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Individual Budgets Evaluation Network

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Evaluation of the Individual Budgets Pilot Programme

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1. Context: Policy and the Pilot Programme

1.1 Policy context

Individual budgets (IBs) are central to the Government's ambitions for 'modernising' social care in England, and sit at the heart of the 'personalisation' agenda. IBs were first proposed in the Cabinet Office Strategy Unit (2005) report, *Improving the Life Chances of Disabled People* and this commitment was repeated in the UK strategy for an ageing population. In the same year, a Green Paper on adult social care called for more opportunities for older and disabled people to exercise choice and control over how their support needs are met as well as for the focus of support arrangements to shift from service inputs to user-defined outcomes. The intention was to build on experiences with two pre-existing schemes: direct payments (where individuals eligible for social care support receive cash payments in lieu of direct service provision) and the pioneering *In Control* projects for people with learning disabilities (where individuals have greater choice and control over the support they receive and how they receive it). As the Green Paper states:

> People could have individual support to identify the services they wish to use, which might be outside the range of services traditionally offered by social care. … For those who choose not to take a direct payment as cash, the budgets would give many of the benefits of choice to the person using services, without them having the worry of actually managing the money for themselves.
> (DH, 2005: 34)

In July 2005 the Department of Health (DH) invited local authorities with responsibility for adult social care to bid to pilot individual budgets. Thirteen local authorities were selected (see section 2) and the pilot projects ran from November 2005 to December 2007.

1.2 The principles underlying individual budgets

Pilot sites were tasked to ensure that IBs reflected the following principles:

- Service users should play a greater role in the assessment of their needs.
- Individuals should know the level of resources available to them before starting to plan how they would like their support needs to be met. The pilot projects should build on the experiences and tools developed by *In Control,* particularly the Resource Allocation System (RAS) to determine how much money an individual should receive. Developing a RAS is an iterative process, balancing the competing requirements for an equitable redistribution of resources between

people with similar levels of need, the need to allocate sufficient resources for people with particularly high needs (and not too much to those with low-level needs), and the overarching requirement to remain within existing budgets, since the process of piloting IBs was to be managed within existing resources.

- The pilot projects should test opportunities for integrating resources from several different funding streams into a single IB. In addition to adult social care, these funding streams should include: Access to Work; the Independent Living Fund (both the responsibility of the Department for Work and Pensions); Supporting People and the Disabled Facilities Grant (both the responsibility of the Department for Communities and Local Government); and local Integrated Community Equipment Services, funded from pooled social care and NHS resources (and therefore already more closely aligned with social care budgets).
- The multiple assessment processes and eligibility criteria should be simplified and integrated or aligned, although adult social care should be the gateway to an IB. The pilot projects should explore how far integration could be achieved within existing legislative and administrative arrangements and identify barriers to integration.
- In planning how to use an IB, individuals should be encouraged to identify the outcomes they wish to achieve and the ways in which they wish to achieve them. Whereas direct payments were generally used to employ personal assistants, IBs could be spent on a wide range of existing services, including the purchase of ordinary community or commercial services (for example, gym membership rather than day centre attendance) or to pay relatives and friends for the help they provide.
- Support should be available to help individuals plan how to use their IBs. Additionally, brokerage support should provide individuals with information on the costs and availability of different service options.
- The pilot projects should experiment with different options for deploying IBs (ways of managing and using the money). As well as direct cash payments, other potential arrangements included care manager-managed ‘virtual budgets’, provider-managed individual service funds, and payments to third party individuals and Trusts. Combinations were also possible for individual IB holders. These deployment options were not all available in every site.

The anticipated advantages of this new system were seen to include: the ability to meet not only personal care needs but also a range of other needs; continuity and choice of care worker; the chance to pay family and other carers; and greater flexibility over how and when to use support resources.

1.3 The individual budget process

The typical process for allocating an IB was as follows:

- A range of assessment processes are undertaken with an individual to determine the level of help needed and the outcomes sought. Other assessments might be needed to determine the allocation of other funding streams because these are not normally aligned or integrated with the IB assessment.
- A decision is made as to whether the individual meets the local authority's Fair Access to Care Services (FACS) eligibility criteria. Unless the person meets these criteria, he or she is not eligible for publicly-funded social care.
- The assessment feeds into the resource allocation system (RAS) and is used to determine an 'indicative IB', setting the level of resources the person can expect to receive from adult social care and, potentially, resources from other funding streams.
- A financial assessment is undertaken to determine the person's financial contribution (if any) to the costs of any services. Further financial assessments for the different funding streams may be required.
- Once the amount of money in the IB is agreed, a support planning process starts to work out the individual's priorities and goals and how to meet them. Help with planning support may come from a care manager, an in-house or external specialist support planner or broker, the person's family and friends, or (unusually) a service provider.
- A team leader or senior manager approves ('signs off') the support plan and also considers the level of risk and possible adult safeguarding concerns.
- The IB is then managed according to the chosen deployment option.
- Like all social care, the IB should be reviewed after a few weeks (typically six to eight weeks) and then annually. Minor changes to support plans can usually be made with the approval of the care manager, team manager or IB lead officer. Substantial changes may require a reassessment, a new allocation of resources, and a fresh support plan.

1.4 The evaluation of the IB pilot projects (IBSEN)

The potential impacts of IBs for local authority adult social care services, for the roles of voluntary and user-led organisations, and for the expectations and responsibilities of social care service users, were expected to be profound. The Department of Health therefore commissioned a wide-ranging evaluation of the IB pilot projects from the Social Policy Research Unit at the University of York, the Personal Social Services Research Unit at the Universities of Kent, Manchester and LSE, and the Social Care Workforce Research Unit at King's College London. The work of the evaluation team (hereafter referred to as the Individual Budgets Evaluation Network – IBSEN) began in August 2005, went ‘live’ in April 2006 and ended in March 2008. This report covers the research carried out during that two-year period.

The evaluation of the IB pilot projects was commissioned as a policy evaluation, which comprised a number of elements, aiming to:

1. examine whether IBs offer a better way of supporting older people and adults with social care needs than conventional methods of funding, commissioning and service delivery;
2. examine the relative merits of different IB models for different groups of people using services; and
3. explore the impacts of IBs on the workforce involved and factors facilitating or constraining implementation of the policy.

The study is the first robust UK evaluation of the implementation of this form of personalised approaches to social care and its impact on the individuals involved, the workforce and providers, as well as the support and commissioning processes. The aim was to offer a reliable basis for considering the national roll-out of policies built on principles of personalisation and participation.

A separate, linked study of the impact of IBs on the carers of people using services will be published in autumn 2008.

2. The IB Pilot Projects

2.1 The 13 pilot sites

Thirteen local authorities were selected as pilot sites. They covered a range of authority types (two London boroughs, five metropolitan boroughs, four counties and two unitary authorities), spread across England. One site was committed to offering IBs by the end of 2005, with the remainder offering the first IBs by June 2006.

The sites varied widely in their demographic and socio-economic characteristics, adult social care activity and overall performance. As a group, however, there were no overall differences from the average in England. The only measure on which the sites appeared atypical was that, overall, they had higher than average take-up of direct payments. Some also had significantly higher expenditure on direct payments, particularly for people with mental health problems and learning disabilities. Many were already working with *In Control*, usually in developing new support arrangements for people with learning disabilities. Nevertheless, significant innovations in social care organisation and practice were required, as well as in the partner agencies contributing funding streams to IBs.

Sites had varying reasons for wanting to pilot IBs. Common reasons included: building on their experiences of direct payments and/or *In Control*; offering opportunities for personalisation to service users who had been reluctant to take up direct payments; creating better outcomes for service users; and consistency with the authority’s existing or desired policy goals. Additional DH funding to support implementation in the pilot sites was important, particularly for small authorities with less flexibility to second staff to new project teams.

Most sites – at least initially – chose not to offer IBs to the full range of adult social care users, but only to selected groups. These choices were influenced by: previous experiences of *In Control* and direct payments; the belief that IBs would benefit particular user groups; and a desire to extend choice and control to those groups often excluded. Table 2.1 provides a summary.

Similarly, most sites initially sought to include only *some* of the possible funding streams, usually determined by their relevance to the user groups involved in the local pilot. Other factors in the choice of funding streams were: ease of access; well-established working relationships between adult social care departments (which took the lead role in implementing IBs) and staff responsible for other funding streams; a desire to increase knowledge and build further such relationships; and an aim to increase take-up of a funding stream.

2.2 Approaches to implementing IBs

Sites were encouraged by DH to adopt an incremental approach to implementation, prioritising those changes necessary to offer small numbers of IBs by spring 2006 and developing fully fledged models thereafter. Most sites therefore started by offering IBs to only one user group, or by working with only one team of care managers. A few introduced IBs locality by locality. Many sites started by offering IBs to people with learning disabilities, expecting this group to be easiest and because they already had experience of working with *In Control*. Others started with people with physical disabilities and/or sensory impairments because of the popularity of direct payments with this group. Most sites offered IBs to both new and existing service users from the start. Some targeted specific groups, such as people living in residential care homes who could move back to community settings, those in transition from children’s to adult social care services, and those dissatisfied with their current arrangements. Otherwise, there was no overall pattern in the approaches to implementation.

