Department
for Education

Evaluation of the extended individual budget pilot programme for families with disabled children: the extended packages

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Contents

Acknowledgements

The team

SQW was commissioned by the Department for Education (DfE) to lead a consortium to undertake the evaluation and support of the extended year of the Individual Budget (IB) Pilot Programme for Families with Disabled Children. The consortium comprised of SQW, Ipsos MORI and iMPOWER, and drew upon expert advice from individual health and education specialists.

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Claire Lambert and **David Jeans** acted as the leads for Ipsos MORI.

Expert health and education expertise was provided by **Rob Whiteford, Professor Anne West** and **Phillip Noden**.

David Colbear acted as the lead for iMPOWER.

Executive summary

1.   This report is one of two volumes containing the findings from the extended year of the Individual Budget (IB) Pilot Programme for families with disabled children. The two volumes cover:

- *The Extended Packages,* which provides an assessment of how the pilot sites sought to broaden their IB offer to include both education and health funding, and the challenges associated with this - **these issues are contained in this volume**

- *The Family Journey One Year On,* which provides an update on the position and views of the original cohort of families that participated in the IB pilot 12-18 months after they began to receive their IB payments.

The extended Individual Budgets programme

2.   The IB pilots were originally commissioned to run from April 2009 to March 2011 by the former Department for Children, Schools and Families (DCSF), to establish if an IB:

- Enabled disabled children and their families to have more choice and control over the delivery of their support package

- Improved outcomes for some, or all, disabled children and their families.

3.   The programme operated in six pilot local authority areas (Coventry, Derbyshire, Essex, Gateshead, Gloucestershire and Newcastle), each of which generated a wealth of information and learning about the introduction of IBs for families with disabled children[1]. However, much of the evidence was based on the inclusion of only or very largely social care funding in the IB packages, with health and education monies often limited, for example to very specific items or nominal amounts of money.

4.   In May 2011, and following the change in Government in 2010 when delivery of the Programme passed to the Department for Education (DfE), the six IB pilots were

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[1] The suite of reports from the original two year evaluation of the IB Pilot Programme can be found at https://www.education.gov.uk/publications/standard/publicationDetail/Page1/DFE-RR145

extended to run for an additional year (i.e. 2011-12) to test how they could broaden their offer to include Education and Health funds/services into their IB packages

5.   It was expected that the development of the extended IB Pilot Programme would be strongly influenced by the concurrent development of the SEND Pathfinder Programme.

Intentions for the extended pilot

6.   Each area was able to choose their own direction of travel and tailor developments to complement local arrangements/structures. As a result, each pilot site chose to explore a different set of funding streams/services, the most common of which were:

- NHS Continuing Healthcare

- Health-based equipment

- Early Year provision

- SEN transport

- School based budgets – including the SEN statement budget.

7.   The rationale for exploring different funding streams/services was largely driven by the 'ease' with which they could be included, with some sites appearing to be more ambitious than others.

8.   Intentions for the extended year also included:

- Alignment, joining up and integration of budgets, assessment and support plans – which was heavily influenced by each site's SEND Pathfinder application

- Expansion of the pilot in terms of increased numbers of children and young people with an IB

- Continued development, testing and evidencing of the effectiveness of the IB and personalised approaches.

9.   The most commonly identified risks associated with taking the IB work forward included: challenges around disaggregating health/education budgets; and a lack of understanding/commitment and capacity on the part of health/education staff to get involved.

Progress made against the intentions

10.   The initial four months of the extended IB pilot were largely developmental, the main outcome of which was additional strategic engagement from health and education colleagues. The majority of the pilot sites suffered a hiatus in activity over the subsequent period – September to November 2011 - as a result of notification that they had been unsuccessful in their application to become part of the SEND Pathfinder Programme. This led to some disengagement from both health and education colleagues, which took considerable resource and effort to rebuild (and even then not all partners re-engaged).

11.   The sites reduced their ambitions considerably during the course of the extended year which led to the adoption of one or more of the following three approaches:

- Refinement of the existing social-care based IB approach

- Development of discrete and often small-scale trials of extended health and/or education IB packages

- Focus on expanding the IB packages of the original cohort of IB families.

12.   The small scale trials that were taken forward resulted in limited consideration of how best to align social care, education and health IB approaches.

Inclusion of education services in an IB

13.   All six of the IB pilot sites set out clear education-related intentions in their Year Three Delivery Plans. This included exploration of early years, school-age and post-16 service/budget areas. The following were explored over the course of the pilot:

- **Community Enhanced Nursery Allocation IBs** – which provided a set sum of money per child and formed part of a notional budget that was provided directly to the nursery setting chosen by the family, to support the child to access/attend that setting. Parents and professionals were involved in planning how to spend the IB allocation

- **IB approach for the Early Years Service –** this approach focused on providing choice and control to families via the introduction of a support planning process, following which a notional budget was calculated and spent accordingly. The approach was still in development at the point of drafting this report, and it was hoped that the site would produce a working Early Years resource allocation model during 2012/13

- **Working with a small number of families with social care IBs, to 'flex' their SEN funding** – which had included creating flexibilities around how the education based therapies provision was used and re-shaping a potential out of county placement budget into locally sourced provision

- **Development of a schools based IB trial to reshape the SEN statementing process** – this trial was still in development at the point of drafting this report and was to be taken forward during 2012/13

- **Roll out of a Personal Transport Budget (PTB) approach** – which was based on a mileage rate paid directly to the family and was monitored via school attendance records.

14. Observations across the range of approaches that have either been trialled or rolled out included: a tendency to reshape existing packages in cases where areas have worked with a small number of families, with wider costing/resource allocation developments undertaken only in cases where an area intends to make a wholesale change to their approach; a reliance on the use notional budgets; and a focus on introducing proportionate support planning processes into the trials/approaches.

15. Only limited evidence could be gathered on the families' experiences of receiving the new education IB packages (as only a small number of families were in receipt of their budget at the end of the extended year). However, early indications have shown that families have reported increased flexibility and more choice and control in their service offer.

Inclusion of health services in an IB

16. Following the hiatus in activity caused by the unsuccessful SEND Pathfinder bids, only three out of the six sites managed to operationalise health budgets during the extended year of the pilot. A fourth site drew on resources provided through DfE funded support, to develop an action plan for targeted health work, which was to be taken forward during 2012/13.

17. Developments across the four sites that had undertaken health-related work included:

- **Work to operationalise NHS Continuing Healthcare (CHC) IBs –** two sites were working to reshape the current CHC processes to align them with the social care IB approach. In one case, this had involved the development of a

CHC based resource allocation tool, based on the existing *Bradford Tool,* which it was hoped could be embedded within the social care RAS. A small number of joint social care and CHC packages had been successfully developed, however, it was too early to assess the effectiveness of the new packages

- **Development of continence-based IB packages –** one site continued the development work they had undertaken during the original pilot, which led to the delivery of a small number of continence related IBs. The continence offer was made to families that were not happy with their existing provision and facilitated through the opening up of the 'continence catalogue of products', thereby creating a wider menu of choice for families to select from. Families existing packages were costed and offered as a notional budget, which was used to purchase alternative products to those previously used. Feedback from families had been positive and had illustrated that they had valued being given an informed choice

- **Intentions to explore the inclusion of Physiotherapy and Occupational Therapy –** which were to be taken forward over the course of 2012/13.

Implications and concluding thoughts

18. Although mixed progress had been made during the extended year of the pilot, much can be learnt from the discrete individual trials that have taken place. Table 1 sets out a summary of the implications of the findings for wider work.

Table 1: Summary of the implications for wider work

Implications for wider work over the short-term:

Gaining **buy-in from the relevant Strategic Lead** is required to unlock potential sources of education and/or health funding/services

The provision of a **dedicated and specialist education/health Project Manager/officer** may help to overcome capacity issues and is likely to speed up the exploration of options, costing of services and development of resource allocation processes

It may be easier to focus on some initial '*quick wins*' in education/health to '*get the ball rolling*', which could lead to resolution for some families that have been dissatisfied with their service provision

Service areas that lend themselves more easily to inclusion within an IB package are likely to be those that:

- Offer a choice of treatment or alternatives

- Can be costed at the level of the individual child/young person

- Services that are centrally funded either by the local authority or relevant health agency

It is likely that in the short term **some education/health services will lend themselves to a resource allocation approach that is similar to that used in social care** (e.g. NHS Continuing Healthcare, Early Years), **whereas others would be more effectively costed on the basis of unit costs** (e.g. Continence aids, Personal Transport Budgets

The **economies of scale offered through purchasing services through the NHS** (and potentially through schools and education settings) may only be **utilised through the use of notional budgets**. This may imply that notional budgets offer better value for money than a direct payment in the short term in particular cases

The pilot sites highlighted some demand for education transport related direct payments, which were taken up as part of the Personal Transport Budget approach, which could be easily understood and influenced by families. However, **SEN direct payments had not been trialled** during the extended year of the pilot. This **will be explored through the SENDP pilot work that is being taken forward over the course of 2012/13**

Wholesale roll out of the social care IB approach should consider the use of transitional budget allocation arrangements to smooth the move from traditional to IB resource allocation methods and **consider the speed and scale at which the roll out** it to take place.

Source: SQW

19. To conclude, a number of different trials were developed within education and health settings to understand how to employ an IB approach. The majority of these trials were small in scale and would require significant resource and cultural change to up-scale. As such, it was felt that there was '*still a way to go'* and a significant number of challenges needed to be resolved before the IB approach was effectively trialled and adopted within the both the health and education sectors.

1: Introduction

Purpose of this report

1.1   This report is one of two volumes containing the findings from the extended year of
the Individual Budget (IB) Pilot Programme for families with disabled children. The
two volumes cover:

- *The Extended Packages,* which provides an assessment of how the pilot sites
  sought to broaden their IB offer to include both education and health funding,
  and the challenges associated with this - **these issues are contained in this
  volume**

- *The Family Journey One Year On,* which provides an update on the position
  and views of the original cohort of families that participated in the IB pilot 12-
  18 months after they began to receive their IB payments.

The extended Individual Budgets programme

1.2   The IB pilots were originally commissioned to run from April 2009 to March 2011 by
the former Department for Children, Schools and Families (DCSF), to establish if an
IB:

- Enabled disabled children and their families to have more choice and control
  over the delivery of their support package

- Improved outcomes for some, or all, disabled children and their families.

1.3   The Individual Budget (IB) approach was built on the premise that it offered greater
choice and control to families with disabled children through the drawing together of a
series of funding streams and use of an outcomes-based approach. This would
enable the development and delivery of a holistic and family-led support plan, with
the option to manage the associated funding in a variety of ways.

1.4   The programme operated in six pilot local authority areas (Coventry, Derbyshire,
Essex, Gateshead, Gloucestershire and Newcastle), each of which generated a
wealth of information and learning about the introduction of IBs for families with
disabled children[2]. However, much of the evidence was based on the inclusion of

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[2] The suite of reports from the original two year evaluation of the IB Pilot Programme can be found at
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only or very largely social care funding in the IB packages, as in most cases it proved difficult for the social care led pilots to gain the active involvement of health and education colleagues. As such the health and education monies were often limited, for example to very specific items or to nominal amounts of money.

1.5   Broadening the IB packages would require the pilots to address a series of barriers that were identified in the original evaluation report:

- The commitment of other services – this was often weak and it remained to be seen how health practitioners, schools and others would commit to the process

- Technical issues around unpacking the budget of an individual in the context of block funding and contracts

- Concerns as to how far families were best placed to judge the most appropriate course of action around education needs (where the emphasis had been on teachers developing personal learning plans for pupils) and in health, especially around clinical judgements.

1.6   Similarly, although the pilots demonstrated a clear linkage between the use of the IB approach and an increased sense of choice, control and satisfaction on the part of families, limited time had passed for the change in process to lead to changes in wellbeing. It was therefore unclear how far the initial short-term outcomes would lead to improved sustained impacts on wellbeing across the group of families.

1.7   In May 2011, and following the change in Government in 2010 when delivery of the Programme passed to the Department for Education (DfE), the six IB pilots were extended to run for an additional year (i.e. 2011-12). With the extension came an expectation that the pilots would:

- Test how they could broaden their offer to include Education and Health funds/services into their IB packages

- Continue to support the cohort of families that had participated in the original pilot, to enable the tracking of distance travelled by these families during the extended year, as a means of understanding whether the approach led to improved wellbeing.

1.8   The change in Government also led to a Special Educational Needs and Disability (SEND) Green Paper, which provided further context for taking forward the extended IB Pilot Programme. The SEND Green Paper highlighted the Government's wish to:

- Give parents the option of a personal budget (*which in this context is the same as an IB*) by 2014, linked to a new 'single plan' which was to draw together education, health and social care services, to give them greater control over their child's support, with key workers helping them to navigate different services

- Recruit a set of Pathfinders to test the best ways to provide a personal budget to children with SEN and/or disabilities, linked to the new plan, building on findings from the IB pilots.

1.9   The development of the extended IB Pilot Programme was therefore likely to be strongly influenced by the concurrent development of the SEND Pathfinder Programme. This created a possibility/expectation that the two programmes would run together to enable the original IB work and experiences to roll forward into the development of an assessment and single plan pathway.

Our extended evaluation and support approach

1.10   Given the intentions set out in the SEND Green Paper, the focus for the third year of the pilots was to gain effective buy-in from education and health agencies, as a means of broadening the scope of the IB packages. Our approach to the evaluation of the extended programme was therefore developed to ensure consistency with the work undertaken during the preceding evaluation along with a broader perspective to reflect changing policy aspirations.

1.11   The approach incorporated a mix of on-the-ground research/support and desk based research. The work programme was divided into three strands, each of which was delivered simultaneously by different parts of the research and support consortium:

- **Scoping strand** – in-depth strategic work with social care, education and health colleagues was undertaken in each of the pilot sites over the course of the first three months of the extension (i.e. late May-August 2011) as a means of identifying the challenges faced in drawing together resources from the three agencies and how these issues might be worked through

- **Evaluation strand** – the evaluation research undertaken during the first two years of the pilot programme was extended, to enable the tracking of both the IB process and distance travelled by the families over an additional year

- **Support strand** – bespoke on-site support was offered and then provided on an ad hoc basis, as requested by sites.

