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How to set budgets – early learning from the personal health budget pilot

Personal health budgets

A personal health budget is an amount of money to support a person’s identified health and wellbeing needs, planned and agreed between the person and their local NHS team. Our vision for personal health budgets is to enable people with long term conditions and disabilities to have greater choice, flexibility and control over the health care and support they receive.

What are the essential parts of a personal health budget?
The person with the personal health budget (or their representative) will:

- 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 plan

How can a personal health budget be managed?
Personal health budgets can be managed in three ways, or a combination of them:

- Notional budget: the money is held by the NHS
- Third party budget: the money is paid to an organisation that holds the money on the person’s behalf
- Direct payment for health care: the money is paid to the person or their representative

The NHS already has the necessary powers to offer personal health budgets, although only approved pilot sites can currently make direct payments for health care.

What are the stages of the personal health budgets process?

- Making contact and getting clear information
- Understanding the person’s health and wellbeing needs
- Working out the amount of money available
- Making a care plan
- Organising care and support
- Monitoring and review
1 Introduction

This good practice guide is aimed at people working in the NHS who are implementing personal health budgets. It brings together learning from the personal health budgets pilot programme on how the amount of a personal health budget can be decided.¹

By April 2014, people eligible for NHS Continuing Healthcare will have the right to ask for a personal health budget, including a direct payment for health care. The NHS will also be able to offer personal health budgets beyond NHS Continuing Healthcare – for example to people with long term health conditions or people with mental health problems.

This guide provides advice and practical examples on setting budgets for people with long term conditions, people with mental health problems, and those who have both health and social care needs.

A separate document provides more detailed advice on setting budgets for people eligible for NHS Continuing Healthcare.²

This guide also gives examples of how personal health budgets relate to other relevant policy initiatives, such as payment by results.

Along with this guide, we have published other good practice guidance that gives more information on the overall approach to personal health budgets, including aspects such as care plans and managing risk. These materials are available from the personal health budgets toolkit: www.personalhealthbudgets.dh.gov.uk/toolkit
2 Personal health budgets for people with long term conditions

Personal health budgets promote a more effective and equal relationship between NHS professionals and people who use the NHS. They will work well only if they lead to everyone making changes in their thinking, feeling and behaviour. This requires changes of role for people, health professionals and commissioners.

Personal health budgets are about moving to an outcome-focused way of working that looks at what people want to achieve, rather than focusing on what services the NHS currently provides.

Personal health budgets are closely linked to other initiatives that aim to promote self-management and to change the relationship between people and health care professionals. Examples include the Year of Care initiative for people with diabetes, and Co-creating Health.

The pilot sites have implemented personal health budgets with a wide range of people, and most sites have done so with people eligible for NHS Continuing Healthcare. Some sites have developed joint budgets for people who have both social care and health needs.

Pilot sites have also offered budgets to other groups, including people with:
- long term conditions (eg chronic obstructive pulmonary disease or diabetes)
- stroke
- acquired brain injury
- mental health problems.

The Audit Commission highlights the potential for personal health budgets to provide more person-centred, joined-up approaches for people with long term conditions and for others with substantial health needs. This could reduce the use of NHS services and unnecessary hospital admissions:

Many people with a long term condition have co-morbidities. They see all their care needs as a whole and don’t divide them into primary, secondary and tertiary care; or health and social care; or disease group. Personal health budgets allow them more scope to choose what services they receive, from whom, and when. This control enables them to become participants, rather than recipients, and improve the quality of their lives by making care more accessible and responsive. By getting it right, there is less need for crisis management and more likelihood of improved outcomes, which can deliver real system level savings for the NHS.
3 Implementing personal health budgets well

It is essential to work with frontline practitioners, clinicians, managers and people with lived experience to build support for personal health budgets. Personal stories are an effective way to demonstrate the benefits of personal health budgets. It is also important to build peer support networks that connect people to others who have a personal health budget.7

Personal health budgets are a major change to the way the NHS works. The process of implementing personal health budgets is likely to challenge current ways of working, and to highlight issues and concerns that will need to be overcome.

When setting budgets, it is important to keep in mind the purpose of personal health budgets. It is good practice to design systems that promote choice and control, and that are simple and streamlined both for people using the NHS and for staff. There is a risk of submerging staff and personal budget holders in paperwork, including multiple assessments. Instead, the focus should be on understanding the person’s health and wellbeing needs and on care planning.
4 Issues and challenges in setting budgets

People may choose to meet their needs in very different ways from those traditionally on offer. It is important to encourage a positive attitude to enable people to make choices, balanced with the duty to have proper arrangements in place to protect people. It is important to ensure people have access to information to enable them to make decisions.

As we begin to develop personal health budgets and put them into practice, issues and concerns will arise. Experience in pilot sites has shown that the NHS can be extremely risk-averse, with a tendency to maintain existing service patterns and ways of working.

There is also likely to be resistance to changing established systems for assessing need, allocating people to services, and managing spending. The process of developing ways to set personal health budgets can bring these issues to a head.

It is important to avoid these concerns being used as reasons to impose restrictions that limit choice and control – for example, by not telling people the value of their budget, or by restricting the use of the budget to services that are already commissioned. There is little point in offering personal health budgets unless people can use their budget in new ways that are right for them. This will mean changing the way services are commissioned, so that money is no longer tied up in block contracts. The personal health budgets toolkit contains detailed advice on market development.

