Title: Personal health budgets **IA No:** 6103 **Lead department or agency:** Health **Other departments or agencies:**	**Impact Assessment (IA)** **Date:** 08/01/12 **Stage:** Consultation **Source of intervention:** Domestic **Type of measure:** Secondary legislation

Summary: Intervention and Options

RPC Opinion: N/A

Cost of Preferred (or more likely) Option				
Total Net Present Value	**Business Net Present Value**	**Net cost to business per year** (EANCB on 2009 prices)	**In scope of One-In, One-Out?**	**Measure qualifies as**
£1,967m	£0m	£0m	No	Zero Net Cost

What is the problem under consideration? Why is government intervention necessary?

By giving people more choice and control over the care they receive, outcomes and cost-effectiveness can be improved. People have valuable insight into what benefits them, which is not always taken into account in discussions between healthcare professionals and patients at present. In the absence of government intervention, these opportunities would likely be missed, or not be realised as fully as they could be.

What are the policy objectives and the intended effects?

Personal health budgets give the individual more choice and control over the money that is spent on their care. This aims to improve their outcomes and potentially to reduce total costs to the system, by helping people to self-direct towards services from which they experience greatest benefit. Personal health budgets may also serve to improve people's satisfaction with the NHS.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

Options considered are:

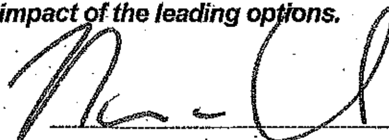
1) Do nothing
2) An announcement about personal health budgets in the Mandate to the NHS Commissioning Board
3) Extension of the direct payments regulations so that direct payments for healthcare can continue
4) An announcement in the Mandate and extension of the direct payments regulations

Option 4 is the preferred option, as this is likely to result in greater numbers of people accessing personal health budgets. Based on the independent evaluation, personal health budgets are beneficial, especially where people have higher levels of health need.

Will the policy be reviewed? It will be reviewed. **If applicable, set review date:** Month/Year

Does implementation go beyond minimum EU requirements?			Yes		
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	**Micro** No	**< 20** No	**Small** No	**Medium** No	**Large** No
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			**Traded:** N/A	**Non-traded:** N/A	

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister:  Date: 12/1/13

Summary: Analysis & Evidence

Policy Option 2

Description: An announcement about personal health budgets in the Mandate to the NHS Commissioning Board

FULL ECONOMIC ASSESSMENT

Price Base Year 2012	PV Base Year 2012	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: £19m	**High:** £568m	**Best Estimate:** £291m

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	£7.3m	2	£2.6m	£28.6m
High	£1.8m		£9.6m	£82.2m
Best Estimate	£4.3m		£6.8m	£57.9m

Description and scale of key monetised costs by 'main affected groups'

The main transition costs come from the set-up of personal health budgets, including project management, the project board, development of systems and market development. The best estimate of ongoing costs associated with care or support planning, ongoing support for patients and running of administrative support is estimated to be £50,000 per 75 patients.

Other key non-monetised costs by 'main affected groups'

Existing providers may experience a cost if people opt away from services they provide, though this is likely to be associated with a benefit for these people. People still wishing to access a particular service may experience a cost if that service becomes unviable as people opt away from it.

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	N/A	N/A	£12.0m	£101m
High	N/A		£71.2m	£597m
Best Estimate	N/A		£41.7m	£349m

Description and scale of key monetised benefits by 'main affected groups'

Benefits are improvements in quality of life, and reductions in costs for people eligible for NHS Continuing Healthcare. This is estimated at £4,340 per person in the final evaluation report, which applies to people receiving high-value budgets. Of the £4,340 benefit per personal health budget recipient, £3,100 is assumed to be a financial saving, as individuals meet their needs with less resource.

Other key non-monetised benefits by 'main affected groups'

There are likely to be additional benefits if commissioners expand personal health budgets to different groups of patients – this was estimated to be an average £2,300 gain per person in the evaluation report. There are also likely to be improvements in quality of life for carers, as set out in chapter 7 of the final report. It is also possible that by introducing personal health budgets, there are benefits beyond those receiving them as the NHS and other providers become more responsive to people's needs and preferences.

Key assumptions/sensitivities/risks — **Discount rate (%)** 3.5%

This assumes that there is a 20% take-up rate of personal health budgets by people who are eligible for NHS Continuing Healthcare, and that gains in cost-effectiveness per person remain constant as more people access personal health budgets. It also assumes there are no wider costs to the system incurred. The announcement in the Mandate on its own is assumed to be sufficient for more people to take up the offer of the personal health budget, even without the option of direct payments.

BUSINESS ASSESSMENT (Option 2)

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs: £0	**Benefits:** £0	**Net:** £0	No	NA

Summary: Analysis & Evidence

Policy Option 3

Description: Extension of the regulations so that direct payments for healthcare can continue.

FULL ECONOMIC ASSESSMENT

Price Base Year 2012	PV Base Year 2012	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: £19m	**High:** £568m	**Best Estimate:** £291m

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	£7.3m	2	£2.6m	£28.6m
High	£1.8m		£9.6m	£82.2m
Best Estimate	£4.3m		£6.8m	£57.9m

Description and scale of key monetised costs by 'main affected groups'

The main transition costs come from the set-up of personal health budgets, including project management, the project board, development of systems and market development. The best estimate of ongoing costs associated with care or support planning, ongoing support for patients and running of administrative support is estimated to be £50,000 per 75 patients.

Other key non-monetised costs by 'main affected groups'

Existing providers may experience a cost if people opt away from services they provide, though this is likely to be associated with a benefit for these people. People still wishing to access a particular service may experience a cost if that service becomes unviable as people opt away from it.

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	N/A	N/A	£12.0m	£101m
High	N/A		£71.2m	£597m
Best Estimate	N/A		£41.7m	£349m

Description and scale of key monetised benefits by 'main affected groups'

Benefits are improvements in quality of life, and reductions in costs for people eligible for NHS Continuing Healthcare. This is estimated at £4,340 per person in the final evaluation report, which applies to people receiving high-value budgets. Of the £4,340 benefit per personal health budget recipient, £3,100 is assumed to be a financial saving, as individuals meet their needs with less resource.

Other key non-monetised benefits by 'main affected groups'

There are likely to be additional benefits if commissioners expand personal health budgets to different groups of patients – this was estimated to be an average £2,300 gain per person in the evaluation report. There are also likely to be improvements in quality of life for carers, as set out in chapter 7 of the final report. It is also possible that by introducing personal health budgets, there are benefits beyond those receiving them as the NHS and other providers become more responsive to people's needs and preferences.

Key assumptions/sensitivities/risks | **Discount rate (%)** 3.5%

This assumes that there is a 20% take-up rate of personal health budgets by people who are eligible for NHS Continuing Healthcare, and that gains in cost-effectiveness per person remain constant as more people access personal health budgets. It also assumes there are no wider costs to the system incurred. No additional costs are assumed as a result of monitoring of direct payments use.

BUSINESS ASSESSMENT (Option 2)

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs: £0	**Benefits:** £0	**Net:** £0	No	NA

Summary: Analysis & Evidence

Policy Option 4

Description: An announcement about personal health budgets in the Mandate to the NHS Commissioning Board

FULL ECONOMIC ASSESSMENT

Price Base Year 2012	PV Base Year 2012	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: £49m	**High:** £1,430m	**Best Estimate:** £734m

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	£7.3m	2	£6.4m	£60.8m
High	£1.8m		£24.0m	£203m
Best Estimate	£4.3m		£16.0m	£138m

Description and scale of key monetised costs by 'main affected groups'

The main transition costs come from the set-up of personal health budgets, including project management, the project board, development of systems and market development. The best estimate of ongoing costs associated with care or support planning, ongoing support for patients and running of administrative support is estimated to be £50,000 per 75 patients.

Other key non-monetised costs by 'main affected groups'

Existing providers may experience a cost if people opt away from services they provide, though this is likely to be associated with a benefit for these people. People still wishing to access a particular service may experience a cost if that service becomes unviable as people opt away from it.

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	N/A	N/A	£30.6m	£252m
High	N/A		£178m	£1,490m
Best Estimate	N/A		£104m	£872m

Description and scale of key monetised benefits by 'main affected groups'

Benefits are improvements in quality of life, and reductions in costs for people eligible for NHS Continuing Healthcare. This is estimated at £4,340 per person in the final evaluation report, which applies to people receiving high-value budgets. Of the £4,340 benefit per personal health budget recipient, £3,100 is assumed to be a financial saving, as individuals meet their needs with less resource.

Other key non-monetised benefits by 'main affected groups'

There are likely to be additional benefits if commissioners expand personal health budgets to different groups of patients – this was estimated to be an average £2,300 gain per person in the evaluation report. There are also likely to be improvements in quality of life for carers, as set out in chapter 7 of the final report. It is also possible that by introducing personal health budgets, there are benefits beyond those receiving them as the NHS and other providers become more responsive to people's needs and preferences.

Key assumptions/sensitivities/risks — **Discount rate (%)** 3.5%

This assumes that there is a 50% take-up rate of personal health budgets by people who are eligible for NHS Continuing Healthcare, and that gains in cost-effectiveness per person remain constant as more people access personal health budgets. It also assumes there are no wider costs to the system incurred as a result of the introduction of direct payments.

BUSINESS ASSESSMENT (Option 4)

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs: £0	**Benefits:** £0	**Net:** £0	No	NA

Evidence Base (for summary sheets)

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A Policy background and wider context

1. Personal health budgets aim to give the individual more choice and control over the services they receive. This is done by giving them direct control over the money, held by the commissioner, by an independent third party or by the individuals themselves. This is one part of the overall personalisation work within healthcare. The overriding aim is to improve individual outcomes.

2. Personalisation in social care has been around for longer than it has in healthcare. In the early 1990s, a small group of physically disabled people asked for more control over the money that was spent on their care, as they were not happy with the services that the council was commissioning on their behalf.

3. As this proved to be successful, legislation to introduce direct payments was introduced in 1996[1], with the first payments under the new regulations being made the following year. This has led to an increasing proportion of social care service users taking control of decisions made about their care.

4. This was initially just for social care; attempts have been made since to expand control over public services received into some of the funding streams provided by the Department for Work and Pensions. In 2005, a joint pilot was launched between the Department of Health and the Department for Work and Pensions that enabled local authorities to bring together all of the funding streams for which an individual was eligible in an 'Individual Budget'. This was generally beneficial, though there were significant difficulties with setting this up and bringing the funds together, as detailed in the evaluation.[2] Since the evaluation of the Individual Budgets pilots, both personal budgets (a budget for social care only) and individual budgets have become more widespread.

5. Within healthcare, there is also an increasing drive for personalisation. Since 2003, patients have had the option of choice of hospital when going for their first appointment, initially choice of 4

[1] http://www.legislation.gov.uk/ukpga/1996/30/contents

[2] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089505

hospitals and since expanded to cover all providers. Choice has since been expanded, and the White Paper *Equity and Excellence: liberating the NHS*[3] set out the proposed expansions of choice policy.

6. People with long-term conditions are also getting the opportunity to take more control over their care, through personalised care planning. A care plan sets out the health and wellbeing needs of the individual, and how they will be met. The aim is to enable patients to be able to take more control over their care, if they would like to do so.

7. Personal health budgets are closely linked to personalised care planning. During the pilot phase, people could only get a personal health budget if they also had a care or support plan[4], as set out in the regulations. It is proposed (detailed below) that this continues within the revised draft regulations.

8. However, personal health budgets (or at least direct payments) were not legally possible until the passage of the 2009 Health Act[5], which meant there was a disconnect for some people when they moved from social care into healthcare. This was especially true for people who became eligible for NHS Continuing Healthcare, which people often move in to from social care where they may have had direct payments. Where this was the case, people then often lost all choice and control when the NHS took over funding of their care. This often led to care packages, that may have been working very well for the individual, being dismantled.

9. The personal health budgets pilot programme was announced within the 2008 report *High Quality Care for All*.[6] In January 2009, the Department published *Personal health budgets: first steps*,[7] which set out what was known at that stage about personal health budgets and invited invitations to become pilot sites. In May 2009, 70 sites were awarded provisional pilot status, and in August 2009, 20 of these sites were selected to be part of the in-depth evaluation. This was based on:

    i. Sites proposing to offer a large enough number of personal health budgets and being ready to do so;

    ii. Geography, to get a national spread;

    iii. Patient groups to be covered, to ensure sufficient numbers in particular groups; and

    iv. Demography of provisional pilot sites, to get a range of age groups, ethnic groups and socioeconomic statuses in particular.

