Social Care in the community

Implementing personal health budgets in England: a user-led approach to substance misuse

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What is known about this topic

- The estimated total annual cost to society in England of drug addiction is over £15 billion, of which the NHS incurs around £488 million (PHE 2014).
- A holistic, person-centred approach to substance misuse is a core focus of the PHE (PHE 2014).
- Based on translational evidence from other relevant fields, e.g. mental health, PHBs could provide a vehicle for enabling this patient-based strategy for substance misuse treatment.

What this paper adds

- The paper provides evidence concerning the implementation and impact of PHBs in the field of substance misuse.
- The paper provides direction for current and future policy initiatives and strategy within the government's personalisation agenda in England and the international PHB programme.

Abstract

Personal health budgets (PHBs) in England have been viewed as a vehicle for developing a personalised patient-based strategy within the substance misuse care pathway. In 2009, the Department of Health announced a 3-year pilot programme of PHBs to explore opportunities offered by this new initiative across a number of long-term health conditions, and commissioned an independent evaluation to run alongside as well as a separate study involving two pilot sites that were implementing PHBs within the substance misuse service. The study included a quantitative and qualitative strand. The qualitative strand involved 20 semi-structured interviews among organisational representatives at two time points (10 at each time point) between 2011 and 2012 which are the focus for this current paper. Overall, organisational representatives believed that PHBs had a positive impact on budget-holders with a drug and/or alcohol misuse problem, their families and the health and social care system. However, a number of concerns were discussed, many of which seemed to stem from the initial change management process during the early implementation stage of the pilot programme. This study provides guidance on how to implement and offer PHBs within the substance misuse care pathway: individuals potentially would benefit from receiving their PHB post-detox rather than at a crisis point; PHBs have the potential to improve the link to after-care services, and direct payments can provide greater choice and control, but sufficient protocols are required.

Keywords: health and social care policy, implementation, personal health budgets (PHBs), personalisation, substance misuse

Introduction

Substance misuse has serious health risks and is associated with a range of short- and long-term mental and physical health problems. In 2012, there were 8367 alcohol-related deaths in the UK, and 1496 deaths related to drug misuse (ONS 2013). Public Health England (PHE) (2014) estimated that the annual cost to society of drug addiction was £15.4 billion, with around £488 million incurred by the NHS (PHE 2014). In terms of alcohol-related harm, the cost to the NHS is estimated at £3.5 billion

a year, with the overall annual cost to society being £21 billion (PHE 2014). The National Treatment Agency for Substance Misuse (2012) predicted that 46% of individuals going through treatment will relapse during the following 4 years and this entails further costs at a time of financial austerity. The negative consequences of relapse, for the individual and society, mean that during the current financial climate, the development and refinement of strategies to reduce relapse are critical. This paper explores the potential of PHBs as a mechanism to effectively support individuals with a substance misuse problem.

A review of existing literature (including previous reviews of the evidence) explored the extent to which current interventions are able to reduce substance misuse and relapse rates (Welch *et al*. 2013). The review highlighted that alternative treatment pathways are starting to be advocated, as well as a shift to a psychosocial approach: a person-centred method to treatment that 'addresses the psychological, social, personal, relational and vocational problems' associated with substance misuse (Turton 2014, p. 5). A number of studies reported that contingency management (treatment that provides positive reinforcement for behaviour change, e.g. in the form of a voucher that can be exchanged for goods or services which are compatible with a drug-free lifestyle) added to standard treatment, improved the ability of cocaine- and opiate-using clients to remain abstinent (i.e. Castells *et al*. 2009, Amato *et al.* 2011). Different types of cognitive behavioural therapy, including relapse prevention, seem to be particularly effective in addressing cannabis and alcohol misuse (i.e. Beecham *et al*. 2009, Magill & Ray 2009).

The reviewed studies indicated that if substance misuse services are to be effective in the long term, relapse prevention programmes should be tailored to the needs of an individual, taking into account the substance or substances being misused, the setting, client history, background and level of family support (Welch *et al*. 2013). One potential way to maintain behaviour change involves developing a patient-based strategy that combines a mixture of treatments and support (Royal Society for the Encouragement of Arts, Manufactures and Commerce (2007)). Building on the NICE Clinical Guideline 51, from the National Institute for Health and Clinical Excellence (2007), the Royal Society for the Encouragement of Arts, Manufactures and Commerce (2007) advocated a better balance between psychosocial and medical interventions, by offering a more personalised community response aimed at patient recovery that focuses on the problems which led to the abuse.

