NHS SEFTON

MERSEYSIDE PERSONAL HEALTH BUDGETS (PHB) PILOT

SUMMARY

Personal health budgets (PHBs) can be used to purchase goods and services that are likely to help individuals achieve their agreed health outcomes and are appropriate for the state to fund as part of individuals' care plans.

The aim of the Merseyside PHB pilot, as with all the in-depth pilot sites, was to recruit 75 people on PHBs, as well as 75 people who weren't, as a comparator group, so that the Department of Health (DH) could evaluate the pilot nationally. It built upon an initial **'Individual Recovery Budget (IRB) Project', run internally by Mersey Care NHS Trust,** and focused upon Mental Health Service Users.

Evaluation has demonstrated that whether PHBs were one-off, part of a complex care package and/or joint with personalised social care packages, service users experienced positive health and well-being outcomes, linked to the outcomes that were agreed within their care plans. It also showed that staff reported a positive experience in being able to support people effectively.

KEY OUTCOMES

Individual Recovery Budget (IRB) Project

A 12 month evaluation was carried out on the initial pilot, which dealt with the implementation of Individual Recovery Budgets (IRBs) within an early intervention service across Mersey Care NHS Trust. The final report showed staff satisfaction and positive outcomes for service users, in relation to their perceptions of the benefits of personalising mental health care.

The key findings were:-

- Support planning prompts a different way of thinking within the early intervention teams and augments approaches used.
- IRBs enabled individuals to access support or items that may not have been open to them in any other way, which had a positive impact.
- The staff group reported a positive experience in being able to support people effectively, and found they led to effective and tangible outcomes for participants.
- The deliberate simplicity and speed of the process provides a more efficient service overall.
- Means of payment for recovery budgets need to be efficient allowing brokers to purchase effectively.
- It has been possible to utilise a range of creative media through the support planning process, which fit well with statutory or other forms of planning, such as the care programming approach (CPA).

The full University of Chester evaluation is attached to this case study as an appendix

Merseyside PHB Pilot

The national pilot will run for three years in total. However, the Department of Health ran an evaluation period of the PHB Merseyside pilot from June 2010 until 31 March 2011. This has not been published yet, but anecdotally the project demonstrated similar results to the IRB pilot and demonstrated that PHBs lead to:-

- Users having access to college courses and faith groups as well as to work and continuity of care. In one example, continuity of care would not have been possible without a PHB jointly funded by the local authority and the PCT as a direct social care payment (as opposed to just through social care)
- Similar results as those demonstrated in the IRB pilot in regards to service users and staff, but with more scope for service users, as PHBs can be funded recurrently if appropriate.

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BACKGROUND

When the Department of Health rolled out a PHB pilot in 2009, Merseyside applied to become one of twenty in-depth pilot sites across the country, and was successful in becoming one of only eight looking at mental health PHBs.

The Merseyside PHB pilot built upon Mersey Care NHS Trust's 'Individual Recovery Budget (IRB) Project', which was utilised by Early Intervention in Psychosis Teams, and was launched to sustain and expand this work, as part of the National PHB pilot.

KEY AIMS

The over-arching aim of the evaluation is to identify whether PHBs ensure better health and social care outcomes when compared to conventional service delivery and, if so, the best way they should be implemented (for full details go to www.phbe.org.uk). Part of this evaluation is to inform the national roll-out of PHBs, by identifying the conditions for which personal health budgets are most appropriate and how they should be implemented.

KEY STAGES OF SET UP

The IRB Project ran from June 2008 and was evaluated over the course of 12 months by the University of Chester. Funding for the Merseyside PHB pilot was then allocated in October 2009 and plans were put in place to enable the pilot to officially launch in May 2010. Evaluation of this wider pilot began almost immediately in June and commenced until March 2011 to provide deeper analysis.

Initially as part of the IRB project, three Early Intervention in Psychosis teams were involved from across Liverpool, Knowsley and Sefton. However, for the PHB Pilot this was widened out to include the three corresponding CMHTs(Community Mental Health Teams) to ensure that mental health was fully addressed as part of the pilot across the full geographic area. Finally, the Personality Disorder Service came on board through the Department of Health.

ORGANISATIONS

NHS Sefton acted as the lead PCT for Merseyside with other key stakeholders in the project including Mersey Care NHS Trust, Liverpool PCT and NHS Knowsley as well as the Liverpool, Sefton and Knowsley Local Authorities and Imagine Mental Health, which is a voluntary sector organisation.

