Direct Payments in Residential Care: Evaluation of Trailblazers

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Outline

• Background
  – Residential care funding and provision
  – Direct payments
  – Trailblazer evaluation

• Defining independence, choice and control

• Key findings from interviews
  – Reasons for accepting, declining a direct payment (DP)
  – Perceptions and experiences of independence, choice and control

• Final thoughts
Background: residential care funding and provision (England)

- Adult social care is allocated according to a national **means-test**. Local authorities conduct the means tests (under national rules):
  - Set eligibility criteria (subject to national minimum)
  - Contract care homes
  - Assess care needs
  - Set personal budget in light of **assessed care needs**

- If qualifying for **residential care**:
  - Councils directly commission services from care home providers able to **meet assessed need** and at **local authority rate**.
  - Top-up payments to care home by third party may be agreed.

- Those over threshold for support (currently £23,250 pa)
  - Pay for care privately – ‘self funders’
  - Often at higher than LA rate
Background: residential care funding and provision (England) cont’

• Dominance of private (for-profit) care homes
  – Mix of self and local authority funded residents (40:60)
  – High level of cross-subsidy high (self-funders subsidizing rates paid by local authorities).

• Care home fees comprise basic ‘package’ (personal care, hotel and activities)
  – Most care homes cater for older people with high care needs and cognitive impairment
  – There are also many care homes for younger people
Background: direct payments

- Policy promoting **personalization of services** through choice and control
  - introduction of individual/personal budgets and direct payments/’cash for care’ schemes.

- **A direct payment is**
  ‘a payment of money from the local authority to either the person needing care and support, or to someone else acting on their behalf, to pay for the cost of arranging **all or part** of their own support’

- Current choice in residential care largely restricted to choice of care home (package deal)

- DPs not available for long-term residential care
  - Law Commission (2011) asked government to consider extending provision for reasons of equity.
Background: trailblazer evaluation

• In 2013 UK Department of Health (DH) invited local authorities to volunteer to pilot the Direct Payments in Residential Care trailblazer programme.
  – 20 trailblazer sites selected in England
  – 14 remained in the programme throughout.
  – Local authorities involved in a scoping study (2013) estimated 430-500 DPs

• Impact evaluation carried out by the Policy Innovation Research Unit (PIRU):
  – Surveys of users and family members, and providers
  – Interviews with users and family members, council and care home staff and representatives of national stakeholder organisations
Key findings of evaluation

- **Only 29 active direct payments** at end of programme (March 2016)
  - Across **10 of 14** remaining trailblazer sites
  - **Full DP**: covering whole care home fee n= **19**
  - **Part DP**: to fund day activities/services (with remainder of care home fee paid direct to care home by council) n = **10**

- Monetary amounts varied:
  - £8pw (part payment DP) to **£1,250pw** (full DP covering whole care home fee)

- Low uptake limited ability to collect interpretable quantitative data on outcomes and quality of life

- Interviews revealed **some benefit to some service users/family members** but often **at a cost**:
  - Full DP increased sense of control (for family members) but less likely to offer greater choice
  - Part DP offered some choice but more difficult to set up
Findings: Sample characteristics of interview participants

• From 9 trailblazer sites

• Participants
  – 8 service users (face-to-face)
  – 25 family members (including advocates and care staff) (telephone)
  – Follow-up interviews with 2 service users, 1 family member (face-to-face)

• Decision on offer:
  – 20 accepted DP
  – 11 declined DP

• At the time of the interview
  (baseline where applicable):
    – 15 active (of 20 accepted)
    – 5 accepted, but inactive
    – 1 withdrawal (post interview)

• Age of service users:
  – <65 = 12
  – 65-84 = 7
  – 85+ = 12
Findings: Reasons for accepting a DP

• More choice in “extra” activities (i.e. leisure, beauty treatments, entertainment)
• Family empowered to “take a stand” if dissatisfied with care
• Family can provide instrumental support to the service user
• Continue previous DP experience in the community
• Simplifies administration of payment
• Improves transparency of care home fees
Findings: Reasons for declining

