Executive Summary

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Direct Payments:

A National Survey of Direct Payments Policy and Practice

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May 2007

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PARTICIPATING ORGANISATIONS

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.