REPORT TO: Health, Social Care and Housing Scrutiny Sub Committee 10 January 2012

AGENDA ITEM: 7

SUBJECT: The Personalisation Programme PILOT – Substance misuse Croydon

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CABINET MEMBER: Not applicable

ORIGIN OF ITEM: This report forms part of the Scrutiny Work Programme

BRIEF FOR THE COMMITTEE: To review the challenges and opportunities for the Trust and for its patients. To review how the service and delivery of the programme will change over the years as initiatives are rolled out and are embed.

Summary Report

This report reviews the implementation issues and progress of the Personal Health Budget Programme pilot study for substance misuse, instigated by Croydon Drug and Alcohol Action Team (Croydon DAAT). This summary briefly covers the key points detailed in the full report.

Key Points

Outline of services

• The Personal Health Budget Programme is an innovative and well designed pilot study instigated by Croydon Drug and Alcohol Action Team (Croydon DAAT) as part of a wider number of pilot programmes which have been organised by the Department of Health
• The Croydon PHB pilot project has grown from a previous study by Croydon Council into personal budgets in addictions recovery.
• Personalisation is a key principle in the future delivery of health and social services and fits well with the strong emphasis on recovery in the substance misuse field.
• South London and Maudsley Foundation NHS Trust is one of four drug treatment agencies in Croydon that are participating in the pilot project.
• Staff training began in early October 2010, following which participants were recruited to the pilot, starting from 13 October 2010.
• All pilot participants are recruited. Subjects will be followed up for up to one year. There is a comparison group of controls that will be followed up over the same timescales.
• 30 active participants and 30 control participants have been recruited. SLaM has recruited 7 service users to each group.
• A Resource Allocation Tool is being which covers assessment of physical and mental health, risk issues, social and practical support needs
• Under the personal health budgets model, a “resource allocation system” (or RAS) is utilised to help decide the level of funding in each person’s personal health budget.
• The Pilot requires staff to recognise the unique circumstances and needs of Service users and to approach each service user with the willingness to understand the individual issues and desired outcomes of treatment.
• Within the personal health budgets pilot, the intention is to share power differently, so that as much power as possible is transferred to people needing treatment and support.
• Personal budgets provide a more recovery-orientated model, expanding the scope of treatment and support.
• Personal budgets have been used to support broader holistic recovery from addictive behaviours rather than “medical” treatment in the narrowest sense.
• With personalisation, people are viewed positively as assets – having skills and abilities, knowledge, connections and resilience – all of which must be brought to bear in helping people improve their lives.

Roles/ commissioning responsibilities

SLaM Roles
• Care Navigator Role: Member of core substance misuse team responsible for recruitment of service users to the pilot and attendance at operational meetings. Completion of comprehensive assessment. This post is now part of the third sector provision.
• Consultant Psychiatrist Role: Sign off of care packages for SLAM and non-SLaM service users ensuring medical needs are being met.
• Borough Lead Role: Support to Care Navigator and Consultant Psychiatrists in implementing the programme.

Other Roles
• The Project Lead and other members of the Croydon Drug and Alcohol Action Team have designed and implemented this project with vision and in a spirit of collaboration and support.
• Croydon Drug and Alcohol Team have already run a personal budgets pilot for recovery based care in addiction with the substance misuse care management team. Many of the lessons learned from this piece of work have been utilised in the current project.

Key issues and challenges
• Striking the right balance between managing risk and giving freedoms and flexibilities has been a key issue.
• Funded options may not always be appropriate – many service users have found support and solutions through community based low cost or no cost options.
• Funding may be better spent on travel/child care to allow attendance at low cost/no cost options for example peer support groups.
• The use of the advocacy service has enabled innovative solutions.
• The implementation has challenged staff and service users to look at the whole person and provide services differently, looking at desired outcomes for the individual rather than an imposed set of outcomes.
The pilot has created an environment of shared accountability and responsibility for use of services.