It is also important to avoid personal health budgets being seen as a cost-saving exercise. Personal health budgets are likely to be cost neutral and a way to get better value from the money the NHS already spends. The budget should always be sufficient to meet the outcomes agreed in the care plan.

Implementation is likely to work better if it is based on an objective approach to managing financial and other risks. The Audit Commission has worked with pilot sites to produce a report on financial sustainability, which discusses the principal financial risks that can result from implementing personal health budgets, and ways to manage those risks.
5 How to set budgets

Who can have a personal health budget?

The government’s aim is that in future, everyone in England who could benefit will have the option of a personal health budget. This commitment includes parents of children with special educational needs and disabilities. By April 2014, people eligible for NHS Continuing Healthcare will have the right to ask for a personal health budget, including a direct payment for health care.

The steps of the personal health budgets process

- Making contact and getting clear information
- Understanding the person’s health and wellbeing needs
- Working out the amount of money available
- Making a care plan
- Organising care and support
- Monitoring and review
The NHS will also be able to offer personal health budgets beyond NHS Continuing Healthcare – for example to people with long term health conditions or those with mental health problems.

Personal health budgets should be available to anyone who is eligible. It is important to avoid assumptions that some groups of people can’t benefit from a personal health budget.

The public sector equality duty introduced by the Equality Act 2010 requires public sector organisations (and others performing public functions on their behalf) to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good community relations in everything they do. In practice, this means providers need to understand how different people will be affected by their activities, so that policies and services are accessible to all and meet different people’s needs regardless of their age, disability, gender, race, sexual orientation, gender reassignment status, religion or belief, marriage and civil partnership or pregnancy and maternity status.

**When should the budget be decided?**

The stages of the personal health budgets process are shown in the diagram on page 8.

The decision on whether a person is eligible for a personal health budget should come before the process of setting the budget.

The third step in the process is to work out the amount of money available – the indicative budget.

**What is an indicative budget?**

An indicative personal health budget (also known as an indicative budget) is an amount of money identified at an early stage in the process to inform care and support planning. It is a prediction – a best guess – of how much money it is likely to cost to arrange the care and support that would be sufficient to meet the assessed health needs and achieve the outcomes in the care plan. The indicative budget is a guide – it should not be used as a limit, a fixed allocation or an entitlement. The indicative budget does not need to be exact, and in practice it is difficult to design a tool that will predict the costs of support accurately.

*Most approaches to setting budgets are accurate in no more than about 80 percent of cases. It is always advisable to have some built in flexibility … to ensure that commissioning organisations can satisfy their legal duties to ensure that people have adequate resources.*

**What is a final budget?**

The final personal health budget (also known as a final budget) is an amount of money that is agreed once a care plan has been written.
This is usually calculated by estimating the costs of the care and support arrangements included in the plan. This is likely to be a more accurate guide to the actual costs of support. The final budget – rather than the indicative budget – is the point at which an approval process is needed.

For most people, the final budget will be higher or lower than the indicative budget, and in some cases this difference may be significant.

**What should be included in the budget?**

The care plan should focus on the person’s whole life, not just their health needs. The situation of the person and their family should be explored, and carers should be offered an assessment of their own needs.

Personal health budgets are intended to promote a holistic approach to health and wellbeing. It is good practice for the budget to cover the full range of health needs over which the person wants to take control.

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**Pat’s story**

*Sandra, a COPD nurse, discussed my health needs with me and an assessment was carried out. Sandra also visited me at home, when we talked about how I could manage my symptoms and improve my general health and mental health. With Sandra, I drew up some health objectives. These included being able to walk to my local bus stop within the next 12 months, treating my depression, losing one stone within six months and increasing my confidence. I was granted a personal health budget, which was used to buy an exercise bike and complementary therapies to help with my anxiety.*

*I have dry legs with bad circulation and the reflexology, which helps relieve my anxiety around my breathlessness, has also helped my circulation. Sandra has been fantastic throughout the whole process of organising my personal health budget. Before I met Sandra, I didn’t have anyone to talk to about my depression. But Sandra was that person. She’s been unbelievable. The help and advice she gave has turned my life around. She realised I was depressed and advised me to see a GP, who prescribed medication. This has really helped. I can now walk to my local bus stop, and my confidence is so much better. The next thing is for me to lose more weight. Overall, my physical and mental health has improved dramatically.*
A person’s health condition will in itself give little or no indication of their overall health needs, or how much will be needed in a personal health budget. Using an approach to budget setting that focuses on only one condition could lead to people undergoing multiple assessments.

Pat from Birmingham, aged 64, has chronic obstructive pulmonary disease (COPD) Her story (see the box on page 9) shows how this holistic approach can work in practice.

This is particularly important where people need a high level of health care and may have many professionals involved in their lives.

In some pilot sites, the scope of a personal health budget has been restricted to only include personal care, leaving the clinical aspects of the … package to be delivered by traditional NHS services. This was largely done as a compromise to ensure that the pilot could move forward, given the scale of cultural change that personal health budgets require.

