

Personal health budgets

Challenges for commissioners and policy-makers

Research summary

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A personal health budget is an allocation of NHS money to someone with an identified health need so that they can buy the services they think will improve certain aspects of their health and wellbeing. It is intended to give the recipient more control over the care that they receive.

In 2009 the Department of Health launched a pilot programme to look at the viability of personal health budgets and an independent evaluation was carried out. It was found that they have a positive impact on care-related quality of life and wellbeing and are cost-effective. It was recommended that they should have a wider roll-out. The Government has since committed that from April 2014 everyone who receives NHS continuing health care funding will have a right to request a personal health budget rather than receiving commissioned services. This will present issues and challenges for commissioners and policy-makers.

In this research summary we describe what personal health budgets are and how they are supposed to work in practice. We also look at the evidence from the national evaluation and explore some of the issues that will be raised for commissioners and policy-makers as personal health budgets are rolled out.

Key Points

- To date, the numbers of personal health budgets implemented in each local area has barely exceeded 100 people. Their extension to people in receipt of continuing care, and after that to those with long-term conditions, presents a much larger challenge for commissioners, who will need to reassure themselves that a wider range of providers demonstrate sufficient quality to merit inclusion.
- Clinical commissioning groups will also need to be ready to decommission services not chosen by budget holders; but at a pace that allows providers the chance to adapt and minimises the risk of market shrinkage (leaving individuals with fewer choices than before). Likewise, efforts aimed at diversifying the market of providers need to be carried out with care to avoid destabilising existing providers.
- For the system to work, new infrastructure around budget setting, care planning and system monitoring is required; funding for which would need to be found in existing budgets. There is some evidence to suggest that some efficiency can be achieved by ‘piggy-backing’ on the systems that already exist to support personal budgets in social care.
- Policy-makers need to be aware that there is a risk of a postcode lottery emerging, with much of the decision-making as to whether to offer personal health budgets, for whom and at what pace remaining in the hands of clinical commissioning groups. Not only will the value of a personal health budget be different in each area, but also the availability of personal health budgets for particular conditions is likely to vary.
- Bringing personal health budgets together with personal budgets in social care to create integrated individual budgets potentially offers a new route to service integration at the level of the user and carer. A ‘dual carriageway’ approach which brings together the referral, assessment, budget setting, planning and monitoring of different budgets without the complexities of structural integration between organisations and government departments may be helpful in this respect.



Introduction

In 2009, the Department of Health launched a national pilot programme to look at the viability of personal health budgets in England (Department of Health, 2009). The pilot programme involved over 70 primary care trusts and covered a range of long-term conditions (chronic obstructive pulmonary disease, diabetes, long-term neurological conditions, mental health and stroke), NHS continuing health care, maternity care and end of life care, with 20 sites involved in an independent, in-depth evaluation.

On 30 November 2012, the Government published the results of the evaluation. The evaluation concluded that personal health budgets are cost-effective (with certain caveats) and thus supported a wider roll-out (Forder and others, 2012). Following this recommendation, the government confirmed its intention that, as of April 2014, individuals in receipt of NHS continuing health care funding will have the right to request a personal health budget (Department of Health, 2012a). This will include an extension of the programme to cover children with special educational needs and disabilities, who will be able to have an integrated budget across the NHS, social care and education. As of 2015, clinical commissioning groups are expected to be able to offer a personal health budget to anyone with a long-term condition who could benefit.

For commissioners, personal health budgets offer a new tool to support self-management and care planning, in line with the Government's mandate to the NHS to place greater emphasis on patients as partners in the management of long-term conditions (Department of Health, 2012b). Moreover, the results of the pilot programme appear to be broadly promising in terms of efficiency. As personal health budgets are offered more widely though, commissioners will increasingly face issues distinct from those encountered during the pilot programme; issues that, understandably, were not investigated as part of the recent evaluation.

In this research summary, we consider some of these issues and how they might be addressed. We begin with a description of a personal health budget and an exploration of how they are supposed to work in practice. We then present an overview of the evidence from the national evaluation, before exploring some of the main issues that the roll-out of personal health budgets raises for commissioners and policy-makers.

What is a personal health budget?

A personal health budget is an allocation of NHS money to an individual with an identified health need in order that they can buy services they believe will enable them to meet specific goals around health and wellbeing.

