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Will direct payments make adult residential care more personalised? Views and experiences of social care staff in the Direct Payments in Residential Care

Trailblazers

Lorraine Williams¹, Stefanie Ettelt¹, Margaret Perkins², Raphael Wittenberg², Jackie Damant², Daniel Lombard², Nicholas Mays¹

¹ London School of Hygiene and Tropical Medicine, Department of Health Services Research and Policy

² London School of Economics and Political Science, Personal Social Services Research Unit

Abstract

Direct payments, i.e. cash payments made directly to the individual in lieu of social care services, have become an established option in council-funded domiciliary care as a means to better personalise care and support. As part of its agenda to modernise social care the Government tested their use in long-term residential care in eighteen trailblazing councils in England.

This paper presents findings from the independent evaluation of this initiative. Interviews were conducted with key council and care home staff involved in implementing direct payments in residential care. These explored practitioners' views and experiences of personalisation in residential care and their thoughts on the potential contribution of direct payments to promoting personalisation. Whilst there was agreement that good care takes personal preferences into account and that many care homes could provide a more personalised service, doubts were voiced about whether direct payments were an appropriate mechanism to achieve this aim. This was seen as particularly pertinent in relation to residents with very high care needs and limited capacity to exercise choice and control. Interviewees also identified a number of risks and challenges to

implementation including financial risks to care homes. The findings from these interviews suggest that the contribution of direct payments to personalising residential care may be more modest than expected.

Key words: Direct payments; residential care; care homes; personalisation; choice and control

Will direct payments make adult residential care more personalised? Views and experiences of social care staff in the Direct Payments in Residential Care Trailblazers

In 2011, the Law Commission asked the Government to consider expanding direct payments to service users receiving council-funded care in long-term residential settings (The Law Commission 2011). The Commission's concern was that adults in residential care were at a disadvantage compared to people receiving community (domiciliary) care, who already had access to direct payments. The Government, through its Department of Health, initiated a programme in 2012 that aimed to test the introduction of direct payments in selected 'trailblazing' councils in England.

Direct payments are established in community care although numbers have remained relatively low, with about 15 percent of eligible service users having opted to take one in 2013-14 (NAO 2016). A direct payment is 'a payment of money from the local authority to either the person needing care and support, or to someone else acting on their behalf, to pay for the cost of arranging all or part of their own support' (DH 2015). Introduced in 1995 for a limited number of service users, direct payments now represent the Government's 'preferred mechanism' of making available the amount of funding allocated to them (DH 2014). Funding for adult social care is means tested and calculated to meet assessed needs. The 2014 Care Act stipulates that all recipients of adult social care receive this funding as a personal budget, including those in residential care from April 2015. However, at the time of the trailblazer personal budgets had not been fully implemented.

The policy aim of direct payments is to provide service users eligible for council-funded adult social care with a choice between receiving services arranged by the council or a sum of money which they can use to make their own decisions about which services to purchase. The rationale is that, by making their own purchasing decisions, service users would select the services that best meet their

needs; i.e. they would have better choice of services by having control over the budget, and thus receive a more 'personalised' service (DH 2006, Leadbeater, Bartlett et al. 2008). Furthermore, it is argued that, by giving service users control over the budget, providers would become more responsive to their clients' needs and preferences (DH 2006).

'Personalisation' of services through giving users choice and control has been a prominent policy idea in adult social care since the mid-2000s (Needham 2011, Gheera 2012), and direct payments have become the main method of increasing individual choice and control for people living in the community. However, while there is evidence that direct payments can enhance choice and control for some service users in community care (Netten, Trukeschitz et al. 2012, Kendall and Cameron 2014, Rodrigues and Glendinning 2014), it is not yet clear how direct payments contribute to personalisation in residential care.

