess clients for direct payments, as fieldwork has shown that some local policies might have a tendency to prohibit social work assistants from undertaking this task. This relates to a belief that direct payments packages are more complex and should be organised only by a fully trained care manager. This may also involve a separate assessment process (CSCI 2005). Although a social work assistant would be required to offer the option of a direct payment (in line with local authorities' statutory duty to do so), they may not be sufficiently knowledgeable or confident of the process to feel comfortable doing so if not otherwise involved. This is likely to impact upon the way the direct payments option is perceived. Indeed, in fieldwork for the Direct Payments Development Fund evaluation, it has been found that where such policies were in existence, no referrals for direct payments had come from social work assistants. The related concern was therefore the ratio of qualified to unqualified staff. Although there was a good response rate to this question, very few authorities provided information on staff ratios, suggesting that they found this question impossible to complete.

In England, roughly half of all local authorities reported that social work assistants were able to assess older people and people with a physical disability, learning disability or sensory impairment for direct payments (see Table 9.5). About a third enabled them to assess carers, people with mental health problems and disabled children. The variations in rates may reflect the historical application of care management within different care groups (such as development of administrative forms of assessment and care management in older people's services, characterised by unqualified staff arranging simple packages) (Stewart et al. 2003).

Table 9.5: Percentage of social work assistants able to assess clients for direct payments, by country

	Mental health	Older people	Physical disability	Learning disability	Sensory impairment	Disabled children	Carers
England	37%	57%	56%	49%	48%	32%	38%
Valid (N)	106	107	107	106	106	106	105
Northern Ireland	0%	33%	0%	0%	0%	0%	0%
Valid (N)	3	3	3	3	3	3	3
Scotland	63%	63%	63%	63%	50%	50%	0%
Valid (N)	8	8	8	8	8	8	8
Wales	0%	0%	0%	0%	0%	0%	0%
Valid (N)	2	2	2	2	2	2	2

In Scotland (see Table 9.5), with the exception of carers, the findings were fairly consistent across care groups, ranging from a half to just under two-thirds of local authorities indicating that social work assistants could provide access to direct payments. Although responses from the other countries were extremely limited, the findings suggest that in Northern Ireland and Wales, either unqualified staff are generally unable to assess for direct payments or they do not have unqualified staff undertaking assessments.

At the regional level (see Table 9.6), there was a stark contrast between the North East (where the proportions of authorities using social work assistants were much higher than the national average) and the North West (where the proportions were relatively low). Above-average rates were also found in the South West and West Midlands for services for older people and people with a physical disability and in the West Midlands for people with learning disabilities.

Table 9.6: Percentage of social work assistants able to assess clients for direct payments, by local authority region

	Valid (N)	Mental health	Older people	Physical disability	Learning disability	Sensory impairment	Disabled children	Carers
East	6	33%	67%	67%	50%	67%	17%	50%
East Midlands	6	50%	57%	57%	50%	50%	33%	33%
London	26	38%	54%	54%	54%	54%	46%	36%
North East	9	56%	89%	78%	56%	67%	67%	67%
North West	17	18%	35%	35%	29%	29%	6%	24%
South East	14	36%	57%	57%	50%	43%	43%	29%
South West	7	43%	71%	71%	57%	43%	14%	43%
West Midlands	10	30%	70%	70%	70%	50%	20%	60%
Yorkshire and the Humber	11	45%	45%	45%	36%	45%	27%	27%

Shire counties most frequently indicated that social work assistants could assess for direct payments, as shown in Table 9.7. This was especially marked for older people and people with a physical disability, where just under three-quarters of responding authorities indicated this to be the case. For people with a learning disability, two-thirds of shire authorities indicated that social work assistants could assess for a direct payment. The proportion of London boroughs and

metropolitan authorities indicating that social work assistants could provide access to direct payments was consistent with the national average for England (see Table 9.5). Unitary authorities, in contrast, least often indicated that unqualified staff could be involved in direct payments assessment. As with the continuity of care management arrangements, there was no apparent link between access to direct payments through social work assistants and the uptake of direct payments.

Table 9.7: Percentage of social work assistants able to assess clients for direct payments, by English region

	Valid (N)	Mental health	Older people	Physical disability	Learning disability	Sensory impairment	Disabled children	Carers
Unitary authority	28	21%	50%	46%	36%	39%	21%	39%
London borough	26	38%	54%	54%	54%	54%	46%	36%
Shire counties	23	57%	71%	71%	65%	57%	35%	39%
Metropolitan district	29	34%	55%	55%	45%	45%	28%	38%

There were some exceptions to these patterns. Social work assistants were rarely able to assess direct payments for disabled children's services. The point of greatest variation was in mental health services, where shire counties were almost three times as likely than unitary authorities to report that social work assistants were able to assess for direct payments.

10 Arrangements for Funding Support Organisations

Introduction and overview

Organisations offering direct payments support rely heavily on local authority funding yet very little is known about how they are funded, or the levels of funding provided. Our survey of support organisations – which will be fully reported separately – suggests that the organisations themselves vary widely, from those that appear to be very well established (in terms of staffing, income and the range of services provided) to those with very limited capacity. This implies considerable variance in the commitment of local authorities to fund organisations which offer services to support direct payment users. In turn, this has potential implications: local authority funding is said to be crucial for both the development and sustainability of such schemes (Hasler 2003; Pearson 2003). On the other hand, as demand for such services grows, local authorities must consider how both to resource these services adequately and to ensure that they provide best value. A critical question for authorities is how the cost of supporting direct payment service users compares to the cost of supporting users of standard services. This section examines the current level of sophistication in local authority funding of direct payments support schemes and how funding varies per capita.

Key findings

- Approximately two-fifths of English local authorities in the sample did not tailor payments to support organisations to either volume of users supported, type of service provided or levels of support provided to the individual. This could suggest a relative lack of sophistication in the commissioning of support services by local authorities.
- The results did not suggest a clear relationship between local expenditure levels on support services and local rates of uptake of direct payments.
- The results suggested a fall in levels of funding of support services in the year of the survey relative to the previous financial year. This fall might be related to the substitution of local funds by DPDF funds.
- A range of sources of funding was used by local authorities to fund support services. The breadth of such funding sources was consistent with the distribution of uptake across client groups.
- Only a very small number of authorities charged users for support services.

Funding allocations to direct payments support organisations – on what basis?

Clearly the growth in uptake of direct payments has the potential to put a strain on the capacity of support services. This is evidenced in the growth of waiting lists for these services in some areas, as revealed through our survey of support organisations. How are local authorities to judge the capacity of these services to respond, and what is required to ensure that service users' needs are met? The survey sought to establish whether local authority commissioning practices implied a clear relationship between levels of payments to support organisations and levels of provider activity and service quality. Local authorities were therefore asked if they funded such schemes on the basis of any of the following:

- the number of direct payment users being served by the organisation;
- the number of services or type of service being provided;
- the level of contact with service users.

In England, half of the 108 responding authorities funded direct payments support services on the basis of the number of users served (see Table 10.1). Approximately 23% of the authorities in the sample had arrangements based on the number of services or type of services being provided. Only 10% had arrangements for funding according to levels of service user contact. Remarkably, approximately two-fifths of English local authorities in the sample did not tailor payments to support organisations to either volume of users supported, type of service provided or levels of support provided to the individual. This finding might suggest a widespread lack of sophistication in the commissioning of support services, and therefore begs the question of the effectiveness of local resources in maximising the level and quality of the support services purchased.

Table 10.1: Basis of funding allocations to direct payments support organisations by country

	Valid (N)	Number of DP users	Number/ type of services provided	Level of contact with service users
England	108	50%	23%	10%
Northern Ireland	2	0%	0%	0%
Scotland	6	67%	17%	0%
Wales	3	100%	67%	0%

The number of responses from outside England was low. Among respondents, a majority of authorities stated that their payment arrangements to support organisations depended mainly on the number of users served.

Although the low numbers available for analysis complicate the interpretation of the results, funding arrangements for support services appeared to vary between regions in England (see Table 10.2). Overall, funding arrangements in authorities in the North East, North West and South East regions were particularly unlikely to depend on indicators of support activity. The extent to which these arrangements were present may reflect the length of relationship with support organisations and the duration of time they have provided services. At the initial stages of developing support infrastructure, prospective contractual arrangements specific to client numbers may be more difficult to put in place, although target client numbers may be negotiated. The prevalence of such funding arrangements may therefore be indicative of longer-standing contractual relationships and greater levels of continuity. Previous research, for instance, has indicated the distinctly lower level of access to support schemes in the North East related to historical reluctance by local authorities to fund such schemes (Hasler and Stewart 2004). At the time of the survey, we found that the North East continued to record below-average numbers of support organisations per authority (see Table 1.3). Findings for the North West and South East are likely to be indicative of the types of relationships between support organisations and local authorities but are not consistent with lower per capita numbers. In those regions, the lack of

such arrangements may instead indicate relatively less formal relationships between support providers and local authorities.

Table 10.2: Basis of funding allocations to direct payments support organisations by region in England

	N	Number of DPusers	Number/ type of services provided	Level of contact with service users
East	6	67%	33%	0%
East Midlands	7	57%	14%	0%
London	27	59%	41%	22%
North East	9	0%	0%	0%
North West	16	38%	19%	6%
South East	14	36%	0%	7%
South West	7	57%	29%	14%
West Midlands	11	64%	27%	9%
Yorkshire and the Humber	11	73%	27%	8%

Table 10.3: Basis of funding allocations to direct payments support organisations by local authority type in England

	Valid (N)	Number of DP users	Number/ type of services provided	Level of contact with service users
Unitary authority	28	46%	11%	7%
London borough	27	59%	41%	22%
Shire county	24	42%	17%	8%
Metropolitan district	29	52%	24%	3%

Per case investment in support services

One key indicator of commitment to direct payments support is the level of funding to such schemes. Table 10.4 indicates, by local authority type and region, overall local authority expenditure levels on support services, for the financial year of the data collection and the previous financial year. In order to control for the effect of the local population, the figures were standardised by total number of direct payments in the area (see Section 2). Clearly, Table 10.4 suggests very significant variability in the level of funding across types of authorities and regions. Levels of expenditure in unitary authorities were significantly greater than in other authority types. At the regional level, authorities in South West and North East regions were found on average to spend significantly above the average observed in England (see Table 10.5). Because we are unable to discount for start-up costs, new schemes with few cases appear highly resourced per case. To some extent, as the number of service users increases the per case cost falls – as the service becomes more efficient. The most highly resourced schemes appeared to be in the North East; however, given earlier findings, we may assume that the high level of average funding recorded for the North East was probably related to low numbers of clients receiving services. This makes it difficult to infer from the results what effect funding levels may have had on uptake. The results do not appear to suggest a clear relationship between levels of expenditure in support services (standardised by numbers of local DPs) and rates of uptake of direct payments per capita. Such a relationship is also not apparent when support expenditure per capita is considered.

Table 10.4: Total local authority expenditure (£) on support services by local authority type and region (standardised by current number of direct payment cases)

	Previous financial year			This financial year		
	Mean	Median	N	Mean	Median	N
LA type						
Unitary authority	1892	789	22	1516	488	29
London borough	934	348	22	844	500	27
Shire county	614	354	18	597	297	24
Metropolitan district	332	355	22	445	368	30
LA region						
East	802	785	4	575	393	6
East Midlands	402	335	7	542	443	7
London	934	348	22	844	500	27
North East	2984	1960	7	1690	439	9
North West	252	138	11	247	2	17
South East	487	405	13	552	393	14
South West	3769	1015	4	2871	834	7
West Midlands	679	403	8	1050	602	11
Yorkshire and the Humber	433	399	8	468	368	12

Table 10.5: Total local authority expenditure (£) on support services by country (standardised by current number of direct payment cases)

	Previous financial year			This financial year		
	Mean	Median	N	Mean	Median	N
England	959	379	84	858	395	110
Northern Ireland	–	–	–	3	1	3
Scotland	257	–	4	130	1	8
Wales	1318	1318	2	2	2	3

Approximately 11% of authorities in England appeared not to fund any support activity. The reasons for this were further investigated using a bespoke postal questionnaire. Some of the most common justifications for the lack of funding included the lack of support services altogether, the fact that such services were provided in-house, or that the local support scheme was being funded entirely through the DPDF.

Changes in funding through time

Table 10.4 shows the average growth in funding by local authorities by region between the financial years 2003/04 and 2004/05. This confirms that there was a dramatic growth in investment to support services in the North East between these years. In the context of the other findings this can be taken to indicate efforts to kick-start direct payments policy across the region.

Table 10.5 shows that England as a whole recorded a decrease of approximately 11% in support service funding levels in the year of the survey relative to the previous financial year. As indicated in Table 10.4, this pattern was also found for most types of authorities and for most regions. Notable exceptions were authorities in the West Midlands, which on average experienced a 54% increase in expenditure levels. The size of the fall in funding appeared greatest for high-spending authorities, with some low spenders experiencing moderate increases.

Levels of funding of support inputs might be expected to change through time, depending on the stage of development of the service. Hence, early developmental stages might require higher resources to be committed in order to meet initial setting-up costs, to develop local infrastructure, or to allow time for local support

services to identify the most effective ways of providing the service. A recorded disinvestment between the two years may reflect a higher than normal level of investment at onset. However, given the relatively low numbers of direct payment recipients achieved nationally by the time of the survey, it is unlikely that the observed drop in funding reflected the degree of maturity in the development of support services.

Another potential explanation for the observed reduction in support funding is that local authorities reacted to the availability of the Direct Payments Development Fund (DPDF). Established in 2003, the fund granted £9m to voluntary organisations (in partnership with local councils) to create and build on support schemes for direct payments. However, since the scheme was introduced there has been a concern that local authority funding may have been substituted with DPDF, against Department of Health guidance. The intention of the fund was that it should be used to *complement* brokerage and support activity. A key expectation for the DPDF was that it would widen the pool of direct payment users, improve access to and utilisation of services, and also improve efficiency in the way that available resources act to improve the welfare of service users. It was anticipated that the funds could be used to increase levels and scope of support available to direct payment service users. However, the emphasis was that funds should not substitute for local authority funding but rather complement it (Wilson and Gilbert 2006). Although the results in Table 10.4 and Table 10.5 provide only circumstantial evidence, they support the hypothesis that at least some substitution between DPDF and local authority funds took place. Such a view is further endorsed by the fact that, as discussed above, some authorities declared the reason for not funding any support services to be related to the presence of the DPDF scheme.

Sources of funding to direct payments support schemes

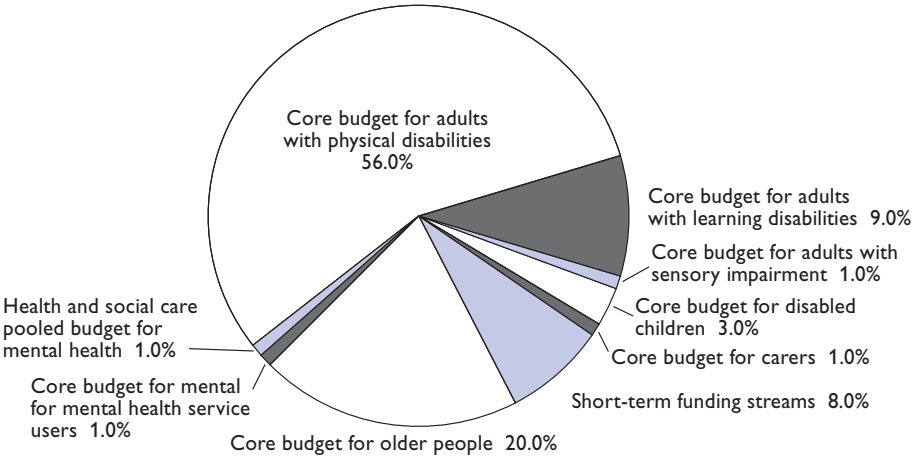
A further interest of the survey was the sources of funding directed to support schemes, especially the frequency with which certain budgets were used and the distribution in the use of funds from different budgetary sources. As indicated in Table 10.6, the results of the survey show that local support funding was not systematically sourced from one particular budget (the paucity of numbers prevented replication of the analysis for non-English authorities). Instead, the range of funding sources was consistent with the distribution of uptake across client groups.

Table 10.6: Prevalence of sources of funding for support services (England)

Budgetary sources	Proportion of authorities (%)
Core budget for adults with physical disabilities	50
Core budget for old people	39
Core budget for adults with learning disabilities	33
Short-term funding streams	30
Core budget for disabled children	27
Core budget for mental health service users	25
Health and social care pooled budget for mental health	23
Core budget for adults with sensory impairment	23
Core budget for carers	21
Health and social care budget for older adults	20
Cost savings	19

Support and brokerage services were most often funded through a community care budget for physical disability services. However, the funding sources did also reflect the promotion of direct payments to other user groups (see Figure 10.1). Older people's budgets funded the second largest share of total support

Figure 10.1: Sources of LA funding for support services, England



expenditure (approximately 20%), followed by budgets for people with learning disabilities. Short-term funding streams were used by 30% of English local authorities in the sample, which might have implications for the future stability of resourcing of support schemes. About a fifth of local authorities sourced part of their expenditure on direct payments support through health and social care pooled budgets either for older people's services or for mental health services.

