Facing up to the challenge of personal health budgets

The view of frontline professionals

Produced in association with
The NHS Confederation

The NHS Confederation is the only independent membership body for the full range of organisations that make up today’s NHS.

We represent over 95 per cent of NHS organisations as well as a growing number of independent healthcare providers.

Our ambition is a health system that delivers first-class services and improved health for all. We work with our members to ensure that we are an independent driving force for positive change by:

• influencing policy, implementation and the public debate
• supporting leaders through networking, sharing information and learning
• promoting excellence in employment.

All of our work is underpinned by our core values:

• ensuring we are member driven
• putting patients and the public first
• providing independent challenge
• creating dialogue and consensus.

For more information on our work, see: www.nhsconfed.org

The National Mental Health Development Unit

The National Mental Health Development Unit (NMHDU) was launched in April 2009 and closed in March 2011. It provided national support for implementing mental health policy by advising on national and international best practice to improve mental health and mental health services. It consisted of a small central team and range of programmes and was funded by both the Department of Health and the NHS.

The NMHDU commissioned or provided:

• specialist expertise in priority areas of policy and delivery
• effective knowledge transfer in research, evidence and good practice
• translation of national policies into practical deliverables that achieve outcomes
• coordination of national activity to help regional and local implementation.

NMHDU’s work was developed in co-production with the Department of Health, the ten strategic health authorities and strategic partnerships with other groups such as the NHS Confederation, the Association of Directors of Adult Social Services (ADASS) and the major mental health third sector organisations.

For more information on our work, see: www.nmhdu.org.uk
# Contents

Executive summary 2  
Introduction 4  
Methodology 5  
Background 6  
Main findings
  - Awareness and understanding is low, demand for knowledge is high 8  
  - Can personal health budgets facilitate patient choice? 9  
  - Additional, not substitute 15  
  - Users and their safeguarding 17  
  - Work practices and processes 19  
  - Overcoming the barriers 22  
Recommendations 24  
NHS Confederation viewpoint 25  
References 26  
Acknowledgements 27
Face up to the challenge of personal health budgets

Positive engagement of frontline professionals is fundamental to the success of personal health budgets. This report presents valuable research into the current attitudes and motivations of some of these professionals to personal health budgets, focusing on six key disciplines: psychiatrists, psychologists, social workers, community psychiatric nurses, occupational therapists and GPs. Whilst the research was specifically conducted amongst professionals working in mental health, the results have practical relevance to personal health budget implementation across all long-term care conditions.

The findings from 60 in-depth interviews and a national survey of 645 frontline professionals working outside the current personal health budget pilot sites, reveal there is strong support for the theoretical principles behind personal health budgets, but endorsement for these abstracts has not yet translated into enthusiasm for their implementation. Professionals believe their service users are already sufficiently involved in decisions about their health. They are yet to be convinced that practical application of personal health budgets will benefit patient care.

Objections centre around two issues in particular:

- Amongst the GPs, psychiatrists and psychologists, concern is greatest about the absence of empirical evidence that patient choice delivered through the use of personal health budgets improves health outcomes. Most worry about the potential trade-offs between giving service users* greater control and fulfilling their duty of care. They are, therefore, keen to manage and direct the choice process.

- Amongst social workers, community psychiatric nurses and occupational therapists, many of whom have experience of personal budgets in social care, the main worry is that bureaucracy will subsume the benefits. They warn that administration associated with assessment, planning and management could reduce face-to-face therapeutic time with patients.

Where professionals do support the use of personal health budgets, this tends to be for supplementary services to the core NHS offer. There is little enthusiasm for personal health budgets to be used to encourage greater competition with non-NHS care, for fear this will ultimately reduce choice. Other significant themes that emerge from the research include potential conflicts of interest around sharing provider choice decisions with service users, and preventing personal health budgets from exacerbating health inequalities.

There is also clear learning to emerge from the research on how to address many of the perceived barriers and to assist implementation of personal health budgets. Professionals believe personal health budgets should:

- be integrated with social care through a single joined-up care plan with clearly defined clinical responsibility
- have their success judged on the basis of individual service user outcomes, not the number of budget holders
- offer the use of advocates and brokers to prevent inequalities, ensuring people with more complex mental health conditions or who are less able to express their needs are not excluded

* We employ the term ‘service user’ throughout the report when referring to mental health service users, and ‘patient’ when referring to users of NHS services in general.
• ensure a clear separation between treatment and provider choice. Clinicians should be involved in discussions around health treatment options with service users, but not necessarily those around provider choice where there may be a conflict of interest

• seek the involvement and engagement of health professionals through peer-led workshops and first-hand experiences of service users benefiting.

On the basis of these research findings, this report makes four key recommendations for policy-makers, NHS leaders and clinicians:

1. Commitment on behalf of the Department of Health to support the suggestions of frontline professionals, as outlined on pages 22–23 of this report, in future policy and implementation of personal health budgets.

2. Collaboration between professional societies and a commissioned independent organisation to deliver a programme of wide-scale professional involvement and engagement through peer-led workshops and learning events.

3. The NHS Confederation to work with members in raising awareness and knowledge at the local leadership level of the issues that will be a priority to engage with their frontline professional staff over when implementing personal health budgets.

