



National Audit Office

Report

by the Comptroller
and Auditor General

Department of Health and local authorities

Personalised commissioning in adult social care

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Department of Health and local authorities

Personalised commissioning in adult social care

Report by the Comptroller and Auditor General

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Sir Amyas Morse KCB
Comptroller and Auditor General
National Audit Office

1 March 2016

This report is one in a series examining adult social care in England. Our report aims to provide central government and local authorities with a review of progress with personalised commissioning.

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Contents

Key facts 4

Summary 5

Part One

Policy context and users' outcomes 13

Part Two

Local progress with personalised
commissioning 29

Part Three

The capacity of the care market 40

Appendix One

Our audit approach 47

Appendix Two

Our evidence base 49

The National Audit Office study team consisted of:
Mark Burkett, Abiola Dina,
Janiece King, Rose Martin,
Oscar Pelka Barreto, Hayley Quick,
Andy Whittingham, Chris Woolley,
under the direction of Aileen Murphie.

This report can be found on the
National Audit Office website at
www.nao.org.uk

For further information about the
National Audit Office please contact:

National Audit Office
Press Office
157–197 Buckingham Palace Road
Victoria
London
SW1W 9SP

Tel: 020 7798 7400

Enquiries: www.nao.org.uk/contact-us

Website: www.nao.org.uk

Twitter: @NAOorguk

Key facts

500,000

approximate number of adults in England whose social care services were paid for through local authority personal budgets in 2014-15

£6.3bn

spending by local authorities on long-term social care for adults in the community, 2014-15

7%

real-terms reduction in spend on adult social care by local authorities between 2010-11 and 2014-15

- 88%** median proportion of users with personal budgets per local authority in 2014-15
- 22%** median proportion of users with direct payments per local authority in 2014-15
- 84%** proportion of local authority directors of adult social services who report that increasing personalisation is a high (43%) or medium (41%) priority area for savings in 2016-17
- £0** amount that the Department of Health expects to save from personalisation
- 26%** proportion of long-term social care users who said it was difficult to find information about support in 2014-15

Summary

1 Social care comprises personal care and practical support for adults who cannot perform the activities of typical daily living, and support for their carers. Social care paid for by English local authorities makes up a minority of the total amount of care. Most care and support is provided unpaid by family and friends (informal care), while many adults pay for some or all of their formal care. The Department of Health (the Department) is responsible for setting national policy and the legal framework for adult social care, securing funding and providing leadership. Through the Care Act 2014, the Department aims to achieve the government's vision for reforming care and support as set out in its 2012 white paper, *Caring for our future: reforming care and support*.

2 Pressures on the social care system are increasing. The need for social care is rising as people live longer with long-term and complex health conditions. Between 2010-11 and 2014-15, English local authorities' real-terms spend on adult social care fell by 7%.

3 Successive governments have tried to improve outcomes for users by introducing policies that enable local authorities to personalise the commissioning of adult social care services. This involves: identifying and fostering a greater variety of services for users to choose from; aligning the services users receive more closely to the outcomes they want to achieve; building on users' existing capabilities; and enabling users to have more control over their care. Users may change the way they receive services, for example they may use direct payments to pay for personal assistants, receive services that meet their cultural and religious needs, or meet their needs through community-based social and sports activities rather than conventional social care services.

4 Some local authorities started to personalise the commissioning of community care services in the 1990s. They supported adults with physical disabilities to have more choice and control over their lives by giving them 'direct payments': money to buy their own care services. In 2007, the government introduced the broader concept of a 'personal budget': a sum of money allocated to an adult to meet their assessed social care needs. A personal budget can be managed by the local authority or by a third party that commissions services for users; or it can be given to users or their carers as a direct payment. In the 2000s, the Department promoted personalised care through the Social Care Reform Grant. The Care Act 2014 prioritised the wellbeing and independence of adults, embedded personalisation into the legal framework for social care and mandated adults' involvement in planning their care. It required authorities to give all eligible users a personal budget, including, for the first time, those in residential care. Previously, they had been limited to community care. Since 2014, the NHS has been introducing personal budgets in healthcare.

Our report

5 This report is one in a series examining adult social care in England. Our report aims to provide central government and local authorities with a review of progress with personalised commissioning. It looks at the practical challenges and opportunities associated with implementing personalised commissioning given the current financial environment and the extension of personal budgets into healthcare. It covers only social care that is fully or partly paid for by authorities. Unless otherwise stated, it excludes carers who receive personal budgets in their own right. It aims to answer four main questions:

- Is personalised commissioning resulting in better outcomes for users?
- How and why does the use of personalised commissioning vary between local authorities?
- What are the financial implications of personalising commissioning?
- Is there capacity in the care market for local authorities to develop personalised commissioning?

6 We reviewed the way local authorities are implementing personalised commissioning in the context of the Department's policies. We undertook our fieldwork when authorities were implementing the Care Act, a period of significant change. Our findings are based partly on evidence gathered from 9 authorities we visited. These were selected to be broadly representative of variation in local circumstances and progress with personalised commissioning across England. During our visits, we interviewed around 200 people: directors, managers, front-line staff, service users and providers. We interviewed the directors of adult social services at 3 more authorities. We also analysed data collected nationally; interviewed representatives of stakeholder organisations; and reviewed relevant literature.

Key findings

7 **We found widespread support across local government and the adult care sector for the concept of personalised commissioning.** We heard from a range of people and organisations who saw personal budgets as an important part of a broader movement to give care users more control over their services (paragraphs 1.2, 1.4 and 1.5).

8 Local authorities across England report a wide range in the proportions of users taking up personal budgets, including direct payments. Authorities spent £6.3 billion on long-term community care in 2014-15. Around 500,000 adults in England received personal budgets in 2014-15, varying between 10% and 100% of users across authorities, with a median proportion of 88%. The median proportion of community care users with a direct payment across authorities was 22%, with a range from 5% to 57%. Take-up of direct payments varies by user group, with higher take-up among younger adults (under 65) with primary support reasons relating to physical or learning disabilities, and lower take-up among younger adults with a primary support reason relating to mental health and older adults (65 and over). Before the Care Act made personal budgets mandatory for all eligible users from April 2015, authorities prioritised implementing personalised commissioning to different degrees. Additionally, before 2014-15, the data collected by different authorities on long-term community care were not on a like-for-like basis. The Department and the Health and Social Care Information Centre, with the social care sector, have together improved consistency in the data collected for 2014-15 (paragraphs 2.3 to 2.5 and 2.7 to 2.10).

Does personalised commissioning improve outcomes for all users?

9 Recent evidence suggests that personal budgets benefit most, but not all, users and that the way a personal budget is implemented is key to whether users benefit from it. Data from user surveys carried out in 2014-15 indicate that most users, but not all, report benefits when services are commissioned through personal budgets, particularly direct payments. However, if a personal budget is put in place without adequate support and information, and without being aligned to a user's circumstances, it may not benefit the user. This can occur if authorities are pursuing personal budgets as an end in themselves, rather than as an enabler of personalised care. These considerations are particularly important for direct payments, which require users to manage their own spending. The Department still relies on its evaluation of personal budgets from 2007. This found that benefits were restricted to adults aged 18 to 64. Users reported greater satisfaction with care, more control over their lives and improved quality of life, but the evaluation did not measure longer-term outcomes such as health. Furthermore, the findings relate to the period before austerity, when local care markets were under less pressure and before authorities had started to focus services on users with the greatest need (paragraphs 1.10, 1.11, 1.13, 1.18, 1.19, 1.21, 2.6 and 3.10).

10 The Department's local authority-level data provide no evidence that personalised commissioning improves user outcomes. User-level data indicate that personal budgets benefit most users. However, when user data are aggregated at the local authority level, there is no association between higher proportions of users on personal budgets and overall user satisfaction or other outcomes. The Department has not investigated the apparent contradiction between user-level and authority-level data (paragraph 1.22).

11 The Department's monitoring regime does not enable it to understand how personal budgets improve outcomes. Indicators specific to personalised commissioning in the Department's Adult Social Care Outcomes Framework measure take-up rather than user outcomes. Other indicators in the framework do measure outcomes, but since its 2007 evaluation the Department has not analysed the relationship between the form of the personal budget and outcomes. In response to our suggestion to improve the usefulness of published data, from December 2015 the Health and Social Care Information Centre has published a more detailed dataset that permits some analysis of this relationship. National data on how users spend their personal budgets are limited. Few local authorities currently participate in an annual survey run by the charity In Control and there are limitations to that survey's design. Smaller-scale reviews are often local and biased towards users with negative experiences (paragraphs 1.10, 1.15 to 1.17 and 1.20).

What are the financial implications of personalised commissioning?

12 Some local authorities are constrained in how, and the extent to which, they can personalise care by the need to reduce overall spending. The Care Act guidance says that personal budgets must be sufficient to meet users' statutory needs, and that they must take into account users' reasonable preferences. Although there are circumstances under which personalised commissioning can make care cheaper, the guidance acknowledges that responding to users' needs can increase the cost of care. For example, giving users greater flexibility over their care may require paying more to providers. However, authorities that need to save money cannot afford to increase the value of a personal budget above the cost of meeting the user's needs through authority-commissioned services. For the most common services which aim to meet basic needs – such as homecare – authorities cannot afford to lose the economies of scale they achieve through large framework contracts. Some users with personal budgets are therefore receiving services through authority-commissioned contracts that are not personalised. Similarly, some authorities that need to save money are adopting direct payment rates that relate to their own commissioning rates, rather than the market prices available to members of the public. Users in some areas told us they were unable to buy enough care using the authority rate, and made higher top-up payments than they would have expected based on their financial assessment. Some authorities are using innovative approaches to make the most of their care markets to identify the most efficient ways of meeting users' desired outcomes (paragraphs 1.9, 2.6, 2.17, 2.18, 3.6 to 3.8, 3.10 and 3.12).

13 The Department does not expect substantial financial savings from personalised commissioning, which differs from local authorities' expectations of savings. In response to an annual survey, 74% of directors of adult social services said they expected personalisation to be a medium or high area of savings in 2015-16, with 84% expecting the same for 2016-17. The Department expects the value for money of personalised commissioning to come from improved outcomes for users, not necessarily from savings. The Department's 2007 evaluation found that care packages were not more expensive for people with personal budgets, but that care management costs were higher (paragraphs 2.17 and 2.18 to 2.21).

14 It is not clear whether local authorities will achieve the spending reductions they have forecast without putting user outcomes at risk. We heard about a range of ways that some authorities have saved money through changes to personal budgets, including direct payments, and to other commissioning practices:

- The authority sets its direct payments at a lower rate than the rate it pays providers through its commissioned contracts. It also increases the proportion of users on direct payments. This assumes that users can obtain the same level of care through buying their own care more cheaply. It also assumes that some users currently using authority-commissioned services will be happy to switch to direct payments.
- Some authorities are using outcomes-based contracts that pass the need to save money on to providers. Others intend to save money by renegotiating contracts, but they do not yet know whether the providers will be able to cope with such demands.
- Some authorities are identifying services provided by voluntary organisations at no or little cost. These include social activities, which meet a user's needs more cheaply than a traditional approach, such as a place at a daycentre. This relies on such services being available and adequately funded.
- Authorities attribute some savings to process efficiencies such as taking back unspent direct payment monies when a certain number of weeks' funding remains unspent in users' accounts.

Authorities anticipating savings were concerned that these will be offset by other planned changes, such as the requirement on providers to pay employees the new national living wage. The Department expects that giving authorities the option to raise money through the adult social care council tax precept, announced as part of the local government finance settlement in February 2016, will support authorities to manage such changes. The Association of Directors of Adult Social Services is concerned that the settlement is not adequate to cope with this and other pressures (paragraphs 2.22, 2.23 and 3.7).

15 Some local authorities are struggling to manage and support their local care markets as well as we would expect of a well-functioning public service market.

The Care Act places new duties on authorities to shape their local care markets to meet adults' social care needs. The Department's ambition, stated in the Care Act guidance, is for local authorities to oversee a sustainable and diverse range of care and support providers. However, some authorities are reducing the number of providers they contract with, to achieve economies of scale, and, in areas where providers are struggling to recruit care workers, to limit the destabilising effect on the care market of workers moving frequently between providers. However, this can restrict choice of provider for users who use their personal budgets to buy authority-commissioned services. Some providers are under financial pressure because authorities have driven fee rates down to potentially unsustainable levels. The Department intends to make its role in market management clear when it publishes its national market position statement in spring 2016 (paragraphs 3.5, 3.6, 3.8 and 3.12 to 3.16).

What approaches are local authorities taking to personalised commissioning?

16 Authorities are taking different approaches to implementing personal budgets; some are struggling to find workable approaches. We encountered authorities that had developed effective systems for administering personalised commissioning, but such good practice is not being taken up extensively. Sector bodies such as the Association of Directors of Adult Social Services and the Local Government Association identify and share good practice through initiatives such as the Think Local Act Personal partnership and regional networks. However, some authorities still appear to be struggling in isolation and Care Act guidance requirements are not yet established in all authorities (paragraphs 1.5, 1.7 and 3.16). For example, some authorities find the following aspects of personalised commissioning particularly difficult:

- **Engendering a culture of personalised commissioning.** We visited authorities where staff viewed personalised commissioning as benefiting a narrow range of users. Some authorities we visited were concerned that innovative ways to spend personal budgets might not work as planned (paragraphs 2.9 and 2.14).
- **Determining the amount of users' indicative personal budgets.** Authorities start the care planning process by looking with each user at their needs. The authority then determines an indicative budget based on the needs identified, giving users a guide amount within which they plan their care. Most staff we spoke with found indicative budgets to be inaccurate and unhelpful, and said they were often ignored (paragraphs 2.11 and 2.12).
- **Identifying how to meet users' needs from a broad range of community-based activities.** Some authorities had a good overview of their provider markets, including directories of services for staff and users to use for care planning. One authority we visited had an advanced system that supported front-line staff in identifying services from more than 700 varied options available in the local area. Staff selected from these with the user to achieve the care outcomes they had jointly identified, an example of outcomes-based commissioning that gave users real choice (paragraphs 3.8 and 3.9).
- **Putting in place adequate and timely user support.** Front-line workers in some authorities said they did not have enough capacity to provide effective support and review (paragraph 1.21).

- **Personal assistants.** Around 120,000 personal assistants are employed by users with direct payments to provide personal care, which is generally a cheaper option than homecare. Personal assistants are unregulated. Users can find it difficult to take on responsibilities as employers of personal assistants, but 82% of authorities have reported gaps in the support they provide to users and personal assistants. The Care Act requires authorities to give users who employ a personal assistant advice on their responsibilities (paragraphs 1.21 and 3.17 to 3.19).
- **Gaining assurance on how users spend direct payments.** Most users receive their direct payments into bank accounts in their own name and must provide the authority with bank statements and receipts. Users can find this burdensome and are slow to provide the information. Some authorities are adopting straightforward solutions that reduce the administrative burden (paragraphs 2.13 and 2.15).