This paper presents findings from the independent evaluation of the Direct Payments in Residential Care Trailblazers. In July 2012, the Department of Health invited councils to express interest to become pilot sites for direct payments in residential care with external evaluation. Twenty councils were selected to participate in the programme, with preparatory work starting in early 2013. Six councils have subsequently left the programme. The remaining 14 have introduced direct payments either as part payment (covering part of the care home fee) or full payment (covering the entire fee) or both. However, progress in setting up the trailblazers has been substantially slower than expected. At the end of the programme, 70 direct payments had been accepted, with 31 active, i.e. involving money transferred to the service user or their representative. This uptake was significantly lower than the 400 direct payments projected as a minimum at the beginning of the programme.

The evaluation began in January 2014 for two and a half years. It was designed to examine the different ways in which direct payments are offered to residents of care homes and the challenges arising from implementing direct payments (process evaluation); to assess the impact of direct payments in residential care on users and their families, care home providers and the provider

market, and councils and their staff (impact evaluation); and to examine, as far as possible, the relative costs and cost-effectiveness of different approaches to providing direct payments for local councils (economic evaluation). More detail about the methods of the evaluation have been published elsewhere (Ettelt, Wittenberg et al. 2015, Wittenberg, Ettelt et al. 2015).

This paper presents findings from interviews with social care staff involved in the programme in care homes and in councils. In these interviews, social care staff reflect on, and make observations about, the potential contribution of direct payments to ‘personalisation’, choice and control in residential care. The paper addresses two questions: what do the twin concepts of personalisation, and choice and control mean to social care staff in the context of care homes; and what contribution do they expect direct payments will make to personalisation, and choice and control?

Personalisation, choice and control in residential care

‘Personalisation’ has been promoted as “the process by which services are tailored to the needs and preferences of citizens. The overall vision is that the state should empower citizens to shape their own lives and services they receive” (Cabinet Office 2007). However, as a policy aim, personalisation has remained ambiguous and is associated with diverse, at times even contradictory policy goals. Needham (2011) noted that personalisation has become one of the broad narratives of social care reform. Others have associated personalisation with specific social care practices, such as person-centred planning, or, indeed, direct payments (Duffy 2010).

In community care, the use of direct payments has somewhat narrowed the interpretation of personalisation to mean user choice and control over services and support (Duffy 2007). This link has been firmly established in the independence movement through the concept of ‘self-directed support’ (Duffy 2007). In practice, direct payments have been mostly used to enable recipients to

employ their own carer or personal assistant or choose other personally selected services (Wanless 2006, Lymbery 2014).

However, in residential care the link between personalisation, choice and control and direct payments is less obvious. A recent scoping study suggests that there is an unmet need for choice and control among older people in care homes with high support needs, and that improved choice and control could increase their feeling of autonomy and thus their quality of life (Bowers, Clark et al. 2009). A number of studies suggest that having a sense of control increases the quality of life and well-being of care home residents (Bowers, Clark et al. 2009, King, Yourman et al. 2012, Simmons, Durkin et al. 2014, Hamilton, Tew et al. 2015). Sandberg et al. (2001) note that entering residential care is often experienced as a loss of control over one's life.

Yet other studies suggest that older people in care homes experienced more control over their daily lives than some of those living in their own homes, challenging the view that living at home is necessarily associated with more autonomy than living in residential settings (Darton 2011, Callaghan and Towers 2014, Hillcoat-Nallétamby 2014). Lewis and West (2014) have questioned the emphasis on user choice in improving the quality of life for older people in residential care. They argue that the care relationship (i.e. the nature of the interaction between service user and care worker) may be more important for residents than having specific choices. In a similar vein, Barnes (2011) argues that the policy narrative of personalisation emphasises choice and control over 'care', with the latter being associated with dependency and paternalism rather than empowerment. 'Care' may therefore become reserved for those not able to exercise choice and control.

