Early experiences of implementing personal health budgets

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1 Acknowledgements

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2 Executive Summary

In 2009, the Department of Health invited Primary Care Trusts (PCTs) and local partners to take part in the personal health budget pilot. Overall, some 70 sites were chosen around the country. Twenty sites from all the pilots were selected to be in-depth evaluation sites, with the remainder being wider cohort sites. The Department of Health commissioned an independent evaluation to run alongside the pilot programme to provide information on how personal health budgets are best implemented, where and when they are most appropriate and what support is required for individuals.

An important aspect of the evaluation of personal health budgets involves exploring early experiences of implementation. Over the period April to June 2010, interviews were conducted with personal health budget project leads in the 20 in-depth sites.

In summary, the findings indicated that a number of factors facilitated or inhibited the implementation of personal health budgets.

The factors that seemed to facilitate the implementation of personal health budgets included:

1. Having the finance department on board during the pilot;
2. Finding the resources to manage the inevitable double running costs when expenditure was not being disaggregated from existing contracts. Furthermore, having a clear understanding of the costs of previous care packages;
3. Acknowledging early in the implementation process that:
    a. a clear process is required to support the direct payment process;
    b. sites need to engage NHS leaders, middle managers, clinicians, health professionals, providers and patients to manage the cultural shift;
    c. workforce training is essential.
4. Setting-up a peer support system to help budget holders through the process.

While all project leads were enthusiastic about the potential of personal health budgets and the positive impact of providing more choice and control, there were a number of challenges they faced in implementing personal health budgets, which all relate to changing the culture of health service delivery. At the time of the interview they were facing the following challenges:

1. Managing additional resources required which were not planned for in terms of:
    a. identifying costs of services;
    b. supporting people through the care planning process.
2. Managing direct payments in terms of limiting risk to the budget holder;
3. Knowing where the boundaries were, in terms of what could be included in the budget;
4. Encouraging representatives in the PCT to let go of current control and encourage them to see individuals as being the best judge of what services they need;
5. Engaging middle managers in the pilot as it was thought that their views could have an impact on the success of the pilot;
6. Promoting choice and control in the absence of a clear and developed market

3 Introduction

3.1 Policy context

Personalisation is an important new policy direction for health care in England, giving individuals more choice and control over the money that is spent on their care. The piloting of personal health budgets is one feature of this policy. It is thought that by giving people greater choice and control over services they receive, personal health budgets can improve both the quality of patient experience and the effectiveness of care (Department of Health, 2009). However, this new way of delivering health care represents a major cultural shift within the health care service, which needs to be explored before any decision on national implementation can be made.

It is thought that personal health budgets are particularly suitable for certain groups of people, such as those eligible for NHS Continuing Healthcare, mental health care or end of life services. Those with chronic conditions who are frequent users of healthcare may be a more generic group targeted, such as people with chronic obstructive pulmonary disease and diabetes.

The introduction of personal health budgets aims to make the service more responsive to individuals' needs. The hypothesis is that this will lead to a better targeting of resources, less waste and duplication, and hence improved patient outcomes and satisfaction. In a time of fiscal challenge, personalisation may also improve value for money by ensuring waste is reduced. Personalisation could encourage clinicians and care co-ordinators to have better informed discussions with individuals (Department of Health, 2009). Potentially, therefore, personal health budgets offer significant advantages.

There are, however, potential risks and disadvantages as well. People will be taking on a greater responsibility as part of having greater control. There may be issues with people using budgets to secure services or equipment that they personally value but that may not best serve their health. Also, personal health budgets could disproportionately benefit people from particular socioeconomic, age or ethnic groups in a way that undermines the equity principles of the NHS. Implementing this new policy will bring extra initial costs to the NHS through, for example, breaking block contracts and moving away from mass commissioning and its associated economies of scale.

3.2 Types of personal health budgets

There are three broad approaches to delivering personal health budgets (Department of Health, 2009):

1. A notional budget, held by the commissioner where individuals are aware of the treatment options with a budget constraint and the financial implications of their choices;
2. A managed budget on behalf of the patient by a third party (e.g. organisations or Trusts); and
3. Direct payments, where the patient receives a cash payment to buy services.

Direct payments were included in the Health Bill 2009 (Office of Public Sector Information, 2009). Regulations have recently been laid in Parliament, and the Department of Health will be able to begin authorising sites to offer direct payments from 1st June 2010.