NHS Continuing Healthcare staff were more comfortable with individual choice and control for personal care than for more clinical types of care. However, by limiting the scope of a personal health budget in this way, individuals experience choice and control in some aspects of their life but not in others which can make it difficult for them to realise their goals. For example, an individual may hire his own personal assistants to get him up in the morning so he can get to work on time but will have no control over when the district nurse comes to change his dressings, making it challenging to hold down a job.\(^{11}\)

Carers

Carers provide a substantial amount of support to many people who receive personal health budgets. The government strategy for carers emphasises the need to take an approach that considers the whole family:

Personalisation can provide individuals, carers and families with more choice, more control and more flexibility in the way that care and support are provided.

Personalisation and a whole-family approach are complementary – it is important to look at a family’s needs as a whole but also to make sure that individual carers’ and users’ views are sought and cultural expectations are clarified when considering how best to support a family. No assumptions should be made about a carer’s ability and willingness to care.\(^{12}\)

It is very important that the situation and needs of carers are fully assessed. Carers need to be able to continue working, stay healthy, and be able to meet other family responsibilities, including having a break from caring. Outcomes for carers could be included in the care and support plan, and the level of the personal health budget should take these needs into account.
One-off personal health budgets

There are some circumstances where it may make sense to offer smaller, one-off personal health budgets that replace a specific aspect of treatment, or complement other services. For some people, small one-off budgets may be a very effective way to take control.

For example, a person experiencing depression who would normally be offered cognitive behaviour therapy might opt instead for a one-off personal health budget, agreed in their care plan, which they could use to pay for therapy. But if, for example, the person continued to be visited by a community psychiatric nurse, those visits would not have to be paid for out of their personal health budget.

Whatever the size of the budget, the care plan should be holistic, covering all aspects of the person’s health and wellbeing.

Razia from Merseyside, aged 32, used her personal health budget to purchase a computer, enabling her to study at home.

Razia’s story

I was referred to a mental health service specialising in helping people in my situation and offered anytime access to the service, but because of travel costs I could not go.

I had meetings with an independent health broker. Their job is to support people to decide the best way personal health budget funds can be used to meet a person’s needs. Together, we discussed what would help me, and what would improve my mental health. We decided a laptop would be of benefit, as it would mean I could stay in touch via email with my family.

I also enrolled on a foundation course at a local college where I am studying ‘Prepare to teach in the lifelong learning sector’, which covers the basics of teaching in adult education.

I have to travel a lot but was finding it too expensive, and travel time extremely lengthy and complicated. I also attend counselling on a weekly basis with an Urdu-speaking counsellor specialising in helping people who had suffered domestic violence, and I go to hospital for physical problems related to the domestic abuse I suffered. To get to college I had to travel weekly by bus – a return journey of more than three hours – and I need to get to mosque. So it was decided that a bus/train pass would be really important to enable me to get to all these places. The pass enables me often to take one train instead of many – and slower – buses.

The personal health budgets for both the laptop and bus/train pass were one-off direct payments. They are of such help to me in building a new life, following the trauma and upheaval of the last 18 months. Being able to stay in contact with my family and keep up to date with my studies is so good. It’s keeping me sane, really! And without the bus/train pass I would not be able to access the support that is helping me recover and move on.
and also maintain supportive email contact with her family. A bus/train pass ensured she could attend vital appointments with mental health professionals (see box on page 12).

Section 6 of this guide gives practical examples of how pilot sites have set one-off budgets.

What should be excluded from a personal health budget?

The costs of some aspects of health care should not be included in a personal health budget:

- emergency or unplanned care
- medication, prescriptions and other chargeable services
- most primary care services, such as visiting a GP.

It is not practical to include acute treatment such as surgery, and other needs that cannot be anticipated, in the costs of a personal health budget. However, part of the purpose of the budget may be to reduce or avoid the need for hospital admissions.

What if the costs are not known?

In the NHS it is not always easy to measure costs. In practice it may be difficult to calculate the costs of the services people use at a personal level. The work carried out by pilot sites shows that it is not practical to set and monitor budgets based on actual use of NHS services. This information is not currently available in most places, and is subject to variation over time as people’s needs change. Indicative budgets need only be approximate, and it is acceptable to use typical costs to calculate them.

What if the person’s needs change?

Many people with long term conditions have health needs that fluctuate. This can be addressed by reserving an amount of the budget for contingencies, or including planning for fluctuating needs in the care plan. It is impossible to plan for all situations, and it is important to take a flexible approach.

How have budgets been set in practice?

In the personal health budgets pilot, sites tried out a wide variety of ways to set budgets:

- costed care package
- banding scales based on NHS care pathways
- costing previous use of NHS services
- flat-rate, one-off budgets
- joint health and social care budgets
- payment by results
- outcome-based budgets.