Methodology

1.12   Table 2 provides a description of the research and support that was undertaken.

Table 2: Research and support undertaken during the extended year of the IB Pilot Programme	
Research Method	**Description**
Scoping	
On site development support and wider consultation	• Liaison with the six IB pilot sites, other areas which are taking forward IB related work and subject experts to more fully understand what could be possible and achievable in terms of bringing wider funding streams into an IB
Two workshops	• Pilot site workshops held in May and August 2011
Development of health and education 'scoping' papers	• Development of health and education scoping papers which set out some of the options and possible paths for local areas to explore – *see separate reports which can be found at* *http://www.sqw.co.uk/services/personalisation*
Review and finalisation of delivery plans	• Support to complete year three delivery plans
Evaluation	
Area case study fieldwork	• 3 rounds of case study fieldwork were undertaken with each of the sites
Monitoring	• Four monitoring submissions for 2011/12 were received and analysed
Workshop	• Pilot site workshop held in Jan 2012 to share lessons learned
Wave 3 family survey	• Wave 3 family survey undertaken over the course of Jan-Feb 2012 with families who took up the original IB offer and were surveyed in 2010 and 2011
Support and challenge	
Development of bespoke support	• Tailored packages of support delivered to two sites to support development of: ➢ Health-related extension activities ➢ Shared objectives and processes between strategic partners ➢ Development of education transport budgets • On-going support and feedback was provided to sites when requested

1.13   A more detailed account of the evaluation approach is provided in the accompanying *Extended Evaluation of the Individual Budget Pilot Programme Technical Report*.

Report structure

1.14   This report seeks to present a detailed assessment of the *process related* progress made by the pilot sites over the extended year, including progress made in relation to the*: inclusion of education and health funding into IB packages*; and the *development of wider infrastructure associated with an extension of the IB approach.*

1.15   The remainder of the report is structured as follows:

- Chapter 2: Intentions for the extended pilot

- Chapter 3: Progress made against the intentions

- Chapter 4: Inclusion of education services in an IB

- Chapter 5: Inclusion of health services in an IB

- Chapter 6: Key findings and implications.

2: Intentions for the extended pilot

2.1 At the beginning of the extended pilot period, it was unclear which additional funding streams should be drawn in. It was for partners in each of the six areas to engage colleagues to ascertain their willingness to work together and develop a local IB offer. This local IB offer could then be tested with families to understand the implications for the IB process that had developed through the first two years of the Pilots, including issues such as assessment, resource allocation, planning and market development.

2.2 Following notification of the extension of the Programme in May 2011, which was associated with an additional £150,000 of grant funding from the DfE, each pilot site was asked to set out their intentions for the extended IB Pilot Programme. This development was undertaken in parallel with the development of the SEND Pathfinder bids, which were also drafted in all six areas over the course of Summer 2011. As a result, the IB pilot Delivery Plans were strongly influenced by each site's SEND Pathfinder intentions.

2.3 The Delivery Plans identified each site's objectives and planned activities for the third year of the pilot. They were written to a common template, focused on three key areas of activity (each of which formed a separate chapter): the inclusion of health services/funding; the inclusion of special educational needs services/funding; and process alignment.

2.4 This chapter provides an over-arching summary of the six Delivery Plans following the structure of the plans themselves.

Overview of objectives and planned activities

Aims

2.5 While the specific aims varied between the individual areas and – as to be expected – were very much tailored to the local context, four common themes emerged:

- The *broadening* of the pilot in terms of health and education funding streams. For some the broadening of education funding streams was to occur through working directly with a limited number of schools to identify which of the funds that were allocated to the school could be flexed; while others intended to focus on funds directly controlled by the local authority. The inclusion of

health funding streams was primarily to be driven through and in conjunction with the wider Personal Health Budgets Pilots

- The *alignment, joining up and integration* of budgets, assessments and support plans. An aim that was largely linked to the SEND Pathfinder bids that all six pilots had submitted

- The *expansion* of the pilot in terms of increased numbers of children and young people with an IB

- Continued *development*, *testing and evidencing* of benefits and effectiveness of the personalised approach to service delivery. This covered a broad range of different aims that included – but was not limited to – embedding and sharing good practice; developing and trialling a revised Resource Allocation System (RAS); ensuring the IB governance process (such as budget approval) became the 'business as usual' approach; testing out a delivery model that sought to prioritise family leadership; and the development of the family choice of support planner/key worker across the public sector and VCS.

Team structure

2.6 Given the objective of broadening the IB approach out from the social-care origin of the pilot sites, all six aimed to change either their delivery team or governance structure at the outset of the extended period. There appear to be two primary drivers for change. The first was the need to engage/recruit additional expertise in health and education – with the engagement of schools particularly apparent for the latter. The second main driver was wider organisational change in the local authority, including retirements, the Aiming High for Disabled Children group no longer operating, internal re-organisation and a new pilot sponsor.

Inclusion of health services/funding

Services/budgets included

2.7 Table 3 provides an overview of the health services/budgets that the six pilot sites intended to explore, the two most common of which were NHS Continuing Healthcare and equipment. Across all eight services/budget lines the rationale for potential inclusion was primarily driven by the either the 'ease' with which they could be included (for instance processes were already in place to enable an individual

allocation) or because of the better outcomes that could potentially result from
inclusion in an individual budget.

Table 3: Health services/budgets to be explored		
Service/budget	**Rationale for potential inclusion**	**Number of pilots exploring the feasibility of inclusion of this service/budget**
Continuing Care	Processes and systems already established which can be built upon	4
Equipment (including communication aids, continence aids)	Major issues for families; crosses health, social care and education boundaries; unit costs easily identifiable	4
Continence service	Opportunity to provider greater choice to parents	1
Community services allocation	Opportunity to provider greater choice to parents	1
Existing flexible support	Agreement already in place to use existing funding streams	1
Speech and Language Therapy (SALT)	Flexibility to fund additional SALTs and therefore opportunity to offer greater choice to parents	1
Children's residential service	Links to short break duty	1
Local joint funding arrangements for children with High Care needs	Links to social care IB	1

Source: SQW based on delivery plans

2.8   The expectation for all services/budgets included was that they would use the
existing assessment procedures and criteria. The intended approach to
disaggregation of the relevant budgets did however vary by both the specific
service/budget line as well as the pilot site. Broadly the intention was to use unit
costs or to reshape funding that was already associated with the child for that
service. For some services/budgets in some pilot areas this was already possible
while for others more work was required either to implement this approach or to
understand whether the existing unit cost was correct. For one of the pilot areas the
relevant PCT had directly allocated the IB team a pot of funding (related to
equipment) for them to allocate and manage accordingly.

2.9   **Management** of the funding was to occur through two main routes, either: direct
payments (where the site already was, or was applying to be a Personal Health
Budget (PHB) pilot); or through a notional or indicative budget while the feasibility of
the IB approach was being explored/tested (see Table 4).

Table 4: Intended options for managing the funds		
Management of funding	**Number of pilots including this form of management**	**Rationale for choice**
Direct Payments	5	Maximising choice and control and builds on developing practice
Virtually managed by the relevant professional	5	Provides a degree of choice and control but also support to families and builds on developing practice
Pre-payment card	1	Builds on developing practice
Budget managed by the service provider	5	Maintains the involvement of the lead professional
Others	2	Other options include a managed account and a combination of the above options

Source: SQW based on delivery plans

PHB pilot

2.10   At the outset of the extension, three of the six pilots were considering whether they intended to join the Department of Health PHB programme. Two of the remaining three pilots were already PHB pilot sites and the final site's intentions were still to be confirmed. It was hoped that the power to pay for health support through a direct payment, which would be granted following a site's approval to take part in the PHB programme, would offer greater flexibility to families who received health funded support.

Risks

2.11   The sites identified the following common risks in the delivery of their health-related plans:

- The difficulties in disaggregating health budgets, which tended to be tied up in block contracts and were not associated with unit costs

- A lack of understanding/willingness on the part of health practitioners to engage or commit to the IB process

- The tight timescales for delivery, which would limit the extent to which cultural change could be embedded across the relevant groups of staff

- Changes to overall NHS structures and wider budget constraints, which would limit the amount of resource that would be available to support the development of the pilot.

Inclusion of Special Education Needs services/funding

Services/budgets included

2.12 Table 5 provides an overview of the special educational needs services/funding streams that the IB pilots intended to explore. A number of observations can be made about the education services/budgets that were included in the delivery plans. For each age group it was clear that there were a number of potential funding streams – notably more than health.

2.13 The most commonly targeted services/budgets were Early Years provision, SEN transport, and the schools based budgets, which included the budget associated with the SEN statement. Rationales for inclusion of each service/budget appeared to reflect the ambitiousness of each site, with some intending to target those that were within the local authority's control, whilst others proposed to explore the feasibility of including delegated schools funding into an IB package

2.14 The wider objectives were largely driven by a desire to increase choice and control but, like health, the 'ease' of including the service/budget was also an important consideration. For instance some of the pilot sites were seeking to work with those schools that were most interested (or had already shown an interest) in collaborating, or were targeting those budgets that had links to social care.

2.15 In terms of the focus on different age groups: four of the pilots intended to focus on the early years, school age and post 16 age groups; while the other two were to focus on school age and post 16 only.

Table 5: Education services/budgets to be explored		
Service/budget	**Rationale for potential inclusion**	**Number of pilots exploring the feasibility of inclusion of this service/budget**
Early Years (0-5 years)		
School transport	Provides greater choice and control	2
Learning support service/ Advisory teaching service	Provides greater choice and control, opportunities to disaggregate from budgets for specialist provision	2
Target (one to one Teaching Assistant support for C&YP with a statement and those on school action plus)	Provides greater choice and control	1

Service/budget	Rationale for potential inclusion	Number of pilots exploring the feasibility of inclusion of this service/budget
Behavioural Emotional and Social Development (BESD) Inclusion	Provides greater choice and control	1
Community based enhanced nursery allocation	Provides greater choice and control	1
Portage	Part of specialist provision for early years with SEN/disabilities	1
Early years provision	Part of specialist provision for early years with SEN/disabilities, increase skills, confidence and knowledge of inclusive practice	3
LA centrally held funding	Easier to influence those funds held by the LA	1
School age (5-16 years)		
School transport	This has been identified as a potential option by parents and schools – for some it is already currently offered as part of IB pilot	4
Specific school based budget (e.g. DSG, Pupil Premium, SEN statement)	Potential to work with specific school(s) to utilise some of its per place allocated funding	6
Equipment	Provides greater choice and control	2
Out of school tuition/support	Increase flexibility of service	2
Learning support service	Provides greater choice and control	1
Target	Provides greater choice and control	1
BESD Inclusion	Provides greater choice and control	1
LA centrally held funding	Easier to influence those funds held by the LA	1
Therapies	Some alternative providers may be available to families	1
Post 16 Education		
Raising Participation Age	To promote employability	1
Funding connected to 139a assessment	Provides greater choice and control	1
Specific school/college based budget	Provides greater choice and control	2
Local authority based budgets	Provides greater choice and control	2

Service/budget	Rationale for potential inclusion	Number of pilots exploring the feasibility of inclusion of this service/budget
Schools/college transport	Already accessed on individual basis – provides parents/young people with greater choice and control	3
YPLA funding	Use is currently restricted to a limited number of providers and course options – exploration of options to expand this	1

Source: SQW based on delivery plans

2.16 The **assessment** of need and eligibility was to be driven by either the statutory assessment for statements or by existing assessments relevant to that service/budget. The frequency of the assessment varied according to the specific assessment in question. In terms of the **disaggregation of the budget**, the situation with education services/budgets is much the same as with health with the broad intended approach being the use of either unit costs or to reshape funding that was already associated with the child for that service. Similarly the **management** of funding was to generally occur through either direct payments or through a notional or indicative budget (Table 6).

Table 6: Options for managing the funds		
Management of funding	**Number of pilots including this form of management**	**Rationale for choice**
Direct Payments	5	Option is already established so building on existing practice
Virtually managed by the relevant professional	5	Option is already established – as often funding is based within and managed by the school
Pre-payment card	1	Option is already established so building on existing practice
Budget managed by the service provider	6	Option is already established so building on existing practice
Others	1	Other options includes a combination of the above options

Source: SQW based on delivery plans

Risks

2.17 The pilots identified the following common risks in the delivery of their education-related plans:

- The market for alternative provision was not sufficiently developed to meet some assessed needs

- Failure to disaggregate relevant education budgets

- Lack of capacity/commitment to deliver the approach by education/school staff and general uncertainty around the appetite of schools to engage with the IB agenda.

Process alignment

2.18   This element of the Delivery Plans was drafted to align with the complementary intentions that were developed as part of the SEND Pathfinder bids. As such, most of the pilot sites intended to work towards the development of some form of integrated assessment and single plan, which was to be wrapped around the evolving IB approach.

Assessment

2.19   All six pilots intended to integrate the relevant assessment processes. How this integration was intended to occur varied between the pilots from: the use of a common assessment framework; to developing a new co-ordinated assessment process that looked at existing assessments across social care, education and health and identified gaps and duplications. The hope across a number of areas was that the SEND Pathfinder bids – if successful – would help in the process of joining up assessment processes.

Resource allocation

2.20   For four of the pilots the intention was to develop separate resource allocation models for differing services/budgets, with the remaining two hoping to develop a single model whereby resources for the IB would be allocated via a single process. For those looking at multiple resource allocation processes the approach was generally to refine the existing models while at the same time developing new ones where they did not exist – this was particularly the case with health funding.

2.21   For the two pilots looking to develop a single resource allocation model the approach was one of review, synthesis and development as they sought to create a model that worked across services and provided clarity for families.

Support planning

2.22   Five of the six pilots intended to develop a single plan for each family, which would grow out of their current IB support planning arrangements. The development of this

approach would however be different across the pilots. For example, two of the pilots intended to use external organisations to assist and facilitate this process. Conversely, the one area that did not intend to develop a single plan intended to undertake some exploratory work to see if it was feasible and could be taken forward in the future.

Review process

2.23   The specific detail of the review process varied across each of the six pilots, but broadly it could be summarised as being undertaken by a multi-agency team lead by a specified key worker.

Recruitment of additional families

2.24   All six pilots intended to recruit additional families to take part in the extended year of the pilot. The rationale for recruitment varied: from testing out the use of IBs with a different cohort (for instance a younger age group); to simply rolling (social care) IBs out further to a larger number; to targeting those that currently receive specific health or education funding that was in the scope of the pilot.

2.25   The earliest date that a family was expected to receive either an extended package was September 2011 with others either later (but usually around the turn of the year, with one site being cautious of changes pre-September 2012 as packages were often agreed to align with the school year). It was apparent from the plans that the date varied by funding stream, by the speed at which families could be recruited to the pilot, and/or by the time it was anticipated it would take to develop and take families through the process (identification of budgets, support plans developed/approved and support commissioned).