Treatment providers such as residential units have already begun to demonstrate that they can be flexible in their treatment provision when the outcomes and the budget to reach them are more explicit.

As care navigators become more aware of alternative treatment options, and alternative solutions to issues, they are using these lessons with other service users and sharing this information with other staff.

Some staff have reported that the management of this system significantly increases time required for dealing with administrative matters.

Administrative issues and payments for small amounts of money need exploring. Some service users may require additional support at the beginning of treatment to support them in working in this new way.

Non-invoiced payments for intermediate amounts of money have been difficult.

There is an issue of how the programme can be ‘scaled up’ which would have issues for commissioners regarding funding allocations

Sometimes information on services and outcomes can be hard to find. In the world of personal health budgets, this information needs to be readily available in the public domain

1. Executive summary

1.1 The Personal Health Budget Programme is an innovative and well designed pilot study instigated by Croydon Drug and Alcohol Action Team (Croydon DAAT) as part of a wider number of pilot programmes which have been organised by the Department of Health and are being assessed by an independent evaluation by the Personal Social Services Research Unit (PSSRU) at the University of Kent at Canterbury, and other partner agencies. South London and Maudsley Foundation NHS Trust is one of four drug treatment agencies in Croydon that are participating in the pilot project.

1.2 Personalisation is a key principle in the future delivery of health and social care. The personal health budget pilot in Croydon utilises the key features of individualized assessment and care planning with a view to a change in the dynamics of the relationship between the client and the commissioned services leading to a recovery care plan which builds on the recovery capital of the client and the utilisation of personally relevant treatment options from a range of potential service providers. The use of a resource allocation tool, which assesses various domains and generates an indicative budget, transparency around costs and desired outcomes of services. The aim is to seek a positive and effective partnership between service user and service providers resulting in better outcomes.

1.3 Croydon Drug and Alcohol Team have already run a personal budgets pilot for recovery based care in addiction with the substance misuse care management team. This was a groundbreaking piece of work which is the subject of evaluation. Many of the lessons learned from this piece of work have been utilised in the current project.

1.4 South London and Maudsley Foundation NHS Foundation Trust Addictions Services are pleased to have been involved in the pilot from the start from the planning and development stage through to implementation. At our site we are in the final stages of the recruitment of clients and controls. The Consultant Psychiatrists have been involved with signing off care plans of our own clients from other sites.
1.5 The Programme so far has shown that clients have instigated a range of innovative recovery care packages. Services have worked well together and paid for services have been able to offer packages of care that vary from the “service as usual” model and outcomes appear to be favourable.

1.6 Potential issues with the personalisation programme appear to centre on some practical issues – non-invoiced payments for intermediate amounts of money have been difficult. There is an issue of how the programme can be ‘scaled up’ which would have issues for commissioners in terms of moving money from block contracts to free it up for individual budgets.

1.7 A very small minority of clients appear to have found the personal health budget slightly overwhelming at times but the majority appear to have utilised this new way of working to produce personally relevant and innovative care packages based on their own specific needs. The care packages are tailored towards recovery in its widest sense and many have had highly successful outcomes.

2. THE PERSONALISATION PROGRAMME

2.1 Introduction

2.11 Personalisation is a key principle in the future delivery of health and social services. In the substance misuse field there is a much greater emphasis on recovery and recovery based outcomes and personalisation fits well with an agenda based on individualized services and outcomes (National Treatment Agency for Substance Misuse, 2011). There is an increasing recognition that traditional service delivery does not achieve recovery for all clients and that some individually relevant outcomes may not be delivered by standard care packages. The move towards an individual recovery based assessment and care plan, with a greater emphasis on a client centred approach sits well with the personalisation approach.

2.12 The Personal Health Budget (PHB) Pilot scheme in Croydon is part of a Department of Health National Pilot Study into the use of PHBs. There are over 60 sites participating in the national pilot, under which personal health budgets will be offered to people with a variety of different health conditions. The focus of this local pilot in Croydon is adult substance misuse and is one of only two pilot sites looking at the implementation of personal health budgets in substance misuse.