Section 6 gives brief details of each approach, illustrated by examples from pilot sites. The table on page 13 lists some criteria to consider when deciding what approach to use locally. No approach to setting budgets is likely to meet all these criteria.
<table>
<thead>
<tr>
<th>Feature</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Up-front</strong></td>
<td>Enables people to know at the start of the process how much money they have to plan with.</td>
</tr>
<tr>
<td><strong>Transparent</strong></td>
<td>Makes it clear how the budget has been calculated; the method is objective and fair.</td>
</tr>
<tr>
<td><strong>Enabling choice and control</strong></td>
<td>Allows people to take control and choose how best to meet their needs, and does not introduce restrictions. Can work whichever option the person chooses (notional budget, third-party arrangement, direct payment).</td>
</tr>
<tr>
<td><strong>Outcome-focused</strong></td>
<td>Moves away from the medical model to be based on outcomes, rather than hours of support or other inputs.</td>
</tr>
<tr>
<td><strong>Holistic</strong></td>
<td>Covers all health and wellbeing needs, enabling people to control all or most of the money spent on their health care.</td>
</tr>
<tr>
<td><strong>Light touch</strong></td>
<td>Keeps it simple for the budget holder and for frontline staff, without lots of paperwork.</td>
</tr>
<tr>
<td><strong>Scalable</strong></td>
<td>Is simple to put into practice for large numbers of people.</td>
</tr>
<tr>
<td><strong>Flexible scope</strong></td>
<td>Could be used with many types of people; does not focus only on people with a particular health condition.</td>
</tr>
</tbody>
</table>
6 Practical approaches to budget setting

Costed care package

At the start of working out the care plan, the person and a practitioner together work out a rough estimate of the cost of their package, based on how many hours of home care support they might need, along with any other items such as equipment. This is used as an indicative budget to help develop a full plan. The budget is adjusted as the plan is worked out.

This approach can work well for people who need a high level of hands-on care and support. The budget could be set to cover a wide range of needs, and also take into account the amount of informal support available. However, there is a risk that it could encourage a focus on hours of support rather than outcomes. It could not easily be applied to people who don’t need personal care, or who have conditions that fluctuate.

Example: Oxfordshire

NHS Oxfordshire has developed an indicative budget setting model based on developing an initial outline of the care and support arrangement required to meet the person’s assessed needs. The elements of the package are then costed using a spreadsheet to reach an indicative budget. The final budget is agreed once the care and support plan has been developed more fully.

NHS Oxfordshire is offering people in receipt of NHS Continuing Healthcare a personal health budget. The indicative budget setting process began by figuring out the average rates for local care agencies, and carrying out local area market research into average pay rates for home care workers and personal assistants.

For example, if a person needs 30 minutes of double-handed care twice a day, multiply by two the average hourly cost of care by a personal assistant or care agency to give a daily rate.

It became apparent that personal health budgets needed to include more than just the cost of care, and other elements were added to the spreadsheet to calculate the overall budget, such as:

- different rates for waking and sleeping nights
- different rates for bank holidays and weekends
- funding to purchase supplies such as gloves and aprons
- funding to train personal assistants
- other start-up costs such as advertising for staff, employer and public liability insurance.
A budget also includes money to help people live their life: eg reasonable expenses for a personal assistant on a day out, or costs to attend a day centre.

Personal health budgets have some flexibility to reflect local circumstances: eg personal assistant costs for clients living in rural areas may be higher than in a town centre.

All funds included in the final weekly budget must be linked to an agreed outcome in the client’s support plan.

The indicative budget form is broken down into the following areas:

- care agencies
- employed staff
- annual charges and start-up costs
- other care and support.

Budget setting is a dynamic process, and NHS Oxfordshire is currently on the sixteenth version of its budget setting spreadsheet. So far 39 people have been offered personal health budgets based on this approach, and it is working very well to help people purchasing care and support to meet their needs.

**Banding scales based on NHS care pathways**

This approach is used to develop budgets for people who have a specific condition, based on the cost of the typical care pathway. The process starts by identifying the costs of the services used by a sample of people over the past year, or the typical cost for the services normally provided. The second step involves developing a banding scale to rate the person’s level of need for care and support: a simple scale could be high, medium and low need. Each band can then be linked to a cost. People are assessed on the banding scale and given an indicative budget.

This approach has the potential to enable a person to take control over most or all of the money spent on their care and support. However, it is usually based on an assessment of the person’s level of functionality and the severity of their condition, which is often based on what they are unable to do. It is not linked to the outcomes that are important to the person.

The banding scale will work for only one condition or pathway, and does not look at the person’s health needs as a whole. The budget may also need adjusting if the person’s condition fluctuates, and depending on the level of informal support available.

For people eligible for NHS Continuing Healthcare, a national framework is in place that includes a decision support tool. But using this banding approach for other groups could require new forms of assessment to be developed and agreed nationally. Work is under way to develop a Year of Care tariff for people with long term conditions, which may provide a basis for this.
Example: Manchester

NHS Manchester has developed a banding scale based on the decision support tool for NHS Continuing Healthcare. The tool has been tested with around 60 people across six pilot sites. It works by estimating the costs of providing a conventional home care package which could be expected to meet the needs identified using the decision support tool. This tool uses the levels from the NHS Continuing Healthcare decision support tool, and the hourly rates for home care being paid locally, to estimate the cost of providing support using a conventional home care package. An adjustment is also made for support provided by carers, and the tool allows an amount to be added to reflect carers’ needs.

The tool has been tested in Oxfordshire, Somerset, Hull and Nottingham. This work has shown that the costs of care and support vary substantially between English regions and also between city and rural areas. In particular, this is the case for services, such as home care, that are provided by independent organisations.

Example: Avon, Gloucestershire, Wiltshire and Somerset cardiac and stroke network

In Swindon, Wiltshire, Gloucestershire and Somerset, personal health budgets have been offered to 116 people following a stroke. The aim was to help people with their recovery from a stroke, and improve health and wellbeing for the person and their family.

