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Personal Health Budgets: Implementation following the national pilot programme; overall project summary

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Introduction

1. The underlying principle of personalisation is to offer people greater choice and control by providing the opportunity to make care decisions in partnership with professionals.
2. Personal health budgets (PHBs) are funds for individuals to purchase services, support and equipment to achieve their health goals, which are set out in a care plan agreed by the individual and health professionals stating the budget amount, what will be purchased and how the budget will be managed.
3. The personal health budget pilot programme was launched by the Department of Health[1] in 2009 and an independent evaluation was commissioned to run alongside (Forder et al. 2012). The aim of the evaluation was to identify whether personal health budgets ensured better health and care outcomes when compared to conventional service delivery and, if so, the best way for personal health budgets to be implemented.
4. The evaluation found that, over a 12-month follow-up period, the use of personal health budgets was associated with a significant improvement in patients' care-related quality of life and psychological well-being.
5. Using care-related quality of life measured net benefits, personal health budgets were cost-effective: that is, budget holders experienced greater benefits than people receiving conventional services, and the budgets were worth the cost.
6. The Department of Health commissioned the current study to explore the continued implementation and impact of personal health budgets following the national pilot programme.

Study design and methodology

7. During the national evaluation, 20 primary care trusts (as they existed then) out of 64 sites participated in the in-depth strand of the study, with the remainder forming the wider cohort. Initially, personal health budget leads from Clinical Commissioning Groups (CCGs) covering one or more of the original in-depth sites were invited to participate in the current study. In addition, personal health budget holders who participated in the national evaluation were invited to take part in the current study. Due to recruitment issues, the invitation was extended to all CCGs covering one or more of the sites (in-depth and wider cohort) that participated in the national evaluation. In addition, the invitation to participate in the study was extended to personal health budget holders who had received their budgets following the national evaluation.
8. Fourteen CCGs agreed to participate in the study: 11 CCGs covering one or more of the original in-depth sites from the national evaluation of the personal health budget pilot programme; and two CCGs covering one or more of the original wider cohort sites.
9. Between March and November 2015, semi-structured telephone interviews were conducted with eight organisational representatives whose work involved the delivery of personal health budgets within the participating CCGs. Twenty-three personal health budget holders were interviewed by a member of the research team between March 2015 and January 2016.

[1] Now the Department of Health and Social Care

10. Fourteen service providers, from seven CCGs, completed the online survey between March 2015 and March 2016. Three service providers agreed to be interviewed between March 2015 and February 2016.
11. A postal questionnaire was sent to 104 patients (or consultees) who gave their consent to take part in the study between June 2015 and January 2016 to explore the potential implications of any context change on service satisfaction and quality of life. Fifty completed questionnaires were returned, providing a response rate of 48%: 34 from the personal health budget group and 16 from the control group.
12. Sixty-nine personal health budget holders provided consent that the research team could have a copy of their support plan. The research team received 42 personal health budget support plans from four participating CCGs.
13. Overall, 92 participants consented for their secondary care service use to be extracted from the Hospital Episode Statistics (HES) database. Sixty-four participants participated in the national evaluation (37 in the personal health budget group and 27 in the control group) and 28 were budget holders who had received their budget following the pilot phase and evaluation.
14. The small sample of participants resulted in the research team being unable to explore the continued impact of personal health budgets on quality of life among participants and on secondary care service use following the pilot phase. The intention had also been to compare the experiences of patients in CCGs where personal health budgets (PHBs) were well-established, with those in CCGs that had adopted PHBs more recently; however the sample was too small to make meaningful comparisons.
15. There are two strands to the current study. The first strand aims to gather views among a number of personal health budget leads, commissioners and budget holders about the reasons why personal health budgets had either positive or negative effects (Jones et al. 2017). The second strand focuses on the views among managers of service provider organisations and perceptions among budget holders regarding the personal health budget process. This strand also explores the content of current personal health budget support plans and the organisation of budgets following the pilot phase (Jones et al. 2018).

Findings

16. Organisational representatives and budget holders perceived that personal health budgets have the potential to impact on both service users and their famillies. The benefits were attributed to:
    a) Giving people a greater sense of control and empowerment; facilitating a supported care planning process; and by allowing people to secure services and support in a more innovative and flexible way to meet their specific care needs.
    b) Relying less on family for care and support, which in turn reduces the pressure on family carers.
    c) Improved relationships between health professionals and patients.
    d) Improved working relationships with social care colleagues.
17. A number of challenges were identified that could potentially impact on the continued effectiveness of personal health budgets, including:
    a) Reduced levels of professional guidance and support following the pilot phase.

b) Perceived lack of awareness of personal health budgets, which potentially influences market development.

c) Strong leadership was viewed as important for the longer-term implementation of personal health budgets and market development. However, leadership was perceived to be problematic following the pilot phase.

d) Freeing up resources tied to block contracts with existing providers.

e) The lack of a fully integrated personal budget process in terms of assessment, support planning and reviews.

18. The analysis of 42 personal health budget support plans showed an average spend of £42,530 per person per year (median = £19,180). Thirty-one personal health budget plans reported the deployment option, with 26 managing the budget as a direct payment and five as a managed-budget.

19. Among the 34 personal health budget holders responding to a questionnaire, 21 reported that they were currently receiving support purchased through their budget. Of the 21 participants, 18 reported that they were either extremely or very satisfied with the support received from the budget and 10 were satisfied with the care planning process. Five budget holders perceived that they needed more support to decide how to spend their budget.

Recommendations for policy

20. Personal health budgets continue to have a positive impact on individuals and families alongside having benefits within the care sector.

21. The implementation of new schemes requires fundamental cultural changes within the care sector that takes time to fully embed into work practices. Strong leadership is a vital ingredient for the required cultural change and for the longer-term implementation of personal health budgets.

22. Some of the implementation challenges and barriers are not specific to the personal health budget policy and mirror those found with the implementation of the current integration policy initiatives such as the Integrated Pioneer programme.

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