There were several partner organisations involved in the running of this pilot including:

- **NHS Sefton** – acts as the leading PCT and lead agency. Chairs Steering Group and has responsibility for co-ordinating the pilot project
- **Mersey Care NHS Trust** – is the NHS provider, initial instigator locally for personal recovery budgets and a partner in the pilot. Service users from Mersey Care NHS Trust are the participants in the pilot and the Trust's community teams and Personality Disorder Hub are the services involved in the pilot. The Trust is committed to ensuring staff and service users participate in the pilot and to working towards personalising mental health care
- **Liverpool PCT & NHS Knowsley** – committed to working to make their complex care mental health budgets accessible for PHBs
- **Liverpool, Sefton and Knowsley Local Authorities** –work together with all partners to look at ways in which the personalisation agenda for social care can be joined up with PHBs
- **Imagine Mental Health** – a third sector mental health organisation. Successful in their expression of interest to provide brokerage for the project and are also currently providing some project management support.

TEAMS/SERVICES

The Multi-disciplinary workforce involved in this pilot included:

- Community Mental Health workers located within Positive Care Partnerships (PCP) and Clinical Business Units (CBU) throughout the geographical areas of Liverpool, Sefton and Kirkby.
- Social work and social care staff, seconded to the Trust and integrated in Community Mental Health Teams, (CMHTs), as described above.
- Early Intervention in Psychosis teams located within Liverpool and PCP CBUs
- Community Personality Disorder Services located in Liverpool and PCP CBUs. This is a hub and spoke model with care co-ordination responsibility residing in CMHTs.

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HOW IT WORKS

For PHBS to work it is important that:

- Needs are carefully assessed and defined in a person-centred, self directed care plan. The assessment of needs is co-ordinated by a care co-ordinator and co-produced with the service user following refocusing the Care Programme Approach, (CPA) and guidelines. Outcomes, including self-directed outcomes, are recorded on the CPA care plan. The service user, care co-ordinator and broker agree self-directed outcomes based on hopes and aspirations for the future, including what the service user believes will support them to sustain their health and well-being
- People are told how much money they can have for support /treatment. For one-off or non-recurring items or services, there is a limit of £450. Currently, complex packages of care that have been personalised are based on the indicative amount allocated on the basis of average spend for traditional services meeting that need.
- Everyone knows what outcomes must be achieved with the money. Outcomes are achieved by many different routes and are individual to each service user. Some common themes include access to:

– employment and self employment

– mainstream community activities

– religious/cultural groups

– creative opportunities/activities, (e.g. music, art, crafts)

– fitness activities

– hobbies/leisure activities

– education and further educational opportunities

- People can then choose to spend the money in ways and times that makes sense to them. Simple rules are followed and there are no restrictions as long as PHBs are spent in ways that are safe and legal and are used to achieve health, well-being and recovery outcomes as identified on the care plan. The DH restrictions are that PHBs should not be used on alcohol or cigarettes, and cannot be used for gambling or paying off debt. Service Users will not be able to pay for emergency care and care they normally get from a family doctor.
- Access to budgets can be through - direct payments, notional budgets whereby no money changes hands but services are personalised and self-directed, or third parties whereby a broker or somebody else manages the budget on behalf of the individual

RESOURCES

- **Mersey Care NHS Trust** – the Trust internally funded one-off PHBs, across seven sites, at a cost of approx £30,000. One-off funding is not recurrent for the next financial year, but individual outcomes are monitored through reviews of care plans under the CPA. There have been examples of additional one-off funding being allocated, but this is very much the minority.

136 people have taken up a PHB from the non-recurring pot of money, of which 75 have signed up to take part in the DH evaluation. Popular requests are for; bikes, computers, gym membership, travel passes and driving lessons. Other requests include holistic and alternative therapies, hair salon, garden clearance, and white goods. The average cost of a purchase is £270.

– 10 people have received or will receive a direct payment/indirect payment

– 3 have been for non – recurrent purchases

– 3 have been for non sustainable funding for recurrent activities

– 4 are receiving ongoing recurrent funding for complex support packages

The Personality Disorder service has had 16 applications and 13 people have accessed goods / services. The average cost is higher than usual at approx £400.