Extent of charging to clients to fund direct payments support

There are few guidelines on the level of council funding of support services and the appropriate costs to be borne by users. A relevant consideration is whether and to what extent the costs of support are passed on to direct payment users. Such charging would be specific to the use of direct payments support and not related to generic charging policies for the package of care received. According to the survey results, only three local authorities required contributions from service users specifically to contribute towards the cost of support services. A further five local authorities stated that contributions could be required, depending generally on the type of service received. Typically, contributions would be required only for using a payroll service. Thus, 97% of the responding authorities in England (106) did not charge clients systematically for direct payments support. None of the responding authorities from Northern Ireland (three), Scotland (eight), or Wales (three) applied a charge for support services. Five English authorities stated that these possible charges may typically be financed by benefits to which the service user may be entitled, such as attendance allowance.

11 Flexibility in the Provision of Support to Direct Payment Users

Introduction and overview

The ability of individuals to access direct payments depends on both the resources provided by local authorities to fund support, assistance and brokerage to those considering or using direct payments, discussed in the preceding section, and the responsiveness of support services to individual needs. The importance of such sensitivity has been demonstrated through research in the context of users of mental health services (Spandler and Vick 2004), older people (Clark et al. 2004) and people from black and ethnic minorities (Clark et al. 2004). This is amid wider endorsement of the importance of access to a range of advisory services to help put individuals with health and social care needs in control of their lives (Department for Work and Pensions 2005; Department of Health 2005d). To what extent do local authorities offer people receiving direct payments a choice of support provider?

Key findings

- Around two-thirds of local authorities in England stated that they would, in principle, facilitate access to an alternative support provider at the request of a service user.
- A willingness to offer a choice of support service appeared to be linked to local supply: areas with more support organisations seemed to offer more choice.
- Local authorities from the North West showed particular commitment to funding an alternative support provider.
- Many local authorities showed considerably less inclination to *fund* alternative support providers, compared to their willingness to facilitate access to them. This was likely to be due to already funding support and brokerage costs via the hourly rates.

Facilitation of service user choice

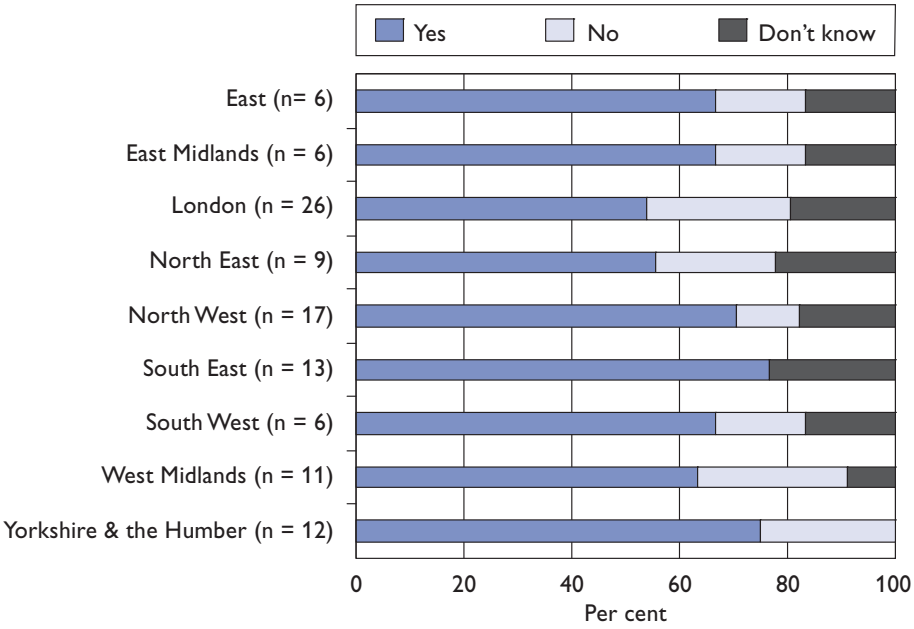
In Section 7 we showed that approximately one quarter of local authorities in England supplied funds directly to service users to meet the costs of any support needed with their direct payment. Such an arrangement implies that service users have some choice in how to meet their support needs, contingent on the availability of services. We were also concerned to explore the overall extent to which local authorities allow service users a choice of support agency when using direct payments (i.e. including situations where these circumstances were not in place). Specifically, the survey asked authorities if they would facilitate choice if a service user wished to obtain support from an organisation other than the one contracted locally for that purpose.

In England, out of 105 responses, two-thirds (65%) of local authorities stated that they would, in principle, facilitate access to an alternative support provider at the request of a service user; indeed, only 12% said they definitely would not do so. Of the seven Scottish local authorities responding to the survey, most indicated that they would facilitate this choice, but the numbers were too small to suggest a clear pattern. Responses from Northern Ireland and Wales were too low to enable analysis of this issue.

At the time of the survey, 40 local authorities in England were host to two support organisations and three local authorities were host to three support organisations, although these were not necessarily involved in multiple service contracts.

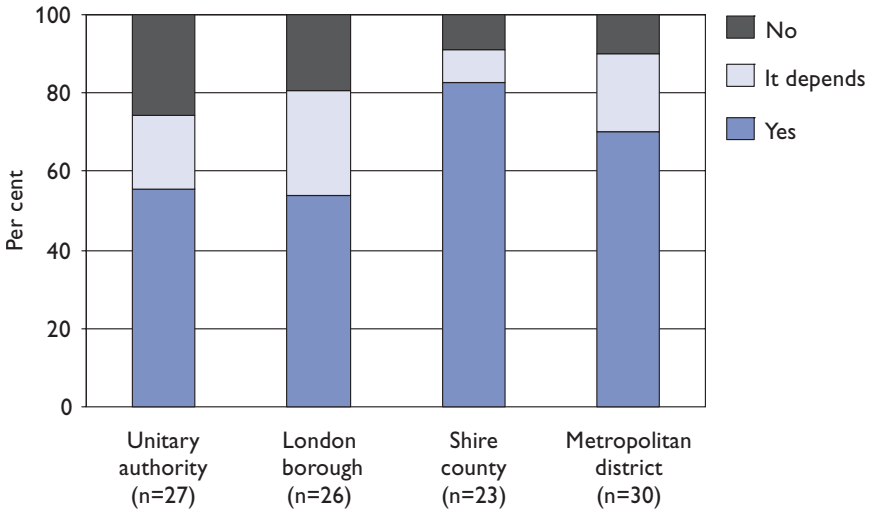
In England, there would appear to be a link between local authority willingness to offer users a choice of support organisation and the number of support organisations within the area. Thus, the regions with the greatest percentage of local authorities offering this flexibility were the North West, South East and Yorkshire and the Humber (Figure 11.1), which were also the regions with the highest concentration of support organisations. This suggests that flexibility in offering a choice of support services may be linked to local supply.

Figure 11.1: Would a service user be able to use an alternative direct payments support provider if they wished?



There also appears to be a greater willingness among shire counties and metropolitan districts to offer this choice, compared to unitary authorities and London boroughs (see Figure 11.2). One explanation for this willingness among shire counties may be their larger geographical size, giving them a greater need to forge links with a selection of support providers across different areas to reach a dispersed population. The converse would be the case for unitary authorities.

Figure 11.2: Would a service user be able to use an alternative provider provider if they wished?



Capacity of local authorities to fund alternative support providers on an individual basis

The survey also inquired whether, in the event of a person choosing an alternative support provider, it would be possible to ring-fence the support costs, to ensure that the provider would be compensated for its services. Fewer local authorities responded to this question, suggesting that this has not been a live issue for them. Of these, only a minority (27%) indicated that such a course would be possible, with the same proportion (27%) indicating that it would definitely not be possible (and the remainder suggesting that it would depend on circumstances). There were some striking variations by region but little contrast by local authority administrative type, as shown in Figures 11.3 and 11.4.

Many local authorities appeared to show considerably less inclination to *fund* alternative support providers than to facilitate access to them. This is particularly visible in the South East, where the greatest proportion of local authorities indicated that they would offer a choice of service provider in principle, but the lowest proportion would be able to make funding available to resource an alternative provider (see Figure 11.3). This was not especially surprising since around half of authorities here funded support and brokerage costs via the hourly

Figure 11.3: Could funding be made available to an alternative support organisation if this was the service user's preference?

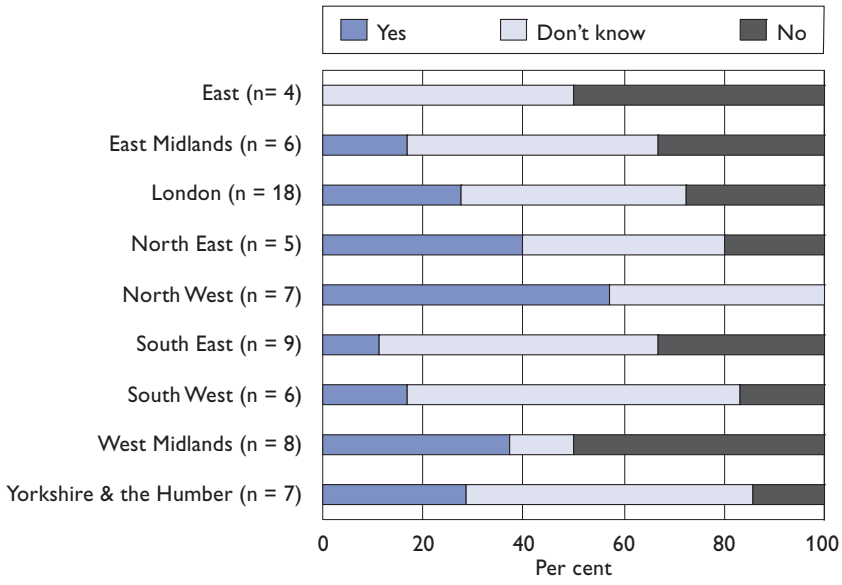
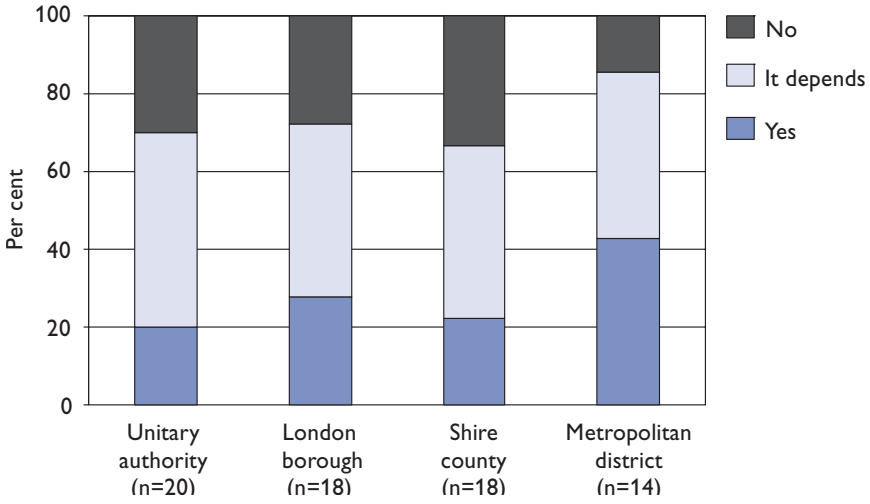


Figure 11.4: Could funding be made available to an alternative support service?



rates (see Section 7) and therefore could be anticipated to be less likely to be able offer funding to service users by another means. Despite this, the majority (56%) of authorities in the South East actually reported that it would depend upon circumstances (whereas only 33% stated that this would not be possible). It would seem that some authorities in the South East would be potentially willing to ring-fence support funds to allow service user choice despite arrangements to fund support and brokerage costs through hourly direct payment rates.

In the East and East Midlands the same percentage stated that they would *not* be able to fund an alternative support provider as stated funds for support and brokerage were paid to the service user through the hourly rate, as would be anticipated.

Local authorities in the North East and West Midlands regions stated frequently that they had capacity to fund an alternative support provider on request. This was consistent with the fact that both regions diverted almost no resources for support and brokerage into hourly rates (see Section 7). The most frequent and most definitive statements of ability to fund alternative support came from authorities from the North West (57%), despite a 35% rate of providing for such costs through hourly rates (second only to the South East). This might indicate a particular North West commitment to service user choice when using direct payments.

Funding alternative support providers: some issues

Although access to a range of support and brokerage services is considered advantageous, there are also potential drawbacks to the different options through which choice of support provider can be achieved. Employing a flat-rate allowance within hourly rates to finance support and brokerage costs requires setting a rate at a level that will suit those with the most complex support need. The fact that generally this practice is uncommon suggests recognition that is not necessarily efficient. Furthermore, it is unlikely that an hourly rate allowance would be representative of the full per capita cost of the service. Such choice is therefore contingent upon either additional local authority resources being paid to support providers, or extra funding being gained by other means, such as charitable or grant funding (as with the Direct Payment Development Fund). Without this, the viability of even limited supply is questioned. Even if unrepresentative of the full cost of support services, an hourly rate allowance does provide a high degree of control for each recipient. This may encourage support organisations to become

more responsive. It would also support alternative options such as third-party support.

Where local authorities pursue flexibility through allowing one individual's quota support funding to be diverted, there is less freedom for service users, particularly if the option is available only on request. What demand may result from such policy is also unlikely to be sufficient to stimulate supply in the absence of other resources.

A final approach to secure access to a range of support and brokerage services would be to invest in multiple service contracts, either alone or in conjunction with the previous methods. This provides the greatest security for providers (albeit often for a limited length of time) and provides a means by which start-up costs can be met. The drawback to this is that relatively limited funds are then spread across a range of different service providers. The process of developing capacity in support services in areas where there was previously little or no provision may require concentrated investment in a single source. Even if support has become well established, investing in multiple service contracts may not be an efficient means of securing services to meet diverse needs. Care would need to be taken to ensure the existence of two service contracts did not result in unnecessary duplication of tasks and costs, as was found in an early study by Dawson (2000b).

In conclusion, at current levels of uptake, service user choice (by the mechanisms discussed) is unlikely to be sufficient in itself to stimulate a wider supply of direct payments support services. Local authorities should therefore encourage organisations to consider either diversifying to meet the needs of different service users or engaging with other local organisations that are better placed to do so. In addition, support organisations would benefit from seeking multiple resource mechanisms. Other practical solutions include collaboration between agencies for the provision of core tasks such as payroll services.

12 Factors Aiding and Hindering the Implementation of Direct Payments

Introduction and overview

Although there has been a slow, steady growth in the numbers of people receiving direct payments since their introduction, overall take up of direct payments has remained low in comparison to the number of people who may be eligible for them. Previous research has highlighted a range of factors that have contributed to or hindered progress in implementing direct payments. Most such research has tended to comprise small-scale, qualitative studies, often with a fairly specific focus in terms of either client group or a specific aspect of implementation. A key aim of the national direct payments survey was therefore to take a more systematic approach to assessing the necessary conditions to support implementation, in order to inform future development. The survey therefore sought local authority views on the extent to which a range of factors either aided or hindered the implementation of direct payments, drawing on variables identified in the literature (6 2005).

Key findings

- Local authorities were more likely to identify factors that positively assist the implementation of direct payments than factors that hinder implementation.
- Several factors were identified as critical in England. Most concerned the local organisational infrastructure (an effective support scheme, staff training and support, local authority leadership and the provision of accessible information for potential recipients), but others included positive staff attitudes, demand for direct payments from service users and carers, and national legislation, policy and guidance.
- Three factors were cited as important in hindering progress: concern about managing direct payments amongst service users and carers, staff resistance to direct payments, and difficulties regarding the supply of people to work as personal assistants.
- Apart from Wales, there was a fair degree of consistency across the countries in the most frequently identified factors that aid implementation, although authorities in Scotland and Northern Ireland suggested additional factors as critical. There was greater variation across countries in the factors identified as hindering implementation.
- While there was reasonable consistency between the national findings on the factors affecting implementation and findings by local authority type, a few issues were perceived differently. For example, unitary authorities tended to suggest that leadership issues represented a challenge to implementation, whereas shire counties most often found that leadership had assisted them.
- Unitary authorities placed more emphasis on lack of service user and carer demand, inadequate staff training and support, and competing priorities for policy implementation as hindering the process. Along with London boroughs,

they identified targeted support within the direct payments support service as having supported progress.

- There were regional differences in the degree to which the supply of potential personal assistants was seen as an asset or a barrier to implementation. Against expectations, personal assistants were most frequently indicated by shire counties as having aided implementation.
- Shire counties most often stated that flexibility in their local commissioning strategy and operating a ring-fenced system had aided implementation. London boroughs placed more weight on central performance monitoring than other local authority types. They were also more likely to view an underdeveloped support service as critical, compared to other regions, possibly linked to weaknesses in the local voluntary sector.
- Metropolitan districts less often identified a strong local voluntary sector as an aiding factor but also less often than other authority types cited service user and carer concerns about direct payments, staff resistance and lack of accessible information as hindering implementation.