Summary

2.26   The extended year of the IB pilot came with an expectation that the pilots would broaden their offer to include education and health funds/services. However, this expectation was not associated with a prescriptive list of funds/services. As such, each area was able to choose their own direction of travel and tailor developments to complement local arrangements/structures.

2.27   As a result, each pilot site chose to explore a different set of funding streams/services, the most common of which were:

- NHS Continuing Healthcare

- Health-based equipment

- Early Year provision

- SEN transport

- School based budgets – including the SEN statement budget.

2.28   The rationale for exploring different funding streams/services was largely driven by the 'ease' with which they could be included, with some sites appearing to be more ambitious than others.

2.29   Intentions for the extended year also included:

- Alignment, joining up and integration of budgets, assessment and support plans – where sites intended to integrate their assessment and planning processes and to use either unit costs or a reshaping of existing funding/service packages as the basis for education/health resource allocation – which was heavily influenced by each site's SEND Pathfinder application

- Expansion of the pilot in terms of increased numbers of children and young people with an IB

- Continued development, testing and evidencing of the effectiveness of the IB and personalised approaches.

2.30   The most commonly identified risks associated with taking the IB work forward included: challenges around disaggregating health/education budgets; and a lack of understanding/commitment and capacity on the part of health/education staff to get involved.

3: Progress made against the intentions

3.1   Unlike the original two year IB pilot programme, which was relatively structured in its nature, the extension sought to enhance the concept of '*drawing together of a series of funding streams'*, with a remit to ensure both health and education funding were explored. This broadening of the IB packages was not associated with a set of family recruitment targets or particular milestones. Instead it came with an expectation that each site would seek to work through the set of local challenges encountered during the original pilot. As such, it was hoped that the extended year would produce a wider variety of lessons learned and examples of how to include a range of health and education funds/services into an IB package.

3.2   This Chapter charts the progress made against the intentions set out in the previous Chapter and provides an account of the inputs and costs associated with this activity. A more detailed account of what education and health packages were developed and how this was undertaken is included in Chapters 4 and 5.

A timeline of progress made

Summer 2011

3.3   Much of the initial period of the extended pilot was developmental in its nature, where sites sought to engage relevant strategic colleagues from health and education and hold discussions on which potential avenues could be explored. Strategic engagement with the wider agencies was achieved in the majority of cases. This was felt to have been largely driven by the potential to join-up the extended IB and SEND Pathfinder developments.

3.4   In the cases where sites had intended to explore the inclusion of the delegated schools budget, it was hoped that commitment from strategic education leads would support the brokering of and strengthen relationships between the IB pilot and individual schools. Discussions tended to focus around the engagement of local authority funded schools, as opposed to special schools or academies. Reasons for this dichotomy included sites feeling that they had more 'influence' over the schools they funded, a lack of understanding around how best to engage academies and a sense that special schools would not want to engage with the IB agenda.

September – November 2011

3.5   Successful areas were notified of their acceptance onto the SEND Pathfinder Programme in September 2011. However, only one of the six IB pilot sites – Gateshead - was successful in their application. The unsuccessful IB sites experienced significant disappointment in light of this decision, especially as each site felt that they would have been well placed to take forward the proposed developments given the experience developed through the IB pilot. This also led to some initial fall-out from both health and education colleagues that had bought into the IB/Pathfinder development process, as the potential funding and catalyst for change had not become a reality. As a consequence of their withdrawal, a hiatus in activity of between 1-3 months was experienced in these sites, as they sought to re-engage partners and re-configure their Year Three Delivery Plans.

3.6   By the end of November 2011, all the sites had managed to re-build some of the relevant strategic engagement with health and education colleagues. However, the extent to which this engagement came with a commitment to move things forward was limited in many cases by the fact that the extended pilot only had a few months left to run. Many of the sites also acknowledged that some partners had not re-engaged, as the relevant individuals did not want to trial new approaches in the absence of the SEND Pathfinder. Rather, they wanted to wait to understand the experiences of the SEND Pathfinders and the Government's subsequent intentions prior to committing to move in a particular direction.

3.7   For example, one Head of Post 16 Education provision stated that although he was committed to trialling personalised and joined-up approaches to service provision, he did not want to take this forward until the School Funding Reforms and response to the SEND Green Paper consultation had been confirmed. Similarly, a Lead Health Commissioner reported that she was now hesitant to get involved as they would not be supported by the extra Pathfinder resource to try out new approaches. She therefore did not want to '*risk making a wrong move'*, which was possible given the lack of clarity on how best to align this work with the on-going health reforms.

3.8   Conversely, the health and education leads that had remained engaged or had been willing to re-engage with the IB pilot had generally done so as there was a feeling that *'assessment and single planning was the way that things were heading'*. However, the majority of consultees agreed that progress would be slower and smaller in scale than originally expected, given the reliance on the short-term IB pilot

resource and the uncertainty of how things would progress beyond the funded period (i.e. March 2012).

3.9 As such, potential reasons for the mixed levels of strategic engagement from health and education colleagues appeared to be related to: the individual's level of risk aversion; their experience or awareness of personalisation, with those starting from further back less willing to get involved; the extent to which they felt the SEND Green Paper was likely to affect their area of work; and the extent to which restructuring/on-going reforms had or was likely to affect their area of work.

3.10 The extent to which the sites' intentions changed during this period depended on which stakeholders were willing to support the development of the IB pilot and their ability to mobilise funding and staff resource within the remaining few months of the extended pilot. This led to the adoption of one or more of the following three approaches, each of which was considerably less ambitious than the original intentions that had been set out in the Year Three Delivery Plans:

- Refinement of the existing social-care based IB approach and ensuring that this was embedded within existing structures and could be sustained beyond the pilot

- **Development of discrete and often small-scale trials of extended health and/or education IB packages**, which would subsequently form the foundation for delivering extended and holistic IB packages for families that were eligible for the relevant set of services

- **Focus on expanding the IB packages of the original cohort of IB families,** of which only a small number of families were likely to be eligible for the health and/or education services/funding that were being explored by the relevant sites.

3.11 It was also evident that the extended packages work would focus on funding streams/services that were felt to be the 'easiest' to include. This implied that only limited consideration would be given to inclusion of elements of the delegated schools budget and of health services that would be more challenging to cost, such as children's residential services.

December 2011 – March 2012

3.12 Following the hiatus in activity, the IB pilots spent much of the final months of the extended pilot developing their thinking around and in some cases beginning to

deliver health and/or education IB packages. In total, 193 new families received a new health and/or education IB package, 13 of which formed part of a combined package with a second service. Of the 193 new packages delivered, 177 of the new packages were delivered by one site, which had rolled out their Personal Transport Budget pilot to all eligible families and had delivered nursery based IB packages (which we describe in more detail in Chapter 5). The other 16 packages were delivered between 4 of the remaining sites (Table 7). The sixth site, which was being led by a newly engaged IB pilot team with little overlap with the original team, appeared to suffer a loss in momentum and as a result delivered no new health and/or education packages.

Table 7: Type and total number of extended packages delivered across the IB sites

Type of IB package	Frequency
Education only	172
Health only	8
Combined Social Care and Education	12
Combined Social Care and Health	1
Total new packages	**193**

Source: IB Monitoring data

3.13   The new families often included those who had stated that they were not happy with their current packages of support or newcomers to the relevant service. Both groups were receptive to trialling a new approach. Chapters 4 and 5 provide more detail on the infrastructure that was set up to develop these packages, the development of the packages themselves and some feedback from the families that received them.

Moving from pilot to roll out in social care

3.14   In addition to the new packages, four of the IB sites considered how best to roll out the IB approach within social care, of which three had begun to gradually deliver this process, either to particular age groups or across the board. This had led to a small increase in the number of children receiving social care led IBs (around 30 families), which was likely to increase over time as the roll outs gathered momentum.

3.15   The differing approaches to roll out included:

- A **change in the role of the IB pilot team** from taking families through the IB process themselves**, to supporting other lead professionals and social**

workers to work with the IB families and use the IB approach as part of their existing role

- Taking **all newcomers to the social care system that were referred into a particular part of the service through the IB approach**, with a view to expanding this offer to wider teams once the relevant operational staff had received the appropriate training

- **Embedding the IB approach for the transition age group**, to provide a smoother transition into Adult Services which also used the IB approach.

3.16   This set of approaches were cautious in their nature and were unlikely to result in wholesale change to the way in which social care services were offered to the local populations of families with disabled children. Use of a range of approaches to service provision may not be problematic at the current time, however, as the numbers of families that take up the IB offer increases, sites will need to consider how they intend to:

- Manage resources within budget limits – the delivery of two parallel systems may lead families to choose to use the system that delivers the larger package, and so risk a higher overall level of spend

- Ensure the IB offer is equitable and manage the expectations of families – in cases where the offer is only being made to a sub-set of the population of families with disabled children, how will the site justify not providing it to other families that would like to take up the offer but do not fall within the relevant target group.

3.17   The fourth site had been bolder in its thinking, and took the decision to roll out the IB approach to all children and young people in receipt of social care funding. This included them undertaking an in-depth review of the Resource Allocation System (RAS) used during their original pilot. Having concluded the review they recognised that any change in approach to allocation would lead to 'winners and losers'.

3.18   The site was keen that the change to an IB approach proceeded smoothly and so facilitated a **consultation with families and professionals** (including three workshop sessions) around the transition. Figure 1 provides the list of options that were developed and consulted on, which considered the extent to which the budget should change and over which period.

Figure 1: Extract from consultation on transitional arrangements

These are the options we would like your comments on:

1) The Individual Budget amount offered will be consistent with the amount shown on the proposed funding allocation table (table 2 and 3 in the background information document) the council will negotiate funding with all families on this basis.

2) To provide as the Individual Budget the cost of funding families currently receive and to further reassess to bring all families funding to consistency within the proposed funding allocation table in a date in 2016.

3) The outcome of the reassessment may indicate that the funding for the child's needs should result in a significantly lower funding offer. In these circumstances the council would offer an Individual Budget 24.5% lower than the present cost of the child's package or the amount shown on the proposed funding allocation table, whichever was the greater sum.

   The outcome of the reassessment may indicate that the funding for the child's needs should result in a significantly higher funding offer. In these circumstances the council would offer an Individual Budget at 3.5% higher than their present cost.

Source: Individual Budgets Consultation undertaken in Pilot X

3.19 The findings from the consultation were reported to the relevant Local Authority in March 2012. The rollout will now proceed in the financial year 2012-13, with changes to budgets introduced over a period of time, to 2016. This will include management of the extent of change over this period for any family currently in receipt of services to ensure any increase/decrease in their allocation is limited upwards or downwards.

Process alignment

3.20 Following the fall-out from the failed applications to the SEND Pathfinder Programme, the majority of the IB sites focused on initiating appropriate small-scale cultural change within targeted parts of the health and education sectors. This resulted in the trialling of small-scale IB approaches (i.e. associated with single as opposed to multiple funding streams). As such, the sites felt it was too early to consider how best to align the developing processes, as it was unclear whether the discrete trials would prove to be effective.

3.21 Looking forward, a number of the sites would like to create an integrated process for families with children with SEND, which would result in some form of single plan. However, most sites were uncertain about how to draw their individual trials together into a coherent single process. They added that they were likely to experience a number of barriers to achieving this goal, the most common of which are described below.

3.22 **Existing multi-agency planning processes were failing in many cases due to a lack of resources** to contribute, as opposed to a lack of desire to undertake joint-working. For example, the existing school annual review process provided the

opportunity to draw together inputs from education, social care and specialist health. However, the review meeting was often not well attended by all agencies.

3.23   In addition, the current legislative framework (especially that governing SEN) was thought likely to restrict the extent to which process alignment could be achieved. It does not provide clarity on what provision each agency was responsible for or a legal basis to ensure each was accountable for this delivery. Therefore, some agencies may seek not to engage to avoid a call on their budget.

3.24   There was limited overlap between the groups of children and young people that were in receipt of SEN, social care and the specialist health services that were likely to form part of an IB package. For example one of the pilot sites estimated that they currently had 2,000 children with SEN statements, around 1,800 of which were not eligible for social care, and of the remaining 200 children, only 5-10 were likely to also have a specialist health package. Similarly, another pilot site had thus far trialled the IB approach in: social care for young people in transition; SEN transport services for children of school age; early years using nursery funding; and intended to develop therapy related health packages, which were unlikely to overlap in many cases. Given the limited overlap, sites felt that they would need to consider whether process alignment would be useful.

3.25   The **feasibility of creating a single resource allocation system was still under consideration** in a number of areas, as the sites had not yet developed sufficient thinking around how to effectively disaggregate their targeted education and/or health funding streams/services. For example, one site was seeking to develop the *Bradford Tool.* This was commonly used as a continuing health care assessment tool and worked by providing a 'score' in hours which could then be translated into three levels of eligibility in terms of need. The site was considering whether it could embed the relevant questions within their existing social care RAS, which would lead to a drawing together of the continuing health and social care tools. Conversely, another site had chosen to develop separate resource allocation models for the individual health and education funds that they had/intended to include within their IB packages. The separate models were/would be based on the same principles of their original social care RAS, which included transparency, equity and a systematic method for scoring a family's support needs.

3.26   In the event that budget allocations are drawn together from distinct resource allocation systems, the sites would also need to consider how to minimise any potential double funding, and how to ensure these decisions are transparent. This

exercise is likely to be most effectively undertaken via joint-planning exercises, which could identify any areas of duplication. It would also provide an opportunity for the professional(s) to demonstrate the cause for any decrease in total budget allocation to the family. For example, a site identified that both specialist health and education had provided funding to buy identical pieces of equipment, one of which was bought to use in school and the other in the home. Joint planning could identify this duplication and seek to find ways to share the relevant costs and transport the equipment between school and home settings.

Pilot inputs and costs

3.27   Each of the pilot sites was issued with a grant payment totalling £150,000 to deliver the extended year of the Programme. As with the original pilot grant, the monies were to be used to fund infrastructure requirements and not for the IB funding allocation for families, which were to be drawn from existing funding streams/services.

3.28   Figure 3-2 sets out the actual spend relative to the grant allocations of each of the sites. This shows that four of the sites, spent either all or nearly all of their grant funding, whilst two sites exhibited significant under-spend. Given the hiatus in activity, it may seem surprising that four sites spent all/nearly all of their grant. However, significant effort and resource was invested in '*getting activities back on track*', the details of which are described below.