Subsequently, the NTA has shifted its focus from short-term pharmacological treatment to concentrate on enabling patients to sustain long-term recovery, shaped by the individuals themselves (NTA 2010). The 2010 Drug Strategy 'Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life' reinforced the need to work holistically, focusing on the underlying social and medical causes, mental health, housing and unemployment (HM Government 2010). This person-centred approach to substance misuse treatment is the current focus of PHE (PHE 2014). While there is a gap in literature exploring the impact of a person-centred approach within the substance misuse care pathway, there is evidence from other relevant fields, e.g. mental health. The Social Care Institute for Excellence (SCIE) 2009 reported that the prevalence of co-existing mental health and substance misuse problems may affect between 30% and 70% of those presenting to health and social care (Social Care Institute for Excellence 2009). Previous research has found that personal budgets in social care (PBs) can provide a mechanism for facilitating the process of recovery in mental health (Hamilton *et al.* 2015, 2016, Larsen *et al.* 2015, Tew *et al.* 2015). For example, Tew *et al.* (2015) suggested that having a PB enabled individuals to enter a 'recovery mindset'. In addition to identifying those social or environmental factors that needed to be addressed to facilitate recovery; a PB acted as a mechanism to broaden the users' thinking, enabling them to identify goals and aspirations outside the traditional mental health system (Tew *et al.* 2015). Mental health, as with substance misuse, can be a mutable condition. If appropriately managed in a flexible way, PBs can support recovery (Tew *et al.* 2015), providing an opportunity for greater power and choice over traditional treatment routes and encouraging greater feeling of control (Hamilton *et al.* 2016). Such strengths are predicated on professionals adopting a more mutual relationship with the patient (Hamilton *et al.* 2015).

However, Larsen *et al.* (2013) outlined key challenges of implementing PBs in mental health services, including: difficulties when working across the social and healthcare sector; engaging professionals; and the importance of strong leadership. They suggested that 'vision and leadership' were crucial factors in breaking down pre-existing culture and uniting staff.

Applying this evidence, while recognising personalised support among individuals with a substance misuse problem is potentially challenging, PHBs that adhere to the same principles underlying PBs in social care, could provide a vehicle for developing such a patient-based strategy within the care

pathway. Following an assessment, the PHB process provides users with a transparent resource to purchase services and care that meet their identified health needs. There should be flexibility in the range of services and support that can be purchased by the budget. Within the substance misuse care pathway, this could potentially include both conventional (e.g. a detox programme) and non-conventional (e.g. complementary/alternative therapies or psychosocial therapies) NHS treatments. Overall, the aim of PHBs for people with substance misuse problems is to widen the choice of treatments beyond the current conventional NHS detoxification programmes. PHBs can be managed in three different ways (or potentially as a combination): notionally, where the budget is held by the commissioner but the budget-holder is aware of the treatment/service options and the corresponding cost; managed by a third party; or as a direct payment, where the patient receives a cash payment to purchase services/support. The budget-holder should be given the choice as to how they would like the resource managed (NHS England 2014).

In 2009, the Department of Health invited Primary Care Trusts to become pilot sites, and commissioned a 3-year independent evaluation. Primary Care Trusts were abolished in 2013 as part of the Health and Social Care Act 2012 restructuring and their roles were subsequently taken over by Clinical Commissioning Groups (CCGs). The overall aim of the evaluation was to explore if PHBs can have an impact on system and patient outcomes and, if so, identify and detail effective models of implementation (Forder *et al*. 2012). Based on the proposals submitted, 20 pilot sites were invited to participate in the in-depth evaluation. They offered PHBs to individuals with long-term conditions (including chronic obstructive pulmonary disease, diabetes and long-term neurological conditions); mental health problems; NHS Continuing Healthcare; and stroke. Two sites exploring the impact of PHBs within the substance misuse care pathway were invited to participate in a separate Department of Health-funded study as their focus sat outside of the other pilot sites (Welch *et al*. 2013).