The purpose of a personal health budget is to give people much more control over how their needs are met, what services they receive and who delivers them. Importantly, it is not intended to meet an individual's entire health needs; rather, it is for specific aspects of ongoing care, such as psychological therapy or pulmonary rehabilitation. Moreover, there are certain aspects of NHS care that are not intended to be covered by a personal health budget, including general practice (GP) services, pharmaceuticals and emergency services (Department of Health, 2012c).

Guidance from the Department of Health specifies that there are five essential features of a personal health budget (Department of Health, 2012d). In using a personal health budget, the budget holder (or their representative) should:

- be able to choose the health and wellbeing outcomes they want to achieve, in agreement with a health care professional
- know how much money they have for their health care and support
- be enabled to create their own care plan, with support if they want it
- be able to choose how their budget is held and managed, including the right to ask for a direct payment
- be able to spend the money in ways and at times that make sense to them, as agreed in their care plan.



The aim of an individual care plan is to utilise the expertise of both clinicians and the individual and their family

At the centre of a personal health budget is an individual care plan. Augmenting more traditional approaches to care planning, the aim of an individual care plan is to utilise the expertise of both clinicians and the individual and their family. The intention is to give each perspective its due prominence and to ‘co-produce’ the end plan of care. Although there is no requirement with a personal health budget to use only treatments approved by the National Institute for Health and Care Excellence (NICE), engagement between the individual and the clinical professionals with whom they work is intended to give the budget holder access to the latest science and evidence. Also, clinical sign-off of the personal health budget ensures that clinicians are comfortable that all aspects of the care plan are safe and likely to help the individual to meet their chosen health and wellbeing goals. Empowering individuals and their families in this manner is considered valuable in itself. However, the thought here is also that, following this process of co-production, people will be more likely to follow through with their care plan and hence it will be more effective at meeting their needs (Epstein and others, 2010). In this way, personal health budgets share common ground with other long-term care planning initiatives in the NHS that have supported greater shared decision-making, such as Year of Care (Department of Health, 2011).

The case study presented in Box 1 illustrates one example of a personal health budget being used successfully in practice.

Setting up a personal health budget involves a seven-step process, as shown in Box 2.

Box 1: Case study: Ann's experience with Northamptonshire's personal health budget pilot in mental health

Ann was eligible for a personal health budget as part of Northamptonshire's mental health pilot. Her indicative personal health budget was calculated based on the cost of her use of the Community Mental Health Team in the previous 12 months, a clinical assessment of her health status and, from that assessment, an estimation of the Community Mental Health Team services that she was likely to use in the following 12 months.

Among Ann's main objectives for her care plan were to reduce her use of services; reduce her number of overdoses; increase her confidence; and decrease her self-harming behaviour. Her primary objective, though, was to be able to help her family rather than being a source of concern to them.

With her personal health budget, Ann bought regular, twice-weekly psychotherapy sessions, three contacts with her consultant psychiatrist and a minimum of 25 contacts with her care coordinator. A short course of NHS psychotherapy in the past had worked well for Ann so she negotiated to reduce her contacts with her care coordinator and psychiatrist to free up funds to pay for a private psychotherapist.

After seven months with a personal health budget, Ann was making steady progress towards achieving her health outcomes. She had had no inpatient admissions or overdoses. She had not needed to use the crisis team or respite service and she had reduced her contact with her psychiatrist. She was especially pleased that her relationship with her family had greatly improved.

Source: Case study provided by Gill Ruecroft at the Nuffield Trust/Department of Health seminar in May 2012 (Nuffield Trust, 2012)

Box 2: The seven-step personal health budget process

1. The first step in developing a personal health budget is a traditional assessment whereby a person is recognised as having a health need.
2. Having established a clear understanding of an individual's needs, it is then necessary to identify the cash value of the personal health budget to which that person is entitled. This is the indicative personal health budget for that particular individual.
3. The personal health budget allocation provides the starting point for developing a care plan, which identifies the goals a person has for their health and wellbeing and how those goals could be met. There is no set menu, allowing people to develop highly personal, creative solutions. The individual can complete their care plan by themselves, with the support of family and friends, with peer support or with an independent broker, and clinicians should also be closely involved in the planning process.
4. The care plan is approved on the basis of being financially and clinically appropriate. Since there is no fixed menu, approval should focus on the likelihood that the plan will meet the individual's identified goals.
5. Individuals can exercise as much or as little direct control over the money in their personal health budget as they choose. They can receive it as a direct payment that they manage, they can use a third party to manage it on their behalf, or it can be held by a provider or commissioner. However the money is held, individuals should be able to spend it flexibly to meet their needs.
6. With decisions about the money made, the services and supports in the plan can be put in place, either by the person themselves or by the organisation that holds the budget in collaboration with them.
7. A person's care plan is reviewed at least annually and its effectiveness is judged on the basis of whether the goals identified in the plan are being met. If a person's needs change significantly, they will complete a new assessment and will be allocated a new personal health budget.

