Department for Education

Evaluation of the special educational needs and disability pathfinder programme

Thematic report: personal budgets and integrated resourcing

Research report

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Key learning points

This report was produced as part of SQW's evaluation of the Special Educational Needs (SEN) and Disability Pathfinder Programme for the Department for Education. **It focuses on the development of personal budgets and integrated resourcing, based on evidence gathered from eight areas, which included pathfinder and non-pathfinders**. Progress made in this area had been largely limited to the development of intended approaches, which are described in this report to inform the considerations of other local areas. The key learning points were:

- Integrated resourcing had been considered at both a **strategic level, i.e. the level of the population,** and at the **level of the individual family**
  - At the **population level**, this had involved individual commissioners working together to build on existing and/or the development of **new joint commissioning arrangements**
  - At the **level of the individual family**, this had involved **mapping of when and how resourcing should be considered within the EHC process**
- **Although there is no formal suite of services that must be considered for inclusion in an EHC plan,** a number of services/budgets had been more commonly considered. This included:
  - **SEN –** high needs block funding, SEN transport and specialist equipment
  - **Health –** community paediatrics, speech & language therapy, occupational therapy, physiotherapy, children's specialist nursing, continuing care and specialist equipment
  - **Social care –** short breaks and specialist provision for children and young people with disabilities
- **Within an individual EHC plan, resourcing could be specified in a variety of ways both across services and areas, with little to no commonality identified in this respect.** This included provision in an individualised plan comprising monetised costs, the number of hours or units of specific service provision and specific forms of support that would be provided by a service
- Areas had to date **most commonly offered personal budgets (PBs) to those eligible for SEN transport, short breaks, funding for disabled children/young people, and adult social care. PBs for Continuing Care and complex SEN needs funded via the high needs block had also been trialled on a limited basis**
- It was expected that the existing **PB offer would gradually be enhanced to include a more varied set of budgets/services,** including the high needs block for complex SEN, Continuing Care (for the under 18 year group) and Continuing Healthcare (for the over 18 years group), health funding for children and young people with life-limiting conditions and potentially funding to support children that fall within the remit of Section 17 of the Children Act 1989

- **Areas identified a number of challenges they were likely to face when enhancing their PB offer**. This included: the **limited availability and reliability of unit cost data**; **inflexibility of existing commissioning arrangements**; **growing the provider market appropriately and sufficiently** to meet family-led demand; drawing in new services into the PB offer whilst **maintaining the viability of individual services**; **releasing of school-based funding**; **and promoting the use of PBs amongst the health workforce**
- In terms of quantifying PBs, **most services were either using, or were in the process of developing a resource allocation tool to support practitioners** to develop indicative budgets. Such **tools had been more commonly developed for use in both children's and adult social care**, and were seen as more of a 'work in progress' in both health and SEN. In addition**, some areas were seeking to develop integrated resource allocation tools across SEN and social care services**, but again, much of this work remained at an early stage
- **The integration of PBs into the wider EHC assessment and planning process had been trialled in only a small number of cases, and therefore remained largely developmental**. Operationalising this form of integration was likely to require consideration of the following issues: how much/what format information should be offered to a family when introducing the PB offer; when to introduce indicative budget(s) to families; how/when potential duplication across PBs and the proposed wider resourcing would be considered; the extent to which PB service provision needs to be specified during the EHC planning meeting; how the integration process would work for families that had existing, live PBs prior to the EHC process; and what level/type of information needs to be included in the Local Offer
- The ultimate goal of **resource integration was perceived to mean different things across the areas and therefore was likely to be achieved in a diverse range of ways.** The **following two forms of integration, which are not mutually exclusive were being explored, with the majority of areas opting to focus on development of the former** as they felt it would be more timely and effective:
    - **Family level integration – drawing together service-specific resourcing at the level of the individual family during the EHC assessment and planning process.** This was being achieved through a combination of: multi-agency decision making panels in the EHC process; professionals coming together after undertaking assessments before the EHC planning stage; and multi-agency discussion between professionals and the family at the EHC planning meeting
    - **Strategic level integration – drawing together distinct service-related resources at the level of the population**, for example via the pooling/aligning of budgets and/or the undertaking of combined assessments
- The **integration of PBs from different services could also be undertaken at either a strategic and/or family level**, with the former involving the pooling/aligning of individual service budgets prior to or during assessment, and the latter involving the consideration of distinct PBs in the round at the planning stage.

1. Introduction

Evaluation of the Special Educational Needs (SEN) and Disability Pathfinder Programme

SQW was commissioned by the Department for Education (DfE) to lead a consortium of organisations to undertake the Evaluation of the Special Educational Needs (SEN) and Disability Pathfinder Programme. A series of reports from the study are available on the government publications website, including six previous thematic reports[1]. This particular thematic report focuses on *personal budgets and integrated resourcing*. Progress made in this area had been largely limited to the development of intended approaches i.e. approaches that would be fully implemented at a later date. Therefore unlike previous thematic reports which presented good practice based on what had worked well, we have sought to describe the intended approaches being taken forward to inform the considerations of other local areas.

Rationale for the research

The new education, health and care (EHC) assessment and planning process is expected to lead to agencies and families coming together to consider whether it would be beneficial to make integrated resourcing decisions, which must include an offer of a personal budget (PB) where relevant. Information gathered from both pathfinder and non-pathfinder areas as part of SQW's October/November 2013[2] assessment of readiness to meet the SEN and Disability reforms illustrated that:

- Further work to implement joint resourcing mechanisms and PBs was required and anticipated in a large number of areas
- The development of PBs remained a challenge for many areas, implying that further guidance and support would be useful.

This thematic therefore re-examines the progress that has been made by pathfinder and non-pathfinder areas since the readiness assessment to identify good practice and lessons learned.

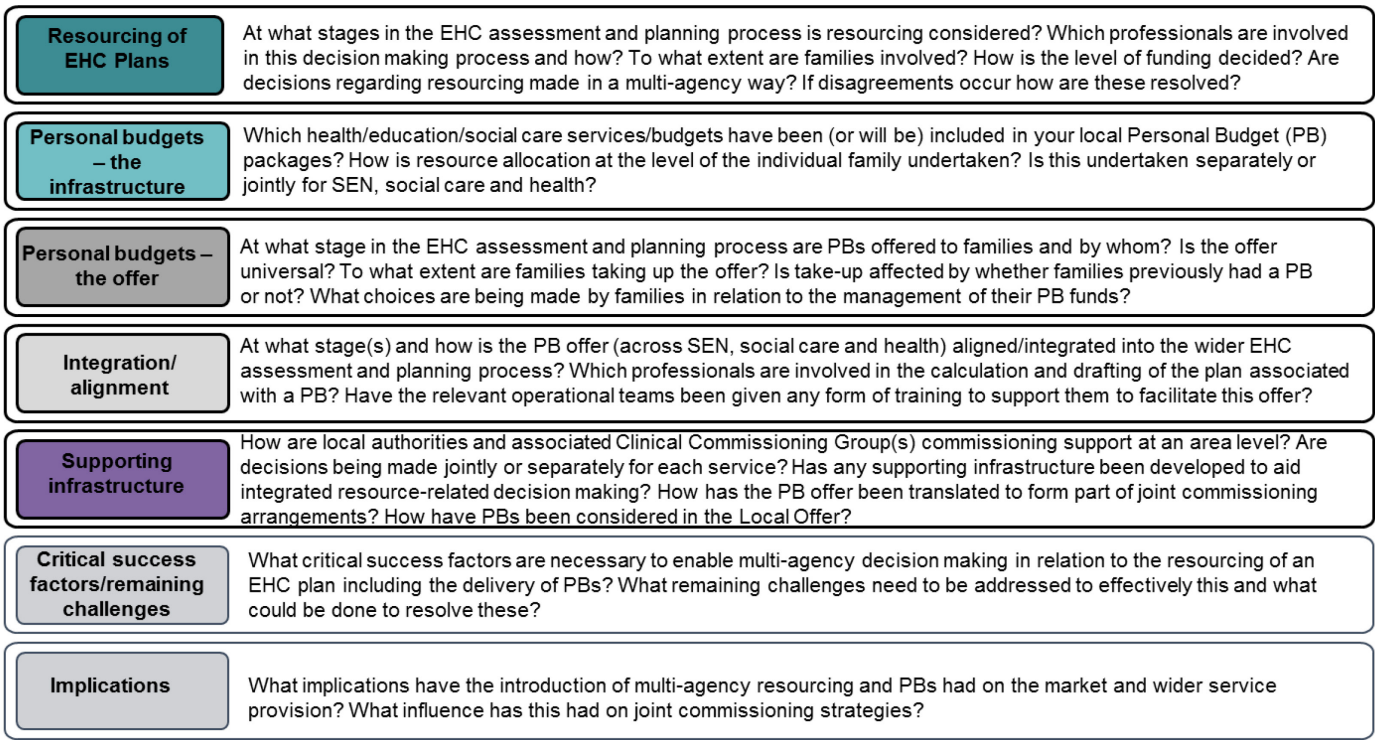
[1] The following six thematic reports have been completed, published and can be downloaded at https://www.gov.uk/government/collections/send-pathfinders#evaluation-of-the-send-pathfinders: Key working and Workforce Development; The Education, Health and Care Planning Pathway; Collaborative Working with Social Care; Collaborative Working with Health; Engagement of Schools; and Transition and the Engagement of Post-16 Providers