While most practitioners and commentators agree that care home residents should receive personalised services, many acknowledge that there are limits to what can be achieved under current financial and organisational arrangements. For example, Bowers et al. (2001) have demonstrated that social care staff have limited time to attend to individual residents and that time pressures crowd out activities that might be valued by residents but considered 'optional' by staff

(Bowers, Laming et al. 2001). Such pressures are likely to have increased with the stagnation of social care funding in many council areas.

Methods

This paper presents findings from interviews with social care staff involved in implementing direct payments in residential care. Interviews were conducted in four of the participating trailblazing sites, selected to represent different approaches to issuing direct payments (covering part or all of the care home fee) and different groups of service users in receipt of direct payments. The interviews were conducted between September 2014 and November 2015. Interviewees included council staff contributing to the trailblazers in various roles, including care managers or coordinators and social workers, managers in care homes and care home owners. These care homes offered residential care to a variety of service user groups, including older people, and younger adults with physical, disabilities, learning disabilities and mental health problems. Care homes were under private for-profit and private not-for-profit (charitable) ownership. Interviews were typically conducted with social care staff who were most involved in setting up direct payments in each organisation. In addition, interviews with trailblazer council project leads conducted in twelve sites were used to provide perspectives from the majority of the remaining sites.

Forty-seven interviews were undertaken with 12 project leads and 35 social care staff across four sites, split between 18 council staff in various roles and 17 care home managers and owners.

Interviews with social care staff were conducted mostly face-to-face and lasted between 30 and 60 minutes. Interviews with project leads were mostly conducted over the telephone. Interviews were semi-structured and an interview schedule was used to guide the conversation. For council staff, questions focused on the process of setting up direct payments and any challenges they were facing

at this time, as well as their initial thoughts and perceptions of any benefits and risks of this to the council, service user, family members and care homes. Care home managers and owners were asked questions about their current care provision and how they became involved in the scheme, including the part they were playing setting up direct payments. Topics also encompassed how direct payments were either used or planned to be used by service users, and their thoughts and comments about any perceived benefits and risks of this scheme to their clients, care staff and their current business model. Interviews were recorded with permission and transcribed verbatim. Transcripts were coded and analysed thematically using the Framework approach (Ritchie and Spencer 1994). The evaluation was approved by the national Social Care Research Ethics Committee and the Research Ethics Committee of the London School of Hygiene and Tropical Medicine.

Personalisation in a residential care setting

Social care staff offered a range of interpretations of what personalisation in care homes meant to them and how it could be achieved in practice. There was broad consensus that promoting personalisation in care homes was a laudable objective and that residents in care homes would benefit from a service that was better tailored to their personal preferences. While care staff in both councils and care homes noted that many care homes already made efforts to provide a personalised service, many acknowledged that the degree to which care homes were able to account for individual preferences was highly variable.

“Well, I think even with the providers that we’ve been working with, this is my personal opinion, that we’re still working with people who might say ‘I take a person-centred approach or a personalised approach’ and I would say that they could go a lot further.” (Project lead)

Some council staff felt that personalisation in residential care was not well understood by providers or what was seen as a ‘personalised’ or ‘person-centred’ approach was not sufficient to meet the

more ambitious objectives of personalisation, although what exactly these objectives looked like and how they could be achieved largely remained implicit.

Personalisation as choice and control

Most respondents associated personalisation with increased choice and control by service users and saw this as compatible with the aims of introducing direct payments. Yet responses varied in what exactly choice and control could entail in residential settings in practical terms. In relation to choice, this involved, for example: choice of care home; choice of services provided within or outside the care home; choice of activities within or outside the care home, as a subset of services; and choice of 'hotel features', such as a larger room. There could also be more specific personal choices such as determining when to go to bed or whom to spend time with, some of which, it was felt by some, might not be achievable with a direct payment.

A number of respondents were sceptical about the extent to which some of these choices were achievable within the wider organisational and financial context of residential care. Such concerns were particularly pertinent among care managers and owners of care homes for older people.

Respondents provided a number of views on why some care homes offered limited choice, ranging from a need to achieve economies of scale; attitudes and practices of care home staff; limitations of time and resources in care homes; and low expectations of service users and relatives.