4. The Department of Health to acknowledge the role of evidence in its plans to implement personal health budgets and how this will be achieved by the national evaluation.

At the end of this report (see page 25) the NHS Confederation gives its viewpoint on these findings: Personal health budgets are still at a very early stage in their development and it is unsurprising that professionals hold concerns about their use. Our impression is that their views are not intransigent and there is scope for influencing them. Given the political momentum now backing a national roll-out of personal health budgets, however, it is imperative that a greater priority be given to professional engagement lest this window of opportunity pass and clinicians begin to feel ‘done to’. Failure to address the concerns identified in this report at an early enough stage will, we think, lead to personal health budgets failing to gain traction and missing the intended benefits of greater personalisation and patient choice. Foremost among these barriers is that, although supportive of the philosophy behind personalisation, most frontline professionals are satisfied with the extent to which they currently involve their patients. Proponents should make it their main priority, therefore, to make the case for change.
This report examines attitudes and motivations to personal health budgets amongst frontline professionals working with mental health service users. These are based on research findings from 60 in-depth, qualitative interviews and a national quantitative survey amongst 645 respondents.

The research study was undertaken in response to earlier research on personal health budgets, published by the NHS Confederation and the National Mental Health Development Unit. This revealed that local health and social care leaders were positive about the potential of personal health budgets, but sceptical about their practicality, with NHS staff seen as a particular barrier.

This report outlines the key challenges involved if frontline professionals are to effectively put into practice the theoretical principles behind personal health budgets. It draws attention to the complex nature of the main barriers involved, as well outlining how professionals might best be supported if these barriers are to be overcome.

Most professionals are still very new to the concept of personal health budgets and are open to having their opinions influenced by learning and debate. Therefore, this report also explores how these opportunities to work with professionals in developing their expectations might best be approached.
Methodology

The qualitative and quantitative phases of our research took place in England between November 2010 and February 2011. We included frontline professionals working with mental health service users, excluding anyone actively involved in the current personal health budgets pilot scheme. We focused on six different professional disciplines:

- psychiatrists
- psychologists
- social workers
- community psychiatric nurses
- occupational therapists
- GPs.

Sixty individual, in-depth interviews were conducted with ten respondents from each of the disciplines. The sample was structured to ensure a cross-section of professionals in terms of geographical location, gender, mental health service users worked with, and whether based in a community or acute setting.

Telephone interviews of 45-60 minutes were carried out using a semi-structured interview approach. The interviews were recorded and transcribed in full. A process of data reduction was conducted on the raw transcripts through extracting themes based on the interview guide and any emerging themes outside the interview format. A conceptual framework of clustered and disparate results was produced to help determine the key findings.

A quantitative, online survey was also undertaken in order to achieve a broader perspective of professional opinion, to help shape the qualitative interview questions and to assist recruitment of interviewees. Dissemination of the survey was predominantly through the official communication channels of professional organisations representing each of the six professional disciplines concerned.

A total of 645 professionals completed the survey, with just over a quarter (167 respondents) saying they were willing to participate in a telephone interview. As anticipated, given their involvement with personal budgets in social care, response levels were higher amongst social workers (104 respondents), community psychiatric nurses/mental health nurses (147) and occupational therapists (179), than amongst psychiatrists (57), psychologists (59) and GPs (30). There were 69 responses from ‘other’ professionals. The total sample size enables statistically reliable conclusions to be drawn across all questions. The varied individual professional sample sizes allow measurement of indicative but not statistically reliable differences between professions, which are highlighted where relevant in the report.

Our key research themes throughout the study were:

- awareness, experience, and understanding of personal health budgets
- perceived benefits of personal health budgets
- perceived problems and barriers to implementing personal health budgets and how these could be overcome
- the likely impact of personal health budgets on professionals’ work
- criteria for success in relation to personal health budgets
- how professionals might best be supported in implementing personal health budgets.

**Definition of a personal health budget used in the research**

“A personal health budget is the allocation of NHS funding which patients/service users, after an assessment, are able to personally control and use for the services they choose to support their health needs.”
Facing up to the challenge of personal health budgets

Personal budgets are a cornerstone of the policy drive to develop more personalised health and social services. The main goal of personalisation is for services to become organised and focused around individuals, giving them more choice, convenience and control over their care. It represents a major cultural change in how health and social services are delivered.

Achieving personalisation through person-centred planning and support is intended to improve patient experience and health and social care outcomes. A key tenet of the personalisation agenda is that it will encourage professionals to have more collaborative discussions with their patients, leading to patients choosing more appropriate services for their needs. It represents a major cultural change in how health and social services are delivered.

Personal budgets were first introduced in social care, with the option to make direct payments to service users available to English local authorities since 1996. A national local authority pilot was undertaken in 2006/7 to test individual budgets on a range of social care needs. Evaluation results showed direct payments gave people more choice and control over their care and led to improved outcomes (IBSEN, 2008). This model of care, now generally referred to as personal budgets, has since become a more mainstream social care option, supported by a national indicator (NI130) designed to encourage local authorities to achieve 30 per cent take-up of personal budgets amongst social care users by March 2011.

