Briefing
February 2015 Issue 281

NHS CONFEDERATION

Getting the sums right

How to sustainably finance personal health budgets

Who should read this briefing?

- Leaders and managers in clinical commissioning groups and providers who are either looking to lead implementation of personal health budgets beyond continuing healthcare or considering how to respond to the implications of expanding personal health budgets.

What this briefing is for

- This briefing shares learning on ways to identify and allocate funds for personal health budgets from within existing budgets, and manage the risk of double-running costs. It makes recommendations for commissioners, providers and national policymakers.

Key points

- Commissioners and providers should start discussing plans for implementing personal health budgets well in advance, to ensure they have a shared understanding of what it is set to achieve and how they will manage risks.
- There are different approaches to identifying personal health budget allocations. Each has pros and cons. Commissioners should choose a single approach at the start, stick with it and build on it.
- Whatever the chosen approach to allocating funds, commissioners should ensure that individual needs for care and support and the health and wellbeing outcomes identified, rather than the budget setting tool itself, drive the assessment.
- Improvements to information on the actual costs of healthcare – particularly in mental health and community services – will be important to support the implementation of personal health budgets.
- Stepped approaches to implementing personal health budgets can be very helpful, by providing some certainty, allowing confidence to grow and enabling a managed transition away from (including decommissioning) any services that budget holders decide to stop using.
- The potential of existing providers to develop the new kinds of services people want and need can help mitigate the risks associated with loss of income.
- Whatever approaches commissioners and providers adopt to financing personal health budgets, they must also enable budget holders to make decisions in partnership with professionals, and take control of the combination of services which is right for them. This is practically and culturally a very different way of working.

Produced in partnership with think local act personal

Background

People want more control and choice over the care they receive. They want to have more say in defining the healthcare outcomes that are important to them and deciding how they will be achieved. There is evidence that individuals who are supported to engage more effectively with their condition and with healthcare professionals make good decisions about their care.

Personal health budgets were piloted and evaluated in a number of areas between 2009 and 2012. People in receipt of NHS continuing healthcare and children receiving continuing care now have the right to have one. The NHS Mandate states that from April 2015, people with long-term conditions who could benefit should have the option of a personal health budget. This is reinforced by NHS England's 2015/16 planning guidance,[1] which sets expectations that:

- clinical commissioning groups (CCGs) lead a major expansion in 2015/16 in the offer and delivery of personal health budgets to people, where evidence indicates they could benefit
- personal health budgets or integrated personal budgets across health and social care should be an option for people with learning difficulties by April 2016
- local joint health and wellbeing strategies should include clear goals on expanding personal health budgets.

In addition, from April 2015, a number of demonstrator sites will implement a new approach called 'integrated personal commissioning', including combined health and social care personal budgets.[2] The Government and NHS England intend to extend personal health budgets further, and they could ultimately be available for anyone with a long-term condition who could benefit.

The challenges of identifying the funds for personal health budgets, and managing the financial risks to commissioners and providers, have been known for some time. To implement them sustainably, commissioners and providers need to understand how to calculate the amount of a personal budget clearly, accurately and fairly, and how to mitigate the financial risks that can result if people choose different services from those already commissioned.

Other challenges include understanding the costs of services for individuals, within block contracts, and decommissioning NHS services as demand shifts to alternatives.[4] As a number of local areas extend the option of personal health budgets to more people, and NHS budgets become even more squeezed, the need to find solutions is becoming increasingly urgent.

The NHS Confederation led a workshop, in partnership with Think Local Act Personal, bringing together people with experience of addressing these issues, and leaders from the NHS and social care, to explore solutions and develop recommendations. This briefing sets out the learning from the workshop and signposts further evidence and practical support.

What are personal health budgets?

Personal health budgets are a way of enabling people with long-term conditions and disabilities to have greater choice, flexibility and control over the healthcare and support they receive, and to be more involved in discussions and decisions about their care.