Conclusion

17 Giving users more choice and control over their care through personal budgets, supported by well-designed local authority processes and a range of genuine choice within an effective and sustainable local care market, can improve their quality of life. However, much of the positive evidence for personalising commissioning is old or relates only to subgroups of users. Centrally collected data on local authorities' progress might be overstating how personalised the commissioning of care really is for some users. There is therefore a strong case for better use of existing surveys and evidence gathering. Learning from the implementation of personalised commissioning in social care will benefit the Department as it extends personal budgets in healthcare.

18 Some authorities are finding personalising commissioning a challenge as they seek to save money, particularly in areas where providers are under financial strain. Authorities are limiting the extent to which some users' services are personalised because of financial pressures. The Department expects personalised commissioning to improve outcomes for users, not necessarily to help local authorities save money. Nevertheless, most local authorities say they expect to save money through personalised commissioning. The Department has not investigated how services can be personalised when money is tight, nor questioned whether authorities' plans to save money would adversely affect user outcomes.

19 Some authorities have transformed their care and support processes to ration their resources fairly, share information about a broad range of local services, and monitor and manage spending on personal budgets efficiently, particularly direct payments. Authorities that do not ensure users are adequately supported to commission services within a personal budget can pass risks on to the users. More authorities could improve user outcomes, and potentially save some money, by learning from or adopting the practices of those authorities that have implemented successful approaches to personalised commissioning.

Recommendations

20 Evidence collected from users indicates that most, but not all, benefit from having a personal budget. However, evidence collected at the local authority level shows no link between the proportion of users with personal budgets and overall levels of user satisfaction. Furthermore, the data available do not make it possible to analyse the best way to implement personal budgets to maximise improvement in users' outcomes.

The Department of Health and its national partners should:

- a** improve the evidence on, and understanding of, the relationship between the different ways to commission personalised services for users, and improvements in user outcomes;
- b** use this improved understanding, supplemented by shared intelligence from established networks to identify successful local approaches to personalised commissioning and share this learning across all local authorities; and
- c** apply learning on successful approaches to personalised commissioning in social care to the roll-out of personal budgets in the health sector.

21 The Department is not expecting local authorities to save money by moving to personalised commissioning, but most local authorities are expecting to make savings. It should:

- d** understand how local authorities intend to make their expected savings; and
- e** understand the implications of funding reductions for local authorities and assure itself that authorities' savings will not be made at the expense of user outcomes.

22 The fragile state of the care market in some areas is inhibiting the progress local authorities are making with personalising care services. The Department should:

- f** actively support national initiatives to oversee and support the care market, including the sustainability of providers and the supply of care workers.

Part One

Policy context and users' outcomes

1.1 This section of the report:

- introduces the policy context for personalised commissioning;
- examines how the Department of Health (the Department) and local authorities monitor users' experiences and outcomes; and
- summarises what this monitoring shows.

Definitions

1.2 In this report we use terms and definitions consistent with the Care Act 2014 (**Figure 1**). **Figure 2** overleaf outlines the personalised commissioning process and gives examples of how the authorities we visited had implemented it.

Figure 1

Personalised commissioning – key terms and concepts

The objective: personalised care

Government policy on social care aims to tailor services to individuals' needs and wishes. Care that gives people control over their lives is also known as **self-directed support**.

The mechanism: commissioning

A **personal budget** is a sum of money that a local authority allocates to a user to meet their assessed social care needs. Since the implementation of the Care Act in April 2015, all users must have their care paid for through a personal budget of some form:

- Under an **authority-managed personal budget**, the authority commissions services for the user. The authority must involve users in care planning, ensure services are commissioned based on the outcomes the users want to achieve, and incentivise providers to tailor care to meet those outcomes.
- An **individual service fund** is a personal budget managed by a provider or other third party. Authorities intend that individual service funds allow users to vary their care according to their needs.
- A personal budget might be fully or partly given to a user or their carer as a **direct payment**, so they can buy their own care. Local authorities pay the money into a dedicated bank account in the user's name or on to a payment card, or allocate the money to another form of account controlled by the user, such as a PayPal account. Authorities set rules on how direct payments may be spent, with regard to national guidance.

Note

1 Department of Health, *Care and Support Statutory Guidance: Issued under the Care Act 2014*, October 2014, available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf

Figure 2 Personalised commissioning process

Personalised commissioning: what should happen

The authority provides personalised assessment, resource allocation and information

- The authority carries out an assessment of care eligibility.
- The authority provides each service user with an indicative budget based on their needs, and with information about the prices of services.
- Users may top up a direct payment or managed budget with their own money.
- The authority takes other public funding into account in care and support planning process.

The authority oversees support planning, enabling effective and efficient choices, and agrees final budget with user

- The user identifies their desired outcomes at the support planning stage. The user and care workers use these outcomes throughout the process to determine the care package put in place.
- If necessary, the indicative budget is adjusted to meet user needs, at support planning. This provides the user with a final budget.
- The budget may be handed over to the user as a direct payment or retained by the authority as a managed budget.
- Either way, the authority provides the user with information and advice about the range of services that can be purchased.
- A range of quality provision is available due to the authority's market shaping.
- The authority supports users who lack mental capacity.

The authority provides ongoing support during service provision and does reviews to ensure needs are met and user choice continues to be efficient and effective

- The authority provides advocacy and mediation services when needed.
- Users can complain and switch providers when necessary.
- The authority is responsible for ensuring care needs are met, so monitors outcomes.
- The authority gets assurance that public money is being spent efficiently and in line with the individual's care plan.

Examples of how we saw these principles implemented

Timely assessment means services are started rapidly: some authorities dedicated resources to financial assessment, knowing this can be a bottleneck.

One authority had an e-marketplace platform with an online directory of more than 700 providers. This ensured service information was comprehensive. Each provider was tagged with user outcomes which they specialised in working towards, which allowed care workers to identify services which would meet users' needs.

Managers at some authorities we visited moderated budgets to ensure the amounts were appropriate and likely to provide good value.

Some authorities we visited commissioned specialist support services for people with direct payments, for example to help them manage employing personal assistants.

One authority we spoke to asked contractors on framework contracts to flex the times of their services in response to user requests made a day in advance.

Authorities with high volumes of providers, and with systems designed to enable easy access to information, facilitated user choice and switching.

Some authorities used payment systems which enabled them to easily monitor expenditure by users with direct payments. Spending outside the care plan can be flagged in real-time for investigation.

Source: National Audit Office, review of Care Act guidance and of evidence gathered from case study visits

1.3 The Department's outcome measures on personal budgets and direct payments focus on community care: homecare, day centres and supported living. Users in residential care receive personal budgets, but the Department does not monitor these. Users in residential care cannot currently receive direct payments, except for a few who participated in the Department's pilot between January 2014 and October 2015. Following completion of the pilot, the Department decided to postpone national roll-out, originally planned for April 2016, until 2020. The Health and Social Care Information Centre's statistics on personal budgets and direct payments consequently focus on community care.

Policy context

1.4 Since the Care Act 2014 was introduced, from April 2015, all users of local authority adult social care should receive a personal budget. This excludes emergency and end-of-life care, advice and one-off pieces of equipment. The Act synthesised more than 15 years of policy development and legislation in personalised commissioning.

1.5 The Care Act stipulates that users should be involved and influential during the care and support planning process. They should:

- be given an indicative budget within which to plan their care;
- be able to choose from a range of options for managing the money (direct payments, authority-managed budgets, third-party-managed budgets, individual service funds, or a combination);
- receive information, advice and support from their local authority to enable them to make informed choices about their care and support; and
- have choice and control over what services are purchased, and from whom.

1.6 Personal budgets exist in other public service areas. Children with special educational needs can receive a personal budget. If they are eligible for social care when they reach adulthood, their transition to adult services can be easier if they are already receiving a personal budget. Adults eligible for NHS continuing healthcare and children receiving continuing care have had a right to a personal health budget since October 2014. The Department has set an ambition that between 50,000 and 100,000 people will have a personal health budget by 2020.¹ Nine local areas are trialling personal budgets that integrate health and social care funding through the Integrated Personal Commissioning Programme. The programme is aimed at individuals with high levels of both health and social care needs, to address acknowledged problems in current care provision.²

1 Department of Health, *The government's mandate to NHS England for 2016-17*, January 2016, available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/494485/NHSE_mandate_16-17_22_Jan.pdf

2 NHS England, *Integrated Personal Commissioning prospectus*, September 2014, available at: www.england.nhs.uk/wp-content/uploads/2014/09/ipc-prospectus-updated.pdf

1.7 The Department funds sector and research bodies to support local authorities in implementing personalised commissioning. For example:

- the Quality and Outcomes of Person-Centred Care Policy Research Unit supports policy development on how to achieve health and social care outcomes;
- the Think Local Act Personal partnership was established in 2011. More than 50 organisations belong to the partnership, including the Department, the Local Government Association, the Association of Directors of Adult Social Services, provider representatives and others. The partnership has published a *Personal budgets minimum process framework*, which provides case studies to show how authorities can manage Care Act processes efficiently;³
- the Care and Health Improvement Programme, established in 2012, provides national and regional support to authorities, including to develop person-centred care, market shaping and commissioning. The programme is delivered in partnership by the Local Government Association, the Department, the Association of Directors of Adult Social Services and others; and
- the National Institute for Health and Care Excellence has published four sets of adult social care quality guidelines, including one on delivering person-centred homecare for older people.⁴

User choice of services

1.8 Users can tailor their care either by adjusting the way services are delivered or by changing the type of service, for example by:

- accessing a broader range of options within the community, for example joining a gym or taking part in social activities run by voluntary organisations;
- using providers that understand and respond to their needs, for example cultural and religious needs; or
- using direct payments for a personal assistant to look after them in their own homes, giving them more control over their care.

3 Available from the Think Local Act Personal website: www.thinklocalactpersonal.org.uk/Personal-Budgets-Minimum-Process-Framework/

4 National Institute for Health and Care Excellence, *Home care: delivering personal care and practical support to older people living in their own homes*, September 2015, available at: www.nice.org.uk/guidance/ng21

1.9 Users’ opportunities to tailor services will depend on the type of support they need and what is available in their local area. We asked case study authorities to tell us how they support a sample of people in the community. Four authorities provided information about 1,500 people in total (**Figure 3**). We found little diversity in the service options for older people: 84% received authority-commissioned homecare services and only 7% had a direct payment. The opportunity for most older people to personalise their services will therefore depend on whether and how the authority has allowed for this in its contracts with homecare agencies. A 2014 survey of users also found that older adults most commonly buy homecare services, while younger adults with physical disabilities most commonly hire personal assistants (**Figure 4** overleaf).⁵ Community and leisure services, for example gym membership, are purchased most by younger adults with learning disabilities.

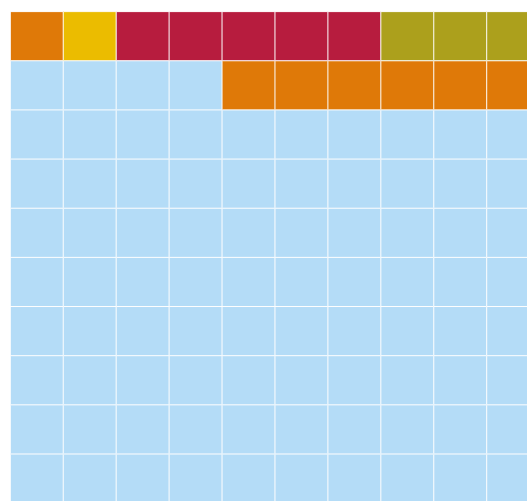
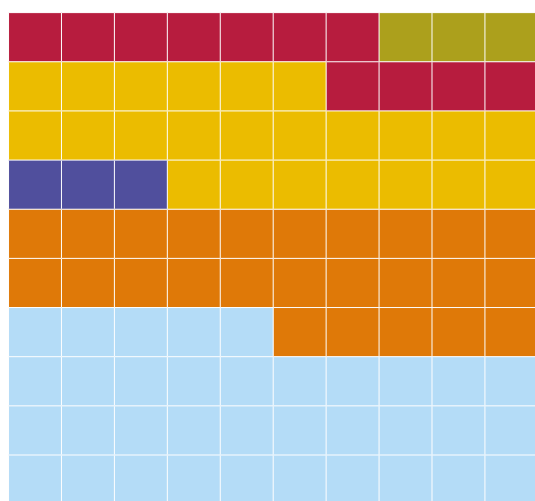
Figure 3

Support provided to a sample of long-term community care users, October 2014 to March 2015

Homecare is the most common form of support for people aged 65 and over. The range of services for people aged 18 to 64 is wider.

Aged 18 to 64

Aged 65 and over



■ Homecare ■ Direct payment ■ Part direct payment ■ Supported accommodation ■ Day service ■ Other combinations

	Homecare	Direct payment	Part direct payment	Supported accommodation	Day service	Other combinations
Aged 18 to 64 (%)	35	25	3	23	11	3
Aged 65 and over (%)	84	6	1	1	5	3

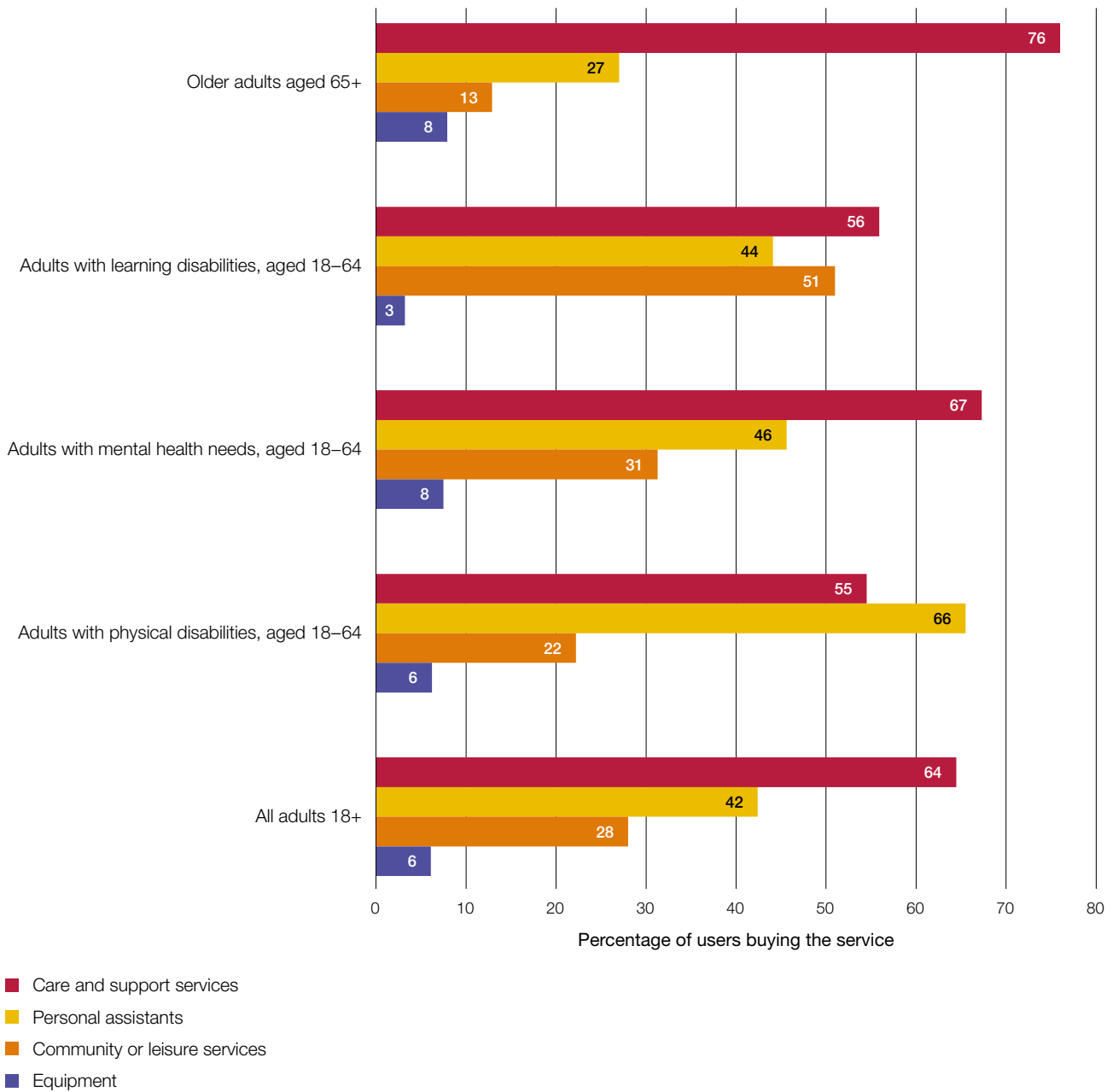
Notes

- 1 Each square represents 1% of adults in the age group.
- 2 Four authorities provided data for adults assessed between 1 October 2014 and 31 March 2015.
- 3 The chart presents data for 561 people aged 18 to 64 and 983 people aged 65 and over.