"I don't think they get [personalisation] when they go into residential care. I absolutely don't, no. I think they do in some homes, I think some homes are better than other homes. I don't think there's a lot of wriggle room for creativity in the homes, because I think [...] they're just at the minimum staffing levels. They [care homes] report they don't get enough money. So, I think their hands are tied very much with that"
(Social worker)

"I think one lady's been to the garden centre several times. People have been to the local park. They've been out for fish and chips because that's what they like. People have had... people come in and do

manicure type things. So, really the range of things that people have wanted to do have been extremely modest.” (Project lead)

Some observed that choices would be tempered by the necessity that they had to contribute to the objectives identified in the service user’s care support plan which determines the level of care provided to the resident. Care support plans are developed by care managers (or equivalent roles) on behalf of councils based on the assessment of eligible users’ care needs. It was frequently acknowledged that care planning could be less comprehensive than desired and care reviews did not take place as regularly as they should. One council worker described a potential tension between the outcomes determined in the care plan and the preferences of users as the difference between ‘a need and a want’, with direct payments being only used appropriately if targeting a ‘need’.

Personalisation was also interpreted as giving residents and their relatives more control, understood as having control over the budget and over the services provided to them. These perceptions echoed the sentiment of ‘self-directed support’ advocated by proponents of the independent living movement (Duffy 2007). However, some questioned whether self-directed support would be as feasible in a care home setting in the same way as it is in community care. In particular, employing a personal assistant was seen as less practical in a care home setting. Bringing in external personnel raised issues for care homes about safeguarding of residents and about the cost involved of employing an additional carer. As a result, personalisation, some reflected, might be different, and perhaps less ambitious, in residential care than in the community:

“I think if we can achieve greater personalisation and I do believe that it can be achieved, I think we’ve managed to achieve it within the community with a direct payment. But it is different in a care home, because actually the person’s already made the decision that they’re going to meet the majority of their needs by living in that care home. So I don’t think we can expect anything dramatically to be different quickly and I think it is about... it’s a slow process and it is about small steps and small differences.” (Project lead)

This raised the question as to whether, and if so how, ideas of self-directed support, independence and autonomy can 'translate' into care in residential settings, with some noting that a 'cultural shift' would be needed in care homes if services were to become better tailored to the wishes of residents (Project lead).

Personalisation beyond 'choice and control'

In contrast, some social care staff felt that the idea of personalisation should not be limited to choice and control facilitated by a direct payment. In residential care, specifically, providing personalised care was viewed as a core component of care delivery and embedded in the everyday act of caring. Such care would involve engagement with the service user and examples provided included care staff taking time to understand what and when the service user wanted to eat, their choices about when to get up in the morning, how to get dressed and whom they would like to be supported by. Spending time with a resident and tailoring care to their preferences was considered an integral part of providing care, not as something that could be delivered as an 'extra' or 'on top' of existing services paid for by a direct payment. These views emphasised the importance of care staff getting to know the person and of taking an interest in the whole person.

"So they'd look at things that somebody's been interested in, in the past. They'd look at how best to support that individual and things that people say about them. So it gives you some key words about that personality. So the idea is, that within that, there might be three or four things that they might like to do. It might be, go out and socialise. It might be, has always done knitting, so would like to continue doing some knitting or crocheting. One individual wants to have her nails done, so it's about allowing that to happen."

(Project lead)

Respondents also suggested that these 'relational' aspects of care were meaningful to both residents and care workers, although, in practice, there was often too little time for care staff to spend with individual residents. Thus, for many of those interviewed, better personalised care could be achieved by increasing or reallocating care staff without any need for a direct payment.

Potential for direct payments to increase personalisation

Most social care staff agreed that, in principle, direct payments could provide service users and their relatives with more choice and control.