Source: Alakeson, forthcoming

Key questions about personal health budgets: the current evidence

In this section we examine some of the evidence on personal health budgets in relation to questions of efficacy, cost-effectiveness, risk, and safeguarding and fraud. A summary of the key findings of the evaluation of the pilot programme of personal health budgets is presented in Box 3.

Efficacy and cost-effectiveness

Evidence from the personal health budget evaluation showed that personal health budgets had a significant positive impact on both the care-related quality of life (measured through the Adult Social Care Outcomes Toolkit or ASCOT) and psychological wellbeing (measured through the General Health Questionnaire or GHQ-12) of budget holders (Forder and others, 2012). This accords with several international studies that have found that personal health budget holders report improvements in the quality of care they receive (Health Foundation, 2010). There is also related evidence from the individual budget pilot in social care in England, which found that younger people with physical disabilities reported higher quality of care, and were more satisfied with the help they received (Glendinning and others, 2008). However, at the same time, it is worth noting that during the evaluation, personal health budgets were not shown to have a significant impact on clinical outcomes or health-related quality of life (measured through the EQ-5D – a standardised instrument for use as a measure of health outcome) (Forder and others, 2012).

In terms of costs, the evaluation of personal health budgets found that inpatient, Accident & Emergency and GP costs were lower for the personal health budget group compared with the control group (Forder and others, 2012). However, total costs incurred by the two groups were not significantly different. In large part this was because in some pilot sites personal health budgets were not offered on a cost-neutral basis because of the challenges of decommissioning existing services for a time-limited pilot. In these sites, personal health budgets were offered in addition to existing services and the savings from a reduction in the use of other services were not adequate to cancel out this additional spending. Where personal health budgets were offered on a cost-neutral basis, total service use was lower compared with care as usual (Forder and others, 2012).

According to the analysis run by the evaluation group, then, using care-related quality of life (ASCOT) measured net benefits, personal health budgets are cost-effective relative to conventional service delivery (Forder and others, 2012).

Risk and safeguarding

One concern with personal health budgets is about risk: the thought being that personal health budgets place people at greater risk than commissioned services by allowing individuals to make choices about which services best meet their needs, and that such choices may not concur with the views of a clinician (Mathers and others, 2012).

However, it is important to remember that all care plans must be clinically and financially sound in order to be signed off by commissioners. Moreover, where individuals hire their own staff, there tends to be a higher level of trust between the individual and the care team, which also reduces risk (Glasby, 2010).

Fraud

Another question often raised about personal health budgets is whether individuals will use their budgets fraudulently, or unwittingly allow their budgets to be abused (Audit Commission, 2010). Drawing on evidence from personal budgets in social care (which are far more widely used internationally), there is little evidence of fraud and abuse.

Box 3: Evidence from the national personal health budget evaluation

The national evaluation of personal health budgets used a controlled trial to compare the experiences of just over 1,000 people selected to receive a personal health budget with those of just over 1,000 continuing with conventional support arrangements across six conditions:

- chronic obstructive pulmonary disease
- diabetes
- long-term neurological conditions
- mental health
- stroke
- patients eligible for NHS continuing health care (Forder and others, 2012).

In some of the 20 evaluation sites, people were randomised into the personal health budget or control group. In others, the personal health budget group was recruited from the caseloads of professionals offering personal health budgets and the control group from non-participating health care professionals. The evaluation followed a mixed design, using both quantitative and qualitative methodologies to explore patient outcomes, experiences, service use and costs (Forder and others, 2012).