3.3 Setting up personal health budgets

In 2009, the Department of Health invited PCTs and local partners to take part in the personal health budgets pilot. Overall some 70 sites were chosen around the country. A condition for becoming a pilot was for sites to engage with a systematic evaluation of the impact of personal health budgets. Twenty sites from all the pilots were selected to be in-depth evaluation sites, with the remainder being wider cohort sites. A range of criteria, including ethnic diversity, degree of rurality and potential readiness, were used to select the in-depth pilot sites. All sites were given additional funding to meet costs of the pilot and its evaluation. In-depth sites were given a higher level of funding than wider cohort sites to reflect the more detailed evaluation being undertaken in these areas. Each site appointed a project team to manage the implementation of personal health budgets.

The Department of Health commissioned an independent evaluation to run alongside the pilot programme to provide information on how personal health budgets are best implemented, where and when they are most appropriate and what support is required for individuals. In addition, the wider organisational impact on the health system of personal health budgets will be explored.

3.4 The national evaluation

Based on the applications received by pilot sites, and what they were proposing to cover, the in-depth evaluation focuses on individuals with the following health conditions: long-term conditions (including chronic obstructive pulmonary disease, diabetes and long-term neurological conditions); mental health; NHS Continuing Healthcare; and stroke. In addition, the evaluation will explore whether personal health budgets have an impact on two specialist services: maternity, and end of life care.

The over-arching aim of the evaluation is to identify if personal health budgets ensure better health and social care outcomes when compared to conventional service delivery and, if so, the best way they should be implemented.

The evaluation will explore:

1. The process of implementing personal health budgets for individuals and carers;
2. The short and longer term impact of personal health budgets on different groups of people and their carers (for example, changes in health and social care outcomes and changes in satisfaction);
3. The impact of personal health budgets on professional workplace outcomes;
4. The cost-effectiveness of implementing personal health budgets for different health conditions compared to conventional service delivery. In addition to this, assessing the costs and benefits of different models of personal health budgets and for different groups

of people (including, as far as possible, age, ethnicity, disability, gender, religion, sexual orientation, socioeconomic status and urban-rural differences);
5. The short and longer term impact of implementing personal health budgets on organisations, staff and the wider health and social care system (for example, in demand for services);
6. The fit of personal health budgets within the context of the NHS, and NHS values (especially underpinning equity principles); and
7. The longer term effects if personal health budgets were to be further rolled out.

An important aspect of the evaluation of personal health budgets involves exploring early experiences of implementation across the 20 in-depth pilot sites. This analysis will look at the different models of implementation to allow a subsequent exploration of the models (if any) that work better for particular health conditions. This interim report presents the early findings from the first wave of implementation interviews among project leads (PLs) in the 20 in-depth pilot sites.

4 Aims and methods

The aim of this report is identify the challenges faced by project teams in implementing budgets and also any strategies and approaches that worked well. One of the overall aims of the evaluation is to provide lessons for successful implementation of personal health budgets in other areas should the policy be taken forward. This report provides early analysis in this regard.

Over the period April to June 2010, interviews were conducted with personal health budget project leads in the 20 in-depth sites.

The interviews were semi-structured, allowing project leads to discuss their implementation processes and other relevant issues. Each interview lasted approximately 1.5 hours. Interviews were transcribed and coded in accordance with the areas covered in the topic guide.

5 Caveat

Readers should note that pilot sites are in the early stages of implementation and, understandably, some of the systems and processes and the barriers described will change over time.

6 Interviews with project leads

A number of broad themes were covered in the interviews: budget setting, care planning, management and accountability, cultural shifting, integrating health and social care, and impact on the workplace. These are explored here with reference to a number of sub-themes.

6.1 Budget setting

Two aspects of budget setting are important to explore: 1) how the level of resource for each personal health budget is being determined; and 2) services that can be included in the budget.