Figure 2: Funding allocation and spend by pilot site
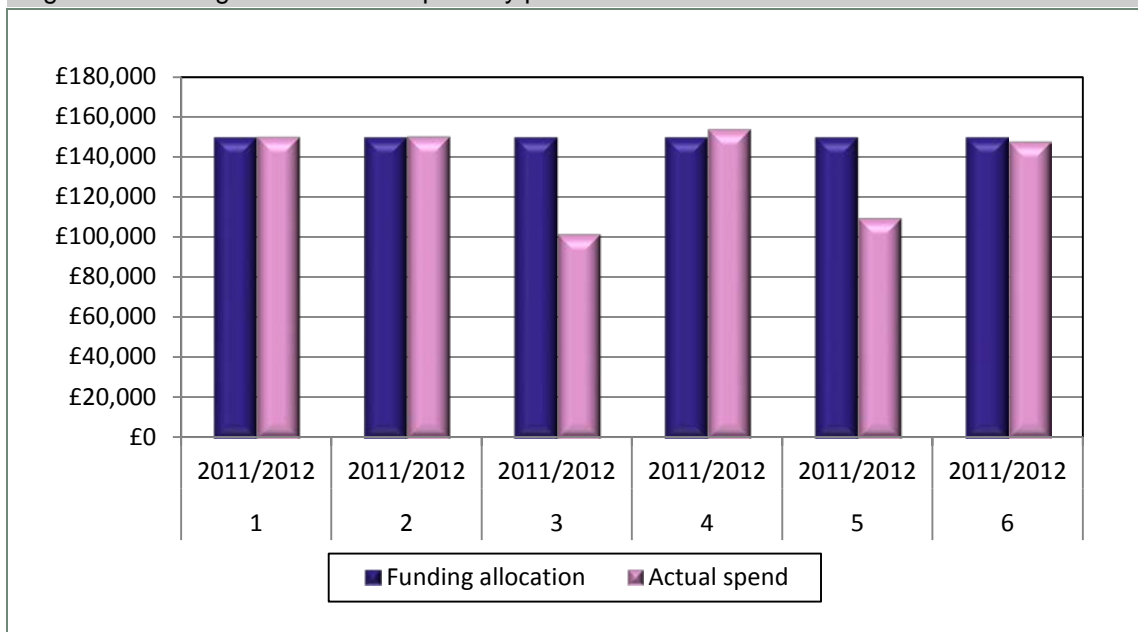
Source: IB monitoring data

Financial and in-kind spend

3.29   The sites were asked to record spend incurred during the extended year of the pilot under the themes of the refined Common Delivery Model[3]. This spend was divided into cash costs funded from the IB grant allocation and in-kind time contributions from staff not directly funded by the pilot. Figures 3-3 and 3-4 illustrate this breakdown by site.

3.30   The cost breakdown illustrates that resource and effort were spent undertaking the following types of activity:

- Funding pilot staff posts to support the development of activities over the extended year

- Work to identify the potential number of families that would be eligible for all the funding streams/services that were being explored

- Building the capacity of families to identify outcomes and undertake support planning

- Continuing workforce development, including re-training on the use of the RAS and supporting planning in one site, to counter-act a loss in momentum from the original IB pilot, which had resulted in operational staff '*lapsing back into their old ways of working'*

- Investment in training for support planners, to ensure appropriate resource was available to scale-up the IB approach

- Consideration of how best to develop the market as the numbers of IBs increases

- Development of an e-market tool to generate a 'local offer' to enable families to access providers and purchase services online

- Further development of an outcomes based IT system that could be used by different agencies which had chosen to adopt the IB approach, which it was hoped would lead to more effective information sharing in the future.

3.31   Sites added that development work during the extended year had often been limited as a result of high staff turnover at both the strategic and operational levels, which

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[3] The Common Delivery Model (CDM) was developed in 2008 to inform the development of the IB Pilot. The model was subsequently refined as part of the evaluation of the original two year pilot, a description of which is provided in the *accompanying Technical Annex to the report.*

had led to a reduction in capacity to take things forward. Changes of staff had in some cases led sites to re-focus their efforts on training new staff, which had further delayed the development of the extended health and education related approaches.

Figure 3: Breakdown of financial costs
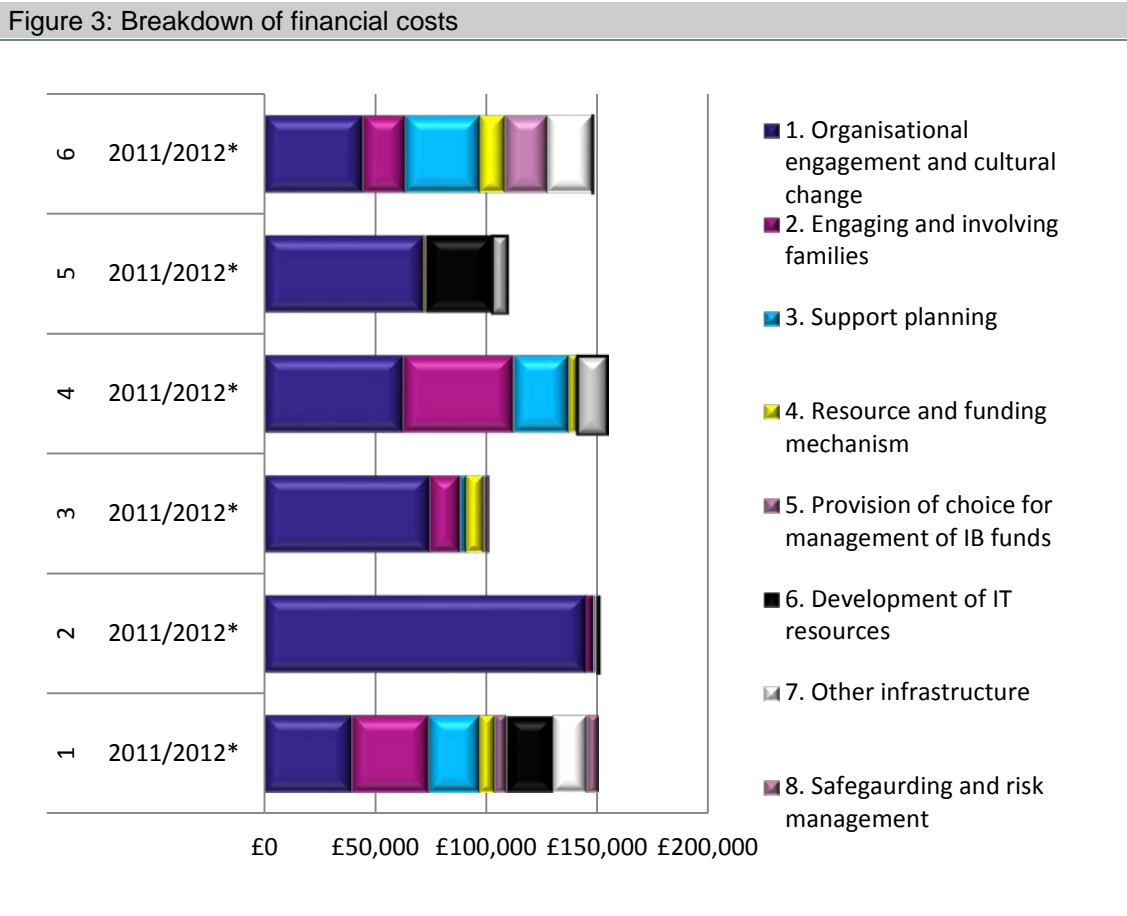
Source: IB monitoring data

3.32   Three of the six sites reported that only small amounts of in-kind time had been spent developing and delivering the extended year of the IB pilot. This reflected either that majority of their developments had been undertaken by IB pilot funded staff or that IB related activities were being undertaken as part of a wider transformational change programme.

3.33   Unlike the original IB pilot, which sought to set up a consistent set of infrastructure across the pilot sites, the pilot inputs and costs for the extended year reflect the individual set of activities that were undertaken by each of the sites. As such, they cannot be extrapolated to illustrate the cost associated with either extending the coverage of the IB packages or of rolling out the IB approach across social care.

Figure 4: Breakdown of in-kind costs
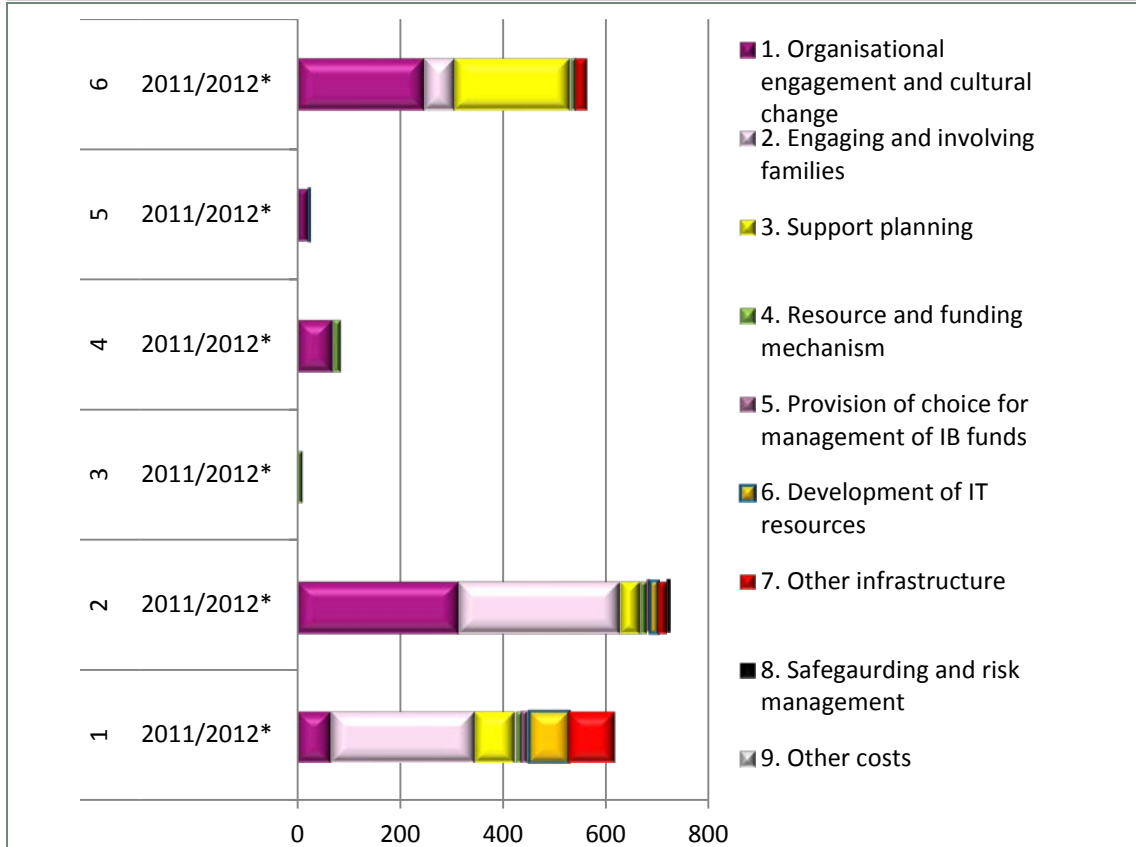
Source: IB monitoring data

Summary

3.34   The initial four months of the extended IB pilot were largely developmental in their nature, the main outcome from which was additional strategic engagement from health and education colleagues. The majority of the pilot sites suffered a hiatus in activity over the subsequent period – September to November 2011 - as a result of notification that they had been unsuccessful in their application to become part of the SEND Pathfinder Programme. This led to some disengagement from both health and education colleagues, which took considerable resource and effort to rebuild (and even then not all partners re-engaged).Given the strong inter-dependencies between the IB pilot Year Three Delivery Plans and the SEND Pathfinder bids, the absence of Pathfinder status had significant ramifications on the scale and speed at which progress was subsequently made by the IB pilot sites. The sites adopted one or more of the following three approaches, which were considerably less ambitious than their original intentions:

- Refinement of the existing social-care based IB approach

- Development of discrete and often small-scale trials of extended health and/or education IB packages

- Focus on expanding the IB packages of the original cohort of IB families.

3.35 The small scale trials that were taken forward resulted in limited consideration of how best to align social care, education and health IB approaches. Emphasis was instead placed on testing how to execute the discrete trials and whether they were effective for both the staff and families involved. Therefore, although a number of the sites intended to create an integrated process for families with children with SEND, which it was hoped would result in some form of single plan, they made limited progress on this in the timescale of the evaluation.

4: Inclusion of education services in an IB

4.1 This Chapter provides a detailed account of which education packages were explored and developed by the IB pilot sites, how these developments were undertaken and the implications of this work for wider education-related work.

Progress against the original intentions

4.2 All six of the IB sites set out clear education-related intentions in their Year Three Delivery Plans. This included exploration of early years, school-age and post-16 service/budget areas.

4.3 Table 8 provides a summary of the education services/budgets that the sites initially intended to explore and those that became a reality over the course of the extended year. This illustrates the rationalisation that took place following the fall-out from the failed applications to the SEND Pathfinder Programme. In practice, five of the six pilot sites had begun to develop/deliver education-related IB packages over the extended year of the pilot. The sixth site had focused on developing wider multi-agency working practices, which had not yet resulted in explicit exploration of how to develop education-related IB packages.

Table 8: Education related intentions vs. progress made		
Service/budget	**No of sites intending to explore inclusion of this service/budget**	**No of sites working towards the inclusion of this service/budget**
Early Years (including portage, early years nursery provision, Children's Centre funding)	3	2
SEN Statement	6	3
SEN transport	4	4
Post 16 funding – alternative to out of county placement	3	1
Equipment	2	1

Source: SQW based on delivery plans and IB monitoring data

Numbers of new education-related IB packages

4.4 In total 184 new families were in receipt of education IB funding and a further 4 were developing their education IB packages at the end of the extended pilot year (Figure

5). Of the 184 live education IBs, 177 were from one site which delivered 138 Personal Transport Budgets (PTB) and 38 nursery provision-related budgets.