“She [the service user] would be able to choose whether she goes to this day centre or this club rather than us taking her to the ones where we go because there are options out there, but we could only manage so much. We can’t give every option available, but she might be able to [with the direct payment]. (Care home manager)

As the trailblazer programme progressed and with more experience available, a number of examples emerged in which direct payments were used to purchase services in ways that were different from previous arrangements.

However, it was also felt that the ability of service users or their relatives to exercise, and capitalise on, choice and control was conditional on a number of factors, crucially the size of the direct payment, the extent to which it could be spent flexibly (e.g. as opposed to paying for existing care arrangements) and creatively, and also the extent to which the decision to take up and manage a direct payment was supported by relatives and other representatives of service users.

“I think obviously if a family, an interested and close family or other significant person was able to negotiate they would be able to get the things they wanted. And as they're paying the bill they would be in that position, they would be able to say... I have to say most providers do provide these things anyway. I don't think the effect would be enormous to be frank, but I think it would make [name of family member] feel better and feel they had greater control.” (Social worker)

Direct payments enabling choice of care home

Respondents indicated that, typically, prospective service users already had a choice of care home under current care arrangements. Such choices, it was argued, reflected the needs of the service

users as well as their personal preferences or those of relatives involved in their care. Yet the process of selecting a care home was shaped by factors other than needs and preferences: for example, the urgency of the decision to go into a care home; the affordability of the home and the contractual arrangements with the council; the ability and willingness of the family to pay a 'top up' fee if required; and the proximity of the care home to relatives. In practice, selecting a care home for a prospective service user was often constrained by circumstances such as the availability of places appropriate to the needs of the user. In this respect, it was argued, the direct payment might or might not increase the ability of service users to choose a home.

Some council managers worried that having a direct payment could limit the choice of care home if the direct payment turned out to be lower than the fees a care home requested for a place. As it was not clear initially how the direct payment would be calculated, it was, in principle, possible that by using a new resource allocation mechanism, the resulting direct payment, if unadjusted, could be lower than the fees currently negotiated between care homes and councils. The concern was that this would lead to a situation in which service users with a direct payment could have fewer rather than more options when selecting a care home. A related concern was that without a contractual agreement between councils and care homes, it would be possible for homes to treat council-funded service user as self-funders and charge them higher fees.

There was also concern that people with a direct payment might select 'better' homes for themselves (e.g. those that were offering a more personalised service) and that this could deprive users without a direct payment of having access to these homes, even if these homes would more appropriately meet their needs than other homes. Some social care staff thus argued that direct payments could make access to care homes less equitable or exacerbate existing inequities. Having a direct payment was also compared to the situation relating to self-funders, who were seen as having more care homes to choose from, although it was acknowledged their degree of choice would not be any different once they were admitted to a care home:

“But these self-funders, though, when you look at the direct payment, it's no different really to a self-funder, and self-funders don't go into a care home and say, 'I want that carer to take me to the market every Friday afternoon and she's got to be out of here for three hours every Friday afternoon, because that's what I want to do'. It just doesn't happen like that.” (Project lead)

Direct payments enabling choice of services within care homes

Social care staff mentioned a range of options for using a direct payment to increase choices of services within care homes. These included paying for services from someone external to the home, for example an alternative day centre or a personal assistant, or for services delivered by the care home in addition to those already provided as part of usual care arrangements.

Council staff noted that direct payments could help make care homes more responsive to the preferences of service users and their relatives, and thus provide a much needed stimulus to effect wider changes in care home provision. This view was supported by a number of care home owners and managers who noted that direct payments could empower residents and relatives to demand a different, more responsive service that could change the way services were provided in care homes:

“Therefore you would end up with more demanding residents and families....I have no problem with that and hopefully homes will again become responsive to that to provide.” (Care home owner)

Yet views about the potential of direct payments to change care provision in residential settings diverged substantially. Some saw an opportunity for homes to differentiate themselves from their competitors by advertising a 'menu' of choices that would attract new customers. Others argued that this would mainly generate benefits for homes that were already in a position to offer a wider range of choices and those in areas in which there is competition for council-funded clients.