Following encouraging evaluation findings from the IBSEN study and consultative discussions, the piloting of personal health budgets was decided on by Government and announced in the Darzi Review of 2008, High quality care for all. The principles used by the Department of Health to underpin personal health budgets state that they should:

• uphold NHS values
• support safeguarding and improve quality
• support tackling of inequalities
• be voluntary
• support working in partnership
• support decision-making as close to the patient as possible.

To further support the pilot programme, the Health Act 2009 provided some of the primary care trusts (PCTs) involved with powers to allocate personal health budgets in the form of a direct payment.

In Control – a social enterprise focused on promoting self-directed support – initiated and is leading the Staying In Control programme. This involves 37 PCTs and their local authority partners sharing innovative solutions and good

Types of personal health budget

The Department of Health has identified three ways a personal health budget could operate:

1. Notional budget. No money changes hands. The service user finds out how much money is available and talks to their doctor or care manager about the different ways to spend that money on meeting their needs.

2. Real budget held by a third party. A different organisation or trust holds the money for the service user, helps them decide what they need and then, together, they buy the services they have chosen.

3. Direct payment. The service user gets the cash to buy the services they and their doctor or care manager decide that they need. They have to show what they spend it on, but they buy and manage the services.

Background
practice in self-directed healthcare. Building on this work, the Department of Health in 2009 awarded provisional pilot status to 68 sites involving 75 PCTs across England. Twenty of these are involved in an in-depth evaluation led by the Personal Social Services Research Unit, University of Kent. The first two interim reports from the evaluators 6,7 highlighted multifactoral difficulties associated with the inception of personal health budgets as well as the potential for benefits to patient health outcomes.

The new Government has clearly endorsed personal health budgets. The white paper, *Equity and excellence, liberating the NHS*, published in 2010,8 presented the initiative as having the potential to improve outcomes, transform NHS culture by improving choice and control for personal health budget holders, and encourage integration between health and social care. The new mental health outcomes strategy published in 2011, *No health without mental health*,9 provides further evidence of the Government’s direction of thinking. It states that Government will “take steps to extend as much as possible the availability of personal health budgets to people with mental health problems” and that “learning from the evaluation, due to report in October 2012, will inform the further roll-out of personal health budgets.”
Main findings:

Awareness and understanding is low, demand for knowledge is high

There is low awareness and understanding of personal health budgets outside the pilot sites. Across all professional groups, few claim to know more than a limited amount about either the principles behind personal health budgets or the operational components.

The majority of respondents (57 per cent) say they know little or nothing at all and only 15 per cent say they know a lot. Awareness is highest amongst community psychiatric nurses (28 per cent know a lot), whereas psychiatrists (9 per cent) and psychologists (4 per cent) know the least. The main sources of information appear to be the media, internet and, most influentially, word of mouth.

As a consequence, responses to the research study were predominantly perceptual and theoretical. The majority of social workers, occupational therapists and community psychiatric nurses formulated their opinions and attitudes in the context of their experiences with personal budgets.

There is substantial demand to know more about personal health budgets, reflected by the high level of enthusiasm to be individually interviewed. Professionals saw the interview process as a useful learning tool and, most being new to the idea of personal health budgets, were evidently keen to advance their knowledge and sought answers to a wide range of questions. To maintain a neutral approach and ensure the views of interviewees were unprompted, we did not provide answers beyond the factual definition of personal health budgets given, but noted the issues raised.
Can personal health budgets facilitate patient choice?

The theoretical principles behind personal health budgets are strongly supported, but this positivity does not translate into enthusiasm for their implementation. Professionals are unconvinced that the introduction of personal health budgets will benefit service user care. Two key tensions are at work. Firstly, most professionals consider themselves to already offer service users sufficient choice. Secondly, an absence of empirical evidence that service user choice as delivered through personal health budgets improves health outcomes is a significant concern for GPs, psychologists and psychiatrists. They are therefore keen to manage and keep control of the choice process.

Support for patient choice

There is consistent support for the principle of patient choice within a personalisation agenda. All the professionals share a philosophical belief that choice has the potential to improve health outcomes by enhancing self-esteem, empowerment and compliance. Increasing choice and freedom is considered to have particular therapeutic value in the context of mental health services, where lack of control can be a significant contributor to some conditions. It is widely accepted that the more collaborative the dialogue between clinician and service user around healthcare choices, the more engaged and committed the service user will be to their healthcare treatment.

“If the patient has choice, they are more likely to be committed to the kind of healthcare that they’re choosing.”
Occupational therapist

It was emphasised by some interviewees that enabling service user responsibility and choice is a fundamental tenet behind their professional work. With mental health service users, they aspire to the recovery model, working on building a therapeutic relationship whereby the service user is in a position to be able to make choices. In turn, showing an interest in service users’ needs and dialogue around choice is thought to strengthen the therapeutic relationship.

“I think one of the most important things for recovering with mental illness is empowerment recovery, and I think if with support, people can be allowed to make valid choices around their recovery paths of services for them, that can be a very positive factor in recovery.”
GP
Most are satisfied with current provision

The majority of professionals think they already offer adequate patient choice. Asked how they feel about the extent to which their service users are personally involved in decisions about their care, over half of all professionals (56 per cent) say they are satisfied, whilst only a quarter (25 per cent) say they are not satisfied (see Figure 1).