During the first four months of the pilot programme (up to April 2006), sites set up implementation structures and planning processes. Developing a resource allocation system was a high priority and was quickly identified as the most challenging early task. Most sites started by adapting methods developed by *In Control*, although there were concerns (in some sites) that these were too simplistic or would inhibit creative responses. There were also concerns that early resource allocation systems would need subsequent adaptation when additional funding streams were aligned or integrated, or simply in the light of experience. One site decided from the start to use an outcomes-focused approach to identify support needs, with resource allocation subsequently determined in the light of users’ desired outcomes.

Early experiences with aligning funding streams prompted a number of concerns. These included how to disaggregate social care resources from jointly-funded services (such as ICES), the exclusion of NHS continuing care systems from IBs, and aligning Access to Work eligibility criteria with those for adult social care. Major changes in care co-ordinators (front-line staff, often known as care managers in some sites) activities and processes were anticipated, as were needs for new accountability and risk-management processes.

Table 2.1 Summary of IB pilot projects

Site	*User groups*	*Number of adult social care teams involved in pilot*	*Funding streams*[*]
1	Physical/sensory impairment, learning disability	1 Long-term conditions, 1 Learning disability (LD), 1 Review team, 1 Intake team	AtW, ILF, SP
2	Physical/sensory impairment, learning disability, older people	1 Occupational Therapist (OT), 2 Older People (OP), 1 Hospital, 1 Physical Disability (PD)/HIV under 65, 1 LD	AtW, DFGs, ICES, ILF, SP
3	Mental health	4 Mental Health (MH)	AtW, ILF, SP
4	Older people	10 OP, 1 OP/MH, 1 Hospital team	DFGs, ICES, ILF, SP
5	Physical disability, learning disability, mental health, older people	1 OP, 1 LD, 1 PD, 1 MH	AtW, DFGs, ICES, ILF, SP
6	Physical disability, learning disability	1 lead team working on IBs	AtW, DFGs (later in pilot), ICES, ILF, SP
7	Physical disability, learning disability, older people	2 OP/Disability (not LD), 1 Sensory Impairment (SI), 1 LD	AtW, ICES, ILF, SP
8	Physical disability, learning disability, mental health, older people	All teams: 5 MH, 1 vulnerable adults, 1 LD, 1 SI, 3 OP.	AtW, DFGs, ICES, ILF, SP
9	Older people	6 OP, 3 LD, 3 PD	AtW, DFGs, ICES, ILF, SP
10	Physical disability, learning disability	1 PD, 2 LD	AtW, DFGs, ICES, ILF, SP
11	Transitions, learning disability, older people	1 Transition, 1 Review (PD, LD, MH)	DFGs, ICES, ILF, SP
12	Transitions, physical disability, learning disability, mental health	3 LD, 1 PD, 1 SI, 1 children’s, 4 MH	AtW, DFGs (later in pilot), ICES, ILF, SP
13	Physical/sensory impairment, learning disability, mental health, older people	5 OP, 1 LD, 1 PD, 1 children’s, 7 MH	AtW, DFGs (later in pilot), ICES, ILF, SP

[*] AtW = Access to Work; ILF = Independent Living Fund; SP = Supporting People; DFG = Disabled Facilities Grant; ICES = Integrated Community Equipment Service.

2.3 Actual implementation against initial plans

Although sites initially planned to offer IBs only to specific user groups, most intended to extend IBs to additional groups before the end of the pilot phase in late 2007. In retrospect, some IB lead officers reflected that they would have preferred to offer IBs to all groups from the start, because of the subsequent additional work in adapting assessment documents and resource allocation systems initially developed for a single group. In contrast, other lead officers thought that gradual implementation had helped refine processes and build on early learning.

Irrespective of any changes planned during the pilot stage, most sites planned to offer IBs to all adult social care users eventually. A number of reasons were offered, including the anticipated benefits for service users, anticipated cost savings, and the need to reduce demand for traditional services to free up resources for IBs. In all sites, future plans beyond the pilot stage entailed a phased or incremental approach. This was to provide time to foster cultural change among both staff and service users, train care managers and other staff; decommission certain services; work with providers to develop new services; and improve the alignment of funding streams.

2.4 Factors affecting pilot sites' experiences of implementing IBs

Sites' experiences were shaped by a number of factors, including the wider national and local policy contexts, the DH deadline for offering the first IBs and the demands of the evaluation. This last factor may have played a particularly notable role. It required sites to randomly select and recruit target numbers of users by mid-2007, collect and return user-level data, and participate in research interviews. The evaluation led some sites to concentrate on selecting particular groups of service users for early IBs, instead of testing new approaches with, for example, the users of a particular day centre or a supported living scheme. The evaluation also meant that potential IB holders whose new support arrangements would take time to put in place, such as those moving from residential care homes, were less likely to be included in the pilot.

Extensive developmental support was provided to the pilot sites by the Care Services Improvement Partnership (CSIP). Pilot sites felt that CSIP staff were particularly helpful in taking key implementation barriers – especially around funding streams – to a national stage and to central government departments. CSIP also assisted sites in developing key IB processes, using *In Control* tools as a natural starting point. However, some sites were concerned that this support – particularly for developing resource allocation systems – was too heavily influenced by the experience of *In Control* and thereby impeded local innovation and diversity.

The overall timetable for implementing the pilot and research was tight, and sites were put under increasing pressure by both DH and CSIP, as many sites were viewed as being behind schedule. The principle causes of the delay, according to an early CSIP report, were that sites were not well oriented to the task and that it took time for senior managers to prioritise the programme. Other research and development activities commissioned by other government departments and CSIP added to the demands placed on sites. IB lead officers and care managers would have liked clearer guidance earlier regarding the types of support and activities that IBs could be used for, as well as more help from central government departments on integrating funding streams.

3. Methods

The evaluation adopted a mixed methods design, at the heart of which was a randomised controlled trial examining the costs, outcomes and cost-effectiveness of IBs compared to conventional methods of service delivery. Nearly 1,000 service users were interviewed six months after they were allocated to either the IB group or to standard services, in order to assess overall experiences and outcomes (measured using well-respected and internationally recognised instruments for measuring social care outcomes). In-depth interviews with a subsample of 130 people who had been offered an IB were also conducted to explore their first experiences of the new processes.

Interviews were also conducted with lead officers responsible for IB implementation, and with other staff responsible for commissioning, resource allocation, support planning and brokerage, service provision, and different funding streams. Representatives of user and carer organisations in some sites were also interviewed. Each interview examined implementation processes and experiences. We also interviewed front-line staff (care co-ordinators) and first-tier managers about their workloads, job satisfaction, training needs, and adult safeguarding, as well as collecting staff activity data. The evaluation team was not commissioned to research the views of central government departments or the CSIP implementation team, although we do set the findings in the context of their activities, and we discussed the evaluation methods, processes and findings extensively with them. Further, the impact of IBs on carers is not included here, as this is the subject of a separate report to be published later in 2008.

The particular strength of the evaluation lies in the randomised controlled trial, supplemented by the more detailed qualitative investigation of the processes and perspectives of a wide range of users and stakeholders. But the evaluation has inevitable weaknesses as a means of assessing the potential impact of a full roll-out of IBs. Most notable here is the inevitable fact that the 13 sites which took part in the pilots had particular advantages. Senior officers and most care co-ordinators and team managers expressed enthusiasm for the principles of IBs – user empowerment, choice and control – even if that enthusiasm was not always easily turned into operational practice. They were backed up by a dedicated national implementation team. And they may have been motivated by the spotlight of a high-profile national pilot and evaluation. These features may not be mirrored in wider roll-out, or at least not on the same scale.

On the other hand, the evaluation was also hampered by some factors. The evaluation timescale permitted only a six-month interval for users to receive their IB and commission their own services, whereas a longer follow-up period would have allowed more time for us to develop a more accurate picture of experiences and impacts. Moreover, the preponderant interpretation of IBs as a form of direct payment at the initial stages meant that other forms of deployment of IBs, such as flexible ‘virtual budgets’ managed by care managers, were uncommon. This could mean that differences between existing patterns of provision and the IB experience appeared smaller than might have been the case, given learning over more time. The findings and conclusions reflect these uncertainties.

4. Description of the User Sample

Across the 13 pilot sites, 2,521 individuals were 'randomised' and invited to take part in the research, of which 1,594 (63 per cent) gave consent. Not all of these people remained in the study: some were ineligible for services; for some the data returns were delayed or incomplete; a small number died; and some people no longer wanted to take part in the study or were unable to do so (because of illness).