10. Many of the pilot sites first introducing personal health budgets for people eligible for NHS Continuing Healthcare. This is one of the factors that led to the announcement on 4th October 2011 about introducing the right to ask for a personal health budget for people eligible for NHS Continuing Healthcare.

11. The pilot programme was independently evaluated. This report is now in the public domain, and is broadly positive about the effects of personal health budgets. This impact assessment is published alongside the consultation document, which sets out next steps for the policy and the

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[3] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353
[4] In health, these plans are called "care plans", whereas in social care they are called "support plans". Both do very similar things – they set out the needs of the individual and how they will be met. The terminology is not important – it is what the document represents. Throughout this document, they are referred to as care or support plans.
[5] http://www.legislation.gov.uk/ukpga/2009/21/contents
[6] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825
[7] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117262.pdf

long-term intention around personal health budgets. This is predominantly based on the evaluation, and the experience within the pilot programme.

12. There are many linked programmes, within both health and social care (as detailed above) and elsewhere across the public sector. The Department for Work and Pensions is currently trialling budgets covering a number of their funding streams in a programme called *Right to Control*. The Department for Education is also trialling budgets for children and young people with Special Educational Needs and Disabilities (SEND). The personal health budgets pilot programme is linked to both of these initiatives, and some of the pilot sites have looked into offering budgets that cover the funding streams set out above, plus health.

13. Within the pilot programme, there were also a number of sites who looked specifically at joining up personal health budgets with personal budgets in social care, to give an integrated budget to the individual. This was one of the specific findings from the Individual Budgets evaluation, that some people felt they suffered as a result of health funding not being included within the Individual Budget. The sites that are attempting to overcome this are finding that it is difficult to resolve, though some progress is being made.

14. This is an impact assessment that covers the whole of the personal health budgets policy. While only the direct payments aspect requires legislation, this document covers the whole policy. This is to be transparent about the evidence, about what is known and what uncertainties remain, to help inform people or organisations responding to the consultation.

B Policy overview and description

15. A personal health budget is an amount of money which the individual has control over and is there to meet their health and wellbeing needs. It is not additional money – it is a different way of commissioning NHS services. The individual, in conjunction with a representative of the commissioner (currently PCTs; to become clinical commissioning groups) agrees a care or support plan that sets out the health and care needs of the individual and how they will be met. The budget is then used to pay for these services.

16. There are three broad methods of offering personal health budgets:

- **Notional budgets**, where the funding remains with the commissioner. Here, people are aware of what the budget is and what the costs of services are, and can therefore plan how they will meet their needs.
- **Third party arrangements**, where the money is transferred from the commissioner to an organisation that is legally independent of both the commissioner and the individual, such as a charity or an Independent User Trust.
- **Direct payments**, where the funding is transferred to individuals for them to buy services themselves.

17. In general, the closer the money gets to the individual, the more control they have. People will want different levels of control over the money – some will want a direct payment, others will want to leave everything up to the commissioner, others will be somewhere in between these two extremes. People will not be forced to have more control than they wish to have – choosing to not have control is also a choice.

18. Personal health budgets can be spent on almost any services that are likely to meet the individual's health and wellbeing need. The only items that are currently specifically excluded are alcohol, tobacco, gambling and debt repayment, as well as anything that is illegal. Some

services are also not felt to be suitable to use a personal health budget to fund – for example, GP services and emergency services. This is discussed in more detail below.

19. As with other personalisation initiatives, the aim is not just to introduce personal health budgets. They are both an end in themselves, and a tool to potentially improve outcomes and efficiency of the system. This is because allowing people to self-direct towards organisations or services from which they derive the most benefit has two effects. Firstly, it means that people should experience greater benefits, both improving outcomes and potentially reducing costs. Secondly, it can encourage all providers to become more responsive to patient preferences, both in terms of the quality of their services and in terms of what services they offer.

20. Table 1 sets out potential numbers of personal health budget holders in the longer term. This is to give an indication of the potential scale of this policy – this is not to say that all of these people could or would be eligible, or indeed that they would take up the offer of a budget.

Table 1: Potential recipients of personal health budgets in the longer term

People who would be eligible	**Potential numbers**
People who are eligible for NHS Continuing Healthcare only (this includes children)	56,000
People who are eligible for NHS Continuing Healthcare, and clinical commissioning groups could expand to other patient groups on a voluntary basis	56,000+
People in the top section of the long-term conditions pyramid (including all people eligible for NHS Continuing Healthcare, and children receiving Special Educational Needs and Disabilities (SEND) single assessments and plans) and clinical commissioning groups could expand to other patient groups on a voluntary basis	250,000+
People in the top two sections of the long-term conditions pyramid (including all people eligible for NHS Continuing Healthcare and children with SEND), and clinical commissioning groups could expand to other patient groups on a voluntary basis	3m+

21. This impact assessment only monetises the benefits and costs associated with rolling out personal health budgets for people eligible for NHS Continuing Healthcare. While there are also benefits for other groups of patients, this is the first group to be included. So, while clinical commissioning groups can expand to other patient groups on a voluntary basis, the quantified effects discussed below and included in the cover sheets are only for people eligible for NHS Continuing Healthcare.

22. The figures in Table 1 are largely based on the long term conditions triangle that was set out in the impact assessment published alongside the original legislation. This does not mean that personal health budgets are only thought to be suitable for people with long term conditions; it is more a way of breaking potential recipients into groups based upon the severity of their conditions. The figures in the table above also represent the numbers of people who could be eligible depending on how criteria are set.

C Problem under consideration

23. Quality of care and outcomes for people receiving services on an ongoing basis are not as good as they could be, and people would often like to have more control over decisions about their care

than they currently have. This can improve outcomes, through helping people access services that are more appropriate for them.

24. This may be particularly relevant to people with ongoing health and care needs. The health professional has expertise that the patient does not have, and provides advice about a person's condition. However, the extent to which this is the case is likely to vary depending on the health need in question. For example, if someone requires complex heart surgery, it is clear that this requires a highly specialised skill, both to diagnose and then to perform the operation. In contrast, if someone has diabetes, they can become an expert in their own condition, so the imbalance in who knows what between professional and patient may be reduced.

25. Furthermore, while the healthcare professional may know more about the condition of the individual, the individual will know more about their lifestyle and their preferences, which can provide valuable insight into what the best treatment option for that person may be. Relying on the health system alone to make decisions about people's care misses potentially beneficial opportunities to involve the patient and offer more appropriate services.

26. There are many examples available to show this in practice, some of which are discussed within the evidence base. When people are offered more control over the care that they receive in both health and social care, there are some highly innovative changes made, with people meeting their needs in very different ways from what traditional services would offer. However, far more people use additional control only to tweak the services they receive or not to alter the services themselves at all. Instead, they use the control they get to change three aspects of the services: where the care is received, when, and who delivers it. These relatively low-level changes can have a major impact on the individual's health and wellbeing outcomes.

27. Individuals and healthcare professionals may also have different views about the aims of care. Towards the end of life, for example, people eligible for NHS Continuing Healthcare or for end of life may be aiming to get the best out of their life they can rather than prolonging it for as long as possible. This may mean that people would prefer different services that improve their wellbeing rather than focusing on a relatively narrow definition of their health status. Giving such people more control over the services they receive again has the potential to be beneficial.

D Rationale for intervention

28. At present, there are regulations in place that permit direct payments for healthcare in personal health budget pilot sites that are specifically authorised by the Department of Health. Other personal health budgets models – notional budgets and third party – are both possible without legislation, as they were at the outset of the pilot programme.

29. However, while notional budgets and third party arrangements are possible, and have been for some time, they were not widely used in practice. At the outset of the pilot programme, the best estimate is that there were fewer than 10 people in receipt of personal health budgets. So, while personal health budgets were possible, and while there was increasing demand for people to have more control when they were in receipt of services on an ongoing basis, commissioners were not widely using personal health budgets. Without the pilot programme and without the pressure from organisations such as *In Control*[8], it is unlikely that personalisation within healthcare would have significantly progressed.

[8] *In Control* are a charitable organisation dedicated to giving people more choice and control over the public services they receive.

30. Therefore, the primary rationale for intervention is that in its absence, opportunities for improved quality of services and reduced costs for meeting people's health and wellbeing needs would be missed. This applies to the outset of the pilot programme more than now, when there were only a handful of people receiving personal health budgets. Now, when the pilots have been running for 2-3 years and a growing number of people (currently approximately 1,500) have access to personal health budgets, commissioners may be more likely to make use of existing flexibilities. What would happen in the absence of any sort of intervention now is discussed more within the 'do nothing' section below.

31. The evaluation suggested some differences resulting from different ways of offering a personal health budget[9], a finding support by the experience of the pilot programme, which was that some people do have a clear preference for direct control over the money. This is only possible through direct payments. It is also likely that direct payments provide momentum to the process, as part of the overall set of options for greater personalisation that were publicised before and during the pilot programme.

32. Part of the reason that personal health budgets were not widely used is that they are a highly complex change to introduce. The operationalisation of them is difficult, and there are a number of challenges to overcome – particularly the setting of budgets, the information, advice and support that people need to make a success of the budget, and how the commissioner carves money out of existing services without excessively destabilising providers. The most difficult change is likely to be culture, of both healthcare professionals and individuals who could potentially receive budgets. People are likely to need support, at least initially, to take more control, and there may also be a challenge in encouraging healthcare professionals to let people take more control where they wish to do so.

E Supporting evidence for personal health budgets

33. At the outset of the pilot programme, an impact assessment was produced,[10] that put forward the options of immediate rollout of personal health budgets, or the launch of a pilot programme. While there was some supporting evidence and information available, this was mainly from social care and from very limited international programmes. Therefore, the decision was taken to pilot the policy, and to commission an independent evaluation alongside it.

Personal health budgets evaluation, and pilot experience

34. The evaluation is the main source of evidence about personal health budgets. There is limited additional experience from elsewhere in the world, other than that derived from social care. There is additional information gathered from the experience of the pilot programme.

35. The main findings of the evaluation are summarised below. The evaluation was undertaken by a consortium, led by the Personal Social Services Research Unit (PSSRU) at the University of Kent. The team had two overarching aims: to evaluate whether personal health budgets worked, and, if so, how best they should be introduced. To do this, they used a mixed-method approach, including both quantitative and qualitative research.

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[9] Table 6-14 of the final report suggests that there was a higher gain in cost-effectiveness for people receiving a direct payment.

[10] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_093305, beginning on page 59.

36. The quantitative aspect of the evaluation is based on a total final sample of 2,235 people, of whom 1,171 received a personal health budget and 1,064 were in the control group. People in both the personal health budgets group and the control group had one or more of the following conditions; diabetes; chronic obstructive pulmonary disease (COPD); stroke; long term neurological conditions (such as multiple sclerosis, motor neurone disease or Parkinson's); mental health; or they were eligible for NHS Continuing Healthcare.[11]

37. There was also a qualitative aspect to the evaluation to inform the quantitative analysis and provide more information about the process of introducing personal health budgets. The 4th and 5th reports in particular give the qualitative experience of approximately 55 budget holders at 3 months and 9 months after the offer of the budget respectively. The 3rd interim report looked at set-up costs of introducing personal health budgets, and the first two interim reports looked at implementation, from the perspective of the project leads (1st report) and healthcare professionals and commissioning staff (2nd report) respectively.

38. Broadly, the results of the evaluation are positive, with personal health budgets being shown to be cost-effective for the individual. This high-level finding masks variations, largely depending on how personal health budgets were introduced. There are also findings that personal health budgets are more suitable for people with high levels of need, and that they may be more cost-effective for particular conditions.

39. In terms of how personal health budgets were expected to operate at the outset of the pilot programme, there are a few key stages:

- Knowledge of the size of the budget at the outset of the process;
- Designing the care or support plan, including how health and care needs will be met;
- Agree the care or support plan;
- Managing the personal health budget on an ongoing basis; and
- Monitoring and reviewing the budget.

40. These steps are important to help ensure that there is a transfer of power from the healthcare professional to the individual. These are largely mirrored by the steps set out by *In Control*. All of these steps are underpinned by the individual being provided with appropriate information, advice and support. This support will be partly from the commissioner, and can take many forms – in the pilot programme, much of it came from the third sector, and there is a suggestion from some of the sites that peer support is particularly effective. The purpose is to help the individual has more of an equal voice in conversations with the healthcare professional about care and services they should receive.

41. The support that someone requires in order to make informed decisions about their care will vary between people. Some people will require very little support, whereas others will need a lot. Commissioners need to be sensitive to this so that they do not indirectly discriminate against people depending on their background (this is discussed in more detail in the *Equality Impact Assessment* section below).