The quantitative strand of the study (structured questionnaires) indicated greater improvements in care-related quality of life (ASCOT) and psychological well-being (GHQ12) for PHB holders compared to those receiving conventional services. PHBs had a positive impact on reducing relapse rates. Additionally, budget-holders were generally more satisfied with the support-planning process and the subsequent interventions paid for by the budget than those receiving conventional support (Welch *et al*. 2013).

The qualitative strand of the study involving interviews with individuals with a substance misuse problem supported these quantitative findings. PHB holders were generally more positive about their relationships with health professionals and their experiences of services (Welch *et al*. 2013).

The current paper explores the second qualitative strand of the study: interviews with organisational representatives responsible for implementing PHBs within the substance misuse care pathway.

Methods

Organisational representatives were invited to participate in a semi-structured interview to explore the implementation process and their views of PHBs. Interviews were conducted at two time points: between June and August 2011 and between June and July 2012. In total, 20 interviews were conducted with 10 organisational representatives.

Project leads within the two pilot sites supplied contact details of operational representatives (for details see Table 1), who were invited to participate in an interview at two time points during the study. During the initial conversation, a member of the research team described the purpose of the research study. It was emphasised that participation would be anonymous, and consent was sought to audio record the interview and transcribe verbatim. An opt-in consent process was applied: meaning agreement to be

Table 1 Interviews with organisational representatives

Type of organisational representative	Number of interviews
Project leads/managers (each site had 1–2 people managing the implementation process of the pilot)	3
Commissioning managers (led the strategic framework for commissioning in their site to ensure the overarching philosophies of the PHB were met)	2
Health professionals (included community detox nurses who, e.g. deliver interventions and support for drug and alcohol users and specialist substance misuse doctors)	2
Support workers (included day centre workers who provide support and deliver treatment recovery and harm reduction advice and information)	1
Front-line operational staff (included care navigators: those staff responsible for working alongside clients to support the identification and delivery of services. These staff were also involved in assisting the project leads with the day-to-day running of the pilot programme and operational matters)	2

interviewed constituted consent to participating in the study. Consent was confirmed prior to starting the interview.

Eighty per cent of operational representatives approached agreed to participate in a telephone interview, along with the two project leads. Those that declined stated they had not been in post long enough or were not involved in the pilot in a substantial way. All the participating organisational representatives agreed to be interviewed at both time points. Table 1 shows the roles of the 10 organisational representatives who were interviewed across the two pilot sites.

During the first round of interviews, the focus was on exploring early experiences of implementation and the perceived success of the local pilot. The topic guide covered: (i) the perceived opportunities for budget-holders and front-line staff, e.g. the advantages and disadvantages of PHBs for the budget-holder and the pilot site; and (ii) the factors that facilitated or inhibited the implementation of PHBs within the substance misuse care pathway.

The second wave of interviews enabled a deeper exploration of the issues considered most pertinent by organisational representatives during the first round, including: (i) the impact of PHBs on working practices, e.g. the state of readiness for implementation of PHBs within the pilot site in terms of staff training; and (ii) the perceived impact on the budget-holder and their families, service providers and commissioners.

The topic guide was used flexibly, enabling participants to express their views, and ensuring that issues raised could be discussed in more detail. Each interview lasted from 30 to 90 minutes and was carried out by two researchers.

Interviews were transcribed verbatim, and data were analysed thematically using a general inductive approach to allow the development of a framework using the reported experiences and processes underlying the raw qualitative data (Thomas 2006). A coding frame was developed based on the topic guide and the emerging overarching themes. The computer software package NVivo was used to organise the data and support the analysis. The research team combined transcripts and identified common sub-themes within the overarching themes identified. Two researchers completed the analysis, and conclusions were verified and affirmed through discussions with the wider research team and by returning to the transcripts. While robust and validated techniques were applied throughout the analysis, the views obtained during the interviews may not reflect the opinions of the organisational representatives who were not interviewed.

A favourable ethical opinion was given by The National Research Ethics Service for the main evaluation, and research governance authorisation was obtained.