2.13 The Croydon PHB pilot project has grown from a previous study by Croydon Council into personal budgets in addictions recovery, which has been the subject of evaluation and was a highly innovative project. The lessons learnt from that project have been incorporated into the current project.

2.2 Implementation of the Personalisation Programme

2.21 Services participating

2.22 South London and Maudsley NHS Foundation Trust, Croydon Addictions services is one of a number of services participating in the pilot. The other services are:

2.23 Croydon Community Drug Agency (Croydon CDA, service provided by Foundation 66)
2.24 Croydon Council substance misuse care management team

2.25 Croydon Drug Intervention Programme (Croydon DIP, service provided by the Westminster Drug Project or WDP)

2.26 **South London and Maudsley NHS involvement.** South London and Maudsley NHS Foundation Trust (SLAM) were invited by the Croydon Drug and Alcohol Action Team (Croydon DAAT) as one of four service providers to take part in the Department of Health’s national pilot of personal health budgets.

2.27 Managers and Senior Staff such as Consultant Psychiatrists have been involved in the consultation exercises since the start of the project and the training programme. We have been involved at all stages and in helping to design the medical sign off to ensure client safety.

2.28 Staff training began in early October 2010, following which participants were recruited to the pilot, starting from 13 October 2010. All pilot participants are recruited. Subjects will be followed up for up to one year. There is a comparison group of controls that will be followed up over the same timescales. So far our SLAM care navigators have recruited 7 active clients and 7 controls. In addition, our Consultant Psychiatrists have been involved in signing off the care plans for those on personal health budgets both within our own service and those clients in the other services involved.

2.3 **Equality impact assessment**

2.31 The aim of an equality impact assessment (EIA) is to ensure that all service developments and trust policies help to promote equality. The EIA contributes to effective service development and policy production by providing an opportunity to minimise risk and maximise the benefits of a new policy, and assists us to meet our requirements under the general equality duties.

2.32 We are committed to extending our EIAs to include the other equality areas in our remit and human rights. All our EIAs consider the potential impact of policies in respect of all seven areas of equality under our remit and human rights.

2.33 Our approach to EIAs will help us to strengthen our work to promote equality. It will also help to identify and address any potential discriminatory effects whilst introducing services and reduce the risk of not meeting need appropriately. SLaM proactively trains staff in how to undertake an EIA and consider both the negative and positive consequences of proposals, service developments and policies.

2.34 As part of the development of personalisation we will work with our partners to promote equality issues are considered and worked through to ensure a positive impact on how we work and deliver care and treatment.

2.4 **Recruitment process**

2.41 The plan for the entire project in Croydon is to recruit a total of 30 participants to the pilot (personal health budgets) group – 15 drug users, and 15 alcohol users. Each of these people will be given personal health budget for their treatment and recovery journey. This group will be known as the “pilot group”. Figure 1 below shows the numbers of participants each agency will recruit.
Croydon Drug Intervention Programme (DIP)
Service provided by Westminster Drug Project (WDP)
Will take clients coming via arrest/referral route
All clients recruited via this route will be drug users, specifically opiate users (7 people)
Clients recruited may also be using alcohol, in addition to drugs

Croydon Community Drug Agency (Croydon CDA)
Service provided by Foundation 66
All clients recruited via this route will be stimulant users (5 people) or will be using other drugs such as cannabis/skunk (3 people)
Clients recruited may also be using alcohol, in addition to drugs

Croydon Council (substance misuse care management team)
As all drug clients for the pilot will be coming via Croydon DIP and Croydon CDA, all clients recruited via this route (8 people) will be alcohol users
Clients recruited may also be using drugs, in addition to alcohol

South London and Maudsley NHS Foundation Trust – Croydon addictions service
As all drug clients for the pilot will be coming via Croydon DIP and Croydon CDA, all clients recruited via this route (7 people) will be alcohol users
Clients recruited may also be using drugs, in addition to alcohol