[2] https://www.gov.uk/government/publications/the-send-pathfinder-programme-evaluation-pathfinder-champions

Research focus

This report provides further insight into seven main subjects, which are summarised in Figure 1. It is broadly structured around these themes, and where possible draws out key learning points based on experience to date.

Figure 1 Research questions



Our approach

This report gives a snapshot of practice in eight local areas – Cambridgeshire, Essex, Gloucestershire, Newcastle, Southampton, Trafford, West Sussex and Wigan. Information was gathered through in-depth face-to-face and telephone interviews with key individuals including the SEN and disability reform lead/pathfinder lead, the operational lead for the EHC assessment and planning process, and professionals who act as budget-holders, commissioners, personal budgets leads, and front-line staff in SEN, health and social care (see Annex B for more detail on the research methods used). We would like to express our sincere thanks to the participating areas and to In Control, NHS England and the Department of Health for providing useful insights into the issues raised.

Intended audience

This report is intended to support those charged with supporting the development of integrated resourcing and personal budgets.

2. Context

"When carrying out their statutory duties under the Children and Families Act 2014…local authorities and health bodies **must** have arrangements in place to plan and commission education, health and social care services jointly for children and young people with SEN or disabilities…

"…Under Section 10 of the Children Act 2004 and Section 75 of the National Health Service Act 2006 local authorities and CCGs have a **statutory duty** to consider the extent to which children and young people's needs could be met more effectively through integrating services and aligning or pooling budgets in order to offer greater value for money, improve outcomes and/or better integrate services for children and young people with SEN or disabilities.''

SEN and Disability Code of Practice (July 2014)

Making the best use of resources

Collaborative working between local authorities, health bodies and families forms one of the key building blocks of the SEN and disability reforms set out in the Children and Families Act 2014 (the Act) and its associated Code of Practice (the Code) [3]. Transition to this new approach is likely to require development and change to the way in which support is provided at both strategic level and to individual families. This **must** include:

- **Strategic level** - the **establishment** of **joint commissioning arrangements** between SEN, health and social care services
- **Individual family level** - the provision of **coordinated assessment, planning, delivery and review of EHC plans**, across the relevant services and in partnership with families.

In addition, local authorities and Clinical Commissioning Groups (CCGs) have a **statutory duty to consider whether it would be beneficial to integrate services and their associated resources** as a means of more effectively meeting the needs of local families.

This thematic **report seeks to explore the ways in which local areas have considered the integration of services, with a specific focus on the integration of resourcing** at both strategic level (hereafter referred to as *strategic integration*) and at the level of the individual family (hereafter referred to as *family level integration*).

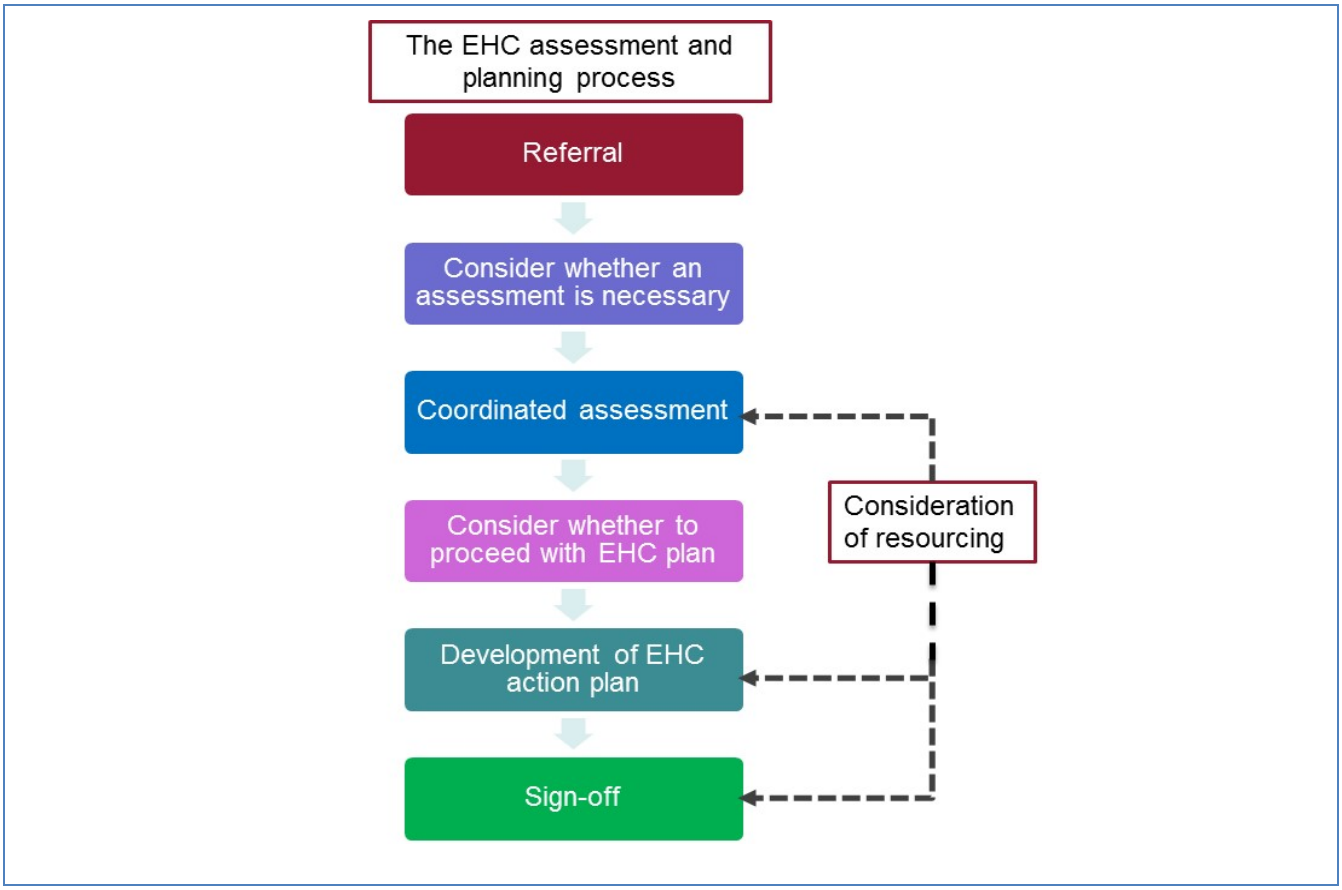
[3] https://www.gov.uk/government/consultations/revision-of-the-send-code-of-practice-0-to-25-years

When and how is resourcing being considered?