The final sample comprised 959 people: 510 in the IB group and 449 in the comparison group. The distribution of the sample across 'primary' user groups was:

- 34 per cent were working-age physically disabled.
- 28 per cent were older people.
- 25 per cent had learning disabilities.
- 14 per cent used working-age mental health services.

The distribution across pilot sites is shown in Table 4.2; one of the sites did not participate in this part of our evaluation.

Table 4.2 Numbers of people included in the randomised study*

Site	*IB group*	*Comparison group*	*Total sample*
1	36	19	55
2	37	21	58
3	21	22	43
4	41	25	66
5	53	54	107
6	73	74	147
7	37	44	81
8	50	69	119
9	24	29	53
10	32	18	50
11	40	37	77
12	-	-	-
13	66	37	103

***** Where IB and comparison group numbers are uneven within any site this was because people in one group (usually, but not always, the IB group) were more likely than people in the other to give consent to participate in the evaluation.

Our sample achieved a good spread across key characteristics, including age, ethnicity and household composition. However, service users in the sample were significantly more likely to have had a direct payment prior to the pilots, compared to the national average of social care recipients, suggesting that people with experience of self-directed support were most likely to be put forward for the IB trial. Our formal analyses of outcomes tested for these effects.

There was very little difference between the IB and comparison groups at baseline, suggesting that the randomisation had not been compromised in any way. This important finding means that the two groups differed significantly only in terms of whether or not they got an IB, and therefore differences between them in average cost and outcome can be attributed to the IB (or lack of it) and not to other factors. We also sought to explore variations *within* the samples and to understand why they occurred.

The sample of IB users did not typically have experience of holding the IB for very long, as the short follow-up time was compounded by considerable delays to implementation against DH expectations. Of those people who were allocated to the IB group, about ten per cent declined to take up a budget but were happy to take part in the evaluation. (A common reason for such refusal, particularly among direct payment holders, was that the indicative resource allocation with an IB represented a reduction of their previous service allocation or direct payments or was in other ways considered insufficient to meet their needs.) About 20 per cent of those allocated to the IB group had not completed their IB assessment at the time of the interview (six months after being selected), and a further 25 per cent did not have their budget in place at that time. In other words, only 45 per cent of the people in the IB sample were actually in receipt of the IB at the time of the six-month interview and, of these, around half had held the IB for under a month. Our analyses of costs and outcomes explore the consequences of these delays.

The in-depth interviews with a subsample of 130 people offered an IB achieved a good spread of characteristics, with the exception of ethnicity: fewer black or minority ethnic service users were interviewed in-depth than were aimed for.

5. Who Got What?

A key issue for the evaluation of IBs is the size of the budget given to service users and the purposes to which it was put. The qualitative interviews found that a number of people had not been told the indicative or final amount of their IB, and less than half of those who had been told were aware of how the amount had been calculated. (As noted, it took longer to put IBs in place than originally anticipated; and these interviews were conducted after about two months.) Even those who received an explanation of the budget calculation found it difficult to understand. Most of those who knew the amount of their IB said that its value was equal to or greater than the amount they expected, although some revised this view when they calculated the actual costs of the services they wanted to purchase. IB holders with mental health problems were more likely than other groups to view their budget as higher than the support they had previously received.

At the time we interviewed people, about a third had planned the support they intended to purchase or were already using new support arrangements. The most common types of support were personal care, help to participate in family activities, assistance with domestic chores, and social, leisure and educational activities.

The average annual gross value of an IB was found to be about £11,450.[1] As expected, the majority of funding in IBs came from social care. With respect to other funding streams, more people (31 in total) received money from Supporting People (SP) than any other source, although the value of funding was highest from the Independent Living Fund (ILF) (mean £15,640). Only five people in the IB sample secured funding from ICES, and only one IB included funding from Access to Work (AtW). Although possible in principle, no IBs included funding from the Disabled Facilities Grant (DFG). There was some variation in use of funding streams across service user groups. Compared to other user groups, older people were less likely to draw on funding from SP, whereas people with mental health problems were more likely to draw on this source. We discuss funding streams further in Section 8.

Most people (59 per cent) for whom we had the information used their budgets to purchase at least some conventional types of support, such as home care, personal care and day care. Indeed, expenditure on these services dominated the use of IBs. In the context of high FACS thresholds, and therefore substantial or critical needs (many of which would be related to personal care), the priority that IB users gave to meeting such needs is not at all surprising. This finding is consistent with the reports of the service commissioners and providers that we interviewed, and suggests that

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[1] Seven IBs comprised only one-off payments. If we exclude the budgets containing only one-off payments, the average annual value of an IB was £11,600, with roughly 90 per cent annual recurrent funding and ten per cent one-off payments.

the impact of IBs on local social care markets may be slow and long term. Within the overall sample, we found that people with mental health problems had a smaller budget to use home care, personal care and day care.

Over half the sample employed personal assistants (PAs). This was more common for people receiving their IB as a direct payment than for those using other deployment options. Nonetheless, we found that nearly half of the user group who elected to have their budget managed by someone else were getting some support from PAs.

After personal and home support, the most frequently cited use of funding was for leisure activities, with a third of the support plans examined identifying this area. The use of leisure activities varied considerably between user groups, from 66 per cent of mental health users to 15 per cent of older people. IBs were used for one-off payments for such purchases as gym membership, going to the cinema and meals out – each allowing service users to participate in society in ways more acceptable to them than those offered by existing day or other services.

6. Outcomes for Individuals

The most important evaluation question concerns the effects of IBs on individual service users. Were the outcomes for people in the IB group better or worse than the outcomes for people in the comparison group?

We interviewed 130 people about two months after they had been offered an IB to learn about their experiences and to gauge the early impact of the new form of support arrangement. Experiences at that stage were quite limited, of course, and we therefore asked people what benefits and drawbacks they *anticipated*. Below we refer to these as the qualitative interviews.

In the randomised trial part of the evaluation, we collected information from 959 service users themselves or their proxies about the quality of their lives, their aspirations, their social care needs and how far they were met, their psychological well-being, and their self-perceived health. These data allowed us to examine the comparative outcomes for the IB and comparison groups

6.1 Complications

As noted previously, we were regrettably hampered by the comparatively short follow-up (six months being very short in the context of what is a lifetime of social care support for many people) and because it took longer to set up an IB than anticipated. If there were benefits to be secured from holding an IB, then people in the sample would have had only limited opportunity to experience them. Some people refused the offer of an IB, after being randomly assigned to the IB group, which we needed to take into account in our evaluation. Some people accepted the offer of an IB but did not have a support plan in place by the time we interviewed them six months later.

Another complication was that some service users were unable to participate in the evaluation interviews, and so we found it necessary to interview someone else (usually a family member) in order to get information on outcomes and other dimensions. In fact, we rely on proxy interviewees for nearly a quarter of the sample. The reason that this is a potential complication is that some of the questions asked in the interviews were about aspirations, personal needs and psychological well-being, and it is not always easy for a proxy accurately to represent the views of the individual service user. Moreover, those people who were unable to respond themselves (so that we had to rely on a proxy) are, on average, likely to have different needs from those who *can* respond. Another consideration in our analysis was that there were considerable missing data.

In analysing the data on outcomes, services used and costs we therefore needed to distinguish not only between people in the IB and comparison groups, but also to make some other distinctions. One was between those people in the IB group who did and did not accept the offer to take up an IB. Another was between those people who accepted to take up an IB who had or did not have a support plan in place by the time they were interviewed. And cutting across these distinctions was the possible additional need to separate proxy from user responses.

6.2 Outcomes for mental health service users

Given the relatively short time elapse before people were interviewed, it is not surprising that our overall finding was of few outcome differences between the IB and comparison groups.[2] Nevertheless, we found that *mental health service users* in the IB group reported significantly higher quality of life than those in the comparison group. A number of these service users had not found the services available under conventional arrangements to their liking, and saw an IB as an opportunity to access more appropriate support. Although not significant statistically, the data also suggest some tendency for psychological well-being to be better for the IB group.

6.3 Outcomes for physically disabled people

For younger *physically disabled people*, the evaluation found one important outcome difference between the IB group and comparison groups. The former were significantly more likely to report higher quality of care, and were more satisfied with the help they received. The choice and control afforded by an IB had apparently given them the opportunity to build better quality support networks.

6.4 Outcomes for people with learning disabilities

People with *learning disabilities* in the IB group were more likely than those in the comparison group to feel they had control over their daily lives, although the difference was not quite statistically significant. If we exclude those people who refused the IB, this difference becomes significant. When we examined this group in more detail, we found that those who *did* take up the opportunity to hold an IB reported they were less likely to be fully occupied in activities. However, this may reflect the perspective of the proxy interviewee or the type of individual who needed

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[2] Indeed, if proxy respondents are excluded, the reduced number of observations based on users' own responses resulted in no outcome differences being statistically significant. In describing the outcome results here we always include proxy responses, and just note when excluding proxy responses makes a difference to the size or direction of effect.

a proxy respondent. When we exclude proxy responses, the more able service users who had accepted the offer of an IB were *more* likely to report that they were fully occupied in activities of their own choice, although the numbers were very small (only 28 service users) and this difference did not reach statistical significance.