Source: National Audit Office survey of case study authorities

Figure 4
Survey evidence on how personal budgets are spent, by user group

User groups differ in what they buy with their personal budgets



Source: In Control analysis of the 2014 Personal Outcomes Evaluation Tool survey: adults who had a social care personal budget. Data from 1,474 respondents: 567 aged 65+; 435 aged 18–64 with learning disabilities; 147 aged 18–64 with mental health needs; 325 aged 18–64 with physical disabilities

Defining users' outcomes in adult social care

1.10 In social care, outcomes are difficult to define and measure. Most care aims to manage long-term conditions, or reduce or delay the development of further need for support. The Department measures users' experiences and outcomes using its Adult Social Care Outcomes Framework. This includes measures of service processes, outputs, user satisfaction and outcomes (**Figure 5** on pages 20 and 21). Indicators directly relating to personalised commissioning measure processes, not outcomes. The outcome measures are influenced by other factors in addition to personalisation.

Evidence from pilots

1.11 The Department of Health and the Office for Disability Issues supported two pilot schemes to increase user choice and control over social care budgets (**Figure 6** on page 22). Adults taking part in the pilot of individual budgets, precursors to personal budgets, reported more control over their daily lives compared with those receiving conventional services.⁶ Satisfaction was highest among users with mental health needs and physically disabled users, and lowest among older people. Little difference was found between the costs of individual budgets and the costs of conventional services. The Right to Control Trailblazers found no evidence of significant positive impacts on users. Both concluded that the way local areas implement personal budgets influences user outcomes.

1.12 Between 2009 and 2012, the Department piloted personal health budgets for adults with long-term health conditions. The pilot took place at 20 sites and involved around 2,000 patients. Patients reported significant improvements in their quality of life and wellbeing. This was associated with good information about the budget amount, greater choice of services and flexibility over how the budget was managed. However, personal health budgets did not have an impact on health status over a 12-month follow-up period. Overall, the pilot concluded that personal health budgets were cost-effective and supported a wider roll-out.

1.13 Findings from the 2007 individual budgets pilot do not necessarily apply in the current financial environment. Local authorities told us that financial pressures mean that personal budgets can now be less generous than those introduced before austerity, so users may not achieve the same benefits. The need profile of users is different: in recent years, authorities have concentrated their resources on users with the highest needs.⁷

1.14 Between January 2014 and September 2015, the Department piloted direct payments for authority-funded care home residents. Interim evaluation indicates that the 20 authorities that started the pilot found it difficult to recruit suitable participants. By 31 July 2015, only 70 users from 11 authorities had accepted a direct payment, while only 30 users from 8 authorities had a payment in place.⁸

6 Individual Budgets Evaluation Network, *The national evaluation of the Individual Budgets pilot programme*, October 2008, available at: www.york.ac.uk/inst/spru/pubs/rworks/lbsenMAINsummary.pdf

7 Comptroller and Auditor General, *Adult social care in England: overview*, session 2013-14, HC 1102, March 2014, available at: www.nao.org.uk/report/adult-social-care-england-overview-2/

8 R Wittenberg et al, *Evaluation of direct payments in residential care trailblazers, second interim report*, Policy Innovation Research Unit, November 2015.

Figure 5

Measures of user experience and outcomes: Department of Health's Adult Social Care Outcomes Framework

Type of indicator	Indicator	Relevance to personalised commissioning	If personalised commissioning is becoming more effective, we would expect the change in this measure to be an...	2014-15 figure
Process	Proportion of users who find it easy to find information about services	High	Increase	74%
	Proportion of community care users with personal budgets	High	Increase However, in practice the indicator reflects local authority records relating to their budget allocation process, so high values may not demonstrate truly personalised care planning (paragraph 2.6)	84%
	Proportion of community care users with direct payments	High	Increase However, we heard about practices to promote direct payments which work against personalised care, so high values may not demonstrate truly personalised care (paragraph 1.22)	26%
Output	Proportion of new service users who received a short-term service where the sequel to service was either no ongoing support or support of a lower level	Moderate, and other factors will affect this indicator	Increase	75%
	Proportion of older people (aged 65 and over) who received reablement/rehabilitation services after discharge from hospital	Moderate, and other factors will affect this indicator	Increase	3%
Experiences and satisfaction	Proportion of service users who have control over their daily life	High, but other factors will affect this indicator	Increase	77%
	Proportion of service users satisfied with their care and support	High, but other factors will affect this indicator	Increase	65%
	Proportion of people who use services who feel safe	High, but other factors will affect this indicator	Increase	69%

Figure 5 *continued*

Measures of user experience and outcomes: Department of Health's Adult Social Care Outcomes Framework

Type of indicator	Indicator	Relevance to personalised commissioning	If personalised commissioning is becoming more effective, we would expect the change in this measure to be an...	2014-15 figure
Outcomes	Social care-related quality of life			19.1 out of 24
	Proportion of people who have as much social contact as they would like			45%
	Proportion of adults with a learning disability in paid employment			6%
	Proportion of adults in contact with secondary mental health services in paid employment	High, but other factors will affect these indicators	Increase	7%
	Proportion of adults with a learning disability who live in their own home or with their family			73%
	Proportion of adults in contact with secondary mental health services who live independently, with or without support			60%
	Long-term support needs met by admission to residential and nursing care homes, per 100,000 population			Younger adults: 14 Older adults: 669
	Proportion of older people who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Moderate, and other factors will affect these indicators	Decrease	82%
	Delayed transfers of care from hospital, and those which are attributable to adult social care, per 100,000 population			Total: 11 Attributable to social care: 4

Note

- 1 The 'indicator' column is based on the Adult Social Care Outcomes Framework; the '2014-15 figure' column is from the Health and Social Care Information Centre's publication on the Framework. The remaining columns are our assessment.

Source: Health and Social Care Information Centre's publications on the 2014-15 Framework, available at: www.hscic.gov.uk/pubs/adusoccareof1415fin

Figure 6

Pilot schemes to increase user choice and control over care budgets

Department of Health: individual budgets (precursors to personal budgets), 2007

Aimed to involve users in assessment and care planning, to inform them about the resources available, and to give them more choice and control through direct payments and authority-managed budgets.

Six months after their assessment, younger users overall reported better quality of life, higher quality of care and more satisfaction with the care they received, and greater control over their lives.

Older users were less likely than younger users to report improvements.

Office for Disability Issues: Right to Control Trailblazers, 2010 to 2012

Disabled adults had identified lack of choice and control as a barrier to their participating and contributing as equal citizens. The Trailblazers gave disabled adults, more than half aged 65+, the right to plan how they received services, based on the amount of money available and the outcomes they wanted to achieve.

Evaluators found no significant evidence of a positive impact on users', or sub-groups of users', experiences of support, day-to-day lives or employment outcomes. The evaluators concluded that provider markets were not sufficiently developed to offer meaningful choice, and there was not a sufficient cultural change among staff, users and providers to enable them to implement the scheme as intended within the timeframe of the pilot.

Sources: Individual Budgets Evaluation Network (IBSEN), *Evaluation of the Individual Budgets Pilot Programme: Summary Report*, October 2008, available at: www.york.ac.uk/inst/spru/pubs/pdf/IBSEN.pdf; Office for Disability Issues, *Evaluation of the Right to Control Trailblazers: Synthesis report*, July 2013, available at: <http://webarchive.nationalarchives.gov.uk/20130812104657/http://odi.dwp.gov.uk/docs/wor/rtc/rtc-synthesis-report.pdf>

Current sources of evidence

1.15 The main source of current data on users' experiences and outcomes is the annual Adult Social Care Survey, which informs the Adult Social Care Outcomes Framework. All local authorities with adult social care responsibilities must participate in the survey.⁹ The Health and Social Care Information Centre gives guidance to authorities so that they can administer the survey. Around 69,000 users completed the survey in 2014-15; 15 authorities did not achieve the minimum sample size. Users with direct payments reported higher levels of satisfaction with their care and support than users overall (**Figure 7**).

1.16 In response to our suggestion to improve the usefulness of published data from the Adult Social Care Survey, from December 2015 the Health and Social Care Information Centre started publishing a fuller range of data. This made it possible, for the first time, to compare the outcomes of users who receive authority-managed personal budgets, those who receive direct payments and those who receive neither.

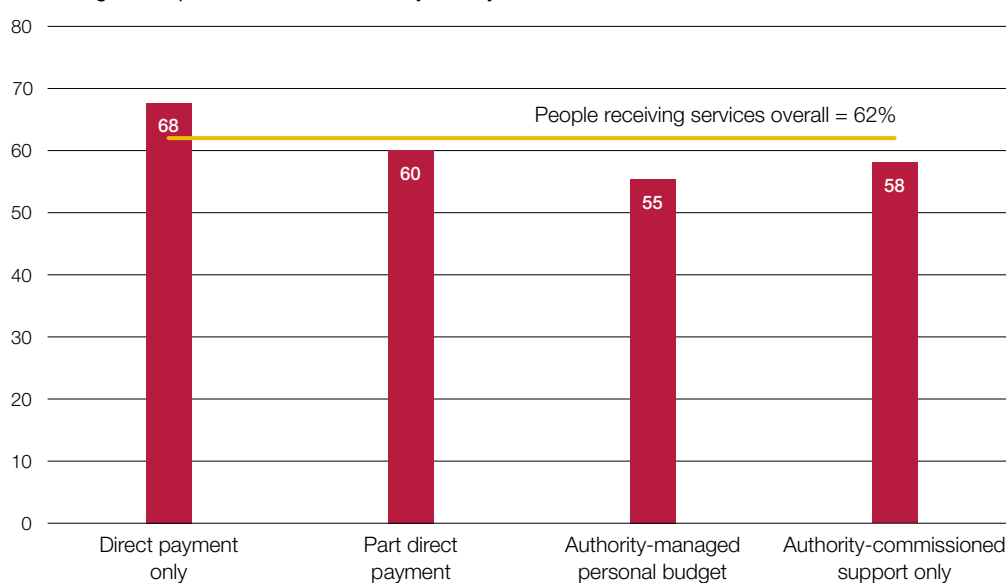
9 The survey is not mandatory for City of London and Isles of Scilly.

Figure 7

Users' views on the care and support they receive, by type of service delivery, 2014-15

Users with direct payments are more likely to be positive compared with all service users

Percentage of respondents either extremely or very satisfied

**Notes**

- 1 Number of respondents: Direct payment only: 7,200. Part direct payment: 3,045. Authority-managed personal budget: 18,670. Authority-commissioned support only: 6,705.
- 2 Responses have been weighted to make them representative of the population they are taken from.

Source: Adult Social Care User Survey, run by the Health and Social Care Information Centre on behalf of the Department of Health

1.17 National data on how users spend their personal budgets are limited. Users in some local authorities voluntarily participate in an annual survey run by the charity In Control using the Personal Outcomes Evaluation Tool (POET). The survey includes questions about the nature of the user's budget, their experiences of using it, and how it affects their day-to-day and longer-term outcomes. However, only 24 authorities participated in the survey in 2014, and just 1 authority has participated consistently over the 3 years the survey has run. Users with direct payments are over-represented, and the survey excludes users without personal budgets. Nevertheless, the survey provides the most detailed information about respondents' experiences of authorities' personalised commissioning processes.

Findings from surveys

1.18 Most users responding to both surveys are satisfied with the services they receive and report that their outcomes have improved. The 2014-15 Adult Social Care Survey found that 77% of users felt they have control over their daily life. Users with a direct payment or an authority-managed personal budget are more likely than those without to report that care services have helped them achieve the activities of daily living (**Figure 8**).

1.19 Both surveys found that three-quarters of users did not have difficulty finding information about services. Respondents to In Control's survey with individual service funds and with broker-managed direct payments found it more difficult to get information, advice and support, whereas respondents with authority-managed personal budgets found it easiest (**Figure 9** on page 26). About three-quarters of respondents said they did not find it difficult to understand what they could and could not spend their personal budget on.

1.20 Other smaller surveys of users have reported more negative findings than those from the major surveys, although they do not have robust sampling methods and may be biased towards dissatisfied users. A survey of 160 adults in one authority, carried out by the authority's local Healthwatch between September and December 2014, found that 21% of respondents had waited more than 9 months for a decision about their personal budget.¹⁰ Between October 2014 and February 2015, the charity Scope surveyed 515 younger adults with disabilities who received local authority care, recruited through social media.¹¹ Around 55% of respondents said they did not have enough hours in their support package.

1.21 Users with personal budgets should be able to vary the services they receive in line with their needs. Scope's survey found that only one-third of respondents with varying needs said the hours of support they received changed according to those variations. Some local Healthwatch organisations have found, and we heard from users, that some authorities were not putting in place adequate support for users with direct payments. Front-line workers in some authorities said they were struggling and felt unable to support and review users adequately, which could lead to difficulties for users whose circumstances were changing. For example, we heard that some users with personal assistants did not find effective cover for assistants' sickness, holiday and maternity leave. Citizens Advice shared with us queries from its clients, showing that lack of support can lead to poor outcomes for users with direct payments. For example, users who do not understand their obligations as employers can get into debt if they do not factor tax obligations into their budgeting. The Care Act requires local authorities to give users who choose to employ a personal assistant clear advice on their responsibilities. In addition, we heard from providers that the process for the local authority to approve even small variations was overly bureaucratic.