Findings

Overall, all interviewees, regardless of the interview time point, or their professional background, expressed similar views of the focus and use of PHBs, the potential they hold and the challenges they pose. However, a number of frustrations were reported during both sets of interviews that echoed the overall change management literature. That is, many of the challenges discussed seemed to be linked to the introduction of a new initiative rather than PHBs *per se*, e.g. the length of time required to fully embed a new initiative into working practice and the importance of managing culture change across organisations.

Two overarching topics were discussed during the interviews: (i) the perceived opportunities for the budget-holder and front-line staff; and (ii) the perceived challenges of implementing PHBs within the substance misuse service. Within these overarching discussion topics, a number of thematic categories emerged.

Perceived opportunities for the budget-holder and front-line staff

Following the main ethos underpinning PHBs (choice and control), all organisational representatives implementing the initiative believed there to be a number of benefits to individuals with a substance misuse problem, including increasing self-confidence, self-esteem and a 'sense of purpose'. Furthermore, they thought that PHBs, if effectively implemented, had the potential to re-build shattered lives following an addiction problem:

He was at risk of estrangement from his children and he used some of his budget to buy a father and child football season ticket, so he can actually spend some quality time with his child. So, it is just breaking out of that substance misuse world, and drawing on everything that's available for them in their community to help their recovery. [Project lead]

Overall, PHBs were perceived as offering the potential for realistic focused community support. Referring the client for treatment elsewhere can often seem like a temporary fix to the user, unrelated to their everyday life:

Rather than just banging them into rehab, now we're looking what package we could put around them in the

community. We are looking at the full picture. Support plans are more holistic as they look at things outside of the medical. [Operational staff]

Increased choice and control

The offer of 'choice' meant a wider range of options for patients, enabling a more 'person-centred' approach. Alternative and more appropriate providers could be selected to offer support not available within conventional service delivery. Staff generally thought that clients were getting a better service than otherwise would have been provided:

For the people who are lower grades [as measured using Alcohol Use Disorders Identification Test (AUDIT-C)], I think that the advantage for them most definitely is that they're probably getting a much better service. They have a choice of detox that gives them the extra support, but they don't necessarily have to go in somewhere to do that. [Operational staff]

Operational staff reported that clients were taking a greater responsibility for their own care, recognising the role that they could play in 'helping themselves' and relying on the mechanism of the PHB to identify and achieve specific goals.

Improved relationships between patients (budget-holders) and their care staff

Staff who worked alongside clients suggested that the holistic support-planning process resulted in a greater knowledge of their needs and an improved understanding of the most appropriate support. Overall, it was thought that the process helped to break down barriers and increase respect and understanding on both sides:

The major advantage is you get to engage with the patient far more and they engage with you on a level where they feel that they can trust you. [Health professional]

It's created an equalisation of power as they are doing their own self-assessment. They're telling you things that they wouldn't have told you before. You're spending more time with them. There is a lot more care that goes into this care plan. It has opened our minds ... so we're looking at the full picture. [Health professional]

One project lead discussed how it had been an 'eye-opener' for staff:

Staff now see individual journeys in a way that they didn't see them before. And that's been revelatory to our staff, on several levels. One, it's made them really aware of the complexity of individual journeys and the fact that journeys aren't necessarily linear and they don't always move forward. Sometimes people move forward a little bit and then they take a few steps backwards, so now staff have a much

greater awareness of the reality of people's treatment and recovery journeys. [Project lead]

Overall, front-line staff, regardless of the agency in which they worked, thought that the PHB model allowed access to the same level of funding for clients, from the same central source. The level of funding for each individual is determined through bespoke assessment which creates a more patient-centred holistic treatment package. Under conventional service delivery, however, it was reported that funding was determined by individual agencies with treatment specific to the episodic involvement of the service:

We were working with little bits of the client rather than the whole client. And I think that what we're developing here is a much closer relationship with the core elements of the client. I'm actually liaising with the criminal justice system, the health system, this person's children's nursery, all on one client, who's got a PHB. It didn't happen before because the role of the care manager would be to meet the person, to assess what treatment they needed in the community and more or less say to them, 'We think you should go to some counselling. So I'm going to send you there for 4 weeks'. There also wasn't a lot of client ownership in that. [Front-line staff]