At a population level, commissioners were working together within each of the eight participating case study areas to build on existing and develop new joint commissioning arrangements. In some areas, this had involved the setting up of new commissioning structures, which brought together all relevant professionals. These new structures had in turn begun to **map out what was currently being provided (and by whom), the resources involved and the potential strategic synergies between these**.

Similar work had been undertaken to map out how and when resourcing should be considered within the EHC assessment and planning process, i.e. at the level of the individual family. It appears that **resource-related decisions were intended to be made at similar stages of this process across the eight case study areas** (see Figure 2).

Figure 2: Resourcing EHC plans



Source: SQW

The key resource decision making points were undertaken during:

- **Coordinated assessment** – distinct assessments were to be undertaken across different services in the majority of areas, which would provide an **indication of the likely associated resourcing requirements.** This **indicative resourcing would be approved** by the appropriate panel(s) or relevant budget holders/service managers

- **Development of an EHC plan** – all assessment information would be drawn together at this stage into a summary assessment or draft plan, and discussed at a Team Around the Family (TAF) meeting, resulting in a proposed plan. This would include **consideration of the required resourcing, based on the indicative resourcing put forward at the assessment stage**

- **Sign off** – final versions of the EHC plan, including **proposed resourcing following the TAF, would be considered and approved** using similar arrangements to the indicative resourcing stage.

Importantly, in the majority of areas, **indicative resourcing was to be developed separately across the services at the assessment stage, with a view to considering the aggregate set of available resources at the planning stage**. Although this should in theory enable the identification of any duplication of provision/resourcing from across the services, few of the participating areas made reference to this consideration. There was therefore a risk that possible efficiency saving could be missed (see Chapters 4 and 5 for further discussion).

Which services/budgets are considered for inclusion in an EHC plan?

> "The purpose of an EHC plan is to make special educational provision to meet the special educational needs of the child or young person, to secure the best possible outcomes for them across education, health and social care and, as they get older, prepare them for adulthood.
>
> SEN and Disability Code of Practice (July 2014)

Unlike its predecessors – the SEN Statement and the Learning Difficult Assessment (LDA) – which were largely SEN focused, **the EHC plan seeks to draw together a holistic and tailored suite of support from across SEN, health and social care**. In addition, the EHC plan is family as opposed to child-specific and seeks to achieve the individual outcomes agreed by the family and set of relevant professionals. **There is therefore no formal suite of services that must be considered for inclusion in an EHC plan**, which instead should be developed to meet the needs of each child or young person and their family. However, looking across the eight participating case study areas, it was clear that a number of services/budgets were likely to be more commonly considered. This included:

- **SEN –** high needs block funding, SEN transport and specialist equipment

- **Health –** community paediatrics, speech and language therapy, occupational therapy, physiotherapy, children's, specialist nursing, continuing care and specialist equipment

- **Social care –** short breaks and specialist provision for children and young people with disabilities.

The eight participating case study areas showed that **resourcing could be specified in a variety of ways both across services and areas, with little to no commonality identified in this respect**. For example, provision in an individual EHC plan could comprise of monetised costs, the number of hours or units of specific service provision, or specific forms of support that would be provided by a service, e.g. teaching assistant to focus support to help improve literacy skills. The basis for each form of specification was generally dependent on how the relevant service had historically worked. Areas also commented that the services that they were able to monetise would lend themselves to inclusion in a personal budget.

3. Development and delivery of personal budgets

> ''A Personal Budget is an amount of money identified by the local authority to deliver provision set out in an EHC plan where the parent or young person is involved in securing that provision''
>
> SEN and Disability Code of Practice (July 2014)

Personal budgets (PBs) were formally introduced through 'Putting People First' (2007). Signed by central, local government and the NHS (amongst others), this set out a desire to allow everyone eligible for publicly funded adult social care support to shape and commission their own services[4]. The Children and Families Act 2014 furthered the position of PBs **for children and young people,** by expanding of the **concept to include** services from SEN, health and social care for children and young people aged 0-25, subject to assessed eligibility**.**

It is also important to recognise that many of the other tools used to facilitate self-directed support have been around for some time. For example direct payments – defined as the power for local authorities to make a payment in lieu of social care services for working age disabled adults – were introduced in 1997 through the Community Care Act (Direct Payments) 1996[5]. The Health and Social Care Act 2001[6] went on to make it mandatory for councils to make direct payments to individuals who consented to, and were able to manage them, with or without assistance[7].

The Act also sets out a number of expectations for what is expected for local authorities through the development and delivery of PBs. These include:

- A need for **joint-commissioning** to include arrangements for agreeing PBs, which should cover: a description of the services across SEN, health and social care that currently lend themselves to the use of PBs; the mechanisms of control for funding available to parents and young people; and clear and simple statements of eligibility criteria and the decision-making processes that underpin them

[4] Other than in circumstances where people required emergency access to provision.

[5] http://www.legislation.gov.uk/ukpga/1996/30/pdfs/ukpga_19960030_en.pdf

[6] http://www.legislation.gov.uk/ukpga/2001/15/pdfs/ukpga_20010015_en.pdf

[7] The Community Care, Services for Carers and Children's Services (Direct Payments) (England) Regulations 2009, extended this duty to allow individuals who lack mental capacity and to persons subject to mental health legislation to identify receive a direct payment if managed by an appropriate individual on their behalf.

- A duty on local authorities to **prepare a PB** if requested by a child/young person or their family where an EHC plan is either being maintained by that authority, or is in the process of being prepared.

The Code provides additional guidance on what services best lend themselves to inclusion within an area's PB offer. These are presented in Table 1.

Table 1 Recommended funding streams for inclusion within personal budgets

	Service		
Age Range	**SEN**	**Social Care**	**Health**
0-18 year olds	• High Needs Block funding	• Funding for disabled children and young people • Funding for children that fall within the remit of Section 17 of the Children Act 1989	• Continuing Care • Long-term health needs
18-25 year olds	• High Needs Block funding	• Funding for disabled children and young people • Funding for children that fall within the remit of Section 17 of the Children Act 1989	• Continuing Healthcare • Long-term health needs

Source: SEN and Disability Code of Practice (July 2014)

The Code also sets out an **expectation that local authority commissioners should work towards the development of a single integrated fund from which a single PB can be drawn** (including funding where appropriate from education, health and social care), although it is acknowledged that the precise scope of PBs will reflect local circumstances and commissioning arrangements. The implications of this are discussed further in the next section.

> "Local authority commissioners and their partners **should** seek to align funding streams for inclusion in Personal Budgets and are encouraged to establish arrangements that will allow the development of a **single integrated fund** from which a **single** Personal Budget, covering all three areas of additional and individual support, can be made available. EHC plans can then set out how this budget is to be used including the provision to be secured, the outcomes it will deliver and how health, education and social care needs will be met.''
>
> SEN and Disability Code of Practice (July 2014)

Existing offer

Across the eight local areas, there was considerable variation in the number of PBs that had been offered historically, and the scope of the services included within their PB offer. Building on the opportunity afforded to children's services through Aiming High for Disabled Children, perhaps unsurprisingly, most progress in developing and delivering PBs had been made in children's social care. In all of the areas we spoke to, PBs were being offered to the families of children and young people eligible to receive support for short breaks. However, less progress had been made in developing personal budgets in health and SEN. The number of personal budgets offered, and the budgets that have been used to support them are presented in Table 2.

Table 2 Funding streams included in PBs and the number offered to date

SEN	Social Care	Health
Funding streams included in the existing PB offers		
• SEN Transport • High Needs Block (Tier 3)	• Short Breaks • Residential Care • Specialist Equipment • Personalised Support	• Continuing Healthcare • Continence
Number of PBs historically offered – 0-18 years		
Total: 281 Min per area: 0 Max per area: 262 No of areas: 7 *One area had offered 262 PBs, the vast majority of which were SEN Transport budgets. Although other areas had offered SEN Transport budgets, figures were only provided for PBs including funding from the High Needs Block and therefore the figures should be treated as indicative.* *One area was unable to quantify the no of PBs*	Total: 1,947 Min per area: 17 Max per area: 900 No of areas: 8 *Majority comprised of short breaks funding*	Total: 79 Min per area: 3 Max per area: 50 No of areas: 5 *Three other areas were unable to quantify the number of PBs*
Number of PBs historically offered – 19-25 years		
Total: 0	*Unable to quantify due to lack of information – but offer is made to all eligible adults*	Total: 13 PBs Min per area: 1 Max per area: 12 No of areas: 2 *In the other six areas we were unable to quantify the number of PBs due to a lack of information*

Source: Participating case study areas

Social Care

The **PB offer was much more developed in social care** across the eight case study areas. Reflective of this, most consultees indicated that the majority of adults assessed as eligible for support were offered a PB. Such PBs can help adults meet a short or long term need, and can be used to purchase specialist equipment or commission personalised support.