In theory, personal health budgets seen as a positive tool

In theory, personal health budgets are viewed as a positive, effective tool to enable and support service user choice. Professionals’ general understanding of personal health budgets is that service users will be at the centre of planning and discussion around how resources will be allocated to meet their health needs. In principle, professionals welcome the shift in power dynamics between service user and professional that this process will entail.
“I feel positive as issues of choice and control are usually taken away from people and are often causative in their mental health issues. Increasing empowerment and choice for people, the idea of more choice and control in using budgets to meet your health needs, it could almost be seen as an intervention in itself.”

Psychologist

Results from the research survey reveal the balance of opinion is significantly in favour of personal health budgets facilitating greater service user choice and control. Just over half of all professionals (51 per cent) agree that personal health budgets will enable a positive shift in power and control to service users, whereas only 20 per cent disagree. Giving more power and control to service users is not thought likely to result in them making poor care choices (48 per cent disagree versus 18 per cent in agreement) and only 9 per cent of professionals believe service users cannot be trusted with personal health budgets.

Professionals also think personal health budgets can support the personalisation agenda through stimulating more focus on individual service users’ needs. Instead of a generalist approach to mental health service delivery, fitting service users into available statutory service provision, professionals claim they will have greater opportunity to plan service choice around specific and individual service user needs. Almost half of all professionals (48 per cent) agree that personal health budgets will allow service users to access services tailored more to their individual needs, as compared with 27 per cent who disagree. Occupational therapists evidence particularly strong accord with this viewpoint (56 per cent agreeing versus 17 per cent disagreeing) (see Figure 2).
Limited enthusiasm

However, this theoretical support for personal health budgets facilitating service user choice does not translate into general passion for them. Only 28 per cent of survey respondents claim to feel enthusiastic about personal health budgets, whilst a significantly larger proportion (39 per cent) is unenthusiastic. Occupational therapists and psychologists are the most enthusiastic amongst the different professions, whilst psychiatrists and community psychiatric nurses are the least enthusiastic (see Figure 3).

Figure 3. Professionals do not feel positive about personal health budgets

By profession

<table>
<thead>
<tr>
<th>Enthusiastic Mean scores</th>
<th>Very enthusiastic</th>
<th>Fairly enthusiastic</th>
<th>Neither enthusiastic nor unenthusiastic</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPNs</td>
<td>-1.0</td>
<td>-0.2</td>
<td>-0.8</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>-0.6</td>
<td>-0.4</td>
<td>-0.6</td>
</tr>
<tr>
<td>SWs</td>
<td>-0.4</td>
<td>-0.2</td>
<td>-0.6</td>
</tr>
<tr>
<td>GPs</td>
<td>-0.2</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Psychologists</td>
<td>0.0</td>
<td>0.2</td>
<td>0.4</td>
</tr>
<tr>
<td>OTs</td>
<td>0.4</td>
<td>0.6</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Don’t know 9%
Very unenthusiastic 16%
Fairly unenthusiastic 23%
Very enthusiastic 4%
Fairly enthusiastic 24%
Neither enthusiastic nor unenthusiastic 24%
Facing up to the challenge of personal health budgets

Insufficient evidence

A major constraint on professionals’ enthusiasm is the lack of empirical evidence that service user choice as practiced through personal health budgets will deliver improved health outcomes. Many psychiatrists, psychologists and GPs express particular sensitivity to this issue. Being generally strong proponents of evidence-based medicine, they are reluctant to embrace implementation of a new health initiative without hard evidence it will ‘first do no harm’.

Inadequate evidence is rated the most significant barrier to implementing personal health budgets by the psychiatrists, psychologists and GPs who responded to our survey. Nearly three-quarters of psychiatrists (71 per cent) agree there is insufficient evidence that personal health budgets produce better outcomes, as do 62 per cent of psychologists and over half of GPs (53 per cent). Professionals least enthusiastic about personal health budgets consider this the key barrier (71 per cent in agreement), whilst professionals overall rank it second (53 per cent in agreement) (see Figure 4).

Managing choice, keeping control

Whilst willing to involve service users in shared discussions, health professionals are not prepared to relinquish control over the choice process. Given the absence of evidence on health outcomes, GPs, psychiatrists and psychologists in particular want to have a level of control over service users’ choices significantly beyond that which personal health budget proponents are intending them to have.

Balancing service user choice with duty of care is the most important concern. Consideration as to whether they should support a service user’s choice with which they disagree raises complex safety and ethical issues for many interviewees. In this context, allegiance to evidence-based medicine dominates the thinking of many GPs, psychiatrists and psychologists, they would only present a service user with choice options that have a scientific evidence base. Some express discomfort at the idea that NHS money might be used to fund non-evidence based...
Facing up to the challenge of personal health budgets

treatments, all the more so in times of financial constraint.

“Yes there is choice, but we are still accountable for public money and therefore if you’re going to ask for something non-evidence based it’s not going to be reasonable. There is financial constraint and therefore we have to be even more aware of the fact that what we are going to spend our money on is going to produce the goods... we shouldn’t be giving them things where there isn’t evidence this isn’t going to give them good health outcomes.”