Staff believed that encouraging clients with an addiction problem to actively make their own choices was in itself therapeutic and beneficial; active participation in their own recovery was as much a key part of the process as any selected treatment plan. However, there were concerns expressed by all staff about the amount of time support-planning was taking, and the consequent impact on staff workload during the pilot programme:

Putting together the person-centred plan, putting together that initial plan which pulls out all their needs, takes a lot more of the practitioners' time. [Project lead]

It is additional work pressure on me. I'm working within a team of other clients. I'm carrying two different types of work at the same time. Working with some clients in the normal way, then working with another set of clients as a PHB care navigator. And there's too much paperwork involved. So many demands and so I've got this increased pressure of work on me as an individual. [Front-line staff]

Nonetheless staff reported that they could justify spending more time on the support-planning process, especially where it was possible to see benefits in terms of clients' care and outcomes:

We're spending a lot more time with them but there's a lot more care going into the support plan. [Operational staff]

Increased power to service providers and commissioners

It was felt that services had become more responsive to the needs of clients as individuals were able to

access a wider range of resources that had previously been excluded (e.g. therapy accessed from private practitioners). In addition, staff suggested that the 'leverage' of PHBs, the view that commissioners could 'take their business elsewhere', resulted in structural and process changes in existing provision. The introduction of PHBs appeared to change the dynamic of the relationship between commissioners and providers, seemingly shifting power towards commissioners and (indirectly) to the service users:

I think the detox provider that we're using as a residential unit is making its provision better because we have the power now to say, 'no actually, I'm not going to send anyone to you'. We're having conversations with them saying 'Some of our clients are saying that they're a bit bored, are there some more groups that they can do?' and they're putting more groups on. Whereas before we would be saying, 'Look, they're not even doing any group work', they'd say, 'Go and find another detox then. Oh, there isn't one'. [Front-line staff]

This power shift resulted in organisational representatives perceiving that they were able to do more for their clients within the same budgetary limits. This was achieved through a combination of reducing the number of block contracts with providers, and avoiding unnecessary referrals to residential detox centres:

We've shifted the [providers] … the inpatient providers have changed and we're getting more for our bucks. [Project lead]

Operational challenges of implementing PHBs to people with substance misuse problems: When, what and how of PHBs

While operational staff viewed the potential of PHBs positively, a number of concerns and frustrations were raised that focused on three elements of the process: when, what and how.

When: There were concerns over 'when' to offer a PHB as often clients were referred at 'crisis point'. It was perceived that providing choice and control at this stage could potentially add to stress and anxiety rather than empower individuals. This view suggests that PHBs should be offered at a later follow-up stage (after-care):

I think the place where this will end up fitting in will be with after-care. Not crisis point, people who are in crisis just want rescuing, they don't want to be thinking too much. [Operational staff]

What: There were concerns around *what* support could be purchased from the PHB, and it was thought

that more guidance was required. Echoing the findings from the national evaluation (Forder *et al.* 2012), one interviewee stated: 'are we talking about budgets that will include funding for medical interventions, or are we talking about a more recovery-orientated model of personal health budget funding?'

All staff groups, in particular those health professionals and care navigators who were more involved with the budget-holders on a daily basis, felt that the PHB would be more appropriately used to prevent relapse:

I think that [relapse prevention] is the most important part of the whole treatment journey. It's one thing to get the client clean, but the main thing is to keep them clean and to keep them focused and moving forward in life. So reintegration is really important, I think that might be even more important than the actual detox. [Health professional]

The staff members provided examples to support this future focus, such as the purchase of a computer and college courses to help one budget-holder set up a business. By the end of the pilot, this individual was no longer in receipt of benefits, was running their own business, attending college and had completed a computer course.