One other, rather puzzling, result was found for people with learning disabilities when we excluded those who refused the IB. Self-perceived health appeared to be significantly lower among those who accepted IBs, compared with the comparison group. When we exclude responses from proxies, however, the result is non-significant. Nevertheless, as in most of our other results, the direction and size of effect was equivalent for proxy and self-report responses. Further analysis suggested that this was not associated with lower levels of physical functioning and there were no other findings from the in-depth interviews that helped explain this finding.

6.5 Outcomes for older people

We found that *older people* were less likely than others to report higher aspirations as a result of the IB process. Another statistically significant finding for older people was that those in the IB group reported lower psychological well-being than those in the comparison group. If proxy responses are excluded, the size of this difference is reduced.[3] While lower levels of well-being or higher anxiety levels might be slightly more prevalent among those older people able to respond in the interview, higher levels of anxiety appear to have been systematically attributed to more vulnerable older people who had IBs *by their proxy respondents*. It is not possible with our data to distinguish whether this is due to the concerns of more vulnerable older people, less able to respond on their own behalf, or of their relatives (the most frequent proxy).

Information from the qualitative interviews with service users and their proxies indicated that many older people supported by adult services do not appear to want what many of them described as the ‘additional burden’ of planning and managing their own support. A similar view was expressed in our interviews with providers, front-line care co-ordinators and others. Anticipated drawbacks included the responsibilities of managing a budget and making new support arrangements (especially where people were already content with existing arrangements, and where there was little perceived scope to change the nature of support used), and the risks associated with directly employing care workers, rather than having them provided by an agency or local authority. As we discuss in section 15 below, it may take time for older people to develop the confidence to assume greater control.

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[3] In other words, the non-significant difference is not simply a result of the sample size becoming small but is partly because service users and proxies responded differently.

6.6 Outcomes for all groups together

When pooling data across the sample as a whole, we found that the IB group were significantly more likely to report feeling in control of their daily lives, the support they accessed and how it was delivered. Given the complications noted above, each of which could make it harder to find a difference between the IB and comparison groups, this is clearly a key finding for what is an important outcome domain.

We did not find significant differences between the IB and comparison groups in the other outcome domains,[4] although the tendencies in the data generally suggested that the IB group was enjoying slightly better outcomes.

Interestingly, almost half of those who accepted the offer of an IB who were interviewed for the qualitative study described how their aspirations had changed as a result, in terms of living a fuller life, being ‘less of burden’ on their families, and having greater control and independence. They were also more likely than other IB holders to report satisfaction with the support planning process and financial arrangements.

6.7 Taking account of individual differences

As a means of controlling for the impact of the many complicated factors in the data (whether someone accepted the offer of an IB, whether they had a support plan in place, and whether data came from a proxy respondent), we undertook multivariate analyses. The aim was to investigate the possible effects on outcomes of these factors, as well as the effects of the level of support received by individuals (as indicated by the weekly cost of the support package) and of a number of key individual characteristics.[5]

These analyses confirmed the differences described, and also showed that – after adjusting for needs and other measured individual characteristics – people with higher cost support had better social care outcomes.

We also found that, adjusting for all these factors, as well as for whether a support plan had yet been agreed, holding an IB was associated with better overall social care outcomes and higher perceived levels of control, but not with overall psychological well-being. The effect of IBs was stronger among those people who felt that their IB allowed them to change what they could achieve in their lives.

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[4] These were personal dignity, safety, meals and nutrition, social participation and involvement, occupation and accommodation cleanliness and comfort.

[5] These were characteristics assessed at baseline; that is, six months before the outcome assessment.

7. Costs and Cost-effectiveness

7.1 Cost differences between IB and comparison groups

We found very little difference between the cost of support received by the comparison group and the cost for IB holders. Over the full sample, IBs funded a mean of about £280 of support per week compared with an estimated mean weekly cost of about £300 for support packages for people receiving standard mainstream services. This difference was *not* statistically significant, but it is likely from this evidence that IBs would be at least cost-neutral.

The costs varied considerably between user groups. The mean weekly value of IB funding was about:

- £360 for people with learning disabilities (median £250).
- £150 for mental health service users (median £150).
- £230 for older people (median £200).
- £310 for a working-age disabled people (median £150).

IB holders reported higher use and higher costs of health care services than the comparison group. Although it is difficult to know why this is the case, it is possible that spending more time in support planning for an IB may have allowed care co-ordinators to identify unmet health needs, leading to increased use of health services.

There were very few IB holders in our sample who received additional funding for support planning or support brokerage. More than half of the IB holders identified themselves as taking a lead in the support planning process, with independent brokers, advocates, providers or other agencies identified by a quarter of the sample as involved in this activity.

The frequency of contact with a local authority social worker or care co-ordinator over the six-month evaluation period was higher for IB holders than for people in the comparison group. Support planning is a personalised process and it is perhaps not surprising that it takes up more time. Moreover, care co-ordinators needed to help IB holders take on new responsibilities. When we converted the data provided by service users and others into costs, we found that the average cost of care co-ordinator support for the IB group was higher than for the comparison group (£18 compared to £11 per week). This difference was statistically significant.

7.2 Cost variations between individuals

Perhaps not surprisingly, we found that care and support costs were associated with some of the baseline characteristics of the individuals who participated in the evaluation. Costs were higher for people with greater needs, reflected by problems with activities of daily living (ADLs), and people with evidence of cognitive impairment (such as severe learning disability or dementia). After adjusting for needs and other factors, age and cost were inversely related. Costs were also lower for people with a co-resident carer and for those who were in paid work (probably reflecting an underlying need effect). Another finding was that, again once all other factors were allowed for, people in the mental health group had lower costs than people in other user groups.

We also looked separately at the IB and comparison groups to see what factors were correlated with care package size (cost). The results suggested that fewer factors affected the size of the IB packages, compared with standard packages. In particular, IBs appeared to focus resources on a narrower range of ADL activities, and did not seem to increase significantly with levels of cognitive impairment once physical disability was accounted for. Other things being equal, the greater the age of the service user, the smaller was the size of the support package. There was slightly more of an age effect in the IB group. Overall, it was easier to explain the size of IB packages with the indicators available.

These more complex and more searching analyses confirmed that there were no cost differences between the IB and comparison groups. There was also confirmation of two tendencies that will need to be factored into discussions about the further development of IBs. First, people who were randomised to the IB group but who declined the opportunity to hold an individual budget, instead opting to remain with their conventional services, had higher service costs. This tallies with a common reason given for declining an IB (as noted above), that the amount offered represented a reduction in services likely to be received or was considered insufficient in other ways. Secondly, people without their support plan in place at the time of the six-month interview had higher costs, suggesting either that it took longer to set arrangements in place for people with more complex support packages, or that conventional services (which most such people continued to use while they awaited their IB support plan) were more expensive for those individuals.

7.3 The cost-effectiveness of IBs

It is possible for one service arrangement to be more costly than another, but still to be seen as more cost-effective, because its outcomes are superior. The cost-effectiveness part of the evaluation asked whether the social care outcomes and psychological well-being differences described above were achieved at a differential cost that is worth paying.

For the full sample of people (pooling all the user groups), we found some evidence that IBs produce higher overall *social care outcomes* given the costs incurred (i.e. they are more cost-effective), but no advantage in relation to *psychological well-being*.

We also analysed cost-effectiveness for the user groups separately, in each case focusing on these same two outcome domains:

- For people who use *mental health services*, IBs appeared to be more cost-effective than standard arrangements on both the social care and psychological well-being outcome measures.
- Similarly, for *younger physically disabled people,* there appeared to be a small cost-effectiveness advantage for IB over standard support arrangements with respect to both the social care and psychological well-being outcomes.
- For *people with learning disabilities*, IBs were found to be cost-effective with respect to social care, but this advantage is only visible when the data covered only people who had support plans in place. Standard care arrangements appeared to be slightly more cost-effective than IBs with respect to psychological well-being.
- There was no evidence of a cost-effectiveness difference between IBs and standard support arrangements for *older people* in terms of social care outcomes. Standard support arrangements were marginally more cost-effective than IBs with respect to psychological well-being.

One conclusion from these analyses is that IBs have the *potential* to be more cost-effective than standard care and support arrangements. The cost-effectiveness advantage of IBs looks clearer for people with mental health problems and younger physically disabled people than for older people or people with learning disabilities. For this last group, however, implementation delays may have played a part: once support plans are in place, there is a greater likelihood that IBs will be found to be a cost-effective alternative to conventional arrangements.