GP

Several professionals exhibited an intrinsic belief that even service users with the capacity to make choices do not have the ability or knowledge to choose wisely. They believe it is only years of training and work experience that enables them to recommend the best treatment options. They are sceptical that service users could make a similarly informed choice. Some clinicians worry that service users will simply opt for what they like rather than what will deliver the best health outcomes. It was suggested much greater health literacy is needed if service users are to become real partners in decisions about their care.

“I’m a highly trained, highly expert specialist in a field which has involved many, many years of training, many years of clinical experience, and my job is to know the best evidence and best practice for the kind of presentations that I’m expected to see within my field. It would be completely against my code of practice to say to a young person, yes go ahead and spend money on something that has no evidence base.”

Psychiatrist

There is also some uncertainty about the degree to which service users with the capacity to exercise choice will in fact want to do so. There are fears that giving service users responsibility for choice might cause them undue stress, anxiety and distress, especially if outcomes are not as expected. Choice management is seen as the means to limit these potentialities.

A number of professionals express an alternative viewpoint as a result of their personal budget experience. They are willing to support a service user’s choice with which they disagree, on the basis that even if a service user makes mistakes, this can be carefully monitored and controlled. They argue it could be an empowering process to give service users freedom to make mistakes, service users’ capacity for choice and control could be enhanced through helping them understand why mistakes happen and what might have worked differently to change outcomes.
Additional, not substitute

Professionals both anticipate and support personal health budgets being used for supplementary services to the core NHS offer. There is very little enthusiasm for using personal health budgets to encourage greater competition with non-NHS care providers. The fear is that this would ultimately reduce choice.

**Additional support**

Personal health budgets are intended to be broadly cost neutral to the NHS because service users will be allocated a sum of about the same financial value as the traditional service they are entitled to.

The concept of personal health budgets being used to buy services to replace a service user’s current package of care, rather than being supplementary to it, was not something of which professionals were aware. When asked how personal health budgets could benefit their service users, professionals’ perceptions were centred around providing additional support in more flexible and creative ways, filling gaps in existing services and reducing waiting lists. Some were quite perturbed by the idea that personal health budgets could be used for substitute services.

Since professionals perceive little potential for personal health budgets to be used to shift demand away from traditional NHS services, they anticipate them being an additional cost. As a result, they cannot see how personal health budgets might be safely implemented in a period of financial constraint.

Additionally, from a commissioning perspective there are concerns that if personal health budgets are operated on a cost neutral basis, it could lead to destabilisation and possible closure of existing NHS services. This would reduce the choices available for personal health budget holders and present a serious challenge in terms of supporting service users whose more complex mental health needs would make them less suited to personal health budgets and who would therefore be dependent on statutory services.

“There’s only so much money to go round. If the pot of money for personal health budgets isn’t going into existing services, they may close and the staff be made redundant.”

*Community psychiatric nurse*

**Expanding the market**

Few interviewees spontaneously perceive personal health budgets being used for service providers competitive to the NHS offer. When prompted to consider this possibility, there is very little enthusiasm. Whilst some professionals welcome competition based on quality, most fear it will be price rather than quality that will determine which services for their service users are sustainable and survive.

There are worries that private companies might undercut NHS services using a temporary loss-leader approach, creating an unequal playing field. Cherry-picking of the most profitable services and patients by private companies is also thought a possibility, leaving the NHS with responsibility for only the costly, more complex mental health cases. As a result, some good quality, high-demand, NHS-run mental health services might become unviable and need to be downsized or closed. Managing workforce requirements and resource provision to meet fluctuating demand is expected to present many difficulties. There is also concern that evidence from the pilots will not offer a valid measure of this issue since personal health budgets will not yet be operating in a fully developed market. As this is unlikely to be
Facing up to the challenge of personal health budgets

something that the small-scale national pilots will be able to measure, additional methods of modelling will be required.

The counter argument is that competition could potentially improve NHS service delivery, to the benefit of service users. Opening up the market is judged a positive development by a minority of research participants. To survive, NHS services would have to redesign and re-configure to more sensitively and effectively meet service users’ needs, rather than delivering a service suited more to the requirements of the organisation. There would be an incentive to become more entrepreneurial by partnering with or setting up new services. In this context, it is suggested there might be business advantage in NHS providers being ‘first movers’ in the new personal health budget market.
Users and their safeguarding

Determining the capacity of service users to manage their own personal health budget is viewed as both a complex and sensitive issue by professionals. In making an assessment, consideration of many factors is thought necessary; in particular, fluctuating mental capacity, the nature and scale of risks involved, and what safeguards should be put in place during periods of crisis.

Capacity

Most of the professionals we spoke to believe capacity decisions should be made on an individual service user basis. They do not want a generic approach linked to diagnosis, or to achievement of a specified percentage of budget holders as has been the case with personal budgets in social care. The latter is felt to have instigated a ‘numbers drive’ at the expense of personalisation and service user choice. It is also thought better to have a multi-professional approach so individual service user capacity can be assessed from a more holistic perspective, reducing the possibility for something of significance being missed.

“In there is a danger of having a blanket policy as there has been with direct payments in social care... it needs to be individualised.”