<u>*Impact on outcomes*</u>

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[11] NHS Continuing Healthcare is not a condition per se, it is more a level of need above which the NHS entirely funds an individual's entire care needs – including their social care support. As such, people eligible for NHS Continuing Healthcare have some of the highest levels of need across the country. Eligibility is decided using the 'Decision Support Tool', which is an objective way of professionals assessing the needs of the individual. People eligible for NHS Continuing Healthcare can have any underlying health condition(s).

42. The evaluation collected information about outcomes based on EQ-5D, GHQ12, ASCOT and a subjective wellbeing question. For both outcomes and costs, only results that are statistically significant are included, or where there is something that is of interest.[12]

- For the whole sample, personal health budgets increase outcomes as measured by ASCOT[13]. The coefficient is 0.028, indicating that holding a personal health budgets increases the ASCOT score by an average 2.8 percentage points relative to the control group in the sample. This finding was significant at the 5% level, suggesting that personal health budgets have a positive impact on this outcome indicator.
- For the whole sample, the personal health budget reduced the GHQ12 score by -0.852 (this represents an improvement in wellbeing), a finding which was significantly different from zero at the 10% significance level.
- No statistically significant results were found for EQ-5D, for subjective wellbeing or for mortality. Similarly, no differences were found for HbA1 scores (which measure blood sugar control, a test for diabetes) or for FEV1 (which measures lung function, and is a test for COPD). While this means that personal health budgets did not improve these scores, they also did not worsen. This was a particular fear at the outset of the pilot programme – that people would spend their budgets on things that were clinically inappropriate and so their health status would deteriorate. This fear appears to have been unfounded.
- Table 5-10 of the final report shows that personal health budgets were more beneficial for people receiving high-value budgets[14], with a 3.2% improvement in ASCOT scores (significantly different from 0 at the 5% level), and a 1.4 point reduction in GHQ12 scores (significantly different from 0 at the 10% level);
- There is a suggestion that personal health budgets for COPD increases outcomes, as measured by ASCOT (significant at the 10% level), GHQ12 (significant at the 1% level) and subjective wellbeing (significant at the 5% level).
- People aged under 75 benefited more, on average, from personal health budgets than people aged over 75, as measured by both ASCOT and GHQ12 (both significant at the 10% level). This is not to say that people over 75 got worse – looking at this group in isolation, there were no observable effects on outcomes.
- The evaluation team split the implementation models into four groups, as set out in table 1-2 of the final report and included below:

[12] More information on all of the outcome measures is available in the final evaluation report.
[13] ASCOT is the Adult Social Care Outcomes Toolkit, and was nominally developed as a social care outcomes measure. It does, however, also have relevance across health outcomes as well, particularly for people with long-term or ongoing conditions. ASCOT ranks people's status on a scale from 0 to 1.
[14] The evaluation team assumed that any budgets over £1,000 were "high-value". This can be taken to mean a higher level of need of the individual, though it could also indicate that they are given more control over the money that is spent on their care. It is likely to contain elements of both of these.

Table 2: Implementation models (Table 1-2 of the final evaluation report)

Implementation models	In-depth pilot sites
Model 1 Personalised budget is known before support planning Flexibility in what help can be purchased Deployment choice (including direct payments)	8 pilot sites
Model 2 Budget is known before support planning (but may not be personalised – a set amount) Service directory Deployment choice (including direct payments)	4 pilot sites
Model 3 Budget is known before support planning (but may not be personalised – a set amount) Lack of flexibility in the help that can be purchased No deployment choice	3 pilot sites
Model 4 Budget is not known before support planning Flexibility in what help can be purchased Variation in the degree of deployment choice	4 pilot sites
Model 5 Model 1 and 2 combined	12 pilot sites

- Model 1 is closest to the original policy intention, with people getting a personalised budget and also choice over both services and how the budget is received. Models 2 and 4 are also reasonably close to this ideal. Model 3 is the furthest away, with people not being offered full choice or services or how the budget is received, and the budget is a set amount of money. Looking at the models one by one:

    i. Model 1 has a positive impact on ASCOT outcomes, with a personal health budget averaging a 3.9 percentage point increase in ASCOT scores in the sample. This finding is significant at the 5% level.

    ii. Model 2 has a positive impact on GHQ12 outcomes, with the personal health budget averaging in a -2.0 point change on the GHQ12 score, a finding that is significant at the 10% level.

    iii. Model 3 has a negative impact on a range of outcomes, with the personal health budget being associated with a 3.7 percentage points reduction in EQ-5D (significant at the 10% level); a 2.4 point increase in GHQ12 scores (significant at the 1% level); and a 1.6 point reduction in subjective wellbeing scores (significant at the 10% level).

    iv. Model 4 has a positive impact on a range of outcomes, with ASCOT scores increasing by 4.4 percentage points (significant at the 5% level); a 2.4 point reduction in GHQ12 scores, and a 3.7 point increase in subjective wellbeing (both significant at the 1% level).

Impact on costs

43. The evaluation team also collected information about the impact on costs. This includes the costs associated with the care or support plan, and indirect costs of the personal health budget in terms of spend on an individual's primary and secondary (including emergency) care needs. The

findings from this section of the report are described below, before being combined with the outcomes information to give an indication of cost-effectiveness:

- Costs of inpatient care fell by £1,320 on average, which is significant at the 5% level. While this cost was not included in the budget, it was an effect of the individual holding a personal health budget, indicating that budgets have a positive, indirect effect on the wider system. Similarly, total indirect costs (which are predominantly inpatient costs – therefore including the £1,320 above - but also include primary care costs and outpatient and A&E costs) fell by £1,360 on average, again significant at the 5% level;
- Direct costs associated with "wellbeing" increased by £510 on average, relative to the control group, a result that is significant at the 1% level. There was practically no spending on wellbeing services in the control group, indicating that this is an area of services towards which people would appear to wish to self-direct;
- For the whole sample, there was no statistically significant difference in total costs, in spite of the increases in direct wellbeing costs and the reduction of indirect costs associated with inpatient admissions;
- The conditions for which personal health budgets had the biggest reductions in indirect costs were mental health, where indirect costs fell on average by £3,050 (significant at the 1% level) and for NHS Continuing Healthcare where indirect costs fell by £4,040 on average (significant at the 10% level);
- Total costs for those aged over 75 fell by £4,300 on average, a result that was significant at the 10% level; and
- For high-value budgets, total costs fell by £3,100 on average, a result that was significant at the 10% level.

44. There were also some set-up costs associated with the introduction of personal health budgets, that were discussed in the 3rd interim evaluation report. These are discussed in more detail in the costs section below.

45. For the NHS Continuing Healthcare group, there was significant variation in the total budgets, as set out in Table 4-2 of the final evaluation report. Of the 155 budgets, the mean was £37,400, ranging from £0 to £379,000. This gives a clear indication of the variation in how different pilot sites introduced personal health budgets, as well as also indicating the variation in severity of needs. This means that the confidence intervals for the costs are very wide, so any cost changes will need to be very large to be picked up.

Impact on cost-effectiveness of services

46. The information that is included about outcomes and costs is then combined into cost-effectiveness information. The aim is to see whether personal health budgets are better or worse value for money than conventional services. The main findings are:

- When ASCOT is monetised at £30,000 for each additional year with perfect ASCOT status, personal health budgets are cost-effective for the whole sample, resulting in an average monetised benefit of £2,300 (significant at the 10% level) – this predominantly derives from improvements in outcomes within the whole sample rather than reductions in costs;
- When comparing health conditions, personal health budgets appear to have been most cost-effective for people eligible for NHS Continuing Healthcare and for people with mental health problems (again using the ASCOT outcomes). For NHS Continuing Healthcare, the average

monetised benefit in the sample is £9,840, and for mental health the average benefit is £4,880. Both of these results are statistically significant at the 10% level;

- Model 1 – that closest to the policy vision – has an average monetised benefit of £4,830, which is significant at the 5% level (this is for all patient groups in model 1);
- High-value budgets are also cost-effective, with an average monetised gain of £4,340, which is significant at the 5% level; and
- When models are run that control for expenditure[15], the results become stronger – holding a personal health budgets remains significant, with an average 5% improvement in ASCOT scores (significant at the 1% level). This is particularly true for people eligible for NHS Continuing Healthcare (an average 15% improvement in ASCOT scores, significant at the 10% level) and for mental health (an average 11% improvement in ASCOT scores, significant at the 1% level).

Impact across protected characteristics

47. There are limited differential impacts across protected characteristics, and nothing that is conclusive. This tends to suggest that the personal health budgets do not systematically benefit specific demographic groups. However, this result is not conclusive. There are a couple of suggestions of differential impacts, though these may be isolated incidents and do not appear to be repeated. Furthermore, sample sizes for some demographic groups are relatively low, and therefore while no results have been found, this could be because the samples were too low to pick up effects. This is discussed in more detail in the *Equality Impact Assessment* section below.

Impact on carers

48. Personal health budgets could have significant impacts on carers of budget holders. For example, personal health budgets may reduce people's reliance on care, be it formal or informal, by improving their outcomes. They may also allow people to access more appropriate services, which means that people may not be reliant on carer to provide these services.

49. Chapter 7 of the evaluation report discusses the impact of personal health budgets on their carers. The findings are positive, with carers of people receiving personal health budgets being more likely to report better quality of life and perceived health than carers of people in the control group. Carers in the personal health budget group also reported lower instances of having their health affected by their caring role, and they seemed to be satisfied with the personal health budget process in terms of care or support planning. While these findings are tentative as they are based on relatively small samples, they do give an indication of the potential positive impacts that personal health budgets can have on carers.

Summary of findings

50. The above information supports the case for the expansion of personal health budgets beyond the pilot programme, and is clear that they work well for some groups and in some circumstances. The evaluation points towards personal health budgets improving outcomes and reducing costs, and therefore improving cost-effectiveness. This particularly applies for people eligible for NHS Continuing Healthcare and mental health, and for people receiving high value budgets. When personal health budgets are implemented as was originally intended – especially model 1, and to a lesser extent models 2 and 4 – they appear to be particularly beneficial, both in terms of outcomes and the effects on total costs for the individual.

[15] This means that if costs are reduced, this reduction is instead included as an outcome increase – so the total cost at the individual level would be assumed to stay the same.

51. However, these high-level findings mask significant variation and uncertainty in some of the results. So, while the effect on outcomes and costs was generally positive, in some cases it was not. For example, Model 3, where the pilot site introduced restrictions on how the personal health budgets would operate, appears to worsen the outcomes for the individual.

52. There remain some unanswered questions. In some models, outcomes improve though this is not always the case – other models show no effects on outcomes. In some models, costs fell, though again, this was not always the case and, in some models, costs did not show significant changes.

53. There are two main reasons why there remains some uncertainty about the effects of personal health budgets. On the outcomes side, this is partly due to difficulties around implementing budgets, which is discussed in more detail below in the risks and uncertainties section. This meant that people did not always have budgets for long enough for there to be discernible effects – as set out in Table 3-8 of the evaluation, 9 of the 52 people in the qualitative sample did not have a budget in place at the time of the 9 month interview.

54. Finally, many of the effects summarised above are only found to be significant at the 90% confidence interval – i.e. there remains a 10% possibility that the observed effects are down to chance alone. 95% or 99% confidence intervals would be preferable. This may mean that some caution is required when interpreting findings, especially where they are only found in one particular instance. In contrast, where the same finding is repeated over a range of different models (for example, high-value budgets being associated with higher levels of benefit and greater cost reductions), this gives greater levels of confidence that the observed findings are real effects.

Experience in social care

55. Overall, these findings mirror the experience of social care. For example, the Individual Budgets evaluation is clear that there are potential benefits resulting from the introduction of personal budgets in social care, but there remain difficulties around how personal budgets should best be introduced, for whom they are most suitable and how best people should be supported throughout the process.

56. Nevertheless, the high level finding of the Individual Budgets evaluation, that they are at worst cost neutral and they do improve outcomes. As with the personal health budgets evaluation, this masked significant variation, and there was a suggestion from the Individual Budgets evaluation that older people may have suffered worse outcomes and that people will mental health problems may have experienced significant barriers to uptake (though they did benefit if they got access to personal budgets).

International evidence and experience

57. Many countries are currently experimenting with personal budgets in social care, including France, Germany, the Netherlands, Austria, US, Canada, Australia, Sweden and Finland. However, as a scan by the Health Foundation in 2010[16] and a forthcoming paper make clear, evidence is far from conclusive. As this paper summarises, *"Most of the information available is descriptive rather than empirical research, and there are particular gaps around health outcomes and cost effectiveness"*. There are a handful of quantitative studies from US programmes, summarised in

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16 http://www.health.org.uk/public/cms/75/76/313/2594/personal%20health%20budgets.pdf?realName=wiYPsk.pdf

the original impact assessment for personal health budgets and from a review of direct payment programmes by Alakeson[17].