In all eight areas, consultees indicated that short breaks funding, at the very least, had been offered as a personal budget to families in receipt of support from children's services. That said a number of areas had expanded this offer to include other funding streams including specialist equipment, residential placements, and personalised support.

Health

In all eight areas, the concept of a Personal Health Budget (PHB)[8] remained relatively new. In all but one area, this offer had been restricted to children in receipt of NHS Continuing Care[9]. It was unclear in the areas we visited how much progress had been made in offering NHS Continuing Healthcare to 18-25 year olds. In most cases personal budgets were being offered on an ad hoc basis.

> "We had a look at including Continence products (within the personal budget offer) but we simply couldn't maintain the same economies of scale achieved through existing commissioning arrangements"
>
> Personal Budgets Lead, Children's Services

Outside of NHS Continuing Care, one area was offering personal budgets that included funding from the Continence Budget, while three other areas had considered this and then proceeded to rule it out. The primary reason for this was concern around financial viability.

[8] A personal health budget is defined by NHS England in their guidance on the subject as 'an amount of money to support a person's identified health and wellbeing needs, planned and agreed between the person and their local NHS team'. See NHS England (2012) About personal health budgets (Online) Available: http://www.personalhealthbudgets.england.nhs.uk/About/ (Accessed: 02/08/2014)

[9] NHS continuing care is support provided for children and young people under 18 who need a tailored package of care because of their disability, an accident or illness. It is different from NHS continuing healthcare, which can be provided to adults who have very severe or complex health needs. The main difference is that while continuing healthcare for adults focuses mainly on health and care needs, continuing care for a child or young person should also consider their physical, emotional and intellectual development as they move towards adulthood

SEN

In SEN, Five of the eight areas we spoke to had offered PBs that included funding from the Dedicated Schools Grant. However, **in most cases these had been offered on an ad hoc basis** to meet a specific need. For instance in one area all five PBs comprised of both the basic needs block (Tier 1 and 2), and high needs block funding (Tier 3). Such PBs were commonly used to fund alternative education placements where it was not felt that the child in question was suited to institutional learning (many of these children went on to access one to one support in an informal setting). Despite these successes, practitioners acknowledged that such cases were always likely to be in the minority rather than the norm. Rather than concentrating effort on such cases it was felt that time should be spent developing a process by which PBs could be accessed by children eligible for high needs block funding. None of the case study areas had a process in place yet to achieve this on a service-wide basis.

> "It is challenging identifying education budgets from which personal budgets could be taken as schools get a very powerful say''
> Service Team Manager, SEN

Half of the areas we spoke to were offering SEN Transport budgets. In most cases budgets were offered where they would be cost neutral or represent an overall cost saving, and had the potential to improve outcomes for the family. For example, a number of areas indicated that families had derived considerable benefits from access to independent travel training.

In most cases where areas had chosen not to offer such budgets they were not considered financially viable. A number of consultees were also concerned that it would be challenging to align the process for allocating a SEN Transport budget into the wider EHC assessment and planning process, as such a budget would commonly be allocated after a Plan had been signed-off (once the child/young person entered the named setting). However, others felt that such budgets could be identified in the plan as it was formally reviewed.

Progress and future intentions

Across all eight case study areas there was recognition that a PB was a valuable tool in improving outcomes for service users. Indeed **all areas were committed to expanding their offer in the future**. However, **progress had been slow** with few areas working towards the inclusion of additional services within their PB offer in the short term. Where work was underway to include particular funding streams within an area's PB offer these are listed in Table 3.

Table 3 New funding streams for inclusion by areas within the PB offer in the short to medium term

Age Group	SEN	Social Care	Health
0-18 year olds	• High needs Block (Tier 3) • Basic Needs funding (Tier 1 and 2)	• Children who do not have a disability but have been assessed as Children in Need (CiN) due to issues of parental capacity or risk	• Children with Life-limiting conditions
18-25 year olds	• High needs block (Tier 3)		

Source: Participating case study areas

Social Care

The majority of areas (six of eight) felt that they **were unlikely to expand upon their PB offer in the short-term**, and instead hoped to focus on increasing take-up amongst service users for whom the offer of a personal budget was already available. A number of consultees noted that their immediate priority was to ensure the effective integration of the PB offer into the EHC assessment and planning process.

In the small number of areas that were looking to expand upon their existing offer, consultees indicated that there was **an opportunity to offer PBs to children who do not have a disability but have been assessed as Children in Need (CiN) due to issues of parental capacity or risk**. That said, it was acknowledged that this might require a degree of creativity in how such PBs were aligned with the EHC assessment and planning process. For instance, while in most cases funding for this group of children is offered in the short term to support a family in crisis (often over a few months), the time horizon for an EHC Plan is substantially greater than that (such a plan will normally be reviewed every 12 months). Given the resource (in terms of time and money) invested in this process, it was felt that it was unlikely that an area would be able to manage to bring such a review forward to react to such a change in circumstances.

Health

In most areas (seven of eight) there was **limited awareness of the duty to consider offering personal budgets for children and young people with long-term health needs** from April 2015. This was in part likely to be because central guidance had not yet been issued in relation to the specifics on this and had led to only one area beginning to explore the feasibility of this. In most cases the priority was felt to be embedding the process for offering PBs for children and young people in receipt of Continuing Care (0-18 year olds) or Continuing Healthcare (18+ year olds).

SEN

Amongst consultees, there was **strong support for the development of PBs which drew upon funding from the high needs block** (for school-age children and those young people accessing FE). All areas considered this a priority. However few areas had a work plan in place to support the introduction of this form of PB. In most cases, the main barrier to progress was a lack of existing infrastructure to support this, in particular the capacity to accurately cost individual services. The challenges facing areas in developing appropriate infrastructure is discussed in more detail in Chapter 4.

A number of consultees also indicated that their key priority was to introduce the wider service changes required to embed the EHC assessment and planning process. Once this was accomplished it was felt it would be much easier to develop an offer around PBs. Furthermore, a number of consultees argued that even where PBs were not available, service users could benefit from personalised packages. For example:

- In one area, a number of children attending the same setting used wheelchairs. As a result they travelled to school in a specially adapted minibus while their peers travelled on the school bus. A number of these children indicated that they would prefer to travel with their friends. However, hiring an adapted bus to take all the children to school was found to be more expensive on a trip by trip basis – and as such the area did not feel able to offer a PB to those children in receipt of support. However, following further consultation between the setting and a local bus company, a deal was struck whereby the cost of hiring an adapted bus was reduced (making it a cost neutral option) as long as the company was given preferred supplier status.

- In a second area, a family had asked if they could access a direct payment in order to employ a private nurse to support their child in school. The school felt unable to support this as it would destabilise the provision offered to other children. Instead practitioners were able to redesign the package of support offered to the child so it better met their needs at no additional cost.

Challenges faced by areas in expanding their offer

Across the eight case study areas, consultees set out a number of challenges facing them in expanding their offer of PBs. These are summarised in Table 4, which also provides potential means of addressing each challenge. While some of these were specific to particular service areas, a number of these were cross-cutting. Moving forward, finding solutions to these may require a strategic multi-service approach.