However, some social care staff also expressed doubts about whether care homes will be able to offer more choice within the budget available. Most associated 'having more choice' within residential care as care homes providing additional or more tailored services, which were likely to

increase demands on staff time and thus the costs of delivering care. Focusing more on individual residents could also require care homes to change their staffing patterns, which might be beneficial for individual residents but negatively affect residents without a direct payment, from whom attention would be diverted.

Choices within the care home, it was noted, were dependent on the interplay of two key factors: whether the service user was able to exercise choice and request changes in service provision; and whether the care home was able, and willing, to respond the changes requested. It was also feared by some that by offering additional choice to selected individuals the currently predominant model of offering particular services to all, such as day activities in older people's homes, would be undermined by diverting resources to cater for individual interests. Some care home managers also voiced concerns about users taking their direct payment to pay for external providers of services or activities, thus diverting funding away from the home. However, this perception of financial risk was not shared universally and others were confident that they could cope with some users spending their direct payment outside the home and/or attract other service users from outside their home.

"We've got people knocking on our doors to come and use our services, so we're actually creating more spaces because if these people are going outside then we can bring in new people." (Care home manager)

Potential of direct payments for different user groups

Social care staff in councils and care homes agreed that all user groups should have access to direct payments. However, there were a number of concerns about whether direct payments would enable all residents equally to exercise more choice and control, especially with regard to older people and people lacking mental capacity.

Concerns relating to the financial impact of direct payments were prominent among those commenting on their implications for older people. These related both to the constraints of funding for older people's residential care and the potential impact of direct payments on the financial

stability of older people's homes. Interviewees involved in managing care homes for older people tended to note that current fees paid by councils for care for older people did not allow for much flexibility in spending as most of the fee was used to cover basic staffing, accommodation and care costs:

"What a person can choose is dependent on the money available to spend...I can tell you that really our fees don't deliver any choice because really there is no buffer at all.... our main cost is staffing, it takes up... three quarters of my income is just staffing." (Owner of a home for older people)

Staff providing care for younger adults tended to be more positive about the prospect of incentivising care homes to provide a more personalised service through the use of direct payments. This relative optimism reflected a difference in funding available for older and younger service users, with many younger adults receiving an additional allocation for daytime activities such as support to attend a local college or gym or to engage in other activities. Converting these budgets into direct payments appeared relatively straightforward, as there was already a specific sum allocated for this purpose. This was not, however, the case for care homes supporting older adults as dedicated funding for daytime activities typically does not exist for adults over the age of 65 years. Care home staff noted that it would often be desirable for older people to have more, and better tailored, activities during the day, depending on what the care home already offered and their own ability and willingness to participate, though, in the experience of those who looked after older residents with a part direct payment, organising such activities required additional resource and time commitment from staff.

Potential of direct payments for those lacking capacity

Respondents also held divergent views of how direct payments would enable choice and control for care home residents who lacked capacity to take decisions for themselves, such as people with advanced dementia or severe learning disabilities. Whilst it was undisputed that people lacking

capacity should be offered direct payments and would benefit from a more personalised service, respondents were less certain as to whether they would be able to benefit from the choice and control associated with direct payments in the same way as people with capacity.

“Younger people who are physically disabled, they may benefit more from [direct payments], people who are in a residential setting, or people, say, perhaps with complex mental health needs, they may benefit from it more, but I think for older people, they’re just... as I’ve said, it’s too late almost to do anything with them because all they’re interested in is getting up in the morning and going back to bed in the afternoon.”