A personal health budget is an amount of money to support a person's health and wellbeing needs, planned and agreed between the person and their local NHS team. At the centre of every budget is a care and support plan. This plan helps the person decide their health and wellbeing goals, together with their NHS team, and sets out how the budget will be spent. Once the plan is agreed, the money itself can be managed in different ways:

- a 'notional' budget with no money changing hands
- a 'real' budget held by a third party
- a direct payment to the person.

It is also possible to join together personal health budgets with personal budgets for social care so that people can have a more seamless experience.[3]

How to identify funding for personal health budgets

Commissioners have used a range of approaches to setting personal health budgets.[5] Each has advantages and disadvantages; there is no single approach that works best in all circumstances.

Bottom-up versus top-down

Approaches to setting indicative budgets can be categorised as either 'bottom-up' or 'top-down'.

A bottom-up approach uses details of the support required by the individual to meet their assessed needs, including the hours of care required, as the basis for costing (see the case study on page 4). One notable risk is that people who are less assertive may ask for less support and therefore be disadvantaged by this approach

A top-down approach means a person's needs can be assessed and an indicative allocation made based on what it would normally cost to meet these needs using traditional means. A significant drawback is that it can be harder to be flexible.

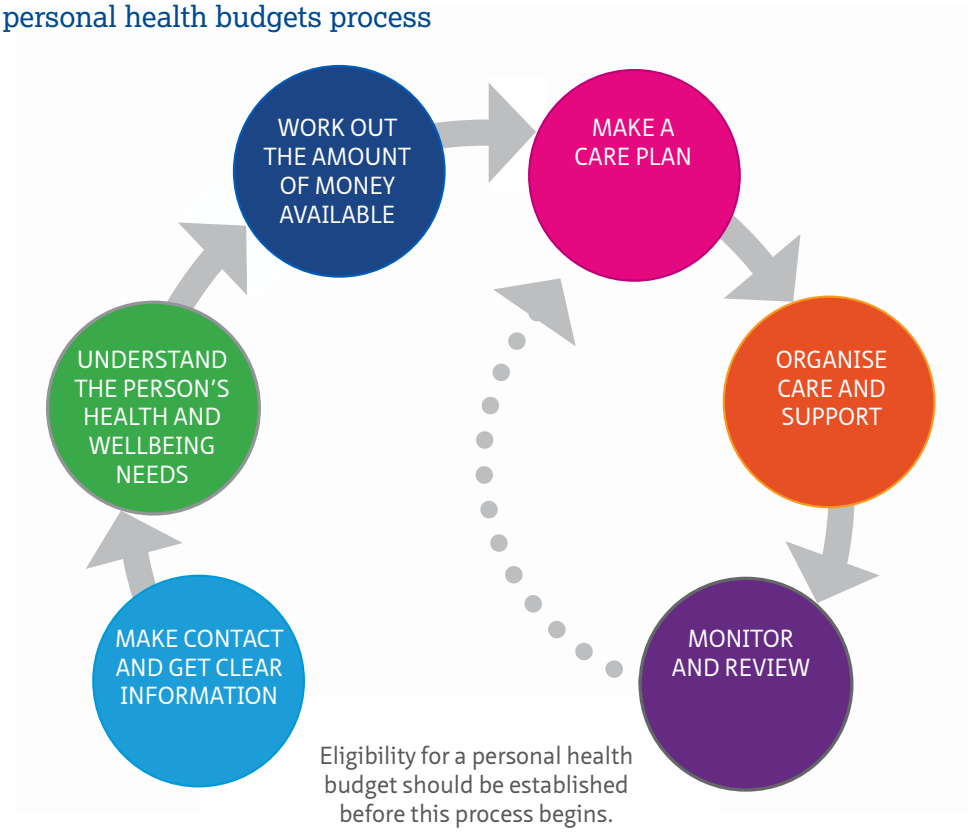
For example, in Northamptonshire, the process begins with top-down indicative costing and the actual budget is then developed bottom-up, based on the care plan (see case study on page 5).