How: The majority of PHBs (79%) were managed notionally, where the budget was held by the commissioner but the budget-holder was aware of the treatment/service options and the corresponding cost. However, the project leads from both pilot sites suggested that direct payments would ensure further flexibility for this client group and perceived such a process as the only deployment option that would allow individuals absolute control over their budget:

We haven't at the moment [got powers to use direct payments] but I think it would make life a lot easier, even for the smaller things that people need, so that they can be even more personalised. I think one of the problems we have is not having fluid cash, to be able to say yes, you can do that and there's that money to do that. [Project lead]

However, concerns were expressed when considering offering such a deployment option to this client group: in particular, the possibility that direct monetary transfer would increase client vulnerability rather than result in patient empowerment:

Well, I think the problem with our client group is that our client group have relapse periods quite often. Or sometimes they're so vulnerable; they can be subject to the criminal activity of others. So I think if it's not held by the care navigators, or managed by the care navigators, then it has to be a responsible adult either within the family or an independent broker, or someone of that calibre, simply because of our client group. [Project lead]

The direct payment deployment option was not offered to individuals with a substance misuse problem during the pilot programme. There was a sense from the project leads that such individuals were being discriminated against because it was assumed that 'these people can't be trusted with money.' The management of risk through the appropriate protocols may mitigate some of the anxieties around offering a direct payment to this client group. When asked to consider what would facilitate the use of a direct payment for clients, one project lead suggested that a condition of abstinence could be required:

I think we would have to say that our client group has to be fully abstinent from drugs or alcohol ... a person would have been totally abstinent from drugs and alcohol for a period of 12 months to 24 months ... And that would probably facilitate them being able to hold their own personal health budget. [Project lead]

Risk, accountability and safety
While concerns around risk, accountability and safety are not specific to the area of substance misuse, the nature of the cohort potentially heightened anxieties among organisational representatives. For example, a concern was raised about what would happen if a patient relapsed after the budget was deployed, and which organisations or individuals would take responsibility for inappropriate use of such a resource:

One of the worries that people have about the PHB was, well, what happens if people use all their money and then they relapse and go back using drugs again? Will we have to spend all the same money all over again? [Health professional]

Similar to the findings from the national evaluation, there was a fear of the discrepancy between the 'need' and 'want' of clients, particularly if the requested support went against professional or evidence-based opinion:

We did have one client who, when he looked at the cost of what he was recommended for, inpatient detoxification, was surprised at how much it cost, and his instinct was to want to minimise the amount of money that was spent on his medical intervention because he wanted to spend more money on other aspects of his recovery. And that did lead us into a difficult situation and he did relapse and ended up needing another detox, but again only wanted another short detox. So we had that issue about 'it's my budget, it's my money'. So this opened one of the problems that can arise when people truly do assume ownership of their budget. [Project lead]

Health professionals also discussed concerns around how they would justify recommending to clients a range of leisure activities and other 'non-conventional' or 'complementary' services or products for which the evidence base was either absent or tentative. However, it was found that staff anxieties were reduced following the development and implementation of clear, applicable guidelines and protocols.

The importance of strong leadership
A strong local leader to help overcome the operational challenges was viewed as a crucial factor by all staff groups. Consistent with the national evaluation and the change management literature (i.e. Higgs & Rowland 2005, Allen *et al.* 2007, Bamford & Daniel 2007), it was thought that the 'inspirational leader' needed the necessary vision and passion to be able to change perceptions and enthuse people to implement and work with PHBs:

I think enthusiasm in the people that are bringing change in [is important for culture change]. I think having inspirational people around who are prepared to ask those difficult questions is vital. You need people who will actually challenge the conventional orthodoxy. We had a fantastic project lead, who was really supportive and amazing. I think you really need somebody like [project lead] to inspire people and carry it along. [Health professional]

Discussion

The aim of the current paper was to explore the attitudes and concerns among organisational representatives implementing PHBs within substance misuse services. In this discussion, we will also review the key facilitators identified by the organisational representatives to inform the continued implementation and roll-out of PHBs.

One message from the study was that PHBs can improve outcomes among individuals with a substance misuse problem by: giving them greater choice and control over services to meet their specific needs; providing flexibility in the way they access services; encouraging innovation and creativity; and in some cases influencing the content or quality of those services. However, it was suggested that a key element within the process was the commitment and willingness of individuals to take responsibility for their own recovery with professional support.