58. The Health Foundation also undertook a review of the *'Persoonsgebonden Budget'* (PGB) programme, which aimed to give people more control over the services they receive.[18] This is often cited as the example that is closest to personal health budgets in the UK. The findings were relatively negative, as while outcomes (especially feelings of being in control) increased, the programme led to significant total cost increases.

59. However, this example, while helpful, is not as relevant to the English context as it first appears. While it is often described as a programme looking at healthcare budgets, this is more focused on social care: the four main areas included are personal care for help with daily living, nursing care, support services and respite care. There were also problems with how the scheme was originally set up and administered. For example, there was a lack of restrictions on how money could be spent, including family care (which is only possible in England in exceptional circumstances), and PGB was designed as an addition rather than a substitute for conventional services.

60. As is clear when information from the Netherlands and elsewhere internationally is investigated in detail, there is no programme that is comparable with the personal health budgets pilots. There is some learning that can be drawn from other programmes – for example, the lessons learnt from the Dutch PGB system are instructive. However, it means that the primary source of information about the projected effects of personal health budgets is the evaluation. This means that the findings, set out above, are those upon which any quantification of effects must be based.

F Description of options considered (including do nothing)

61. There are a lot of potential options about personal health budgets, which patient groups they are offered to, what services can potentially be included and the speed of rollout (among others). For simplicity, this has been reduced to four options:

- Do nothing;
- Have an announcement about personal health budgets in the Mandate only;
- Introduce legislation to extend the use of direct payments for healthcare only; and
- Have the announcement in the Mandate and introduce legislation to extent the use of direct payments for healthcare.

62. Much of the information included within these options is the same across all of them. This is because we do not have enough information from the evaluation about differential effects of personal health budgets. The main difference between options is that they will likely result in different numbers of people having access to personal health budgets.

63. Any further options, for example around the speed of rollout, the patient groups to be included and what services should be included, are then discussed as sub-options. There is no reason at this stage to think that this will depend on how personal health budgets are expanded, and so these sub-options can be viewed as independent of the decision on the options set out above.

[17] http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2010/Feb/1370_Alakeson_intl_devel_selfdirected_care_ib_v2.pdf

[18] http://www.health.org.uk/publications/personal-health-budgets/

64. The options and discussion are also restricted to personal health budgets only, as there are already other policies relating to personalisation more generally, such as personalised care planning.

Option 1: Do nothing

65. The base case is the 'do nothing' scenario. Here, direct payments will, at the end of the pilot programme, no longer be permissible, as the regulations for direct payments at present were written so that direct payments only continued for as long as the pilot programme. Notional budgets and third party arrangements would still be possible for the individual.

66. While the evaluation found no differences between direct payments and other models of personal health budget, this does not mean that direct payments have no additional benefits on top of other models. What is clear from the pilot programme is that some people have a clear preference for direct payments above other models. Furthermore, much of the initial momentum for personal health budgets came from recipients of social care direct payments who were transferring into NHS Continuing Healthcare, where they were losing control over the care they received, who delivered it, and when and where it was delivered.

67. This option could also mean a return to the situation prior to the pilot programme – where notional budgets and third party arrangements were possible, but were rarely used. Given the experience of the pilots, it is unlikely that personalisation would regress this far, but it is a possibility, and not extending the regulations would represent a significant backwards step.

68. Sites introducing direct payments may also be an indicator of sites that are introducing personal health budgets as intended. The aim was for people to be able to access personal health budgets in the three possible forms, so that people could take as much control as they wanted. The majority of sites have been offering a variety of options for holding the budget.

69. The consideration of the do nothing scenario is therefore that direct payments are no longer possible. It is also assumed, for the reasons set out above, that this would lead to a significant loss of momentum and potentially the policy regressing or stagnating altogether.

Option 2: An announcement about personal health budgets in the Mandate

70. Option 2 is that there is only an announcement in the Mandate to the NHS Commissioning Board about personal health budgets. As the Mandate says, anybody who could benefit from a personal health budget could access one, subject to the evaluation. While this is the longer term policy intention, there are no specifics included within the Mandate, about dates or patient conditions.

71. The precise wording included in the Mandate is:

> *"Patients who could benefit will have the option to hold their own personal health budget, subject to the evaluation of the pilot programme, as a way to have even more control over their care."*[19]

72. This gives the longer term aim. While it is not feasible for this to be immediately achieved as there are significant risks involved – this is discussed in the 'risks and assumptions' section

[19] Available at http://mandate.dh.gov.uk/. This option has technically already been done, as the Mandate was published on 13th November 2012. This was informed by the findings of the evaluation, and of the wider experience of the pilot programme.

below – progress is expected following the positive results of the evaluation. The NHS Commissioning Board is therefore expected to operationalise personal health budgets.

73. There are sub-options within this option, about precisely how the wording included in the Mandate is interpreted. This includes for which groups personal health budgets are viewed as being beneficial, based on the evaluation, and about the scale and pace of rollout. This is the same question that exists for the other options, so this is dealt with in the section below about 'sub-options'.

74. This option does not permit the continuation of direct payments, and the legislation would cease following the pilot programme. This would mean that people cannot gain access to direct payments, and those currently in receipt of them would also have to revert to other forms of personal health budget, if they wished to do so.

75. Compared with option 1, under option 2 it is likely that greater numbers of people would access personal health budgets, and all clinical commissioning groups would need to be able to offer personal health budgets. However, it would also mean that as the direct payments option is removed, there may be less of a cultural shift, and fewer people may wish to take up the option as they do not have as much choice and control as they would wish.

Option 3: Extension of the regulations so that direct payments for healthcare can continue

76. Option 3 is that legislation is amended so that direct payments can continue. This means that commissioners can continue to transfer money directly to individuals to commission their own healthcare services, but that this power is available to all commissioners rather than just those specifically authorised by the Department of Health.

77. This would mean that people currently receiving direct payments could continue to do so, and that people who would like to start accessing direct payments and that the commissioner also thought could benefit could also start to do so. It would help to continue the momentum across the health and care system for greater personalisation of healthcare services, and would help to ensure that people can still have a smooth transition from social care direct payments in to NHS Continuing Healthcare.

78. Compared with option 1, this option would result in greater numbers of people accessing personal health budgets. This is because it would help to maintain (and potentially accelerate) policy momentum, as well as giving people the choice of all potential models of personal health budgets. Compared with option 2, it is difficult to say which would create the greatest momentum or have greatest benefits. Both options help to create momentum in their own right, but there is not enough information to make a comparison. Option 2 is likely to push commissioners further into delivering personal health budgets, whereas option 3 is likely to encourage potential recipients to push more for personal health budgets. It is not possible to say which affect is likely to dominate.

Option 4: An announcement about personal health budgets in the Mandate, and extension of the regulations (a combination of Options 2 and 3)

79. Under this option, there would be both an announcement within the Mandate about personal health budgets, and regulations would be amended so that direct payments for healthcare can continue beyond the pilot programme. As set out within options 2 and 3 above, this would combine momentum from the part of commissioners, for whom it would be mandated for them

to offer personal health budgets, and on the part of patients, who could access all of the budget options from which they could potentially benefit.

Options about what 'rollout' means, and what could be included within the regulations

80. Within options 2-4, there are sub-options about what 'rollout' of personal health budgets means. For options 3 and 4, this also includes sub-options about what is included within the regulations. Given the significant overlap between options around rollout and for what is included within the regulations, both are dealt with in this section.

81. It would be possible to be very prescriptive, both for policy guidance and for regulations. In general, the more certain the 'right' option is, the more justifiable it is to be prescriptive, be it through guidance or through regulations. Therefore, this section discussed how much certainty there is about particular options before suggesting a particular option. These options correspond to the questions posed within the consultation.

82. While there is much positive evidence about personal health budgets, outlined above, uncertainties remain. Therefore, the Department aims to be non-restrictive in its approach. This means that local areas would have autonomy about how personal health budgets are introduced. This does not apply to all areas where it would be possible to be prescriptive. Therefore, this section discusses where clear directions, through guidance or through regulations, could be used, and why the Department has followed a particular path.

<u>Care or support plan</u>

83. One of the areas of certainty is that transferring control to the individual, with support from the commissioner, is one of the key tenets of personal health budgets and is also beneficial to the individual. The evaluation is clear that models 1, 2 and 4, all of which give the individual a high level of control, have much better outcomes than model 3, where pilot sites imposed restrictions. Therefore, it is proposed that the regulation continues that stipulates that the personal health budget must be based on a care or support plan.

Proposal: personal health budgets will be based on a care or support plan, and for direct payments this will be mandated in the regulations.

<u>Patient groups</u>

84. It is clear from the evaluation that personal health budgets can be beneficial, and that they are cost-effective. They are more beneficial for people with higher levels of need (or at least higher budgets, which could represent a higher level of need or could represent the individual being given more choice and control, indicated through their budget covering more aspects of their care. It could be a combination of the two). They also appear to be more cost-effective for people eligible for NHS Continuing Healthcare, and those with mental illnesses.

85. The evaluation, and the experience of the pilot programme, is also clear that there are challenges associated with introducing personal health budgets. This includes around the information, advice and support that someone requires, how to carve money out of contracts to fund budgets, and how to set budgets, among others.

86. These challenges have been easier to overcome for NHS Continuing Healthcare than for other conditions. Here, there is a relatively well-defined budget already, there is a budget-setting mechanism (the Decision Support Tool, while nominally a needs assessment, has been developed to become a tool to inform budget-setting), and both patients and staff are used to the care or support planning process.

87. As there will be a major overlap between people who are eligible for NHS Continuing Healthcare, where personal health budgets are the most straightforward to introduce, and high-value budgets, where people experience the greatest improvements in outcomes and reductions in costs, this is the most sensible patient group with which to begin. This is supported by the average budget for people eligible for NHS Continuing Healthcare within the evaluation.

88. For other patient groups, it is clear that there are potential benefits. In particular, personal health budgets appear to be cost-effective for people with mental illnesses, and there is a suggestion that people with COPD experience particular benefits. However, based on the experience of the pilot programme, there are more difficulties introducing personal health budgets for other patient groups. This is particularly because of the difficulty in carving out money from existing contracts in the short-term: if this is not possible, there would be greater double-running costs. This is discussed in more detail in the *Risks and Assumptions* section below.

89. Therefore, at this stage it is proposed only people who are eligible for NHS Continuing Healthcare have the right to ask for a personal health budget, and the Government intends to introduce this right from April 2014. In the longer term, the aim is to broaden the right to include other patients who would benefit, but this will take longer given the challenges and uncertainties of implementing personal health budgets on a large scale. At present, it is up to clinical commissioning groups to offer budgets to other patient groups, if they feel that they have resolved some of the challenges around implementation. This means that people currently receiving budgets can continue to access them, and do not experience a discontinuity.

90. This is the same across options 2, 3 and 4. Regarding the announcement in the Mandate, this does not specify particular conditions, instead saying that personal health budgets will be introduced for people who could benefit, informed by the evaluation. There is a clear lesson from the evaluation and the pilot programme that personal health budgets are most effective for people with levels of need, and that they are easier to introduce for people eligible for NHS Continuing Healthcare. If clinicians believe that other patient groups can benefit, and the practical challenges are surmountable, then they can also be included.

91. Therefore, it is not proposed to include specific conditions in the regulations. Instead, the regulations will simply permit direct payments for healthcare. This will enable them to be offered for people eligible for NHS Continuing Healthcare, as well as for other patient groups where commissioners feel they will benefit.

Proposal: The first stage of rollout is for people eligible for NHS Continuing Healthcare to have the right to ask for a personal health budget. It is then voluntary for clinical commissioning groups to offer personal health budgets for other patient groups. This will not be specified in regulations for direct payments.

Services that a personal health budget can be spent on

92. Personal health budgets will not be an appropriate method of funding to meet all of an individual's health and wellbeing needs. For example, emergency services (including surgery) and GP services should not be included. For emergency services, it is because by their very nature they cannot be planned for, and therefore it is not realistic to include them in a budget. For GP services, this is because GPs provide a holistic service, which is funded separately.

93. The regulations for the pilot programme did not specify what services direct payments could be spent on. Personal health budgets can be spent on anything (with the exception of alcohol, tobacco, drugs and debt repayment, and anything illegal), provided that it is agreed by the commissioner in the care plan.

Proposal: Personal health budgets can explicitly not be spent on some health services, including emergency services and GP services. This will be specified in the regulations for direct payments.