Table 4 Common challenges faced by case study areas in expanding their offer of PBs

Challenge	Description	Potential Response
Strategic Challenges		
Availability of unit cost data	Consultees noted that an effective PB offer relied on the capacity of practitioners/decision-makers to identify the cost of meeting an individual's needs. In a number of areas, practitioners indicated that such data simply was not available	A number of areas had either created, or were in the process of creating a provision map. While varying from case to case in terms of its contents this commonly included a list of the types of provision included within an areas PB offer and the unit cost of accessing this service. For example the cost of accessing support from a Learning Support Assistant for an hour.
Reliability of unit cost data	In a number of areas unit cost information was available and had been used by decision-makers to support the allocation of resources. These costs had functioned as a guide rather than an accurate estimation of the cost of care. For example, in one area, the provision map used by SEN provided a single unit cost for support from a teaching assistant. It was acknowledged that a number of different practitioner types were captured in this broad categorisation, and attracted different pay rates.	In such cases, areas were commonly reviewing their existing provision map to ensure it was robust enough to support the allocation of PBs.
Inflexibility of existing commissioning arrangements	Consultees across all three service areas commented that areas of their service had been commissioned as a block contract. In most cases commissioners had found it difficult to support individually commissioned packages, without incurring additional costs.	Over the medium term, a number of consultees indicated that they were committed to re-evaluating these contracts and exploring alternatives. A number of areas indicated that they would look to move to a call-off model, although it was acknowledged that such arrangements would only be sustainable if the provider market was sufficiently developed to support this type of commissioning.
Growing the	A number of consultees indicated that while they could see the value of	A number of consultees indicated that over the medium-long term

Challenge	Description	Potential Response
provider market	PBs they were concerned that, the provider market in their area was not strong enough to support individual level commissioning. In such cases independent providers would either be likely to fold if not supported by the commissioner, or there would not be enough providers to offer a family sufficient to choice to make a PB worthwhile	they would like to take advantage of the learning from Aiming High for Disabled Children and much of the market development work that had been undertaken in Short Breaks. Over time it was felt that other services could support the development of a provider market in a similar way. For example for providing seed funding to organisations to support their development until a time at which they could enter a fully competitive marketplace.
Maintaining service viability	A common concern of areas was the challenge of balancing the desire to offer PBs, against the need to ensure the continued viability of existing provision. For example two areas, commented that were they to offer PBs for families in receipt of residential support, they were concerned that their sole remaining setting would be forced to close. There was concern that this would reduce choice for those parents that continued to want access to this service	One area had looked to respond to this challenge by applying a moderator to the amount offered to families as a PB where they decided to opt out of particular services. Such packages were set a level where it was felt that they would be sufficient to allow services to be commissioned from a provider at a level that would meet the needs of a child/young person, and subsidised existing provision. That said it was acknowledged that this type of arrangement would only be feasible in some circumstances.
Challenges in SEN		
Negotiating the release of school funding	A number of areas indicated that schools were reluctant to release funding to support individual children/young people. In most cases this was due to concern that this would affect the quality of support offered to other children and young people at the setting.	Even in those areas, where PBs had been offered to children/young people using funding from the Basic Needs Block, there was an acknowledgement that this was likely only to happen in exceptional cases. In most cases it was felt that the introduction of the High Needs Block would provide areas with a much stronger mandate to deliver PBs using this funding.

Challenge	Description	Potential Response
Challenges in Health		
Promoting PBs amongst the health workforce	A number of consultees acknowledged that they had found it difficult to persuade practitioners of the potential benefits of offering PBs, as many felt that this had the potential to undermine the principle of providing care 'free at the point of use'. In such cases some practitioners had been reluctant to make decisions about financial packages.	A number of areas were starting to think about what type of workforce development activities may be required to support attitudinal change.

Source: SQW

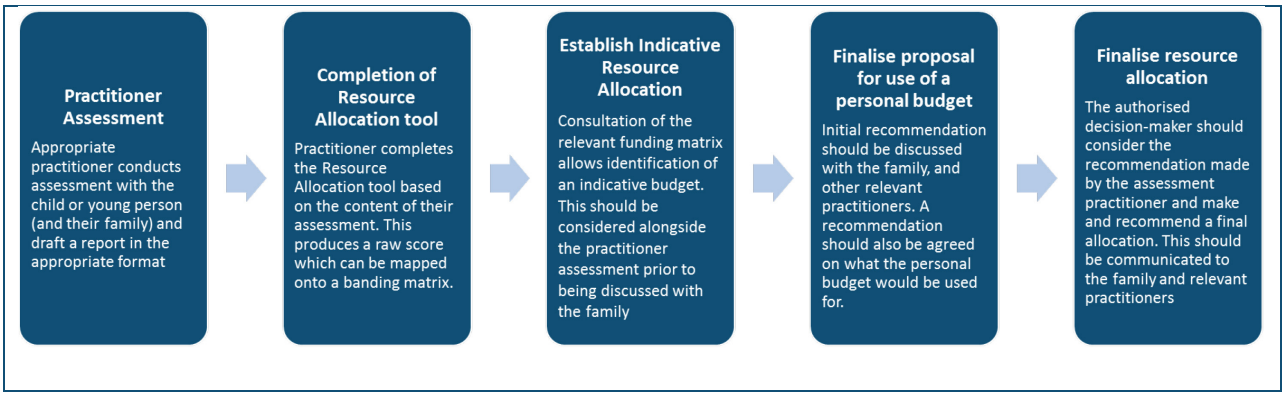
4. Calculating a PB and its position in the EHC assessment and planning process

This chapter considers two issues around PBs. The first section of this chapter discusses the methods used by areas to decide the amount of money allocated through an individual's PBs. The second section then considers at which points PBs have been integrated in to the wider EHC assessment and planning process.

Methods of quantifying personal budgets

A variety of different methods were observable between areas, and individual services within some areas. That said a number of common elements were identifiable. These are presented in Figure 3.

Figure 3 A common approach to resource allocation



Practitioner Assessment

The starting point in all areas for the identification of a PB was a practitioner assessment. Indeed a number of consultees commented that even where a resource allocation tool had been developed, the role of this tool was to guide rather than dictate the amount offered as a personal budget.

Completion of a Resource Allocation Tool

In the eight case study areas **most services were either using, or were in the process of developing a resource allocation tool to support practitioners** to develop an indicative budget. However, the extent to which such processes were embedded varied considerably between service areas. That said across the different tools used by different areas/services a number of common characteristics were evident:

- Tools were **completed following an initial assessment**
- Tools were **structured around a series of domains**. While dependent on the number of services included within the coverage of the tool, in most cases there were between five and ten such domains

- **Within each domain one could expect to find between one and five individual questions**

- **Commonly responses to each question were considered against a series of descriptors**. Each descriptor is assigned to a specific banding which provides a summary of a service user's level of need for example 'requiring no other support' or 'requiring exceptional support'

- **Each descriptor in turn is allocated a score which allows a practitioner to assess a child/young person's overall level of need**.

In Health and Social Care, **all of the areas** we spoke to **were using some sort of tool to support resource allocation** in Children's and Adults Services. However, such processes were considerably more developed in Social Care than in Health. **In Social Care,** all eight areas were using some sort of **locally developed tool** (often developed on the basis of a template developed by In Control). However, the coverage of these tools was variable. While in some sites the tool was used to assess need across a broad range of services, in others, only Short Breaks was assessed in this way. In most cases, as areas looked to expand their offer of PBs, so they hoped their existing tool could be adapted to reflect this.

There was also some evidence of integration. In one area an integrated resource allocation tool had been developed for use by SEN and Social Care Practitioners. This was completed by the lead practitioner at the TAF, taking account of the assessments completed by those practitioners involved in the case. This was felt to be important to ensure that practitioners were comfortable with the outcome. To support an integrated assessment of need, the tool was split into a series of service specific domains and cross-cutting domains .This had been done to reduce duplication while allowing for consideration of the precise nature of the need for each service, and support discussion of if a multi-agency solution was appropriate (for example a 50:50 split between SEN and Social Care).