Both bottom-up and top-down approaches have pros and cons. Commissioners should choose a single approach at the start and stick with it, so that staff and budget holders can be confident that people are treated equitably and avoid the additional cost of setting up multiple processes. It is vital that everyone involved is clear that indicative budgets are just that: the final amount is likely to be different once more detailed care planning has been done. Commissioners should ensure their approach to budget setting is transparent to individuals and families, so they know what to expect.

Beyond NHS continuing healthcare

NHS continuing healthcare covers all of an individual's care needs, encompasses a small group of people, and is already a clearly separate budget from the commissioner's perspective.

The steps of the personal health budgets process



Eligibility for a personal health budget should be established before this process begins.

Source: Department of Health

Case study: a 'bottom-up' approach for adults with NHS continuing healthcare

In Oxfordshire, a bottom-up approach to costing is used, based on individual assessed healthcare and wellbeing needs, both reflecting the requirements of the national framework for NHS continuing healthcare and being equitable between people who have personal health budgets and those who do not.

The approach begins with a conversation with the individual / their family about how best to support them, using the 12 domains in the NHS continuing healthcare assessment tool (Decision Support Tool). An indicative budget is developed, based on the weekly schedule of care and support needs identified. The indicative budget can also incorporate an allocation to enable the individual to access social and leisure outcomes, based on the allocation non-budget holders would have for the same needs. The final budget is adjusted to reflect the actual care needed as well as the individual's choice of whether to use agency carers or directly employ personal assistants.

Early support was sought from senior managers and commissioners, and with personal health budgets delivered from within continuing healthcare funding there were no surprises for those holding commissioning budgets.

Currently, services already commissioned via block contract from Oxford Health NHS Foundation Trust (i.e. physiotherapy and podiatry services) are not funded as part of individual personal health budgets as to do so would be inequitable to non-budget holders; however, people can still purchase these services themselves if they use the allocated budget creatively.

For further information, contact Anita Kromer, Oxford Health NHS Foundation Trust (**Anita.Kromer@oxfordhealth.nhs.uk**) or Suzanne Jones, Oxfordshire Clinical Commissioning Group (**suzanne.jones@oxfordshireccg.nhs.uk**).

Scaling up to offer personal health budgets to other groups will require the development of less time-intensive approaches to budget setting.

It will not be possible to develop perfect, sophisticated budget setting tools initially; local areas should not allow this to prevent them from starting to offer personal health budgets.[6] Learning from the pilot programme showed that good outcomes can be delivered without needing a 'perfect' budget setting tool. Partnership working with social care may also help. In Oxfordshire, the NHS and social care were able to use a shared process for making direct payments and establish joint framework agreements for direct payment support services.

Approaches to setting people's budgets should ensure that their needs for care and support and the health and wellbeing outcomes identified, rather than the budget setting tool itself, drive the assessment and allocation of funds. Conversations with individuals about what they want to do with their lives, what assets, skills and talents they have, and how they can best be supported can be challenging when putting budgets in place. Some standard questions for professionals to use can improve consistency in how decision making is shared, as well as consistency of the information used for costing.

Costing services

Commissioners may need a mixed approach of costing models to cover people with relatively common needs as well as those with very complex, high-level needs. Workshop participants suggested that for some groups the health service could use a tool similar to the resource allocation system tool used by local authorities, perhaps with a set of questions designed to capture individual needs. Providers and commissioners could also start by looking at which part of a long-term condition pathway a personal health budget covers, and the costs associated with that, as a way of starting to understand the money involved at a strategic level.

As they look at separating budget costs from within block contracts, commissioners should be prepared for the process of securing detailed costing information from providers to be difficult and time consuming. Providers may be concerned about commercial sensitivity, and for some services data is weak due to a lack of nationally agreed measures.

Commissioners and providers should aim to develop a shared understanding of what they are trying to achieve for people by implementing personal health budgets and how risks will be managed. The experience of the most advanced sites is that conversations between commissioners and providers need to start as early as possible – potentially, at least a year before the intended start date. Contracting levers may be helpful in securing access to data, although partnership approaches will offer the best way to develop and refine processes over time.