Social worker

Our survey research shows that professionals hold a generally positive view about the proportion of their service users who have the capacity to manage a personal health budget. Whilst the majority (51 per cent) believe under 30 per cent of their service users could take responsibility for a budget, a significant minority (20 per cent) think over 60 percent could. Nonetheless, a sizeable proportion of professionals (46 per cent) judge personal health budgets not suitable for service users with fluctuating mental health needs, even if managed by a carer.

Inequalities

There are widely expressed fears that personal health budgets may impact negatively on health inequalities by only being offered to more capable and functional service users and not to those with complex mental health conditions. There are anxieties that service users without a budget might have reduced access to healthcare if the services they have been using are forced to close by market conditions.

Differential levels of service user demand are also thought likely to generate inequalities; articulate, informed service users with greater capacity to express their needs being most likely to benefit, to the detriment of those with higher need. Interestingly, several professionals admit it is sometimes difficult to resist ‘pester power’ from service users or their carers.

These worries are reflected in responses to our survey. Only 15 per cent of professionals agree that personal health budgets will enable resources to be allocated more fairly and equitably, whilst 42 per cent disagree.

Risks

Many professionals are exercised by the potential risks involved in relation to service users handling a personal health budget. They mention a wide range of risks that personal health budget systems would have to be designed to look out for, including: fraudulent use on drugs and alcohol; money running out before health needs are fully met; financial exploitation of the budget holder by family members, friends or carers; dependency problems leading to service users not wanting to make health improvements; and unknown individuals and organisations providing healthcare.
Findings from our survey show that professionals are both divided and undecided in their opinions about the scale of the risks associated with personal health budgets. Just over a quarter of respondents (26 per cent) say they think the safety risks involved are too high, whilst just over a third (34 per cent) disagree. However, almost another third of respondents (31 per cent) claim to be unsure.

To overcome the risks identified with personal health budget use, some clinicians want stringent checks and balances to ensure safeguarding at every stage. However, with learning from experience of personal budgets, several social workers, occupational therapists and community psychiatric nurses propose a lighter-touch, flexible approach; with review processes put in place proportionate to an individual’s assessed risk level. These reviews would both monitor healthcare and audit financial expenditure. Some safeguards felt to have worked well for personal budgets include: paying money by instalment; counter-signing of account withdrawals; vouchers given in lieu of money; and relapse contingency planning. However, to be operationally effective, these safeguarding measures still require significant staff time and resources.
Work practices and processes

The practices and processes required to implement personal health budgets worry many professionals. Negative impacts on clinical roles are a key concern. Amongst social workers, community psychiatric nurses and occupational therapists, in particular, there are warnings that the bureaucracy associated with the assessment, planning and management of personal health budgets could subsume the potential benefits. This could make frontline staff resistant to service users taking up personal health budgets.

Bureaucracy

The additional bureaucracy and paperwork that might be needed for personal health budgets is a major concern for professionals. This is rated as the leading barrier to implementation. Over half (54 per cent) of all professionals and almost three-quarters (72 per cent) of those least enthusiastic about personal health budgets agree that the introduction of personal health budgets will result in too much additional bureaucracy. Community psychiatric nurses (74 per cent in agreement), social workers (58 per cent) and occupational therapists (48 per cent) all rate this by far the most important barrier.

Their experience of personal budgets in social care leads them to worry that the administration and paperwork associated with assessment, planning and management of personal health budgets will reduce face-to-face therapeutic time with service users. It is estimated that personal budgets have reduced their clinical time spent with service user clients by up to a quarter. There is considerable resistance to personal health budgets being introduced in isolation from the personal budgets process. The inevitable duplication of time spent on assessments and administration leads to fears that they will become ‘pen pushers’ rather than frontline clinicians. The effort that will be required to determine which treatment choices go under which type of budget is thought time wasting and unproductive, especially since service users tend to not understand the distinction (see Figure 5).

Figure 5. Professionals think personal health budgets will generate too much extra bureaucracy

<table>
<thead>
<tr>
<th>% agreeing PHBs will create too much additional bureaucracy &amp; paperwork</th>
<th>% disagreeing PHBs will create too much additional bureaucracy &amp; paperwork</th>
</tr>
</thead>
<tbody>
<tr>
<td>80</td>
<td>0</td>
</tr>
<tr>
<td>70</td>
<td>10</td>
</tr>
<tr>
<td>60</td>
<td>20</td>
</tr>
<tr>
<td>50</td>
<td>30</td>
</tr>
<tr>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>30</td>
<td>50</td>
</tr>
<tr>
<td>20</td>
<td>60</td>
</tr>
<tr>
<td>10</td>
<td>70</td>
</tr>
<tr>
<td>0</td>
<td>80</td>
</tr>
</tbody>
</table>

All professionals | Least enthusiastic about PHBs | CPNs | Social workers | OTs
The distinction between treatment and provider choice

Most professionals welcome sharing discussions with service users around treatment choices, but are resistant to discussing choice of provider. Across all professional groups there are conflict of interest worries. Few think they could discuss choice of provider impartially, particularly when they personally or their own organisation might be one of the options involved. It is believed this could damage the service user-clinician relationship, especially if service users come to feel that the provider recommendations are finance-driven. In general, it is thought the role of discussing provider choice is best left to administrative staff, although some interviewees are insistent that clinical skills are required.