(Social worker)

However, it was also strongly argued that it should not be assumed that people lacking mental capacity would not benefit at all from having a direct payment and that such assumptions illustrate a predisposition in some parts of the sector to underestimate, even negate, the benefits of choice and control for people with reduced capacity. Social care staff in councils and care homes emphasised the crucial role of intermediaries in helping people with no or reduced capacity to negotiate and use a direct payment, including care brokers, advocates and relatives involved in advising and negotiating care arrangements on behalf of service users. Such support was seen as important for all service users, and essential for those with reduced capacity. Two types of support were mentioned specifically: the first type was support in managing the financial aspect of the direct payment such as paying bills and submitting accounts to the council for annual review. Such support was largely seen as unproblematic and well established in community care. A number of councils had contracted with organisations that provide such a service. It was also noted that family members often already had a role in overseeing the provision of care to their relatives. The second type was support in making choices resulting in decisions as to how to ‘invest’ the direct payment in the purchase of services. This type of support requires intermediaries to determine the preferences of a service user to be able to make choices on their behalf.

Some social care staff questioned whether choices made by intermediaries would be the same as those made by residents themselves if they had capacity to do so:

“I also think that people, relatives especially, they’ve got different expectation then, of what the needs are, of the service users. They’re very easily guided by a posh looking place, and think ‘oh, this is okay’, because it actually fits quite nicely in with their guilt.” (Care home owner)

“Because they’re not able to present capacity outright, and able to say to you, ‘well, look, I want to use my money to do so-and-so project’, it’s very difficult for someone to advocate their beliefs in what that person would like or how would like to use the funds, and that’s why the representatives have come back to say, ‘no, they don’t think it would benefit the current group’ ” (Care home manager)

Such concerns highlighted both the potentially complex relationship between care home staff and relatives in making decisions about care provision, and the uncertainty about the role of direct payments in facilitating choice and control for service users with reduced capacity to choose for themselves.

Potential direct and indirect effects of direct payments

Social care staff also reflected on the mechanisms through which direct payments would promote choice and control, and, by extension, personalisation of services. While it was conceded that some service users might be directly able to make their own purchasing decisions, the process of care planning involving a council social worker and the service user or representative was highlighted as fundamental for personalising care arrangements and exercising choice.

Care planning was seen as the crucial step in determining the care arrangement appropriate to meet the assessed care needs of a service user within the budget available. Most council staff emphasised that while direct payments should be used to increase the flexibility of care arrangements, they could only do so if they met the outcomes defined in the care plan of the service user:

“It’s the support plan that is the guidance on how they would be using that money, you know, to meet those needs, whether it’s buying the more traditional services or whether it’s doing something entirely differently, it is still quite prescriptive on a support plan.” (Social worker)

Some council staff noted that there had been occasions where the conversation about the offer of the direct payment was enough to change, and intensify, the planning process. Respondents observed that the process of discussing the direct payment sometimes resulted in a more in-depth relationship between the council, the care home and the user or family, and that this change had led to care planning becoming more detailed and better coordinated with care homes, thus achieving better personalisation. In some cases, this happened in spite of the fact that the user or family eventually decided against taking up the direct payment:

“This is the catalyst to start that, because without any significant change, nobody’s doing anything different, whereas just with a slight financial change, a slight impetus, if there’s a little bit of money to do something a little bit differently, people are already thinking differently, doing things differently, making attempts to think about personalised services within a care home.” (Council social worker)

Direct payments, it was then argued, could be the channel for changes in the provision of care in residential settings, a spur for doing things differently in a care home, either by directly enabling greater choice and control or indirectly providing an impulse for change

Discussion

Responses from social care staff suggest that personalisation is an accepted policy objective in adult residential care, with many professionals recognising a need for more personalised care in residential settings. However, responses also indicated a lack of clarity about the meaning, and practical implications, of personalisation in the context of care homes. In interviews, social care staff noted that direct payments were likely to bring about the choice and control element of personalisation: in particular, choice of care homes and services, and control over (whole or part of the) budget. However, while it was acknowledged that greater choice and control contributed to personalisation, it was less clear to what extent direct payments would allow for more choice and

control, and by extension personalisation, in residential settings. Such concerns mostly related to the organisational arrangements underpinning residential care with regard to the collective provision of some services and to financial pressures on care homes with appreciable numbers of council-funded residents.