Improvements to information on the actual costs of healthcare – particularly in mental health and community services – will be important to support the implementation of personal health budgets. Current work at national level to develop more sophisticated approaches to costing relevant services will be crucial. The learning from developing patient level information costing systems (PLICS), the NHS Year of Care, capitated budgets, mental health clusters, new metrics for community services and learning and evaluation from Integrated Care and Integrated Personal Commissioning demonstrators should all be used to help improve the data available.

Ultimately, better data about the costs of providing services should help commissioners and providers find ways to reflect the potential impact of personal health budgets on the use of other services, and enable providers to move to a resource allocation system which is based on individual assessment of need (with PLICS as an enabler).

Case study: Using clustering to cost personal health budgets in mental health

In Northamptonshire, the clustering approach to costing mental health services, developed at national level, has been used as a basis for costing personal health budgets for long-term mental health conditions. An indicative budget is developed based on cluster costing (excluding crisis and inpatient care), with detailed care planning used to refine this.

Particular mental health cost clusters (8, 10, 17) represent high-cost and relatively long episodes. Given it takes time for demand for personal health budgets to grow, these areas characterised by long episodes were good areas to focus on offering budgets.

The indicative budget then develops into a final budget based on a detailed individual care plan. The care plan, rather than the cluster cost, is used to finalise the amount of the personal health budget, with the cluster cost serving as a sense check and predictor. A joint panel meets to discuss the plan; both the supporting clinician and the service users are encouraged to attend this. The panel is an opportunity to discuss and resolve any issues regarding health or financial risks.

For further information, contact Chris Williams, Northamptonshire Healthcare NHS Foundation Trust (**Chris.Williams@nhft.nhs.uk**) or Sarahlee Richards, NHS Nene Clinical Commissioning Group (**Sarahlee.Richards@neneccg.nhs.uk**).

"Mitchell's personal health budget has transformed the quality of his care, and helped us join up services. It has enabled us to build a skilled team around him, using the years of expertise we have developed."

Jo Fitzgerald, founder of the peoplehub personal health budgets peer network

As the NHS starts to build its understanding of what it should cost to deliver specific outcomes, this might in future facilitate a simpler model of costing personal health budgets. Given the broader importance of outcomes-based approaches in seeking to meet the needs of the growing number of people with multiple conditions and personalise care, this should be explored. We hope to see valuable learning from experiences of making elements of a capitated budget* available at an individual level for people who might benefit from personal health budgets, as part of the Integrated Personal Commissioning demonstrators.

Value for money

Areas that have experience of implementing personal health budgets have found large variations in what they are currently spending on care for people who could potentially receive personal health budgets. This makes it hard to determine the total sums of money involved in implementing personal health budgets. However, opportunities to secure better value from elements of the care package may develop.

In setting up monitoring and review arrangements to assure value for money and address the risk of fraud, commissioners will need to take particular care that their processes are proportionate, easy to understand and not overly bureaucratic for budget holders. Traditional processes and culture around assurance may make it very challenging for individuals to use personal budgets as a route to being fully involved in decisions about their care. Commissioners, in particular, will need to work with corporate functions that are particularly concerned with risk – such as finance, audit and IT – to build understanding of personal budgets and agree appropriate approaches to risk management.

Case study: Managing the costs of care agency support

Traditional care agency costs in Oxfordshire are very high compared to the costs associated with direct employment of personal assistants. A decision was taken early in the development of the local personal health budget offer, that hourly rates used to set individual budgets should reflect how individuals choose to be supported.

If an individual chooses to have their care and support provided by employing personal assistants rather than a care agency arrangement, the amount of money offered in the budget covers all the associated costs of employing staff, with the indicative hourly rate offered to personal assistants linked to:

- Agenda for Change pay scales for healthcare assistants and general nurses
- the National Minimum Wage
- local area research on hourly pay offered to care workers employed by care agencies.

Individuals who opt for care agency provision have an indicative budget based on average local care agency rates.