8. Funding Streams

The original plan for the pilot projects was for resources to be pooled from a number of funding streams. In consequence, lead officers for IBs and for the various funding streams believed they were expected to work towards aligning, if not integrating, non-social care funding streams with adult social care. The integration of Supporting People funding was generally felt to have been most successful. Indeed, support for integration or alignment of most funding streams was positive, although the majority of our interviewees were disappointed at the slow progress with integration of other funding sources. This was despite often significant local investment in understanding how the different funding streams operated and how integration might be achieved. Some of the reported difficulties may be ‘pilot effects’, i.e. concern about radically changing systems for an initiative that may not have been carried forward. Other difficulties reflected the challenges of integrating or aligning funding streams within existing legal and regulatory frameworks. Nevertheless, most IB lead officers reported that attempts at integration or alignment had at least raised understanding and awareness of the various funding streams among front-line staff.

Reported difficulties with alignment/integration across all funding streams included:

- incompatibility in eligibility criteria;
- lack of control over award decisions;
- continuing restrictions on how resources could be used, some related to legal issues and the limits of flexibility;
- separate accountabilities between service users, adult social care and non-social care funding streams;
- parallel and sometimes conflicting monitoring and review arrangements;
- poor engagement between central and local government agencies; and
- variation in local arrangements among the local authority funding streams.

These issues presented practical difficulties, but were also thought to challenge the very principles of transparency and flexibility that sites and the government were aiming to achieve. Pilot sites worked with CSIP and central government departments to clarify these difficulties and develop understanding of the issues entailed.

8.1 Supporting People (SP)

SP was widely identified as integral to the success of individual budgets and, indeed, this funding stream was the most successful in terms of integrating the processes of assessment, funding, resource allocation and review. SP resources were ‘top-sliced’ and included in the RAS in about half the sites, and usually there was only low-level monitoring of how these resources were spent. IB and SP lead officers reported that challenges with integration included differing local aims, objectives and priorities; the fact that many individuals eligible for SP were not eligible for social care; and problems arising from two-tier authorities working with several district housing authorities. However, no single hurdle was reported by more than two sites.

There were concerns that the integration of SP could result in some service users being charged for short-term support that was previously not chargeable. Some were concerned about the possible dismantling of crisis services. Further, a lot of Supporting People funds are tied up in block contracts, and in the short-to-medium term, this could result in expensive double-funding. SP lead officers expected the demand for SP monies to increase as awareness of this funding stream grew. Demand might also increase as individuals who had not previously approached or accepted social care services would do so, some of whom would be eligible for SP funding. Despite the budgetary implications, this could mean that SP resources would support more people and support them in more personalised ways.

8.2 Access to Work (AtW)

Few IB holders were likely to be eligible for AtW, but a number of sites nevertheless included employment-related questions in their assessments. AtW monies could not be top-sliced and included within the IB RAS, partly owing to difficulties in how to incorporate employers’ expected contributions. However, one site reported that AtW had dropped some of its requirements in order to streamline the process (for example, around the use of existing PAs and transport arrangements). It might also be noted that although the inclusion of AtW in IBs was very low, several IB lead officers reported that improved information and marketing materials from AtW meant that care co-ordinators and service users spent more time considering employment options.

8.3 Disabled Facilities Grants (DFGs)

While it was acknowledged that equipment or adaptations could transform a person’s need for personal care, and also reduce social care costs, most IB lead officers and lead officers for DFG did not feel that DFG was a suitable or legitimate funding stream to align with IBs. Applications for DFGs required specialist assessments; timescales were not compatible with the IB process; and DFGs involved capital sums, not an income stream to the individual. Most interviewees did not expect individuals would benefit from taking responsibility for managing a DFG (for example, contracting with builders).

8.4 Independent Living Fund (ILF)

IB lead officers reported considerable frustration at ILF processes, with separate assessments, separate financial assessments, slow decisions, tight constraints over the use of resources and separate reviews. However, a number of sites acknowledged the relatively faster turnaround for ILF applications associated with an IB. The ILF team working with IBs acknowledged the frustrations in the pilot sites, but noted that they were tied by the terms of their trust deeds, which meant that ILF monies must be spent on personal care and domestic assistance. A single financial assessment was felt to be challenging, as the ILF required more information than the local authority needed or could legally collect. A combined assessment was deemed possible by the ILF, but this would need to be undertaken by the ILF (in accordance with its trust deeds) and local authorities would need to check out the legalities of handing over responsibility for their assessments. The ILF reported difficulties in working with different RAS models across the pilot sites and advocated a consistent national approach to resource allocation. Nonetheless, the ILF reported an increase in applications since its inclusion within IBs in the pilot sites.

8.5 Integrated Community Equipment Services (ICES)

The Equipment service is resourced from baseline social care and NHS primary care trust budgets. Consequently, IB lead officers reported that ICES were easier to integrate than most funding streams. Including ICES in IBs did enable service users to customise or personalise their equipment, for example to select a different colour of handrail or to order a bespoke piece of equipment. ICES monies would cover the cost of a standard piece of equipment and users would need to top this up from other parts of their IB or their own resources.

However, across the sites, IB lead officers did not anticipate great benefits to users from including ICES funds within their IBs, largely owing to the capacity of the local authority to purchase in bulk and thus to benefit from economies of scale, and because the ICES service pays for the installation and maintenance of equipment. ICES lead officers expressed some concern around integrated assessments, fearing that care co-ordinators might lack the skills to conduct a full assessment and to advise service users appropriately on different types of equipment, particularly in complex cases. In addition, service users and their families/carers might be at risk if they were to purchase ‘less suitable’ items of equipment.

8.6 Additional funding streams

Despite the challenges of attempting to align or integrate different funding streams, IB lead officers were supportive of the principle of integration. Indeed, they suggested additional resource streams that could potentially be included, such as disability benefits, some NHS funding, resources to support education, training and labour market activity, and transport.

8.7 Service users' awareness of non-social care funding streams

Service users and proxy interviewees had only very limited awareness of (a) which funding streams were included in their IB assessment, and (b) for those who had been told their indicative allocation, which funding streams were contributing to their IB. Only nine of the 130 people interviewed in depth had any such understanding. This lack of awareness suggests a lack of transparency about the inclusion of non-social care funding streams. Further, few people reported a reduction in the number of assessments they had experienced. Given the limited progress made with integrating the funding streams, particularly at the time the qualitative interviews were undertaken, this observation is not surprising. Nevertheless, most interviewees commented that they did not care where the money came from as long as they received it.

9. Eligibility, Assessment and Resource Allocation

9.1 Eligibility and capacity

All but two of the pilot sites kept their eligibility criteria unchanged over the period of our evaluation (eight offered support to people meeting ‘substantial’ and ‘critical’ criteria; three additionally offered support to people meeting ‘moderate’ criteria). The two that changed their criteria (by dropping ‘moderate’) did not do so because of the introduction of IBs, but were concerned that this might be the interpretation of some people, for example, those with direct payments facing reassessment. Across a number of sites, the processes of resource allocation revealed that FACS criteria were not always being applied consistently, or were being applied to eligibility for specific services rather than to support needs as a whole. A broader difficulty was mentioned: how to manage the tension between the long-term focus on outcomes of some IB arrangements with the shorter-term risk focus within the FACS approach. FACS eligibility was seen as particularly difficult in mental health. IB lead officers argued that care co-ordinators needed to focus on eligibility for support rather than be caught up in a concept of ‘FACS-eligible services’, which could tend to limit the content of support plans to traditional approaches to meeting personal care or basic social support needs. FACS eligibility was seen as particularly difficult in mental health, where practitioners were felt to be less familiar with the requirements, and circumstances were prone to change. This also reflected the difficulties of employing FACS criteria in the context of substantially NHS-led joint provision.

Over and above this formal consideration of eligibility, many of the care co-ordinators interviewed in the evaluation reported that they took other factors into account when deciding on capacity to manage an IB. These included whether an individual was able and willing to make changes, and whether they had the ability to manage money or understand the process. These issues indicate that care co-ordinators were not making a fundamental distinction between IBs and direct payments, which could well reflect the early publicity around IBs and the slow development of alternative deployment options. Many sites were offering standard service arrangements for people in crisis and introducing them later to IBs.

9.2 Assessment

In addition to statutory community care assessments, the introduction of IBs also put greater emphasis on outcomes and self-assessment, although assessment processes did not necessarily change greatly across all sites. Complexities were created by the need to integrate information from a wider range of information sources.

Self-assessment usually involved additional input from family members and care co-ordinators, and sometimes from advocates. Conflicts identified in the assessment process included divergence between care co-ordinators and service users (or families) views of needs, and occasionally differences between the views of users and carers about needs or goals. Making such conflicts explicit may make the likely levels of family support clearer and also potentially identify risks that could have been hidden.

9.3 Resource allocation processes

In most sites, resource allocation was an iterative process involving integration of a number of sources of information from community care and self-assessments. This often required a degree of negotiation between care co-ordinators and panels of managers, which had to sign off the allocation of funding. An element of the process was development of a Resource Allocation System (RAS), which itemises the levels of help a user needs across a number of domains in order to achieve particular outcomes; each answer is scored so as to reflect the extensiveness of the help needed. An individual's total score can therefore be translated into a single sum of money – the IB.