Such views echo those found among organisational representatives (Jones *et al.* 2010) and budget-holders (Irvine *et al.* 2011, Davidson *et al.* 2012) interviewed during the in-depth strand of the national evaluation. In the current study, the views held by the organisational representatives provide

potential reasons for why PHBs seem to have worked among individuals with a drug and/or alcohol problem (Welch *et al*. 2013). The quantitative arm of the study found that PHBs can have an impact on their quality of life and well-being. A sense of empowerment and the positive impact of taking control can have an impact on the quality of life and well-being reported by budget-holders.

However, the organisational representatives highlighted that the potential of PHBs can be affected by internal factors within the organisation, such as: (i) 'buy-in' among senior managers; and (ii) the implementation process in terms of the 'when', 'how' and 'what' of PHBs.

Senior management 'buy-in'

It was suggested that the potential of PHBs could only be fully realised with the commitment and 'buy-in' from senior managers. Consistent with the national evaluation (Forder *et al*. 2012), change management literature (i.e. Higgs & Rowland 2005, Allen *et al*. 2007, Bamford & Daniel 2007) and echoing key findings from similar studies (i.e. Larsen *et al*. 2013), it was suggested that vision and leadership from senior managers were essential to effectively implement PHBs. According to Bamford and Daniel (2007), a number of lessons can be learnt from previous research when implementing organisation change, including:

1 The importance of stating the reasons for the change through effective and consistent communication channels;
2 The commitment of the organisation to the change process, through effective and positive leadership;
3 The importance of managing the change process in a way that is sensitive to the impact on the organisation and individuals.

During the current roll-out of PHBs, the change process could be facilitated by senior managers working with operational representatives to explore the impact on the workplace, listening to concerns and enthusing people to implement and work with the new initiative. Strong leadership could also explore the training staff needs to be able to offer PHBs effectively and so ensuring the appropriate level of information is made available to staff and budget-holders.

'When', 'How' and 'What' of PHBs

When: The findings indicate that some individuals could benefit more from receiving their budget post-detox rather than at a crisis point. Flexibility in when

a PHB could be offered seems to be a key feature that could be achieved within the substance misuse care pathway and equally within long-term condition pathways. NHS England (2014) highlighted that at times it may be appropriate to delay the start of a PHB, while emphasising that Clinical Commissioning Groups (CCGs) must review their decisions so the budget can be put in place as soon as possible.

What: A key message was that support and guidance are vital to ensure that organisational representatives implementing PHBs are provided with all the required information. The in-depth strand of the national evaluation also highlighted the importance of having support and guidance from professionals. Similarly, better information and signposting to help people choose (evidence-based) support was highlighted in a report by the Cabinet Office '*The Barriers to Choice Review*' (Boyle 2013). Equally, NHS England (2014) have highlighted that CCGs should publicise the availability of PHBs and provide the required information and support to all concerned. The publication and promotion of PHBs could also have an impact on the provider market and the opportunity for more innovative care solutions to become available. As we found, operational staff perceived the PHBs as 'leverage' to improve and develop services and interventions to be more patient-focused. Furthermore, market development could be encouraged by commissioners and service providers working together to encourage the availability of innovative support.

How: PHBs were managed notionally, despite the view that direct payments were the only deployment option allowing individuals full control over their budget. Fears were reported among the organisational representatives around the inappropriate use of the resource. However, such fears are not specific to this cohort as similar views were reported among organisational representatives implementing PHBs within long-term condition care pathways during the national evaluation. Effective leadership from senior managers and access to appropriate information, as outlined above, have the potential to reduce such fears.

Overall, the current study adds to the evidence base that highlights the positive impact of PHBs, as well as the challenges that CCGs could face during the continued roll-out of PHBs. The findings should be used to guide the implementation of PHBs within the NHS and improve the experience for budget-holders. Furthermore, the findings can help support new policy developments around person-centred care, including the Integrated Personal Commissioning programme and the Vanguards programme.

Nonetheless, while the study makes a significant contribution to the evidence base, readers should acknowledge that the research was carried out during the pilot programme at a time when many challenges were being addressed. Many of the challenges faced by the organisational representatives may have been resolved as the pilot progressed.

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Conflicts of interest

The authors declare that there is no conflict of interest.

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