Newly eligible clients may already have care workers paid on different hourly rates, previously paid by self-funding or a social care personal budget; 'unpicking' these arrangements has been challenging. Personal assistant hourly rates are generally only adjusted to enable a transitional period or where there is evidence the client is unable to recruit personal assistants at the indicative rate.

Regular monitoring and review of care arrangements and assessed needs is essential to ensure that the personal health budget continues to work for the individual in the longer term.

* A capitated budget is based on the needs of an identified population, providing a per-person, average cost for a range of services over a fixed period of time. The budget generally covers all care for a group of people, including acute, community, mental health and social care costs.

Expanding personal health budgets without new money

System-wide benefits

The cost implications of implementing personal health budgets should be considered on a system-wide basis. Although personal health budgets start by offering individuals control of the same amount of money that would anyway have been spent on their care, they may lead to reduced costs elsewhere in the system (and from different organisations' budgets) due to improved outcomes. It is, however, currently extremely difficult to release such savings.

The 2012 evaluation of personal health budgets found a reduction in unplanned admissions and use of acute services among budget holders. In Oxfordshire, sustainability testing over three consecutive years in NHS continuing healthcare showed that the cost of funding personal health budget care arrangements, compared with traditional care arrangements, resulted in 16 to 19 per cent less expenditure (after costs for third party direct payment support services, support planning and on-costs were included).

Engagement between commissioners and a range of providers is needed from the start, to find ways to release the savings that could be generated by, for example, reduced use of acute care by people with personal health budgets. This will become more important as more people hold personal budgets and any resulting reductions in the use of services reach a scale at which it becomes possible to release savings. It may, however, be more challenging in the early years when uptake is slow. A joined-up approach across health and social care will be important to avoid any overlap in provision.

Commissioners will need to be aware that offering personal health budgets may, in some cases, generate additional demand, as needs that have not been met through the traditional offer are addressed. This is a good thing for the individual as it will improve their outcomes. It may well also avoid 'downstream' care costs, but it might nevertheless mean additional costs for some budgets. Commissioners should be mindful of this during the planning process.[7]

Stepped approach to implementation

Personal health budgets can mean significant financial risks for providers. Existing providers are often concerned about the extent to which personal health budget holders may choose to commission alternative providers, how fast this might happen and the implications for the sustainability of their services. If budget holders choose to commission away from the trust, the trust's income will be less than planned for, and as more patients take up personal health budgets these risks will increase. Commissioners and providers will need to work in partnership with individuals, carers and families to address the risks.

Stepped approaches to implementing personal health budgets (see case study on page 8) can be helpful by providing some certainty for providers in the early years, allowing confidence to grow, enabling a gradual approach to decommissioning any services that personal health budget holders decide to stop using, and allowing time to refine models of provision and costing.

For example, Northamptonshire Healthcare NHS Foundation Trust found its patient data did not enable it to separate the cost data for group contacts from the cost data for one-to-one contacts.[8] Per-contact prices based on the average of both would have artificially inflated the price of group contacts, making these very poor value from the perspective of budget holders. The trust, therefore, made a pragmatic decision to change the 'cost' of the group contact to 25 per cent of that of the average cost per contact. Although manageable while few people hold budgets, this would need to be revisited in order to be sustainable at large scale.

> "The personal health budget enabled me to organise my care and achieve what I wanted at home. Without it, I could not have got back so much use from my left side in the time that I have."
>
> Tom, 18, lost the use of his left side after a brain haemorrhage

Given that the uptake of personal health budgets is expected to rise gradually, it should still be possible for a stepped approach to have a pace of implementation that reflects the speed at which demand for personal health budgets grows.

However, the administrative processes and systems required are inevitably significant and this aspect may ultimately be more sustainable over a larger population. Commissioners and providers should also be aware that the administrative systems that can deliver personal health budgets at small scale may not suit large-scale delivery; future proofing is worth considering.

Case study: A stepped approach to unpicking a block contract

Commissioners in Leeds wanted to expand personal health budgets to children with long-term conditions, beginning with children eligible for NHS continuing healthcare. Most NHS support for children needing continuing healthcare was an integral part of a single community services block contract, which included a range of other services.