The evaluation reported the following main findings:

- Personal health budgets had a significant positive impact on the care-related quality of life (ASCOT) and psychological wellbeing (GHQ-12) of budget holders but did not have a significant impact on clinical outcomes or health-related quality of life (EQ-5D).
- Inpatient costs were lower for the personal health budget group compared with the control group but total costs were not significantly different. In large part this was because the direct costs of those personal health budgets that were offered in addition to conventional service delivery cancelled out the savings in indirect costs.
- Using care-related quality of life (ASCOT) measured net benefits, personal health budgets were cost-effective relative to conventional service delivery.
- High-value personal health budgets (over £1,000 a year) were found to be more cost-effective than low-value budgets.
- The net benefits of personal health budgets for continuing health care and mental health were tentatively found to be greater than for other patient groups.
- Carers were more likely to report better quality of life and perceived health than carers in the control group.
- There were no significant differences in outcomes for service users by age, sex or socioeconomic status.

Source: Forder and others, 2012

In general, personal budget holders pursue value for money, negotiating prices with providers, maximising the use of resources and only using what is required to meet their needs (Fox, 2012). Moreover, direct payment support services that manage the financial aspects of individual-level commissioning, such as a payroll facility for directly employed workers, are usually available to help people with the responsibilities of being an employer and a third party arrangement can be used for those who cannot or do not want to manage directly the financial responsibility of a personal health budget (Fitzgerald and others, 2012).

The roll-out of personal health budgets: issues for commissioners

Implementing personal health budgets is now the responsibility of clinical commissioning groups. While the pilot programme addressed a wide range of implementation challenges and provides important lessons for clinical commissioning groups as they take forward personal health budgets, there are further issues to be addressed as personal health budgets move out of the pilot phase and into the wider NHS. This section highlights four important issues for commissioners:

- determining the value of a personal health budget
- decommissioning existing services to free up funding for personal health budgets
- developing the provider market
- funding the necessary infrastructure.

Determining the value of a personal health budget

In order to implement personal health budgets, clinical commissioning groups need to develop a process for allocating NHS resources to each eligible individual in a way that is fair between individuals, ensures that each person can meet their needs from within their allocated resources and is sustainable for the NHS as a whole. In this respect, pilot sites generally adopted one of three approaches:

- one-off payments
- allocating resources on the basis of existing services
- needs-based budgets (Cattermole, 2012a).

As the experience of the pilot sites showed, each of these approaches has its advantages and disadvantages (Forder and others, 2012). For example, developing needs-based budgets is typically the most equitable of the three options; yet it requires the development of a new funding system that can be technically complex and resource intensive. One-off payments are often an easy way to experiment with choice and control for individuals. However, as they are generally offered on top of existing services, they are hard to sustain in a tight financial environment and they do not sufficiently demonstrate that individual choice and control can improve outcomes over traditional service delivery. Finally, basing personal health budgets on the value of existing services ensures cost neutrality with the current system, yet it also means that existing biases are built into personal health budgets. For example, if the current system does not emphasise prevention in its use of resources, it can be more difficult to create this shift in health behaviour with a budget based on existing patterns of service use.

In some places, commissioners have sought to align personal health budgets with existing finance infrastructure. For example, Nene Clinical Commissioning Group in Northamptonshire has been trialling mental health Payment by Results as the basis for allocating resources for personal health budgets (Department of Health, 2013). In mental health, Payment by Results is based on 21 care clusters (Department of Health, 2012e). Following a cluster assessment or review, each individual receiving mental health services is assigned to a care cluster. If individuals opt to control their own services instead of receiving a traditional care package, the cluster cost becomes their indicative budget and the starting point for care planning (Cattermole, 2012a). Like personal health budgets, mental health Payment by Results is relatively new to the NHS and the fit between the two systems will have to be monitored closely.

Decommissioning existing services

In order to prevent the duplication of services as personal health budgets are implemented, clinical commissioning groups will need to decommission those services not chosen by budget holders. Moreover, this needs to be done at a pace that allows providers the chance to adapt, otherwise there is the danger that the market will shrink, leaving individuals with fewer choices than before.

This is a relatively new challenge in terms of personal health budgets. To date, the scale of personal health budgets implemented in each local area has barely exceeded 100 people. As a result, it has been possible to introduce personal health budgets and run existing systems side by side. The double running costs that have been incurred have thus far not been significant enough for commissioners to need to release money from existing provider contracts (Audit Commission, 2012). Indeed, even the first phase of the roll-out of personal health budgets will focus on continuing health care, which is largely commissioned on a bespoke, individual basis (Cattermole, 2012b). However, the extension of personal health budgets to other long-term conditions will present a much tougher challenge for commissioners, particularly in community services where block contracts are often still the norm.