To develop a budget setting tool, the head of finance and the finance lead in one primary care trust looked at the actual costs for a sample of 51 people. They identified the cost of services, used over a two-year period following a stroke, that were related to the stroke (other services such as podiatry were excluded). In addition, the level of need for each person was rated as mild, moderate, severe or very severe, depending on the level of impairment and prospects for recovery. This allowed average costs to be calculated for each level of need. These costs were used as the basis for a budget setting tool.

People offered a personal health budget in the pilot were assessed to decide which of the four bands should be used for budget setting. The budget was then used to help to produce a care plan. However, everyone in the pilot had a notional budget, so the budget needed to be used on services or equipment that the NHS was able to procure.

There was some useful learning from this approach:

- the tool provided a quick, simple way to calculate a budget
- it helped make costs clearer, enabling people to choose how to use their budget.

However, there were also disadvantages:

- it took a lot of work to gather the data on costs and it was not always clear what should be included
some budgets were too low or too high and needed to be adjusted – in particular the tool took no account of carers’ needs, or the degree of support provided by informal carers, which could make a big difference to the amount of formal services needed

some people recover more quickly than others, and both the budget and the care plan needed to be changed regularly

the needs scale was based on judgment as there is no national assessment for stroke.

The stroke network has begun developing a new tool based on the decision support tool for NHS Continuing Healthcare. This requires a multidisciplinary assessment, with the person’s needs rated on each of 12 domains. This is used to identify the person’s level of need on a five-point scale of bands. It is intended that the tool should also take into account other health conditions and the needs of informal carers.

Costing previous use of NHS services

This approach to budget setting is based on calculating the whole cost of the services used by a person in the past 12 months, and using this to set the budget. Use of primary care and emergency services is excluded.

This approach was used in one pilot site that had access to very good information about use and costs of services at the personal level. This information proved very useful to other pilot sites, but it was evident that in most places it is currently very difficult fully to cost the use of NHS services in this way. Also, a person’s future needs may not be closely related to their past use of services. In practice such a system could be very complex to implement.

Example: Torbay

In Torbay, personal health budgets have been offered to people with a wide range of long term conditions, including people with Parkinson’s disease, multiple sclerosis, epilepsy, acquired brain injury and stroke.

In the pilot, personal health budgets were developed by Torbay Care Trust – an integrated health and social care trust. The trust has an information system called Mede, which records all use of health and social care services at an individual level. This enables managers to calculate the actual costs of services for people offered personal health budgets. This provides very useful and detailed data, unavailable in other sites.

People in Torbay were not provided with an indicative budget. As part of the support plan, information about their spend on health and social care services in the past 12 months was made available and discussed. This enabled more informed decision making regarding health and care support to identify whether goals and outcomes were being achieved and, if not, how a personal health budget may be used to achieve them. This information was used to help understand if outcomes were
already being met through social care funding, to avoid funding the same needs twice. In some cases this has meant that personal health budgets are not required. Other people have been offered small, one-off personal health budgets. It has proved possible to reduce costs for some people – for example by providing rehabilitation at home rather than in a specialist residential service.

Example: Bedfordshire

In Bedfordshire, personal health budgets have been offered to people who have survived a stroke, or have multiple sclerosis or Parkinson’s disease. To be eligible, people had to receive an NHS service such as physiotherapy, occupational therapy or speech and language therapy.

Initially budgets were based on the value of a person’s current therapy. For example, if a person was due to receive three sessions of physiotherapy each week for the next 10 weeks, and it cost NHS Bedfordshire £30 per session, then their budget would be calculated at £900.

However, in practice with long term conditions it is impossible to predict what services a person will need in the future. So, although this method could be useful, the person would need continuous reassessments to provide additional funding if their needs change. The time this would take could make this an impractical option.

Example: Teesside

In Teesside, personal health budgets have been offered to people with chronic obstructive pulmonary disease (COPD) or long term neurological conditions, people in receipt of NHS Continuing Healthcare, and people with long term pain.

At the start of the pilot, NHS Tees calculated indicative budgets by costing each person’s use of NHS services over the previous 12 months, excluding primary care and emergency admissions. This approach was very time consuming and could not be sustainable when personal health budgets are rolled out.

NHS Tees is looking at other ways to set budgets. One option is to offer a flat-rate budget based on average costs – for example, £800 per year for a person with COPD.

Joint health and social care budgets

Some pilot sites have offered joint budgets to people eligible for social care who also have health needs. This has been on a small scale, and each site has taken a different approach. For example, the personal budget for social care can be calculated by the council, while the NHS carries out an assessment of the specific health needs and estimates what would normally be spent. This amount is added to the personal care budget to make a joint budget.
Another option is to develop a joint budget setting system that looks at the whole of a person’s needs and calculates a budget. The NHS and the council then agree how to share the cost, depending on the extent of the person’s health needs.

In principle, these approaches could enable the whole of a person’s care and health needs to be included in a single plan with a single budget. In practice, sites are still at an early stage of looking at ways to set joint budgets. The approaches to budget setting used so far could be difficult to scale up. The budget could change frequently for people whose condition fluctuates, or whose health improves so that they are no longer eligible for the health component of the budget. The social care part of the budget is means tested, while NHS care is free – so it is important to have a clear basis for identifying the NHS contribution. These issues mean that the process is likely to involve extra steps for the budget holder and for staff. There is a risk that health and social care needs are separated rather than looking at the person’s needs as a whole.