The CCG in Leeds needed to understand the breakdown of the current contract, including activity, to enable development of a unit cost to convert to a personal health budget. Limited service-line reporting and activity data was available, and the process of disaggregating costs and activity within the contract proved far lengthier and more complex than commissioners had expected.

In year one, the CCG guaranteed 80 per cent of the NHS continuing healthcare contract value, releasing 20 per cent to develop the personal health budget offer. Guaranteeing 80 per cent of the contract in year one addressed much of the provider concern about risk, at least in the short term. This enabled the CCG to move forward with personal health budgets while work was ongoing to refine understanding of unit costs and for the provider to understand how its services could change so that budget holders would want to continue using them. Further 20 per cent stepped reductions year on year are planned.

Over time, the CCG felt the conversation about personal health budgets had moved from provider wariness and resistance, to being able to work together to address the provider's fears and find ways to mitigate risks. The CCG felt they had initially needed to be very assertive in order to get the provider to engage, but further into the process both were clear that working constructively together would ultimately be key to successfully overcoming the challenges of implementing personal budgets.

For further information, contact Sue Bottomley (**s.bottomley@nhs.net**) or Brian Ladd (**brian.ladd@nhs.net**), Leeds South and East CCG.

"The process allowed us to look beyond the normal services that are available... the provision of reflexology to help Pat manage her depression and anxiety, in conjunction with the support and medication she received from her GP was most beneficial."

Sandra, chronic obstructive pulmonary disease nurse

The provider response

Adapting services to attract personal health budget spending

A key lesson learnt from personal budgets in social care is not to neglect the potential of existing providers to develop the new kinds of services people want and need. For providers, the development of relevant new services can help mitigate the risks associated with loss of income. For example, existing providers could make personal assistants available, perhaps in partnership with social care.

In Leeds, the existing provider of children's services has been asked to take on some of the assurance and governance support for individuals holding personal budgets. The CCG offered support to develop competency-based training and improve case management and the provider now 'flexes their offer' for families who choose not to have direct payments. The trust could potentially seek to win new business for this service. In Northamptonshire, patients wanted to access chronic obstructive pulmonary disease services closer to home, so the existing provider moved them from an acute setting into the community.

Providers will need to factor in the ways that new technologies are being used to help personalise care. For example, social care personal budgets are increasingly managed online and Skype is used more frequently for consultations. Frontline staff will need to be open to using technology in new ways in response to people's personal needs.

Service change at a strategic level may, in time, significantly reduce the costs of delivering particular types of support. For example, the development of care hubs has affected social care costs. In some cases, what people really want may be cheaper than what is currently provided. For example, enabling people to visit family members regularly may be cheaper and lead to better outcomes than paying for them to attend day centres.

Given that people usually choose to have a personal health budget because they want their care to be delivered differently, it is vital that providers embrace the change of culture and mindset that is required to personalise care, adopt shared decision making and facilitate people, families and carers to live the lives they want, rather than seeking to fix things for them.

Developing the market

The number of charity, social enterprise and independent sector providers of the kinds of services that budget holders want is limited. Where they do exist patients, families, carers and support staff may not be aware of all relevant alternative services.

It is not yet clear how the health service market might develop in response to the growth in personal health budgets, but experience of how the social care market has developed in response to personal budgets is instructive. This has included:

- a greater role for the voluntary sector
- a significant rise in the number of people employing care workers directly
- reconfiguration of day services towards community-based activities funded individually, rather than day centres
- a growth in marketplaces and online portals to help people navigate and purchase care and support.

Commissioners have much work to do to develop and manage the market locally, to enable people with personal health budgets to have choice. They will also need to consider and plan for the support budget holders may need, to services which meet their needs, and are safe and high-quality, for example, access to training and up-to-date information on all relevant services. It will also be important to encourage existing providers to adapt their 'offer' to better reflect people's needs and aspirations.