In tackling this issue, there is a range of transition strategies that commissioners can use to support the provider market to move towards a system where money is able to follow individual choices. For example, commissioners can phase in personal health budgets by keeping the total contract value with a provider the same but introducing a percentage of the contract that must be delivered as personal health budgets. This percentage can increase year-on-year to allow providers to unbundle their services and develop unit costs over time. This will put providers on a stronger footing to eventually adjust to not having any guaranteed income (Audit Commission, 2012). Commissioners can also use the Commissioning for Quality and Innovation (CQUIN) payment framework as a tool to stimulate changes towards personal health budgets. CQUIN payments are incentive payments that commissioners can include in provider contracts to stimulate certain types of activity. For example, in 2009/10 Devon and Torbay Primary Care Trust included a CQUIN payment in its contract with Devon Partnership NHS Trust linked to the trust increasing the number of people receiving its mental health services who took up a personal budget or personal health budget (Devon Partnership NHS Trust, 2011).



Personal health budgets require a diverse market with a greater variety of providers

Developing the provider market

To be able to cater effectively to the individual needs of budget holders, personal health budgets require a diverse market with a greater variety of providers. An important challenge for clinical commissioning groups, therefore, will be in fostering such a market in their locality.

Some of this will involve encouraging new market entrants, including peer- and user-led organisations and technology-based services. Here, commissioners will need to work more closely than before with personal health budget holders and their families in order to understand what matters most to them, what they judge to be lacking in the current marketplace and how they judge existing providers (Bennett, 2012). Market development

needs to be undertaken incrementally so as not to destabilise existing providers and leave personal health budget holders with fewer options. In addition, commissioners will have to find new methods of quality assurance that are appropriate to a broader range of service providers, some of whom will not fall under the remit of the Care Quality Commission. Based on the spending patterns of budget holders in the pilot programme, 12 per cent of the average value of a personal health budget goes to providers outside the NHS (Forder and others, 2012).

Existing evidence also suggests that much can be done in this regard by working closely with existing providers. For example, Dorset Primary Care Trust introduced personal health budgets for people with an acquired brain injury. In this case, there was a benefit to both patient and commissioner – for those people who took up a personal health budget, rehabilitation was more successful and took less time than the traditional service – and so commissioners are now working with existing providers to see whether they can change the traditional service to be more flexible and individually tailored (Cattermole, 2012c).

Funding the necessary infrastructure

Implementing personal health budgets will also require clinical commissioning groups to fund three types of infrastructure:

- a system for allocating resources to individuals as discussed above
- a system of support for personal health budget holders that includes care planning
- the infrastructure for financial management and monitoring of service quality to prevent fraud and abuse.

On average, pilot sites invested around £146,000 over two years in developing this infrastructure (Jones and others, 2011). Sites involved in the in-depth evaluation of the pilot programme received additional support from the Department of Health that could be put towards these costs. However, as personal health budgets are extended, these costs have to be found from within existing budgets.

There is some evidence to suggest that some efficiencies can be achieved by piggy-backing on infrastructure that is already in place to support personal budgets in social care. For example, many local authorities use independent support brokers to work with personal budget holders who can also provide information, advice and support to personal health budget holders. Similarly, NHS commissioners have used existing local authority systems to transfer direct payments to personal health budget holders who choose this option (Brewis and Fitzgerald, 2013).

Moreover, over time, there is the possibility that incorporating personal health budgets into existing processes can significantly reduce the costs of offering this option. For example, in NHS Oxfordshire, the approach to individualised care planning and reviews developed through the personal health budget pilot has become central to continuing health care and is offered to all individuals regardless of whether or not they also choose to manage a personal health budget (Reynolds, 2012). As a result, it may be that personal health budgets will not require a separate, additional process that adds costs to the system.

The roll-out of personal health budgets: issues for policy-makers

As well as implementation issues for commissioners, the extension of personal health budgets raises a series of questions for policy-makers that were not fully answered by the pilot programme. These are discussed below.

The scope of personal health budgets

While personal health budgets are intended to improve the ongoing care of those with long-term conditions and disabilities, the pilot programme did not provide clear answers about the appropriate scope of personal health budgets and where they can add most value. Some types of care were expressly excluded from personal health budgets, for example, GP and pharmacy services and emergency care. But beyond this, some personal health budgets covered the value of an individual's entire continuing health care package, including clinical services, and were worth £150,000 a year, while others paid for only additional supports, which cost less than £500. The average budget size was £10,000 a year but over half of all personal health budgets in the pilot programme were worth less than that.

