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Research findings

How local authorities allocate resources to carers through carer personal budgets

STUDY AIMS

Key aims of the study were to explore:

- What approaches local authorities in England were using to determine eligibility for, and levels of, carer PBs.
- Why these approaches were used.
- Anticipated changes to these approaches following implementation of the Care Act (the study was conducted before the Care Bill received Royal Assent).

KEY FINDINGS

Establishing carer eligibility

- Survey responses across the sample of local authorities indicate that an initial eligibility threshold – that carers must be providing 'regular and substantial' care – is often applied by authorities.
- Some local authorities define more specifically the threshold of 'regular and substantial care'. Approaches include:

– specifying a minimum number of hours per week spent caring. The numbers of hours spent caring used by local authorities in this study as minimum eligibility thresholds ranged from 19 to 35 hours per week

– systems which grade carers, e.g, in terms of the risk of breakdown in the care-giving relationship

– other authorities graded carers as being in 'high' or 'low' need, depending on the assessed effect of care-giving on the carer's personal health and well-being, with only 'high' impact carers eligible for a PB. In another authority, carers are

BACKGROUND

Department of Health (2010) guidance recommends local authorities use transparent and equitable approaches to allocating resources to carers to meet their own support needs. Processes should be proportionate and carers should have maximum choice and control over the use of these resources. Support to carers should be allocated to carers in their own right as a personal budget (PB), with the preferred option of receiving the PB as a cash direct payment (DP) (see note below).

The Care Act 2014 strengthens carers' rights and places a duty on authorities to assess carers and meet their eligible support needs; the importance of carers receiving PBs in their own right is also emphasised.

Earlier research (Mitchell et al. 2013) indicated that local authorities use different approaches to determine eligibility for, and the allocation of, PBs to carers. Other research (Carers Trust 2012) also suggests considerable inconsistencies between authorities in both the processes of assessing carers for PBs and the outcomes.

Note: Study participants used the terms grants, personal budgets and direct payments in varying ways, with little consistency between them. Here, the term 'personal budget' (with a preference for taking them as cash direct payments) is used, with additional qualification/ explanation when required.

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banded into having 'basic', 'standard' or 'enhanced' levels of need, with only carers in the latter two bands qualifying for a PB

– a further approach was to use a points-based system to establish eligibility with, for example, those carers scoring 19 out of a possible 25 points eligible for PBs.

- However, not all authorities had such systems; some established eligibility through more discretionary professional assessments of the impact of the caring role on a carer's personal health and well-being.
- In a few local authorities, carers were also required to be 'financially in need' – for example, dependent on state benefits – to qualify for a carer PB.

How are carers assessed?

- Most authorities used individual carer assessments to establish carer eligibility. Joint assessments between the carer and the person they supported were used less frequently. Only one authority indicated that it was not always necessary for carers to have an assessment in order to qualify for a carer PB – social worker discretion was sometimes used.
- Responsibility for conducting carer assessments differed between authorities. Half (10) used only 'in-house' local authority staff. Among the remaining authorities, assessing carer eligibility for PBs could be conducted by a mix of 'in-house' local authority staff and outsourcing to local voluntary organisations or NHS professionals. Only one authority outsourced all its carer assessments.
- Outsourced assessments were usually undertaken by voluntary sector organisations, especially local carers' centres. Less commonly, charities focusing on specific conditions such as the Alzheimer's Society or the Stroke Association were involved in conducting carer assessments. The importance of consistency between in-house and external assessments was raised by a small number of lead officers. Some authorities provided training and appraisal for staff undertaking outsourced assessments. This study was not able to compare the impacts of these different approaches and this is one potential area for future research.

Determining the level of carer PBs

- Both standard, fixed sum and variable amount (according to intensity of care-giving or severity of carer need) PBs were awarded by local authorities. Variable PBs were more common than standard, fixed sum amounts.
- Among authorities offering standard, fixed sum PBs, amounts ranged from £60 to £300 p.a.
- Among authorities allocating variable PBs, amounts ranged from 'no minimum' to 'no maximum'. However, most authorities had an upper limit for carer PBs, reported as being £250, £300 and £500 p.a. Although some authorities reported that they had no maximum ceiling, it was acknowledged that PBs above a certain amount (e.g. £1,000 p.a.) would require special permission and were unusual.

How carer grants are paid

- A range of methods were reported: lump sum annual payments; lump sum payments less frequent than once a year; and regular monthly payments to carers. One or two authorities reported giving carers a choice between annual or monthly payments and one or two authorities included carer PBs in the PB of the person being supported.
- Most authorities opted for lump sum payments because they were considered administratively straightforward and proportionate, given the relatively small sums involved. Some lead officers also thought that carers preferred lump sums as they were better suited to the types of support carers used PBs for, such as paying for gym membership. Lump sums were also considered to increase carers' choice over when and how they used their PB.

Local authorities' future plans

- Over half the carer lead officers anticipated future changes to their authority's system of assessing eligibility for, and allocating, PBs to carers, although none yet knew the timing or details of these plans.

- Some authorities were waiting for further Government guidance following implementation of the Care Act in 2015. Others anticipated moving to a points-based system but were unsure when or how this would happen.
- Moving to points-based systems raised mixed feelings. Some feared this would be less sensitive to individual carer needs, whereas others hoped it would create more consistent practice. Monitoring and assessing these developments will be a potential area for further research.

IMPLICATIONS FOR PRACTICE

Most local authorities allocate resources directly to carers in their own right but allocation processes differ between authorities and transparency was often not apparent among the resource allocation systems reported. Different practices currently exist across authorities for establishing the eligibility of carers for PBs: who conducts assessments of carer eligibility; establishing the levels of a carer PB; and how and when PBs are paid to carers. Outcomes for carers and carers' experiences of resource allocation can differ both between and within local authorities. These variations raise concerns about equity. For example, awarding carers standard lump-sum PB payments, while administratively simple, may not reflect differences in levels of carer need or in the impact of care-giving on carer's health and well-being. It is highly likely that differences between local authorities in eligibility thresholds for carers and levels of carer PBs risks will lead to carers with similar levels of need being treated differently in different local authorities.

Ensuring maximum choice and control for carers over allocated resources is a government objective. In this study, authority respondents may report that carers had choice and control over how they used their PB (so long as this met agreed carer support needs and outcomes) and that they were not prescriptive about, and/or imposed restrictions on, how carers used their PB but implications were that very little monitoring was done.

Implementation of the Care Act in 2015 will strengthen carers' rights and place a duty on local authorities to meet carers' eligible support needs equitably and transparently. This study suggests that guidance may helpfully cover the following issues:

- Minimum eligibility thresholds to qualify for a carer PB.
- Consistency in conducting assessments for carer PBs; training and appraisal may need to be offered where carer assessments are outsourced to voluntary organisations or NHS practitioners.
- The merits of different approaches to calculating levels of carer PBs and to paying PBs to carers.

ABOUT THE STUDY

The study was conducted with local authorities in two regions in England from October 2013 to April 2014. It involved:

- an online survey to 30 local authorities exploring the resource allocation system they used. Carers lead officers in 20 authorities completed the survey
- individual telephone interviews with three of the 20 responding carers lead officers. The three case study interviews explored the process and outcome of resource allocation for carers in more depth.

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