7 + 8 + 8 + 7 = 30 people in pilot group (15 drug users, 15 alcohol users)
plus
7 + 8 + 8 + 7 = 30 people in comparison group (15 drug users, 15 alcohol users)
2.5 Recruitment and Staff Roles and Support at South London and Maudsley NHS Foundation Trust and staff roles

2.51 Care Navigator Role: At each site there is a care navigator appointed who is a member of the core staff team for the organisation. At SLAM this role was fulfilled for one year by a drug worker who has recruited nearly the full complement of subjects and has recently been taken over by another worker who was keen to become involved with the pilot. The care navigators have received bespoke training and a system of ongoing support by means of weekly meetings with other care navigators and the lead from Croydon Drug and Alcohol Action Team. In addition the Care Navigators attend the operational meetings on a monthly basis.

2.52 Consultant Psychiatrist Role: For the SLAM clients, the care packages are signed off by one of the Consultant Psychiatrists. The rationale for this is explained in the protocol. The Consultant psychiatrist also signs off plans for clients in the other services (Appendix 1). The main reason for this is to ensure that medical needs are being met. The Consultant Psychiatrists at SLAM have been involved in the project and the training from the start and also participated in the training. The Consultant Psychiatrists have attended the training and have also attended the operational meetings and other meetings with the Project lead.

2.53 Borough Lead Role: The Borough Lead for the SLAM services was involved with the project from the start and their role is to support the care navigator and the Consultant Psychiatrists in implementing the programme, for example by reviewing care plans of the clients in the SLAM service, ensuring that the work is prioritised, supporting the staff and facilitating staff attendance at the relevant meetings.

2.6 The assessment process

2.61 All clients have a comprehensive assessment in accordance with the Croydon Models of Care Assessment using a specially designed tool which was designed and piloted locally. This is a comprehensive assessment of need and risk. In addition to this, clients will be assessed with regard to a number of domains which will generate resource allocation.

2.7 Allocation of Resources

2.71 For patients on the Personal Health Budget Study a Resource Allocation Tool is being used (Croydon DAAT, 2011) which covers assessment in the following domains:

- Opiate use stabilisation
- Ongoing prescribing (opiate substitute)
- Detoxification
- Help with symptoms of withdrawal
- Practical obstacles/barriers to treatment
- Risk/harm reduction
- Helping change behaviour/use of substances
- Emotional/mental health
• Repairing damage to key relationships with family and friends
• Community integration/community life

2.72 For each of these domains, an indicative budget is generated. Please refer to the Operational Policy by the Croydon Drug and Alcohol Action Team 2011 for further information

2.8 Some examples of how personal budgets have been used

2.81 Below is a list of examples of how personal budgets have been used. Some of these choices were informed by the previous work on personal budgets. It is apparent that many of these choices are about broader holistic recovery from addictive behaviours rather than “medical” treatment in the narrowest sense.

• Inpatient and residential detoxification
• Community prescribing (methadone or buprenorphine)
• Crisis intervention followed by residential rehabilitation for three months
• 1 month residential treatment followed by 3-month day programme
• One-to-one counselling sessions, including travel (to improve mental health)
• Pottery-making classes (relaxation, structure and socialisation)
• Training in the use of power tools (for self-employment)
• Theatre tickets (to help repair damage to family relationship)
• Gym membership (to improve health/fitness)
• Travel to meet family members (re-connecting, after years of separation)
• DIY course, including travel (to develop new skills)
• Diagnostic adapters and cables (for self-employed motor mechanic)
• Historical research course, including travel (vocational/educational)
• Dancing classes (to help repair damage to relationship with partner)
• Father and child football season ticket (quality and fun time together)

3. The Principles of Personalisation (Croydon Drug and Alcohol Action Team 2011, please refer to this for further information)

3.1 Greater choice and control for people needing treatment and support Clients are placed at the Centre of the assessment and decision making process.