Some care co-ordinators and team managers applauded this approach as being clear and equitable, but others considered it too simplistic, with questions seen as inappropriate or responses ambiguous. One site took a different approach, developing an outcome-focused approach to assessment and support planning; costs of each IB were only identified after these processes had been completed. The site was given DH permission to take this approach, but it was not in line with the original policy direction.

All but one of the sites initially developed the outcome domains in their assessment documents by modifying material from *In Control*. Most sites introduced or were working towards a single assessment form that would apply to all relevant user groups, and some had also adopted a single 'price per point' across all user groups. This was not the practice everywhere, however, with budget limitations cited as the main reason for believing such an approach to be unworkable at the time.

Perhaps inevitably with such a new approach to the allocation of social care resources, the processes continued to evolve over the period of our evaluation and are still being refined. Care co-ordinators and team managers were not always involved in the initial development of RAS processes and felt they could have offered valuable front-line experience. Greater involvement might have helped their understanding of IBs and might also have improved staff engagement with the development of methods to allocate resources.

10. Support Planning and Brokerage

The purpose of support planning is to decide how to use an IB to pursue the objectives (outcomes) set out in assessments and related processes. It was envisaged that it would replace the 'care planning' function in a conventional care management system. Care co-ordinators worked with IB holders to decide which goals were most important (and realistic) and to identify the kinds of support needed in order to reach them, as well as any associated risks. They also tried to build confidence and empower service users and carers to think more broadly about their lives. Because IBs offer greater choice and flexibility than the care systems they replace, the responsibility for support planning may become more onerous for those involved. Some care co-ordinators were being given more freedom to develop creative approaches.

External organisations or advocates were sometimes involved in support planning, beyond simple involvement in brokerage or payroll support. Several sites employed or redeployed staff to work exclusively on support planning, leaving other care co-ordinators with little role in this process. However, during the pilot, IB holders were more likely to receive support from care co-ordinators than from such specialists. Support planners tended to have more time-limited involvement with service users than care co-ordinators, who would take responsibility for cases at the point of the initial review. While this was a separate role, much liaison was reported between local authority-employed support planners and care co-ordinators, who felt that these workers could support the process well, although there were fears about a potential fragmentation of roles. Some IB holders felt that specialist support planners were able to develop better relationships with them, although there was a concern about waiting times to see these workers.

Support planning was often judged to be person-focused and accessible. However, some problems were experienced over the level and complexity of the paperwork, difficulties agreeing the support plan, changes to the level of the budget during the support planning process, and slowness of the support planning process.

While some care co-ordinators felt that almost any form of expenditure was acceptable if it could be seen to meet assessed goals, many found it difficult to judge what expenditure should be deemed legitimate or acceptable as part of a support plan. Some were concerned about the appropriate balance between leisure and personal care needs, but many other questions arose, such as:

- What kinds of material goods, such as computers or equipment, could be purchased with IBs and who was responsible for their upkeep?
- Could money allocated on the strength of personal care or social support needs that reached the FACS criteria be used to pay for different kinds of support?

- Could IBs be used to pay family members to provide support?
- Who was responsible for resolving conflicts and crises?

11. Risk and Risk Management

While ‘positive risk-taking’ was part of the philosophy and a central benefit of IBs, it was also seen as a difficult culture shift for care co-ordinators in light of their responsibilities for safeguarding. Furthermore, several sites had developed ‘risk enablement’ panels to identify ways of supporting those involved and managing risk. Many of the staff interviewed voiced concerns about risks of: poorer quality services, misuse of funds, financial abuse, neglect, and physical harm. Many were clearly struggling to decide how far those risks should sit with the individual, how they should be managed, and, crucially, what were the implications for the safeguarding of vulnerable adults? Of particular concern was that there was no means of enforcing Criminal Record Bureau checks on people employed directly by IB holders.

Unlike more traditionally commissioned services, there were rarely clear mechanisms for monitoring and identifying risk once support packages had been put in place. Among the suggestions for overcoming these difficulties were: firming up Adult Safeguarding policies, regular expenditure reviews, building risk assessment into the support plan, better guidance for care co-ordinators, better information for people holding IBs, training and audit. By the second round of interviews with Adult Safeguarding staff, there were signs that relevant policies were under review. Indeed, some changes in staff or service configuration were being proposed or implemented to improve safeguarding practice in the context of IBs, revealing an increasing understanding of the impact of implementing IBs.

Monitoring and reviewing support packages are important for minimising and managing risk. Many of the care co-ordinators interviewed reported that monitoring or review systems currently were essentially the same for people holding IBs and those supported conventionally. Where changes had been made, they reflected the need to monitor whether an individual was being supported in the way intended (rather than focusing on delivery or quality of services), to look at a broader set of outcomes, and perhaps to re-examine resource allocation in the light of how well outcomes were being achieved.

Care co-ordinators typically worked with IB holders until a stable situation had been achieved and support plans were in place. Thereafter, responsibility was handed to the ongoing review team, or the case remained open to the team although not allocated to the original care co-ordinator. Complex and unstable cases were more likely to remain open to a named care co-ordinator, although this was again not dissimilar to what happens with standard care management practice.

12. Workforce

Major shifts in working culture, roles and responsibilities were reported for in-house staff. Some saw these shifts – and IBs more generally – as a reinvigoration of social work values, while others saw them as eroding social work skills. On the positive side, the opportunity to work with people to identify a wider range of goals and aspirations, and to develop support plans to achieve them, were specifically linked to traditional social work roles. But particular concerns were that the care management process was being fragmented, that professional skills and qualifications would not be thought to be needed to undertake tasks related to IBs, and that crisis work, safeguarding and high-end complex casework would come to dominate social work.

To meet the needs of the new support arrangements, team managers provided more intensive staff supervision through both formal and informal mechanisms, but were themselves having to come to terms with the new processes and philosophy of IBs. Training and communication activities could cover assessment, support planning, brokerage, knowledge of services, practical aspects of IBs such as employing staff and managing finances, financial aspects of support planning, and managing risk. However, the extent and type of training on offer varied enormously across different sites.

A widespread view among staff was that more and better training was needed across these areas. While most sites had specific resources set aside for training, the variable amounts identified reflected the pilot status of IBs. Not surprisingly, in sites where the implementation of IBs was viewed purely as a pilot, training efforts were less concerted than in sites where they were seen as the future of social care. In the latter localities, efforts were underway to integrate IBs and their core principles and processes into wider organisational structures and cultures.

As part of the evaluation we asked care co-ordinators to keep diaries of time use. Analysis of these diaries showed that those staff with some IB holders on their caseloads spent significantly more time than others on a number of activities: completing assessments with service users, assessing carers needs, support planning, and training. This additional time may in part be a function of the sites' pilot status and the work needed to develop tools, templates and processes from scratch. It is therefore possible that such additional demands on care co-ordinators' time might be reduced if the roll-out of IBs is supported by materials that can be adapted for local use. Consequently, it is not clear whether IBs will require more or less time from care co-ordinators in the long term. This creates further uncertainties about the cost-neutrality of IBs.

13. Providers and Commissioners

The providers of social care services interviewed in four pilot sites warmly welcomed the principles of IBs, and many had used the pilots as an opportunity to expand their service base or to develop new and innovative services for clients.[6] Examples included the opportunities to open a new personalised home care service, a drama group (previously run by the local authority) and PA payroll and management services.

Views were generally positive on the impact of IBs on the providers' workforce. Although several providers had experience of losing staff who became PAs for IB holders, this was not yet generally felt to be a major concern. One provider reported that new recruits enjoyed the prospect of caring for users in a more individualised manner, compared to the current task-oriented care.

Providers felt that administering a large-scale IB system would be more costly, most notably through managing individual accounts, invoicing and non-payment. One provider had already recruited a head of finance and planned to expand the back-office staff, and others said that they would need to invest significantly in their IT systems to prepare for a larger-scale system of personal budgets.

Related to extra administration costs, home care providers reported that it was not practical to meet all the demands of service users – especially for short-notice care – without extra investment in staff. The prevailing tight rostering and task-oriented care were acknowledged to compromise personalisation, but were seen as being driven by local authority demands for volume discounts.

Both providers and commissioning managers identified a host of key roles that the local authority would need to adopt in moving to an IB system. High on the list was the importance of informing the market – both users and providers – of services available and services wanted. Most were looking for interactive mechanisms for doing this, ensuring the approach was bottom-up rather than commissioner driven. Other important roles included 'policing' the system and maintaining standards, with providers especially concerned about the unregulated PAs, with minimum or no training and no CRB checks.

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[6] The views noted here are based on small numbers of providers (n=16) and commissioners (n=7), and may not therefore be either representative or comprehensive.

14. IBs and Interfaces with NHS Funding and Services

14.1 Contexts

IB pilot sites had generally already established joint commissioning arrangements with NHS partners for many of their adult social care services. Some pilot sites had extensive arrangements using the 1999 Health Act Section 31 ‘flexibilities’ to pool budgets, delegate commissioning and integrate service provider organisations. Closely integrated services were particularly common in those sites offering IBs to people with mental health problems.