“I don’t think it’s appropriate for me to be discussing with the patient what their (provider) options are because of the risk of advising them in any way. It should be a totally impartial individual.”

Psychologist

Changing roles and job losses

A major anxiety amongst those with experience of personal budgets is that personal health budgets will lead to changing roles and job losses. They are worried that service users will have less need of their clinical input and they will become more navigator and signposter than care provider. Some anticipate a blurring of professional distinctions between community psychiatric nurses, occupational therapists and social workers, with less value being attached to their different professional skills. In turn this could lead to their replacement by less qualified, cheaper, non-clinical support workers. Job losses are also thought likely to accrue if service users choose to spend their personal health budgets with alternative providers. As one respondent described it, offering service users a personal health budget “could be like turkeys voting for Christmas.” The current environment of public sector spending cuts makes it all the more feasible that the introduction of personal health budgets will lead to redundancies.

“I think what will happen is we will move further on the road to being social care bureaucrats orchestrating people’s access to services. We won’t be clinical staff. The amount of paperwork is a nightmare. A ridiculous waste of time. You’re taking people with clinical skills and you’re using them for administrative work.”

Community psychiatric nurse

Alternatively, some interviewees hold a more positive and entrepreneurial outlook. They see potential opportunities in setting up their own provider organisations as social enterprises or private businesses, and selling their services back to the NHS. Others welcome the prospect of their own organisations having to adopt a more service user-oriented and needs-focused approach to delivering mental health services if they are to be successful in the new health market.

“I might go privately because it gives the client the opportunity to pick people they really want to work with rather than being told you’re working with this person or you’ve got to have this consultant.”

Occupational therapist

Incorporation with other care systems

There is uncertainty as to how personal health budgets might operate in tandem with other patient care systems currently being introduced,
especially clinical care pathways for mental health and Payment by Results. It is anticipated there will need to be some choreographing between the systems, otherwise tensions could arise; there being potential conflict between service user choice and the provision of specific treatments within a defined clinical pathway. Continuity of care is another concern, with professionals highlighting how fragmentation of service provision can lead to less coordinated care and a greater chance of people with complex needs falling through the gaps.

“I think if we were working in a more fragmented basis... then it undermines any continuity of care or ability to predict, plan and manage. I think there would be more likelihood of early relapse not being picked up, coordinated interventions not being offered and managed, these sorts of things.”

Psychiatrist
Overcoming the barriers

If personal health budgets are to be successfully introduced, enthusiasm amongst professionals for their intrinsic theoretical benefits needs to be translated into willingness to embrace their practical implementation. Our research identifies possible solutions to the barriers identified in this report and provides valuable learning on how to actively support implementation of personal health budgets.

Integration with social care
A single, joined-up care plan should form the facilitative linchpin of a single personal budget. This will help cut down on duplicative assessments, administration and bureaucracy for frontline professionals, thereby saving time and resources; and help free them up for more face-to-face therapeutic time with service users.

Clearly defined clinical responsibility
Clinical responsibility and oversight needs to be clear and made part of the care plan. It will help ensure continuity of care as well as coordination across a range of fragmented service providers. It will enable better joined-up services around the service user and prevent signs of relapse not being picked up.

National guidance and protocols
Such are the perceived complexities and associated worries around issues of risk and safeguarding, national guidance with clear lines of accountability will be valuable. This will help build common understanding and reduce inconsistencies and inequalities in service user access to personal health budgets across different trusts and commissioning consortia.

Used to maintain service users in the community
By providing services not currently available to better meet service users’ needs, personal health budgets can help sustain service users in the community for longer. Service users can be better supported during transition from inpatient to community settings if they have personal health budgets put in place before discharge. Personal health budgets should also be used to identify service users’ capabilities so if they do relapse professionals have a goal to help them work back to.

Not judged by numbers
Professionals do not want to see success of this new model of healthcare measured in terms of numbers of service users with a personal health budget, as in social care. The ethos of personalisation and patient choice was often felt lost in the push to get more and more service users onto personal budgets. Assessment of the scheme should be on the basis of individual service user outcomes in relation to needs.

Use of advocates and brokers to prevent inequalities
Advocates and brokers should be used as a means of ensuring that people with more complex mental health conditions, or who are less able to express their needs, are empowered to access personal health budgets. Service users with very variable conditions, able to manage a budget when well, could nominate an advocate to act on their behalf during periods of ill-health or crisis when they have poor capacity. This will help negate professionals’ fears that personal health budgets may impact negatively on health inequalities.

Separation of treatment and provider choice discussions
Clinicians should be involved in discussions with service users around their choice of health treatment under a personal health budget, but not necessarily in discussions on provider options. This could reduce the administrative burden professionals associate with personal health budgets, as well as potential conflict of interests in relation to choice of provider.
Clarity and transparency over budget allocations

There should be clarity and transparency around budget allocation and budget setting to ensure professionals, service users, carers and advocates have common awareness and understanding. This will help the management of service user expectations and reduce the likelihood of giving service users unrealistic expectations. It will limit abuse of the system by those more ‘in the know’. It should also prevent time and resource being taken up on inappropriate assessments and applications.