3.2 Person-centeredness. This requires staff to recognise the unique circumstances and needs of Clients and to approach each client with the willingness to understand the individual issues and desired outcomes of treatment.

3.3 Sharing power differently under the personal health budgets pilot, the intention is to share power differently, so that as much power as possible is transferred to people needing treatment and support. However, accountability with checks and balances in the system is central to this. This transfer of power takes place in a structured way, where staff have clearly defined roles, and people needing treatment and support have both rights and responsibilities. People needing treatment and support are seen as equal partners in relationships with staff.
3.4 **Equity and transparency** under the personal health budgets model, a “resource allocation system” (or RAS) is utilised to help decide the level of funding in each person's personal health budget.

3.5 **The RAS allocates resources fairly and transparently**, so each person knows approximately how much money is available, before beginning to plan their treatment and support. The aim is to ensure that money is used to enable each individual's personal outcomes to be met in the most cost-effective way possible.

3.6 **A different kind of dialogue** about “sufficiency” (how much money is needed) the resource allocation system calculates an “indicative” personal health budget for each individual. This is an approximate amount of money that can be used as a guide, when beginning to draft a treatment and recovery plan. Some outcomes may be achieved at lower or no cost and others may require more funding than originally budgeted for.

3.7 **Flexibility in use of monies.** A key feature of the personal health budget is that flexibility can be offered in the use of personal budgets. If a lower-cost option than the indicative allocation allows for one type of treatment and support (thereby “saving” money in meeting one personal outcome), but can make a good case for spending more money than allocated to achieve another personal outcome, the “transfer” of money from one domain of need to another can occur where this is possible.

3.8 **Flexibility in implementation.** Enabling the personal health budgets model to work well for each individual. The personal health budgets model provides an individual with an ideal opportunity for planning and achieving a sustained recovery. However, for various reasons, it may not be appropriate or possible for a client to decide on an entire recovery journey at the outset of treatment. For these reasons there is flexibility around implementation.

3.9 **Shopping for treatment and support.** This is a central facet of the personal health budget. However, sometimes information on services and outcomes can be hard to find. In the world of personal health budgets, this information needs to be readily available in the public domain, so that people needing treatment and support can use it to make informed choices. Information on treatment services is being compiled. In addition it has become clear that treatment providers can offer alternative “packages” to the standard treatment service when budgets and required outcomes are made more explicit.

3.10 **A more recovery-orientated model.** Expanding the scope of treatment and support One of the criticisms frequently made of the current substance misuse treatment and support system is that it focuses too narrowly on treating the substance misuse problem in isolation from other factors, and fails to address adequately the broader range of individual and family needs and aspirations which if addressed more effectively – might better promote a full and lasting recovery. In our personal health budgets pilot, and notably through the resource allocation system itself, we aim to address a wider range of individual needs by expanding the scope of treatment and support offered, and extending it into the early phases of recovery.

3.11 **An “asset-based” approach.** People needing treatment and support are sometimes perceived solely in terms of their problems and needs. However with
personalisation, people are viewed positively as assets – having skills and abilities, knowledge, connections and resilience – all of which must be brought to bear in helping people improve their lives. Focusing on the things people can do and working on their passions and interests is often the key to unlocking the potential for effective recovery.

3.12 “Recovery capital” – making use of every available resource, including “ordinary” community solutions.

4. Some key issues in the implementation of personal budgets

4.1 Striking the right balance between managing risk (duty of care) and giving freedoms and flexibilities. Public services have a legal duty of care for vulnerable people whom they support in various different ways. It is therefore important that the right balance is struck between exercising the duty of care, and giving greater freedoms and flexibilities to the individual. The following bullet points describe how the pilot intends to strive to achieve the right balance in the personal health budgets pilot.