Figure 5: Numbers of new packages in development or delivered including an education element
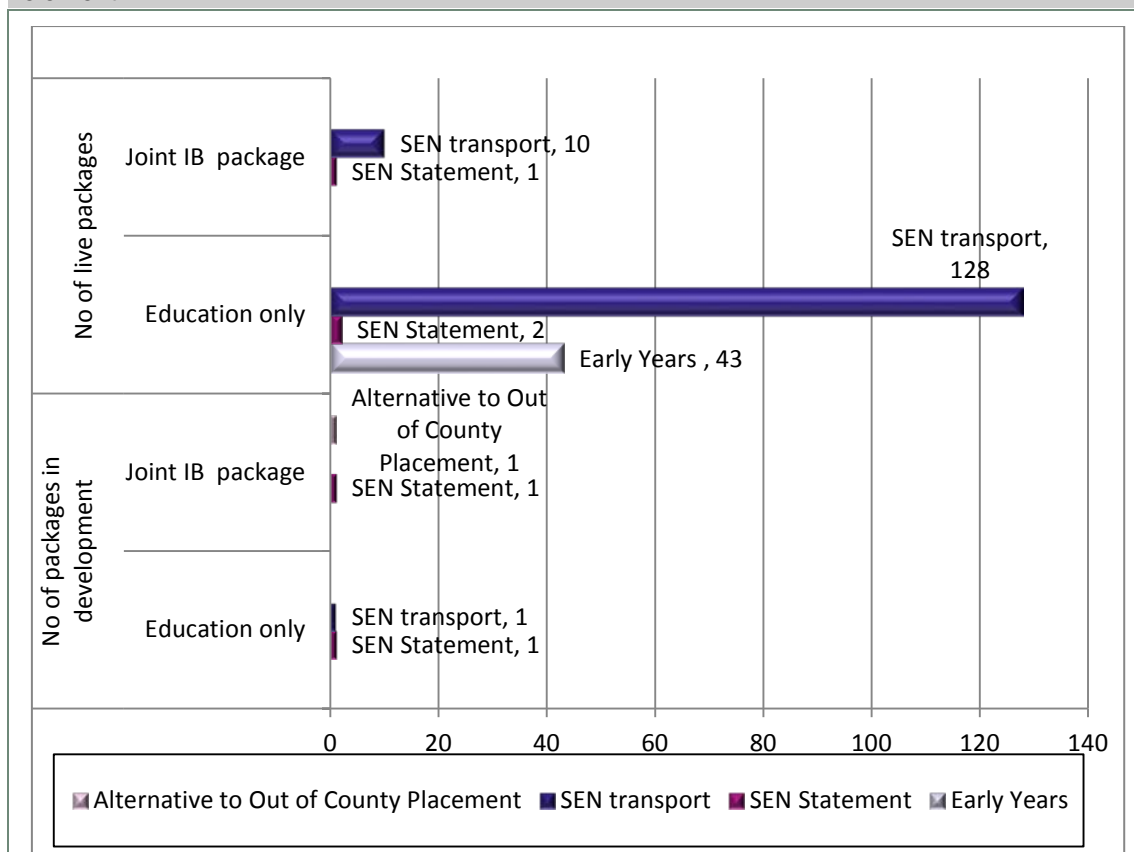
4.5   Further detail on the development of these packages and reflections on lessons learnt are set out in the sections below.

Developing education-related IB packages

Early Years

4.6   Two sites sought to develop IB packages for families with children aged 0-5 years old. The first of these targeted their community-based enhanced nursery allocation (CENA), which had been used to fund 24 specialist places in two nurseries located in the North and the South of the local authority. This form of provision had led to a limited choice of options and lengthy travel times to and from the settings for many families.

4.7   In light of these challenges, a decision was made by the Head of SEN services to replace the existing enhanced resource nurseries with a more flexible form of

provision that enabled families to send their child to any nursery setting of their choice. Consequently, the two enhanced nurseries were closed in July 2011 and their funding allocation was divided into two parts:

- a proportion of the allocation was used to fund extra staffing in the pre-school service to deliver the reconfigured offer

- the remaining funding was provided on an individual child basis to the nursery setting chosen by the families that were eligible for the service.

4.8   The assessment process and eligibility criteria for the service were retained, which involved referrals from SEN support services into the CENA panel, which then determined whether a child and their family was eligible to receive the support.

4.9   During the first year of the reconfigured approach[4], the site was able to offer up to a maximum of 40 CENA places, which represented a considerable increase from the previous limit of 24 places. The individual child based allocation of CENA funding was divided equally by the 40 potential places to give a set funding allocation for each child that used the service.

4.10   Thirty-eight families received this form of provision, which worked as follows:

- Parents were provided with a caseworker, who supported them to select an appropriate pre-school setting and informed them of the allocation of funding that would be provided to the setting to specifically support their child

- Discussions were then held between the caseworker, parents and the setting about how the budget would be spent, with the only proviso being that the money was spent to support the child's educational targets/outcomes

- Caseworkers attended termly meetings with the setting and the parents to discuss how the funding had been used and how this had benefitted the child.

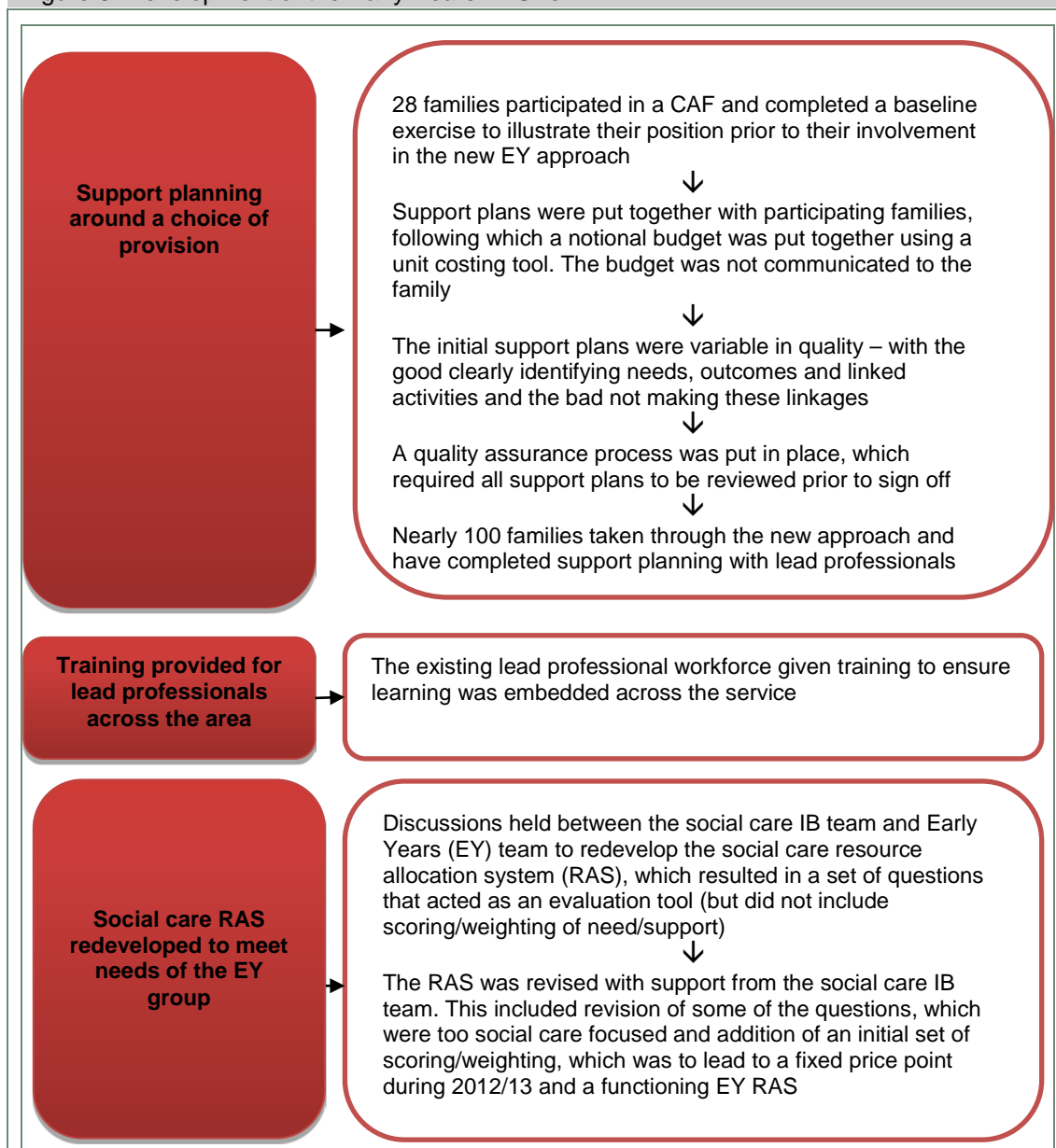4.11   The Head of SEN Services had also delivered training to the pre-school staff delivering the CENA offer. This training was repeated termly and was complemented by a weekly meeting to review casework issues as they arose.

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[4] A working group consisting of representatives from educational psychology, the sensory support service, the autism support service and pre-school education services developed the reconfigured offer.

4.12 The first year of the approach was seen to have been a '*learning year*' and a positive experience for all those involved. The education caseworkers that had been involved commented that all children were now in mainstream settings, most of which were linked to local schools, which should ease the transition process from nursery to school. They added that families could now have their needs met within their local community as opposed to having to travel across the local authority to one of the two former enhanced nurseries. This therefore implied that local capacity to offer services to this group had improved as a result of the change.

4.13 A number of challenges were identified during the first year which the site intended to address over the subsequent year, including:

- The need to **increase the involvement of parents in the decision making processes** around their packages of support, which had not been the norm for either the families or the staff in the pre-school settings that were providing the support

- **Ensuring that parents were provided with sufficient information about how their budget could be spent** – the SEN casework team were drafting a document to illustrate the types of support that could be funded based on the experiences of families that took part in the first year of the approach

- **Consideration of whether to offer the parents a direct payment for the CENA budget**, as opposed to the current notional budget approach – parents were asked to consider whether they would like a direct payment, but most expressed a preference for the money to continue to go to the setting than to be paid directly to them, suggesting they had some confidence in how the setting had used their funding.

4.14 The second site had sought to replace their existing Early Years panel arrangements (for 0-3 year olds), which was professionally-led with an IB approach that would enable families to have more choice and control. An initial pilot of a potential approach was undertaken towards the end of the original IB pilot, which has been refined over the course of the extended year of the pilot. This development process is illustrated in Figure 4-2.

Figure 6: Development of the Early Years IB Offer

Support planning around a choice of provision

28 families participated in a CAF and completed a baseline exercise to illustrate their position prior to their involvement in the new EY approach
↓
Support plans were put together with participating families, following which a notional budget was put together using a unit costing tool. The budget was not communicated to the family
↓
The initial support plans were variable in quality – with the good clearly identifying needs, outcomes and linked activities and the bad not making these linkages
↓
A quality assurance process was put in place, which required all support plans to be reviewed prior to sign off
↓
Nearly 100 families taken through the new approach and have completed support planning with lead professionals

Training provided for lead professionals across the area

The existing lead professional workforce given training to ensure learning was embedded across the service

Social care RAS redeveloped to meet needs of the EY group

Discussions held between the social care IB team and Early Years (EY) team to redevelop the social care resource allocation system (RAS), which resulted in a set of questions that acted as an evaluation tool (but did not include scoring/weighting of need/support)
↓
The RAS was revised with support from the social care IB team. This included revision of some of the questions, which were too social care focused and addition of an initial set of scoring/weighting, which was to lead to a fixed price point during 2012/13 and a functioning EY RAS

Source: SQW case study research

4.15   The developments have been led by the Head of the Early Years Service and a dedicated Early Years Project officer that was funded through the IB pilot grant. Both acted and will continue to act as champions for the new approach. This dedicated resource had supported the evolution of the Early Years IB approach, which it was hoped would be fully developed during 2012/13.

4.16   Information provided from families that had completed both a baseline (at the beginning of the process) and follow-up (at the point of review of their package) of the early evaluation tool, had provided positive evidence to support the use of the approach. That is, positive impacts were illustrated across all aspects of the tool, with the largest change being seen in 'access & empowerment', which suggested that

families had felt more involved in their decision making processes. This finding also illustrates the importance of support planning and implies that communication of a budget to the family may not be required to achieve improved levels of choice and control.

4.17 Development of the Early Years unit costing tool, which had been used to cost the initial set of support plans, had included input from the IB Finance Officer, who had helped to draw up unit costs for specialist forms of provision. This had included putting together information on special school placements and nursery costs, and information drawn from practitioners e.g. how many contacts they had had with families, grade of staff, salary of staff etc. Although the developments of unit costs had proved challenging, as much of this form of provision had been historically provided through block contracts, the site had been able to develop a unit costing tool, which was being used to cost the support plans. However, operational staff had found the tool difficult to use, as the unit costs could only be used to price services of a similar nature and therefore did not cover new forms of support.

4.18 In order to address this issue, the team intended to cost non-specialist services (e.g. level 2 provision) over the course of 2012/13. On completion of this exercise, the site intended to feed this information into their RAS development process, to create a working set of costs against which a price point could be fixed, thereby creating a tool that would be simpler to use. Therefore in future, for cases where a family chose to take up specialist provision, the local authority would provide the service through existing contracts and the relevant amount would be deducted from their IB.

4.19 Additional reflections on the evolving approach included:

- More innovative support plans tended to be linked to more confident lead professionals, therefore illustrating the importance of workforce development

- Support planning had been mainly education focused to date, and needed to become more holistic as the process evolved

- Concerns around a shift away from specialist provision/schools, as Lead Members supported this form of provision

- A need to work up the age range and include the 3-5 year olds in the process once development was completed

- Although much had been achieved, the service still had a '*way to go*' to complete the development of the new approach and subsequently to roll this out

- The Early Years Support plan could form the basis of a '*single plan'*, which it was hoped could then be used by the relevant school, without the need for an SEN statement – in conjunction with the SEN team, the Early Years team has identified 5 families with children that are known to the service, due to start school in the Autumn, and who are willing to trial a single planning process (please refer to the '*SEN statement'* section below for further details).

4.20 Looking ahead, the service had secured an additional year of funding for 2012/13 to further develop and refine the approach. This funding was to be used to: retain the Early Years Project Officer; provide a part-time Data Officer; provide an inclusion grant to support settings to build their capacity or to purchase new equipment; provide training to staff; and to explore individual level commissioning with a group of NHS therapists and infant mental health staff, to understand how best to commission support from these groups.

SEN statement

4.21 The three sites that had explored the SEN statement budget had sought to include the local authority based element of the budget into an IB package. The first site had made progress creating flexibility around the education based therapies provision that was included in the SEN statements of two children. This led to the release of the funding that would have been used to provide therapy into the relevant IB packages, which was subsequently used to buy alternative forms of therapy.