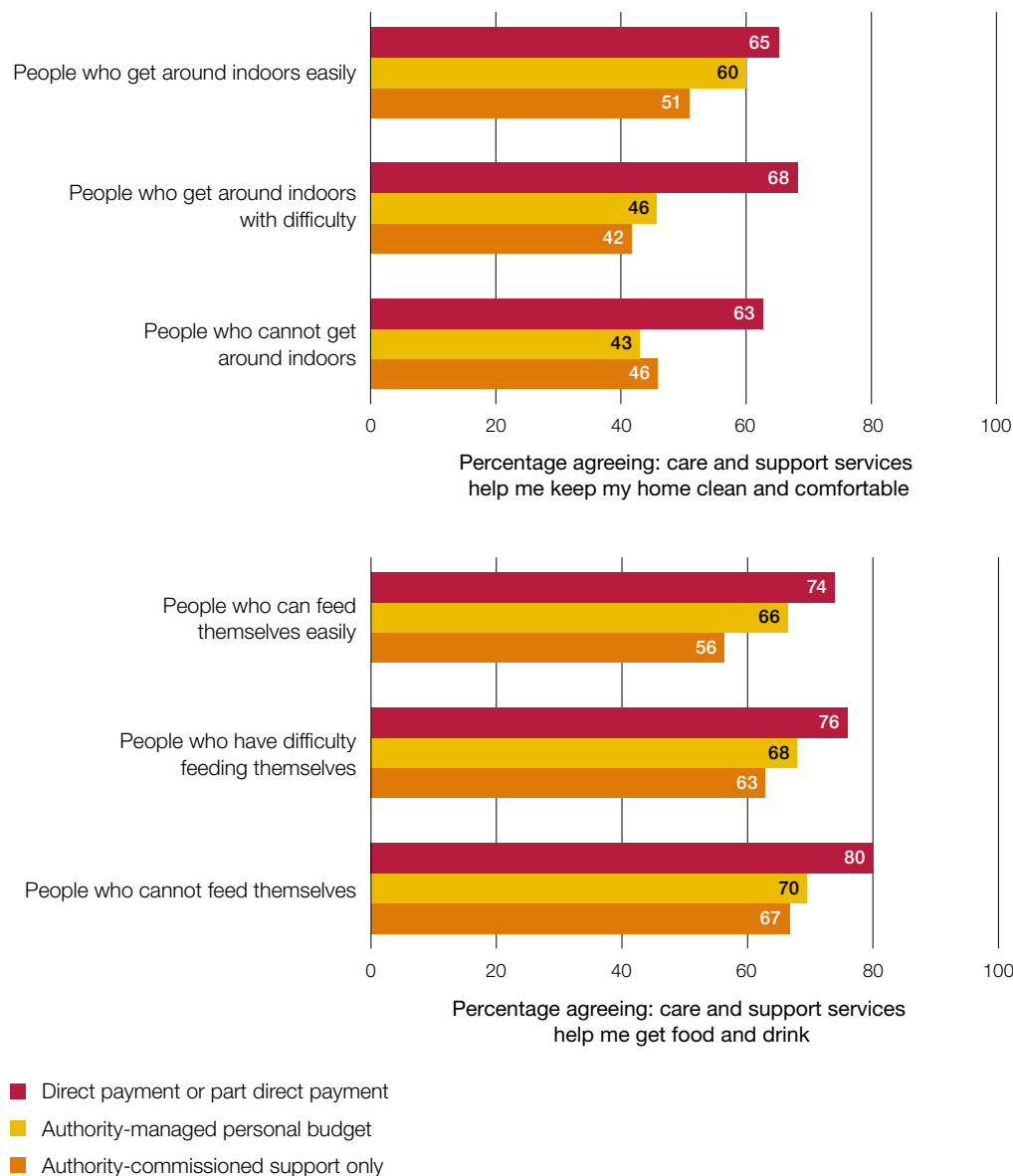
¹⁰ Local Healthwatch organisations gather and reflect the public's views on health and social care services in England.

¹¹ Scope, *Disabled people's experiences of social care: findings from the Better Care Project*, 2015, available at: www.scope.org.uk/Scope/media/Documents/Publication%20Directory/Disabled-people-s-experiences-of-social-care.pdf

Figure 8

Users' views on how their needs are met, by type of service delivery and by degree of difficulty with daily activities, 2014-15

Users with direct payments and local authority-managed personal budgets report better support with activities of daily living



Notes

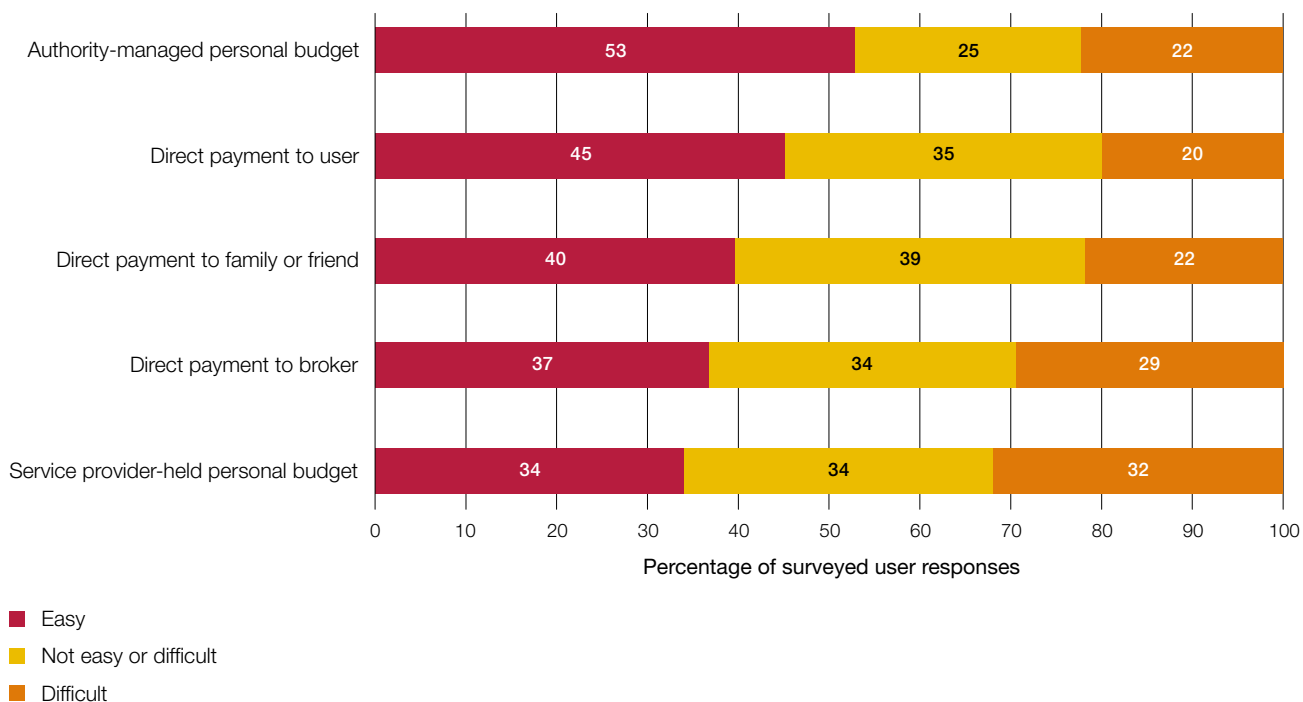
- 1 Results calculated from number of survey responses and have not been weighted to make them representative of people receiving support, because the Health and Social Care Information Centre's weights are not publicly available.
- 2 Analysis of people receiving community services only.
- 3 Differences between groups are statistically significant (chi-squared tests; $p < 0.05$).

Source: National Audit Office analysis of the Adult Social Care User Survey, run by the Health and Social Care Information Centre on behalf of the Department of Health; data available at: www.hscic.gov.uk/catalogue/PUB18642

Figure 9

Users' views on the ease of access to information, advice and support, by personal budget type, 2014

Respondents with authority-managed personal budgets found it easiest to get information, advice and support

**Note**

- 1 There is a statistically significant difference between the groups (chi-squared test: $p < 0.05$).
- 2 Percentages may not sum to 100% due to rounding.

Source: In Control analysis of the 2014 Personal Outcomes Evaluation Tool survey

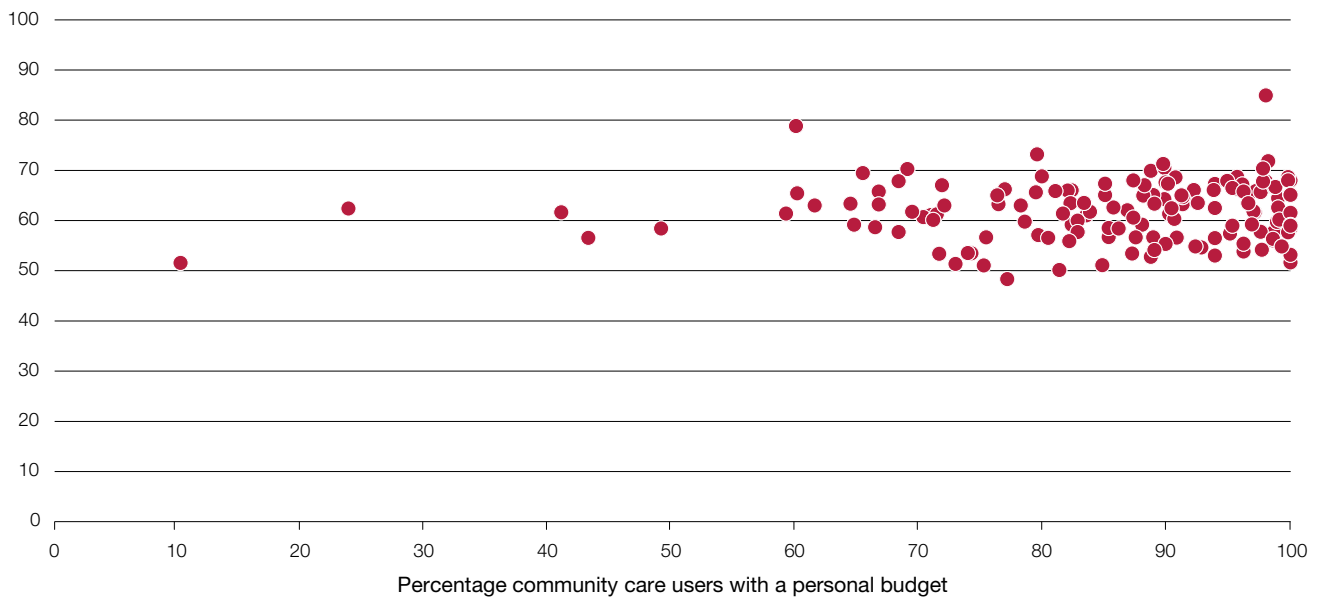
1.22 Data at the local authority level show no association between higher rates of uptake of personal budgets and direct payments and better care outcomes (**Figure 10**). The Department has not investigated why aggregated authority-level data suggest no improvement in outcomes through personalised commissioning, whereas user-level data do. From our visits to authorities, we found that factors that influence users in their choice of personal budgets are varied and can pull in opposite directions. For example, in areas where authority-commissioned care is considered poor quality, or where the choice of authority-commissioned providers is very limited, users may feel pushed to take a direct payment, leading to relatively high rates of take-up. Conversely, authorities that value good-quality, well-commissioned care can promote the benefits of personal budgets and supporting users. This also leads to high rates of direct payments.

Figure 10

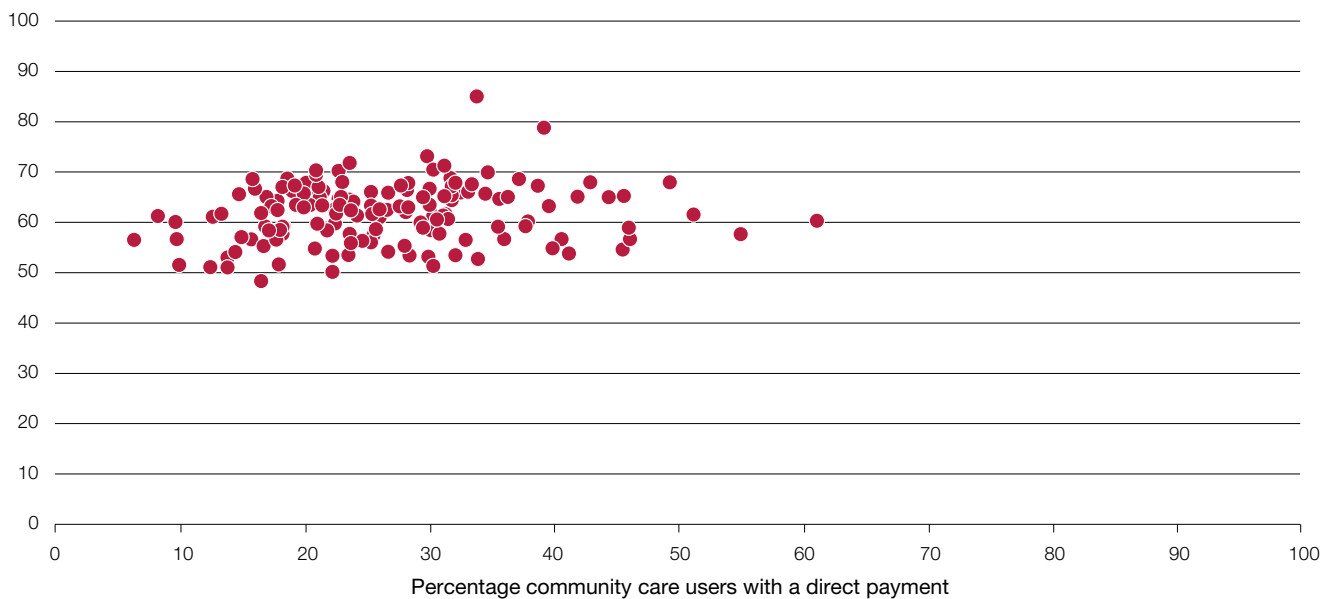
Relationship between take-up of personal budgets and direct payments and satisfaction rates, by local authority, 2014-15

There is no association between rates of take-up of personal budgets or direct payments and community care users' satisfaction

Percentage of community care users very or extremely satisfied with care



Percentage of community care users very or extremely satisfied with care



Note

1 Correlation coefficient for relationship between personal budget take-up and satisfaction: 0.22; coefficient for relationship between direct payment take-up and satisfaction: 0.15.

Source: National Audit Office analysis of the Health and Social Care Information Centre's publication of Adult Social Care Outcomes Framework indicators, available at: www.hscic.gov.uk/pubs/adusoccareof1415fin, and unweighted data from the Adult Social Care Survey, available to download at: www.hscic.gov.uk/catalogue/PUB18642. Data from the Adult Social Care Survey are calculated from number of survey responses and have not been weighted to make them representative of people receiving support, because the Health and Social Care Information Centre's weights are not publicly available

Safeguarding

1.23 Local authorities we spoke with had initially been concerned that personalised commissioning, particularly the use of direct payments to hire unregulated personal assistants, could cause more abuse and neglect of users. None of the authorities we spoke with had experienced an increase in reports of abuse and neglect that they related to personalised commissioning. Some authority safeguarding leads we spoke with expressed concern over relying on users to understand and report safeguarding issues.

Part Two

Local progress with personalised commissioning

2.1 This part covers local authorities' progress in implementing personalised commissioning and the implications for public spending.