The national evaluation suggests that larger-value budgets have greater potential for positive impact, assuming that they are implemented to offer choice and flexibility (Forder and others, 2012). Given that the initial expansion of personal health budgets is taking place in continuing health care, it is likely that most personal health budgets will be larger in value and have a broad scope. However, further experimentation is required for other long-term conditions to determine the appropriate scope of personal health budgets and the range of services that should be included. Should personal health budgets include the cost of clinical services such as physiotherapy and psychological therapy or only long-term support services such as those provided by care agencies, day programmes and respite services? There are, as yet, no definitive answers.



What approaches can ensure individual safety and service quality, while encouraging new and diverse providers into the market?

Quality of care

As mentioned above, several concerns have been raised about personal health budgets in relation to quality and risk. As explained, some of these may be met with certain safeguards (for example, with an individual's care plan only being signed off if clinicians and commissioners are confident that the plan will achieve an adequate standard of care). However, now that personal health budgets are being implemented within the mainstream NHS, policy-makers may be forced to address issues of quality and risk more seriously. For example, can personal health budgets continue to sit outside the reach of NICE and Any Qualified Provider? What are appropriate forms of quality assurance for a broader provider market than the NHS has traditionally commissioned and what approaches can ensure individual safety and service quality, while encouraging new and diverse providers into the market? Here, policy-makers have a difficult balance to strike. One point noted during the pilot programme was that where personal health budgets were implemented with little or no flexibility over what could be purchased, or how the money could be held, their impact was generally negative (Forder and others, 2012).

Financial sustainability

The Dutch experience with PGBs (Persoonsgebonden budget) highlights the need to manage the longer-term financial sustainability of personal health budgets within the NHS. PGBs were introduced in the Netherlands in 1996 for people with long-term care

needs not covered by the health insurance system. PGBs cover personal care, nursing care, support services, such as day care, and short stays away from home, including respite care.

Following the introduction of PGBs, take-up rocketed from 5,401 in 1996 to 123,000 in 2010. People who had not accessed traditional services were drawn into the health care system by the prospect of being able to buy their own services with a PGB. This was driven largely by parents of children with autism and attention deficit hyperactivity disorders for whom little was available from traditional providers. However, the result was that the PGB programme exceeded its budget and a waiting list had to be introduced. The Dutch government has since changed the eligibility criteria to better manage demand (White, 2011). Some local authorities in England have found a similar, although less pronounced, increase in demand for social care following the introduction of personal budgets (Dafter, 2012).

In continuing health care in England, eligibility is set by a national framework and assessment based on a standardised instrument – the Decision Support Tool. Individuals have to be deemed eligible for continuing health care before they can be offered a personal health budget. Therefore, managing demand for personal health budgets within continuing health care will be relatively straightforward. However, policy-makers will have to work with commissioners to develop ways to manage demand in other areas to ensure financial sustainability if personal health budgets lead to an increase in demand for services. In addition, commissioners will have to develop approaches to resource allocation that recognise improvements in health status and adjust personal health budgets accordingly. If not, personal health budgets risk being seen as a long-term entitlement even when they are no longer needed and this will add costs to the NHS.

The potential for a postcode lottery

Policy-makers need to be aware that there is a risk that a postcode lottery in personal health budgets will emerge because much of the decision-making as to whether to offer personal health budgets, for whom and at what pace will remain in the hands of clinical commissioning groups. Not only will the value of a personal health budget be different in each area, but also the availability of personal health budgets for particular conditions is likely to vary. Individuals who could benefit from a personal health budget may find that in their area, personal health budgets are not being offered for their condition, whereas in another area, they are.



A postcode lottery in the NHS raises more criticism [than in social care] given the universal and nationally managed nature of the service

Experience from social care shows that, despite a binding target on local authorities for the implementation of personal budgets up until 2011 and ongoing national commitments, there is significant variation in take-up rates across local authorities and across different disability groups (Routledge and Lewis, 2011). An individual's experience of personalisation in social care varies – depending on where they live. While social care has always tolerated variation, a postcode lottery in the NHS raises more criticism, given the universal and nationally managed nature of the service. It remains to be seen whether this will be tolerated by the public and whether it could exacerbate existing health inequalities.