Identification of factors likely to have aided or hindered the implementation of direct payments

The survey sought local authority views on the extent to which a range of factors either aided or hindered the implementation of direct payments, drawing on variables identified in the literature (6 2005). These include:

- Leadership within the local authority, including a local champion (Carlin and Lenehan 2004) and support from senior management to develop the necessary infrastructure and engender the cultural context (Spandler and Vick 2004; Witcher et al. 2000).
- Local political support (CSCI 2004).
- Support of public sector trade unions, the lack of which may contribute to local authority caution in rolling out direct payments (Hasler et al. 1999; Riddell et al. 2005).
- A strong local voluntary sector, including organisations that can be commissioned to provide support (Fernández et al. 2007).
- Articulated demand from service users and carers (Stainton and Boyce 2002; Glasby and Littlechild 2002).
- Accessible information for service users and carers (Barnes and Mercer 1996; Kestenbaum 1996; Hasler et al. 1999; Newbigging and Lowe 2005. Simon-Rusinowitz et al. 2001), the lack of which can hinder local authority promotion (Maglajlic et al. 1998; Ridley and Jones 2003; Clark et al. 2004).
- An effective support scheme, including sufficient resources and capacity, its independence from the local authority and its taking a proactive stance (Hasler 2003; Ridley and Jones 2002; Stainton and Boyce 2002; Witcher et al. 2000).
- Targeted support to promote take up amongst certain groups, such as ethnic minorities or other marginalised groups (Lewis 2005).
- Training and support for front-line staff (MacFarlane 2002; Maglajlic et al. 2000; Brandon et al. 2000; Glasby and Littlechild 2002; Ridley and Jones 2003), which may also be linked with improved confidence in handling direct payments (Carmichael and Brown 2002). Some support services provide advice and assistance to staff (Spandler and Vick 2004).
- Positive staff attitudes, including willingness to support and promote the policy (Holman and Bewley 1999; Stainton 2002; Fernández et al. 2007), possibly affecting attitudes to issues of consent, control and management of direct payments, as well as risk (Holman and Bewley 1999; Revans 2000; Dawson 2000; Evans and Carmichael 2002).
- Local availability of people to work as personal assistants, which may be linked to pay levels and working conditions (Carmichael and Brown 2002; Ungerson 2004; Glendinning et al. 2000a).

- Flexibility of commissioning strategy and ring-fenced budget for direct payments (Witcher et al. 2000; Spandler and Vick 2004).

Over the last few years, increasing the number of people receiving direct payments has been a key government objective. To this end, various imperatives and incentives have been introduced. These include revised regulations to support local implementation (DH 2003), the provision of the direct payments development fund (DPDF) awards and the introduction of a performance indicator on the numbers of adults and older people receiving direct payments (from 2004–05, this became a key performance indicator in determining local authority 'star' ratings). Inspection and regulation services can also aid the implementation of direct payments. For example, consideration of progress in implementing direct payments across service user groups is a recent feature of the Commission for Social Care Inspection's review of local services. In recognition of these changes, our list of factors affecting the progress of direct payments included, in addition to the above:

- National legislation, policy and guidance;
- Direct payments development fund award;
- Central government performance management; and
- Inspection and regulation of local authority services.

Attention was also given to the potential contribution of:

- The National Centre for Independent Living;
- The Belfast Centre for Independent Living; and
- Direct Payments Scotland; in providing information, training and other assistance to the development of direct payments.

Although in most cases, the factors hindering the implementation of direct payments were the converse of those helping it, the item on trade unions and three of the central government 'drivers' were omitted from the list of hindering factors:

- The direct payments development fund award;
- Central government performance monitoring; and
- Inspection and regulation of local authority services.

Three other factors were added to the list of hindering factors, the first two of which concern general issues associated with policy implementation:

- Competing priorities for policy implementation;
- Incongruence of direct payments policy with other local authority duties; and
- User and carer concerns about managing direct payments, including fears of being unable to manage a budget (Glendinning et al. 2000a, b; Ridley and Jones 2003) and concern about the administrative burden of being an employer (Leece et al. 2003; Macfarlane 2002; Carmichael and Brown 2002).

Survey respondents were, of course, able to add additional factors to these lists. For all factors, respondents were asked to indicate whether it had been *critical, important* or *(un)helpful* in hindering or supporting implementation.

We analysed the selection of items overall as well as the weight given to selected factors – whether they were deemed to be *'critical', 'important* or *'helpful'*. It was assumed that a factor which was not selected at all was seen to be *not relevant* to the local area, indicated in Tables 12.1 and 12.2 as '*not applicable'*. Further fieldwork confirmed that items not ticked were not deemed to be relevant. Any apparent inconsistencies in response were checked, such as a manager who felt that 'leadership' had both aided and hindered implementation because she had contributed to expanding the local direct payments scheme but had been unable to give sufficient time to the strategic development of the local direct payments arrangements.

The weight given to specific factors helps to signal where priorities might lie in facilitating further local development of direct payments, although some particular contextual or structural factors may present additional challenges.

Table 12.1: Factors aiding direct payments implementation – responses from local authorities in England

Aiding factors (listed in order of 'critical' rating)	Critical	Important	Helpful	Not applicable*	Total
	%	%	%	%	%
Effective direct payments support scheme	63	18	7	11	100
Training and support for front line staff	59	19	8	14	100
Leadership within the LA	53	19	8	19	100
Positive attitude to direct payments among staff	48	17	16	20	100
National legislation, policy and guidance	41	28	12	18	100
Accessible information on direct payments for service users and carers	36	28	14	22	100
Demand from service users and carers for direct payments	32	28	17	22	100
Availability of people to work as personal assistants	31	16	8	45	100
Targeted support within the direct payments support service to promote direct payments	25	23	8	44	100
Local political support for direct payments	25	21	20	34	100
Central government performance monitoring	18	21	27	34	100
Strong local voluntary sector	15	19	19	47	100
Direct payments developments fund award	13	21	22	44	100
Flexibility of commissioning strategy	12	29	8	51	100
Inspection and regulation of local authority services	7	13	19	60	100
Other factors (1)	6	2	1	91	100
Ring-fenced budget for direct payments	6	14	6	75	100
Other factors (2)	3	2	1	95	100
Support from the National Centre for Independent Living	2	6	33	59	100
Support of public sector trade unions	1	2	9	88	100

Valid (N) = 109

* It was assumed that a factor which was not selected at all was seen to be *not relevant* to the local area and is counted as '*not applicable*'.

Table 12.2: Factors hindering direct payments implementation – responses from local authorities in England

Hindering factors	Critical	Important	Unhelpful	Not applicable*	Total
(Listed in order of 'critical' rating)	%	%	%	%	%
Difficulties with the availability of people to work as personal assistants	17	30	16	37	100
Concern about managing direct payments among service users and carers	17	29	22	32	100
Resistance to direct payments among staff	12	32	21	35	100
Competing priorities for policy implementation	11	13	15	62	100
Inadequate training and support for front line staff	10	17	12	62	100
Underdeveloped direct payments support scheme	10	7	7	75	100
Lack of demand from service users and carers for direct payments	8	17	15	60	100
Incongruence of direct payments policy with other local authority duties	7	13	11	69	100
Inflexibility of commissioning strategy	6	6	7	81	100
Weak local voluntary sector	5	11	13	72	100
Insufficient leadership within LA	5	7	5	84	100
Lack of targeted support within the direct payments support	4	12	12	73	100
Lack of accessible information on direct payments for service users and carers	4	5	24	68	100
National legislation, policy and guidance	3	7	13	77	100
Lack of ring-fenced budget for direct payments	2	8	9	81	100
Lack of local political support for direct payments	1	4	7	88	100
Lack of support from the National Centre for Independent Living	–	4	6	91	100

Valid (N) = 109

* It was assumed that a factor which was not selected at all was seen to be *not relevant* to the local area and is counted as '*not applicable*'.

Factors deemed to have positively aided the implementation of direct payments

Seven factors stood out as being deemed most *critical* to the implementation of direct payments in England (see Box 12.1). In all cases, the proportion of authorities rating these seven factors as *critical* outnumbered the proportion not identifying them as an aiding factor at all.

Discounting the ratings given, over three quarters of all responding local authorities in England indicated that these seven factors had in some way positively aided the implementation of direct payments in their area (see Table 12.3). An effective direct payments support scheme was the most frequently selected factor, noted by 89% of authorities. Respondents also frequently cited staff training and support (86%), leadership within the local authority (81%) and positive attitudes among staff (80%) amongst the local factors with a positive impact. Demand from service users and carers, and the provision of accessible information for them about direct payments were both identified by 78% of responding authorities. Of particular interest, national legislation, policy and guidance was also cited by 82% of English authorities, suggesting that central government efforts to provide technical advice and direction to facilitate local progress has been felt to be beneficial.

Box 12.1: Top seven critical aiding factors

- Effective direct payments support scheme
- Training and support for front-line staff
- Leadership within the local authority
- Positive attitude to direct payments staff
- National legislation, policy and guidance
- Accessible information on direct payments for service users and carers
- Demand from service users and carers

In addition to the above, the following factors were also seen to have aided implementation, on average identified by over half of all responding local authorities (see Table 12.3):

- Local political support for direct payments;
- Central government performance management;
- Targeted support within the direct payments support service to promote or assist the take up of direct payments within specific service user groups;
- Direct payments development fund;
- Availability of people to work as personal assistants;
- Strong local voluntary sector.

Almost a third of English local authorities ranked the availability of people to work as personal assistants as a *critical* aiding factor. Around one quarter considered targeted support to be a *critical* aiding factor, while a further quarter considered it to be *important*. The results for local political support were fairly evenly spread across the *critical*, *important* and *helpful* bands, although it was identified slightly more frequently as *critical* to supporting progress. Most authorities that cited central government performance monitoring as aiding implementation (27%) rated this factor as *helpful*, although around a fifth also rated this as either *important* or *helpful*. The direct payments development fund was also rated as a *helpful* by 21% of authorities and an *important* factor by another 22%. Similar results were found for strong local voluntary sector, with approximately a fifth (19%) of local authorities citing this as either *important* or *helpful*.

Table 12.3: Aiding factors overall in England

	(n=109)		
	Rank[a]	Valid (N)	%[b]
Effective direct payments support scheme	1	97	89
Training and support for front-line staff	2	94	86
National legislation, policy and guidance	3	89	82
Leadership within the local authority	4	88	81
Positive attitude to direct payments among staff	5	87	80
Demand from service users and carers for direct payments	5	85	78
Accessible information on direct payments for service users and carers	7	85	78
Local political support for direct payments	8	72	66
Central government performance monitoring	9	72	66
Targeted support within the direct payments support service	10	61	56
Direct payments developments fund award	11	61	56
Availability of people to work as personal assistants	12	60	55
Strong local voluntary sector	13	58	53
Flexibility of commissioning strategy	13	54	45
Support from the National Centre for Independent Living	15	45	41
Inspection and regulation of local authority services	16	43	39
Ring-fenced budget for direct payments	17	27	25
Support of public sector trade unions	18	13	12
Other factors (1)	19	10	9
Other factors (2)	20	6	6
Support from Belfast Centre for Independent Living	21	1	1

a Factors of were given equal weighting and then ranked according to the frequency in which they occurred

b Percentages refer to the proportion of local authorities that cited the item as either 'critical', 'important' or 'helpful'

The remaining factors were cited by less than half of English authorities (see Table 12.3). Most notably, almost a third of authorities (29%) indicated that flexibility of commissioning strategy was an *important* aiding factor and about a fifth (19%) pointed to the inspection and regulation of local authority services as *helpful* in supporting implementation. At the end of the spectrum, fewer than a third of English local authorities rated having a ring-fenced budget for direct payments (25%) as aiding implementation, although among those that selected this factor, it was most often rated as *important*. Little more than a tenth (12%) of local authorities cited the support of public sector trade unions as aiding implementation.

In general, there appeared to be a fair degree of consistency across the UK in the factors identified as aiding implementation. In Scotland, six of the top seven *critical* aiding factors were the same as those in England, the exception being demand from service users and carers for direct payments, which was cited by all but one of the responding Scottish authorities, but generally rated as *important*. Furthermore, six of the eight responding Scottish councils also indicated the availability of people to work as personal assistants and having a strong local voluntary sector as factors facilitating implementation, but the weight given to these factors varied across councils.

Although based on very limited data, all three of the responding Health and Social Services Trusts in Northern Ireland rated an effective direct payments support scheme, staff training and support, the provision of accessible information, positive staff attitudes and the support from the Belfast Centre for Independent Living as *critical* to implementation. In addition, all three also cited national legislation, policy and guidance, service user and carer demand, the availability of people to work as personal assistants, the flexibility of commissioning strategy and central government performance monitoring as aiding implementation overall. Of

these, the first three factors were rated by two trusts as *critical* to supporting implementation.

Great caution needs to be exercised in interpreting the results from Welsh authorities, given that only three responses were received. From this limited response however we noted that only three of the seven most frequently cited factors by English authorities were cited: effective direct payments support scheme, staff training and support and accessible information for users and carers. The other factor cited by these authorities was local political support.

Factors deemed to have hindered the implementation of direct payments

There were notably fewer responses concerning the factors that hinder implementation of direct payments. Nonetheless in England, approximately two thirds of local authorities (see Table 12.4) cited the following three factors as having hindered implementation:

- Concern about managing direct payments among service users and carers
- Resistance to direct payments among staff
- Difficulties with the availability of people to work as personal assistants.

Table 12.4: Hindering factors overall in England

	(N=109)		
	Rank[a]	Valid (N)	%[b]
Concern about managing direct payments among service users and carers	1	74	68
Resistance to direct payments among staff	2	71	65
Difficulties with the availability of people to work as personal assistants	3	69	63
Lack of demand from service users and carers for direct payments	4	44	40
Inadequate training and support for front line staff	5	42	39
Competing priorities for policy implementation	5	42	39
Lack of accessible information on direct payments for service users and carers	7	35	32
Incongruence of direct payments policy with other local authority duties	8	34	31
Weak local voluntary sector	9	31	28
Lack of targeted support within the direct payments support service	10	30	28
Underdeveloped direct payments support scheme	11	27	25
National legislation, policy and guidance	12	25	23
Inflexibility of commissioning strategy	13	21	19
Lack of ring-fenced budget for direct payments	13	21	19
Insufficient leadership within LA	15	17	16
Lack of local political support for direct payments	16	13	12
Lack of support from the National Centre for Independent Living	17	10	9

a Factors of were given equal weighting and then ranked according to the frequency in which they occurred.
b Percentages refer to the proportion of local authorities that cited the item as either 'critical', 'important' or 'unhelpful'.

Most frequently, local authorities rated all three factors as *important*, rather than *critical* or *unhelpful* hindering factors (see Table 12.2).

Further, between a third and two-fifths of local authorities in England cited the following five factors as hindering implementation (see Tables 12.2 and 12.4):

- Lack of demand from service users and carers for direct payments, most often rated as an *important* or *unhelpful* hindering factor;
- Competing priorities for policy implementation, with fairly similar proportions of authorities rating this as an *unhelpful*, *important* or as a *critical*;
- Inadequate training and support for front-line staff, most often cited as an *important* factor;

- Lack of accessible information on direct payments for service users and carers, generally rated as an *unhelpful* hindering factor;
- Incongruence of direct payments policy with other local authority duties, most frequently cited as either an *important* hindering factor or as *unhelpful* to implementation.

Lastly, around a quarter of English local authorities pointed to the following factors as hindering progress in implementation (see Tables 12.2 and 12.4):

- An underdeveloped direct payments support scheme, mostly seen as a unhelpful;
- A lack of targeted support within the support service to assist service users and carers to take up direct payments, generally rated as either an *important* or an *unhelpful* hindering factor;
- National legislation, policy and guidance, possibly associated with a lack of clarity regarding certain issues; interestingly, this had been cited as a key factor aiding implementation.

The remaining hindering factors were cited by fewer than a fifth of local authorities (see Table 12.2). Where they were selected, lower weights were given to their relevance compared to the previous items (see Table 12.4).

Limited data from the other countries, in particular from Wales and Northern Ireland, restricted the extent to which comparisons could be drawn. However, there did appear to be some differences in the perceived barriers to progressing direct payment implementation.

In Scotland, less significance was given to staff resistance as a hindering factor, although the other two key factors identified by English local authorities (concerns among service users and carers about managing direct payments, and difficulties with the availability of people to work as personal assistants) were cited by the majority of Scottish councils (most often rated as an *important* hindering factor, as in England). In addition, Scottish councils cited the lack of demand for direct payments by service users and carers and competing priorities for policy implementation slightly more frequently than their English counterparts, although the differential in the volume of responses from the two countries makes it difficult to draw firm conclusions.

All three of the responding health and social care trusts from Northern Ireland selected difficulties with the availability of people to work as personal assistants, and concern about managing direct payments among service users and carers as having hindered implementation (twice rated as *critical)*. Two trusts also identified the following hindering factors, with assigned ratings of either *critical* or *important*:

- Lack of local political support for direct payments
- Incongruence of direct payments policy with other local authority duties
- Lack of demand for direct payments by service users and carers
- Lack of accessible information on direct payments for service users and carers
- Resistance to direct payments amongst staff
- Competing priorities for policy implementation.

Only one factor was cited by all three responding Welsh authorities: lack of accessible information for service users and carers (twice rated as *critical)*. Two authorities identified staff resistance as hindering implementation, but only one identified the other two factors most frequently selected by English local authorities. On the other hand factors cited less frequently by English local authorities were identified by two out of the three: insufficient leadership within the local authority and an underdeveloped direct payments support scheme (and rated as *critically* hindering). Two of the factors cited by a third to two fifths of English authorities were identified as hindering progress: inadequate staff training

and support, and lack of demand from service users and carers (most often rated as *important*).