The raw score (adjusted depending on the age of the child/young person) was then matched to a banded funding matrix to establish an indicative funding allocation. Where appropriate this could be used to support a discussion with the family about how they could use a PB. At this point, a practitioner from each service was responsible for recommending the agreed approach to an appropriate budget-holder (one in SEN and one in Social Care) at which point it could be signed-off (the budget-holder would vary dependent on the size of the indicative allocation). To date there was no mechanism to support the allocation of joint-PBs, indeed PBs were only routinely offered to children or young people eligible for short breaks. However, it was hoped that this might be possible in the long-term. It was acknowledged that developing a process to support the allocation of PBs using funding from the SEN high needs block would be essential to making progress in this area, although conversations around how to do this remained at an early stage.

Seven of the eight case study areas were using the Decision Support Tools developed by the Department for Health. The relevant tool was used to support the assessor to identify the level of need of a particular service user in a consistent way. In most cases progress in developing a systematic process for converting these judgements into an indicative budget were at an early stage. As a result, decisions regarding the size of an individual PB were being made on an ad hoc basis directly by budget-holders (or those with delegated authority). Despite the benefits of developing such a process a number of areas expressed concern about the lack of guidance in this area, and the danger that locally developed solutions could leave them open to challenge at tribunal. Where this concern constitutes a barrier to progress in this area, additional guidance from the Department of Health might be helpful.

In SEN, the use of such tools was much more mixed and SEN personal budgets had only been offered on an ad hoc basis outside of the conventional assessment and planning process. **Two of the eight case study areas were using a resource allocation tool** similar to those used in social care. In the remaining areas individual practitioners were responsible for recommending package amounts based on their assessment alone. That said there was broad recognition that if the PB offer was to be rolled out to all those children and young people eligible for the High Needs Block, then adoption of a resource allocation tool would help to lower the risk that the area would be left open to challenge, and as a result they would be looking to develop this form of tool in the short-medium term.

Establish an Indicative Resource Allocation

In most cases **practitioners moved from scores generated from the resource allocation tool to establish an indicative budget through using a banded funding matrix** (although in one case price points were used). Such tools were available to social care practitioners in all eight case study areas. Banding was generally preferred due to the flexibility this afforded decision-makers to consider each case in the round. For instance, a number of consultees noted that while a resource allocation was useful, no single tool could be expected to be sensitive to the needs of all children or young people. In such cases it was felt to be important that decision-makers were given the scope to reflect on this in assigning a final allocation.

> "While our RAS is a good tool, it measures some things better than others. For example it often underestimates the needs of children with autism or mental health issues ''
>
> Team Manager, Children's Social Care

In SEN four of the eight areas had a funding matrix in place. This was used to support decision-makers rather than practitioners in making final rather than indicative funding allocations. Moving forward, a number of areas expressed a desire to develop a banded funding matrix to support practitioners to identify indicative allocations in a manner similar to that commonly adopted in social care.

Finalise proposal for a personal budget

All eight case study sites were strongly of the view that a personal budget retained its value only when delivered as part of a transparent and person-centred assessment and planning process. Following the development of an initial recommendation, it was considered vital that the indicative resource allocation was communicated to the family/service user, so that consideration could be given to how a personal budget could be used to support a child or young person.

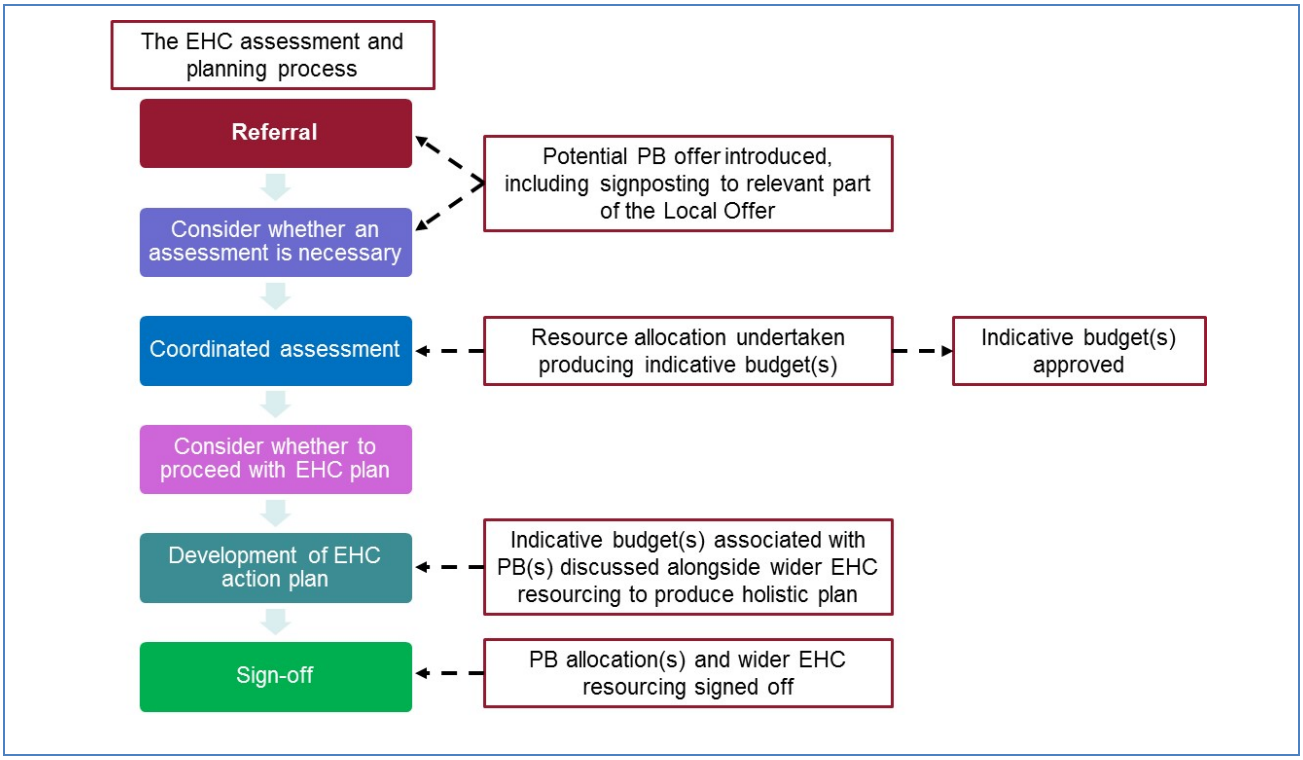
Finalise Resource Allocation

A variety of different decision-making processes had been adopted to finalise individual resource allocations. While a number of areas continued to use a panel structure, others operated a graduated system with different practitioners given different levels of delegated authority depending on the size of the proposed package of care, and their level for seniority within the service. Consultees considered there to be pros and cons with each approach. There was broad agreement that panels, particularly where they contained multi-agency representation were more resource intensive than a delegated model. However, it was felt that such panels often ensured a degree of consistency which was often not maintained where a number of different practitioners had authority to approve resource packages independently of each other.

Integrating personal budgets into the wider EHC assessment and planning process

Although only two of the eight case study areas had trialled the integration of PBs into the wider EHC process with families, **nearly all identified a common pathway describing their intentions to do so** (see Figure 4). Areas also commented that this form of integration had been relatively simple to map out, as the process by which an individual PB and EHC plan were developed followed a similar sequence.

Figure 4 Common sequence of integrating PBs into the EHC assessment and planning process



Source: SQW

However, when working through the detail of how the intended integration would be operationalised with families, it was evident that a number of the case study areas still needed to consider the issues set out in Table 5.