2.2 Between 2008 and 2011, the Department of Health (the Department) distributed £520 million in Social Care Reform Grant to local authorities to support the transformation of adult social care, including personalised commissioning. The Department set a target to have all users on personal budgets by April 2013. It later reduced this to 70% of users because the data collection at the time included in its scope some users for whom personal budgets were not appropriate. Around 55% of authorities met the 70% target. Since April 2015, the Care Act has required authorities to give all eligible users a personal budget.

Take-up of personal budgets

2.3 In 2014-15, around 500,000 users and 100,000 carers accessed long-term community care with personal budgets, including direct payments (**Figure 11** overleaf). The proportion of users with a personal budget varied between 10% and 100% across authorities, with a median proportion of 88%. Of younger adults with a primary support reason relating to physical disability, 90% had a personal budget, as did 87% of younger adults with a primary support reason relating to learning disability and 83% of older adults.^{12,13} However, only 43% of younger adults with a primary support reason relating to mental health had a personal budget. Spending on long-term community care managed by local authorities was £6.3 billion in 2014-15.¹⁴ Local authorities spent £1.37 billion on direct payments for users and £42 million on direct payments for carers in 2014-15.¹⁵

¹² Prior to 2014-15, authorities recorded users' 'primary client group', which described users' main health condition. After the zero-based review of social care collections, recording practices changed and 'primary support reason' replaced primary client group. Primary support reason is determined through the care assessment and describes the main support required by the user.

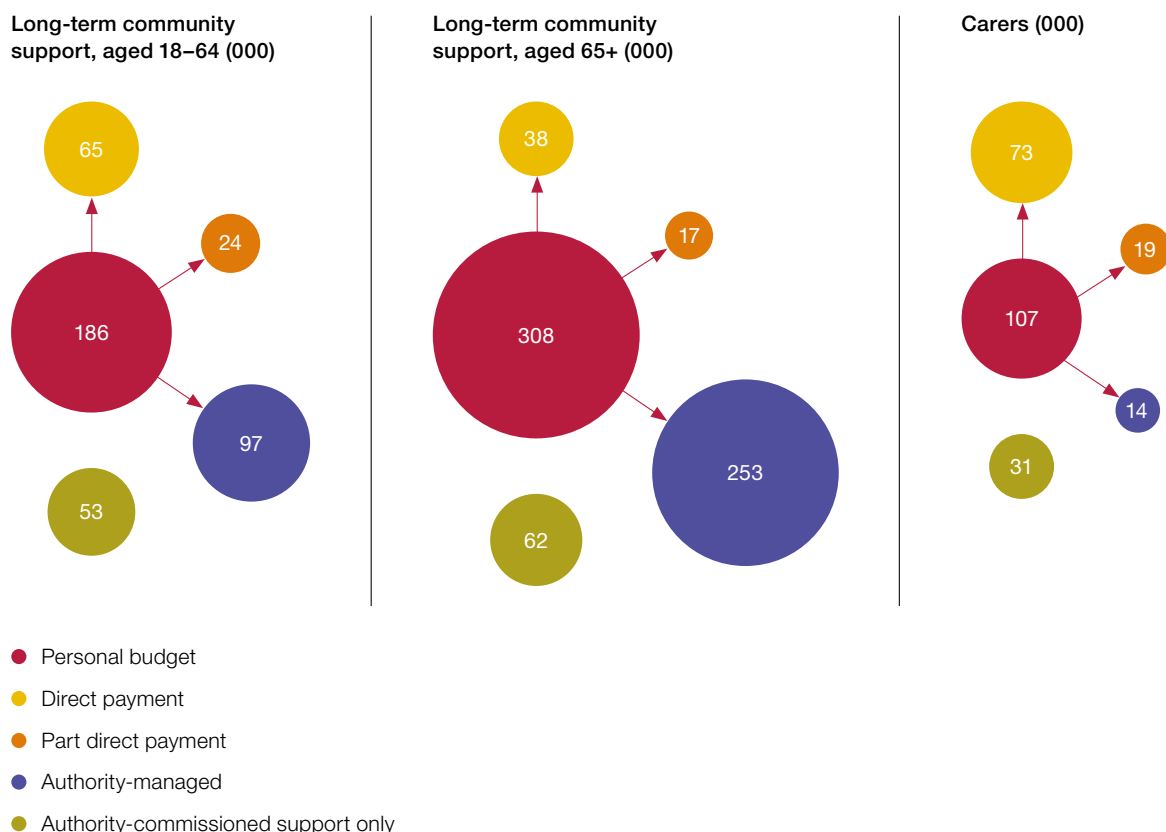
¹³ This 'physical disability' group is made up of users with the following primary support reasons; 'physical support', 'sensory support' and 'support with memory and cognition'. See also Note 3 to Figure 14.

¹⁴ Gross total expenditure on long-term community care; includes £198 million client contributions.

¹⁵ Gross total expenditure on long-term community care; includes £53 million and £1 million of client contributions, respectively.

Figure 11

Numbers of users and carers receiving long-term community support with personal budgets, 2014-15

**Note**

1 Numbers of people aged 18 and over receiving long-term support and number of carers supported in year, rounded to the nearest thousand.

Source: National Audit Office presentation of long-term support in the community SALT Table LTS 001a. Carers SALT Table LTS 003a. Health and Social Care Information Centre

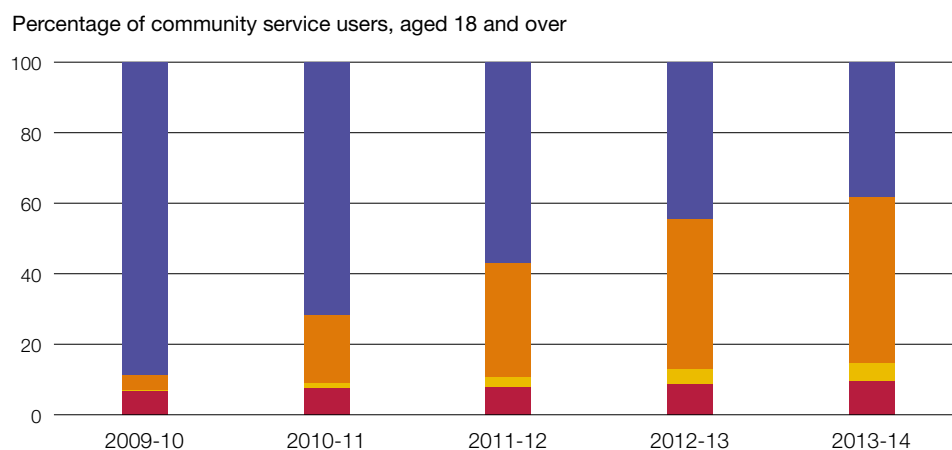
2.4 Between 2009-10 and 2013-14, the proportion of users with a personal budget reportedly increased from 12% to 62% (**Figure 12**). The proportionate increase is partly a result of the total number of people receiving adult care services decreasing. Over the same period, the number of people with a personal budget increased from 169,000 to 647,000. Authority-arranged personal budgets account for almost all of the increase. Before the Care Act made personal budgets mandatory for all eligible users from April 2015, authorities prioritised implementing personal budgets to different degrees.

2.5 Growth in take-up of personal budgets has been slowest for younger adults with mental health needs, who may have difficulty managing their own affairs (**Figure 13** on pages 32 and 33). Local government and the NHS share responsibility for providing mental health services. The NHS is in the early stages of setting up personalised commissioning.

Figure 12

Proportions of community service users with personal budgets, 2009-10 to 2013-14

The proportion of adults supported in the community with a personal budget doubled between 2010-11 and 2013-14



■ Direct payment	7	8	8	9	10
■ Part direct payment	0	2	3	4	5
■ Authority-managed personal budget	4	19	32	43	47
■ Authority-commissioned support only	88	72	57	44	38

Note

1 Number of personal budgets in year (RAP SD1). Number of community service users in year (RAP P1).

2 Table percentages may not sum to 100% due to rounding.

Source: National Audit Office analysis of Health and Social Care Information Centre data

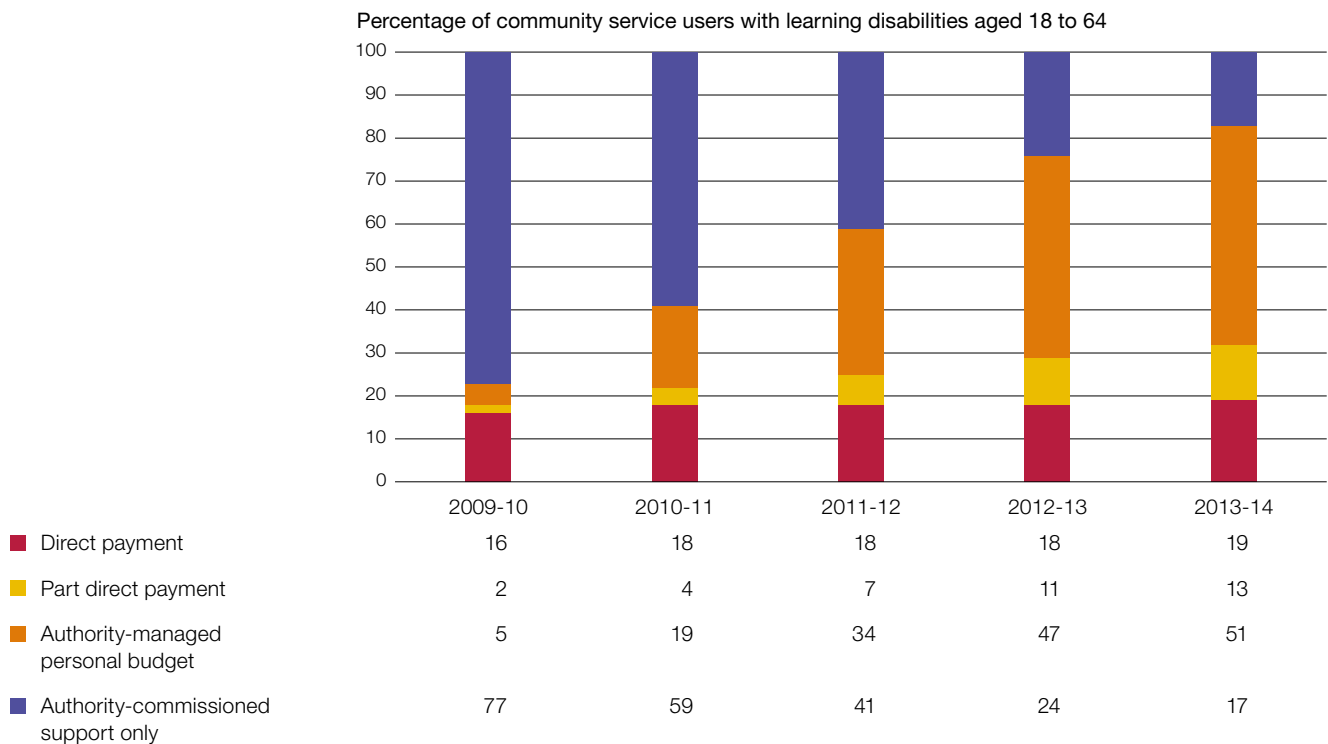
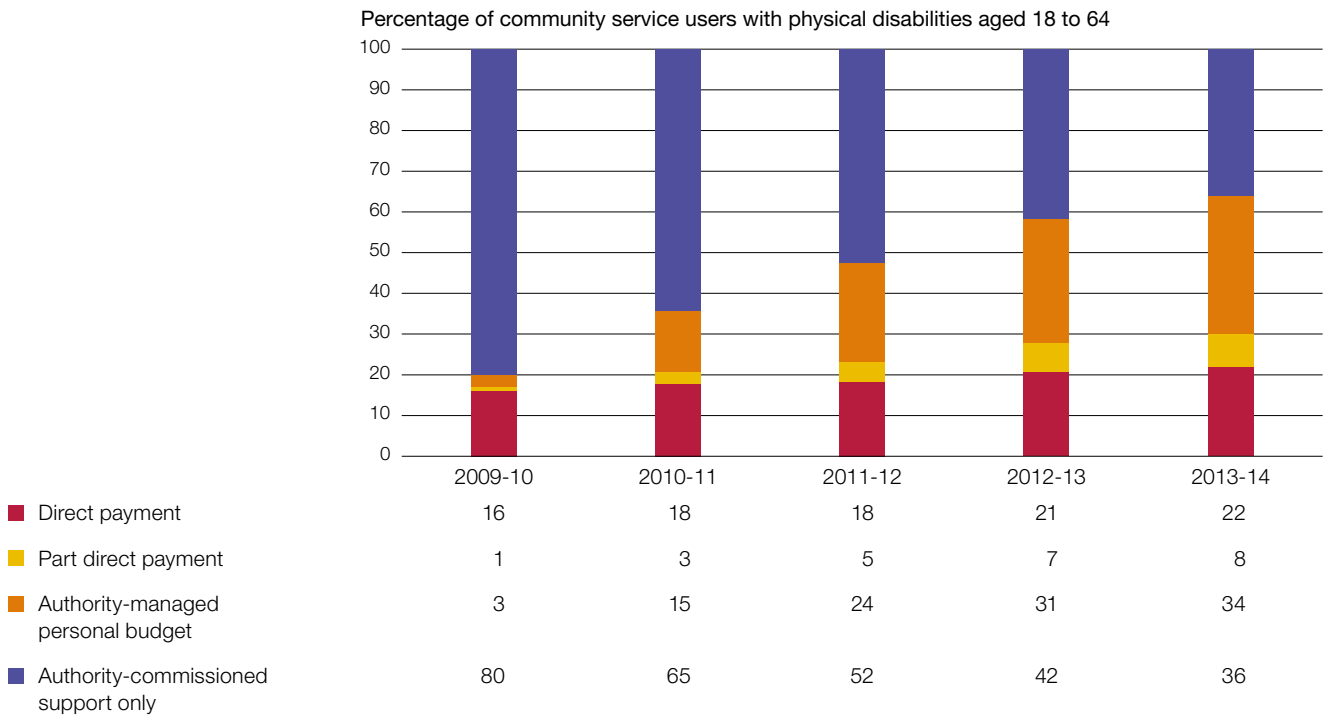
2.6 We encountered inconsistency in how local authority staff described personalised commissioning, for example by using the term ‘personal budget’ to refer specifically to direct payments. Some staff we spoke with did not distinguish between services for people receiving authority-arranged services through a personal budget and services not through a personal budget. This lack of front-line distinction implies the move to a personal budget can be administrative and not reflect genuine personalisation. The Think Local Act Personal partnership told us that in many authorities a personal budget has become an end in itself, rather than an enabler of personalisation.

2.7 Before 2014-15, some authorities included users who received one-off or short-term support in their reported totals of users with personal budgets, whereas other authorities did not. In 2010-11, the Department commissioned a zero-based review of adult social care data because it realised that the data being collected did not match social care practice. Following consultation with the social care sector, the Department and the Health and Social Care Information Centre introduced new data collections in 2014-15, which improved the consistency and comparability of data collected across authorities. Authorities we spoke with welcomed the improved framework for collecting data. However, comparing 2014-15 with previous years is not possible.