Variations in responses to the implementation factors

The findings were fairly similar for local authority type,[1] but some regional variation was seen, both in the responses and in the weights ascribed to them.[2] This section outlines some of these variations.

Local authority issues

As with any development process, successful implementation of direct payments is likely to be dependent on a range of inter-related issues, particularly the local infrastructure, culture and context. Leadership seemed to be an important issue in this context. Shire counties cited leadership most frequently (92%) as a factor aiding implementation (along with an effective support scheme and national legislation), with many more viewing this as *critical* compared to other local authority types. High proportions of all authorities cited leadership as positively aiding implementation although identified least often by unitary authorities (66%). Conversely, insufficient leadership was cited slightly more often by unitary authorities and London boroughs as *hindering* implementation. The size of an authority may have a bearing on the resources that can be dedicated to leadership roles, with implications for capacity to focus on the development of direct payments.

The contribution of local political support to assisting strategic leadership and direction for direct payments was cited, on average, by 66% of local authorities in England, with some variation by region. Such support was particularly indicated as helpful by authorities from the Eastern region (83%). There were few differences by local authority type, although metropolitan districts rated this most frequently as *critical*.

As highlighted in Section 8, local commissioning arrangements may also affect the expansion of direct payments. Shire counties cited flexibility in commissioning strategy more frequently than other local authority types (63%, compared with 52% of London boroughs, 43% of metropolitan districts and 41% of unitary authorities). Whereas all types of authority selecting this factor generally rated it as *important*, shire counties most often assigned a *critical* rating.

Shire counties also most frequently cited operating a ring-fenced budget for direct payments as positively aiding implementation (38%), but, notably, they utilised this budgetary arrangement most often. Only one fifth of other local authority types indicated that a ring-fenced budget for direct payments had positively aided implementation.

Much emphasis has been placed by the literature on the role of front-line staff in mediating access to direct payments. The authorities selecting positive staff attitudes least frequently as an *aiding* factor were those in the West Midlands (64%) and North East (67%) regions, compared to authorities in London (89%). Overall, a positive attitude among staff was most often rated as *critical* to development, particularly by London boroughs and shire counties.

Put in the negative, resistance to direct payments amongst staff was cited less frequently by metropolitan authorities than others as hindering implementation, and London boroughs were most likely to rate this factor as *critically* hindering implementation. There was also some regional variation, with authorities in the

Eastern region citing this as a hindrance most frequently (83%), compared to authorities in the North West, where the proportion was only one quarter. This finding was somewhat unexpected, given that the Eastern region has some of the highest average numbers of direct payment clients.

Service user issues

Lack of awareness and understanding of direct payments among potential users has often been cited as a barrier to take-up. A lack of demand from service users and carers for direct payments was most often identified by authorities in the North East (86%), the region with fewer people receiving direct payments across all groups and below-average numbers of support organisations. It has been suggested that access to direct payments in the North East might be linked to poor availability of centres for independent living and fewer disability groups, compared with other parts of the country (Hasler and Stewart 2004). Although there is no evidence to suggest a clear relationship between the presence of these factors and demand for direct payments, it is generally recognised, at least in the areas of physical and learning disability, that these can help to stimulate access. This possible link is challenged by results from the South East, however; although the region has the second greatest number of support organisations, a relatively high proportion of authorities (69%) also selected lack of demand from service users and carers as a hindering factor. This compared markedly with the responses from the East Midlands and Yorkshire and the Humber, where fewer than a fifth of authorities cited this as a hindering factor.

With respect to raising awareness amongst potential recipients, a higher proportion of metropolitan districts rated accessible information for service users and carers as an *important* aiding factor, whereas the tendency among other local authority types was to rate this factor as *critical*. Regionally, lack of accessible information was found to be most frequently an issue among authorities in the South East (54%), West Midlands (45%), North East (44%) and East Midlands (43%), compared to fewer than a fifth of authorities in the South West and Eastern regions. It might be noted that all of the responding authorities from the Eastern region identified the provision of accessible information as aiding implementation.

Service user and carer concerns about managing direct payments has been identified as a key issue in the literature. Whilst cited as one of the three key factors hindering implementation overall (national average 68%), this factor was most often cited by authorities in the Eastern (83%) and East Midlands (86%) regions and by unitary authorities (79%) and shire counties (75%); it was least often identified by metropolitan districts (57%) and by authorities in the North West (45%). However, London boroughs (30%) were most likely to rate this factor as *critically* hindering implementation, compared to very few (7%) metropolitan districts.

Recruitment of personal assistants

Although not all direct payments are used to employ personal assistants, this is a common use of direct payments (Flynn 2005; Glasby and Littlechild 2002). Problems in recruiting personal assistants may be associated with a range of issues, including the nature of the local labour market and the rates paid through direct payments, affecting the ability of people with such payments to compete as potential employers. The survey found wide variation in the extent to which the availability of people to work as personal assistants was viewed to be an issue aiding or hindering implementation. It was anticipated that London boroughs and shire counties would report the greatest difficulty in the supply of personal assistants, given that these types of authorities offer the most flexibility to increase

hourly rates in order to match local labour costs (see Section 7). Contrary to expectations the availability of people to work as personal assistants was cited more frequently as *aiding* implementation by shire counties (67%) and London boroughs (56%), compared with metropolitan districts (50%) and unitary authorities (48%). The regional breakdown showed wide variation, ranging from 83% of Eastern authorities to none of the authorities from the South West. Conversely, *difficulties* in finding people to work as personal assistants was most often highlighted by authorities in the East Midlands (86%) and South West (86%) and least frequently by authorities in the Eastern (50%) and North West regions (50%). Between local authority types, unitary authorities also rated difficulties recruiting personal assistants as a *critically* hindering factor far more often than other authority types.

Support organisation issues

As indicated, overall, an effective direct payments support scheme was the factor identified most often as aiding implementation, while an underdeveloped support service was cited by around a quarter of local authorities as hindering the process. London boroughs cited this issue more frequently as a problem and were more likely to view it as *critical* than other regions and local authority types.

The majority of London boroughs (63%) and shire counties (58%) cited a strong local voluntary sector as positively aiding implementation, compared to a minority of metropolitan districts (40%). A sizeable minority of boroughs (37%) also cited a weak local voluntary sector as hindering implementation. Although this may seem inconsistent, it suggests that the distribution of voluntary organisations which might provide support is patchy. There was wide regional variation in the identification of a strong local voluntary sector as aiding implementation, ranging from only 14% of authorities in the East Midlands and South West to 69% of those in the South East. Authorities in the North West and South West also identified a weak local voluntary sector as hindering implementation.

There were marked difference between local authority types in the importance attributed to targeted support as a means of enabling access to direct payments. Overall, London boroughs and unitary authorities both cited this factor frequently (70% and 69% respectively) while a much lower proportion of metropolitan authorities (40%) and shire counties (38%) did so. This could be interpreted to mean either that targeted support is less frequently operated by metropolitan authorities and shire counties or that the approach has been found to be less helpful in these authorities. Of those authorities that selected this factor, London boroughs and metropolitan districts most often rated it as *critical*, while unitary authorities and shire counties most often rated it as *important*. Some regional variations can be noted, with the highest proportion of authorities citing this factor being those in the Eastern region (83%) and the lowest in the North West (41%). A lack of targeted support appeared to be of some concern to authorities in the West Midlands (45%), but far less so for those in the South East (15%) and Eastern regions (17%).

Central government issues

The central government initiatives aimed at increasing the take-up of direct payments have been noted above, including revised guidance and changes to the regulations, awards via the direct payments development fund and the use of performance monitoring to assess progress.

Shire counties most often indicated national legislation, policy and guidance as an aiding factor overall (92%). Regional factors were notable, for instance all responding authorities from the Eastern region indicating that this had supported

implementation, compared with the national average of 82%. London boroughs selected this factor least often, although it was still identified by three quarters of responding boroughs. They also less often saw this as *critical* to implementation, suggesting that the impact of revised guidance and legislation had been less effective for this type of authority.

Interestingly, although a slightly higher proportion of metropolitan districts had been given direct payments development fund awards,[3] shire counties were most likely to cite these as positively aiding implementation (67%). It might be noted, however, that a slightly higher than average proportion of the responding shire counties had received awards in the first round. Unitary authorities selected this factor least often (48%). There were also differences by region, ranging from 44% of authorities from the North East to 82% of authorities in the North West, reflecting the regional distribution of DPDF funding, with 64% of local authorities in the North East receiving funding (via their partner voluntary organisations) and 82% of those in the North West.

Although the proportion of authorities indicating that central government performance monitoring had aided implementation was fairly similar across authority types, there was some variation in the weighting given to this factor. Unitary authorities and shire counties most often rated this factor as *helpful* to implementation, whilst metropolitan districts were most likely to rate it as *important*. Of the London boroughs that selected this factor, the highest proportion rated such monitoring as *critical*. Regionally, a lower proportion of authorities (44%) from the North East selected such performance monitoring as an aiding factor, compared to the average for England (66%).

Overall, half of the responding unitary authorities and shire counties identified competing priorities for policy implementation as a hindering factor, compared to a third of London boroughs and metropolitan districts. However, a third of London boroughs cited this as a *critical* hindering factor, compared to less than a tenth (7%) of metropolitan districts. There was also wide regional variation in the proportion of authorities identifying this factor, with approximately three quarters of authorities in the South East citing it, but only two authorities in the North East (22%).

There were also regional variations in the weight given to the incongruence of direct payments policy with other local authority duties, with higher proportions of authorities in the Eastern (67%), South West (57%) and South East (46%) regions citing this factor, compared to authorities in North East (11%). Shire counties (42%) and unitary authorities (36%) cited this as an issue more often than London boroughs (26%) and metropolitan districts (23%).

Support with implementation

The survey findings demonstrate the perceived contribution of national organisations in England, Scotland and Northern Ireland to supporting the development of direct payments at local level. As indicated, all three responding trusts from Northern Ireland rated the support from the Belfast Centre for Independent Living as critical to aiding implementation. Similarly, all responding Scottish councils cited support of Direct Payments Scotland as either helpful or important to aiding implementation. Around two-fifths (41%) of English local authorities considered that the support from the National Centre for Independent Living (NCIL) had assisted implementation, with the majority (33%) rating this as helpful. Overall, over half of shire counties (58%) cited support from NCIL as aiding implementation. This contrasted sharply with the findings from the responding metropolitan districts, where only 27% of authorities indicated that NCIL's support had been of help.

Other factors

As noted, responding authorities were able to append additional factors to our list. Although only a small minority did so (10%), the information provides useful contextual information for the survey. Where mentioned, the majority of respondents tended to indicate that these 'other' factors were *critical* to aiding implementation.

Five factors were highlighted by multiple respondents, namely:

- Organisational capacity within the local authority, including the appointment of a dedicated direct payments manager/team or secondment of staff to lead the expansion of direct payments;
- The establishment of a steering group to steer implementation or development;
- A close working relationship between the local authority and the support service;
- Promotion of direct payments, for instance through local publicity campaigns or via the direct payments support organisation or a local voluntary organisation;
- Involving user perspectives, including the involvement of service users in the development of the local scheme, publicising success stories from direct payments recipients and general peer support.

Most of the factors identified as hindering implementation were the converse of the above, such as a lack of capacity within the authority to manage or develop the local scheme. However, a number of systems issues were also raised, including the absence of policies and procedures, lack of sufficient financial and administrative support systems, and delays in the system that deterred service users from taking up direct payments. A handful of authorities also commented on barriers associated with limited funding for services and the inflexibility of local commissioning arrangements. These included tensions between direct payments and the cost-effective purchasing of high volumes of service, the inflexibility associated with block contracts, the challenges of double funding and maintaining directly provided services as direct payments numbers rise.

Notes

1 Response rates to these questions by local authority type were as follows: unitary authorities (28), London boroughs (27), shire counties (27), metropolitan district councils (30).

2 The number of local authorities that responded from each English region was as follows: East (6); East Midlands (7), London (27), North East (9), North West (17), South East (13), South West (7), West Midlands (11), Yorkshire and the Humber (12).

3 Nationally, the proportion of local authorities receiving DPDF awards over the two rounds were: unitary authorities (77%), London boroughs (64%) shire counties (68%) and metropolitan districts (83%).

13 Conclusions

Pace of growth

There is little doubt that take-up of direct payments has increased markedly since the introduction of the 1996 Community Care (Direct Payments) Act, yet it is also clear that implementation varies considerably across the UK and between service user groups. As we have shown from the survey, take-up – and policy development generally – has been considerably stronger in England than in Scotland, Wales or Northern Ireland. (Official figures for the period to March 2005 support this finding, suggesting that the number of recipients per thousand adult population in England is approximately double the number elsewhere in the UK.) This raises questions about the impact of devolved governance on equity and social justice for people supported by social care services and their carers across the UK (Priestley et al. 2006).

The higher response rate to the survey among local authorities in England may also be symptomatic of greater readiness and resourcing for policy development. Local capacity for implementation in many English authorities has been underpinned by the Direct Payments Development Fund established by the Department of Health. Reports from the National Centre for Independent Living suggest that this Fund may have had a positive impact on overall numbers of direct payments users and on the extension to specific 'new' user groups – 70% of development funding was targeted at specific user groups (Hasler 2006) – although a fuller evaluation of this initiative has not yet been completed. There are also signs of increased policy responsiveness in Scotland: supplementary survey work conducted for the Scottish Parliament in early 2006 indicates that Scottish authorities are now in a much stronger position to monitor and report on direct payments than was the case in 2005.

People with physical impairments continue to be the largest group in receipt of direct payments, mirroring the historic prominence of this group in advocating policy reform prior to 1997 and the later extension to some other groups. However, there is substantial evidence of change, with particular increases in the rolling out of direct payments to older people, and to parents of disabled children. But such growth needs to be seen in context: uptake remains very low compared to the overall pool of potential recipients.

There has also been a shift in the dynamics of implementation. While the development of direct payments was strongly associated with local user-led support organisations in the early years, this relationship is becoming less pronounced, with increased diversity in types of support organisation and in new user groups. The historical legacy of early activism and policy development remains most evident for people with physical disability or sensory impairment, with greater take-up of direct payments persisting in those local authorities or regions particularly associated with pioneering schemes prior to implementation

of the 1997 Act. On the other hand, many of those same areas had some of the lowest levels of direct payments uptake among people with learning disabilities.

New dynamics have emerged, a good example being the influence of In Control – initially strong in North West England, but now nationwide – with its support for person-centred planning and direct payments for people with learning disabilities. Making direct payments available to people with learning disabilities requires investment in intensive and ongoing support using methods such as user-controlled or family-led independent living trusts (Williams 2006; Gramlich *et al.* 2002; Leece 2003) and these systems of support are still in very short supply (Luckhurst 2006). It is also relevant that people with learning disabilities continue to receive low-level access to the kind of individualised services that direct payments could be used to purchase, such as supported self-employment (Ridley *et al.* 2005). People with learning disabilities are now at the forefront of the general policy swing towards individual budgets and there is likely to be an increasing focus on the role of direct payments within schemes being developed to support people to work out their own life plans and support services (Williams 2006).

Data on the growth of direct payments and the timing of policy developments suggest that central government initiatives have had considerable impact on implementation. Prima facie, the shift to mandatory duties, the provision of development funding in England, and the introduction of performance targets and indicators appears to coincide with increased provision of direct payments, particularly where implementation was lagging (Fernandez *et al.* 2007; Priestley *et al.* 2006).

On the other hand, there appear to be limits to the impact of central drivers. In comparison with other groups, the number of direct payments recipients identified as mental health service users remains very low. This has partly been attributed to the episodic nature of some mental health experiences and the recruitment or retention of appropriate staff (Spandler and Vick 2004), but recent explanations also point to the impact of uncertainties among staff about roles and responsibilities and accountabilities in the wake of local service reorganisation to integrate health and social services, workload pressures (including the extent to which work is dominated by crisis response), often compounded by the view that direct payments are more demanding on care coordinators' time (Spandler and Vick 2005). The recent Department of Health guide to action aims to alleviate such dilemmas in England and underline the necessity for progress despite ongoing work pressures (Department of Health 2006a), while a Care Services Improvement Partnership toolkit provides local councils and their partners with the means to make an assessment of their current situation and develop an action plan to support direct payments implementation (Care Services Improvement Partnership 2006).

The challenge for care managers

Alongside the explanations of poor implementation of direct payments to mental health service users described above, there is also evidence that care managers impose selective criteria in decision-making – for example, generally only offering direct payments to clients who are able to express their needs and clarify the types of support arrangements they wanted (Spandler and Vick 2005). It appears that the drive towards enabling more individual control over services is leading to greater understanding of the imbalance between direct payments and institutional modes of social care practice. Foster et al. (2006) have identified how care managers for older people identify needs which comply with the organizational and resource environment. This leads to selective interpretation of needs in the

process of assessment for older people's services, with implications for the option of direct payments. In the field of learning disabilities, care managers have struggled with the task of finding creative and flexible solutions, including direct payments, to the demands thrown up by person-centred planning and the modernisation of day services (Robertson et al. 2005). The current In-Control programme is likely to provide further insights into the potential ramifications of self-directed services for the role of care managers in this field.