6.1.1 Level of resource for each personal health budget

Determining the size of the budgets was viewed as *"one of their biggest challenges" (*PL1) and a number of techniques were used to estimate costs. These included:

- Developing an outcome-focused cost-setting matrix. The matrix is based on the cost of hourly, half hourly or unsocial hourly services that the individual requires. The matrix is very much based on the social care model and the history of previous block contracts. The hours required are entered into a very simple Excel spreadsheet and the costs are calculated;
- Using the cost of existing care packages as a basis for an approximate cost of each service used;
- When it was not possible to calculate accurate costs, sites were using their best 'guesstimates' as a basis for budget setting. The estimated costs were used to either:
    - Derive an indicative amount for each service;
    - Derive an overall indicative amount for each budget holder;
    - Derive a cost range depending on the severity of the health condition.

Within each site, approaches to setting budgets seemed to be dependent upon the health condition for which budgets were being set and the ease with which funds could be moved around the system. Where sites are concentrating on a number of health conditions, setting budgets for NHS Continuing Healthcare was seen as relatively simple and the initial area on which they focused because of the lack of block contracts: *"The money isn't tied up and so it will not impact on the way the system works and in fact this is helping develop more their thinking around how they are going to move forward the commissioning in that area"* (PL3).

For NHS Continuing Healthcare *"it's a question of putting a pound sign on their existing care packages, moderating that, maybe taking out some aspects of it, to then come up with a personal health budget…what we're doing is using our existing costs from community health care providers and home care agencies that deliver care to our cohort of patients"* (PL1).

Information from existing care packages was also being used for setting budgets among the other health condition cohorts, although moving the funds around the system was causing anxiety within sites. However, the approach was not always possible, and the accurate estimation of costs was a source of uncertainty. The degree of uncertainty of the costs for a particular disease pathway was alarming to a number of sites, and project leads questioned how scientific their process was in practice: *"We have ended up deciding on a nominal amount based on some guesswork and what seemed reasonable and then 'suck it and see' to some extent"* (PL7).

While budget setting was a challenge for sites, it was thought that the process was useful in terms of PCTs actually beginning to look at the cost of health services: *"The whole process makes certain services start looking at unit costs in a way that they never have done before. We will be getting a much better handle on what we spend now and what we would be spending otherwise. In a way that has been interesting in itself, I have had a lot of interesting conversations about unit costs" (*PL7).

6.1.2 Budgeting for personal health budgets

In budgeting for personal health budgets, sites discussed three challenges: extracting monies, double running costs and the scope of personal health budgets. One important issue linked to budget setting was putting funding in place in order to provide individuals with a personal health budget. The majority of project leads stated that funding for personal health budgets could not be extracted or disaggregated from existing (committed) expenditure. The source of this funding was therefore a challenge for the pilot as to how monies could be made available from the system.

Furthermore, primary and acute services are not being included in the budget which, again, sites thought would lead to double running costs: *"In my view there is no way of doing this without double-funding, you can have mainstream services if you had someone with COPD who would be using acute hospital services, consultant, specialist nurse, they are going to carry on because you can't de-commission them, in which case if you're going to provide a budget you've got to find additional money to do it, so it's got to be double funded – and that's a risk"* (PL2).

In one area the funding for each personal health budget for people in need of NHS Continuing Healthcare was found by top-slicing existing budgets for this health condition, even though it was consistently thought that funds could easily be moved around the system. Their finance department was currently using an estimate of the top-slice arrangement to be used for the personal health budgets. The process of top-slicing was also being followed in identifying budgets for people with neurological conditions in a different pilot site: *"We have top-sliced £90,000; we know it isn't a lot of money, but it is approximately £2,000 per person to go along with to at least start the process. Although we do recognise there will be double running costs, we would like to really encourage people to look beyond current services and to use some of these funding streams in an alternative way"* (PL11). Although it was recognised that the sum of money was small, it was thought based on experience that: "*For a very modest sum of money some people can reach their outcomes. However for others obviously it takes a lot more money"* (PL11). In the event that the budget required to meet outcomes was more than £2,000, the project lead thought that they would try to find the additional resource.

In the same pilot site, the funding for NHS Continuing Healthcare was not viewed as a problem because pooled health and social care resource was already in place: "*As we already have health and social care pooled resources we would say that that money is potentially being used to support some people with accessing different kinds of services. We don't see that as a difficulty"* (PL11).

Another site was using previously ring-fenced funds that had been allocated to project work[1] to support the pilot where there were double-running costs because of block contracts. One project lead thought that potentially there would be budget savings within the contract process and that would be used to resource budgets.