Peer-led workshops

A lot of activity is generally needed to change clinical culture, but dissemination workshops are considered particularly key by the professionals we interviewed. Peer learning and discussion can influence opinion and practice. Professionals want to hear from peers treating similar mental health service user groups to their own about both what has worked and what has not worked in the pilot sites, and share discussion to find possible solutions to the difficulties and problems encountered.

First-hand experience of service users benefiting

This is felt to be one of the main ways that clinical opinion around personal health budgets can be shifted. Many of the professionals that use personal budgets said that early positive experiences of benefits among their own service users were critical in overcoming doubts and worries. Even professionals for whom empirical evidence will always be the key determining influence acknowledge that first-hand experience of service users benefiting from the use of personal health budgets could positively sway their opinion.

“For me, if I had a patient sitting in front of me with a smile on their face, saying you know I’ve done all of this and six months down the line I’m feeling so much better, that would be hugely successful. It does come down to that individual experience doesn’t it? It is about seeing people taking control of their lives again.”

GP

“To be able to hear from colleagues, people who are working in a similar situation to you, that’s so much more powerful than just being told ‘these are the results’. If you actually talk to people who have been going through this and who’ve faced all the problems you know you are likely to face, that will have a big influence.”

Social worker
Recommendations

As a result of the research findings presented in this report, the following actions are recommended:

1. Commitment on behalf of the Department of Health to support the suggestions of frontline professionals, as outlined on pages 22 to 23 of this report, in future policy and implementation of personal health budgets.

2. Collaboration between professional societies and a commissioned independent organisation to deliver a programme of professional involvement and engagement through peer-led workshops and learning events.

3. The NHS Confederation to work with members in raising awareness and knowledge at the local leadership level of the issues that will be a priority to engage their frontline professional staff over when implementing personal health budgets.

4. The Department of Health to acknowledge the role of evidence in its plans to implement personal health budgets and how this will be achieved by the national evaluation. Findings from the in-depth pilot sites to be widely disseminated and discussed with professional bodies on an iterative basis and their views fed back into the pilot sites to in turn be evaluated.
NHS Confederation viewpoint

This study was conducted to test the validity of our members’ views on personal health budgets after they expressed doubts about the acceptability of this policy to their frontline staff.10 Given the early stage of personal health budgets’ development, it should not be surprising that the leaders appear to have been correct; it takes time for any reform as radical as this to be designed, debated and deployed in a form professionals can support.

Yet such is the political momentum the Government has placed behind personal health budgets, it is now imperative that the concerns outlined in this report are taken into account and wide-scale professional engagement given greater priority. Failure to do this risks missing the opportunity to influence clinicians while their views are still forming and creating a sense that this new model of care is being done to them, not done with them.

It is encouraging that health professionals positively embrace the philosophical principles behind personal health budgets. However, this is not translating into enthusiasm for their introduction, first and foremost because the majority do not see a convincing need for change. Our view is that this confidence in the status quo is misplaced; however, this difference of opinion sets a challenge for proponents of personal health budgets to engage with and persuade professionals of their value. The Department of Health needs to listen to the concerns outlined in this report and in particular absorb the professionals’ recommendations about administration, the use of advocates and brokers and integration with social care.

Finally, the national pilots have a vital role to play in winning over health professionals and recording the lessons of those areas that are experimenting with personal health budgets already. Clinicians are looking to this evaluation for robust evidence of how personal health budgets work in practice in order to formulate their opinions. In our view it is inadequate, therefore, that this evaluation be used simply to “inform the further roll-out”11 of personal health budgets, as this implies the key decisions about their future have already been taken – without any evidence. A more rigorous and substantive approach is needed if professionals are to have confidence in the findings. Given that the pilots are coinciding with one of the biggest reorganisations in the NHS’ history and that, as a result, early feedback from them is reporting low uptake, we see no other option but to extend the period of evaluation until 2015. Any decisions about their roll-out should then be postponed until there is sufficiently strong evidence in support of national implementation.

For more information on the issues raised in this report, please contact jonty.roland@nhsconfed.org
References


11. HM Government (2011) op. cit.
Francesca Taylor, NHS Confederation, for conducting and analysing the research, and writing this report.

The NHS Confederation and the National Mental Health Development Unit would like to thank all the professionals who very kindly gave their time to complete the research survey and to be interviewed in depth for this report.

The Royal Society of GPs, The Royal College of Psychiatrists, The College of Occupational Therapists, The Royal College of Nurses, The British Psychological Society, The British Association of Social Workers, UNISON and UNITE, for helping disseminate the research survey to their members who work with mental health patients and service users.

Simon Pearson, NHS West Midlands, for setting up and running the online survey and for data administration.
Facing up to the challenge of personal health budgets

This report examines attitudes and motivations to personal health budgets amongst frontline professionals working with mental health service users. These are based on research findings from 60 in-depth, qualitative interviews and a national quantitative survey amongst 645 respondents.

It outlines the key challenges involved if frontline professionals are to effectively put into practice the theoretical principles behind personal health budgets. It draws attention to the complex nature of the main barriers involved, as well outlining how professionals might best be supported if these barriers are to be overcome.