Table 5 Issues for consideration when operationalising the integration of PBs into the wider EHC process

Issue	Description
How much information to offer to a family when introducing the PB offer and in what format this introduction should be made	Although most of the case study areas were clear that the offer of a PB/PBs needed to be made during the initial stages of the EHC assessment and planning process, they were less clear about how the offer should be made e.g. through a face to face meeting, written information etc. and the scale/type of information to offer. It will therefore be important to work with local families to understand when and how best to do this, which may require using a differentiated approach for families of differing capacities

When to introduce the indicative budget(s) to families	All but one of the case study areas intended to develop indicative budgets for their PBs. However, the process by which this budget was communicated to families had not been firmed up in the majority of cases, as areas were considering how best to do this. In the main, this involved a choice between two options, communicating the information as part of the summary assessment/draft plan that is put together in advance of the planning meeting or communicating the information at the meeting. Although both options appeared to have their merits, it is likely that earlier communication prior to the planning meeting would better enable families to more effectively prepare and consider their preferences
How and when potential duplication across PBs and the proposed wider EHC resourcing would be considered	Although all consultees stated that the multi-agency (and family) planning stage acted as the fundamental point at which holistic planning would take place, very few mentioned using this to consider potential duplication between proposed resourcing/provision. Although this is likely to form an implicit element of this stage of the process, it may be beneficial to formalise this requirement and the stages at which it will be considered to ensure both families and professionals make the most efficient use of available resources
The extent to which service provision associated with a PB/PBs needs to be specified during the EHC planning meeting	The two areas that had trialled the integration of PBs into their wider EHC assessment and planning process had used a staged process which involved an initial discussion about the PB during the EHC planning meeting, and was followed by a separate PB specific meeting to map out the detail e.g. specific service provision, associated with the PB provision. This staged approach was used to minimise the burden placed on both professionals and families during the EHC planning meeting. Other areas expressed an intention to undertake all required planning during a single EHC planning meeting, although the feasibility of this approach had not yet been tested.
How the integration process would work for families that had existing, live PBs prior to the EHC assessment and planning process	A small number of the case study areas were intending to deliver a graduated assessment and planning approach. This would be holistic in its nature, applicable to all children and young people with additional needs and would result in an EHC plan for those with the most complex needs. In these cases, it is likely that a family may develop and already be in receipt of their PB prior to being 'escalated' to the EHC plan stage, implying integration of these packages may need to be considered in a different manner. For example, if the PB support package(s) had been signed off shortly before the EHC process was begun, it may be more appropriate to incorporate the PB/PBs as is and consider any modifications as part of the first review of the EHC plan.

How to integrate PBs into the wider EHC process for families undergoing a translation from an existing SEN Statement/LDA to an EHC plan	The majority of areas had mapped out their intentions on how they would integrate PBs into the wider EHC process for families that were 'newcomers' to the system. However, limited progress had been made in relation to the approach used for families with an existing SEN Statement/LDA (and potentially existing PBs). This issue is similar to the previous challenge (see above) and may require the mapping and delivery of a modified pathway.
What level and type of information needs to be included in the Local Offer to ensure families could weigh up their options in relation to PB and wider EHC resourcing	Development of the PB and resource-related elements of the Local Offer had been fairly limited across the participating case study areas, with many still considering the scale/type of information that would be required to meet the needs of local families. Although most had begun to collect information from across their service providers, it remained unclear to what extent individual services (and indeed providers) could and should be asked to provide monetised or unit costs wherever possible. This form of information was likely to be useful to families as it will enable them to understand how any monetary resource could be used and to make comparisons between different providers.

Source: SQW

5. Family vs. strategic level resource integration

All eight of the participating case study areas had begun to consider whether the **integration of resourcing** could be a beneficial addition to the new approaches they were developing to support children and young people with SEN and disabilities. This was **considered by the majority of the case study areas to be one of the most challenging aspects of the SEN and disability reform agenda. As a result, progress towards achieving this remained largely developmental at this stage, with most having mapped out a set of initial intentions, and viewing integration as a 'work in progress'**.

> "We had a vision that we could crack it (service integration) in a year but we know better now, it takes longer''
>
> Head of Service

It was also evident that the ultimate goal of **resource integration was perceived to mean different things across the areas and therefore was likely to be achieved in a diverse range of ways**. This chapter is therefore structured under the following two headings, each of which explores a different form of integration (albeit they are not mutually exclusive):

- **Family level integration** – drawing together service-specific resourcing at the level of the individual family during the EHC assessment and planning process
- **Strategic level integration** – drawing together distinct service-related resources at the level of the population, for example via the pooling/aligning of budgets.

Family level integration

The majority of the areas felt it would be more timely and effective to aim to achieve family level integration as opposed to strategic integration. This was to involve the development of service-specific 'indicative or proposed' resourcing assessments, with a view to considering these in the round at the point at which assessment and/or planning information was drawn together. The main rationale provided for this preference was that it would lend itself better to a process that evolved over time and was therefore more likely to have the capacity to incorporate an increasing number of services/budgets over the longer-term.

This form of integration was to be achieved through a combination of:

- **Multi-agency decision making panels in the EHC assessment and planning process** – areas intended to put in place multi-agency panels to consider and approve provision and resourcing both post-assessment (and pre-planning) and post planning. This kind of forum was seen as instrumental in supporting the adoption of more creative multi-agency resource packages (with or without a personal budget component). For example in one area, arrangements were in place to support the joint funding of personal health and social care budgets.

While signed-off separately these were presented as one budget to the service user

- **Professionals coming together after undertaking their assessments and before the EHC planning stage –** a number of the areas intended to bring professionals together once they had undertaken their individual assessments to discuss how best to holistically support and resource the meeting of the outcomes that had been agreed with the family. However, a small number of consultees from the relevant areas voiced their concerns around the burden that this was likely to place on professionals, by requiring them to attend an additional meeting

- **Multi-agency discussion between professionals and the family at the TAF EHC planning meeting –** the TAF EHC planning meeting was seen by most as the vital stage at which professionals and the family could have a discussion about what support should be provided and how this could be resourced to best meet the identified need and outcomes. The main challenge to achieving this was likely to be around ensuring those practitioners attending the meeting had sufficient authority and confidence to make resourcing decisions.

> "We expect professionals attending the TAF planning meetings to discuss and where possible decide on the relevant resource…in the main in SEN, the professional will be offering their own time or resource, which they will have the authority to do so"
>
> Head of Specialist Teaching Service

Strategic level integration

The remaining small number of case study areas were intending to undertake a combination of both strategic and family level integration, as they felt that change was required at both these levels to bring about the anticipated benefits. **This decision also appeared to have been influenced by the extent to which existing commissioners from distinct services were already working together.** That is, strategic integration was being developed by those areas that had already established some joint commissioning protocols and/or where good working relations between the commissioners were apparent.

In addition to the intended approaches described previously, this set of areas was also aiming to:

- **Pool and/or align budgets between the local authority and health** – including Section 75 agreements between the CCG and the local authority for specialist equipment (held and managed by SEN), speech and language therapy, (held and managed by SEN), and specialist health care tasks (held and managed by the CCG). And in relation to aligned budgets, included continuing care and the

children with disability social care budgets (between the CCG and social care), speech and language therapy (between the CCG and SEN) and physiotherapy (between the CCG and local authority).

- **Undertake combined assessments** – either via multiple professionals undertaking assessments with a family simultaneously or via the development and delivery of a combined assessment, often by two professionals from different backgrounds e.g. a CHC nurse assessor and children's disability social worker.

Consultees from this set of areas added that although this form of change was likely to take time and only be fully achieved over the longer-term, it would lead to the reduction in duplication across services and create the appropriate signals to bring about the required cultural change across the piece.

Integration of PBs from different services

The integration of PBs from different services could also be undertaken at a strategic and/or family level, with the former involving the pooling/aligning of individual service budgets prior to or during assessment, and the latter involving the consideration of distinct PBs in the round at the planning stage. Again, both options had been considered by all the case study areas, resulting in the majority stating an intention to integrate PB at the level of the family only. That is, **whilst a small number of areas felt it was important to pool together all flexible budgets into a single, integrated PB, others felt that the strategic pooling of budgets was a 'red herring'** and instead intended to continue to develop distinct PBs and focus on considering these together at the planning stage of the EHC process.

> "It is easy to get distracted by the move to pool budgets at a strategic level. We are taking a different approach and pooling resource at the individual level, as this is much more timely"
>
> SEN and Disability Commissioner

Of the areas that were pursuing the strategic integration of PBs, professionals were working together to address how best to pool and determine multi-agency resource allocations using the available budgets. As described in Chapter 4, this had involved the trialling of multi-agency resource allocation tools in some cases, which sought to draw together both common and distinct elements of individual resource allocation tools. However, much of this development remained a work in progress as the relevant areas had not yet developed a model of working that they were happy to roll out.