Information, advice and support

94. As was clear in both the fourth and fifth interim evaluation reports, the role of information, advice and support is hugely important. People's experience of personal health budgets, and the benefits they derive from them, is highly dependent on how informed they are. In some cases, this will mean that the individual requires very small amounts of support as they are already fully informed. In other cases, people will need substantial amounts of support. This is important upfront, during the care and support planning process, to ensure they are informed about the treatments and services that may be on offer to them. It is also important on an ongoing basis to ensure that they are supported to manage the budget, for example if they have a direct payment and are employing someone directly.

95. To help maximise the likelihood that people benefit from personal health budgets, people will therefore need information, advice and support to enable them to make informed decisions. What this is, and how it is provided, will vary between individuals. This could, for example, include leaflets or pamphlets, internet information, advice from healthcare professionals or peer support. It is likely that this will impose an upfront cost, which is discussed in the section below about the costs of introducing personal health budgets. Not doing this properly introduces a risk that people who could benefit do not – this is further discussed in the *Risks and assumptions* section below.

96. Unfortunately, the evaluation has not been able to estimate the amount of additional support that may be required, as there were large difficulties in estimating support for the control group. There is work that has recently been commissioned to look at this in more detail. It is likely, based on previous programmes (such as the Individual Budgets work and the Partnerships for Older People Projects (POPPs)) that this will fall over time as staff and individuals get used to new ways of working.

97. It is proposed that the regulations will set out in more detail what kind of information, advice and support the patient might be offered. It is not proposed that the regulations are any more explicit than this, as not enough information was available from the pilot programme to be able to say exactly how this should be done.

Proposal: Recipients of personal health budgets should get the information, advice and support they require to make informed decisions. This will be specified in the direct payments regulations.

Separate bank accounts (direct payments only)

98. The legislation is proposed to continue with the requirement in the pilot programme that direct payments should be paid into a separate bank account. This will enable individuals to keep their direct payment separate from their personal finances, and allow them and the commissioner to track spending of the direct payment. It will also help to avoid fraud as spending will be transparent, which will mean that any misspends are picked up quickly.[20]

99. However, it is proposed that if an individual is getting a direct payment for a single item, it should be possible for this to be paid into an existing bank account. There were a few examples in the pilot programme, for example in the case of something like a laptop to help reduce social isolation for someone with mental health problems. Having this possibility should help to reduce

[20] While there have been no examples of misspends of the budget during the piloting phase, it may still remain a risk. Having a separate back account for direct payments helps to mitigate against this risk. This is discussed in more detail in the *Risks and assumptions* section below.

potentially unnecessary costs associated with a one-off payment will help to ensure that personal health budgets remain cost-effective.

Proposal: Recipients of direct payments require a separate bank account, unless it is for a single item. This will be included in the regulations.

Safeguarding

100. To help ensure that individuals can remain confident that their care is safe and their carers are suitable persons to be involved in the delivery of care, it is proposed that personal health budgets holders can continue to ask for Criminal Record Bureau (CRB) checks. This means that both the individual and the commissioner can be confident in the people delivering care. In some cases, this may not be desirable – for example, in cases where the individual has a family member delivering care – as the budget holder would be willing to go ahead with a particular person regardless of their background or history. This may be beneficial in some cases, and therefore it is not proposed to include in regulations that people with a criminal record cannot deliver care. Instead, either the commissioner or the individual can request a CRB check, and then make a decision about whether a particular person should be allowed to deliver care with full information of the particular situation.

Proposal: Personal health budgets holders can request a CRB check about their carer. For direct payments holders, this will be included in regulations.

Budget setting

101. One of the key tenets of personal health budgets is knowledge of the size of the budget. This is to help the individual to plan the care and services they will access to meet their health and wellbeing needs. Therefore, to enable this, the commissioner needs to be able to set the budget. How this could be done varies. It could be based on a needs assessment, or it could be based on existing utilisation, or on some combination of the two.

102. While the pilot programme provided information about this, it did not give a definitive method. There was significant variation both across condition and across pilot sites. For NHS Continuing Healthcare, eligibility is set by the Decision Support Tool, a needs assessment across a range of domains. Some of the pilot sites, with support from the Department, have converted this into a cash allocation across the domains.[21] For other conditions, most notably long term conditions, this has proved to be more difficult to do, as robust cost estimates of particular services are harder to generate.

103. Budget setting is an area of continuing work within the Department and with some of the pilot sites. However, it is not yet possible to provide a robust budget setting tool, and therefore it is not proposed that a particular method is mandated, or that this is included within the regulations.

Proposal: How the budget is set will not be mandated from the centre, nor will it be included in regulations.

G Monetised and non-monetised costs and benefits of each option (including administrative burden), and supporting evidence

104. This section makes estimates about the costs and benefits of the particular options, based on the information that is available from the evaluation. Where this information is incomplete, or where there is uncertainty, these estimates are caveated accordingly.

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[21] http://www.personalhealthbudgets.dh.gov.uk/Topics/latest/Resource/?cid=8425

Benefits of introducing personal health budgets

Option 1: do nothing

105. By definition, the benefits of the do nothing option are zero. This is the baseline against which the effects of the intervention will be assessed.

Options 2, 3 and 4: included an announcement in the Mandate, extend the regulations for direct payments for healthcare, or both

106. As set out above in the results of the evaluation, personal health budgets appear to be cost-effective for the individual. Using a monetised version of the ASCOT where one full unit is worth £30,000 gives an average benefit of £2,300 per individual.[22]

107. The cost-effectiveness of personal health budgets for people who are eligible for NHS Continuing Healthcare is much greater – with a suggested total benefit of £9,840 per person. This covers both the cost reduction (which was predominantly from reduced indirect costs), improvements in the ASCOT rating of the individual. The analysis below uses the smaller figure of £4,340, which is the cost-effectiveness gain resulting from a high value budget. This is to be consistent with the use of the £3,100 reduction in costs per person, also resulting from holding a high value budget. Both figures are included in Table 3 below.

108. As of quarter 1 2012/13, the latest time for which data is currently available, there were 56,411 people currently eligible for NHS Continuing Healthcare, with a total spend of approximately £2.67bn.[23] This is a snapshot at a given point in time of numbers of people who are eligible – some people will have been in receipt of NHS Continuing Healthcare for months or years, whereas others will have been on the list for a short period of time and do not have long to live. This means that for some people, a budget could potentially be very beneficial, whereas for others it is likely that the personal health budget, if introduced at that point, may not be worthwhile as the individual has a matter of days left to live.[24] This means that not all of the 56,411 people are likely to benefit from a personal health budget.

109. Based on some information about NHS Continuing Healthcare recipients in London, that gives a breakdown of people eligible for NHS Continuing Healthcare at a given moment in time and the category of eligibility they fall in to, approximately 15% of this sample are eligible through "fast-tracking". These are the people who are likely to only have a few days or weeks to live. The working assumption is therefore that 85% of people could be eligible.

110. There is then uncertainty around what proportion of this 85% of people would take up the offer of a personal health budget, if they would also be thought to be suitable by the commissioner.

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[22] Using a monetised ASCOT measure is a relatively new concept, and thus may be open to challenge. However, as set out above, the ASCOT measure relates both to wider than a social care outcome only to also include quality of life related to ongoing health status. Furthermore, as set out in the evaluation section above, the general finding from the evaluation is that costs tend towards falling while outcomes tend towards improving, so even in the absence of ASCOT being monetised there are some of the models and cases in which personal health budgets serve to reduce total costs.
[23] http://www.dh.gov.uk/health/2012/09/continuing-healthcare-spreadsheet/. This is a snapshot of people eligible for NHS Continuing Healthcare at a particular moment in time. It will therefore be made up of people who have been eligible for a number of months or years, as well as those who are eligible for a matter of days at the end of their life. The best estimate of the overall expenditure on NHS Continuing Healthcare is £2.67bn. This figure is not publicly available, and is based on the Financial Monitoring and Accounts forms for 2010/11. This is not, however, an audited figure, and therefore must be treated as an estimate only.
[24] It may be different if the individual already has a personal health budget or a social care personal budget or direct payment when they become eligible for NHS Continuing Healthcare. In these cases, it may be that the care arrangements for the individual can be continued or tweaked slightly. But, for others, it will not be suitable as a personal health budget will add unnecessary stress to an already difficult situation for the individual.

This is likely to vary between options 2, 3 and 4. Option 4 is likely to lead to the greatest proportion, while option 1 will lead to the lowest proportion. The working assumption is that for options 2 and 3, 20% of people eligible for NHS Continuing Healthcare will take up the offer of a budget, while for option 4, 50% of eligible people will take up the offer.

111. Table 3 summarises the benefits of introducing personal health budgets. This is based on the following assumptions:

- 'Low' take-up of personal health budgets is assumed to be 20% of people eligible for NHS Continuing Healthcare (0% in year 0; 10% in year 1, 20% thereafter);[25]
- 'High' take-up of personal health budgets is assumed to be 50% of people eligible for NHS Continuing Healthcare (0% in year 0; 25% in year 1, 50% thereafter);
- Cost-effectiveness gain per person is £4,340 per person, and cost-saving is £3,100 per person, which are not assumed to vary as more people get a personal health budget; and
- There is a 3.5% discount rate.

Table 3: Benefits of introducing personal health budgets

NB Sensitivity analysis is included in Annex A, covering the range of potential cost-effectiveness gains and cost-savings that were set out in the evaluation report.

	Best estimate (using point estimates)										
Year	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**Total**
Discount rate	1.00	0.97	0.93	0.90	0.87	0.84	0.81	0.79	0.76	0.73	
Number of recipients (low personal health budget uptake)	0	5,600	11,300	11,300	11,300	11,300	11,300	11,300	11,300	11,300	
Cost effectiveness gain (£m)	0.0	24.3	49.0	49.0	49.0	49.0	49.0	49.0	49.0	49.0	**416.6**
Cost effectiveness gain (discounted) (£m)	0.0	23.5	45.8	44.2	42.7	41.3	39.9	38.5	37.2	36.0	**349.2**
Cost saving (£m)	0.0	17.4	35.0	35.0	35.0	35.0	35.0	35.0	35.0	35.0	**297.6**
Cost saving (discounted) (£m)	0.0	16.8	32.7	31.6	30.5	29.5	28.5	27.5	26.6	25.7	**249.4**
Number of recipients (high personal health budget uptake)	0	14,100	28,200	28,200	28,200	28,200	28,200	28,200	28,200	28,200	
Cost effectiveness gain (£m)	0.0	61.2	122.4	122.4	122.4	122.4	122.4	122.4	122.4	122.4	**1,040**
Cost effectiveness gain (discounted) (£m)	0.0	59.1	114.3	110.4	106.7	103.0	99.6	96.2	92.9	89.8	**872.0**
Cost saving (£m)	0.0	43.7	87.4	87.4	87.4	87.4	87.4	87.4	87.4	87.4	**743.1**
Cost saving (discounted) (£m)	0.0	42.2	81.6	78.8	76.2	73.6	71.1	68.7	66.4	64.1	**622.8**

112. This table is calculated using the assumptions set out above. This gives the cost-effectiveness gain and cost-savings nationally of introducing the policy. This means that the total discounted cost-effectiveness gain for Option 4 over the 10-year time horizon is £872m, while the total national discounted cost-saving is estimated to be £623m. For Options 2 and 3, the total discounted cost-effectiveness gain is £349m, and the national discounted cost-saving is estimated to be £249m. There are additional assumptions, such as that improvements in cost-

[25] Based on the experience of the pilot programme, it takes about 2 years for a local area to be able to offer significant numbers of personal health budgets. Therefore, the full proportion is only assumed to be achieved by year 2, with half in year 1. This assumption is used for all of the options.

effectiveness remain the same per person as the number of personal health budget recipients increases. This is discussed in more detail in the *Risks and assumptions* section below.

113. Personal health budgets were also found to be beneficial, in general, for other patient groups as well, particularly people with mental health problems. Table 1 above set out potential numbers of personal health budget holders in the longer term. That said, while personal health budgets do seem to be generally beneficial, with a monetised benefit of £2,300 (again using a £30,000 cost per ASCOT threshold) there is likely to come a point when the individual's condition is relatively minor and the costs of introducing a personal health budget outweigh the potential gains. This is likely to be the case when someone has limited interaction with the health system. While in some cases the individual may be able to benefit and it would be cost-effective from the perspective of the system, this is more likely to be suitable for introduction on a case-by-case basis rather than a universal right to everyone.

114. Therefore, the benefits for groups beyond NHS Continuing Healthcare have not been included in any calculations at this stage. This is partly because there is greater uncertainty about the effects, and partly because it is less clear at this stage how best personal health budgets should be implemented for these groups.