Around half the sites had previously established informal arrangements enabling NHS resources to be transferred to the local authority and paid as a direct payment. This was achieved either through jointly-funded packages for people with complex needs or by enabling direct payment users who became eligible for fully funded NHS continuing care to keep their existing support arrangements.

14.2 The experiences of the IB pilots

IB lead officers were very disappointed at the exclusion of NHS funding from the IB pilots. They argued that the separation of health and social care was incompatible with the more holistic approach of IBs. They felt that they would have had more success in integrating some elements of NHS resources into an IB than they had with other funding streams that were included.

Sites were keen to maintain existing local partnership arrangements. One had adapted self-assessment documentation to identify health as well as social care needs, and four reported having offered IBs that included some NHS resources to people with complex needs.

Particular difficulties in the pilots arose in relation to NHS continuing care. People receiving an IB who became eligible for NHS continuing care risked losing their PAs if they were no longer able to receive support in the form of a direct payment. In at least four sites, these restrictions grew following the publication in 2007 of new guidance on eligibility for continuing care. IB lead officers were anxious that these restrictions would deter IB users from applying for NHS continuing care funding, with consequent cost-shunting implications.

There were also problems with respect to mental health services, because typically services were jointly funded and highly integrated. It was difficult to disaggregate the social care resources for IBs: the local authority could become liable for the full cost of support that had previously been jointly funded, while some benefits of IBs, in terms of reduced hospital use, fell to the NHS. Implementation was also difficult because IB lead officers had to work with front-line NHS staff with whom they had no line management relationship; culture change among such staff was also particularly challenging.

Finally, difficulties in distinguishing between health and social care needs and outcomes were highlighted, leading to concerns over the potential use of IBs to purchase services (e.g. complementary therapies) that might be considered health care, as well as about the applicability of charging policies. Where IB users were asking personal assistants to perform health-related tasks, IB lead officers expressed anxieties about where responsibilities for training, quality assurance and risk management lay.

14.3 Future prospects

Despite these difficulties, it is notable that in two-thirds of sites, considerable interest was reported from PCTs in learning from the social care IB pilots. Difficulties in sustaining engagement were significantly more likely to arise in large county authorities with multiple PCTs, which underwent organisational change during the IB pilot period.

Including NHS resources was considered essential for the success of IBs for people with mental health problems, given the high levels of integration of funding and service delivery in this sector and the perceived risks of cost-shunting. Allowing NHS continuing care funding to be allocated through IB mechanisms was also a high priority where this enabled existing support arrangements to be sustained despite deteriorations in health.

15. Discussion

This section discusses the main conclusions of the evaluation; those features of the pilots that contributed to these findings; and the implications for the longer-term roll-out of personalisation.

15.1 Strengths of the evaluation

The evaluation used a multi-method design to address multiple questions. A randomised, controlled trial examined the costs, outcomes and cost-effectiveness of IBs, compared to conventional methods of service delivery. There were no systematic differences between the IB and control groups at the start of the evaluation, which means that differences in observed outcomes can be attributed to the impact of IBs. The trial was complemented by in-depth interviews with sub-samples of people offered IBs; by repeated semi-structured interviews with a wide range of senior managers and others involved in implementation in the pilot sites; and by investigation of the experiences of front-line care co-ordinators. It constitutes the most extensive and rigorous evaluation of self-directed support in England to date.

15.2 Implications of the pilot projects for outcomes

Only 13 sites took part in the pilot projects. Sites appeared reasonably representative, but appeared to have high levels of commitment to the ethos of personalisation. The requirement to implement IBs within a short timescale meant that processes evolved rapidly during the evaluation. At least some outcomes reflected interim implementation experiences. The evaluation captured these changes and provides valuable insights into the challenges of implementation and the factors influencing users' experiences and outcomes during this process of change.

Bidding to pilot a high-profile initiative, with on-going support from CSIP, was likely to create or reflect high levels of motivation and commitment to change, particularly among senior managers. These features may be less prominent in a national programme of personalisation.

In some sites, selection of service users for IBs was biased towards those less likely to experience difficulty using an IB (such as people already using direct payments). There were also high numbers of direct payment users in the comparison group. Without these selection biases, greater impacts of IBs might be observed.

Because they were in the national spotlight, uncertainties associated with major processes of change, and because new systems for monitoring and review took time to be established, care co-ordinators were sometimes unsure about how much freedom IB users might be permitted. They invested more time in assessment and support planning than with other users. There was widespread early reliance on established deployment options, particularly direct payments and care-managed ‘virtual budgets’, that differed little from previous arrangements. With more flexible deployment of care-managed budgets and the expansion of specialised support planning and brokerage services, both front-line staff and users may become more confident about how to use IBs, leading to more marked differences in support arrangements and in outcomes.

Indeed, risk management was a very important element of sites’ approaches to implementation; this incurred high support and monitoring costs. Such caution is also likely to characterise the introduction of personalised approaches elsewhere. In the longer term, as staff and users become more confident and competent with new systems, some may require less support and be willing to experiment with new deployment options, with more people opting for direct payments. All these factors may lead to greater measurable benefits in future.

Given the time it often took to put IBs in place, and develop individually tailored support arrangements, the period between recruitment to the evaluation and outcome follow-up was short. Of those with an IB in place by the six-month outcome interview, many had this only for a short time and greater impacts may be seen over a longer period. The two-year evaluation also limited evidence of other longer-term implications of IBs, such as service providers’ development of new service options in response to increased user aspirations.

15.3 Understanding the outcome findings for different groups of service users

There were encouraging indications of the impact of IBs on people’s lives, particularly the fact that those receiving IBs felt more in control of their lives than the comparison group. However, only limited gains were observed overall, and these varied by user group. It is important to understand these differences, as they have implications for the roll-out of ‘personalisation’ policies.

The contexts in which IBs were offered, attributes of individuals, levels of resources and the interactions of these factors varied between user groups. The most positive outcomes in overall well-being were found among people using mental health services, albeit a relatively small proportion of all IB users. Adults with mental health needs requiring social care are a heterogeneous group, varying by diagnosis, the severity and duration of problems and wider circumstances. The evaluation suggests that IBs offered a greater range and flexibility of support arrangements than are available for this group from standard services. Unfortunately, small numbers and lack of detail on individual characteristics prevent generalisations to the wider population about which groups of people with mental health needs are particularly likely to benefit from IBs.

For working age people with physical and/or sensory impairments, IBs had positive effects on all dimensions of social care outcomes, although these did not reach statistical significance. As demonstrated by their take-up of direct payments, this group has most experience of and appetite for taking control of their support arrangements. Active peer-support networks allow shared learning. Moreover, levels of resources allocated through IBs, particularly compared with older people, were relatively generous, allowing greater flexibility and more innovative approaches to addressing support needs.

Mixed outcomes were found for people with learning disabilities. If IBs allowed reductions in expensive care packages (a stated aim of some sites), then negative impacts on psychological well-being might be anticipated, at least in the short term. People with learning disabilities and their carers were thought to find IB processes stressful. This may have been exacerbated by the large numbers of people with learning disabilities who did not have an IB in place by the time of the six-month outcome interview and hence had not had an opportunity to experience any counteracting benefits. Learning disabled people in both groups had more social care resources allocated to leisure or social participation activities than other user groups, leading to greater well-being overall. Both groups may also have experienced previous policies of normalisation and person-centred planning that might render any additional benefits of IBs less pronounced.

The evaluation of the pilots raises questions about the impact of IBs on older people. Concerns expressed by care co-ordinators, IB lead officers and providers alike about how older people would cope with the responsibility of an IB were supported by the lower levels of well-being among older IB holders than the comparison group. This suggests that the anxieties and stress voiced by some older people in the qualitative interviews continued to moderate any potential gains from the increased transparency, control and flexibility offered by IBs, and these were reflected in the outcome interviews.

Evidence from different strands of the evaluation suggests that older people often approach services at a time of crisis when they feel vulnerable or unwell, find decision-making difficult and hence are likely to experience support planning as stressful. Older people satisfied with their current care arrangements were reported to be reluctant to change, so differences in outcome would be minimal. Other attributes of older people that have previously been noted to act as barriers to take-up of direct payments, also affect IBs. The evaluation suggests that a potentially substantial proportion of older people may experience taking responsibility for their own support as a burden rather than as leading to improved control. Older people's support plans reflected high levels of need for personal care, rather than domains such as occupation and social participation, restricting the scope for improvements in wider well-being. Older people's smaller IBs compared to those for younger adults also restricted scope for innovation.

The particular challenges of implementing IBs with older people make the care co-ordinator role a demanding one. In the early stages of the pilots, care co-ordinators were less experienced and confident in developing more innovative and creative support plans with older people. Moreover, organisational arrangements for flexible deployment of care-managed 'virtual budgets' were generally not in place and there was a lack of alternative deployment options and services that could bring greater flexibility and control without the well-documented drawbacks.