- Satisfied with status quo; no perceived benefit for service users
- DP will interfere with quality and choice of services provided by care home
- Take-up discouraged by care home
- Fears that DP could be used dishonestly
- Destabilise sense of security of service user
- Too complicated to administer
- Care needs of service users are too complex
Defining independence, choice and control

• **Individual independence** (Townsend, 1981)
  – Measure of physical, sensory, cognitive abilities to conduct activities of daily living
  – Widely used by health and social care practitioners as sole measure of independence

• **Interdependence** (Plath, 2009)
  – “Each person is dependent on others in a variety of ways…A feature of the human social condition” (p.211)
  – Maintaining independence by depending on others
  – Distinguish difference between functional capabilities and capability to deploy resources (familial, cultural, financial) that can help undertake activities of daily living

• **Autonomy**
  – Taking **decisions** about what to do and how to do it (Doyle and Gough, 1991)
  – Individual’s ability to make decisions and take “**control** over daily life” (Boyle, 2008)
  – Since 2005 health and social care policy emphasises “**choice and control**”
Findings: Individual independence

• Many service users with memory loss or cognitive impairment
  
  “[My relative’s] dementia is so bad now that he cannot look after his own financial affairs.”
  
  (Family member, site7)

• Some service users with complex health needs:
  
  – E.g. A service user declined in part because of uncertainty about how to manage weekly oxygen supply when on trips outside the care home potentially funded by a DP.

• Some family members made generalisations about independence of older people in residential care:
  
  “I think that nowadays anyone who’s in a care home who is getting funding, it’s going to be a bit beyond them to do it for themselves. [My relative] definitely wouldn’t be able to [manage a DP].”
  
  (Family member, Site12)
Findings: Interdependence

• All service users relying on family members (including care staff, advocates, charities) to manage DP
  – Similar level of assistance given when service users living in the community

• Bi-directionality of interdependence
  – Some family members used DP to continue participating in relatives’ care

• Interdependence of wider care home community
  – Perceptions of some family members who declined a DP, that DP payments for the individual could negatively impact the care home community as a whole

  “The [care] home that [my relative] is in is first class and not over-priced. It is a charitable organisation and [my relative] doesn’t pay for many of the activities arranged by the [care home]; [all funds are] ploughed back into the [care] home. I’m not prepared to take money away from the care home and give it to [my relative] because it’s like robbing Peter to pay Paul.”

  (Fam1, Site 8)
Findings: choice and control

• **In interviews held before DP started:**
  – perceptions of *more choice* over extramural activities
    “I’m going to go to all the art galleries in London”

• **In interviews held after DP started:**
  – For majority of older residents: DP only covered care home fees; *did not improve choice*
    “It’s not as if that there is money for anything else – like [my relative’s] hair dressing or chiropody. We pay for that separately. So, the [direct payment] money is just for [my relative’s] care. I can’t see any difference [to if the council paid the care home].”
    (Family member, site 12)
  – Expressed perception of *more control* over care home by using DP
    “I think it does give me more control with the care home because if certain things weren’t quite right, I’d just remind them that I’m paying the bill for this.”
    (Family member, site 12)
  – Some younger residents *unable to exercise choice*: market infrastructure unprepared to meet individual demand
    “It’s been seven months and he hasn’t been able to go horse riding or do any woodwork. So if the idea is presented that you will be able to do these things but then if it hasn’t actually happened, it could be a little bit disappointing.”
    (Family member, site 6)
Final thoughts
Independence, choice and control achievable with DPs in residential care?

• Through the **prism of interdependence:**
  – “Independence” is improved when benefits aimed at family unit, rather than individual
  – **Family members** are the main beneficiaries in terms of **perceived control**

• Interdependence can only exist with support
  – Unequal access to support networks (formal, informal) for service users in residential care
  – Analysis of interviews with family members suggests:
    • service users in residential care, **without access to external support**, may have less access to direct payments, and in turn may have less independence, less choice and less control that those who are have external support

• Choice needs to be supported by care market
  – Currently not the case

• **Perceived** control by family members enhanced, **actual** control untested
References

Reports from this evaluation:
http://www.piru.ac.uk/assets/files/DP%20Trailblazer%20Final%20Report.pdf

Publications:
Disclaimer

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