Integration between health and social care

As well as several challenges, the introduction of personal health budgets presents a real opportunity to foster greater integration between health and social care. One in eight personal health budget holders and a majority of carers in the personal health budget evaluation also received social care funding. Integration is one of the opportunities highlighted by the Royal College of General Practitioners in its 2012 position statement on personal health budgets (Mathers and others, 2012) and is strongly supported by the national evaluation, which recommends that ‘personal health budgets should be considered as a vehicle to promote greater service integration’ (Forder and others, 2012, p. 168).

Despite 40 years of efforts to coordinate resources across health and social care, less than five per cent of the combined NHS and social care budget is spent through joint funding arrangements (Humphries and Curry, 2011). Furthermore, integration at the organisational level does not guarantee a joined-up experience of care (Miller and others, 2011). Starting from the point of view of the individual is more likely to lead to an integrated experience, in large part because they have the strongest incentives to ensure that their support is well coordinated (Rosen and others, 2011). Bringing personal health budgets together with personal budgets in social care to create integrated individual budgets offers a new route to service integration at the level of the user and carer.

Of course, integration across funding streams at the individual level is not straightforward. In the evaluation of personal health budgets, only a minority of personal health budget holders who also received a social care personal budget were able to manage both through a single bank account (Forder and others, 2012). In some cases, administrative procedures that were set up for one budget were not considered adequate for the other and separate systems had to be put in place (Forder and others, 2012). Furthermore, the 2005 individual budget pilot in social care (which sought to implement integrated individual budgets for disabled people) came up against the challenges of coordinating funding streams that have different eligibility criteria, narrowly defined purposes and where accountability for spending remains with the original government department (Glendinning and others, 2008).

However, the challenges appear more surmountable if a ‘dual carriageway’ approach to integration between health and social care can be adopted that leaves organisational structures in place. This involves bringing together the referral, assessment, budget setting, planning and monitoring of different budgets without the complexities of structural integration between organisations and government departments. The individual experiences the benefits of a single system, although behind the scenes, the systems remain separate (NHS Confederation, 2012). Several local areas are experimenting with this ‘dual carriageway’ approach. Further work is needed in this area to identify effective approaches, and health and wellbeing boards (local fora where key leaders from the health and care system attempt to improve the health and wellbeing of their local population) could play an important role in promoting integrated individual budgets as part of their wider remit to drive forward integration between health and social care.

Conclusion

The recent national evaluation of personal health budgets indicates that they could make an important contribution to the care of those with long-term conditions. However, significant challenges remain. For example, over the next year, clinical commissioning groups nationally may have to respond to requests for personal health budgets from up to 56,000 people currently eligible for NHS continuing health care and, in some areas, from others with long-term conditions at less severe levels of need.



Over the next year, clinical commissioning groups nationally may have to respond to requests for personal health budgets from up to 56,000 people

A lot has been learned from the pilot programme to inform the national roll-out of personal health budgets. However, the pilot programme was not able to answer many of the questions about how personal health budgets fit within the wider NHS landscape and what their longer-term impact will be on the quality of patient care, on outcomes and on costs. Will greater individual choice and control result in reduced use of inpatient services over a three- to five-year period rather than a 12-month period? Given current pressures on the NHS budget, the financial sustainability of personal health budgets is critical to determine. Answers to these questions and challenges will emerge as personal health budgets move forward. Policy-makers will need to review the extent of take-up and its impact on individuals and on the system as a whole over the coming years.

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Our work programme

This report forms part of the Nuffield Trust's work on commissioning. Our research, analysis and debates aim to support the work of clinical commissioning groups and NHS England, and track their development and impact.

Project highlights include:

- a major study of how primary care trusts commissioned care for people with long-term conditions
- developing a person-based risk-adjusted formula for allocating commissioning resources to general practices in England
- research to inform the development of NHS England's work programme, drawing on research and practice in other member countries of the Organisation for Economic Co-operation and Development (OECD).

Find out more at:


www.nuffieldtrust.org.uk/our-work/commissioning


We have also produced a slideshow which provides an overview of the main changes resulting from the Health and Social Care Act 2012, as implemented from April 2013.

See the slideshow at:

www.nuffieldtrust.org.uk/talks/slideshows/new-structure-nhs-england

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