Example: Oxfordshire

In Oxfordshire over 300 people now have joint health and social care budgets, with many having a significant contribution from the NHS to their care. Social services carries out an initial assessment and at the same time checks whether the person has any health needs. If so, social services makes a referral to the NHS shared care team.

The primary care trust has developed a list of delegated health tasks, which can be funded by the NHS. This has five levels according to the level of skill required. The time taken to complete each task is calculated and converted into a cost. Based on the health needs identified in the assessment, this is used to calculate the NHS contribution to the joint budget. This can be made as a direct payment, in addition to the social care personal budget. The NHS funding may be time limited – eg support with taking medication for six weeks.

Example: Nottingham

In Nottingham, if a person is assessed as eligible for a jointly funded support package, the council and the NHS use the social care resource allocation system to calculate a total indicative budget. A support plan is written around this indicative budget, including input from a lead clinician.

The support plan is then submitted to the health and social care panel, which decides what percentage of the total package should be funded by health. This share is set on a case-by-case basis, taking account of the extent of the health needs identified in the assessment. This has worked on a small scale, but would not be ideal if more people take up joint budgets.

Flat rate, one-off budgets

People are offered a relatively small personal health budget up to a fixed maximum amount. The money may be given for a
specific purpose. For some people the purpose may be to promote recovery; for others it could be a preventive measure. The person continues to use mainstream NHS services, although part of their plan may be to reduce their reliance on these services.

Alternatively, the budget can be set to match the cost of a specific treatment or service, such as a course of therapy that the person would normally be offered. The person can then choose whether to take the service or to use the budget in a different way.

This approach has been tried in mental health services, and can fit well with the recovery model. However, it could also work for other people. It has the potential to enable people to achieve a much wider range of outcomes, such as education, work and reducing social isolation, which could reduce their need for NHS services. While the approach provides a simple way to set budgets, it can be put into practice on a large scale only if some money is released from mainstream services. There is a risk of increased costs if some people continue to use mainstream services in addition to the budget. The approach does not enable people to control all the resources spent on their support.

Example: Merseyside

In Merseyside, people with mental health problems have been offered personal health budgets as part of the pilot programme, which covers the areas served by Liverpool, Knowsley and Sefton primary care trusts. Mental health services in these areas are provided by Mersey Care NHS Trust.

This builds on an initial pilot initiated by Mersey Care NHS Trust, which offered individual recovery budgets to service users in the early interventions in psychosis service. Over 150 people have been offered one-off individual recovery budgets of up to £400.

A voluntary organisation, Imagine16 provides support planning and brokerage to people who have been offered a personal health budget. An advisor from Imagine spends time with each person and their family, to help them to think through what they want to achieve and how they might go about doing it. The support plan is then discussed and agreed with a health professional such as the person’s community psychiatric nurse, social worker or occupational therapist.

People define their own health and social care outcomes (what in their view will contribute to their recovery and keep them well), and the intended outcomes are recorded in the care plan. As long as the money is used in ways that are legal and safe, it can be used in any way that makes sense to the service user.

One-off recovery budgets have been used to help people get back to work, for education and training, for holidays and for other leisure activities. The money has been used in ways that are very different from conventional NHS services, but that have enabled people to achieve goals directly linked to better mental health and rebuilding their confidence. Items bought include bus passes, singing lessons,
art classes, equipment to start a business, fishing tackle, garden tools, laptops, computers, gym membership, short breaks, relaxation sessions and bikes. Six service users pooled their money to set up an allotment using vouchers for a local gardening centre.

Example: NHS Outer North East London

In the pilot, personal health budgets were offered to people with COPD, diabetes and stroke. It proved difficult to release money from existing services to provide funding for personal health budgets, so a separate fund was created. The budgets were set without reference to the usual costs of services or the person’s previous use of services. Instead, each person was offered a one-off budget of up to £500. Most people opted to take this as a direct payment.

This approach had the advantage of being simple, but some practical problems emerged:
- it was not easy to decide who should get a personal health budget; some people were given a budget who would not previously have had a service at that time
- a person’s condition in itself is not a good way to decide eligibility, eg people with diabetes vary greatly in their use of NHS services
- some people who had a budget also continued to use services, leading to double running costs
- some people found the idea of an indicative budget confusing and preferred to know the exact amount of the budget.

To implement the approach more widely, the following steps would be necessary:
- define clearly who can have a personal health budget
- be able to release money from existing services, eg by changing contracts to enable this to happen
- decide which elements of a service or pathway should be replaced by a personal health budget, and ensure the budget is instead of, rather than in addition to, services.

Since the pilot, no further budgets have been offered to people with long term conditions. Instead, NHS Outer North East London has focused on implementing personal health budgets for people eligible for NHS Continuing Healthcare, including children.

Payment by results

Payment by results is the payment system in England under which commissioners pay health care providers for each person seen or treated, taking into account the complexity of the person’s health care needs. Payment by results currently covers the majority of acute health care in hospitals, with national tariffs for admitted patient care, outpatient attendances, accident and emergency, and some outpatient procedures.

The government is committed to expanding payment by results by introducing currencies and tariffs for mental health, community and other services. A Year of Care funding model is being developed for people with long term conditions. The scheme will enable
commissioners to pay providers to care for a person with a long term condition for a year, rather than receiving payment each time the patient is admitted to hospital.