> "It is vital that providers embrace the change of culture that is required to personalise care."

Conclusions and recommendations

Personal health budgets are about a very different relationship between people and healthcare services in which people co-produce their care, to reflect the outcomes they want, in partnership with professionals. They should enable people, families and carers to reshape their own day-to-day care around their needs, aspirations and capabilities. Challenges to implementation include:

- supporting and equipping staff to engage with patients differently and share decision making
- ensuring technologies and innovation can be deployed to support patients as well as to enable the personal budget process
- addressing the financial risks associated with personal health budgets at a time of unprecedented financial pressure.

Skilled leadership is needed as well as practical solutions.

Whatever approaches commissioners and providers adopt, they must also enable people to make decisions in partnership with professionals, and take control of the right combination of services. Practically and culturally, this is a very different way of working.

The financial challenges for NHS commissioners and providers in implementing personal health budgets are huge and complex. We are a long way away from tried and tested solutions, but this briefing illustrates some successful approaches that have emerged.

Given that the financial risks are smaller while personal health budgets are at a relatively small scale, commissioners and providers should be able to jointly address financial sustainability issues sufficiently to start rolling them out gradually for people whose outcomes would improve. We must evaluate impacts and outcomes, so that we can learn from experience and improve approaches to implementation over time.

If personal health budgets are to lead to better experience and outcomes, three groups will need support: people with health and care needs, commissioners and providers. We make the following initial recommendations for commissioners, providers and national bodies.

Recommendations for commissioners and providers together

- Exercise local leadership – don't wait for national bodies to tell you exactly what to do about personal health budgets.
- Develop a shared understanding of the opportunity for personal health budgets to improve patient care and outcomes, as well as how risk will be managed. A collaborative, partnership-based approach is vital.
- Start discussing proposed approaches to implementation as early as possible.
- Stepped approaches to implementation can be very helpful in mitigating financial risk, allowing time to improve processes, services and costing, and build provider confidence.
- Discuss ways to release any savings generated through reduced need for some types of care.
- Consider developing incentives that reward providers for personalised care.

Recommendations for commissioners

- Don't wait for costing and processes to be perfect – instead, find ways to mitigate the risks of imperfect systems (such as stepped implementation). Stick with, and build on, one approach rather than switching between different approaches.
- Systems that can deliver personal health budgets at small scale may not suit large-scale delivery. Consider whether your approach can be future proofed.
- Work with local authorities to re-use and adapt processes that have already worked to implement personal budgets in social care, including direct payments.† There is no need to reinvent the wheel.
- Work with corporate functions that are particularly concerned with risk – such as finance, audit and IT – to build understanding of personal health budgets and agree appropriate approaches to risk management.
- Be prepared for market development to need a lot of work. The social care experience can be instructive here.

† Local authorities have had the option to make direct payments to service users since 1996.

Recommendations for providers

- Look to understand the risks to your organisation associated with expanded access to personal health budgets, and talk to your commissioners about how these can be managed. In particular, personal health budgets will mean some block purchasing is replaced by smaller scale contracts and people buying care directly.
- Consider the kinds of provision people with personal health budgets will want to purchase. People often want personal health budgets because they want their care to change, so if the existing provider can adapt to deliver the change they want, budget holders may well continue to use their services:
  - ensure you have effective ways to listen and respond to what people say they want and need
  - don't forget the role of technology.
- Take time to build trust and support culture change among clinical staff. It is important people understand personal health budgets are part of a wider, developing model of person-centred care with the potential to improve patient experience and outcomes, and that direct payments are not the only means of delivering a personal health budget.
- Review back-office systems and processes to ensure they don't get in the way of people making different choices and taking control.