4.22 The second site was working with one family to think through how the local authority held funding element of the SEN statement could be used to more effectively meet their needs, as the family did not feel that their current package of support met their needs. This thinking would then be translated into an IB package of support and provide an example of how the site could work with other families.

4.23 Following on from their work in Early Years (described above), the third site were developing a small trial to understand how to use the local authority element of the SEN statementing budget more flexibly as a means of providing more choice and control to families. This was being led by the Operational Head of SEN and a dedicated Educational Psychologist, who had been funded to support the

development of the approach. In addition, the Strategic Lead for SEN was acting as the senior champion for the work, as they recognised the significance placed on personalisation in the SEND Green Paper and therefore that it was likely to become the norm. As such, it was hoped that this development would be aligned with the social care IB process (and developing health IB process) to form the basis of a single plan.

4.24   Progress to develop the approach was delayed as a result of the fall-out from the Pathfinder bidding process. However, at the point of drafting this report the site had:

- Engaged three schools that were interested in trialling the IB approach – including one special school, one mainstream junior schools and one secondary school

- Identified 5 Early Years children that require an SEN statement and whose families were willing to take part in the trial – where it was felt that it would be easier to work with newcomers to the SEN system in the first instance

- Put together an advisory group of education practitioners (all from mainstream schools) to help develop the IB approach – including a nominated SENCO to represent Secondary Head Teachers, two additional SENCOs and a primary Head Teacher

- Held a first meeting of the advisory group – discussions were held on how to redevelop the SEN Statementing process, how IBs can work in a school and what safeguards need to be put in place, how to work together to improve things for children and young people and how to develop a RAS within the parameters, including making funding more child centred than institution focused.

4.25   Future plans over the course of 2012/13 included a desire to develop support/single plans over the Summer term in advance of the 5 children moving into primary school in the Summer. Initial thoughts on the subsequent process included a plan to first identify the needs of the child, attach a budget to this set of needs (where only the local authority budget was to be devolved into the IB package) and to develop a support/single plan.

4.26   As part of the initial development process, the site had identified the following challenges, which would need to be addressed:

- The area supported a large number of special schools which were funded via delegated budgets in the main and therefore the local authority based staff involved in the pilot felt that they would not easily engage in the IB approach, as it would mean giving up control of some of their school budget

- Uncertainty around who the budget holder should be for education IB packages – for example, if parents became employers of people in school, who would monitor their activity? Who would conduct the appropriate safeguarding checks? What would be the legal implications for the schools? Would this require some form of joint decision making between the school and the parents?

- Uncertainty around whether it would be possible to combine the roles of a personal assistant and a teaching assistant to enable a child to work with one individual as opposed to several individuals.

4.27 It was hoped that this trial may include the provision of a small number of SEN Direct Payments, which would also be explored over the course of 2012/13.

SEN transport

4.28 Personal Transport Budgets (PTBs) were originally developed in one of the IB pilot sites as a means of offering parents/carers more choice and control over their home to school transport arrangements, whilst reducing local authority SEN transport costs. A pilot for the PTB approach was undertaken, following which the approach was refined and rolled out across the population of families that were eligible to receive home to school transport support.

4.29 The development of the approach was undertaken by the SEN and finance teams. Additional support was provided by the IB social care team, the local Travel Bureau and iMPOWER[5], the latter of which played a central role in the development of the financial model underpinning the approach and delivered training and support for operational staff.

4.30 The financial model aimed to determine an equitable mileage rate to offer to families and to reduce the existing SEN transport costs by 20%. Development work included looking at the actual costs of transporting children to schools in different parts of the local authority. This resulted in the creation of a set of mileage rates that were based

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[5] iMPOWER were funded through a combination of monies from the Evaluation and Support contract and the IB pilot site's grant.

on distance and the type of school attended (which often related to the type of transport that would be required to support a child) and would be offered to parents/carers through a direct payment.

4.31   A test of the proposed pricing scheme was undertaken in one school and received a good response from parents, following which the offer was rolled out. SEN caseworkers introduced the offer to all eligible families via phone calls, to ensure that parents/carers had an opportunity to ask any questions they may have in relation to how the PTB might work. This direct approach led to a take-up of 114 families (out of approximately 700).

4.32   Families that took up the offer received monthly funding allocations, which could be used in whatever way the family felt was appropriate. As such, there had been a deliberate lack of restrictions placed on how the funding could be spent and parents/carers were not asked to account for their expenditure. Monitoring and review was instead undertaken on the basis of school attendance and punctuality; and in the event this dropped below an acceptable level, the SEN team could action sanctions to stop the PTB payments.

4.33   The PTB offer also included consideration of whether each child/young person would benefit from an opportunity to take part in Independent Travel Training (ITT). If applicable, the family were placed on a temporary PTB whilst the child/young person completed the training, following which the PTB was removed. Figure 7 provides an illustration of how the ITT has been used.

4.34   Feedback provided from families illustrated that parents/carers had taken up the offer as they felt that their existing SEN transport offer was not flexible and often resulted in stressful situations for either the parent and/or their child. Examples of how the PTBs have been used and the effectiveness of the new approaches are illustrated in Figure 7.

Figure 7: Examples of how the PTBs have been used

Child A was taken to school by car by her mother. It was difficult for her mother to ensure that the time the minibus was going to pick her up fitted with the medication and her readiness, but on the other hand taking her by car was more expensive.

Child A's mum was very impressed by the Personal Transport Budgets, and the increase in choice and control it represented for parents, as well as the savings it produced for her.

Child B used to travel to school using a local authority provided taxi, which cost around £20-25 for a return journey. The taxi provision had proved problematic as Child B often wasn't ready when the taxi arrived and in these cases, the taxi operator had charged an additional amount for the waiting time, and in other cases, the taxi had not arrived due to traffic issues, which had caused the family a great deal of stress.

The PTB had provided the opportunity for the parent to take their child to school themselves, which would have been unaffordable in the absence of the PTB. The parent went on to describe how the PTB had changed her life and how she had built better relationships with her child's teachers as a result of dropping her child to school, as previously she hadn't really had much contact with them.

Child C had previously travelled to school by school bus, but had been bullied on the bus, which had made the child scared of using that method of travel. The bus journey was also felt to be quite long, which had been tiring for the child.

The PTB offer had enabled the family to drive their child to school, which had addressed the child's anxieties and had reduced the journey time.

Child D used to travel to school via minibus, which took what she felt to be a 'very long time' and was therefore encouraged to participate in independent travel training, as it was felt that she would benefit from gaining more independence, which in turn would enable her to use public transport. She was apprehensive about travel training but reported that she enjoyed the independence it had given her and stated that it had enabled her to get out and about to see her friends and join activities that she couldn't have done prior to the training. She added that she felt safe when she travelled.

Source: IB Evaluation Focus Group and iMPOWER Case Study in one of the Pilot sites

4.35 Additional benefits of the PTB offer, gathered from the SEN caseworkers included:

- Children enjoying their school life more, as they no longer needed to '*endure'* stressful bus or taxi journeys

- Parents felt more able to plan how and when to take their child to school as they were no longer dependent on an inflexible mode of transport

- Improved parental health as a result of a reduction in stress

- Parent communications with schools have improved as they now interacted with the teachers on a daily basis.

4.36 Feedback from the pilot site had also been positive. This included encouraging reports from the SEN caseworkers that had worked with the families and confirmation that the transfer of parents onto PTBs and away from traditional, local authority provided/funded transport was likely to bring about considerable cost savings to the site. Table 9 illustrates the projected cost savings over a three year period.

Table 9: Projected savings produced via PTB approach	
Year	**In year saving (£)**
2011/12	£50,880*
2012/13	£167,842*
2013/14	£223,686*
Total	£442,408*

Source: iMPOWER PTB Case Study Report on Pilot x

* Based on latest financial projections/ assumptions and assuming 2 years of saving per case

4.37 Two of the other IB pilot sites were seeking to use the learning from the PTB approach to set up similar arrangements in their areas. These developments were likely to be rolled out over the course of 2012/13.

4.38 The fourth IB pilot site had included SEN transport funding in their social care IB packages during the original IB pilot. That is, the SEN transport budget-holder in the area had devolved some of the funding to be used within IB packages and the site was working towards formalising this arrangement to align with the roll out of social care IB packages in the area.

Post 16 funding - alternative to Out of County Placement

4.39 One site worked with a family who could not source appropriate post-16 education provision within the area, which had resulted in them being offered an out of county placement. However, the family did not want to take up this offer and therefore at the point of drafting this report, the IB pilot manager was working with the family to flexibly use the funding that would have been used to deliver the out of county placement to provide in-county provision.

Equipment

4.40 One site considered how to integrate the Specialist Equipment budget into an IB package. In this case, the funding was held by SEN and packages of support were based on assessments and prescriptions drawn up by specialist health services, and required multi-agency sign-off.

4.41 Consultation with the multi-agency panel led to an agreement that it would not be appropriate to include SEN equipment funding within an IB. Two main reasons were provided to support this decision: the first resulted from the prescribed nature of the service, which would not lead to much choice in terms of what could be provided; and

the second related to the risk associated with a health alert being issued to recall pieces of equipment, which would be difficult to implement if a family was given the opportunity to purchase their own equipment. The site has since made a decision to integrate their specialist and mainstream equipment budgets in conjunction with health, to streamline this form of provision.

4.42   Evidence from both the Department of Health's Personal Health Budgets (PHB) Programme and from Adult Social Care has shown that the problems highlighted above could be overcome. For example, several of the PHB pilots have and continue to pilot equipment-related PHBs, which have provided flexibility in the choice of equipment that could be purchased. This choice has been provided during the support planning stage of the process, during which the service user has been shown the 'standard' piece of equipment and 'NHS list of options' that could be purchased and provided with an opportunity to suggest alternative equipment either from the 'NHS list' or from another source. Early evidence on outcomes has also shown that some PHB users had:

> *'…experienced greater choice and control over their care, who provided it (including the opportunity to access non-NHS services or alternative therapies) and when. In some instances, this had already led to direct health gains. For example, new, more efficient equipment such as a nebuliser, or new treatments like acupuncture, were already leading to improvements in health and wellbeing. Others reported improvements to their overall quality of life, for example, by having a new wheelchair that enabled them to get out more…'[6]*

4.43   Similarly, in relation to maintenance responsibilities, Milton Keynes Adult Social Care Department developed a Direct Payments and Equipment Policy in 2007, which set out the responsibilities associated with the purchase of 'standard' and 'non-standard' equipment. Table 10 provides an excerpt from this policy, which illustrates that the provision of sufficient information to service users and families could address issues of risk.

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[6] Department of Health (2011) *Personal Health Budgets: Early experiences of budget holders* Fourth Interim Evaluation Report

Table 10: Guidance from Milton Keynes Adult Social Care Department			
Where an item of equipment needs to be maintained or it is of such a nature that it may breakdown it must be agreed who has the responsibility for maintenance. This must be arranged in one of the following ways:			
	Purchase arrangement	**Equipment specification**	**Responsibility for maintenance / repair / breakdown**
either	**Item purchased from a contracted/approved provider or manufacturer**	**Item purchased is standard equipment from the "standard list"**	**MKC will maintain/repair and respond to breakdowns**
or	**Item purchased from a contracted/approved provider or manufacturer**	**Item purchased is** NOT **standard equipment from the "standard list"**	**Service user is responsible for all maintenance and repair**
or	**Item** NOT **purchased from a contracted/approved provider or manufacturer**	**Item purchased is** NOT **standard equipment**	**Service user is responsible for all maintenance and repair**

Source: Direct Payments and the Provision of Equipment Policy and Guidance, Milton Keynes Council, 2007

Summary

4.44   All six of the IB pilot sites set out clear education-related intentions in their Year Three Delivery Plans. This included exploration of early years, school-age and post-16 service/budget areas. Only a limited number of these funding/service areas were explored over the course of the pilot:

- **Community Enhanced Nursery Allocation IBs** – which provided a set sum of money per child and formed part of a notional budget that was provided directly to the nursery setting chosen by the family, to support the child to access/attend that setting. Parents and professionals were involved in planning how to spend the IB allocation

- **IB approach for the Early Years Service –** this approach had focused on providing choice and control to families via the introduction of a support planning process, following which a notional budget was calculated and spent accordingly. The approach was still in development at the point of drafting this report, and it was hoped that the site would produce a working Early Years resource allocation model during 2012/13

- **Working with a small number of families with social care IBs, to 'flex' their SEN funding** – which had included creating flexibilities around how the education based therapies provision was used and re-shaping a potential out of county placement budget into locally sourced provision

- **Development of a schools based IB trial to reshape the SEN statementing process** – this trial was still in development at the point of drafting this report and was to be taken forward during 2012/13

- **Roll out of a Personal Transport Budget (PTB) approach** – which was based on a mileage rate paid directly to the family and was monitored via school attendance records.

4.45   Observations across the range of approaches that have either been trialled or rolled out included: a tendency to reshape existing packages in cases where areas have worked with a small number of families, with wider costing/resource allocation developments undertaken only in cases where an area intends to make a wholesale change to their approach; a reliance on the use notional budgets; and a focus introducing proportionate support planning processes into the trials/approaches.

4.46   Only limited evidence could be gathered on the families' experiences of receiving the new education IB packages (as only a small number of families were in receipt of their budget at the end of the extended year). However, early indications have shown that families have reported increased flexibility and more choice and control in their service offer.

5: Inclusion of health packages in an IB

5.1   This Chapter provides a detailed account of which health packages were explored and developed by the IB pilot sites, how these developments were undertaken and the implications of this work for wider health-related work.

Progress against the original intentions

5.2   Five out of the six pilot sites illustrated a clear set of health-related intentions in their Year Three Delivery Plans, the majority of which built on areas that they had explored/ developed during the original pilot. Table 11 provides a summary of the health services/budgets that the five sites initially intended to explore and those that became a reality over the course of the extended year. This shows a reduction in the range of services/budgets that were explored/delivered and when broken down by pilot site, highlighted that only three out of the set of five sites managed to operationalise health budgets.

Table 11: Health related intentions vs. progress made		
Service/budget	**No of sites intending to explore inclusion of this service/budget**	**No of sites working towards the inclusion of this service/budget**
Continuing Care / Community Services allocation	4	2
Equipment (including communication aids, continence aids)	4	2
Existing flexible support	1	1
Speech and Language Therapy (SALT)	1	0
Children's residential service	1	0
Local joint funding arrangements for children with High Care needs	1	0

Source: SQW based on delivery plans and IB monitoring data

5.3   The remaining two out of the five sites had begun to undertake some initial thinking in health, which had been led by their Children's Health Commissioners and had included consideration of which services/budgets to pursue and how to disaggregate budgets. However, both had made little real progress by the end of the extended year. Reflections on why this had occurred in one site included a sense that they had

tried to design a '*perfect approach'* before committing to taking anything forward. Lack of progress in the second site appeared to be related to a lack of prioritisation of the health work and intermittent engagement from the Health lead. Looking forward, both sites still intended to develop this area, but conceded that developments were taking a long time to get off the ground.