Costs of introducing personal health budgets

<u>*Option 1: do nothing*</u>

115. The costs of doing nothing are by definition 0. This is the baseline or counterfactual against which other options will be assessed.

<u>*Options 2, 3 and 4: included an announcement in the Mandate, extend the regulations for direct payments for healthcare, or both*</u>

116. Costs of the introduction of personal health budgets can be split into two. The first are "set-up" costs – i.e. costs associated with ensuring that the system can support the introduction of personal health budgets. These are assumed to only be incurred in the short term. This would, for example, involve the development of the local workforce, the development of local systems, and development of the care or support planning process. The second is ongoing costs associated with the longer term running of personal health budgets, for example increased costs associated with spending more time on the care or support planning process.

117. The 3rd interim report[26] estimated costs to be £150,000. This was based on average costs over the 20 in-depth pilot sites, over two years of implementation. This masked some variation, with the total costs ranging from £92,000 to £258,000. These were costs that would not have been incurred without the introduction of the pilot programme, and are broken down in more detail in Table 4 below:

[26] http://www.dh.gov.uk/health/2011/08/personal-health-budget-pilot/

Table 4: Costs incurred by in-depth pilot sites in year 1

Expenditure item	Number of observations[27]	Mean cost
Project management[28]	18	£52,760
Overall additional expenditure for the project board[29]	12	£19,150
Overall additional expenditure for the development of systems[30]	10	£38,980
Additional resource for support planning[31]	8	£18,470
Additional resource for market development[32]	3	£5,750
Total cost for first year	**18**	**£93,280** [33]

118. The 3rd interim report also included estimates about the costs required for implementing personal health budgets in the second year of the pilot programme. Based on information received from sites, this gave a total figure of £146,040 per pilot site. However, as the estimated costs for the second year were based on predictions only, the year 1 figure is taken as a more accurate figure. Therefore, the total implementation figure for a commissioning unit is assumed to be £187,000 (£93,280 for 2 years).

119. As the third report set out, this is likely to be an overestimate of the true implementation costs upon rollout. As the report said, *"Following previous studies, such as the evaluation of partnerships for older people projects (Windle et al., 2009) it is assumed that as personal health budgets become more mainstream the level o resource required will be reduced"*. Nevertheless, the estimates from the 3rd report are the best information that is currently available, but, in light of this experience from previous comparable projects, this will be taken as an upper estimate of the likely costs.

120. It is also clear from the items discussed in Table 4 that some of these costs would be associated with personal health budgets on an ongoing basis. Some of the items included within categories, especially around additional resource for support planning, are likely to continue, or at least some aspect of them will. However, it is difficult to make any assumptions about the extent to which this will be the case. It may also vary depending on the number of people who receive personal health budgets.

121. Based on some assumptions, it is possible to come up with estimates. Table 5-4 from the 3rd report gives an average cost of £18,470 for pilot sites that reported costs around information, advice and support. This is viewed as a low estimate, not least in light of the experience set out in the 4th and 5th interim reports that the provision of information, advice and support is of paramount importance. Therefore, the alternative estimates are £50,000 per commissioning unit (which is taken as the best estimate), and £75,000 per commissioning unit (high estimate). These are the costs assumed to be ongoing, though were included as part of the total set-up costs in the 3rd interim report.

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[27] Not all of the pilot sites reported costs for some of the areas. In some cases, it was done entirely by the project lead, and so was subsumed within the cost of project management. Mean costs are then just for those sites who reported costs in particular areas.
[28] From table 5-1 of the 3rd interim report.
[29] From table 5-2 of the 3rd interim report. This includes brokerage activities, direct payment services, emergency carer support and premises / office costs.
[30] This is from Table 5-3 of the 3rd interim report, covering the assessment process, budget-setting, support planning, review process, financial administration and information set-up.
[31] This is from Table 5-4 of the 3rd interim report, covering peer support, private and voluntary sector support planning and marketing materials for in-house services.
[32] This is from Table 5-5 of the 3rd interim report, covering procurement, contract renegotiation and transitional arrangements.
[33] Individual items will not sum to the total figure as the total is the mean across all sites, while the means for individual items only correspond to where money was spent on that area.

122. These ongoing costs are assumed to increase as more people receive personal health budgets. As the pilot sites had an aim to recruit 75 people, the figures above are assumed to cover 75 people only. More people means a greater cost, increasing proportionally.

123. Based on the experience of the pilot programme, the estimated number of commissioning units is approximately 50.[34] This is based upon the PCT clusters. The expectation is that clinical commissioning groups will continue to work together for things such as the commissioning of NHS Continuing Healthcare and for personal health budgets, and therefore it is assumed that there will be 50 commissioning units.

124. This is not a genuine additional cost. As the third evaluation report set out, the costs included are additional costs that would not have been incurred without the introduction of personal health budgets, but some of this is displacement of work that would otherwise have happened. This may therefore represents an opportunity cost rather than a financial cost.

125. Table 5 summarises costs across a 10-year time horizon. This is based on the following assumptions:

- 'Low' take-up of personal health budgets is assumed to be 20% of people eligible for NHS Continuing Healthcare (0% in year 0; 10% in year 1, 20% thereafter);
- 'High' take-up of personal health budgets is assumed to be 50% of people eligible for NHS Continuing Healthcare (0% in year 0; 25% in year 1, 50% thereafter);
- Set-up costs are incurred in years 0 and 1 only;
- Ongoing costs are £50,000 per 75 people;
- There is a 3.5% discount rate.

Table 5: costs of introducing personal health budgets

NB Sensitivity analysis is included in Annex A, covering the range of ongoing costs for implementing personal health budgets.

Best estimates (medium ongoing costs)											
Year	0	1	2	3	4	5	6	7	8	9	
Discount rate	1.00	0.97	0.93	0.90	0.87	0.84	0.81	0.79	0.76	0.73	
Set-up costs (£m)	2.2	2.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**4.3**
Ongoing costs (low personal health budget uptake) (£m)	0.0	3.7	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	**64.0**
Total costs (low personal health budget uptake) (£m)	2.2	5.9	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	**68.3**
Discounted total costs (low personal health budget uptake) (£m)	2.2	5.7	7.0	6.8	6.6	6.3	6.1	5.9	5.7	5.5	**57.9**
Ongoing costs (high personal health budget uptake) (£m)	0.0	9.4	18.8	18.8	18.8	18.8	18.8	18.8	18.8	18.8	**159.8**
Total costs (high personal health budget uptake) (£m)	2.2	11.6	18.8	18.8	18.8	18.8	18.8	18.8	18.8	18.8	**164.1**
Discounted total costs (high personal health budget uptake) (£m)	**2.2**	**11.2**	**17.6**	**17.0**	**16.4**	**15.8**	**15.3**	**14.8**	**14.3**	**13.8**	**138.2**

[34] There are approximately 50 PCT clusters. Towards the end of the pilot programme, many of the pilot sites expanded their projects to cover other PCTs within their cluster, so this is taken as the base commissioning unit.

126. Costs are also assumed to be equivalent across the options 2, 3 and 4, in terms of both set up costs and ongoing costs per person. It may be that there is some additional cost associated with putting in place monitoring (set up cost) and undertaking the monitoring (ongoing cost) for people receiving direct payments when compared with those receiving third party budgets or notional budgets.

Comparison of costs and benefits

127. Table 6 gives a net benefit, based on the best estimates of costs and benefits set out above. This is based on 50% take up of personal health budgets by people who are eligible for NHS Continuing Healthcare, and the best estimates of costs, cost-effectiveness and cost-savings set out in Tables 3 and 5 above.

Table 6: Net benefit of introducing personal health budgets

20% take-up of personal health budgets (Options 2 and 3)											
Year	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**Total**
Costs (£m)	2.2	5.7	7.0	6.8	6.6	6.3	6.1	5.9	5.7	5.5	**57.9**
Cost-effectiveness gain (£m)	0.0	23.5	45.8	44.2	42.7	41.3	39.9	38.5	37.2	36.0	**349.2**
Cost savings (£m)	0.0	16.8	32.7	31.6	30.5	29.5	28.5	27.5	26.6	25.7	**249.4**
Net benefit (£m)	-2.2	17.8	38.7	37.4	36.2	34.9	33.8	32.6	31.5	30.5	**291.3**
Net cost saving (£m)	-2.2	11.1	25.7	24.8	24.0	23.2	22.4	21.6	20.9	20.2	**191.6**
50% take-up of personal health budgets (Option 4)											
Costs (£m)	2.2	11.2	17.6	17.0	16.4	15.8	15.3	14.8	14.3	13.8	**138.2**
Cost-effectiveness gain (£m)	0.0	59.1	114.3	110.4	106.7	103.0	99.6	96.2	92.9	89.8	**872.0**
Cost savings (£m)	0.0	42.2	81.6	78.8	76.2	73.6	71.1	68.7	66.4	64.1	**622.8**
Net benefit (£m)	-2.2	48.0	96.7	93.4	90.3	87.2	84.3	81.4	78.7	76.0	**733.8**
Net cost saving (£m)	-2.2	31.1	64.1	61.9	59.8	57.8	55.8	53.9	52.1	50.3	**484.7**

128. Therefore, as option 4 is estimated to deliver the highest net benefit, this is the preferred option. This (and the other options) does not take into account the potential benefits of extending to other patient groups, which means that it will be an underestimate of the true total benefit. This will increase as more people get personal health budgets, and so option 4 will remain the preferred option.

129. This means that the net present value of option 4, over 10 years, is £734m. The net cost-saving alone is £485m. For options 2 and 3, the net present value is £291m, and the cost saving is £192m. These are policy options 2, 3 and 4 in the summary sheet. As policy option 1 is the "do nothing" option, this is not included in the summary sheets. The "high" and "low" estimates in the summary sheets are taken from Annex A, that gives sensitivity analysis around the figures above.

H Rationale and evidence that justify the level of analysis used in the IA (proportionality approach)

130. In the short term, it is envisaged that personal health budgets are available predominantly for people eligible for NHS Continuing Healthcare, with commissioners offering budgets to other groups on a voluntary basis. The longer term aim, that anybody who could benefit from a personal health budget has access to one, will clearly have a much wider effect on the system. However, and as set out in the *Risks and assumptions* section below, the effects of this are, at this stage, uncertain. The evaluation of personal health budgets is effectively a "proof of concept" – that is to say, they can work. This does not mean that personal health budgets are effective for all people, or for all services. It is also clear that there are challenges around implementation, and

that some people experienced worse outcomes as a result of the personal health budget – particularly people receiving budgets under "Model 3".

131. The differences in implementation are partly a result of uncertainty at the outset of the pilot programme about how best personal health budgets should be introduced. In this regard, when it becomes clearer that some factors, such as having a personalised amount of money and having choice over both services received and the model of the budget, have a major impact upon the effects of the personal health budgets, these differences will disappear over time. This is because local areas will see what is successful and will amend their practices accordingly.

132. However, some of these differences may persevere in the longer term. This is because in some cases, they will be the result of different practices or different cultures within the NHS. This could, for example, be where staff in one area are very willing to transfer a lot of control to the individual, whereas in other areas this may not be the case. Here, in spite of evidence clearly pointing towards a certain method of implementation, it may take a long time to change the culture within individual organisations and localities. This points towards the need for more information at the local level about how things are implemented.

133. Furthermore, even where personal health budgets are implemented well and are generally beneficial, they are unlikely to benefit everyone. The evaluation points towards a general improvement in outcomes, which applies to a majority of people rather than being concentrated in a small group, but personal health budgets will inevitably not work for some people, for entirely unpredictable reasons. It is important to bear in mind that this is the same as with existing services. Part of the reason that personal health budgets are effective is that they help people to self-direct towards treatments that offer them greater benefit. Therefore, they represent an average improvement on the existing situation.

134. Given the uncertainties, especially beyond NHS Continuing Healthcare, it is likely to be necessary to gather further information about both methods of implementation and effects of personal health budgets. This will be used to inform longer term policy development. To aid this, the Department recently announced nine "Going further, faster" sites.[35] Part of their aim is to investigate further how best personal health budgets should be implemented. It may be necessary over the longer term to accompany this with further evaluations, looking at alternative patient groups.

I Risks and assumptions

135. The information above has been candid about some of the challenges associated with the implementation of personal health budgets. None of these are insurmountable, and at worst are likely to delay implementation and realisation of the benefits rather than to pose specific risks to the policy.

136. However, there are some risks and uncertainties that could pose more significant questions. While the evaluation, and the pilot programme more generally, provided a lot of information, and much more than was available at the outset of the pilot programme, not all questions have yet been answered. Some more have also been raised.