It is of note that neither patterns in the continuity of care management arrangements nor patterns in access to direct payments through social work assistants *per se* appear to relate to patterns in provision of direct payments even if qualitatively there is some evidence to suggest that these may have a bearing on efforts to develop arrangements for direct payments (see Section 9).

Nonetheless, there are clearly challenges ahead at this level, bound up not only in the knowledge base and practice of social care professionals, but within organisational norms, policies and procedures. The underlying structure and organisation of service provision are likely to be increasingly put to the question en route to the delivery of a 'personalised social care service that fosters independence and dignity' (Prime Minister 2006). Consequently, an important message of this survey report is the extent to which some localities have risen to these challenges – at least in so far as we can measure by take-up patterns. Moreover, direct payments remain one just possible tool in this quest. Complementary approaches and options are also required in order to reduce levels of social exclusion. Key examples of this may be found in the very fields where progress with direct payments appears to be so hard – such as in mental health. In Bromley, South London, work has been going on over several years to create new models of care to increase work opportunities. These models focus on recovery, person-centred planning, building bridges with the community and access to direct payments (Forrest 2005). Linking these are a series of 'life domains' – housing, education, sports, arts, finance, employment, faith communities and volunteering – linked to the choice agenda. A key point to be learnt from these examples is that extensive staff training is needed, a requirement echoed in a wide range of studies focusing on the implementation of both direct payments and other forms of support that address individual needs and choices (Priestley et al. 2006; Luckhurst 2006; Hasler 2006).

Expenditure on direct payments packages and intensity of service provision

The survey adds to our understanding of take-up of direct payments by providing new information about the size of direct payments packages. As with take-up there is substantial variation between localities and regions. At least three-quarters of people with physical impairments who receive direct payments are receiving intensive packages of more than ten hours per week (with a third receiving the equivalent of more than 31 hours per week). A similar picture emerges for people with learning disabilities, with two-thirds receiving intensive packages of support and almost a quarter receiving more than 31 hours per week. For older people too, the size of packages appears to be relatively high, with the proportion receiving intensive support much higher than for those receiving equivalent home care packages (Health & Social Care Information Centre 2006). By comparison, the payments received by mental health service users are for smaller numbers of hours, although this is perhaps not unexpected given the typical levels of social care input for people with mental health problems.

These findings suggest that the proportion of high-intensity packages (according to the DH definition of packages of more than 10 hours of care per week) among direct payment users is much greater than among home care users. This may allay

some of the fears from the independent living movement that direct payments would result in lower levels of support for disabled people. For policy makers and purchasers this poses further questions.

If resources are being allocated equitably then it would imply that direct payments are generally serving people with particularly complex support needs. This might suggest that direct payments are particularly effective in circumstances of high-level need, as was identified by early research (Maglajic et al. 2000). At a time when direct payments are expected to become a central plank of future social care provision (Department of Health 2006b), it is crucial to understand why provision is higher among those with large packages of care.

Alternatively, it may also be that demand is skewed because, among people with low-level packages, the perceived benefits of using direct payments do not outweigh the perceived burden of administrative responsibility. If so, this may stem from the manner in which the service is promoted to them by care managers. Care managers do not always fully appreciate the level of support that can be accessed through support services and thus may over-emphasise the burden of responsibility for people with low-level packages (Fernández et al. 2007). Early research on direct payments commonly reported difficulties and dissatisfaction among direct payment users in relation to levels of responsibility and commitment, but there has been considerable growth in support schemes since this time (Carmichael and Brown 2002; Glasby and Littlechild 2002; Maglajlic et al. 2000). The Direct Payments Development Fund evaluation by PSSRU will provide further insight into the significance of support schemes among older clients receiving direct payments. Moreover, our forthcoming report on the national survey of direct payment support organisations conducted in parallel with this local authority survey will provide information on the capacity of support schemes operating across the country.

There may be other reasons why direct payment users tend to receive more hours of care per week than mainstream service users. The survey results (and feedback received on the results) suggest that the Independent Living Fund (ILF) threshold may have had the effect of driving package sizes upwards to more than 31 hours per week. However, the distribution of direct payments packages for older people in England by levels of intensity was broadly similar to that for physically disabled people (with a slightly lower proportion receiving packages of 31 or more hours per week). Since ILF is not available to older people, our findings may also be revealing the impact of a more outcomes-based approach to meeting need (driven, for example, by the role of support organisations as advocates for service users). If so, might this suggest that, as demand for direct payments increases, there may be a significant increase in the intensity of social care services being provided? This would generally be welcomed if it could be achieved without extra cost.

The survey found that expenditure in 2004/05 on direct payments for people with physical disabilities was *higher* than average per person expenditure in mainstream services, but *lower* than average mainstream expenditure for people with learning disabilities. For older people the two expenditure figures were roughly equal (see Section 4). Taking into account the fact that the distribution of package intensities received by clients from the learning disability group and physical disability was very similar, this is very surprising. One factor to take into account in understanding this finding is the pattern of take-up by people receiving intensive support, as we discussed earlier. Another possible explanation is the use of standardised direct payment rates for all user groups which may not reflect the costs of mainstream services for people with learning disabilities (see Curtis and Netten 2004). This raises the question of whether or not clients with learning disabilities receive equal opportunities when using direct payments as compared to other clients.

A further issue is how levels of service intensity and expenditure might change as the direct payment client base grows. Research by Fernández et al. (2007) shows that, on the basis of early indications of changes in provision over time, as the number of direct payment holders goes up, so expenditure per capita tends to fall, regardless of user group. If so, this raises questions about equity of access and support over time, or it could be an indication of targeting: the client base expands by including people with lower-level needs.

Use of one-off payments

There was surprisingly limited provision of one-off payments. Although three-quarters of authorities in England had used one-off payments, generally this was for very few people, and provision elsewhere in the UK was even more sparing. Local authorities commented that this may be due to the fact that one-off payments are not counted towards the CSCI direct payments performance indicator. Indeed there were some suggestions that payments that may be considered to be one-off are being counted as recurrent in order to boost ratings.

Interestingly, larger volumes of one-off payments were provided to groups who have as yet received very few ongoing direct payments, namely carers and people with mental health problems, although a large proportion of these one-off payments were made by just a few authorities. One-off payments to mental health service users may cover the cost of annual gym membership, for example. However, the popularity of applying non-recurrent payments to this service user group may partly be explained by the fact that local authority staff feel that there is less risk involved when providing one-off payments. This dynamic may be altered when ongoing direct payments become a performance indicator for the joint Healthcare Commission/ CSCI reviews of community mental health services (Healthcare Commission 2006). Similarly, the development of direct payments to carers still has far to go. Direct payments are a potential life-line to caregivers who are often unable to use mainstream services because of factors such as inconvenient hours of operation, lack of availability or cost (Brodaty et al. 2005).

It may be of concern that the survey revealed a limited range of uses for which one-off payments had been made. One-off payments were mostly used to purchase respite care and equipment; few local authorities had offered one-off payments to enable access to education or employment as a means of promoting social inclusion. This raises questions about the assessment decisions affecting different groups of users, the prioritisation of needs by local purchasing panels, and the outcomes of such purchasing decisions for users.

Direct payment rates

The survey found marked variations in hourly direct payment rates, and also in what was included in those rates. Variation is an indication of local authority autonomy or discretion, and it is partly driven by market forces, but there would appear to be more variation than can be explained by the latter. Concerns have been expressed about the rates being generally too low to allow direct payment users a fair stake in the market. There is some anecdotal evidence from the National Centre for Independent Living and staff of support organisations around the country that people move between local authorities to get better direct payment rates, although this would not be a realistic option for many social care users. Moreover, a number of local authorities revealed that they may increase the intensity of package (number of hours of care per person) in lieu of raising the hourly rate if the set rate is insufficient to purchase care that meets the assessed needs. Not only does this compound the difficulty in understanding patterns in

the size of packages received by direct payments users, it also serves to mask the problems of low payment rates and reduces transparency.

Difficulties in recruiting personal assistants have been noted in a number of research projects and were recorded as a significant barrier to progress by local authorities responding to the survey (see Section 12), and there are reports that this can be particularly acute in some rural areas (D'Aboville et al. 2000). In some instances, these difficulties are said to reflect the low rates imposed on direct payment users and/or the lack of flexibility in applying rates (for example, not providing extra to cover travel costs in order to match rates of pay provided by local agencies). However, recruitment difficulties are also likely to reflect the more general difficulties in recruiting people to relatively low-paid occupations (Gramlich et al. 2001). There is relatively little information available on salary levels for personal assistants. One small-scale study suggested that personal assistants received a rate slightly lower than the local average for domiciliary care workers in the independent sector (Leece 2006). Our survey has revealed that the calculated national average rate would be consistent with a similar wage. However, we also found that the funds available for pay are highly contingent upon the total number of hours worked. It would be feasible for those on small packages, or those employing a number of workers for only a few hours per week each to pay higher wages – wages that may work out to be very competitive.

Flexibility and transparency are paramount in setting rates, something that is widely acknowledged (see Section 7). Rates are most often reviewed according to need, and this is most prevalent for service users with a learning disability. Not surprisingly, shire counties most often review payment rates so as to accommodate any recruitment difficulties due to the location of the service user. Some local authorities still operate two separate rates: one for people who employ a personal assistant and another for those purchasing services from an agency. The question is how the choice to recruit a PA or use an agency is made and who drives this? Do service users that receive the personal assistant rate feel limited in their range of choices due to the level at which their direct payment rate is pitched and do they appreciate the alternatives? Such two-tiered systems may be led by the desire for cost containment. But given that unspent funds may be recouped by the local authority, there seems little justification for not providing the same rate for all users – one that is competitive within local markets.

Local authorities also revealed separate regimes for funding direct payments if users required live-in care or night care (further distinguished between 'sleep-disturbance' and 'sleepover' night care). These separate rates are probably an attempt to contain costs and presumably bring the cost of funding direct payments of this sort into line with the comparative costs of care purchased by the local authority. These rates raise a number of questions. For example, it appears that live-in rates are substantially lower than average unit costs of residential care for people with physical disabilities, learning disabilities and disabled children. Arguably this is not in keeping with the recommendation that a direct payment should equal the cost of providing equivalent care from mainstream services. Live-in rates for older people and mental health service users work out substantially higher than mainstream costs of residential care. Because of the restriction on providing health funds as a direct payment even if these live-in cases involve components of nursing care, social services are unable to use health funds that would have gone towards the cost of the nursing care element had care been received in a nursing home.

The legality of such rates has also been questioned. Local authorities report that it remains unclear whether or not paying a sleepover rate breaches European law on working conditions if, when quantified on an hourly basis, the rate of pay falls below the statutory minimum wage. In practice, it is reported that these rates are

accepted by personal assistants, acknowledging that there is a differential level of input required during sleepover periods than during the day time.

Funding of support organisations

There are wide variations in the levels of funding of support organisations, with different grant levels for direct payments support depending on locality. Further work using data gathered in our parallel survey will try to establish underling factors in these variations. Research by Hasler and Stewart (2004) suggested that some local authorities are reluctant to fund direct payments support schemes when demand for direct payments is low, on the grounds that demand could not justify the expense. But such a 'causal impasse' needs to be broken.

The survey data show that there was a decrease of approximately 11% in support service funding levels between the two years covered by the questionnaire. Support services are surely a prerequisite to successful implementation and although not a requirement, the expectation of local authorities to provide access to and invest in services to support direct payment users is clear (Department of Health 2004a; CSCI 2004). This decrease in average funding has potentially enormous implications for service users at a time when demand for such services is rising, as well as having obvious implications for the support organisations themselves. The support organisation survey shows that many organisations are heavily reliant on local authority funding. On the other hand, local authorities have little information on what it costs to provide effective support to service users. Information from the support organisation survey will illustrate current average costs of support for different levels of support input. Given the primacy of support services, should CSCI pay greater attention to investments made in direct payments support within its performance reviews?

Choice of direct payments support

Individual budgets aim to support service users to identify and access the support services they need (Office of the Deputy Prime Minister 2006). It is therefore crucial that sufficient choices exist. We asked local authorities if they facilitate choice for direct payment service users; for example, do they enable service users to access support organisations not contracted with social services, or to utilise alternative mechanisms of support? Local authorities said that they do, but it is not clear that they always deliver since funds are not always made available to support this intention. Individual budgets may bring about considerable changes in this regard, as each service user will have full control over funds which have been allocated to them to access the support services they need.

Commissioning

The proportion of each purchasing budget spent on direct payments remains low, and shows enormous variation across the country and between user groups. It is generally much greater for people with physical disabilities than for other groups. However, there is evidence of widespread growth in purchasing through direct payments and this inevitably raises questions about the future impact on mainstream service commissioning in some service areas (particularly in relation to services for small client groups). The development of direct payments has provided a welcome focus on the needs of the individual as a mechanism for implementing changes in the social care market. However, as yet there is little evidence that direct payments is transforming commissioning strategies except in areas of the highest uptake where efforts are being taken to negotiate with

providers to offer services to direct payments users in lieu of a proportion of their block contract (Murray and Holroyd 2006). It is particularly striking that local authorities reported that the majority of services are purchased on a spot-contract basis, whereas there are numerous reports that implementation of direct payments is constrained by funds being tied up in block contracts (Spandler and Vick 2004; Direct Payments Scotland 2003).

Implementation messages

Analysing the implementation questions and responses, similar patterns emerge from the responses of local authorities and support organisations. It is important to emphasise the similarity of these messages, many of which follow from the observations made above. A commonly mentioned implementation factor was the local organisational infrastructure, with respondents stressing the need for effective support schemes, better staff training and support, better leadership from the local authority, and provision of more accessible information to potential direct payment recipients. It would appear that authorities could do more to counter what respondents identified as staff resistance to direct payments. Another hindrance to implementation was the limited supply of people to work as personal assistants, which is doubtless linked to the low rates of pay that many users feel able to offer. A number of local authority respondents, particularly in unitary authorities in England, also pointed to low levels of demand from service users and carers.

14 Policy and Practice Recommendations

Findings from this survey of direct payments implementation across the UK suggest that a number of issues need to be tackled. The recommendations set out below apply to the development of direct payments schemes, but are also likely to have some relvance for other forms of individualised funding such as the pilot individual budget schemes in England.

- The increased diversity of users receiving direct payments needs to be considered when developing support strategies. Local authorities need to be aware of the changing dynamics of direct payments. Experiences in the development of direct payments for people with physical disabilities may not all be relevant to other user groups, for example when looking to promote uptake. Greater investments need to be made in developing appropriate support mechanisms.
- Although direct payments are spreading across different user groups, access is very limited for some (especially mental health service users and carers) and remains very low overall in relation to the overall population of social care users. Local authorities themselves state that local organisational infrastructure is crucial for direct payments development. In order to develop direct payments, local authorities should clearly establish their leadership, provide adequate staff training and support, ensure that accessible information is available for potential recipients, and ensure that effective support schemes are in place. Many examples of good practice exist across the country, and can be tapped into via regional direct payments networks.
- Staff resistance to direct payments remains a significant barrier to development and needs to be tackled.
- Direct payments have been developed much further in England than in Northern Ireland, Scotland or Wales. Factors in this development in England undoubtedly include the shift to mandatory duties, the provision of development funding, the use of performance targets and indicators, and the implementation messages stemming from local authorities. There are transferable lessons here.
- Understanding how direct payments work in practice could be greatly enhanced by routine collection of expenditure data, including information on unspent funds returned by service users. However, local authorities should avoid making blanket judgements on the value for money of direct payments on the basis of expenditure data without considering both the characteristics of service users in receipt of direct payments and of course the outcomes in terms of met needs and quality of life improvements.
- Direct payments tend to be received by people with high-intensity packages (with the exception of the mental health service user group). This may be because direct payments are believed to be of most benefit to users with high-level complex needs, yet local authorities should monitor if people with lower-level needs are achieving equal access to direct payments, and whether direct payments are being as effectively targeted as mainstream services.

- The application of standardised hourly direct payment rates should be routinely monitored through local surveys that examine the affordability of care that is to be purchased via direct payments. This would provide useful feedback on issues related to purchasing power, access to services in specific localities, and the challenges and opportunities experienced by direct payment users.
- Live-in rates appear to be substantially lower than average unit costs of residential care for people with a physical disability, people with a learning disability and disabled children, but higher for older people and mental health service users. Attention needs to be paid to the direct payments guidance regarding fair costing of a direct payment.
- Mechanisms need to be developed centrally to allow health funding for the nursing care components of packages to be provided as a direct payment. This would prevent the expenditure burden being placed on local authorities to provide high-level support packages to direct payments users with nursing needs, such as those requiring live-in care. It would also reduce disincentives to providing high-intensity support where it is needed.
- The use of one-off payments still has some distance to go: local authorities should work actively to promote their use among a wider client base and for a more diverse range of uses that enhance social inclusion. Local authorities should ensure that one-off payments are not being disproportionately used for some user groups because of risk-aversion associated with providing an ongoing direct payment.
- Organisations providing support to direct payment users rely heavily on local authority funding. An expanding client base requires year-on-year investment in these services. Better service specification would improve the links between resources and supply.
- There is little evidence that direct payments are transforming commissioning strategies, except in areas of the highest uptake where efforts are being made to negotiate with providers to offer services to direct payments users in lieu of a proportion of their block contract. Commissioners need to adapt strategies now to ensure that future demand is not hampered by inflexible commissioning strategies.