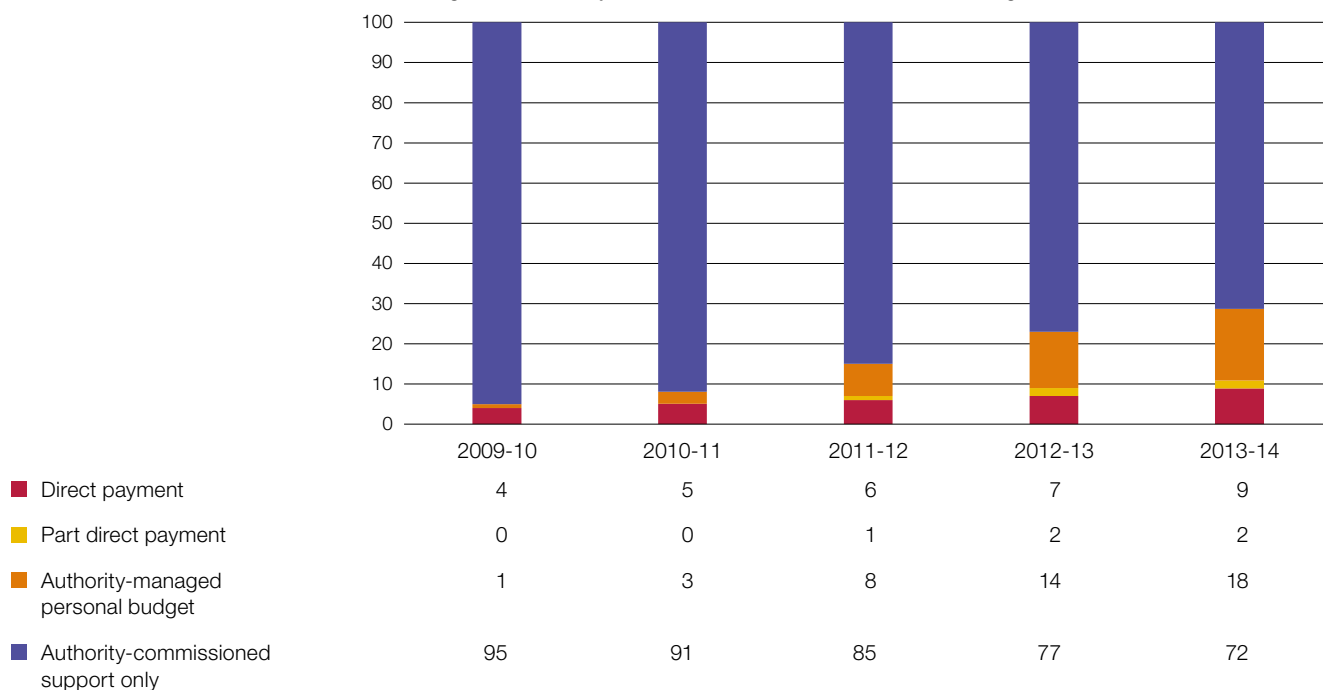
Figure 13

Proportions of community service users with personal budgets, 2009-10 to 2013-14, by user group

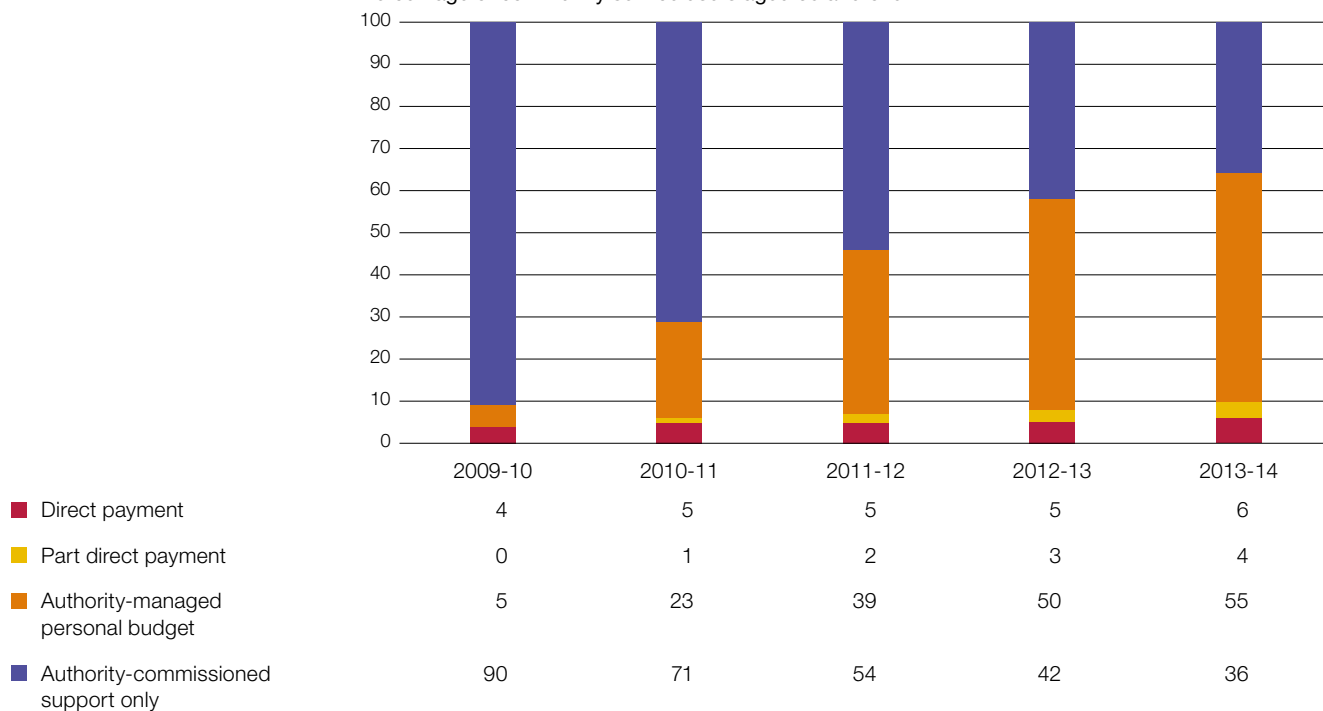
There are considerable differences between rates of take-up of personal budgets and direct payments for different user groups



Percentage of community service users with mental health needs aged 18 to 64



Percentage of community service users aged 65 and over



Note

1 Number of personal budgets in year (RAP SD1). Number of community service users in year (RAP P1).

2 Table percentages may not sum to 100% due to rounding.

Source: National Audit Office analysis of Health and Social Care Information Centre data

Take-up of direct payments

2.8 In 2014-15, the median proportion of users with a direct payment was 22%, ranging from 12% to 40% across nine-tenths of local authorities. Historically, rates of take-up of personal budgets and direct payments differed considerably between different user groups. In 2014-15, younger adults with a primary support reason relating to physical disability were twice as likely to have a direct payment as users overall, whereas older people were about 40% less likely to have a direct payment. Within these groups, proportions of users with direct payments varied widely, for example for younger adults with a primary support reason relating to learning disability the range was 17% to 66% (**Figure 14**).¹⁶

2.9 Variation in take-up of direct payments relates to the circumstances and views of users, their carers and front-line care workers:

- Users who are frail or lack mental capacity, particularly older adults, have less desire to move away from conventional, authority-commissioned services.
- Younger adults with physical disabilities are more likely to be able to manage their own affairs, to want to undertake activities with their peers and to be active members of their communities. They greatly value choice and control over the services they receive, and were the first to adopt and champion direct payments: consequently, take-up has been highest for this group.
- Younger adults with learning disabilities are often supported by their families, who are willing to take on the responsibilities of direct payments and value the benefits they bring.
- We visited authorities that stressed the importance of organisational culture change to realising the benefits of personalised commissioning. They had put much effort into helping staff to understand the benefits that personalised commissioning can bring to all users.

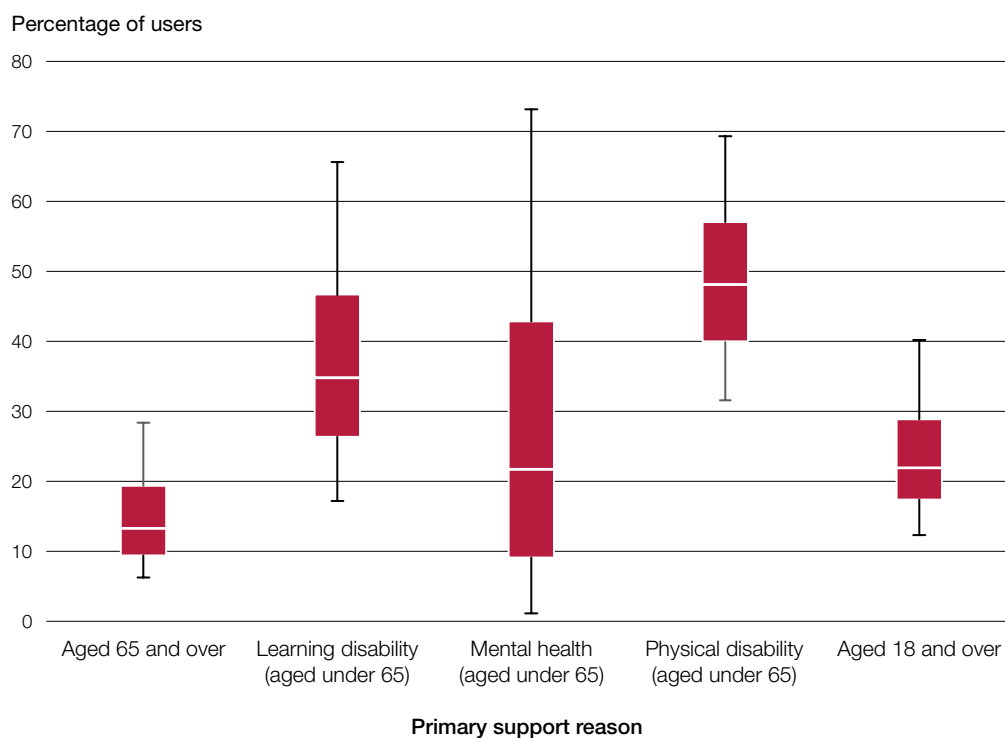
2.10 Historically, rates of take-up of direct payments have varied considerably between authorities. We compared authorities' use of direct payments over 3 financial years (2011-12 to 2013-14) against information about local populations, user outcomes, service delivery, costs and spending. These features did not explain the big differences in take-up we observed. This suggests that the differences reflect local factors not captured by available data. For example, one authority's director of adult social services told us he had looked into why users in some other authorities were more willing to take on direct payments. He had concluded that in some authorities users were dissatisfied with the quality of authority-commissioned services, and were choosing direct payments because they felt they could commission better services themselves.

¹⁶ Excludes the top 5% and bottom 5% of local authorities.

Figure 14

Proportions of community service users with direct payments, 2014-15

The median proportion of adults with a direct payment is 22%, ranging from 13% for older people to 48% for younger people with a primary support reason relating to physical disability.



	Aged 65 and over	Learning disability (aged under 65)	Mental health (aged under 65)	Physical disability (aged under 65)	Aged 18 and over
5th percentile	6	17	1	32	12
25th percentile	9	26	9	40	17
Median	13	35	22	48	22
75th percentile	19	47	43	57	29
95th percentile	28	66	73	69	40

■ Middle 50% of councils

Notes

- 1 Number of direct payments and community services users in year (SALT LTS001a).
- 2 The lower and upper bars show the 5th percentile and 95th percentile respectively.
- 3 The user groups shown in the chart reflect a breakdown created by the National Audit Office, using primary support reasons in the original data. For users aged 18-64, our 'learning disability' and 'mental health' user groups consist of the numbers of people with a primary support reason of 'learning disability support' and 'mental health support' respectively. Our 'physical disability' user group consists of people with the following primary support reasons: 'physical support', 'sensory support' and 'support with memory and cognition'. Our 'aged 65 and over' group consists of people in that age group with any primary support reason.

Source: National Audit Office analysis of Health and Social Care Information Centre data

Resource allocation

2.11 At the start of the care planning process, local authorities give users an indicative budget within which to plan their care. The final personal budget is the actual cost of the agreed care plan and may be higher or lower than the indicative budget. Authorities typically identify an indicative budget through a resource allocation system. This uses data on user characteristics and spending to predict new users' budgets. The Care Act guidance lays out three principles for resource allocation: timeliness, transparency and sufficiency. The guidance states that resource allocation models may not work for all client groups and that authorities should consider alternatives when appropriate.

2.12 Most authorities we spoke with were struggling to develop resource allocation systems. Care planning staff found the indicative budgets generated by their resource allocations systems useful in only 2 of the authorities we visited. In these authorities, managers checked whether indicative budgets were reasonable, giving particular attention to users with complex needs. However, in most authorities, staff generally ignored the indicative budget when planning care packages. One authority had dispensed with a resource allocation system.

Financial management and accountability

2.13 Where a user receives authority-commissioned care through a personal budget, the authority retains control of all finances. Direct payments are spent by the user, by their carer or appointee, or by a broker. Most direct payments are paid into dedicated bank accounts, and the user must give bank statements and receipts to the authority regularly. Authorities told us they have to chase users for this information. Authorities that use payment cards or similar systems with oversight, such as PayPal accounts, have ready access to financial information. This removes the need for users to submit information. Such systems cost money and authorities need to review potential costs and benefits in line with the Care Act guidance on direct payments.

2.14 Some local authorities we visited were concerned that innovative ways to spend personal budgets might not work as planned, leading to authorities spending more to ensure that users' needs are met. Under the Care Act, direct payments should be used flexibly and innovatively to meet users' eligible care and support needs, with no unreasonable restriction placed on their use. Authorities recognised the potential benefits from innovative spending but were concerned that if, contrary to expectations at planning stage, users' needs were not met the authority would need to fund additional care in the event of a crisis. Some authorities were considering tightening restrictions on spending.

2.15 In practice, users occasionally spend direct payments on services outside their agreed care plan, either knowingly or inadvertently. Authorities aim to detect inappropriate spending through monitoring. They investigate any suspected cases, ensure the user's needs are being met, and recoup any misspent funds. Some authorities had good monitoring systems, particularly where payment cards were used. These quickly alerted staff and enabled them to support the user. In other authorities, front-line staff and internal auditors expressed concerns that systems were poor and that cases of inappropriate spending could go undiscovered for long periods.

2.16 The Audit Commission (the Commission) reported that local authorities detected 438 cases of social care fraud in 2013-14 – more than three times the number in 2009-10 – with a total value of £6.3 million.¹⁷ However, the Commission also highlighted that most authorities did not detect any social care fraud. The increase may reflect true growth in fraud, or improved detection. The Commission reported that authorities viewed personal budgets as a significant new fraud risk. Examples of fraud include multiple claims across different authorities and payments continuing after a user has died. Authorities we visited did not report an increase in fraud associated with personal budgets and direct payments, although we heard of specific examples. Since 2014-15, authorities must submit data on those receiving personal budgets to the National Fraud Initiative. This identifies data matches that may indicate fraud. The Care Act guidance provides information, in line with standard anti-fraud practice, about fraud. For example, it describes how authorities should handle funds when delegating functions to external parties.