15.4 Factors affecting costs – longer-term issues

Resource allocation systems have fundamental implications for costs and outcomes. Developing robust resource allocation systems was an iterative and on-going process; early resource allocations may be different from those in a mature IB system. The level at which local authorities pitch the RAS and revise this in successive years will have a major bearing on whether IBs are cost-saving, cost-neutral or more expensive in the longer term. Costs will also be affected by whether IB users can negotiate higher IBs to match existing direct payment levels, as was reported in some pilot sites; or whether currently high support costs can be pegged and protected during a medium-term transition period. Increased demand on social care budgets, particularly by mental health service users, was reported, and this could stretch social care budgets.

Only limited progress was made with integrating additional funding streams during the pilots; yet expectations of additional resources to support IB users from, for example, Supporting People or the Independent Living Fund, were factored into sites' approaches to cost-neutrality. Developments in integrating funding streams may affect the overall level of resources as well as overall management costs, if assessment, allocation and audit processes are integrated. They may also lead to efficiencies in their use at individual levels.

Administrative processes for allocating resources, assessing, monitoring and review should become more efficient over time. However, there is no evidence from the evaluation of dramatic reductions in management and other administrative costs in the short term. Indeed, the implementation costs for sites were considerable.

There is potentially a major tension between volume discounts and delivering individualised services. Personalisation therefore risks the loss of economies of scale from current high volume, low price contracts with service providers, but the protection offered by existing contracts meant that few such losses were experienced during the evaluation. However, all sites experienced organisational and budgetary tensions in operating dual systems of IBs alongside traditional commissioned services. Despite the roll-out of personalisation in adult social care, some IB users will continue to use local authority commissioned services, so these parallel systems are likely to continue.

16. Recommendations for Policy, Practice and Research

The Department of Health has already announced the extension of personalisation across adult social care in England. However, the evaluation of the IB pilots highlights some outstanding issues.

16.1 Integrating funding streams

Decisions are needed as to whether personalisation is to incorporate additional funding streams as originally proposed. This was widely viewed as an exciting and innovating – but ultimately disappointing and frustrating – element of the pilots. Legislative and accountability barriers were experienced, despite the efforts of IB lead officers and local managers from other funding streams alike. National policy decisions are needed about whether these barriers are removed. Decisions are also needed about the inclusion of NHS resources in social care individual budgets, particularly NHS continuing health care and mental health expenditure; these resources were widely viewed as important for increasing the gains from personalisation. Moreover, as NHS personalisation pilots are currently being planned, it will be important to ensure that these build on the experiences of the social care pilots, particularly in relation to continuing care and mental health.

16.2 Resource allocation principles

The original policy proposals for IBs made no recommendations about how resources were to be allocated to users. Resource allocation systems adapted from *In Control* were undoubtedly initially helpful in many sites. These were also controversial, however, and there was no consensus on the appropriateness of the RAS compared with processes where professional judgement and discretion play greater roles, or with the outcomes-focused approaches adopted to a greater or lesser extent in a few sites. The generally more transparent allocation of resources to people with highly variable sets of needs brought equity issues underlying resource allocation into sharper focus for local authority staff. Given that such transparency is fundamental to personalisation, the principles underpinning resource allocation systems and their desired outcomes need debate at national level. This could be informed by the current consultation on the future of adult social care.

16.3 Fair Access to Care Services and charging policies

There were debates within pilot sites about the operation of Fair Access to Care Services (FACS) eligibility criteria in the context of a wider use of self-assessment. FACS criteria were also poorly aligned with some of the funding streams that were to be included in IBs. It would be helpful to extend the current review of FACS by the Commission for Social Care Inspection to cover these emerging issues and prevent new problems arising, as personalisation is rolled out across adult social care. Similarly, many sites experienced difficulties with existing charging policies, particularly when IB users opted for mixed deployment options. Charging policies will therefore also need review as personalisation is extended, and particularly so if current principles are revised following the 2008 consultation on the future funding of adult social care support.

16.4 The ‘boundaries’ of adult social care

Senior managers, care co-ordinators and users alike raised questions about the boundaries and legitimate role of adult social care. Resources were allocated on the basis of need and risk, but IBs allow these resources to be used in new and creative ways that focus on goals, outcomes and inclusion. It will be important for these new approaches to be endorsed and legitimated in public and policy debates.

16.5 Success factors

Although most IB pilots started gradually, most had extended IBs to other user groups by the end of the pilot. Their experiences therefore illustrate the key factors for success. Like other processes of managing change, key success factors include active support from the most senior managers and decision makers in the organisation, together with an implementation team that is enthusiastic, able to problem-solve and bring in other people as required.

16.6 Proportionate controls

Concerns about financial and individual risks for IB users were widespread and these may have inhibited creativity, although there was little evidence about the actual impact on risk. However, it is quite possible that such concerns may prompt staff to work within self-imposed limitations on creativity. Developing monitoring and review systems that reduce risks and safeguard vulnerable individuals, both when approving support plans initially and on an on-going basis, are high priorities for local implementation.

16.7 Alternative deployment methods

Although perhaps inhibited by the pressures of the pilots, relatively little use was made of new options for deploying IBs; most people opted for direct payments to employ a personal assistant or made use of care-managed ‘virtual budgets’. Very few used agency or trust arrangements or individual service provider accounts. Arrangements to enable care manager-held ‘virtual budgets’ to be used flexibly and creatively could helpfully be developed. These other options need developing so that their relative advantages and drawbacks for different groups of IB users can be assessed and communicated to front-line social care staff.

16.8 Culture changes

Implementing IBs required major shifts in culture, roles and responsibilities of existing staff. As with direct payments, front-line social care staff played a key role in introducing people to IBs and helping them through unfamiliar and potentially stressful changes. Intensive staff support and extensive training and communication activities, supported by levels of ring-fenced funding, are needed. More specifically, priority needs to be given to developing specialist skills in support planning and brokerage, either in local government or external organisations; if the latter, liaison arrangements are also needed. Improvements in all these activities should be accompanied by an emphasis on the importance of transparency, so that far more people are aware of the level of resources allocated to them and how these have been determined.

16.9 Local market development

Although there was little evidence of change during the lifetime of the pilots, in the longer term local authorities may need to encourage the development of new services and support arrangements for IB holders. Some developments may have been inhibited by prior contracts with existing providers. However, difficulties were already being reported by some IB users in finding people to employ as personal assistants. Such difficulties are likely to increase as care co-ordinators and users become more confident, users’ aspirations increase and demands change. Local authorities’ commissioning strategies will need to be adapted, with more emphasis on communicating the demands of IB users to providers and in supporting providers in adapting to these demands.

16.10 Research issues

Although there were ethical and practical constraints on extending the period before outcome interviews were conducted, many IB users had little time to experience their IB before their outcome interview. Longer-term follow-up of the benefits and drawbacks of different approaches to IBs is an urgent priority. A further priority is the more detailed examination of the relative benefits and drawbacks of IBs for different groups of service users, in order to understand why IBs appear to lead to fewer benefits for some groups and how these problems can be overcome. There is also a pressing need for a longer-term evaluation of the cost-effectiveness of IBs in comparison to conventional support and allocation arrangements, and for further examination of different approaches to IBs.

The evaluation measured the differences in resource allocation between the IB and control or comparison groups and between different groups of IB users. However, as noted above, resource allocation systems were not based on any explicit principles. Research is needed on the impacts of different resource allocation approaches, including outcomes-focused approaches, to assess their adequacy and their respective redistributive and equity implications.

Given the relatively small impact on existing patterns of service provision, even in sites with extensive IB pilots, longer-term research is needed into the dynamics of local social care markets following personalisation. This needs to cover the impact on provider stability and service unit costs as block contracts are replaced by individual purchasing; on the quality and supply of personal assistants and other supporters; and on the quality and supply of care workers more generally, if IB users demand greater flexibility from agencies and providers.

Finally, although a linked study of the impact of IBs on carers will be completed in autumn 2008, more research is needed into the role of carers in support planning, managing IBs and, indeed, in providing support that is paid for with an IB.

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ibsen
Individual Budgets Evaluation Network

Evaluation of the Individual Budgets Pilot Programme

Summary Report

About the evaluation

Individual budgets (IBs) were piloted as a new way of providing support for older and disabled adults and people with mental health problems eligible for publicly funded social care.

The Department of Health set up IB pilot projects in 13 English local authorities, running from November 2005 to December 2007, and commissioned a national evaluation.

This evaluation is the first robust UK study of the implementation and impact of personalisation approaches in social care.

The research network

The Individual Budgets Evaluation Network (IBSEN) team who conducted this research are from:

Social Policy Research Unit, University of York

Social Care Workforce Research Unit, King's College London

Personal Social Services Research Unit, University of Kent

Personal Social Services Research Unit, University of Manchester

Personal Social Services Research Unit, London School of Economics

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