Appendix I

Survey Forms

(Reduced from the original colour A4 sheets.)

Reference number: ☐☐☐☐/☐☐☐☐/☐☐
[to be completed by the research team]

Direct Payments Survey

QUESTIONNAIRE TO LOCAL AUTHORITIES

SECTION 1: DIRECT PAYMENTS TO ALL USER GROUPS

1. Please indicate the number of direct payment users* per service user group (as at end of September 2004). If there are no direct payment users among a particular client group, please indicate as 0:

Older People		Physical Disability		Carers	
Mental Health		Sensory Impairment			
Learning Disabilities		Disabled Children			

* 'Direct payment users' includes people receiving direct payments indirectly e.g. through mechanisms such as a circle of friends, or a trust. 'Direct payment users' does not include people receiving ILF funding to direct their own services.

2. Please indicate the approximate date (month and year) when service users / carers within each of the following client groups first received direct payments. If there are no direct payment users among a particular client group, please indicate as not applicable (N/A).

Older People	Mental Health	Learning Disabilities	Physical Disability	Sensory Impairment	Disabled Children	Carers

SECTION 2: DIRECT PAYMENTS TO PEOPLE WITH PHYSICAL DISABILITIES

3. What proportion of the budget for people with physical disabilities was spent on direct payments to people with physical disabilities?

This financial year§ ____ % Previous financial year ____ %

§ In all instances where data for this financial year are requested, please indicate amounts from the beginning of this financial year (April 2004) up to the end of September 2004. From this information we will calculate an estimated outturn.

4. ____ % Please indicate the proportion of people with physical disabilities receiving social services using direct payments.

5. **Profile of service users by level of assessed need**

How many **people with physical disabilities** do you have using direct payments for the following *levels of care package* (as at end of September 2004)?

0-2 hours per week	3-5 hours per week	6-10 hours per week	11-15 hours per week	16-20 hours per week	21-25 hours per week	26-30 hours per week	31+ hours per week

SECTION 3: DIRECT PAYMENTS TO OLDER PEOPLE

6. What proportion of the budget for older people was spent on direct payments to older people?

This financial year§ ____ % Previous financial year ____ %

7. ____ % Please indicate, what proportion of older people receiving social services use direct payments?

8. ____ % Please indicate, what proportion of social services recipients aged 65 years plus, with mild to moderate levels of dementia, use direct payments?

Direct Payments Survey

9. **Profile of service users by level of assessed need**

How many **older people** do you have using direct payments for the following **levels of care package** (as at end of September 2004)?

0-2 hours per week	3-5 hours per week	6-10 hours per week	11-15 hours per week	16-20 hours per week	21-25 hours per week	26-30 hours per week	31+ hours per week

SECTION 4: DIRECT PAYMENTS TO PEOPLE WITH LEARNING DISABILITIES

10. What proportion of the budget for people with learning disabilities was spent on direct payments?

This financial year[§] ____ % Previous financial year ____ %

11. ____ % Please indicate, what proportion of people with learning disabilities use direct payments?

12. **Profile of service users with learning disabilities by level of assessed need**

How many **people with learning disabilities** do you have using direct payments for the following **levels of care package** (as at end of September 2004)?

0-2 hours per week	3-5 hours per week	6-10 hours per week	11-15 hours per week	16-20 hours per week	21-25 hours per week	26-30 hours per week	31+ hours per week

SECTION 5: DIRECT PAYMENTS TO MENTAL HEALTH SERVICE USERS

13. What proportion of the budget for mental health service users was spent on direct payments?

This financial year[§] ____ % Previous financial year ____ %

14. ____ % Please indicate, what proportion of mental health service users receiving social services use direct payments?

15. **Profile of mental health service users by level of assessed need**

How many **mental health service users** do you have using direct payments for the following **levels of care package** (as at end of September 2004)?

0-2 hours per week	3-5 hours per week	6-10 hours per week	11-15 hours per week	16-20 hours per week	21-25 hours per week	26-30 hours per week	31+ hours per week

SECTION 6: ONE-OFF PAYMENTS

16. Please state the number of one-off direct payments (if any) provided to the following service user groups in the past year (October 2003 to September 2004). (See boxed key below.)

OP	MH	LD	PD	SI	DC	C

Key

OP Older people
MH Mental health service users
LD Adults with learning disabilities
PD Adults with physical disabilities
SI Adults with sensory impairment
DC Disabled children
C Carers

17. Please indicate the range of purposes for which one-off direct payments have been made to service users.

SECTION 7: DIRECT PAYMENT RATES

18. Please detail (as applicable) the average hourly rate(s) in £ paid to direct payment users from each service user group indicated. (See the key on page 2 for abbreviations used.)

	OP	MH	LD	PD	SI	DC	C
Day							
Evening							
Weekend							
Bank holiday							
Sleepover							
Sleep-disturbance							
Live-in							

19. Please indicate which of the following are included in the direct payment rates listed above: *(please tick)*

☐ Tax ☐ National Insurance ☐ Holiday pay
☐ Sickness pay ☐ Start-up costs ☐ Contingency funds
☐ Support costs ☐ Other (please specify)

20. As an alternative to supporting the above costs through the direct payments hourly rate, are extra payments provided either on a periodic or *ad hoc* basis? *(Please tick)*

☐ Yes ☐ No ☐ It depends

Please attach any available information to describe the local authority's policy on making extra payments.

21. Are any variations to these average rates ever available on the basis of any of the following? (**please tick and describe**)

	Tick if applicable	Describe
Level and complexity of need (e.g. higher rates for service users with more complex needs)	☐	
Location of service user (e.g. higher rate for rural location)	☐	
Local labour market prices	☐	
Other (please state and describe)	☐	

22. How does the hourly rate(s) **for older people** compare to the hourly cost of in-house domiciliary care?

☐ Lower ☐ Higher ☐ The same ☐ Not applicable (no in-house domiciliary care)

23. How does the hourly rate(s) **for older people** compare to the average hourly cost of preferred independent sector providers of domiciliary care?

☐ Lower ☐ Higher ☐ The same

24. ☐ % If a direct payment service user (from any service user group) has accumulated funds at the end of the financial year, what proportion of these funds (if any) may they retain?

Direct Payments Survey

SECTION 8: LOCAL COMMISSIONING PRACTICES

27. Does the local authority devolve budgets to care managers and / or social work team managers for individual level spot-purchasing? Please indicate for all service user groups.

	MH	OP	PD	LD	SI	DC	C
Tick if yes							

28. Approximately what percentage of community care packages for each user group are purchased as a spot-purchase (not including direct payments)?

	MH	OP	PD	LD	SI	DC	C
Per cent							

29. Is there a generic budget for direct payment users? ☐ Yes ☐ No

30. If not, are funds ring-fenced from core budgets for each service user group? Please indicate for all service user groups.

	MH	OP	PD	LD	SI	DC	C
Tick if yes							

SECTION 9: CASE MANAGEMENT POLICIES AND PROCEDURES

31. Does the local authority organise case management such that service users are **typically** passed from their assessing care manager onto a review team(s) once a care package is established and considered to be stable?

    Please indicate for all service user groups.

    If no to all, go to question 35.

	MH	OP	PD	LD	SI	DC	C
Tick if yes							

32. What is the **average** proportion of case managers to social work assistants within the review team(s)? Please indicate for all service user groups.

	MH	OP	PD	LD	SI	DC	C
Proportion of case managers, e.g. 1:50							

33. What is the average number of weeks it takes for a service user to be passed onto the review team(s)? Please indicate for all service user groups.

	MH	OP	PD	LD	SI	DC	C
Number of weeks							

34. Does local policy require that direct payment service users remain continuously the responsibility of the assessing case manager / care co-ordinator (rather than ever being passed on to a review team)? Please indicate for all service user groups.

	MH	OP	PD	LD	SI	DC	C
Tick if yes							

35. Are social work assistants able to assess clients for direct payments? Please indicate for all service user groups.

	MH	OP	PD	LD	SI	DC	C
Tick if yes							

SECTION 10: SOURCES OF FUNDING SUPPORT TO DIRECT PAYMENT USERS

36. Is the funding that is provided to the support organisation(s) allocated on the basis of any of the following? *(Please tick)*

    ☐ According to the number of direct payment users it is serving
    ☐ According to the number/ type of services it is supplying to direct payment users
    ☐ According to the level of contact with direct payment users

37. To what extent (if any) is support to direct payments users, as supplied through a support organisation(s), funded by any of the following sources? *Please indicate approximate amounts for this financial year (TFY, 5 April to 30 September) and previous financial year (PFY), where available*

TFY	PFY	
£	£	Core budget for older people
£	£	Health and social care pooled budget for older adults
£	£	Core budget for mental health service users
£	£	Health and social care pooled budget for mental health
£	£	Core budget for adults with physical disabilities
£	£	Core budget for adults with learning disabilities
£	£	Core budget for adults with sensory impairment
£	£	Core budget for disabled children
£	£	Core budget for carers
£	£	Cost savings (from where?) _____
£	£	Short-term funding streams (please describe) _____
£	£	Contributions from direct payment service users

38. Are direct payment service users required to contribute towards the costs of the support organisation? *(Please tick)*

☐ Yes ☐ No ☐ It depends

39. Does the level of contribution levied from service users vary according to: *(Tick if yes)*

☐ Utilisation of support services? ☐ Level of need? ☐ Income? ☐ Other?

40. Please explain or attach details of contribution rates.

41. Are contributions from direct payment service users financed from any benefits to which they are entitled? (i.e. from attendance allowance or similar)

☐ Yes ☐ No ☐ It depends

Please explain or attach relevant information.

SECTION 11: FLEXIBILITY IN THE PROVISION OF SUPPORT TO DIRECT PAYMENT USERS

42a. If a direct payment service user wished to obtain support using direct payments from an organisation other than the one that is contracted locally to provide support, could this be facilitated? *For example, an organisation for minority ethnic elders that does not typically provide support to direct payment users, but that the user feels better understands their needs.*

☐ Yes ☐ No ☐ Don't know

42b. If yes, please provide details

Direct Payments Survey

43. Would it be possible to ring-fence the costs of supporting the service user to ensure that the organisation chosen is compensated for providing support?

☐ Yes ☐ No ☐ It depends

SECTION 12: IMPLEMENTATION OF DIRECT PAYMENTS

44. Please indicate which of the following factors have **positively aided** the implementation of direct payments within the local authority. Please tick to indicate if this factor has been a helpful factor, an important factor or a critical factor. If the item has not positively aided implementation, please do not put a tick against it. Add any other factors not included in the list at the end.

Helpful factor	Important aiding factor	Critical aiding factor	
			Leadership within local authority
			Local political support for direct payments
			Effective direct payments support scheme
			Support of public sector trade unions
			Training and support for front line staff
			Demand from service users and carers for direct payments
			Accessible information on direct payments for service users and carers
			Strong local voluntary sector
			Availability of people to work as personal assistants
			National legislation, policy and guidance
			Direct Payments Development Fund award
			Positive attitude to direct payments among staff
			Ring-fenced budget for direct payments
			Targeted support within the direct payments support service to promote/assist the take up of direct payments within specific service user groups
			Support from the National Centre for Independent Living (NCIL)
			Central government performance monitoring
			Flexibility of commissioning strategy
			Inspection and regulation of local authority services
			Other factor(s) _____
			Other factor(s) _____

45. Please indicate which of the following factors have **hindered** the implementation of direct payments within the local authority. Please tick to indicate if this factor has been an unhelpful factor, an important hindering factor or a critical hindering factor. If the item has not hindered implementation, please do not put a tick against it. Add any other factors not included in the list at the end.

Unhelpful factor	Important hindering factor	Critical hindering factor	
☐	☐	☐	Insufficient leadership within local authority
☐	☐	☐	Lack of local political support for direct payments
☐	☐	☐	Underdeveloped direct payments support scheme
☐	☐	☐	Inadequate training and support for front line staff
☐	☐	☐	Concern about managing direct payments among service users and carers
☐	☐	☐	Lack of demand from service users and carers for direct payments
☐	☐	☐	Lack of accessible information on direct payments for service users and carers
☐	☐	☐	Weak local voluntary sector
☐	☐	☐	National legislation, policy and guidance
☐	☐	☐	Difficulties with the availability of people to work as personal assistants
☐	☐	☐	Resistance to direct payments among staff
☐	☐	☐	Lack of ring-fenced budget for direct payments
☐	☐	☐	Competing priorities for policy implementation
☐	☐	☐	Lack of targeted support within the direct payments support service to promote/assist the take up of direct payments within specific service user groups
☐	☐	☐	Lack of support from the National Centre for Independent Living (NCIL)
☐	☐	☐	Incongruence of direct payments policy with other local authority duties
☐	☐	☐	Inflexibility of commissioning strategy
☐	☐	☐	Other factor(s) _____
☐	☐	☐	Other factor(s) _____

continued/…

Direct Payments Survey

SECTION 13: NOTES AND FURTHER DETAILS

Please also supply any further comments you have on the implementation and development of direct payments and direct payments support within the local authority. Please continue on extra sheets if necessary and attach as required.

In case we need to clarify anything, we would be grateful if you could add your contact details. These will be kept confidential.

Name _____

Job title _____

Organisation _____

Phone number, email or other contact details _____

Please return the questionnaire in the enclosed Freepost envelope.
If you have questions about the survey or completing the questionnaire, please contact Vanessa Davey: email V.Davey@lse.ac.uk, telephone 020 7955 6376.

Reference number: ☐☐☐☐/☐☐☐☐/☐☐
[to be completed by the research team]

Direct Payments Survey

QUESTIONNAIRE FOR ORGANISATIONS PROVIDING SUPPORT TO DIRECT PAYMENT USERS

This questionnaire is intended for completion by all organisations, groups or agencies providing support to direct payment users. The generic term 'organisation' is used throughout the questionnaire to cover the range of schemes that are provided nationally.

If you are an organisation which runs direct payments support services in a number of different local authority areas, we would prefer one questionnaire to be completed for each of the local authority areas, as indicated by the multiple copies of questionnaires that have been sent to you.

In local authorities where more than one organisation is providing direct payments support, a questionnaire will have been sent to each.

SECTION 1: ORIGINS OF SUPPORT ORGANISATION

1. When was the organisation established? ☐

2a. Does the organisation provide services other than support to direct payment users?

☐ Yes ☐ No

2b. If yes, please describe below or attach any information that describes the other role(s) of the organisation.

* 'Direct payment users' includes people receiving direct payments indirectly e.g. through mechanisms such as a circle of friends, or a trust. 'Direct payment users' does not include people receiving ILF funding to direct their own services.

3a. Does the organisation provide support to all direct payment* user groups?

☐ Yes ☐ No

3b. If not, please tick those user group(s) supported by the organisation:

Older People	Mental Health	Learning Disabilities	Physical Disability	Sensory Impairment	Disabled Children	Carers

4. For how many years (if any) has the organisation provided support to direct payment users? ☐ Years

5. Please indicate how many direct payment service users from each user group are supported by the organisation (as at the end of September 2004)

☐ Older People
☐ Mental Health
☐ Learning Disabilities
☐ Physical Disability
☐ Sensory Impairment
☐ Disabled Children
☐ Carers

6. Please indicate which labels best describe your organisation, its *general* role(s) and geographical coverage by ticking all that apply.

Sector

☐ Voluntary
☐ Other not-for-profit (including trust floated off from local authority)
☐ For-profit
☐ Public (council in-house)

Direct Payments Survey

(Question 6 continued)

Roles (Specific information on the services you provide to direct payment users is requested in Section 5)

- ☐ Individual-level advocacy
- ☐ Campaigning
- ☐ Self-help
- ☐ Residential, domiciliary or day care services
- ☐ Other direct services to users
- ☐ Grant making to individuals or national organisation

Geographical coverage / affiliation

- ☐ Purely local group
- ☐ Local group / member of regional or national federation
- ☐ Local branch or department of regional or national organisation

SECTION 2: STAFFING

7. Please complete the table below indicating all staff members as at the end of September 2004. (If you are a national affiliate or subunit of a national organisation please provide data only for the local organisation.) Please round percentages to the nearest 5%, and continue on an extra sheet of paper if required.

Staff member	Tick if paid	Tick if full-time	If part-time, please state percentage of full-time equivalent	Percentage of time allocated to direct payments support	Tick which service user group(s) the staff member supports, or tick 'All' if they work across all service user groups supported by the organisation (see the box below for the abbreviations used)								Staff grade/ position or equivalent
					All	OP	MH	LD	PD	SI	DC	C	
1			%	%									
2			%	%									
3			%	%									
4			%	%									
5			%	%									
6			%	%									
7			%	%									
8			%	%									

Key

OP Older people
PD Adults with physical disabilities
DC Disabled children
MH Mental health service users
SI Adults with sensory impairment
C Carers
LD Adults with learning disabilities

SECTION 3: FUNDING SOURCES

8. Please indicate total income and components for both this financial year (TFY — 5 April to 30 September) and the previous financial year (PFY) *(See instructions on next page).*

	Total income	Components			
		Social services	Direct Payments Development Fund	Non social services grant* (short-term)	Non social services grant (long-term: 5 years duration or more)
TFY	£	£	£	£	£
PFY	£	£	£	£	£

* *Such as a grant from a local primary care trust, or from a charitable organisation.*

	Direct payment user contribution	Components			
		Membership	Voluntary contributions	Payment for particular activities§	Other
TFY	£	£	£	£	£
PFY	£	£	£	£	£

§ *Such as providing training to care managers or providing information leaflets.*

In all instances where data for this financial year are requested, please indicate amounts from the beginning of this financial year (April 2004) up to the end of September 2004. From this information we will calculate an estimated outturn.
If you are a national affiliate or sub-unit of a national organisation please provide data **only for the local organisation**.