4.2 Models of care assessment. Before someone is offered a personal health budget, they will have a full/comprehensive assessment under Croydon’s “Models of Care” policy. This assessment will identify risks to the person’s health, safety, well-being and independence, as well as risks to other people such as family members, including children and other dependents. All significant risks identified through this assessment must be addressed in the treatment and recovery plan, without which the plan will not be signed off/approved.

4.3 Developing treatment and recovery plans All staff are trained in recovery care planning, which is a key feature of modern drug services and which is also a feature of the PHB Project. Good treatment and recovery plans will be the product of co-production or collaboration between people needing support and members of staff involved in supporting them.

4.4 Supporting innovation and creativity. This pilot project is designed to support, nurture and encourage innovation and creative thinking, so that people can find the best ways to achieve their personal outcomes. Thinking “out of the box” or beyond the usual “service solutions” is often the key to unlocking individual creativity, and building a strong sense of personal aspiration and ambition.

4.5 Treatment and recovery plan sign-off/approval. Once a treatment and recovery plan has been drafted, it must be approved by the care navigator and their manager. A Consultant Psychiatrist should also sign off as to whether the proposed treatment is likely to be suitable and effective (“clinical sign-off”) and that medical needs have not been missed. This is the single most important check and balance in the system, as it means that monies will not be released or spent unless the content of the draft plan is agreed.

4.6 Managing the money - direct payments. Under the personal health budgets pilot, a new legal power has been granted to offer direct payments for health care to people with substance misuse problems. This means it is possible to give money to people needing treatment (or their nominee or representative), so they can purchase and arrange their own treatment and support. There are restrictions to this power (set out in statutory regulations), which exclude people on certain criminal justice system
orders/community sentences from being eligible for direct payments, and many further rules and regulations governing direct payments, all of which will be upheld in full in our pilot, ensuring local practice remains lawful. In addition we have several local safeguards in place to reduce risk.

Further details of how personal budgets will be managed in the pilot can be found in the detailed protocol by Croydon Drug and Alcohol Action Team (Appendix 1, Appendix F).

4.7 **Ongoing reviews of treatment and recovery plans.** Once a treatment and recovery plan has been agreed/signed-off, and the plan has been put into action, the care navigator will meet at agreed intervals with the pilot participant, to monitor how things are going, and to review progress against the identified outcomes.

5. **Involvement of the third sector**

5.1 The third sector has been involved in both the pilot in terms of third sector organisations already in the Borough providing care navigators and being part of the pilot. In addition, patients have often chosen third sector providers for their ongoing care needs. The Independent Brokerage Service has been particularly important in helping subjects to look at their needs and what services might best address them. The Independent Brokerage service has been particularly skilful at helping clients think about needs and options as oppose to predetermined treatment services and their work has been very helpful in the pilot.

5.2 SLAM treatment services are committed to working closely with the third sector and treatment provision in Croydon currently has a mixed economy of treatment provision including the NHS and the third sector. SLAM is working in partnership with third sector providers such as Foundation 66 and KCA. There is a fundamental commitment to shared working and recognising the valuable contributions that the various services make to ensure the best possible outcomes for the clients presenting to services in Croydon for assessment and treatment.

6. **Perception of personalisation**

6.1 Personalisation has been warmly welcomed by staff in all the services as a chance to work differently and more effectively with clients and to improve outcomes and to promote recovery. There has initially been an increase in demands on staff time, for example in training and understanding the project. The clients in the active arm of the pilot study have needed longer appointment times initially, for example to complete the assessment tools and to discuss the use of budgets. However, many of the patients have been engaged with various services as their treatment journey has progressed and the demands on the statutory services have reduced as clients have gone moved onwards with recovery and been utilising services that they have purchased.