In one case where a site had attempted to find monies by un-picking an existing block contract with a provider (to avoid double running), they had been met with resistance and an unwillingness on the part of the provider to engage with the personal health budgets pilot. According to the project lead, this had in turn led to poor relations between the commissioning leads and the provider.

Overall, one of the greatest fears for sites around budget setting was starting to offer personal health budgets when the process for identifying the resource was so unclear and questionable. In addition, a number of project leads discussed how they felt about starting at a very different place compared with their social care colleagues. They described concern around deciding on the scope of personal health budgets, without fully understanding what services might be available in the wider health, social and third sector economy.

6.1.3 Scope of personal health budgets

A consistent view was that, while the Department of Health had given a list of what could not be included, such as anything illegal, or primary care and acute services, some sites were struggling at this early stage of implementation to know where the boundaries lay in their local pilot: *"We know that nationally, primary care and emergency services are out of scope, but for our pilot, across all sets of clients, medication and acute care is also not going to be included within the scope. This is because of the risks, and we haven't got time to implement that properly, not because we believe that there's a problem philosophically with doing that long term, it's just not practical within the pilot period"* (PL1).

There seemed to be a difference of opinion as to how prescriptive sites should be concerning the scope of the budget. This ranged from setting clear boundaries in terms of asking budget holders to choose from a menu of services, to allowing individuals to choose any service that would meet their health needs. The view in some sites is: *"It is all about choice"* (PL9)*... "and personalisation"* (PL10), whereas other sites had greater concerns about the risks associated with safety in 'letting' patients choose services to meet their needs: *"We won't stop them if they still go ahead with these services as long as it's clinically safe"* (PL1).

In one area, the project lead questioned the degree of flexibility in a budget when an individual was looking to going into a nursing home: *"We are working with a social care broker to see what value we can add. OK they are going to get their £749, or whatever that is, what can we add on which is a nominal amount of money but will make a huge difference"* (PL13).

[1] The sum of money sits outside the £100,000 a year that sites received from the Department of Health for the pilot programme.

6.2 Holding a personal health budget

Following the principles of transparency, the individual is told or given the transparent sum of money following the budget setting stage and will be helped through the care planning process. One aspect of this process is for the budget holder to choose how they would like their resource to be delivered. The majority of sites stated that all deployment options would be open to all individuals unless there was good reason that, for example, a patient could not be offered a direct payment. However, in practice there were some concerns across PCTs on reducing the level of responsibility over how the resource was managed. One site commented: *"At the end of day, direct payments are not the right way to go for some people and in some situations. It is public money and health should have some responsibility over how that is managed and spent. I totally agree with the concept but we need to be really careful"* (PL7). Although the project lead did raise the issue that by not offering direct payments at this stage, it was thought that they have more responsibility which may end up being one of their key pieces of feedback. In a couple of areas, the direct payment route was not available during the initial phase, but they would be discussing the option again.

> *"We have the finance team on board and we don't want to frighten them off. They could block this and they are not – they are working with us. In a few months time and if it is working then we will discuss whether we should go down the direct payment route"* (PL10).

> *"The finance team preferred the notional budget to begin with in the early cases. I have made it clear that is OK to begin with from a learning perspective, but they needed to move to the 3rd party option from there on. In terms of direct payments, it is an ambition for us to move towards. We need to provide evidence that we are capable doing that"* (PL5).

Project leads thought that there were many advantages and disadvantages over the different deployment options.

> *"The notional budget, the PCT has more control over the money and therefore less risk. But from the individual perspective it represents a lip service approach as in there is the money you have but there is no control. The 3rd party provider in terms of contract management makes more sense* [in terms of releasing] *the money along with the responsibility for managing brokerage. I think it will allow organisational flexibility and practically will be able to manage things much quicker than if we held the budget here"* (PL5).

> *There will be a cost implication for the third party organisation as we have to pay a small fee and that will vary depending on the size of the budget. My greatest concern is over the budget being held by the commissioner and to ensure that individuals actually do have choice and control whilst the commissioner holds the money. They are having the power over that"* (PL3).

In the majority of pilot sites, the direct payment options will be offered during the pilot as it was viewed that it provided the best way to give choice and control to the budget holder if

they chose to. However, it was consistently thought that adequate processes need to be in place prior to offering the direct payment option because of the risks to the individual: *"I personally do not have concerns over direct payments; I'm not scared as I know we have the appropriate processes in place"* (PL3). With the correct process in place, it was thought that the evidence suggests that people will use the money wisely: *"The evidence we have from the international and local picture about people managing their own budgets, is that people use the money very wisely and their outcomes are met"* (PL11). However, one project lead thought that carers were extremely anxious about the amount of paperwork that would be involved with a direct payment and also about the amount of responsibility around employment with this deployment option.