Purchases include items as outlined below as well as existing health funding streams for extra contractual complex care packages

- **Department of Health (DH)**- £100,000 per year was allocated by the DH for pilot infrastructure and the communications strategy, which includes internal and external communications with staff, service users and stakeholders. This can include conferences, seminars, magazine articles, briefings etc. The infrastructure funds also include project management and brokerage costs for the pilot and any other associated costs, e.g. equipment for the peer support worker, who is supporting service users to tell their stories in relation to PHBs.

What the IRB money purchased in 2008–09

ITEM	NUMBERS PURCHASED
IT equipment	13
Annual gym membership	11
Driving lessons	10
Bike	7
Course	7
Home furnishings/decorating/improvements	6
Musical instruments	4
DJ/sound recording equipment	4
Activity budget	3
Broadband	3
Sporting gear	3
Holiday/weekend break	3
Clothing	2
Travel to college/bus pass	2
Freezers	2
PAYG mobile phone & top-up budget	2
Pet related	1
Car tax & insurance	1
Study book voucher	1

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- **Imagine** – this voluntary sector organisation provided a Project Manager and external brokerage. Imagine are a mental health third sector provider organisation who amongst other services, run supported housing, day centres, floating support services and a service which supports people to access mainstream community activities/ services. They have been interested in PHBs and brokerage from the outset of the initial internal IRB project.
- **Personality Disorder Service** – When the new personality disorder hub was commissioned the funding for the service included £10,000 per year for personal health budgets

KEY CHALLENGES

Recruitment of Comparators

The aim was to recruit 75 people on PHBs as well as 75 people who weren't as a comparator group so that evaluations could be made. Unfortunately only 62 comparators could be recruited due to comparators being discouraged by the in-depth evaluation questionnaire. This challenge was managed by negotiating with the DH to lower the target for the comparator group to 60, who were satisfied that this wouldn't have an adverse effect on the overall evaluation.

Also DH funds were used to pay for extra staff from Imagine to recruit to the comparator group, and team managers from the project group were engaged to assist in drawing up a targeted action plan.

Engagement

Engagement was required from a wide range of people, across multiple sites and organisations, from operational service managers, to service users, and Executive Directors. To achieve this, the project needed to employ methods of engagement such as a project launch, briefings, seminars, conferences, training, and articles in staff magazines. Each site had the same initial training on person-centred ways of working and self-directed support, with other engagement activities targeted at wider audiences, including staff and service users who are not part of the pilot.

Engagement activities included:-

- Presentation to the Mersey Care Executive Team.
- Briefing of participant CBU's Senior Management Teams (SMTs), prior to pilot commencement as well as at PCT and Local Authority SMTs.
- A launch conference opened by the Trust Chief Executive, to demonstrate senior level commitment.
- Trust podcast outlining the positive benefits of PHBs.
- Response to individual requests to talk about PHBs to ward managers and teams, outside of the pilot project.
- Ensuring that all Team Managers involved in the pilot were members of the Project Management group.
- Workshops facilitated by members of the Steering Group who have been asked to speak at national, regional and local conferences on personalisation.

Cross-Organisational Implementation

It was challenging to implement PHBs across three PCT and LA areas, all of which had different systems and processes for funding care. Recruiting to the comparator group was also a challenge. Therefore it was necessary to agree systems and processes for personalising complex, health-funded care packages. For example, existing Local Authority systems were used to administer PHB Direct Payments, and the team worked with all the PCT and Local Authority funding panels to agree processes and systems to implement PHBs.

Staff Perceptions and Resistance

There was initial resistance amongst some health staff from non-Health and Social Care integrated teams, in relation to the IRB pilot. Initially they felt it wasn't something that was in their clinical remit or appropriate for them to undertake. However these barriers were overcome by training, case stories and staff witnessing firsthand the benefits that their service users experienced when their health and social care was personalised. This turned initial scepticism into enthusiasm. Similar responses have been witnessed with the DH pilot.

New processes were also kept as simple as possible and linked to existing processes and systems to avoid major changes e.g. the use of existing funding panels, CPA processes and Direct Payment systems

Response to training

There was a mixed response to person-centred training and staff can feel patronised by some of the training. In both the IRB and the DH pilot projects, staff overcame resistance and scepticism by experiencing the positive benefits for service users when working in this way. Not all staff were initially resistant to this. Within teams, the benefits to service users and the consequent increase in work satisfaction for staff created local champions and then other staff in the teams were encouraged to participate.