If you are an organisation that provides services other than direct payments support we would like you to indicate your income **only for direct payments support.** It may not be possible for you to give this. If so, please indicate the organisation's total income and we will calculate an approximate amount.

SECTION 4: COSTS AND EXPENDITURES

9. Please summarise the organisation's costs and expenditures in the table below. If available, please attach last year's annual report of income and expenditure.

	Total expenditure	Components			
		Rent	Staff	Management and administration	Other revenue costs (any costs not noted at left)
TFY	£	£	£	£	£
PFY	£	£	£	£	£

SECTION 5: SERVICES PROVIDED TO DIRECT PAYMENT USERS

10. Does the organisation have a contract or service-level agreement with the local authority for the services that you provide to direct payment users?

☐ Yes ☐ No → go to question 12

11. If so, are any of the following conditions defined in this agreement? (*please tick*)

☐ Type of services to be supplied
☐ Minimum supply of services per individual user
☐ Minimum level of contact with direct payment users
☐ Requirements for training of care worker / care managers or social work assistants
☐ Information to be supplied to users

12. Will funding for direct payments support be available for the next financial year?

☐ Yes ☐ No ☐ Don't know (Add more details below if appropriate.)

Direct Payments Survey

13. Please tick which services are provided by the organisation.

Funded by social services	**Not** funded by social services	
		Advocacy services
☐	☐	Lists of personal assistants
☐	☐	Lists of local agencies
☐	☐	Bank of emergency staff
☐	☐	Any other back-up service
☐	☐	Assistance compiling job descriptions
☐	☐	Assistance compiling contracts
☐	☐	Financial advice
☐	☐	General advice and support
		Assistance with recruiting
☐	☐	Assistance with interviews
☐	☐	Assistance with training
☐	☐	PA training (either arranged by the organisation or run by the organisation; for example manual handling training)
☐	☐	Peer support
☐	☐	Support with applying for direct payments
☐	☐	Training in undertaking self-assessments
☐	☐	Support with undertaking self-assessments
☐	☐	Direct payment awareness raising
		'Employment agency'
☐	☐	Care worker introduction service
☐	☐	Employee scheduling / rotation service
☐	☐	Finance and insurance management service
		'Employment business' services
☐	☐	Contract care workers
☐	☐	Organisation of payment to care workers
☐	☐	Ensures that care workers work under the direct control of the hirer (i.e. the direct payment user)

14. If you provide services that are not funded by social services please describe why you provide these services.

15. If you provide services that are not funded by social services please describe why these services have not / could not be funded by them.

16. How often are peer support meetings facilitated on average (if at all)? ☐ per year

17. Are costs of attending these meetings met by the support organisation?

☐ Yes ☐ No

18. On average how many **direct payment service users** attend these meetings (on each occasion that they are held)? *Please provide information on the number of users per service user group.* See key on page 2

OP	MH	LD	PD	SI	DC	C

19a. Does the organisation provide support to private payers? (i.e. people who are ineligible for social services support but who wish to have advice and assistance in organising services for their care needs)

☐ Yes ☐ No

19b. If yes, please state how many private payers the organisation has assisted and what, if any, contribution these people have paid for the support provided.

SECTION 6: LEVEL OF SERVICE UTILISATION

20. Understanding that circumstances and needs vary by individual (and that your service will respond to each individual's needs), please indicate approximate / average values for the following based on your experience with each user group.

	OP	MH	LD	PD	SI	DC	C
Average length of time (in weeks) between initial assessment and services being set up (i.e. required services recruited and up and running)							
Average number of visits **per month** in period between initial assessment and services being set up (i.e. required services recruited and up and running)							
Average number of telephone consultations **per month** in period between initial assessment and services being set up (i.e. required services recruited and up and running)							
Average length of time (in weeks) between services being set up (i.e. required services recruited and up and running) and user becoming independent of support service.*							
Average number of visits **per month** in period between services being set up (i.e. required services recruited and up and running) and user becoming independent of support service.*							
Average number of telephone consultations **per month** in period between services being set up (i.e. required services recruited and up and running) and user becoming independent of support service.*							
Number of times a case is reviewed per year **by the support organisation**.							

*The definition of an independent user is one who is comfortable with their required support in managing direct payments and relatively stable in their requirements from your organisation (whatever services they may be obtaining from you). Where the direct payment is managed by either a trust, a circle of friends or a relative, please indicate the average length of time until this partnership has become relatively stable in its requirements from your organisation (whatever services they may be obtaining from you).

Direct Payments Survey

21a. Have you been involved in discussions with the local authority regarding what level of support your organisation would be able to supply to direct payment service users if either:

Local targets for direct payments uptake were reached?

☐ Yes ☐ No

Demand for direct payments increased considerably, exceeding expectations (such as doubled)?

☐ Yes ☐ No

21b. If so, please give a brief account of the outcome of these discussions.

SECTION 7: IMPLEMENTATION OF DIRECT PAYMENTS

22. Please indicate which of the following factors have **positively aided** the implementation of direct payments within your local authority. Please tick to indicate if this factor has been a helpful factor, an important aiding factor or a critical aiding factor. If the item has not positively aided implementation, please do not put a tick against it. Add any other factors not included in the list at the end.

Helpful factor	Important aiding factor	Critical aiding factor	
			Leadership within local authority
			Local political support for direct payments
			Effective direct payments support scheme
			Support of public sector trade unions
			Training and support for front-line staff
			Demand from service users and carers for direct payments
			Accessible information on direct payments for service users and carers
			Strong local voluntary sector
			Availability of people to work as personal assistants
			National legislation, policy and guidance
			Direct Payments Development Fund award
			Positive attitude to direct payments among staff
			Ring-fenced budget for direct payments
			Targeted support within the direct payments support service to promote / assist take up of direct payments within specific service user groups
			Support from the National Centre for Independent Living (NCIL)
			Central government performance monitoring
			Flexibility of commissioning strategy
			Inspection and regulation of local authority services
			Other factor(s) _____
			Other factor(s) _____

23. Please indicate which of the following factors have **hindered** the implementation of direct payments within the local authority. Please tick to indicate if this factor has been an unhelpful factor, an important hindering factor or a critical hindering factor. If the item has not hindered implementation, please do not put a tick against it. Add any other factors not included in the list at the end.

Unhelpful factor	Important hinderng factor	Critical hindering factor	
			Insufficient leadership within local authority
			Lack of local political support for direct payments
			Underdeveloped direct payments support scheme
			Inadequate training and support for front line staff
			Concern about managing direct payments among service users and carers
			Lack of demand from service users and carers for direct payments
			Lack of accessible information on direct payments for service users and carers
			Weak local voluntary sector
			National legislation, policy and guidance
			Difficulties with the availability of people to work as personal assistants
			Resistance to direct payments among staff
			Lack of ring-fenced budget for direct payments
			Competing priorities for policy implementation
			Lack of targeted support within the direct payments support service to promote / assist take up of direct payments within specific service user groups
			Lack of support from the National Centre for Independent Living (NCIL)
			Incongruence of direct payments policy with other LA duties
			Inflexibility of commissioning strategy
			Other factor(s) _____
			Other factor(s) _____

SECTION 8: NOTES AND FURTHER DETAILS

Please also supply any further comments you have on the implementation and development of direct payments and direct payments support within your local authority. Please continue on extra sheets and attach as required.

continued/…

Direct Payments Survey

In case we need to clarify anything, we would be grateful if you could add your contact details. These will be kept confidential.

Name _____

Job title _____

Organisation _____

Phone number, email or other contact details _____

Please return the questionnaire in the enclosed Freepost envelope.
If you have questions about the survey or completing the questionnaire, please contact Vanessa Davey: email V.Davey@lse.ac.uk, telephone 020 7955 6376.

Appendix II

Survey Covering Letters

(Reduced from the original A4 colour letters.)

correspondence to:
Personal Social Services Research Unit
London School of Economics
Houghton Street
London WC2A 2AE

tel: 020 7955 6238
fax: 020 7955 6131
email: pssru@lse.ac.uk

October 2004

Direct Payments ☐ ☐ ☑ Survey

Department of Health

E·S·R·C ECONOMIC & SOCIAL RESEARCH COUNCIL

Modernising Adult Social Care Research Initiative

Dear Direct Payments Co-ordinator,

The enclosed questionnaire has been sent to you on behalf of the Direct Payments Survey Group.

Researching the implementation of direct payments and the experience of direct payment service users has been given high priority nationally. This unique survey is being carried out by three leading research groups and is backed by the Department of the Health and the ESRC. Information is being requested from all local authorities / health and social services trusts in the UK and all organisations in the UK providing support to direct payment users.

Support to users is crucial to the provision of direct payments. Lack of information on the arrangements for direct payments support nationally has so far prevented systematic evaluation. This survey aims to:

- Provide a UK-wide map of resources being supplied to supporting direct payments users
- Assess and determine the necessary conditions to support implementation of direct payments
- Explore the variations in the way that direct payments are structured and their possible impacts
- Consider the variations in the costs of supporting direct payment users and possible explanations for this including the quality and scope of the support that is being provided
- Identify best practice in the provision of direct payments support
- Explore the impact of variations in local resources on both levels of uptake and intensity of direct payments care provision, taking into account interrelated factors as described above

The survey will also inform the work being carried out by the three research teams (which is described briefly overleaf).

We would be grateful if you would complete the questionnaire and return it in the Freepost envelope enclosed by 12 November 2004. If you need further copies of the questionnaire you can download them from the survey web pages at www.pssru.ac.uk/dps.htm. If you have questions about the survey or completing the questionnaire, please contact Vanessa Davey: email V.Davey@lse.ac.uk, telephone 020 7955 6376.

None of the information you provide will be shared with any other sources or for any other purposes. The names of local authorities or HSS trusts will not be disclosed in the reporting of data. Local authorities will be described by

continued/…

The Direct Payments Survey has ethical approval from the Research Ethics Committees of the London School of Economics and Political Science and the University of Glasgow. Approval has also been granted by the Association of Directors of Social Services.

geographical location, local authority type and political control (e.g. a Labour run unitary authority in Greater London; a Conservative run rural county council in North West England.) Such descriptions will not be used in cases where they would allow particular local authorities to become identified.

Data from the survey will be analysed during 2005. Results will be published later in the year and made available to respondents. In some cases you may asked by one of the three research teams if you would be prepared to take part in follow-up telephone interviews and/or further case-study work.

With thanks and best wishes,

The Direct Payments Survey team:

Ms Vanessa Davey, Professor Colin Barnes, Mr José-Luis Fernández, Ms Debbie Jolly, Dr Jeremy Kendall, Professor Martin Knapp, Dr Geof Mercer, Dr Charlotte Pearson, Dr Mark Priestley, Professor Sheila Riddell, Dr Paul Swift and Ms Nicola Vick

The Direct Payments Survey National Direct Payments Projects

Disabled People and Direct Payments: A UK Comparative Study

Two-year study funded by the Economic and Social Research Council (ESRC).

Dr Charlotte Pearson; Professor Sheila Riddell; Professor Colin Barnes; Ms Debbie Jolly; Dr Geof Mercer; Dr Mark Priestley

www.leeds.ac.uk/disability-studies/projects/ukdirectpayments.htm

An Evaluation of the Impact of the Social Care Modernisation Programme on the Implementation of Direct Payments

Three-year study funded by the Department of Health as part of the Modernising Adult Social Care (MASC) research initiative.

Ms Nicola Vick; Dr Paul Swift; Dr Perri 6; Ms Roseanne Tobin; Dr Helen Spandler

www.healthadvisoryservice.org/special_projects/direct_payments.htm

Evaluation of the Direct Payments Development Fund Implementation

Two and a half year study funded by the Department of Health focusing specifically on direct payments to older people and mental health service users.

Ms Vanessa Davey; Professor Martin Knapp; Mr José-Luis Fernández; Dr Jeremy Kendall

www.lse.ac.uk/collections/LSEHealthAndSocialCare/researchProjects/evaluationOfSocialCare.htm

PARTICIPATING ORGANISATIONS

PSSRU Personal Social Services Research Unit

LSE The London School of Economics and Political Science

DH Department of Health

Modernising Adult Social Care Research Initiative

the Foundation for People with Learning Disabilities

HASCAS Health and Social Care Advisory Service

The University of Birmingham Health Services Management Centre

scdr strathclyde centre for disability research university of glasgow

The University of Edinburgh

University of Glasgow

University of Leeds

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October 2004

Direct Payments Survey

Dear Direct Payments Support Co-ordinator,

The enclosed questionnaire has been sent to you on behalf of the Direct Payments Survey Group.

Researching the implementation of direct payments and the experience of direct payment service users has been given high priority nationally. This unique survey is being carried out by three leading research groups and is backed by the Department of the Health and the ESRC. Information is being requested from all local authorities / health and social services trusts in the UK and all organisations in the UK providing support to direct payment users.

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We understand that a number of direct payments support organisations provide support to more than one local authority area. If so please complete and return the supplied questionnaires — one for each of the areas you cover. If it is not possible to do this, please specify whenever you provide us with information which applies for all of the local authority areas that you cover. If you have problems supplying information in either of these ways, please contact Vanessa Davey to discuss this further.

continued/...

None of the information you provide will be shared with any other sources or for any other purposes. The names of direct payments support organisations will not be disclosed in the reporting of data. Organisations will be described by geographical location, local authority type and political control (e.g. a direct payments support organisation operating in a Labour run unitary authority in Greater London; a direct payments support organisation operating in a Conservative run rural county council in North West England.) Such descriptions will not be used in cases where they would allow particular direct payments support organisations to become identified.

Data from the survey will be analysed during 2005. Results will be published later in the year and made available to respondents. In some cases you may be asked by one of the three research teams if you would be prepared to take part in follow-up telephone interviews and/or further case-study work.

With thanks and best wishes,

The Direct Payments Survey team:

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References

6 P (2005). *The Implementation of Direct Payments: independent variables and hypotheses from the literature*. Working Paper. Nottingham Trent University, Nottingham.

Barnes C and Mercer G (eds.) (1996). *Exploring the Divide: Illness and Disability.* Disability Press, University of Leeds.

Barnes C, Mercer G and Morgan H (2000). *Creating Independent Futures: An Evaluation of Services Led by Disabled People. Stage One Report.* The Disability Press, University of Leeds.

Brandon D, Maglajlic R and Given D (2000). The information deficit hinders progress. *Care Plan*, June, 17–20.

Brodaty H, Thomson C, Thompson C and Fine M (2005). Why caregivers of people with dementia and memory loss don't use services. *International Journal of Geriatric Psychiatry*, **20**, 537–46.

Care Services Improvement Partnership (2006). *Increasing the Uptake of Direct Payments. A self-assessment and action planning guide for local councils with social services responsibilities and their partners.* Department of Health: London.

Carlin J and Lenehan C (2004). *Direct Experience: A Guide for Councils on the Implementation of Direct Payments in Children's Services*. Council for Disabled Children, London.

Carmichael A and Brown L (2002). The future challenge of direct payments. *Disability and Society*, **17**, 797–808.

Clark H, Gough H and McFarlane A (2004). *It Pays Dividends': Direct Payments and Older people*. Joseph Rowntree Foundation, The Policy Press, Bristol.

Commission for Social Care Inspection (2005). *Social Services Performance Assessment Framework Indicators 2004–2005.* Commission for Social Care Inspection, London.

Commission for Social Care Inspection (2004). *Direct payments: What are the Barriers?* Commission for Social Care Inspection, London.

Curtis L and Netten A (2004). *Unit Costs of Health & Social Care*. Personal Social Services Research Unit, University of Kent.

D'Aboville E, Boffey S, Duff J, Woodward JE, Henderson L, Gibson B and Sofio M (2000). *Direct payments: the impact on choice and control for disabled people*. Scottish Executive, Edinburgh.

Dawson C (2000a). *Independent Successes: Implementing Direct Payments*. York Publishing Services, York.

Dawson C (2000b). Implementing direct payments. *Findings.* Joseph Rowntree Foundation, London.

Department for Education and Skills (2005). *Children Looked After by Local Authorities, Year Ending 31 March 2004* (Internet only). Available at: http://www.dfes.gov.uk/rsgateway/DB/VOL/v000569/index.shtml. Accessed 4 February 2006.

Department for Work and Pensions (2005). *Opportunity Age – Opportunity and Security Throughout Life*. Department for Work and Pensions, London.

Department of Health (2006). *Our Health, Our Care, Our Say: A New Direction for Community Services* (Cm 6737). The Stationery Office, London.

Department of Health (2006a). *Direct payments for people with mental health problems: A guide to action. Care Services Improvement Partnership.* Department of Health, London.

Department of Health (2005). *Green Paper Independence, Well-being and Choice: Our Vision for Adult Social Care in England* (Cm 6499). The Stationery Office, London.