6.3 Care planning

Care planning to meet the health outcomes of budget holders is one of the fundamental processes for the personal health budgets pilot programme. Project leads were very positive about the move towards allowing people to be involved in the care planning process, and they had the view that an individual knows their own care needs better than most. However, concerns were raised over the challenges that pilot sites face with supporting the individual through this process and the resulting cost implication. One project lead thought that: *"The philosophy that the budget holder takes the care plan away overnight and fills it in over a cup of coffee overnight is not going to happen for loads of reasons, 99 per cent of the time"* (PL7). The project lead agreed with the concept but thought that the documents they had now would be time costly. Despite this concern, the pilot site thought that one of the main reasons for doing the pilot was to find out what people value through the care planning process.

A number of project leads actually thought that the care process would take time, particularly during the initial stage and the support would need to be provided.

6.3.1 Care planning support

During the early stages of implementation, support planning is commonly being undertaken by clinicians, care navigators and health professionals involved in the offer of the personal health budget and the care planning process. A number of sites have recruited additional support to help with care planning which has been resourced through the funding from the Department of Health. In addition, project leads may also be involved in the process initially at the beginning of the pilot: *"The clinician is going to do this with support with myself or a project support officer"* (PL1). A number of sites have also organised a third party organisation to help with this process, although there will be a cost implication to the PCT which will need to be met.

A number of sites thought that the amount of support required would be dependent on the health condition and whether person-centred care planning already existed, such as in NHS Continuing Healthcare and in mental health. In terms of the end-of-life cohort, it was consistently reported that sites needed to have the processes in place before they began offering personal health budgets to be able to ensure that the care planning process could be delivered in the appropriate time-frame.

The importance of peer support was acknowledged as being extremely important for the success of the pilot owing to the learning that could be brought by individuals who have gone through the process. A number of sites were also engaging with user-led organisations to provide assistance and information to personal health budget holders.

6.3.2 Giving choice and control

A number of project leads discussed using the care planning process to exploit the more autonomous nature of personal health budgets. They felt that taking this approach was in line with the ethos of the pilot, and the personalisation agenda more generally. In adhering to this approach, sites had a sense that individuals should be involved in having input into their own care plans and the planning process as they know their health better than anyone else. However, within this enthusiasm, some caution was reported as to what would and could be agreed by the care planner, and particularly that agreed plans would need to meet a specific health need.

> *"We are trying to be more creative with care planning…so where the patient has a view on what they want in terms of their services, and if we feel it meets a legitimate health care need, and it will deliver an agreed outcome, then we'll go with it"* (PL1).

Going through the care planning process in partnership with individuals had, according to a number of sites, resulted in arriving at new and previously un-considered solutions to patients' needs. This had also, in part, contributed to challenging the views of some clinicians that patients should not be involved in determining the care that they receive.

> *"Some clinicians might tell you 'there is only one way you can meet health needs', but actually what we are finding is that the patients are coming up with examples that we wouldn't of even dreamed of. And I think we'll start to get more of these"* (PL1).

However, there were concerns as to whether commissioners would sign off a care plan that consisted of services or equipment that were viewed as luxuries rather than being essential to meet health needs. For example, a number of sites questioned whether items such as the 'Nintendo Wii Fit' would be approved as opposed to a gym membership.

6.3.3 Equity issues

During the interviews it was clear that the majority of sites held a positive view of individuals having an input into their care plan. However, some concern was expressed about whether or not specific groups of patients would gain greater benefit from receipt of personal health budgets. A view held by one site was that 'self-selecting (white middle class)' people would be more likely to access personal health budgets and, in particular, be happier utilising the direct payment deployment option. In trying to address this, one project lead asserted that in order to have equity of service there cannot be equity of input, and that they (as the organisation offering and delivering personal health budgets) would have to do more work to get the same outcomes for some groups. This additional support will have a cost implication and an impact on the workload of health professionals.