A new system for commissioning mental health services is being implemented nationally. It currently involves everyone who is referred to adult mental health services receiving a robust assessment of their needs, which are then matched to one of a possible 20 care clusters. Each care cluster package is designed to meet the person’s needs at that time. It is expected that a person may move between packages according to their needs at the time of review. Each cluster will have a tariff set locally indicating the price of meeting that person’s need within that care cluster. It is therefore possible to develop a pathway: following initial assessment and matching the person’s needs to the care cluster, the person is asked whether they would like to consider a personal health budget, and the care cluster price is used to indicate the level of budget to support the personal plan.

Currently the majority of services are provided through block contracts to NHS trusts. But within the tariff for the care cluster it is possible in future to have different elements of a person’s needs provided by different services, such as social care or third-sector services. Mental health payment by results is not setting-specific, but focuses on ensuring services are provided to a recognised standard of care and support to meet the identified need. Partnership and collaborative approaches may be taken by providers to enable good coverage of provision to meet people’s needs. At the personal level, a number of factors can affect how much people use NHS-funded services, thus affecting costs. The following factors should be considered when setting budgets for people with mental health problems.

- Informal support provided by family, friends and other informal carers (this is taken into account in one of the payment by results assessment scales).
- Use of social care services – in some places budgets are pooled, in others services are integrated, elsewhere services are provided separately.
- Some people also have physical health problems and make use of other NHS services.

Despite these complicating factors, commissioners in pilot sites found that payment by results is a useful tool, both at the population level and when developing care plans with people taking up personal health budgets.
Example: Northamptonshire

In Northamptonshire, personal health budgets were offered to people with mental health problems during the pilot. The commissioner for mental health services worked closely with the project manager for personal health budgets and the mental health trust to develop the approach.

The commissioner and the mental health trust agreed to vary the normal contract arrangements for people taking part in the pilot. For people with a personal health budget, the trust would be paid only for the actual use by that person of the trust’s services. This enabled money to be freed up which the person could spend in different ways.

For people taking up personal health budgets, the use of services in the past 12 months was calculated, to give a baseline. The mental health trust provided detailed information on costs, so that the cost of each contact with mental health services could be calculated. Each person then worked with a care co-ordinator to estimate what they might have used in the following year if they continued to use services. The total cost of these services was used as an indicative budget, and this figure was used to help each person develop a support plan.

The budget could be used flexibly. Some people opted to see their community psychiatric nurse or psychiatrist less often. This freed up money to be used in other ways that would enable people to achieve the outcomes that were important to them, as in the following examples.

- Amanda negotiated with her social worker, who she had been working with for six years, to release £4,600 from her personal health budget of £10,500 to buy twice-weekly counselling sessions, which they both felt may help improve her health and meet the health outcomes she wanted to achieve. The remaining £5,900 was budgeted to allow for three psychiatrist contacts and 25 social worker contacts during the year.

- Brian was given a budget of £4,800. He decided with his occupational therapist that 12 contacts with her, at a cost of £2,400, would be sufficient during the year, particularly if he was making progress towards his health outcomes. The rest of the budget was used to buy IT equipment, a personal assistant for two hours a week, some new clothes, a drum kit and physiotherapy.

During the pilot, the trust was preparing for the introduction of payment by results into mental health services, which started in April 2012. This work is expected to continue over the next few years before full implementation of a payment by results system is in place. As part of this work, it was agreed to test whether payment by results could also serve as an opportunity to transform services and improve personalisation. It also had the potential to provide a robust, standardised approach for assessment of need and a price payment to services for meeting those needs.

During 2012–13, work has been under way to identify the average costs of delivering services for each care cluster.
The new type of contract between commissioner and provider is based on the number of people using services during the period for each cluster. By making contracts more transparent and based on people’s needs, payment by results could, in theory at least, help remove one of the obstacles to introducing personal health budgets in mental health services.

The commissioners in Northamptonshire are now working in partnership with the mental health trust to include the option of a personal health budget for people with mental health problems as part of mainstream services to begin roll out from April 2013. A steering group, chaired by a service user, has come together to drive the work forward. The group is developing a memorandum of understanding between the organisations, with clear aims and objectives, one of which is to develop, in partnership, a proposal for a Commissioning for Quality and Innovation goal for the 2013/14 contract and linked to the development and implementation locally of mental health payment by results.19

This work includes exploring the possibility of using the locally agreed prices for care cluster packages as a useful guide to the size of a personal health budget.

Commissioners are keen not to develop a two-tier system of care for people accessing NHS services, but to ensure that all those using services have the same opportunities. The aim is to ensure all care cluster packages offer people choices and personalised care. Where the person states it is their wish, their budget and care plan can be held by that person (or a preferred other on their behalf) as a personal health budget.

Outcome-based budgets

This approach extends the idea of flat-rate budgets. It involves developing a menu of outcomes, which are relevant to people with a wide range of health problems. Outcomes might be linked directly to health improvement – such as improving mobility, getting more exercise, losing weight, reducing drug or alcohol use, stopping smoking, reducing anxiety or depression. It would also be possible to include support for family carers, or outcomes known to be indirectly linked to health, such as social contact, education and work opportunities.