Recommendations for national bodies

- Datasets for the types of care relevant to personal health budgets – particularly community-based physical and mental health – need to improve radically to help providers translate costs to outcomes.
- National bodies have a crucial role to play in facilitating the sharing of learning – including useful learning from a wide range of initiatives beyond personal health budgets and Integrated Personal Commissioning. This should include:
  - lessons on how to sustainably manage the transition to new models of care, including decommissioning
  - lessons on how to cost personalised care, for example, from the Long Term Conditions Year of Care Commissioning programme and the development of patient level information and costing systems
  - developing learning on how to cost community-based care, including how to disaggregate costs within block contracts and how to cost for outcomes
  - emerging evidence on the pros and cons of different approaches to setting up personal health budgets.
- National bodies which hold commissioners and providers to account must clarify how they will allow for the risks associated with personal health budgets. Commissioners and providers want to feel confident that they will not be unduly penalised if budget holders make choices which lead to less good clinical outcomes (these choices may reflect other outcomes people wish for). Commissioners may also be concerned about meeting their legal duty to make arrangements to monitor and improve the quality of care where budget holders choose a wide range of small providers that the CCG does not normally commission; guidance on this area would be helpful.
- National bodies should enable commissioners and providers to better plan for personal health budgets by articulating the relationships between personal health budgets and other major initiatives to support personalisation. In particular, the interface between relevant local authority and NHS processes (including the new duties in the Care Act 2014 and education, health and care planning) and the potential implications of the Better Care Fund and outcomes-based commissioning for personal health budgets. They should also set out clearly the levers that are available to local leaders to put personal health budgets in place.
- National leaders must make publicly clear their genuine and sustained commitment to personal health budgets. They must also actively challenge misperceptions and misleading media coverage about 'inappropriate' spending. Local leaders who are just starting to implement personal health budgets must not be left to deal with this alone.

For more information on the issues covered in this briefing, contact **kate.ravenscroft@nhsconfed.org**

Useful resources

Personal health budget information and news on the NHS England website (**www.personalhealthbudgets.england.nhs.uk**).

NHS Confederation resources on personal health budgets (**www.nhsconfed.org/health-topics/integration/personal-health-budgets**).

Think Local Act Personal web pages on self-directed support and personal budgets (**www.thinklocalactpersonal.org.uk/selfdirectedsupport**).

Resources on personal budgets for children and young people with special educational needs and disabilities are available from the **SEND Pathfinder** website.

References

1. NHS England (2014) ***Forward view into action: planning for 2015/16***.
2. NHS England (2014) ***Integrated personal commissioning prospectus***.
3. NHS Confederation (2012) ***Joint personal budgets: a new solution to the problem of integrated care?***
4. Nuffield Trust (2013) ***Personal health budgets: challenges for commissioners and policymakers***.
5. Cattermole et al, (2012) *How to set budgets – early learning from the personal health budget pilot*.
6. Department of Health (2013) ***Personal health budgets guide***.
7. For more detail, see Audit Commission (2012) ***Making personal health budgets sustainable***.
8. ***Personal health budgets for mental health: the experience in Northamptonshire***.

The NHS Confederation

The NHS Confederation is an independent membership body for all organisations that commission and provide NHS services; the only body that brings together and speaks on behalf of the whole of the NHS.

For more information, visit **www.nhsconfed.org**

Think Local Act Personal

Think Local Act Personal is a national partnership committed to transforming health and care through personalisation and community-based support. The partnership brings together people who use services and family carers with central and local government, the NHS, major providers from the private, third and voluntary sector and other key groups. TLAP works closely with members of the National Co-production Advisory Group – a network of people with lived experiences of care and support.

For more information, visit **www.thinklocalactpersonal.org.uk**

Acknowledgements

With thanks to Emma Knowles at Healthcare Financial Management Association, Martin Cattermole at NHS England and Sam Bennett at the Social Care Institute for Excellence for reviewing.

NHS CONFEDERATION

Further copies or alternative formats can be requested from:

Tel 0870 444 5841
Email publications@nhsconfed.org
or visit www.nhsconfed.org/publications

Registered Charity no: 1090329
Stock code: BRI028101

NHS Confederation
50 Broadway London SW1H 0DB
Tel 020 7799 6666
Email enquiries@nhsconfed.org
www.nhsconfed.org

Follow the NHS Confederation on Twitter @nhsconfed