> *"From a care planning point of view, if somebody is more competent at managing their own affairs it makes life easier, but it means that those that are 'less competent' will need a higher level of support so if we're trying to do an equity of service we cannot do an equity of input"* (PL2).

Further to the view that some 'more able' groups may find the process somewhat easier to navigate than others, was the view that this in turn may lead to a reluctance on the part of some people to take up a personal health budget for various reasons: *"Older people may not want to participate, it may be too much for them. People who are very ill certainly for end of life as it is such a sensitive area"* (PL3).

Personal health budgets should be compatible with the core principle of the NHS that care and support be provided based on clinical need rather than ability to pay. There is appropriate censure on individuals topping up the budget from their own resources to purchase additional services. Nevertheless, a number of sites were worried that the 'more affluent individual' will know how to play the system. One site questioned how they could stop 'top-ups' for this group: *"If I picked my menu and my care plan and you told me my personal health budget is £2,000 but mine adds up to £2,300 – that's fine I will put the additional £300 in myself. This isn't supposed to happen and it is supposed to be so wrong – how are they are going to stop that happening. It is absolute nonsense!"* (PL7).

6.4 The effect on 'the market'

A number of project leads felt concerned as to how far choice and control could be promoted where services could not be provided locally. It was recognised that the pilot was in the early stages of implementation and that the market may grow to accommodate such 'new' demands from personal health budget holders. While pilot sites were engaging with service providers, it was thought that the length of the pilot might not be enough to develop the much needed external market for health services. The view was that the market would only fully develop if there was a national rollout of the initiative. In the absence of services that budget holders wanted to purchase, a number of sites queried the whole ethos of the personal health budgets pilot, in terms of having individual control to choose services. Those project leads who questioned any likely development across the health market raised concerns as to the validity of the pilot programme and evaluation: *"If there is not a choice of services, what are we measuring?"* (PL4).

One site described how unit costs had been driven down in their region, in part due to the spending power of the PCT. It was therefore a concern that in the absence of this (spending power), unit costs for services may increase and lead to a situation whereby patients cannot afford the care they were previously getting, because their budget could be based on old costs.

> *"One risk is that we could get patients turning round and saying I cannot buy in what I was getting under the old system"* (PL2).

6.5 Management and accountability

During the interviews a major theme that emerged was the management and accountability process that was in place, particularly for the direct payment deployment option as previously mentioned in section 6.2. While sites described having some anxiety, it was thought that 'risks' could be negated by having specific processes in place to counter such challenges. For example, most sites will have a process in place to review care packages closely to ensure that health needs are met and also to assess clinical outcomes. Furthermore, individuals signing off care plans have the expertise as to whether the services chosen are suitable and would actually meet the individual's health needs, and if they are not they can signpost patients to more appropriate interventions. It was recognised that such processes should not become too prescriptive, needing to balance risk management with the overall ethos of the pilot programme: choice and control.

While trying not to be too prescriptive, for some sites the issue of 'quality assurance' of services for individuals was their greatest concern. That is, whilst the care plan will be signed off within the PCT, how do they protect individuals from using their budget to purchase services that are considered to be of low quality? Again, this was a risk associated with the direct payment deployment option but will be monitored closely through reviews.

> *"If someone wants to employ a personal assistant say Aunt Betty down the road. Without doing a risk assessment on Aunt Betty, how do you know that she can fulfil the need the individual requires?"* (PL3).

What the project lead hopes is that the care navigator visiting the individual will be able to address any training issues.

Underpinning the concerns that sites had regarding the management and accountability of personal health budgets was who (or what organisation) would be responsible if something went wrong: for example, if a patient had a bad experience or achieved 'worse' outcomes as a result of using a personal health budget. Sites were concerned about liability in terms of a 'worst case scenario', where a patient might seek legal compensation. However, while discussing this issue, some sites described how, according to their current understanding, this should not be a concern because liability would and should fall to the patient if the direct payment option was opted for. This, according to one site, was the 'price' of having individual choice.

> *"The issues then come as …if something goes wrong who's responsible, the latest I've heard from the local authorities is that they are now pretty certain that it's the individual…The authority is the funding source and, providing the user support organisation does what it's meant to do, then they are not liable. Otherwise there's no way [they would agree] if they were liable then why would they use another organisation…they say this is because of the choice so it's their risk"* (PL2).