Risks to patients

137. At the outset of the pilot programme, this was repeatedly raised as a risk. It was assumed that people, when given more control, would make decisions that were not in their long term

[35] http://www.personalhealthbudgets.dh.gov.uk/News/item/?cid=8607

interests and would result in worse health outcomes. This has not proven to be the case, and while there are no benefits to an individual's health status (as traditionally defined), there are also no negative impacts. Furthermore, in general there are benefits to an individual's quality of life, as measured by ASCOT.

138. This is not always the case. As the evaluation makes clear, Model 3 has resulted in worse outcomes for the individual. There are clear lessons to learn from this about how best personal health budgets should be implemented, and that commissioners should resist putting restrictions in place that limit choice or impose specific methods of holding the budget onto the individual.

Mitigation: share practice from where the introduction of personal health budgets has been more beneficial.

Wider system risks

139. Personal health budgets are a major change to how the system operates. They give more control to the individual, direct control in some cases, and mean that there could be significant changes in commissioning patterns. This is to be welcomed – as seen in the evaluation, patients do make choices that benefit them and are cost-effective. However, this will clearly impact on the system, and if people are opting away from a particular service, there are clear implications for the long-term viability of that service.

140. This is a risk that needs managing but not avoiding. If people are selecting different services that are benefiting them more, then there is a question as to whether the original services should be commissioned. That said, it is clearly not feasible to move away from such services immediately. The capacity in new services will not be immediately available, and the commissioner may well have funding tied up in a particular provider. Instead, this would be reduced over time.

141. This assumes that all people will opt away from a particular service, which is unlikely to be the case. Instead, it is likely that some people will opt away from a particular service while others will want to continue to access it. However, as numbers reduce, it may be that the unit costs of that service become unsustainable, which could have a detrimental impact on people who want to continue to access it.

142. The pilots were not large enough to provide learning about the extent to which this may be the case. However, the evaluation team did attempt to estimate money that could potentially go to different providers as a result. These findings are highly speculative, and give an initial indication that £2,180 may go to different providers[36], particularly providers of social care services. Within social care, there have been instances of day centres in particular being systematically closed by local authorities where people have begun opting away from them, to the potential harm of some people.

Mitigation: implement personal health budgets slowly, and be clear about what individuals are choosing to do when they have more control and the implications on providers, and manage this accordingly.

Fragmentation

143. Linked to the above, if people begin accessing many different services, this could lead to fragmentation of services. This applies to the individual, where coordination of care may become more of a challenge, especially around information sharing and similar. It could also be more of a challenge for commissioners as they need to keep aware of a greater number of services, beyond their traditional areas of expertise.

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[36] The evaluation team could not be specific about the providers that this finding was likely to go to, but hypothesised that as it was wellbeing services and social care services it was likely to the voluntary or private sector providers. This may give an indication about how providers, from the public, voluntary and private sectors, should respond to provide services that people want and that benefit them.

Mitigation: care or support planner to maintain oversight at the individual level as necessary; commissioners to adapt over time.

Blurring of the boundary between health and social care

144. While this is not a risk per se, it does present a potential challenge. One of the clear findings from the pilot programme was that people access different services to meet their health and wellbeing needs, potentially from social care. In some instances, commissioners have allowed this, recognising that the service is to meet health needs; in other cases, it has not been permitted.

145. This may cause some practical challenges around tracing back spending for accountability purposes. This does not, however, mean that this risk should be avoided. As with the wider system change discussed above, if people are accessing different services that are better meeting their health and wellbeing needs, this should be positively encouraged, though managed.

Mitigation: introduce gradually, and be clear about the impact on existing services and providers.

Increasing costs to the system

146. One of the fears at the outset of the pilot programme was that personal health budgets would result in greater costs to the system. This could be through increased costs associated with care or support planning, or through people selecting inappropriate services and requiring expensive inpatient treatments as a result, or through people wilfully misspending their budget and the NHS being required to pick up the bill.

147. This has not proven to be a risk in practice. Costs have been neutral, or have fallen in the case of high-value budgets. There have been no cases of wilful misspending of budgets, and as a result there have been no increases in costs to the system.

Mitigation: there is no risk to currently mitigate here, though commissioners will need to monitor this to ensure that if it does occur, they take action.

Cost effectiveness rather than affordability

148. Personal health budgets are cost-effective at the individual level, as shown by the evaluation. However, this is not the same things as being cost-effective or affordable at the system level. While there has generally been a reduction in inpatient expenditure as a result of personal health budgets, this means the individual has not been admitted: it does not mean that admissions across the system have fallen – it could instead be that a marginal case filled the bed, where the cost-effectiveness of the treatment was not clear but where the individual benefited.

149. This is a much wider risk than personal health budgets only. This applies to any policy aims to reduce admissions to hospital. Mitigating this risk therefore needs to link in to commissioning more generally, and thinking about how treatment of individual could be moved away from secondary care. Given the scale of the pilots, this was not explored in detail.

Mitigation: investigate as part of "Further, Faster" work (see below), and for commissioners to be aware of and to monitor accordingly.

Fraud

150. Combined with wilful misspending of budgets on treatments that may not benefit the individual discussed above, fraud was another fear that was highlighted at the outset of the pilot programme. Especially in the case of direct payments, it was thought that people may take the money and run away with it. This too has proved unfounded in the pilot programme, with no known examples of fraud by budget holders. Cases in social care are also very limited in number,

possibly indicating that people receiving budgets view this as an opportunity to improve the care that they require rather than an opportunity to steal public funds.

Mitigation: there is no risk to currently mitigate here.

<u>Cultural change and potential risks of transparency</u>

151. As a result of personal health budgets, there will be much greater transparency to the individual about costs of particular treatments. In part, this is to be encouraged. When people are more aware of the cost of services, they are likely to be more careful about wasting resource, and to think about the benefits of the treatments they are accessing.

152. However, this does also present two risks. One is that people increasingly view things as "my" budget, potentially eroding the community aspect of the NHS. There is no evidence of this so far, though it may be a risk as personal health budgets expand. Secondly, people may see how much their treatments cost the NHS, and view themselves as a burden so select less invasive or cost-effective treatments (or no services at all).

Mitigation: neither of these risks have yet been observed. Monitoring may be helpful in the longer term.

<u>Top-ups</u>

153. Given the greater transparency associated with personal health budgets, and potentially exacerbated by potential restrictions on funding, there may be more of a pressure to allow top-ups in personal health budgets. This was seen in one case in the pilot programme, when an individual was directly asked to top up their budget. Top-ups are unlawful except when specific patient charges are required by legislation, and they go directly against the NHS Constitution, which is clear that the NHS treats people on the basis of need and not ability to pay.

Mitigation: reiterate that top-ups are not permitted, and that the personal health budget is there in lieu of NHS services so is subject to the same rules.

<u>Minimising costs resulting in lower benefits</u>

154. While personal health budgets are cost-effective, it is also clear that there is some upfront investment required to make them a success. This includes the setting up of systems, training of the workforce and investment in the personal health budget process. In times of financial constraint, commissioners may look to minimise these costs, which could mean that personal health budgets are implemented in ways that do not benefit the individual. This could, for example, be through not investing in the information, advice and support that is required.

Mitigation: emphasise the need to implement personal health budgets with regard to the findings of the evaluation, and also emphasise their cost-effectiveness.

<u>Implementation challenges</u>

155. It is clear form the pilot programme and the evaluation that when personal health budgets are implemented well, they are beneficial. However, in the pilot programme, among pilot sites who are likely to be enthusiasts, it is clear that there were implementation challenges even here. Therefore, as personal health budgets are expanded across the country, there is no guarantee that commissioners will implement them well.

156. This is a clear risk, and the experience from the pilot programme shows there are some clear pitfalls in the implementation. Perhaps counter-intuitively, these appear to be greater if the commissioner goes for a gradual approach – i.e. giving the individual a bit of control within restrictions. However, given that part of the reason for piloting was the uncertainty around

implementation, there were always going to be pilot sites who implemented personal health budgets in more beneficial ways than others did.

Mitigation: emphasise the learning from the pilot programme through the toolkit, and use the "Further, Faster" sites to investigate some of the remaining issues.

Do the results hold at scale?

157. While the results from the evaluation are broadly positive, they are for a limited group of people where there have been enthusiastic pilot sites, run by proponents of personal health budgets. They may not be as beneficial when they are expanded nationally, or to all people who are eligible for NHS Continuing Healthcare.

Mitigation: ongoing monitoring will be required to see if this is an issue.

Differential effects depending upon the person's background

158. While this is an issue, and was raised in the impact assessment and equality impact assessment that was completed at the outset of the pilot programme, this has not proven the case during the pilot programme, though there may be a tentative suggestion of some differential impacts. This is discussed in more detail in the *Equality Impact Assessment* section below.

Mitigation: ongoing monitoring, combined with learning about how best to implement personal health budgets for different groups of people and tailoring the information, advice and support that people receive to their particular circumstance.

Further risk mitigation: the toolkit, and the Further, Faster sites

159. Alongside the consultation, a toolkit was published. This summarises learning from the pilot sites about how best personal health budgets should be implemented. This providers practical suggestions and guidance for how some of the risks and challenges should be overcome. Based on the pilot programme, none of the challenges are insurmountable.

160. There are also nine *Further, Faster* sites. These sites are expanding their pilot programmes (eight were originally pilot sites), and are also looking at addressing unanswered questions about implementation. This includes addressing the risks that are set out above, where more work is required. Their work will be important for the longer term policy direction, and will help to revise guidance or recommendations about how personal health budgets should be implemented in the longer term. They will also help to give more information about how any further rollout should be planned and implemented.

J Direct costs and benefits to business calculations (following OIOO methodology)

161. The regulations that are introduced affect commissioners, and are therefore for public sector organisations only. The only impact on the voluntary sector or the private sector is that following the introduction of personal health budgets, it may be easier for them to provide NHS-commissioned services (either directly or via the individual), if they are providing services that the individual wants and that the care or support planner agrees are in their best interests. While this may mean that voluntary and private sector providers are required to comply with particular regulations, it is then their choice whether they decide to provide services are not, and therefore this is not imposed specifically on them.

K Equality impact assessment

162. At the outset of the pilot programme, a full Equality Impact Assessment was undertaken as part of the Impact Assessment that was published. This was updated when the legislation for healthcare direct payments moved from the Commons to the Lords. It was also then reissued in July 2010,[37] when more information was available about the potential impact of personal health budgets on different groups of people.

163. There is some additional information that is now available about how different groups of people access NHS services, or disease prevalence among different groups. For example:

i. Population ageing means numbers of people with dementia will increase. This is particularly relevant for people from Black and Minority Ethnic (BME) backgrounds, who are in turn currently under-represented in dementia services. This may be the result of stigma or lower levels of awareness.[38, 39]

ii. BME groups are less likely to report a positive experience of NHS service provision, particularly about access and about information and choice.[40]

iii. Over 50% of gay men have not disclosed their sexual orientation even though doing so may help their GP to deliver more appropriate healthcare.[41]

iv. Black Caribbean men have a much higher prevalence of stroke – a two-thirds greater risk. US research suggests that ethnic minority patients may have more severe strokes and do less well in rehabilitation.[42]

v. Diabetes prevalence is 4 times high for Bangladeshi men, and 3 times higher for Pakistani and Indian men compared to the general population.[43]

164. This information gives a snapshot of some of the differences in needs of individuals, which may be influenced by their background. This gives some context to the environment into which personal health budgets will be introduced. It also gives an indication about some of the issues that may need to be overcome as personal health budgets are implemented. This includes where personal health budgets may best be targeted. It is also likely to include the provision of information, advice an support, which is discussed in more detail below.

165. The earlier Equality Impact Assessments discussed how personal health budgets could help to address some of the challenges set out above, by helping to make the NHS more responsive to the needs and preferences of the individual. If implemented well, so there are closer working relationships between healthcare professionals and patients, then this should serve to improve things for all patients, regardless of their background. Some of the issues outlined above, and in the original Equality Impact Assessment, will be addressed by closer working relationships.

166. The initial Equality Impact Assessments also discussed the information that was available from social care. This in particular included experience and results suggesting that personal budgets in

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37 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117289.pdf

38 http://www.runnymedetrust.org/uploads/publications/pdfs/TheFutureAgeingOfTheEthnicMinorityPopulation-ForWebJuly2010.pdf

39 http://www.scie.org.uk/publications/briefings/files/briefing35.pdf

40 http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_100471.pdf

41 Keogh, P, Weatherburn, P, Henderson, L, Reid, D, Dodds, C and Hickson, F (2004) *'Doctoring gay men: Exploring the contribution of General Practice'*, Sigma Research, Portsmouth

42 Ethnicity and Health, Parliamentary Office of Science and Technology, Jan 2007 and Stansbury JP, Jia H, Williams LS, et al; Ethnic disparities in stroke: epidemiology, acute care, and postacute outcomes. Stroke. 2005 Feb;36(2):374-86. Epub 2005 Jan 6.