5.4   Conversely, and aided by support provided by iMPOWER (as part of the DfE funded Evaluation and Support contract), the pilot site that struggled to set out their intentions at the outset of the extension made tangible progress. Initial support focused on brokering the relevant relationships with health. This led to further work to explore which health services/budgets could be included in an IB package and the development of an action plan for targeted work to be taken forward during 2012/13. This work was likely to include the exploration of two health services – Physiotherapy and Occupational Therapy – which were selected as they were both small and discrete, and therefore should lend themselves for inclusion in an IB package.

Numbers of new health-related IB packages

5.5   Looking specifically at the numbers of new health IB packages that were either in development or had been delivered (i.e. were 'live' budgets), it was clear that some small-scale progress had been made (see Figure 8). In total, 9 health-related packages had been delivered and a further 6 were still in development at the end of the extended year.

Figure 8: Numbers of new packages in development or delivered including a health element
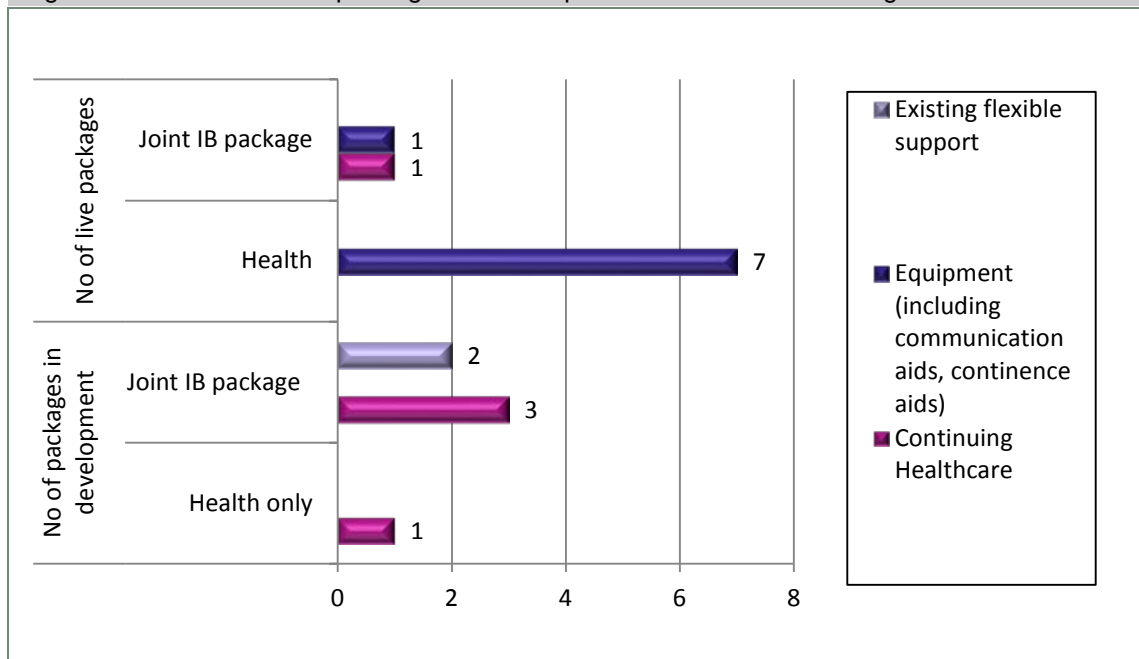
Source: IB monitoring data

5.6   Further detail on the development of these packages and reflections on lessons learnt are set out in the sections below.

Developing health-related IB packages

Continuing Healthcare (CHC)

5.7   Figure 9 provides a summary of the CHC process for children to illustrate how it could lend itself for inclusion within an IB package.

Figure 9: Understanding more about the CHC process
There are three parts to the continuing care process for children: • **The assessment phase** – seeks to assess the needs and understand the preferences of the child and their family and requires a holistic approach drawing on the views of education and social care services if relevant. This leads to a recommendation on both eligibility for CHC and where relevant a costed care package • **The decision phase** – usually comprises a panel with professional representation from health, education and social care, which decides if the child is eligible and whether the suggested costed package of care is appropriate • **The arrangement of provision phase** – all relevant organisations work together to put together the agreed care package. As such, the CHC process is similar in nature to the social care led IB processes developed during the original two year pilot, and it should therefore lend itself to inclusion in an IB

Source: SQW's Health Scoping Paper (Sept 2011) – Initial thoughts on health opportunities

5.8   Two of the pilot sites had sought to broaden their IB packages to include CHC funding and services. The first of these sites had joined the Personal Health Budgets (PHB) Programme during the original two year IB pilot and had as a result pooled together individually allocated CHC and social care funding into an IB package for a small number of young people. However, engagement from the CHC team had been limited to the identification of quality assurance of assessments and subsequent provision of funding, based on an estimate of the level and type of support that would be required. Both the assessment and planning processes were undertaken by the IB Project Officers. As such, no operational CHC staff had been involved in either the assessment or the development of these IB packages, which was felt to reflect their inexperience of using personalised approaches to service provision.

5.9   The extended year of the pilot provided the opportunity for the pilot site to source an operational health professional – a new community nurse - to work with families to undertake the CHC assessment role (including the costing of the potential CHC package). This specialist resource provided a direct link to the CHC team, which helped to streamline the joint health-social care IB process. It was also hoped that

this individual would also support families to plan how they would use their budget using an IB-centred approach.

5.10 The families had not been restricted in the way in which they were able to spend their CHC funding. The only proviso was that the relevant service/equipment was used to meet health outcomes, which were identified during support planning. This was in-keeping with the ethos that had been developed for the social care packages, which the site felt was important to maintain.

5.11 The site also reflected that they were pleased with the outcome of their efforts but emphasised that other sites seeking to draw in CHC funding should seek to identify and train operational health staff as part of their development processes.

5.12 The second site was in the process of applying to form part of the PHB Programme and in the meantime had undertaken the following developments:

- Identified and consulted their target population, i.e. the young people that were eligible for both social care and CHC – which was only a small number

- Refined the '*Bradford Tool*' to align with the social care RAS - the Bradford Tool was used to assess CHC needs and provided a score in hours, which could then be translated into three levels of need-based eligibility. The two resource allocation models had been kept separate during the extended year, as there was no value in combining the two allocations in the absence of the power to pay the CHC funding via a direct payment. They instead undertook holistic planning, which drew the funding allocations from both services. It was hoped that the questions in the Bradford Tool could be embedded within the social care RAS once they had acquired PHB pilot status, which would enable the sites to pay all funding via a direct payment

- Identified that the wider NHS transition to a model of '*Any Qualified Provider (AQP)*' – which had resulted in the development of a register of accredited providers who could deliver a range of specific services within a community setting – provided families with a menu of choice. Families were therefore able to spend their health funding on any of the specified services/providers on the AQP list, which minimised the risk of working with unknown and un-vetted health providers.

5.13 The site had one live joint social care-CHC IB package by the end of the extended year and reflected that the process had been more complex and significantly more

time consuming for both the family and the professionals involved relative to the social care only packages. Some of these complications had been caused by the uncertainty of when they would receive PHB pilot status, as the site and family were keen to provide the funding via a direct payment, but had to set up an interim managed budget before this was possible. The IB Pilot Manager added that although the package had taken longer to put together, it had delivered a set of activities that would not have been achieved through two unitary packages. As such, the additional resource could be justified in this instance, however, it will be important to assess the success of additional joint packages, to justify the additional resource required to undertake the assessment and planning process.

On-going challenges

5.14   As both sites had worked mainly with young people in transition, they had considered how to ensure their IB families made smooth transitions into adult services. This process had proved less challenging to initiate in social care, as both sites offered adult IBs and the children's and adult social care services were working closely together. However, transition from children's to adult CHC was expected to be problematic, as the assessment criteria for both services was different and no work had been undertaken to align these as yet.

Information from the Personal Health Budgets Programme

5.15   In October 2011, the Secretary of State for Health announced that subject to the evaluation of the PHB Programme, by April 2014 everyone in receipt of NHS CHC will have a right to ask for a PHB, including a direct payment. This will form part of a broader rollout of personal health budgets to people with long term health conditions.

5.16   A recent report published by the Department of Health[7], reported that:

> *'Introducing personal health budgets is complex, but early evidence
> from the pilots suggests that this is easier in NHS Continuing
> Healthcare than other areas. More is known about the costs of
> individual NHS Continuing Healthcare packages people receive,
> and both healthcare professionals and individuals who are eligible
> for NHS Continuing Healthcare are more used to personalising and
> developing individualised packages of care'*

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[7] Department of Health (2012) *Personal Health Budgets and NHS Continuing Care, A Discussion Paper*

5.17   The right to ask for a PHB will also be applicable for families with children/young people who receive NHS CHC through the National Framework for Children and Young People's Continuing Care. As such, the lessons learnt during the extended year of the IB pilot programme, provide timely information for other areas, who will need to work towards establishing processes that will enable this form of provision.

Equipment (including communication aids, continence aids etc).

5.18   Equipment aids are discrete in their nature and should in principle be relatively easily to cost, as they tend to be purchased in batches or as single items and should therefore be associated with a reference unit cost. For this reason, two of the sites chose to develop relevant processes to include equipment provision in their IB packages.

5.19   The first site had successfully worked with health colleagues and one family to incorporate new health equipment funding into their IB package, to support the family to more effectively manage caring for their child through the night. The equipment significantly reduced the amount of night-time input required from the family, which also led to a reduction in the associated social care-related RAS scoring for the family.

5.20   The second of these sites continued to fund a Health based Project Manager to take forward the exploratory work that had been conducted during the original pilot. They sought to further understand what a health related IB might look like. This exercise resulted in formal sign up from the Continence Service and Paediatrics to participate in the piloting of continence based IB packages. However, the piloting itself did not take place during the original pilot and the site therefore used the extended year to trial the approach that had been developed. This involved:

•   Stage one: The Health Project Manager working with the Continence Service, Paediatrics and finance representatives to cost a menu of continence products to illustrate what could be purchased

•   Stage two: Exploratory work with a small group of families to understand how a continence related devolved budget might work and the types of alternative products they may want to purchase

•   Stage three: Piloting of continence IBs from Jan – 6th April 2012 to align with the extended IB timescales and because the continence service ordered on a 12 weekly cycle.

Stage one: Developing the continence offer

5.21   Prior to the pilot, families were only able to access a small part of the 'continence catalogue of products' as the Continence Service had selected to buy a limited range of products, which they felt would meet the needs of their service users. The Health Project Manager therefore held discussions with the Continence Service to negotiate a widening of this offer, which resulted in the pilot families being able to purchase any products in the catalogue.

5.22   A Continence Service pathway group was set up to work alongside the pilot to address service specific issues. It was hoped that if the pilot went well, this group would maintain and potentially roll out the IB Continence offer.

Stage two: Exploratory work with families

5.23   Families were recruited through the continence service and a local VCS organisation. They were not a representative sample, as all had had difficulties with the existing service meeting their needs and therefore were more likely to be willing to try something new. A letter was sent to these families, who were asked to get in touch if they were interested, and 9 out of 25 responded (some of whom were the IB families that had taken part in the previous scoping exercise that was held during the original IB pilot).

5.24   The nine families took part in the exploratory work, which involved taking them through the social care RAS and explaining the subsequent social care support planning process. This provided an example of how the IB Continence Offer may work and resulted in two families dropping out and the remaining seven proceeded on to take up the IB continence offer[8].

5.25   The scoping exercise importantly illustrated that the families would lose the NHS purchasing power if they bought the products themselves, as opposed to buying them through the Continence Service. In light of this finding and the fact that the site did not have full PHB pilot status, it was agreed that products would be purchased using notional budgets through the NHS to utilise the associated purchasing power/economies of scale.

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[8] All families were informed that they were taking part in a 3 month pilot. They were therefore made aware that the Continence Service may not be able to sustain their new packages of support beyond the pilot period.

Stage three: The IB Continence pilot

5.26   The seven participating families were all existing users of the Continence Service and were therefore already in receipt of a care package. Therefore their funding allocations were calculated on the basis of their most recent purchase from the service. This funding allocation was offered as an indicative budget to ensure small increases/decreases in budget could be accommodated (as all products had to be purchased in packs).

5.27   Each family was then sent a spread-sheet detailing all of the potential products they could access and based on their indicative budget were asked to select what they would like to purchase. In the event that a family was unclear what a particular provider/product could offer, they were asked to look at the provider's website, to ask the Health Project Manager for support or to discuss their requirements with the provider representatives.

5.28   Given the NHS is free at the point of use families were not allowed to top up their notional IBs through private funding. However, if they chose to independently approach the providers, they were able to buy additional products at non-NHS prices.

Results of the pilot

5.29   All seven families were reported to have been open and positive about the offer, and had used their IB funding allocations to buy a combination of alternative products/more variety than they had previously purchased. A number of the families had based this decision on conversations with other families participating in the pilot and on discussions that had been held with provider representatives.

5.30   Examples of how the IBs were used are illustrated in Figure 10.

Figure 10: Examples of how the Continence IBs were used
Example 1
One family used the opportunity to undertake toilet training with their child. They selected an initial batch of products to trial, which proved ineffective as the sizing of their requested product did not fit their child. The family therefore reported that they had chosen to purchase the incorrect size and were subsequently supported to send back the unused packs and to purchase alternatives, which had been effective.
Example 2
One family chose to purchase protective bed sheets, which had not been previously available from the Continence service. The traditional products that they had used were not effective and had generally leaked.
This had proven challenging for the Continence Service, as they were currently only providing a service for children with continence issues, which did not cover 'bed wetters'. The Service therefore had concerns about opening up their offer to meet the needs of this additional group.

> Continuing discussions were being held with this family, who had also asked whether they could purchase protective duvet covers. At the point of drafting this report, the Continence Service had gone back to the NHS supply chain to see if they could be made available and what the future implications of providing these would be.