Summary

Local areas have a statutory duty to consider the potential benefits and feasibility of embedding family and/or strategic integration into their new approaches. This decision

making process is likely to be heavily influenced by the local context and existing infrastructure within each local area, for example, the extent to which joint commissioning was already in place between the local authority and the CCG).

Table 6 presents a summary of the likely benefits and challenges associated with both family and strategic level integration.

Table 6 The advantages and disadvantages associated with family and strategic level integration

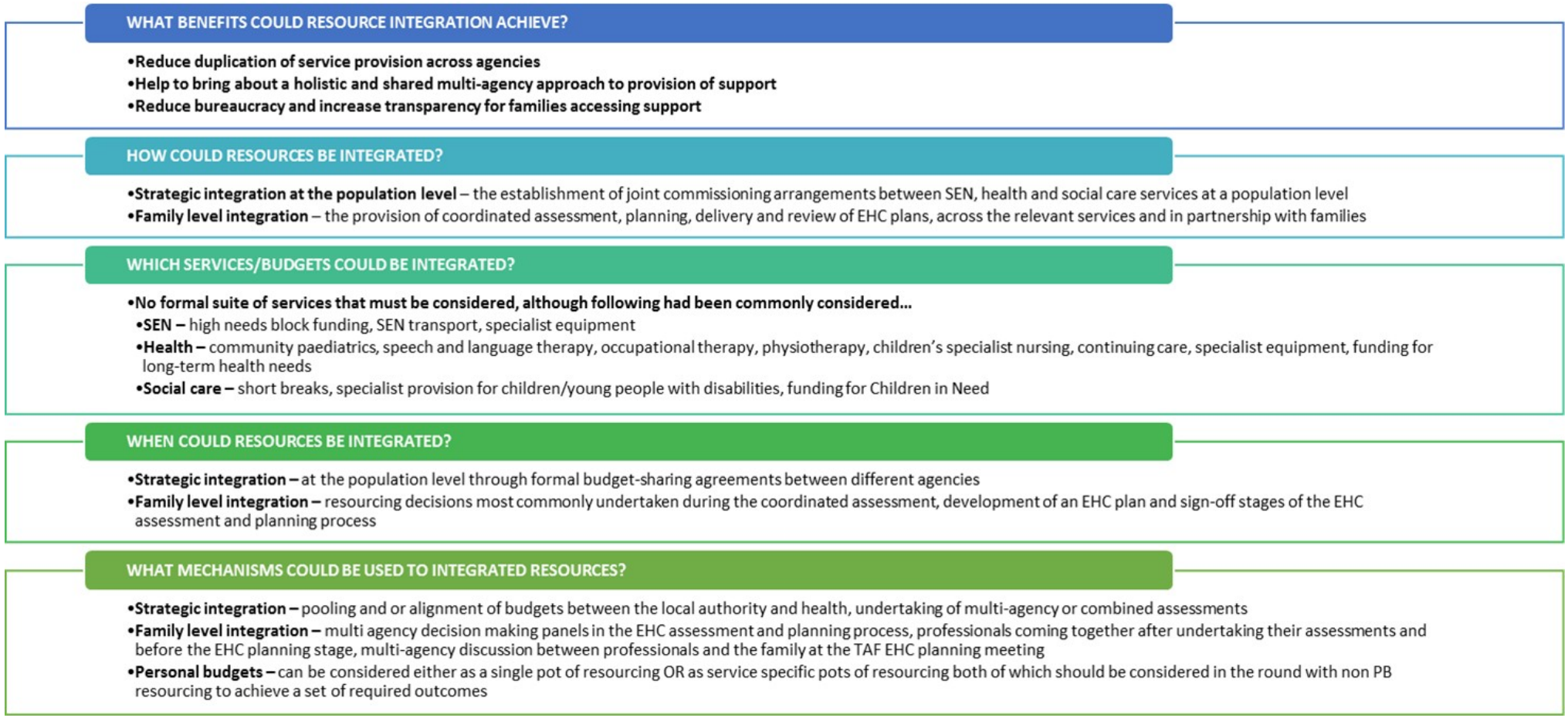
	Benefits	Challenges
Family level integration	• Can be delivered in the short-term as involves little to no strategic change • Increases transparency of the resource allocation process • Avoids or limits the issue of resource duplication • Supports the undertaking of holistic planning as enables resources to be considered in the round	• Front-line professionals attending multi-agency meetings will require a specific skill-set to effectively negotiate resourcing with families • Depending on model(s) used, may require professionals (front-line and/or budget holders) to attend more meetings and therefore be resource intensive • Adoption of this approach may require a delegation of authority to develop an indicative resource allocation (to front-line professionals) • Is unlikely to comprehensively identify duplication of resourcing across services
Strategic level integration	• Provides a valuable signal to front-line staff and families that cultural changes are being made at the strategic level • Over the longer-term is likely to improve the timeliness of multi-agency working • Avoids or limits the issue of resource duplication • Supports the undertaking of holistic planning as enables resources to be considered in the round	• Likely to take time to develop and therefore be achieved over the longer-term • Potential loss of control by some those who act as budget holders for the distinct services • Could require upfront investment to support service transformation • Will entail a detailed debate about how much each relevant service should contribute to the integrated pot of resources – and an ability to flex the use of this integrated pot to meet holistic outcomes, as opposed to service-specific outcomes • May require the establishment of new oversight / control mechanisms

Source: SQW

6. Checklist of questions to consider

Figure 5 presents a summary of the key questions that local areas should think through when considering whether it would be beneficial to integrate the resourcing available to support families with children and young people with SEN and disabilities.

Figure 5 Key questions to consider in relation to integrated resourcing



Annex A: Glossary of terms

CC	Continuing Care
CCG	Clinical Commissioning Group
CHC	Continuing Healthcare
DfE	Department for Education
EHC	Education, Health and Social Care
LDA	Learning Difficulty Assessment
NHS	National Health Service
PB	Personal Budget
PHB	Personal Health Budget
SEN	Special Educational Needs

Annex B: Research methods

Research was undertaken in eight pathfinder areas, selected in discussion with the DfE, DH and Pathfinder Support Team. The basis for selection of the areas included: areas that were either advanced in their development of PBs and/or are delivering these as part of their EHC assessment and planning process; both pathfinder and non-pathfinder areas; a mix from across the regions; a mixture of rural/urban and large/small areas; and where possible at least one pathfinder champion. Three scoping consultations were also undertaken with representatives from the Department of Education, In Control and the Department of Health, to ensure the feasibility, deliverability and usefulness of the research outputs, and identify emerging practice. In addition, further input was provided by NHS England during the course of the fieldwork.

Once the eight areas had agreed to participate, a scoping consultation was held with the SEN and disability reform lead, and in some cases the PB lead, in each area. This involved providing an introduction to the research, a discussion about the progress they had made to date and the identification of further contacts to participate in the fieldwork.

Fieldwork

Fieldwork was conducted in July 2014, and consisted of:

- Face-to face or telephone interviews in each area with the operational lead for the EHC assessment and planning process, budget-holders for SEN, social care and health, commissioners, lead(s) for personal budgets from SEN, social care (children and young people, and adults) and health (most likely CHC), PB support organisations/advocates
- Face-to-face interviews or group discussions with front-line staff that had been involved in the development and delivery of EHC plans and PBs.

The interviews followed a semi-structured topic guide designed by the research team, covering the seven broad research questions outlined in the introduction of the report. Participants were asked to set aside approximately one hour for the consultations, and all interviews were recorded.

Analysis and reporting

The analysis took place in two stages. Firstly, each area ‘case study’ was written up in alignment with the seven research questions. Secondly, the research team looked across the eight write-ups to explore commonalities and differences in responses across areas and the themes covered by the research questions.

The report was drafted based on these findings, with an emphasis placed on developing a readable and pragmatic report, which drew on a range of experiences and would be useful to both those involved in the development of PBs and integrated resourcing.

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The views expressed in this report are the authors' and do not necessarily reflect those of the Department for Education.

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