43 http://www.ic.nhs.uk/pubs/hse04ethnic

social care may have benefited younger people more than older people, and that personal budgets may be more beneficial for white people than BME people.[44]

167. The personal health budgets evaluation and pilot programme were informed by previous experience from social care. The original equality impact assessment focused on the areas and protected characteristics where there appeared to be the most risk. This particularly included age, ethnicity and disability. Socioeconomic status was also included, because, as with all choice initiatives, there is a risk that personal health budgets become a tool for affluent, articulate people only. The evaluation team therefore collected information across the following areas:

   i. Age
   ii. Gender (including trans)
   iii. Disability (from medical records template)
   iv. Ethnicity
   v. Socioeconomic status (measured by type of accommodation; employment; education; and income)
   vi. Sexual orientation
   vii. Marital status
   viii. Religion

168. There are also now findings available from the personal health budgets evaluation. Unfortunately, this does not cover all of the strands outlined above as in some cases numbers were insufficient to undertake any meaningful analysis. For example, there was one person only who was trans, and so any analysis and inferences would not be worthwhile.

169. Where meaningful analysis was undertaken, there were the following results. None of this suggests that there is a systematic difference in how people from different backgrounds experience personal health budgets, but there are some suggestions of differences that are inconclusive at this stage, and where more work may be required.

- There was some weak evidence that personal health budgets may have been more beneficial for people aged under 75.
- People who had a university or college education, or who were not in receipt of benefits, tended to report improved outcomes in some models.
- There were no significant differences in costs for any of the sub-group analysis.
- Personal health budgets were more cost-effective for over 75s. This may seem contradictory with the above finding regarding outcomes; the likely interpretation is that less was spent on the care of over-75s without worsening their outcomes.
- No other differences in cost-effectiveness were found on analysis looking at gender or socioeconomic status.
- No differences were found in outcomes, costs or cost-effectiveness based on ethnicity. This is included as a finding, but the evaluation team caveat this as numbers of people from BME backgrounds are too low to give robust results.

[44] "BME people" may not be a helpful group, as there will clearly be major differences between sub-groups within this. However, sample sizes in evaluations of personalisation initiatives have meant that it is not possible to break the BME group down further.

- It was not possible to conduct analysis based on disability – for example, to look at people with a learning disability – as the medical record information was incomplete and there the sample size was too low.

170. Therefore, it would tend to appear that personal health budgets can benefit everyone regardless of background, as there is nothing above that gives conclusive evidence about people from specific backgrounds specifically doing worse. None of the findings outlined above would be defined as robust, as they have only been observed in one particular model. That said, they do give indications of where they may be potential challenges.

171. Information, advice and support will be vital to overcome any problems that may arise. As set out above from the 4th and 5th interim reports, the information, advice and support that people received had a major impact on their experience of the pilot programme. This is likely to be the case regardless of the individual's background. There were some good examples of sites providing information, advice and support during the pilot programme, as set out below:

- In one of the pilot sites, dedicated work to reach BME people and those from deprived backgrounds resulted in referral figures from these communities into personal health budgets programmes being the same as for referral figures more generally.
- One of the SHAs has a "roadshow", in which a tour bus travels around travellers' sites, areas with high BME populations and areas with high levels of deprivation. This both introduces the concept of personal health budgets, and has GPs and health visitors on the bus to offer services.
- One of the pilot sites has flexible information provided and tailored as required. This includes translation of material as provided, health and 3rd sector staff on hand to help explain information as required, and individual brokers. They are also getting feedback from people as they go through the process about what is successful and what is less so to help them revise the provision of information, advice and support over time. This has led to the inclusion of pictures and easy-read versions of documents to help simplify them.

172. This is in addition to the work that has been done nationally around promoting personal health budgets. For example, there are a number of stories on the personal health budgets website, that are also available on DVD, that help explain to people what personal health budgets are and what people's experience of them has been. These have proven to be very helpful locally, and a second DVD is currently in production. Some local areas are also producing their own material.

173. There is still a long way to go. While there are some good examples of what sites have been doing, it is not yet certain how best information, advice and support should be provided, in what formats, or at what time and place. This is likely to vary between individuals, and the information, advice and support that people receive should be personalised to them in the same way that services are.

174. Recognising the importance of this area, and that while progress has been made, there is not yet a complete answer, the Department has commissioned some additional work around information, advice and support. This aims to summarise what has already been done and learn from it, to then recommend how best information, advice and support should be provided in practice. This will build on what is already known from the pilot sites about what they did, what worked and what they changed, and the team undertaking the work is aiming to provide a final document outlining principles about what commissioners should consider when implementing personal health budgets. Where unanswered questions remain, these will also be included and discussed, with suggestions for what could be done where there is no practical work to draw on.

175. This will then inform the longer term implementation of personal health budgets. As the implementation of the policy is transferring to the NHS Commissioning Board, as set out in the Mandate, it will be for them to decide what national guidance and support to local commissioners may be required. The NHS Commissioning Board is subject to the same equality duty as the Department of Health, and therefore they will ensure that future work will incorporate equality principles. If they devolve responsibility for personal health budgets to clinical commissioning groups, the same will apply to them.

176. Where there remains a lack information about how personalisation and personal health budgets should best be implemented to not be discriminatory, it will be up to the NHS Commissioning Board to address. So, for example, as there is no information about trans people, the NHS Commissioning Board could work with the Gender Identity Research and Education Society to ensure that trans people are not unintentionally discriminated against as personal health budgets are offered to more people.

Annex A: Sensitivity analysis for benefits and costs of implementing personal health budgets

A1. This Annex gives the sensitivity analysis around the benefits and costs of introducing personal health budgets. This information is then included in the summary sheets. The information used in the main body of the text gives the best estimates.

Table A1: Sensitivity of benefits of introducing personal health budgets

A2. This information is based on the final evaluation report. The cost-effectiveness gain and the cost-saving of introducing personal health budgets figures set out in the main document are the mid-point estimates of the analysis. This Annex gives the full range based on the confidence intervals.

A3. The 90% confidence interval is used. While the cost-effectiveness gain was statistically significant at the 95% level, the cost-saving was only significant at the 90% level. For consistency, the 90% range is used for both.

A4. This means that:

a. The cost-effectiveness gain ranges from £1,253.86 to £7,418.69

b. The cost-saving ranges from £226.38 to £5,979.48

Table A1: Range in cost-effectiveness and cost-savings

Year	0	1	2	3	4	5	6	7	8	9	Total
Discount rate	1.00	0.97	0.93	0.90	0.87	0.84	0.81	0.79	0.76	0.73	
Low personal health budget uptake (Options 2 and 3)											
Number of recipients (low personal health budget uptake)	0	5,600	11,300	11,300	11,300	11,300	11,300	11,300	11,300	11,300	
Cost-effectiveness gain (lowest confidence interval) (£m)	0.0	7.0	14.2	14.2	14.2	14.2	14.2	14.2	14.2	14.2	**120.4**
Discounted	*0.0*	*6.8*	*13.2*	*12.8*	*12.3*	*11.9*	*11.5*	*11.1*	*10.8*	*10.4*	***100.9***
Cost-effectiveness gain (highest confidence interval) (£m)	0.0	41.5	83.8	83.8	83.8	83.8	83.8	83.8	83.8	83.8	**712.2**
Discounted	*0.0*	*40.1*	*78.3*	*75.6*	*73.1*	*70.6*	*68.2*	*65.9*	*63.7*	*61.5*	***596.9***
Cost saving (lowest confidence interval) (£m)	0.0	1.3	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	**21.7**
Discounted	*0.0*	*1.2*	*2.4*	*2.3*	*2.2*	*2.2*	*2.1*	*2.0*	*1.9*	*1.9*	***18.2***
Cost saving (highest confidence interval) (£m)	0.0	33.5	67.6	67.6	67.6	67.6	67.6	67.6	67.6	67.6	**574.0**
Discounted	*0.0*	*32.4*	*63.1*	*60.9*	*58.9*	*56.9*	*55.0*	*53.1*	*51.3*	*49.6*	***481.1***
High personal health budget uptake (Option 4)											
Number of recipients (high personal health budget uptake)	0	14,100	28,200	28,200	28,200	28,200	28,200	28,200	28,200	28,200	
Cost-effectiveness gain (lowest confidence interval) (£m)	0.0	17.7	35.4	35.4	35.4	35.4	35.4	35.4	35.4	35.4	**300.6**
Discounted	*0.0*	*17.1*	*33.0*	*31.9*	*30.8*	*29.8*	*28.8*	*27.8*	*26.9*	*25.9*	***251.9***
Cost-effectiveness gain (highest confidence interval) (£m)	0.0	104.6	209.2	209.2	209.2	209.2	209.2	209.2	209.2	209.2	**1,778.3**
Discounted	*0.0*	*101.1*	*195.3*	*188.7*	*182.3*	*176.1*	*170.2*	*164.4*	*158.9*	*153.5*	***1,490.5***
Cost saving (lowest confidence interval) (£m)	0.0	3.2	6.4	6.4	6.4	6.4	6.4	6.4	6.4	6.4	**54.3**
Discounted	*0.0*	*3.1*	*6.0*	*5.8*	*5.6*	*5.4*	*5.2*	*5.0*	*4.8*	*4.7*	***45.5***
Cost saving (highest confidence interval) (£m)	0.0	84.3	168.6	168.6	168.6	168.6	168.6	168.6	168.6	168.6	**1,433.3**
Discounted	*0.0*	*81.5*	*157.4*	*152.1*	*146.9*	*142.0*	*137.2*	*132.5*	*128.1*	*123.7*	***1,201.4***

A5. This therefore means that for options 2 and 3, the discounted cost-effectiveness gain ranges from £100.9m to £596.9m, and the discounted cost-saving ranges from £18.2m to £574m. For option 4, the discounted cost-effectiveness gain ranges from £251.9m to £1,490.5m, and the discounted cost-saving ranges from £45.5m to £1,201.4m.

A6. Table A2 then gives the sensitivity analysis around the cost estimates used in the main document. This is based on the following assumptions:

a. Ongoing costs make up £20,000, or £75,000 of the initial £93,280 per pilot site for years 1 and 2;

b. Set-up costs are the residual of the £93,280 cost per pilot site, and are incurred in the first 2 years only; and

c. This cost is assumed to be the cost of ongoing support for 75 personal health budget holders – the cost then rises proportionally.

Table A2: Range in cost estimates

Year	0	1	2	3	4	5	6	7	8	9	**Total**
Discount rate	1.00	0.97	0.93	0.90	0.87	0.84	0.81	0.79	0.76	0.73	
Set-up costs (low ongoing costs) (£m)	3.65	3.65									**7.3**
Set-up costs (high ongoing costs) (£m)	0.9	0.9									**1.8**
Low personal health budget uptake (Options 2 and 3)											
Numbers of budget holders	0	5,600	11,300	11,300	11,300	11,300	11,300	11,300	11,300	11,300	
Low ongoing costs (£m)	0.0	1.5	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	**25.6**
Total costs (discounted) (low) (£m)	**3.7**	**5.0**	**2.8**	**2.7**	**2.6**	**2.5**	**2.5**	**2.4**	**2.3**	**2.2**	**28.6**
High ongoing costs (£m)	0.0	5.6	11.3	11.3	11.3	11.3	11.3	11.3	11.3	11.3	**96.0**
Total costs (discounted) (high) (£m)	**0.9**	**6.3**	**10.5**	**10.2**	**9.8**	**9.5**	**9.2**	**8.9**	**8.6**	**8.3**	**82.2**
High personal health budget uptake (Option 4)											
	0	14,100	28,200	28,200	28,200	28,200	28,200	28,200	28,200	28,200	
Low ongoing costs (£m)	0.0	3.8	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	**63.9**
Total costs (discounted) (low) (£m)	**3.7**	**7.2**	**7.0**	**6.8**	**6.6**	**6.3**	**6.1**	**5.9**	**5.7**	**5.5**	**60.8**
High ongoing costs (£m)	0.0	14.1	28.2	28.2	28.2	28.2	28.2	28.2	28.2	28.2	**239.7**
Total costs (discounted) (high) (£m)	**0.9**	**14.5**	**26.3**	**25.4**	**24.6**	**23.7**	**22.9**	**22.2**	**21.4**	**20.7**	**202.7**

A7. This means that discounted total costs are assumed to range from £28.6m to £82.2m for options 2 and 3, and from £60.8m to £202.7m for option 4. These figures are then included in the cover sheets.