6.6 Managing the cultural shift

One aspect of the personal health budgets pilot, and of the wider personalisation agenda discussed in the interviews, was the cultural shift that this would require for different groups. This included: clinicians, as they (according to project leads) would be unfamiliar with the concept of encouraging patients to be included in the care planning process; patients, as they would also be unfamiliar with this process and had become accustomed to the tenet that 'doctor knows best'; and service providers as they would potentially need to alter their contractual arrangements that they may currently hold with PCT organisations. It was thought by one project lead that the degree of cultural change has been totally underestimated nationally.

The majority of sites discussed an awareness of the issues related to a culture shift in terms of organisational and structural changes that may be necessary to ensure success of the pilot programme. Many stated that, in anticipation of this, efforts were being made by sites to engage various groups (providers, clinicians and patients) to make them aware of the pilot. It was hoped that this would introduce a potential shift in mindset with regard to the delivery of health care services. A number of sites included various representatives, such as GPs, clinicians and service providers on their project board to prepare for the inevitable cultural shift. However, it was felt that engaging with GPs seemed to be a huge hurdle that some sites had yet to overcome.

When project leads were asked about their views of how the personal health budgets pilot was being received 'more widely', there was some variation in response. The perceived 'acceptance' of personal health budgets and personalisation as the direction for health provision differed between stakeholders, patients, clinicians, middle managers and NHS leaders. It was hoped that holding local events would help to improve the view of the potential impact of personal health budgets. Generally the view was held that NHS leaders such as the Chief Executives were very positive about the personalisation agenda in health care, while there were less consistent views in terms of middle managers. In some areas, middle managers were very enthusiastic; however, other project leads were less convinced. There were anxieties that if middle managers were unsure of the initiative, such anxieties would be communicated to the rest of the PCT(s), which would impact on the pilot.

In terms of health professionals, project leads described differences within and between the different groups. In one area, it was thought health professionals were more positive in areas where person-centred care processes already existed, such as in mental health and NHS Continuing Healthcare. However, in another area it was suggested that health professionals thought that: *"There is a perspective that this is work on top of what they are already doing. We are trying to get away from that saying this is part of it and it is the same process"* (PL13).

Where the approach is new, some project leads thought that health professionals were more worried about the impact that this initiative would have on their own workplace and was a challenge to their view that they know best in terms of health needs of individuals. It was identified that there was an advantage in having a number of champions within the PCT who understood the difference that personal health budgets could make to the lives of people.

Consistently, workforce training was highlighted as essential to help with cultural change and the success of the pilot.

One project lead expressed a view on why they might anticipate such opposition from differing areas of health and social care services, and this was shared by a number of other sites in terms of the range of views held by representatives in the PCT.

> *"Very broadly speaking, I would say that the social services and the councils, staff are generally kind of OK with it and they see it as natural extension of personalisation and are very positive…PCTs mixed, more negative, I think part of the reason is that a lot of PCT staff have a clinical background, although they're managers, most have a clinical background"* (PL2).

6.7 Integrating health and social care

The majority of sites expressed an interest in developing links across health and social care services with specific reference to personal health budgets. While a number of sites described how provisional plans had been put in place to enable partnership working across care providers, some sites were further down the line of integration. To make sure that integration could be developed, a number of sites have local authority representatives on their programme board. The project leads thought that for the success of the pilot, integration was essential and *"the way forward"* (PL3). Where integration exists, sites were discussing with their local authority colleagues to develop one care plan across health and social care to reduce the paperwork. However, one project lead discussed that, while they had good links between health and social care, it was thought that at this initial stage they would intentionally keep the care planning process separate. However, it was thought that perhaps they would change the process further down the line: *"Just because we have started off with one thing we may find ourselves finding that this doesn't work and we may change it. We need to be flexible and we recognise that"* (PL11). This project lead thought that if they had a separate health care plan they could clearly identify budgets purely around that person's health intervention.

As a result of initial work to encourage joint working and integration, one project lead described how this had (inadvertently) led to some cross-pollination of services and skills. This was described in terms of providers of services engaging with each other to meet the need of patients in their particular locality. This had additionally led to a degree of market development.

> *"They're talking about putting some of their specialist rehab staff into a new resource that's being funded from the private sector and vice versa as the other organisation has the expert physiotherapists who would actually cross-pollinate. So this pilot is becoming a catalyst for that [joint working] in that private and public sector are both developing services, and that has been an unexpected side-effect – market development"* (PL2).