Project Risks

The risks associated with such a project were mitigated by the required DH project management processes. The DH provided a template for the PID, Project Plan and Risk Assessment. These had to be completed to the Department's satisfaction before the pilot could commence. Specific criteria also had to be met before Direct Payments could be authorised.

Mental Health Provision

Mental health clinicians and managers can be divorced from mainstream local authority agendas around person-centred recovery and its benefits, although this is changing in the light of the national policy agenda for mental health.

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Fair, Transparent and Equitable Access

In the long term, there is a need to ensure fairness and equity of access to PHBs in resource allocation, without the introduction of overly bureaucratic resource allocation systems. However, it is difficult to achieve transparency of equity without complexity, because "one persons need is another person's want". For example somebody may want a laptop but may not need one to facilitate further education, whilst another person who has difficulty at times in getting out of the house, may need a laptop to ensure they can keep up with college work.

Service User Concerns

Many service users are sceptical at first because in this economic climate they fear that PHBs can be used as an excuse to close down valued services. The team have worked with service users in the local Mental Health Consortium to explore their fears and the Consortium has developed a service user charter for personalisation.

KEY LEARNING

- Training and development needs to build upon the skills, knowledge and attitudes within the services.
- Capability building systems in accessing services should be part of training and development.
- Developing confidence in accessing available funds, support and services will be central in maintaining an individual recovery plan.
- The processes of working creatively, considering alternative means of obtaining resources within the service user's life, is central to the process.
- Governance issues require development to maintain the recovery approach and probity of public monies.
- Other areas of mental health service delivery could be encouraged to develop person centred individual budgets.

The importance of the following points was recognised:-

- Keeping systems and processes as simple as possible
- Not adding extra layers of work and administration wherever possible
- Recording the positive outcomes of this work, through communicating with the staff witnessing the affects
- Offering training to overcome resistance
- Publicising the positive outcomes to staff and service users
- Senior management and Board level ownership
- Committed leadership across stakeholder organisations

NEXT STEPS

This pilot continues to be part of the national pilot until the end of the third year. The evaluation stage has been completed and the national evaluation report is awaited in 2012. The DH has set up national work streams of which Merseyside is a part, to take forward the learning so far and develop sustainable implementation of PHBs for the future. It is anticipated that the Government will proactively roll out PHBs.

The NHS Future Forum has published its recommendations to the Government on its proposals for NHS modernisation. The Government published its full response on 20 June 2011, which says that, subject to evidence from the pilot, the mandate to the NHS Commissioning Board will make it a priority to extend personal health budgets, including integrated budgets across health and social care". (Government Response to the NHS Future Forum report, 2011)

SPECIFIC STEPS

- Keep focused on health and social care outcomes and recovery.
- Embed personalisation and recovery into key training programmes on an ongoing basis.
- Celebrate success and spread the word: collate experiences of PHBs making a difference to people; staff become enthusiastic when experiencing the positive outcomes of working in this way.
- Focus more attention on recurrent PHBs, complex care.
- Ensure recovery budgets are available for final 12 months of project.
- Look for opportunities in future to creatively combine funded person-centred health and social care budgets, to meet self-defined recovery, health and well-being outcomes.
- PBR and PHBs: majority of Trust service users not on CPA
  - ▶ Incentivise recovery outcomes, PBRecovery, and Recovery Budgets
  - ▶ Embed PHBs in ongoing Trust Service and business development plans
- Link to ImRoc pilot (Implementing Recovery through Organisational Change). The Trust was successful in their application to become a pilot for this and a presentation will be given at to the next PHB Steering Group.

SUPPORTING MATERIAL

The following resources are available as an appendix to this case study

- IRB Evaluation Report: Recovery Budgets in a Mental Health Service – University of Chester
- DH Evaluation Report – Early experiences of implementing PHBs
- Presentation: Personalisation in Mental Health: Individual Recovery Budgets in Early Intervention Services
- Presentation: Introducing Personal Health Budgets within Mental Health
- Presentation: Introducing ImRoc project to PHB Pilot Board
- For further information about PHBs and the DH evaluations carried to date **click here**

REFERENCES

Department Health (2011) Government Response to the NHS Future Forum Report. Norwich: TSO, 2011

CONTACT FOR FURTHER INFORMATION

- Jenny Robb - Deputy Director of Social Care - Mersey Care NHS Trust

Email: Jenny.robb@merseycare.nhs.uk
Telephone: 0151 471 2331
Mobile: 07970 779 647