Personalised commissioning and savings

2.17 Personalised commissioning is taking place in a difficult financial context. Between 2010-11 and 2014-15, local authorities' real-terms spend on adult social care reduced by 7%.¹⁸ In its submissions to the 2010 and 2013 spending reviews, the Department anticipated small savings from personalisation: £72 million over the period 2012-13 to 2014-15, and £10 million in 2015-16, respectively. The Department expects the value for money of personalised commissioning to come from improved outcomes for users, not necessarily from savings. We found no association between authorities' use of direct payments and their overall spending on care.

2.18 The 2007 evaluation of individual budgets found that, while the cost of social care services was roughly the same for adults with a personal budget and adults without, those with a personal budget used the health service more.¹⁹ The evaluators thought this may have been because the more careful support planning process exposed greater need for healthcare. These users also received extra care management. An examination of a single authority in 2008-09 compared the experiences of 378 users of the authority's services with 180 people in an experimental group who had personal budgets. The study found care costs for adults with personal budgets were higher than for adults without.²⁰

17 Audit Commission, *Protecting the Public Purse 2014*, October 2014, available at: <http://webarchive.nationalarchives.gov.uk/20150421134146/http://www.audit-commission.gov.uk/2014/10/protecting-the-public-purse-2014/>

18 Health and Social Care Information Centre, *Personal Social Services: Expenditure and Unit Costs, England – 2014-15*, Final release, Table 3.1, November 2015. Available at: www.hscic.gov.uk/catalogue/PUB19165/pss-exp-eng-14-15-fin-rep-tabs-chrt.xlsx

19 Publications from the 2007 evaluation are available at: <http://php.york.ac.uk/inst/spru/research/summs/ibsen.php>

20 J Woolham and C Benton, 'The costs and benefits of Personal Budgets for Older People: Evidence from a single local authority', *British Journal of Social Work*, vol. 43, issue 8, December 2013, pp. 1472-1491.

2.19 Personalised care can be more expensive than traditional authority-commissioned care for some users. Some authorities have historically used block or framework contracts with providers which benefited from bulk discounts. Therefore if services are personalised for a user, this may result in the authority needing to pay more. The Care Act guidance says that personal budgets must be sufficient to meet users' statutory needs, and that they must take into account users' reasonable preferences. The guidance indicates that an authority should base the amount of a personal budget on the cost of good-quality local provision in order to meet the care and support needs identified, whether this cost is lower or greater than that which the authority would otherwise pay for services. Some authorities criticised the Care Act guidance for not taking into account current financial pressures on authorities. Although the guidance includes an example of how a personal budget might result in cheaper care, it also indicates that authorities should be prepared to increase direct payment amounts to enable users to have greater flexibility over their care, for example over the timing of homecare visits.

2.20 Some front-line workers we spoke with were concerned that personalising care increased the pressures on their time, as users required more support. They gave examples of users contacting them frequently about what they could spend their budgets on. We met authorities that had managed this pressure through good information and support.

2.21 However, many local authorities see personalised commissioning as a way to save money. Three-quarters of local authority directors of adult social services surveyed in 2015 said they expected personalisation to be a medium or high area of savings in 2015-16, with 84% expecting the same in 2016-17.²¹ Directors responding to the survey saw personalisation as one of a number of areas to make savings. Other areas in which they expected savings included integration of health and social care, prevention and better procurement.

2.22 Local authorities we visited which told us they were saving money for some groups of users through personalised commissioning identified four mechanisms (**Figure 15**). However, authorities were concerned that new policies, such as the introduction of the national living wage and pension auto-enrolment, will increase their costs and negate any savings.

2.23 The Department expects the local government finance settlement announced in February 2016 to support authorities to manage changes such as the introduction of the national living wage, for example by giving authorities the option to levy a council tax precept of 2% a year, intended for adult social care. According to a survey by the Local Government Information Unit in January 2016, the majority of authorities expect to levy the precept.²² However, the Association of Directors of Adult Social Services is concerned that the settlement is not adequate to meet financial pressures on authorities.

21 Association of Directors of Adult Social Services, *Budget survey 2015: report*, June 2015. Available at: www.adass.org.uk/budget-survey-2015/

22 LGiU and the Municipal Journal, *2016 State of Local Government Finance survey*, February 2016. Available at: www.lgiu.org.uk/report/2016-state-of-local-government-finance-survey/

Figure 15
Examples of savings mechanisms

Description	Assumptions and dependencies	Potential costs or impact	Evidence to date
The authority sets its direct payments at a lower rate compared with the rate it pays providers through its commissioned contracts, and increases the proportion of users on direct payments.	Assumes users can achieve the same level of care through purchasing their own care more cheaply. For example, they may employ a personal assistant rather than use agency homecare. Assumes there is scope to transfer more users onto direct payments.	Direct payments are not suitable for everyone. User outcomes may be negatively affected if users switch to a direct payment which, on review, is found not to be appropriate.	By definition this will save money, but according to Care Act guidance local authorities should base payment rates on user needs, not savings targets. The guidance also says authorities must not force users to take a direct payment against their will. Authorities told us that in areas with competitive labour markets, users struggle to recruit a personal assistant at cheaper rates. Direct payment recipients need support services, which introduces an overhead.
Using outcomes-based contracts which pass the need to save money on to providers; other money-saving contract renegotiations.	Cost-saving contracts generally assume providers can innovate to personalise services while spending less or the same.	Shifts financial risks to providers.	Some authorities have reported good experiences with, and savings from, outcomes-based contracts. A 2014 National Audit Office report, <i>The impact of funding reductions on local authorities</i> , found that cost savings through price reductions have reduced in recent years, which may suggest such price negotiations have become less effective.
Identifying services which meet users' needs at no or little cost. For example, community/ social activities run by charities can meet a need for social contact more cheaply than a daycentre.	Relies on authorities or charitable bodies providing free or low-cost services.	May increase costs for other organisations.	Authorities we spoke with have used this approach successfully. However, according to the National Council for Voluntary Organisations, funding to the voluntary sector has been reducing.
Authorities recoup unspent direct payment money when a specified number of weeks' funding remains in users' accounts. Prior to taking the money, authorities check that users' needs are being met.	Relies on a cost-effective financial management system. Improves cash flow rather than making long-term net savings.	Recouping money from users can be resource-intensive for authorities.	Authorities we visited that had moved to payment cards and similar systems were able to identify unexpected spending patterns and recoup money quickly and easily.

Source: National Audit Office case studies

Part Three

The capacity of the care market

3.1 This part looks at whether there is capacity in the care market for local authorities to develop personalised commissioning in line with the Department of Health's (the Department's) expectations. It covers our findings about:

- pressures on the supply of care, such as labour market challenges; and
- the major demand issues – in particular, user choice.

3.2 The Care Act places new duties on local authorities to facilitate and shape their market for adult care and support, so that it meets the needs of all people in their area, whether their care is funded by the authority or by the individual themselves.

Pressures on providers

3.3 Many providers in the adult social care sector are under pressure. In October 2015, the Care Quality Commission (CQC) reported concerns about the sustainability of adult social care provision. These related to the increasing complexity of adults' care needs, significant cuts to local authority budgets, increasing costs for providers, high staff vacancy rates and pressure from local commissioners to keep fees as low as possible.²³ From its inspections to 31 May 2015, the CQC found that around 40% of services required improvement or were inadequate. In October 2015, the Local Government Information Unit (LGIU) reported that 77% of authorities that responded to a survey (53 of 69) had experienced provider failure between April 2014 and March 2015.²⁴

3.4 In December 2014, the Burstow Commission reported that the homecare system was not working well, because the way many local authorities commissioned care was resulting in care workers receiving low wages and poor training.²⁵ Recent analysis by the Chartered Institute of Public Finance and Accountancy (CIPFA) concluded that providers are moving away from the public sector homecare market.²⁶ It cites the example of Allied Healthcare, a subsidiary of Saga, which announced in January 2015 that it was exiting the market for publicly funded care because of tightening budgets. At the time, Allied Healthcare reported it had contracts to provide homecare with 93% of authorities.

²³ Care Quality Commission, *The state of health care and adult social care in England 2014/15*, November 2015, available at: www.cqc.org.uk/content/state-care-201415

²⁴ LGIU, *Care and Continuity: Contingency planning for provider failure*, October 2015, available at: www.lgiu.org.uk/report/care-and-continuity-guide

²⁵ LGIU, *Key to Care, Report of the Burstow Commission on the future of the home care workforce*, December 2014, available at: www.lgiu.org.uk/wp-content/uploads/2014/12/KeyToCare.pdf

²⁶ CIPFA, *Developing a Reasonable Cost Care Market*, October 2015, available at: www.cipfa.org/training/s/-/media/22db_ebd28b5442558eece089f839ebdc.ashx

3.5 We visited local authorities where providers were unable to fulfil contracts because they could not recruit enough staff. Care work is low paid, and in many areas other jobs can be more attractive or workers' availability varies seasonally. Some authorities have reduced the number of homecare providers they contract with, to limit the destabilising effect on the care market of workers moving frequently between providers. One authority where providers had difficulty with recruitment told us it had developed a workforce strategy to make the care market more attractive for workers, and to encourage providers to embed personalisation in their own practices. Authorities in rural areas generally pay higher amounts for homecare, when compared with pay rates for all low-paid employees in the area. Authorities in urban areas pay comparatively less for homecare (**Figure 16** overleaf).

3.6 Similarly, we encountered authorities that are moving to fewer, larger contracts with providers of homecare. This enabled providers to achieve economies of scale, thereby charging authorities lower rates. One county authority we visited had attracted more homecare providers into the area, but reverted to a small number of contracts. This was because it could not afford to pay the increased rates charged by providers that had fewer clients and were struggling to recruit care workers. Authorities told us that having fewer providers means they need fewer staff to manage contracts, and users are less likely to have to change provider.

3.7 Some authorities are putting in place outcomes-based payment schemes. In one authority we visited, contracts with providers incorporated year-on-year reductions in fees. This aims to push providers into becoming more efficient by developing more innovative services. However, the authority did not have a clear idea of how providers could change services but still meet users' needs, or what the impact of reduced fees would be on the sustainability of providers. A review of emerging practice in outcomes-based commissioning in social care found that, while the approach has potential, it requires major changes in order to be done well.²⁷ Furthermore, the measurement of outcomes is challenging. There are limited studies to date exploring the impacts of outcomes-based commissioning.

Choice for users

3.8 We found that some authorities were increasing choice of provision for users by identifying diverse local options to meet users' needs. The Cabinet Office's 2013 report *The Barriers to Choice Review* advocated taking into account users' capabilities as well as their needs during care planning.²⁸ It also recommended identifying informal and community options, rather than assuming that formal services are the only way to meet users' needs. Community groups based on social activities can offer good alternative ways of addressing particular needs, such as reducing social isolation. They can cost the local authority little or nothing, although they may rely on other, often public, funding. One authority we visited had asked its younger adults with learning disabilities about activities they would like to try, such as rock climbing. It was working with Mencap to set up activity groups.

²⁷ J Bolton, *Emerging practice in outcome-based commissioning for social care: discussion paper*, April 2015, available at: https://ipc.brookes.ac.uk/publications/pdf/John_Bolton_Outcome_Based_Commissioning_Paper_April_2015.pdf

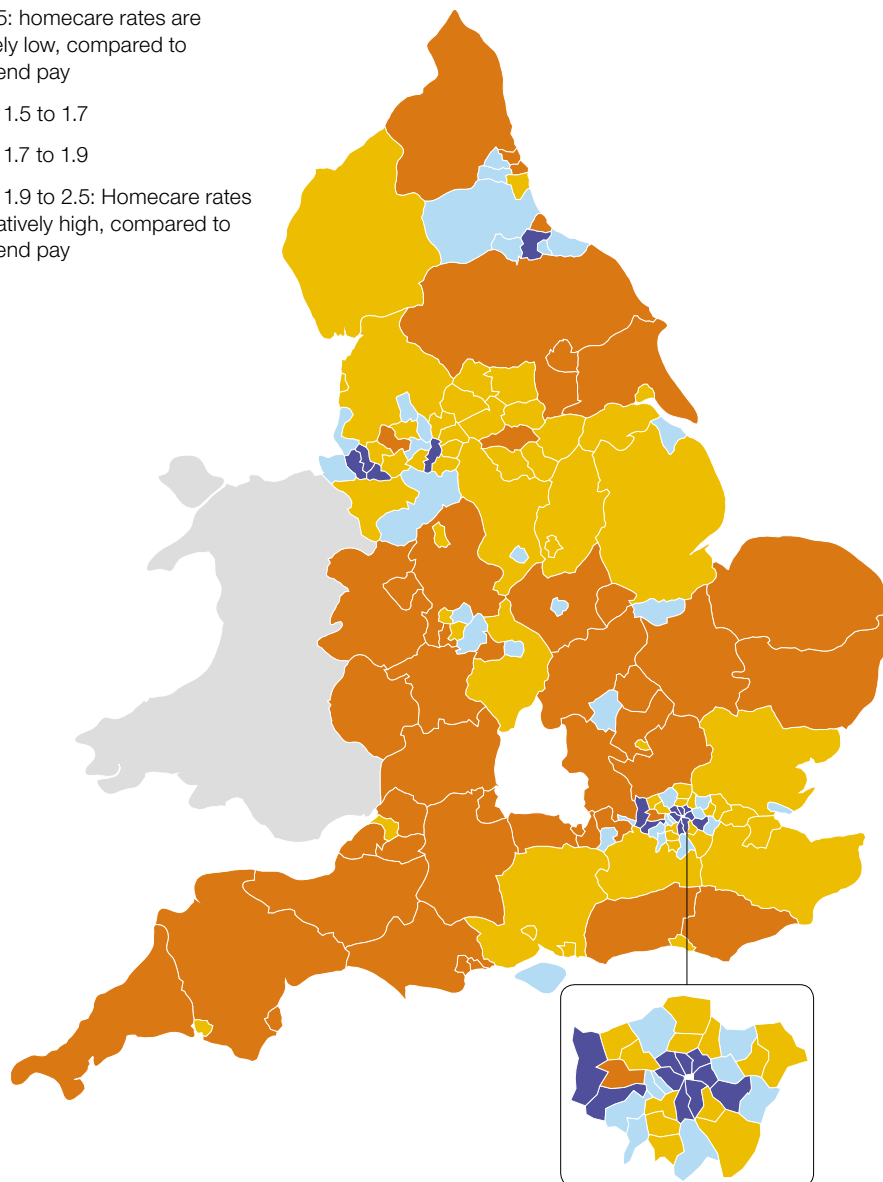
²⁸ Cabinet Office, *The Barriers to Choice Review*, January 2013, available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/80070/Barriers_to_choice_review_0.pdf

Figure 16

Local authority homecare rates compared with local rates of pay for all employees, 2014-15

Rural authorities pay more than urban authorities for homecare compare with lower-end pay

- 1 to 1.5: homecare rates are relatively low, compared to lower-end pay
- Above 1.5 to 1.7
- Above 1.7 to 1.9
- Above 1.9 to 2.5: Homecare rates are relatively high, compared to lower-end pay



Notes

- 1 Colours in the map show the average standard hourly rate for provision of home care, divided by 20th percentile of gross hourly pay across all jobs in each authority area.
- 2 15 authorities had a ratio under 1.5; 33 between 1.5 and 1.7; 56 between 1.7 and 1.9; and 46 over 1.9.
- 3 Oxfordshire's data treated as missing.
- 4 Hourly rate for provision of homecare from ASC-FR collated by the Health and Social Care Information Centre (2014-15).
- 5 Gross hourly pay from Annual Survey of Hours and Earnings data (2014).