For each outcome, a budget can then be estimated based on the cost of what the NHS would normally spend on services intended to address that outcome. So, for example, the budget for reducing anxiety or depression could be based on the cost of cognitive behaviour therapy. The budget could be varied according to level of need on a scale of high, medium, low or no need – giving an increase or decrease in the budget.

When a person is referred, the budget setting tool will be part of a conversation with an NHS professional, leading to agreement about which outcomes are relevant to the person’s health, and at what level of need. The person would then be given an indicative budget and would use it to help develop their care plan.
For each outcome, the person would be able to choose whether to use the commissioned NHS service, or use the budget in a different way. For each outcome selected, the plan would include an agreed progress measure.

This approach has the advantage that it could work for people with a wide range of health needs, and for people with multiple health conditions. If used in primary care, it has the potential to lead to efficiencies by preventing people being referred multiple times to different secondary health care services. The approach could also be adapted to include outcomes linked to recovery, such as rehabilitation following a head injury or stroke, but as part of a generic approach rather than developing a different model for each condition. For people eligible for social care, it has the potential to be developed as a system to set joint budgets.

So far, this approach has been tested only on a small scale. This has resulted in relatively small budgets under £500, although such a system could lead to much larger budgets. It will need more development work to test whether the approach could be used on a wider scale.

**Example: Dorset**

NHS Dorset decided to try using personal health budgets as a different way to enable people to recover following a brain injury. So far, three people have taken up a personal health budget. Of these, two live in the north of the county, outside the area covered by the community rehabilitation service. The personal health budget was set based on the cost that would normally be expected for a package of rehabilitation for each person.

This early work has proved successful. There is good evidence that the three people have met their goals for recovery faster than the norm. The key features of the arrangements were that goals were set at the start of the process and a person-centred plan put in place, ensuring that day-to-day support arrangements remain focused on helping the person achieve their goals.

This work demonstrates the potential for personal health budgets to be given for rehabilitation, linked to specific goals for recovery such as returning home and returning to work. The primary care trust now plans to extend the use of personal budgets to approximately 15 people likely to need rehabilitation after leaving hospital. It is also looking at whether other people living in residential rehabilitation units could be enabled to return home through having a personal health budget.

**Example: Nottingham**

In Nottingham, personal health budgets have been offered to people eligible for NHS Continuing Healthcare, people with long term neurological conditions such as Parkinson’s disease, and people with dementia.

Early in the pilot, budgets for people with long term conditions were set by calculating the cost of services the NHS would normally
offer. For example, if a person might be expected to have six sessions of physiotherapy, the cost would be estimated and that amount offered as the budget. The person’s care plan specified how the money would be spent – they could continue to use the conventional services, or choose to spend the money differently. This method had some disadvantages. Basing costs on commissioned services made it harder for staff and personal budget holders to think of alternatives. It maintained a focus on specific health conditions and health services, rather than encouraging a holistic approach to care planning. And it could cause staff to worry that their service might be reduced as a result of personal health budgets.

As a result of this learning, managers in Nottingham are developing an outcome-based method of budget setting. Instead of specifying services, the tool lists health outcomes, and identifies the costs that might usually be expected to be spent on commissioned services linked to that outcome. For each outcome, a high, medium or low cost is calculated based on typical costs plus or minus 33 percent. The person and a clinician agree together which outcomes should be included in the care plan, and agree the cost band for each outcome depending on the person’s level of need. Some outcomes might be more relevant for people with specific conditions, but the tool aims to be holistic. The outcomes included in an early version of the tool included improved balance and mobility, prevention of hospital admission, reduced medication, improved breathing, control of blood sugar levels, reduced GP contact, health training/education, improved health of carers, improved speech and language and improved nutrition. For improved balance and mobility, the budget was calculated based on the typical cost of six sessions of NHS physiotherapy – high needs £317, medium £238, and low £159.

In early testing, several advantages of this outcomes-based approach emerged:

- it encourages a focus on the whole of a person’s health needs rather than just one condition
- it helps everyone to be clearer about the plan’s goals and to explore a range of options for how these can be achieved
- the outcomes can be included in support plans and linked to progress measures such as blood sugar levels and use of medication.

So far, two people have been offered personal health budgets based on this approach. One was offered a budget based on improving balance and mobility, and chose to access the gym; the other was offered a budget to improve mood, and chose to access massage and other holistic therapies. Their budgets were £238 and £398, respectively.
7 Conclusion

Pilot sites have used a range of approaches to set personal health budgets. Each has advantages and disadvantages. Some of these approaches may be a good way to get started with personal health budgets, but may be difficult to implement for large numbers of people.

It isn’t necessary to develop a sophisticated budget setting tool before beginning to offer budgets; it’s better to start on a small scale and learn from experience. Whichever approach is taken, it’s important to keep the purpose of personal health budgets in mind, keep the focus on outcomes, and keep the system simple and flexible for both people with personal health budgets and frontline staff.
8 References


5 Health Foundation. Co-creating Health. www.health.org.uk


13 The Department of Health plans to carry out a consultation in 2013 on new regulations which will confirm what services will be excluded from a personal health budget.


16 Imagine. www.imaginementalhealth.org.uk


19 **The Commissioning for Quality and Innovation (CQUIN) payment framework** enables commissioners to reward excellence by linking a proportion of providers’ income to the achievement of local quality improvement goals. www.institute.nhs.uk
Gateway Ref No. 18328

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