Discussions between pilot sites and organisations regarding integration had, for some, also led to the recruitment of third sector organisations where this was possible. In general, project leads reported enthusiasm from the third sector to be involved with the pilot, particularly regarding the provision of services.

"One of the third sector organisations are quite keen to be involved in individual planning and offering their expertise in the assessment and the care planning process because they are specialists in their field, so they are quite keen in being fully integrated in that process" (PL2).

6.8 Impact on the workplace

The 'impact on the workplace' emerged as a similar theme to that of 'managing the cultural shift' discussed above. The similarities stem from the importance of these to the relative success of the pilot. If strategic and operational staff do not engage with the underpinning ethos then a level of persuasion will be necessary to implement personal health budgets locally. Project leads may have to find different individuals and routes to navigate down, and they may have to exclude some clinicians as the effort of involving them within the time frame of the project will be too great. Such processes will inevitably have an impact on workload.

Another major issue impacting on the workplace was the capacity of staff involved in the delivery of the pilot. One project lead described that the pilot had resulted in a strain on the workforce because there are also other priorities for the workforce in addition to the personal health budgets pilot.

"I don't think my colleagues would mind me saying…that it's been quite a strain for them because they have not had any time freed up for this project, and they're doing it on top of their day jobs and it's really difficult" (PL1).

The degree of impact on the workplace seemed to be dependent on the number of different health conditions on which they were concentrating during the pilot. Unsurprisingly, sites thought that the workload had increased because they had to work across different sets of health professionals and possibly had to design different care plans. However, project leads thought that there were advantages of not concentrating only on one health condition in the pilot. For example, they could be better placed if there was a national rollout of the initiative due to the processes that would already be in place.

7 Conclusion

This report highlights early experiences of implementing personal health budgets across the pilot sites. In summary, we can see that implementing the initiative has led to a number of different challenges for project leads. These have included: budget setting, care planning, management and accountability, cultural shifting, integrating health and social care, and impact on the workplace. We can also see that a variety of strategies have been employed by sites to meet these challenges.

During the interviews a number of factors seemed to facilitate the implementation of personal health budgets including:

1. Having the finance department on board during the pilot;

2. Finding the resource to manage the inevitable double running costs when expenditure was not being disaggregated from existing contracts. Furthermore, having a clear understanding of the costs of previous care packages;
3. Acknowledging early in the implementation process that:
    a. a clear process needs to have been designed to support the direct payment process;
    b. sites need to engage NHS leaders, middle managers, clinicians, health professionals, providers and patients to manage the cultural shift;
    c. workforce training was essential.
4. Setting up a peer support system to help budget holders through the process.

While all project leads were enthusiastic about the potential of personal health budgets and the positive impact of providing more choice and control, there were a number of challenges they faced in implementing personal health budgets. The challenges discussed relate to being in the midst of a changing culture of health service delivery, similar to those faced when implementing individual budgets in social care (Glendinning, et al., 2008). At the time of the interviews the following challenges included:

1. Managing additional resources required which were not planned for in terms of:
    a. identifying costs of services;
    b. supporting people through the care planning process.
2. Managing direct payments in terms of limiting risk to the budget holder;
3. Knowing where the boundaries are, in terms of what could be included in the budget;
4. Encouraging representatives in the PCT to let go of current control and encourage them to see individuals as being the best judge of what services they need;
5. Engaging middle managers in the pilot as it was thought that their views could have an impact on the success of the pilot;
6. Promoting choice and control in the absence of a clear and developed market.

It is worth noting here that in meeting a number of these challenges sites reported the value of using the networks facilitated by Department of Health, and using models of best practice where these had been developed by other pilot sites.

At this stage in the implementation of personal health budgets and in the evaluation, it is too early to draw any significant conclusions, although the interviews did highlight important factors that either facilitated or inhibited the process.

The evaluation team will continue to collect information on implementation issues and will compare processes, commissioning strategies and other issues over the coming 24 months. We will also be interviewing a number of representatives within the pilot site, including commissioning managers, health professionals and operational staff to explore their early experiences of the implementation process. In addition to the impact of personal health budgets at an organisational level, we will be exploring the experiences of personal health budget holders and carers. Findings from all interviews will be reported at various points during the next couple of years.

8 References

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