Some social care staff also wondered whether better choice and control through the use of direct payments would benefit some groups more than others, especially younger adults and those with capacity to make their own decisions. Such concerns echo findings from earlier studies of direct payments (and similar initiatives) in community care. For example, the evaluation of individual budgets in the community (budgets composed of several funding streams and mostly provided as direct payments) showed that younger people were more likely to report feeling satisfied as a result of having more choice and control than older people, while older people were more likely to experience stress and anxiety (Glendinning, Challis et al. 2008, Netten, Trukeschitz et al. 2012). A number of studies have shown that older people can find having additional choice, especially around financial decision-making, challenging (Daly and Woolham 2010, Hall 2011, Daly 2012, Moffatt, Higgs et al. 2012, Lewis and West 2014). These differences between the experiences of different groups are likely to be exacerbated in residential care given that care home residents, on average, have more complex care needs. Importantly, the current study has also highlighted that there are substantial concerns among social care staff as to whether direct payments, under current funding arrangements and in times of austerity, can add much to facilitate choice and control, especially for older people whose care typically attracts less public funding than care for younger adults (Fernandez, Snell et al. 2013).

Other findings relate to the specific conditions of providing residential care, such as the communal aspects of care provision in care homes (e.g. participating in joint activities, economies of scale of provision). These raise questions about the desired organisation of residential care and whether these communal aspects are seen as beneficial or as outdated, with current trends moving towards

alternative forms of care provision such as supported living, extra care or housing with care (Demos 2014). The question will be whether such forms are expected to complement, or substitute for, more traditional forms of residential care, and whether there is a direct link between different forms of providing residential care and the quality of care, including personalisation, experienced by users. Daly and Woolham (2012) have argued that personal budgets may lead to new forms of inequality, with some people able to choose better services for themselves, thereby preventing others from using these services. They argue that such arrangements are likely to leave behind those who are most frail and vulnerable. Similar concerns have been voiced by the care staff in this study. Further empirical analysis will be needed to establish whether such inequities materialise in practice since the current trailblazers were too small to have a significant impact on individual homes and local care markets.

Questions have also been raised about the willingness and ability of service users to exercise choice and control, and whether the restricted capacity of some service users (e.g. with advanced dementia or severe learning disability) to make decisions about their own care can be entirely substituted for by relatives, advocates or other intermediaries. These findings resonate with earlier observations by Kendall and Cameron (2014) and Samuel (2010) about the potential effect of delegating choices to others (e.g. relatives, brokers, care homes) which, in the extreme, could reduce choice and control available to users rather than increase it. The question is whether constraints in decision-making capacity can be compensated by support from others, and whether such support effects an improvement in personalisation.

It should be noted that many social care staff interviewed had not yet experienced a resident with a direct payment in place, as the uptake of direct payments remained slow during the Trailblazer programme. Thus findings are likely to be skewed towards concerns about changes to care provision, at the expense of actual experience of such changes. Social care staff's views may also have been influenced by other contemporary events in the social care sector, especially the

preparations for the implementation of the Care Act (2014) and the reductions of social care budgets in many councils.

Conclusions

Responses from social care staff in care homes and councils involved in the Direct Payments in Residential Care Trailblazer programme indicated that personalisation is largely seen as compatible with concepts of choice and control in residential care. However, respondents raised a number of concerns about the implications and practicalities of choice and control in care homes. While it was agreed that direct payments should be made available to all user groups, respondents held different views as to whether some groups, especially those with limited or no capacity to make decisions, such as people with advanced dementia, would benefit from direct payments and from greater choice and control, as much as people with capacity. It would be helpful to clarify the expectation of personalisation in the context of residential care, to explore further whether and how direct payments can contribute to personalisation in such settings and to understand better the limits of, and alternatives to, direct payments to achieve better care for people in residential care.

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