Source: National Audit Office analysis of Health and Social Care Information Centre and Office for National Statistics data

3.9 One authority we visited had designed a commissioning system that allowed front-line staff to identify services from more than 700 options available in the local area, including unpaid options. However, we visited other authorities that were struggling to transform their commissioning processes.

3.10 The Department has explored the commissioning practices of local authorities. It concluded that there is little difference between the services offered by different homecare providers, so even if users can choose from several providers, they are not getting a meaningful choice of services. The Department regards individual service funds, where the provider manages the personal budget with the user, as a way of introducing more choice into homecare. However, only 4% of users had an individual service fund in 2013-14. The Think Local Act Personal partnership reviewed individual service funds in 2014 and found they are poorly understood by users, providers and authorities, and many providers are not contracted by authorities in ways that allow them to offer flexible support.²⁹ Some authorities we visited said they were encouraging providers to offer users choice within authority-commissioned contracts, for example by allowing them to rearrange their homecare at relatively short notice. However, we heard that such flexibility can require a premium to the provider that the authority cannot afford to pay.

3.11 Users, and those supporting them in care planning, need accurate and comprehensive information on the range of local services so they can make the best choices about what to buy. The Cabinet Office's 2013 report *The Barriers to Choice Review* concluded that users need better information, signposting and interpretation of available local service options.³⁰ The Care Act requires local authorities to ensure that information and advice services for users are available in their areas, including on choice of types of care and choice of provider.

3.12 The choices available to users are limited by the direct payment rates that local authorities set. Some authorities told us they set their rates by subtracting overheads from their own homecare agency rates. This reflects findings in our earlier report, *Deciding prices in public services markets: principles for value for money*.³¹ Users in some areas told us they were unable to buy enough care using the authority rate, and were topping up with their own money. However, other authorities offer different rates depending on users' circumstances.

29 Think Local Act Personal, *Individual Service Funds (ISFs) and contracting for flexible support*, available at: www.thinklocalactpersonal.org.uk/_library/Resources/SDS/TLAPISFsContractingFINAL.pdf

30 See footnote 28.

31 National Audit Office, *Deciding prices in public services markets: principles for value for money*, December 2013, available at: www.nao.org.uk/report/deciding-prices-public-services-markets-principles-value-money

Shaping the care market

3.13 The Care Act places a duty on local authorities to support and shape local care markets. The Department wants authorities to encourage diverse local providers and service options. Authorities are required to publish annual market position statements, describing current and projected demand for social care, and current supply of care services. The statements should include analysis of the strengths and weaknesses in their market, and describe the authority's approach to widening the market. Statements are intended to communicate what services will be needed to meet projected demand, so that existing and potential providers can consider opportunities for future business in the local area.

3.14 The Department's most recent stocktake of local authorities' progress in implementing the requirements of the Care Act found that most authorities reported good progress in shaping the market.³² In October and November 2015, 91% of councils reported being confident that they are actively shaping a diverse and sustainable market that meets the needs of the local population for 2015-16, and 90% are confident for beyond 2015-16.

3.15 CIPFA recently analysed the market position statements and found that local authorities are aiming to increase take-up of direct payments and individual service funds, especially for older people.³³ Some authorities aim to encourage more micro-businesses and social enterprises as these are potentially cheaper options because they have lower overheads.

3.16 The Department is the national steward of the market for care providers, making sure the overall pool of providers remains effective and that it can deliver appropriate care for the whole population. The Department plans to publish a draft national market position statement in spring 2016. The national statement will include a focus on personalisation. The Department has supported market development by collaborating with sector bodies to produce good practice guidance for commissioners. Its guidance includes *Commissioning for better outcomes*, co-produced with, among others, the Local Government Association and the Think Local Act Personal partnership.³⁴ This offers broad guidance on commissioning, including how to support a diverse and sustainable market. The CQC monitors the financial health of difficult-to-replace providers, supporting local authorities in their oversight of the adult social care market and working with the Department to support national market stewardship.

³² Available at: www.local.gov.uk/care-support-reform/-/journal_content/56/10180/6341378/ARTICLE

³³ CIPFA, *Developing a Reasonable Cost Care Market*, October 2015, available at: www.cipfa.org/training/s/~/-/media/22db_ebd28b5442558eece089f839ebdc.ashx

³⁴ Local Government Association, University of Birmingham, Association of Directors of Adult Social Services, Department of Health, Think Local Act Personal, *Commissioning for better outcomes: a route map*, October 2015, available at: www.local.gov.uk/documents/10180/5756320/Commissioning+for+Better+Outcomes+A+route+map/8f18c36f-805c-4d5e-b1f5-d3755394cfab

The personal assistant market

3.17 In March 2015, Skills for Care estimated that 120,000 personal assistants were employed by users through direct payments. Users either employ a personal assistant directly or make use of an intermediary organisation.³⁵ Personal assistants are unregulated, and can be friends or family. Some users we met with told us the responsibilities of being an employer put them off engaging a personal assistant through a direct payment. In some areas we visited, users could transfer employment responsibilities to another organisation, for example to organisations that provide payroll services.

3.18 In 2014, Skills for Care gathered information on local personal assistant markets from 100 local authorities. They found that most authorities offered a range of support for users who employ personal assistants (**Figure 17** overleaf), and support had improved since their previous review in 2013. However, support was not comprehensive: 82% of authorities reported gaps in the support provided to users and personal assistants. In 75% of cases, the authority provided the support; in 53% of authorities, user-led organisations (additionally or solely) provided the support.

3.19 Some authorities told us that users have difficulty recruiting personal assistants because not enough people are willing to undertake the role, which is typically low paid. Some authorities expressed concern that the roll-out of personalised commissioning in health would exacerbate competition within the personal assistant market.

³⁵ Skills for Care, *Supporting individual employers and their personal assistants*, March 2015, available at: www.skillsforcare.org.uk/Document-library/Employing-your-own-care-and-support/Report-Supporting-individual-employers-and-their-PAs.pdf

Figure 17

Skills for Care's findings on support for users who employ personal assistants

Type of support available	Proportion of local authorities (%)
Information about becoming an employer	93
Payroll service	89
Disclosure and Barring Service checks	87
Employer–personal assistant relationship advice (where relationship has broken down)	86
Information on rates of pay	84
Advice and information regarding legal responsibilities	81
Register of personal assistants	56
Pre-employment employer training	52
Employer–personal assistant relationship advice (general)	52
Support to access or use technology	46
Peer support	37

Note

1 Based on responses from 100 local authorities.

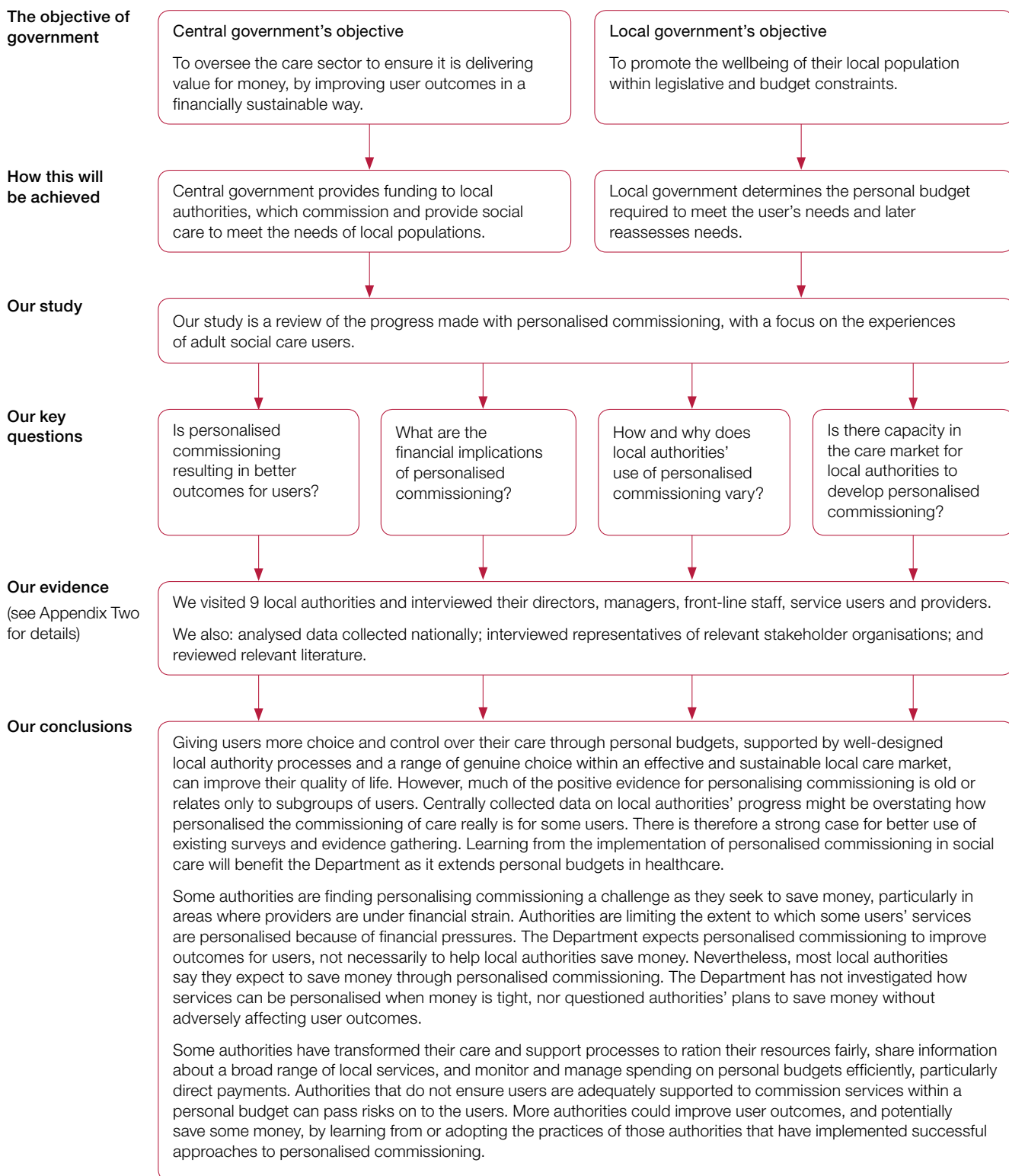
Source: Skills for Care, *Supporting individual employers and their personal assistants*, March 2015, available at: www.skillsforcare.org.uk/Document-library/Employing-your-own-care-and-support/Report-Supporting-individual-employers-and-their-PAs.pdf

Appendix One

Our audit approach

- 1 This study examined:
 - whether personalised commissioning results in better outcomes for users;
 - the financial implications of personalised commissioning;
 - how and why local authorities' use of personalised commissioning varies; and
 - whether there is capacity in the social care market for local authorities to develop personalised commissioning;
- 2 There were four main elements to our work.
 - We undertook 9 case study visits to local authorities in England. Our case study visits included review of the local authority's data, discussion with the director of adult social services, other members of staff, providers, users and carers.
 - We gathered and analysed data, including data from the Health and Social Care Information Centre; data collected from local authorities; and data from the charity In Control's survey, the Personal Outcomes Evaluation Tool.
 - We held meetings with stakeholders, including the Department of Health and the Department for Communities and Local Government.
 - We collated and reviewed academic and other literature resources.
- 3 Our audit approach is summarised in **Figure 18** overleaf. Our evidence base is described in Appendix Two.

Figure 18
Our audit approach



Appendix Two

Our evidence base

1 Our independent conclusions on central government's and local authorities' progress with personalised commissioning were reached between April 2015 and March 2016. Our audit approach is outlined in Appendix One.

2 We analysed authority-level and user-level data on processes and outcomes relating to personalised commissioning.

- We carried out a quality review, and trend analysis, on nationally collated data from 2010-11 to 2013-14.
- We carried out data analysis on nationally collated data covering 2014-15.
- We analysed data from the 2014-15 Adult Social Care Survey.
- In Control analysed its Personal Outcomes Evaluation Tool data on our behalf.

3 We visited case study local authorities. We spoke to directors of adult social services, managers, front-line staff, service users, carers and providers at 9 local authorities: Cambridgeshire County Council; Harrow Council; Hertfordshire County Council; Leeds City Council; Liverpool City Council; Nottinghamshire County Council; Oxfordshire County Council; Redbridge Council; and St Helens Metropolitan Borough Council. In addition, we conducted telephone interviews with directors of adult social services and personalisation managers at a further 3 local authorities: Cornwall Council; Middlesbrough Council; and North Yorkshire County Council. These were selected to be broadly representative of variation in local circumstances and progress made with personalised commissioning. The local authorities were visited to observe how each one was implementing personalisation. We aimed to understand why there is variation between authorities in the use of personal budgets and whether there is capacity in local care markets to develop personalised commissioning.

4 We interviewed Department of Health and Department for Communities and Local Government representatives as well as stakeholders and academics.

- We interviewed representatives for personalised care at the Department of Health. We covered a wide range of topics, including how departments interact, the expected financial impact of personalised commissioning, the Care Act, measuring outcomes, sharing knowledge and local practices in areas such as allocating resources.
- We also spoke to representatives from the Department for Communities and Local Government regarding the local authority financial system.
- We spoke to personalisation and adult social care leads at the Association of Directors of Adult Social Services and the Local Government Association.
- We spoke to sector experts with an insight into progress with personalised care including: Skills for Care; Healthwatch England; the National Institute for Health and Care Excellence; the Social Care Institute for Excellence; the Think Local Act Personal partnership; the Care Quality Commission; the Health and Social Care Information Centre; Scope; National Voices; the Centre for Welfare Reform; Shaping Our Lives; In Control; the Centre for Collaborative Care; the Alzheimer's Society; Community Catalysts; and Disability Rights UK.
- We spoke to academic experts to provide a background to the personalisation landscape, to understand issues with evaluation, and to identify relevant publications and areas of concern to focus on in more depth.

5 We undertook a literature review. We undertook a systematic review of existing research and evaluations from the UK home nations to understand: what personalised commissioning has been achieving in terms of outcomes and cost-effectiveness, the processes in place to achieve outcomes, and how personalisation varies between service user groups. In addition to the systematic element of the review, we examined documents from academics and stakeholders.

Report by the Comptroller and Auditor General

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CORRECTION

Paragraph 16, fifth bullet (page 11) was produced in error and should read:

- Around 120,000 personal assistants are employed by users with direct payments to provide personal care, which is generally a cheaper option than homecare.

and not:

- Around 120,000 users with direct payments employ personal assistants to provide personal care, which is generally a cheaper option than homecare.

Paragraph 3.17 – first sentence (page 45) was produced in error and should read:

3.17 In March 2015, Skills for Care estimated that 120,000 personal assistants were employed by users through direct payments. Users either employ a personal assistant directly or make use of an intermediary organisation.

and not:

3.17 In March 2015, Skills for Care estimated that 120,000 users engaged personal assistants through direct payments, either employing them directly or making use of an intermediary organisation.

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