Department of Health (2005a). Direct Payments and Health. Available online: http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/DirectPayments/DirectPaymentsArticle/fs/en?CONTENT_ID=4104420&chk=GQsPsD. Accessed July 2005.

Department of Health (2005b). *Community Care Statistics 2003–2004: Referrals, Assessments and Packages of Care, for adults: Report of findings from the 2003–04 RAP collection – information for England for the period 1 April 2003 to 31 March 2004* available at http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsStatistics/PublicationsStatisticsArticle/fs/en?CONTENT_ID=4104361&chk=JzAYv/ accessed December 4 2005

Department of Health (2005c). *Independence, Well-being and Choice* (Cm 6499). Department of Health, London.

Department of Health (2005d). Department of Health, London.

Department of Health (2004). *Carers and Disabled Children Act 2000 and Carers (Equal Opportunities Act) 2004 Combined Policy Guidance*. Department of Health, London.

Department of Health (2004a). *Community Care (Direct Payments) Act 1996. Policy and Practice Guidance*. Department of Health, London.

Department of Health (2003a). New Regulations Offer Direct Payments to all in Need. *Press Release 2003/0155*. Department of Health, London.

Department of Health (2003b). *Direct Payments Development Fund (DPDF) Section 64 Specific Scheme of Grants*. Department of Health, London.

Department of Health (2003c). *Direct Payments Guidance. Community Care, Services for Carers and Children's Services (Direct Payments) Guidance England 2003*. Department of Health, London.

Department of Health (1997). *Community Care (Direct Payments) Act 1996: Policy and Practice Guidance*. Department of Health, London.

Department of Health, Social Services and Public Safety (2006) Number of direct payments and amount of payment for each Community HSS Trust in Northern Ireland, 31 March 2006. Available online at: http://www.dhsspsni.gov.uk/direct_payments_mar06.xls

Department of Trade and Industry (2003). *Your Guide to the Working Time Directives*. Department of Trade and Industry, London.

Department for Work and Pensions (2005). *Statutory Sick Pay (SSP)*. Available online: http://www.dwp.gov.uk/lifevent/benefitd/statutory_sick_pay.asp. Accessed 8th February 2006.

Department for Work and Pensions (2001). Independent Living Funds – Quinquennial Review 2001. Available at: *http://www.ilf.org.uk/quin.htm. Accessed 24th November 2004*.

Direct Payments Scotland (2003). *Direct Payments Finance Project Report*. Direct Payments Scotland, Edinburgh.

Evans C and Carmichael A (2002). *Users' Best Value: A guide to user involvement good practice in Best Value Reviews*. York Publishing Services, York.

Fernández JL, Kendall J, Davey V and Knapp M. (2007). Direct payments in England: Factors linked to variations in local provision. *Journal of Social Policy*, **36**, forthcoming.

Flynn M (2005). *Developing the Role of Personal Assistants*. Skills for Care, Leeds.

Forder J, Knapp M, Hardy B, Kendall J, Matosevic T and Ware P (2004). Prices, contracts and motivations: institutional arrangements in domiciliary care. *Policy and Politics*, **32**, 2.

Forder J, Knapp M, Kendall J and Matosevic T (2002). D*egrees of separation: are local authorities changing their commissioning behaviour?* Research Summary 24. Personal Social Services Research Unit (PSSRU), University of Kent, Canterbury.

Forrest E (2005). Mental health. The future is bright. *Health Service Journal*, **115**, 20–2.

Foster M, Harris J, Jackson K, Morgan H and Glendinning C (2006). Personalised social care for adults with disabilities: a problematic concept for frontline practice. *Health and Social Care in the Community*, **14**, 125–35.

Glasby J and Littlechild R (2002). *Social Work and Direct Payments*. Policy Press, Bristol.

Glendinning C, Halliwell S, Jacobs S, Rummery K and Tyrer J (2000a). Bridging the gap: using Direct Payments to purchase integrated care. *Health and Social Care in the Community*, **8,** 192–200.

Glendinning C, Halliwell S, Jacobs S, Rummery K and Tyrer J (2000b). New kinds of care, new kinds of relationships: how purchasing services affects relationships in giving and receiving personal assistance. *Health and Social Care in the Community*, **8,** 201–211.

Glendinning C, Challis D, Fernández JL, Jones K, Knapp M, Manthorpe J, Netten A, Stevens M and Wilberforce M (2006). Evaluating the individual budget pilot projects. *Journal of Care Services Management*, **1**, 123–128.

Gramlich S, McBride G, Snelham N, Myers B, Williams V and Simons K (2002). *Journey to Independence. What self advocates tell us about direct payments.* BILD Publications, Glasgow.

Great Britain Northern Ireland Assembly (2002). *Carers and Direct Payments Act (Northern Ireland) 2002.* Chapter 6. The Stationery Office, London.

Hasler F (2006). The Direct Payments Development Fund. In Leece J and Bornat J (eds) *Developments in Direct Payments*. The Policy Press, Bristol.

Hasler F (2005). The Direct Payments Development Fund. In Leece J and Bornat J (eds), *Developments in Direct Payments*. The Policy Press, Bristol.

Hasler F (2003). *Clarifying the evidence on Direct Payments into practice*. Available online at http://www.ncil.org.uk/evidence_paper.asp.

Hasler F and Stewart A (2004). Making direct payments work: Identifying and overcoming barriers to implementation. Joseph Rowntree Foundation. Pavilion Publishing, Brighton.

Hasler F, Campbell J and Zarb, G (1999). *Direct Routes to Independence: A guide to local authority implementation and management of direct payments.* Policy Studies Institute, Bristol.

Health and Social Care Information Centre (2006a). http://www.ic.nhs.uk/pubs/commcare05adultengrepcssr/Final%20National%20Tables%202004_05.xls/file. Accessed 8th March 2006

Health and Social Care Information Centre (2006b). Personal Social Services Expenditure and Unit Costs: England: 2004–2005. Bulletin: 2006/01/HSCIC. Available online at http://www.ic.nhs.uk/pubs/persocservexp2005/Personal_Social_Services_and_Unit_costs_England_2004-2005.pdf/file. Accessed 8th March 2006.

Healthcare Commission (2006). *Joint Community Mental Health Services Review Assessment Framework*. Healthcare Commission, London.

Heslop P (2001). *Direct Payments for Mental Health users/ Survivors.* National Centre for Independent Living. National Centre for Independent Living, London.

Holman A and Bewley C (1999). *Funding Freedom 2000: People with learning difficulties using Direct Payments*. Values into Action. London.

Illingworth D (2004). *Direct Payments in Oxfordshire*. Oxfordshire County Council. Supported by CETC London.

Jolly D (2004). Working paper on direct payment patterns in the UK: preliminary analysis of quantitative mapping and potential research issues. Centre for Disability Studies, Leeds University.

Kestenbaum A (1996). *Independent Living: A Review.* Joseph Rowntree Foundation, York.

Knapp M. (2007). Social care: choice and control. In Hills, J. Le Grand, J., Piachaud D (eds) *Making Social Policy Work: Essays in Honour of Howard Glennerster.* Policy Press, Brsitol.

Knapp M, Comas-Herrera A, Astin J, Beecham J and Pendaries C (2005). Intellectual disability, challenging behaviour and cost in care accommodation: what are the links? *Health and Social Care in the Community*, **13**, 297–306.

Knapp M, Hardy B and Forder J (2001). Commissioning for quality: ten years of social care markets in England. *Journal of Social Policy*, **30,** 283–306.

Knapp M and Wistow G (1998). Commissioning: strategic choices. Personal Social Services Research Unit and Nuffield Institute for Health. Briefing Paper 2 to the Department of Health, London.

Leece J (2006). 'It's not like being at work': a study to investigate stress and job satisfaction in employees of direct payment users. In Leece J and Bornat J (eds) *Developments in Direct Payments*. The Policy Press, Bristol.

Leece J (2003). *Direct Payments.* Venture Press, Birmingham.

Leece J, Babb C and Leece D (2003). Money matters: an evaluation of Direct Payment Pilot Project for parents of disabled children in Staffordshire. *Journal of Integrated Care*, **11**, 33–38.

Lewis S (2005). *Direct Payments: Answering frequently asked questions*. Adult Services Resource Guide 05. Social Care Institute for Excellence, London.

Luckhurst L (2006). Can intensive support widen access to direct payments? In Leece J and Bornat J (eds) *Developments in Direct Payments*. The Policy Press, Bristol.

MacFarlane A (2002). A response to the Best Value review of Direct Payments in Wiltshire undertaken by disabled people. *MCC: Building Knowledge for Integrated Care*, **10**, 45–48.

Maglajlic RA, Brandon D and Given D (2000). Making direct payments a choice: a report on research findings. *Disability and Society*, **15**, 99–113.

Maglajlic RA, Bryant M, Brandon D and Given D (1998). Direct payments in mental health: a research report. *Breakthrough*, **2**, 33–36.

McCann S, Ryan AA and McKenna H (2005). The challenges associated with providing community care for people with complex needs in rural areas: a qualitative investigation. *Health & Social Care in the Community*, **13,** 462–469.

Murray-Neill R (2006). Direct Payments Analysis of 31 March 2005 CSCI figures for direct payments use in lieu of adult mental health services. NIMHE National Social Inclusion Programme. National Institute for Mental Health Exclusion, London.

National Assembly for Wales (2000). The Community Care (Direct Payments) Amendment (Wales) Regulations.

National Institute for Mental Health in England (2003). *Cases for Change: Emerging Areas of Service Provision,* NIMHE, Department of Health, London.

Netten A, Darton D, Davey V, Kendall J, Knapp M, Williams J, Fernández JL and Forder J (2005). *Understanding Public Services and Markets*, King's Fund Publishing, London.

Newbigging K and Lowe J (2005). *Direct Payments and Mental Health: New Directions.* Joseph Rowntree Foundation. Pavilion Publishing, Brighton.

Northern Ireland Office (1996). *Personal Social Services (Direct Payments) (Northern Ireland) Order 1996* [1996 No. 1923 (NI 19)].

Office of the Deputy Prime Minister (2006). *A Sure Start to Later Life. Ending inequalities for older people*. Office of the Deputy Prime Minister, London.

Office of the Deputy Prime Minister (2004). *Mental Health and Social Exclusion*, Social Exclusion Unit, ODPM, London.

Payne M (2000). The politics of case management and social work. *International Journal of Social Welfare*, **9**, 82–91.

Pearson C (2003). Exploring the Role of Support Organisations for Direct Payments. Report prepared for Direct Payments Scotland. Strathclyde Centre for Disability Research, University of Glasgow.

Pearson C (2004a). Keeping the cash under control: what's the problem with direct payments in Scotland? *Disability and Society,* **19**, 3–14.

Pearson C (2004b). The implementation of direct payments: issues for user-led organisations in Scotland. In Barnes C and Mercer G (eds) *Implementing the Social Model of Disability: Health and Social Support Services.* The Disability Press, Bristol.

Pearson C, Barnes C, Jolly D, Mercer G, Priestley M and Riddell S (2005). Promoting personal assistance in the UK: What's the problem with direct payments? *Disability Studies Quarterly*, **25**(1).

Priestley M (2005). Implementing direct payments for disabled people in the UK: initial findings from interviews with purchasing authorities. Discussion Paper. Centre for Disability Studies, Leeds University.

Priestley M, Jolly D, Pearson C, Riddell S, Barnes C and Mercer G (forthcoming). Direct payments and disabled people in the UK: supply, demand and devolution. *British Journal of Social Work*.

Prime Minister (2006). Letter to the Secretary of State for Health. Monday 15 May, 2006 – 12:42. 10 Downing Street, London.

Prime Minister's Strategy Unit (2005). Improving the life chances of disabled people. Prime Minister's Strategy Unit, London.

Rankin J (2005). *A Mature Policy on Choice*. Institute of Public Policy Research, London.

Revans L (2000). Direct payments stalled. *Community Care,* 4th October 2000.

Riddell S, Pearson C, Baron S, Jolly D, Barnes C, Priestley M and Mercer G (2005). The development of direct payments in the UK: implications for social justice. *Social Policy and Society*, **4**, 75–86.

Ridley J and Jones L (2003). Direct what? The untapped potential of direct payments to mental health service users. *Disability and Society*, **18**, 643–658.

Ridley J, Hunter S and Infusion Cooperative (2005). *"Go for it!": Supporting people with learning disabilities and/or autistic spectrum disorders in employment.* Research Findings No 45. Scottish Executive, Edinburgh.

Robbins D (2004). Treated as people: an overview of mental health services from a social care perspective, 2002–04. Social Services Inspectorate, Department of Health, London.

Robertson J, Emerson E, Hatton C, McIntosh B, Swift P, Krijnen-Kemp E, Towers C, Sanderson H, Routledge M, Oakes P and Joyce T (2005). *The Impact of Person Centred Planning*. Lancaster University, Lancaster.

Roche D and Rankin J (2004). *Who Cares? Building the Social Care Workforce*. Institute of Public Policy Research, London.

Scope (2003). *The Direct Approach: Disabled People's Experiences of Direct Payments*. Scope, London.

Scottish Executive (2004). *Direct Payments in Scotland 2004*. Statistics Release. Scottish Executive, Edinburgh.

Scottish Executive (2005). *Direct Payments in Scotland 2005*. Statistics Release. Scottish Executive, Edinburgh.

Scottish Executive (2003). *Direct Payments Social Work (Scotland) Act 1968: Sections 12B and C: Policy and Practice Guidance*. Scottish Executive Health Department, Community Care Division, Edinburgh.

Scottish Office (1997). *Community Care (Direct Payments) Act 1996: Policy and Practice Guidance*, Enclosure to Circular No. SWSG3/97. Scottish Office Social Work Services Group, Edinburgh.

Simon-Rusinowitz L, Mahoney KH, Shoop DM, Desmond SM, Squillace MR and Sowers JA (2001). Consumer and surrogate preferences for a cash option versus traditional services: Florida adults with developmental disabilities. *Mental Retardation*, **39**, 87–103.

Social Services Improvement Agency, Wales (2006). Numbers of direct payment service users in Wales. Available online at: http://www.allwalesunit.gov.uk/media/excel/7/r/Authority_Annual_Comparison.xls

Social Services Inspectorate (1997). *Better Management, Better Care, the Sixth Annual Report of the Chief Inspector Social Services Inspectorate 1997/97*. Stationary Office, London.

SPAIN (2005). *What Price Care in Old Age?* Social Policy on Ageing Information Network, London.

Spandler H (2004). Friend of foe? Towards a critical assessment of direct payments, *Critical Social Policy*, **24**, 187–209.

Spandler H and Vick N (2005). Enabling access to direct payments: An exploration of care co-ordinators decision-making practices. *Journal of Mental Health*, **14**, 145–55.

Spandler H and Vick N (2004). *Direct payments, independent living and mental health*. Health and Social Care Advisory Service, London.

Stainton T (2002). Taking rights structurally: disability rights and social worker responses to direct payments. *British Journal of Social Work*, **32**, 751–763.

Stainton T and Boyce S (2002). I have got my freedom back: A report on an evaluation in Cardiff and the Vale of Glamorgan. *Llais*, **64**, 3–5.

Stewart K, Hughes J, Challis D, Weiner K and Darton R (2003). Care management for older people: access, targeting and the balance between assessment, monitoring and review. *Research Policy and Planning*, **21**, 13–22.

Ungerson C (2004). Whose empowerment and independence? A cross-national perspective on 'cash for care' schemes. *Ageing and Society*, **24**, 189–212.

Vick N (2005). *The impact of social care modernisation on direct payments. Emerging Issues.* Modernisation of Adult Social Care Research Initiative, London.

Wanless D (2006). *Securing Good Care for Older People*. King's Fund, London.

Williams V (2006). *How can local authorities increase the take-up of direct payment schemes to adults with learning disabilities?* OutLine 3, Research in Practice for Adults, Totnes. http://www.ripfa.org.uk/publications/outlines/outlinesPDF/3.pdf.

Wilson R and Gilbert K (2006). An experience of the Direct Payments Development Fund. In Leece J and Bornat J (eds) *Developments in Direct Payments*. Policy Press, Bristol.

Wistow G, Knapp M, Hardy B, Forder J, Kendall J and Manning R (1996). *Social Care Markets: Progress and Prospects.* Open University Press, Buckingham.

Witcher S, Stalker K, Roadburg M and Jones C (2000). *Direct Payments: The Impact on Choice and Control for Disabled People*. Scottish Human Services Trust and Lothian Centre for Integrated Living. The Scottish Executive Central Research Unit, Edinburgh.

Direct Payments: A National Survey of Direct Payments Policy and Practice

Direct payments give greater control to people assessed as needing social care or support and form a key part of the agenda for the developing social care system. But they also raise many challenges – for the individuals holding the budgets, for the people they employ, their families and other unpaid carers, local authority staff and the organisations set up to support them. As more people take up the opportunity to purchase their own services, including employing their own personal assistants, so the commissioning, provision and regulating functions of social care agencies may need to change. This report describes how local authorities across the UK are responding to the practical challenges of policy change.

Data collected in two UK-wide surveys allow us to explore how the national policy of direct payments has been implemented locally. This report documents the main parameters of such implementation: the numbers of people receiving direct payments, the funding they receive, the support they are offered and the typical utilisation of this service. It also identifies the challenges that will need to be met if this policy is really to achieve the objective of enhanced individual choice to which so many people subscribe.