Source: Case study evidence from Pilot x

5.31   The Health Project Manager also reflected that traditionally the Continence Service had sent a sample of their recommended product to the family to trial to see if it worked well. However, families had reported that one sample was generally not sufficient, as it did not enable them to trial the product over a period of time or in different conditions. They also stated that they had welcomed the opening up of the NHS catalogue of products for the pilot. For this reason, families had reported that the IB offer had provided them with a better way to trial more products and had offered them more choice of provision.

5.32   Additional reflections from the site illustrated that families felt the offer had provided them with an informed choice, which in the majority of cases had led to the identification of products they felt were effective. Although some families had experienced issues with the products they had selected, all had felt sufficiently empowered to work directly with the provider representatives to discuss and access alternative products.

5.33   One of the seven families dropped out of the pilot, as they wanted to buy a specific product that they had researched prior to the pilot. However, this product was not available through the NHS catalogue.

Looking forward

5.34   The Health Project Manager was drafting a closure report for the health commissioning team to inform the future development of the Continence Service. This report was to reflect on the extent to which the offer could be sustained, how far the NHS catalogue of products should be 'opened up' and the resource implications associated with this.

Existing flexible support

5.35   Home-based health support was identified by the Health Commissioner in one site as something that could be integrated into an IB package (with social care funding) and used in a more holistic way to meet the needs of the child and their family. Following this recommendation, the site had pooled the social care and home-based support funding into an IB package for two families, who were beginning their support planning.

Summary

5.36 Following the hiatus in activity caused by the unsuccessful SEND Pathfinder bids, only three out of the six sites managed to operationalise health budgets during the extended year of the pilot. A fourth site drew on resources provided through DfE funded support, to develop an action plan for targeted health work, which was to be taken forward during 2012/13.

5.37 Developments across the four sites that had undertaken health-related work included:

- **Work to operationalise NHS Continuing Healthcare (CHC) IBs –** two sites were working to reshape the current CHC processes to align them with the social care IB approach. In one case, this had involved the development of a CHC based resource allocation tool, based on the existing *Bradford Tool,* which it was hoped could be embedded within the social care RAS. A small number of joint social care and CHC packages had been successfully developed, however, it was too early to assess the effectiveness of the new packages

- **Development of continence-based IB packages –** one site continued the development work they had undertaken during the original pilot, which led to the delivery of a small number of continence related IBs. The continence offer was made to families that were not happy with their existing provision and facilitated through the opening up of the 'continence catalogue of products', thereby creating a wider menu of choice for families to select from. Families existing packages were costed and offered as a notional budget, which was used to purchase alternative products to those previously used. Feedback from families had been positive and had illustrated that they had valued being given an informed choice

- **Inclusion of home based health support into a joint health and social care IB package**

- **Intentions to explore the inclusion of Physiotherapy and Occupational Therapy –** which were to be taken forward over the course of 2012/13.

6: Key findings and implications

6.1   This final chapter sets out the main evaluation findings and considers the implications of these findings for the wider developments of IBs (which are becoming more commonly known as *Personal Budgets*). In doing so, it considers how the findings from a set of discrete and often small-scale trials may inform the development of an Individual/Personal Budget approach which is to be offered to all families with an Education, Health and Care Plan by 2014.

Key findings

Intentions

6.2   The extended year of the IB pilot came with an expectation that the pilots would broaden their offer to include education and health funds/services. This expectation was not associated with a prescriptive list of funding/services, and as such, each area was able to choose their own direction of travel and tailor development to complement local arrangements/structures.

6.3   As a result, each pilot site intended to explore a different set of funding streams/services, the most common of which were:

- NHS Continuing Healthcare

- Health-based equipment

- Early Years provision

- SEN transport

- School based budgets – including the SEN statement budget.

6.4   The pilot sites exhibited varying levels of ambition in their intentions, with the more cautious sites opting to explore funding streams/services that appeared 'easier' to include. Their intentions were also heavily influenced by each site's SEND Pathfinder application, which was developed in parallel with the Year Three IB Delivery Plan. As a result, the sites also intended to integrate their assessment and planning processes, to support the development of the single assessment and planning approach that was to be trialled through the SEND Pathfinder Programme.

Progress made against the intentions

6.5   Five of the six IB pilot sites were unsuccessful in their SEND Pathfinder bids, which led to some initial disengagement from both health and education colleagues. This created a hiatus in activity of between 1-3 months, during which the sites sought to re-engage their partners.

6.6   Changes to individual site's intentions reflected the extent to which partners were willing to support the development of the pilot and their ability to mobilise funding and staff resource within the few remaining months of the extended pilot. This led to the adoption of one or more of the following three approaches, each of which was considerably less ambitious than the original intentions:

- **Refinement of the existing social care-based IB approach** and ensuring that this was embedded within existing structures and could be sustained beyond the pilot

- **Development of discrete and often small-scale trials of extended heath and/or education IB packages,** which would subsequently form the foundation for delivering extended and holistic IB packages for families that were eligible for the relevant set of services

- **Expanding the IB packages of the original cohort of IB families,** of which only a small number of families were likely to be eligible for the health and/or education services and funding that were being explored by the relevant sites.

Moving from pilot to roll out in social care

6.7   Four of the sites considered how best to roll out their social care based IB approach, three of which had begun to gradually deliver this process, either to particular age groups or across the board. This had resulted in a small increase in the number of children receiving social care IBs (around 30 families), which was likely to increase overtime as the roll outs gathered momentum.

6.8   The fourth site had been bolder in its thinking, and took the decision to roll out the IB approach to all children and young people in receipt of social care funding. The site was keen that the change in approach proceeded smoothly and so facilitated a consultation with families and professionals to consider how best to manage the transition. The findings from the consultation have been used to inform the roll out. This is to take place during 2012/13, with changes to budgets introduced over a

period of time, to 2016, with the extent of change for any individual family limited upwards or downwards.

6.9   **As such, wholesale roll out of the social care IB approach should consider the:**

- **Use of transitional budget allocation arrangements** to smooth the move from traditional to IB resource allocation methods

- **Speed and scale at which the roll out is to take place.**

Development of extended packages

6.10   A limited number of extended health and/or education package were developed – 184 live education packages and 9 live health packages – the majority of which originated from two out of the six sites. These sites had sought to replace existing processes with new IB approaches, which: were championed by a senior strategic lead from the site; developed by dedicated pilot resources (including input from finance officers); included the development of specific resource allocation/costing models; involved elements of staff training, to introduce the new approaches and the means by which staff would work with families; and were backed by senior strategic leads, who were keen to trial new ways of working.

6.11   The **achievement of a transition from a traditional to an IB approach provided evidence to illustrate that changes in approaches were possible to achieve within short timescales** and that some of the concerns around disaggregating budgets and developing unit costs could be addressed through the use of dedicated resource and inputs from the finance teams. It was also evident that progress of this nature also required:

- **Buy-in from the relevant Strategic Lead** to unlock potential sources of education and/or health funding/services

- The provision of a **dedicated and specialist education/health Project Manager/officer** may help to overcome capacity issues and is likely to speed up the exploration of options, costing of services and development of resource allocation processes.

6.12   The remaining sites focused on working with a small number of families that were in receipt of a social care IB, who had expressed dissatisfaction about their traditional education and/or health service provision. This provided some useful examples of how additional elements of funding could be '*flexed'* to offer more choice and control,

and a useful starting point to make '*in-roads*' to initiate consideration of wider service change. As such, the sites illustrated that **it may be easier to focus on some initial '*quick wins'* in education/health to '*get the ball rolling*',** **which could lead to resolution for some families that have been dissatisfied with their service provision.**

6.13   Table 12 sets out the funding streams/services that were (or are to be) explored by the pilot sites. Details of how each of these was developed are set out in Chapters 4 and 5.

Table 12: Health and education budgets/services that were explored	
Health budgets/services explored	**Education budgets/services explored**
NHS Continuing Healthcare	Community enhanced nursery allocations
Equipment – continence service and specialist equipment	Early Years provision
Home-based health support	SEN funding – therapies, SEN statement and out of county placement funding
Physiotherapy and Occupational therapy – *will be explored over the course of 2012/13*	SEN transport
	Equipment

6.14   Looking across the list of funding streams/services that were explored, it appeared that **the areas that lent themselves more easily to inclusion within an IB package in the short term** were likely to be those that:

- **Offered a choice of treatment or alternatives**

- Could be **costed at the level of the individual child/young person**

- **Were centrally funded** either by the local authority or relevant health agency.

6.15   The sites trialled the use of several forms of resource allocation. This included the development of a resource allocation mechanism, similar to the RAS used in social care, the development of unit costs that formed the basis of a costing mechanism and the reshaping of existing packages of support. Each mechanism was developed or used in different circumstances. This indicated that it was likely that in the short term **some education/health services would lend themselves to a resource allocation approach that is similar to that used in social care** (e.g. NHS Continuing Healthcare, Early Years), **whereas others would be more effectively**

costed on the basis of unit costs (e.g. Continence aids, Personal Transport Budgets).

6.16　Sites also considered whether to offer their extended budgets as notional allocations or direct payments. This led to a reliance on the use of notional budgets, which in most cases had been easier to facilitate. However, one site also undertook some health scoping work, which illustrated that families would lose the NHS purchasing power if they bought products themselves, as opposed to buying them through the NHS. As such, the **economies of scale offered through purchasing services through the NHS** (and potentially through schools and education settings) may only be **utilised through the use of notional budgets in the short term**. This **may imply that notional budgets offer better value for money in the short term than a direct payment in particular cases.**

6.17　**One of the pilot sites highlighted some demand for education transport related direct payments**, which were taken up as part of the Personal Transport Budget approach, which could be easily understood and influenced by families. However, **SEN direct payments had not been trialled** during the extended year of the pilot and therefore the evaluation is unable to comment on their likely demand. This **will be explored through the SENDP pilot work that is being taken forward over the course of 2012/13**

6.18　The majority of families that were in receipt of the new packages were either newcomers to the system or had expressed dissatisfaction with their existing service package, as sites felt there was likely to be more value in working with these two groups.

6.19　Only limited evidence could be gathered on the families experiences of receiving the new packages, as only a small number were in receipt of their budget at the end of the extended year. However, early indications have shown that families had reported increased flexibility and more choice and control as a result of the new offer.

Process alignment

6.20　The small scale trials that were taken forward resulted in limited consideration of how best to align social care, education and health IB approaches. Emphasis was instead placed on testing how to execute the discrete trials and whether they were effective for both the staff and families involved. Therefore, although a number of the sites intended to create an integrated process for families with children with SEND, resulting in a single plan, they felt it was too early to consider how best to do this.

On-going challenges

6.21   Given the limited progress that had been made by the end of the extended year of the IB Pilot Programme, the sites were still grappling with a number of challenges. These can be divided into external challenges which were beyond the control of the sites, and internal or local challenges, which needed to be worked through – see Table 13.

Table 13: On-going challenges

External challenges	Internal/local challenges
Uncertainty on the contents of the DfE's response to the SEND Green Paper and therefore confirmation of the direction of travel for services for families with children and young people with SEND – which may also influence how the sites align their processes and what their single plan may look like	How to effectively engage academies and special schools – the sites felt that had more influence over schools that were local authority funded and therefore were unsure of what levers could be used to work with other settings
How to use the School Funding Reforms to '*free up'* some funding to take forward an IB approach	How to effectively engage operational health staff and involve them in delivering the IB approach with families
Uncertainty on how the health reforms and transition to clinical commissioning groups would affect services and budgets – and whether the new structures would house the appropriate expertise to understand and take forward personalised approaches and within these IBs	Given the limited overlap between the groups of children and young people that were in receipt of SEN, social care and the specialist health services that were likely to form part of an IB package, sites would need to consider whether process alignment would be useful and provide value for money
The current legislative framework (especially that governing SEN) was thought likely to restrict the extent to which process alignment could be achieved – sites felt that it did not provide clarity on what provision each agency was responsible for or a legal basis to ensure each was accountable for this delivery	The feasibility of creating a single resource allocation system was still under consideration
	How best to disaggregate budgets that are traditionally either tied up in block contracts or which are held by the health/education setting, e.g. the delegated schools budget

Source: SQW

Concluding thoughts

6.22   Although mixed progress had been made during the extended year of the pilot, much can be learnt from the discrete individual trials that have taken place. Figure 11 sets out a summary of the implications of the findings for wider work.

Figure 11: Summary of the implications for wider work

Implications for wider work over the short-term:

- Gaining **buy-in from the relevant Strategic Lead** is required to unlock potential sources of education and/or health funding/services

- The provision of a **dedicated and specialist education/health Project Manager/officer** may help to overcome capacity issues and is likely to speed up the exploration of options, costing of services and development of resource allocation processes

- **It may be easier to focus on some initial '*quick wins*'** in education/health to '*get the ball rolling*', which could lead to resolution for some families that have been dissatisfied with their service provision

- **Service areas that lend themselves more easily to inclusion within an IB package** are likely to be those that:

  ➢ Offer a choice of treatment or alternatives

  ➢ Can be costed at the level of the individual child/young person

  ➢ Services that are centrally funded either by the local authority or relevant health agency

- It is likely that in the short term **some education/health services will lend themselves to a resource allocation approach that is similar to that used in social care** (e.g. NHS Continuing Healthcare, Early Years), **whereas others would be more effectively costed on the basis of unit costs** (e.g. Continence aids, Personal Transport Budgets

- The **economies of scale offered through purchasing services through the NHS** (and potentially through schools and education settings) may only be **utilised through the use of notional budgets**. This may imply that notional budgets offer better value for money than a direct payment in the short term in particular cases

- **The pilot sites highlighted some demand for education transport related direct payments**, which were taken up as part of the Personal Transport Budget approach, which could be easily understood and influenced by families. However, **SEN direct payments had not been trialled** during the extended year of the pilot. This **will be explored through the SENDP pilot work that is being taken forward over the course of 2012/13**

- **Wholesale roll out of the social care IB approach should consider the use of transitional budget allocation arrangements** to smooth the move from traditional to IB resource allocation methods and **consider the speed and scale at which the roll out** it to take place.

Source: SQW

6.23   To conclude, a number of different trials were developed within education and health settings to understand how to employ an IB approach and the outcomes that this produces. The majority of these trials were small in scale and would require significant resource and cultural change to up-scale. As such, it was felt that there was '*still a way to go'* and a significant number of challenges needed to be resolved before the IB approach was effectively trialled and adopted within the both the health and education sectors.

Looking forward, it was hoped that the learning derived from the extended packages would in the longer-term be synthesised alongside the wider social care experience, with a view to aligning the different tools and resource allocation mechanisms, to develop an integrated approach and possibly a single plan. However, for most this still seems some way off.