6.2 The use of personal health budgets has effected an important change in the relationship between clients and workers. No longer is the client the passive recipient of services but an active participant in assessing their treatment needs and planning appropriate interventions to meet those needs. In some cases local services have been felt by the client to meet those needs but for many clients, additional and innovative ways of meeting identified needs have been purchased.
6.3 However, for one or two patients, mainly those who are very unstable in terms of their drug and alcohol use, some particular challenges have arisen. For example, one patient seemed to become quite overwhelmed at the responsibilities involved and disengaged from treatment for a while. In another case, the patient appeared to have some unrealistic ideas about utilising the money for social issues before addressing their (quite significant) treatment needs. Overall though, our impression has been that patients are retained in treatment for significant periods and have made some valuable and innovative choices with regard to their treatment plans. Some example of treatment spends that address various domains have been given above.

7. **Allocation of Resources**

7.1 Resources are allocated using an objective and transparent assessment tool. Thus far we have not experienced clients having insufficient resources to meet their needs. The transparency of the financial issues seems to be important in helping clients to understand treatment spends and to focus on issues that are necessary for their own personal recovery. Clients are able to make informed choices about spends on identified needs and to look for best value for money, as money can be moved between domains as necessary.

8. **Some lessons so far**

- Funded options may not always be appropriate – many clients have found support and solutions through community based low cost or no cost options
- Funding may be better spent on travel/child care to allow attendance at low cost/no cost options for example peer support groups
- The use of the advocacy service has enabled innovative solutions “outside the (usual) box”
- The implementation has challenged staff and clients to look at the whole person and individual issues rather than a purely 'treatment as usual' service
- The implementation has challenged staff to provide services differently, for example some patients have asked for a specific keyworker to work with
- The implementation has changed the dynamic in the consultations with an emphasis on shared assessment and solutions
- The implementation has enabled a dialogue about treatment effectiveness and value for money rather than simply “gifting treatment”
- The pilot has created an environment of shared accountability and responsibility for use of services
- The implementation has challenged staff and clients to look at desired outcomes for the individual rather than an imposed set of outcomes
- Treatment providers such as residential units have already begun to demonstrate that they can be flexible in their treatment provision when the outcomes and the budget to reach them are more explicit.
- Positive 'mission creep' (in a good way) – the programme has had an effect on treatment for all clients. As care navigators become more aware of alternative treatment options, and alternative solutions to issues, they are using these lessons with other clients and sharing this information with other staff. Clients on PHBs are sharing their experiences with other service users and staff.
- Some staff are reporting that the management of this system significantly increases time required for dealing with administrative matters. It will be prudent to consider how transaction costs are impacting on the day to day running of the service.
9. Other Issues:

9.1 The Project Lead and other members of the Croydon Drug and Alcohol Action Team have designed and implemented this project with vision and in a spirit of collaboration and support. The project has been well designed with various safeguards built in and their help has been invaluable.

9.2 The leader of the pilot has invited a team from the Council and from SLAM (the SLAM care navigator and a Consultant Psychiatrist) together with a Care Manager to present the experiences of the project so far at the Department of Health on the 7th December 2011.

9. Conclusion

9.1 The Croydon Drug and Alcohol Team’s personalisation programme has built on the work of its predecessor programme in the substance misuse care management team. Both pilots have shown that the use of personal health budgets for both social and medical care planning for clients with substance misuse issues is possible and has appreciable benefits.

9.2 The use of personal health budgets has been associated with a change in the dynamics of the relationship between client and worker, has challenged staff and services to personalise treatments, has led to an explicit recognition that cost effectiveness needs to be explored and has led to the formulation of high quality, personalised care packages that are based on individual recovery outcomes.

9.3 Administrative issues and payments for small amounts of money need exploring. Some patients may require additional support at the beginning of treatment to support them in working in this new way.

Appendices

Croydon Drug & Alcohol Action Team, Operational Pilot for Personal Health Budgets Pilot, ‘Clinical Sign Off’, 3.3, p19

Croydon Drug & Alcohol Action Team, Operational Pilot for Personal Health Budgets Pilot, ‘Managing the Money’, Appendix F, p61

National Treatment Agency for Substance Misuse (2011) Recovery Orientated Drug Treatment: An Interim Report by Professor John Strang, Chair of the expert Group

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