Personal Health Budgets
November Update

1 What are we required to do?

The Minister of State for Care Services Norman Lamb announced the national roll out of personal health budgets on 30 November 2012. This follows the three year pilot programme in the NHS, which ended in October 2012, and the publication of an independent evaluation report, led by the University of Kent. Personal health budgets will initially be aimed at people who are already receiving NHS Continuing Care, who will have a "right to ask" for a personal health budget from April 2014 and from October 2014 this group will further be given the "right to have" a PHB (excluding cases where there is a compelling clinical or financial reason otherwise).
CCGs can decide to offer personal health budgets to other groups that they feel may benefit from the additional flexibility and control as soon as they like, however, it is likely that there will be a requirement to offer personal health budgets to people with a broader set of long term conditions by April 2015. It's therefore imperative that CCGs and governing bodies begin the learning and rollout process immediately and design a process that will be easily and quickly scalable.

2 Governance

The CHC Reference Group has created a personal health budgets Task & Finish Group, and have engaged the services of a project and change manager to drive the project between now and April. The Task & Finish Group will make recommendations to the CHC Reference Group for decision or escalation to the Surrey CCG Collaborative as required (see appendix 1 for full governance framework).

3 Co-creation and Culture Change

The successful implementation of personal health budgets (ensuring the best possible experience for patients) will involve significant cultural change for the whole health economy specifically in the areas of person-centred thinking, the way we commission (moving from block contracts to a much more individual level), financial control and risk enablement. Experience from the national pilot suggests that it will be imperative that we truly co design our personal health budgets offering by involving representatives from every group that will touch the process right from the start.

We will be running a stakeholder engagement event on 4th December aimed at clinicians, commissioners, patients, carers, care workers, providers, community services, CCG finance teams, Surrey County Council and voluntary organisations. We also plan to commission a 6 to 8-month culture change programme which will work with all groups over an extended period of time to tackle the necessary changes in thinking and practise.

4 Integrated Health and Social Care

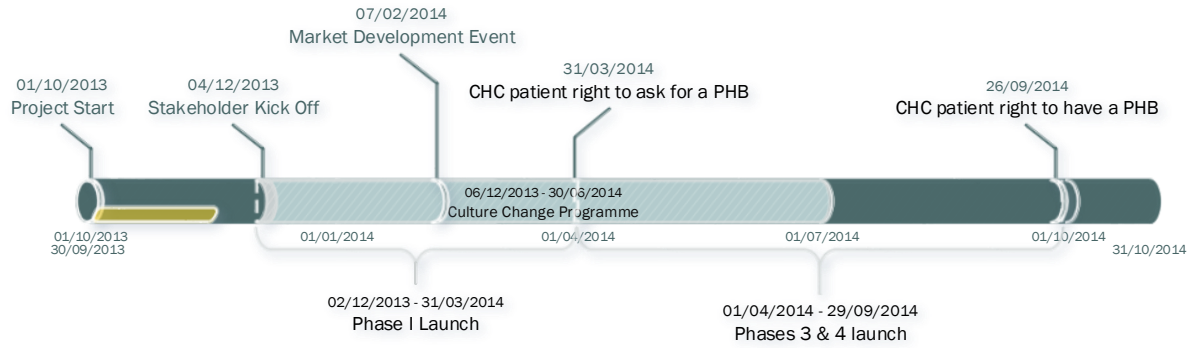
Personal health budgets are an excellent opportunity to co-create a solution that works best for people within Surrey, whether they are health or social care funded. There are significant opportunities at all stages of this project for closer integration with Surrey County Council.

5 Phase 1 Approach (December to March)

We intend to learn quickly by doing and propose to work with a maximum of 20 existing and new continuing healthcare funded patients between December 2013 and March 2014.

We will partner closely with SCC and use existing processes where possible to help us learn quickly. During this period we will work within the funds already allocated from the Whole System Funding budget to deliver any additional management costs (project management, stakeholder events,

training, care planning/brokerage resource costs, direct payments, direct payments support, advocacy, communications). The design of the pilot has been signed off by the CHC Reference group which is comprised of representatives from each Surrey CCG. See appendix 2 for more details of our recommended approach.



6 Phases 2 & 3 (April to October)

We plan to manage the roll out of personal health budgets closely to ensure that we can continue to learn as we implement, ensure good patient experience as we scale, and control the impact on the CHC team. We will individually invite people who are already CHC-funded to explore whether a personal health budget will be of benefit to them, and will probably work first with the young physically disabled and people with learning difficulties who are CHC-funded. As new people become eligible for CHC funding, we will assess their suitability and appetite to explore a personal health budget on an individual basis.

7 Financial Impact

The findings from the National Pilot would suggest that personal health budgets are cost effective overall (see Appendix 3), and create a real improvement to people's quality of life, but should not, when implemented in the spirit in which they are intended, directly drive savings within Continuing Healthcare. Our working assumption from the pilot is that there will be a neutral impact on CHC care package budget (some budgets will be higher and some lower than today, but that on, average, we will see little difference to funding) but there will be recurrent management costs (to include incremental care planning/brokerage resource costs, direct payment administration, pre-paid card administration, direct payments support, advocacy, communications). The National Pilot shares evidence to demonstrate that these increased management costs are counterbalanced by a decrease in indirect costs for personal health budget patients (unplanned hospital admissions, GP visists, etc). We will monitor financial impacts closely to inform future commissioning approach. To give a sense of scale, we're looking at working with a maximum of 20 patients in Phase1 and perhaps up to 50 patients before October.

In December, we will share a personal health budget budget impact assessment (which we will integrate with findings from the CHC Review) with you which we will then test through phase 1. We will then be able to provide some guidance for estimated budgetary impact in time for the 2014/15 budget cycle.

8 What the Task & Finish Group will do for you

- Provide you with regular updates

- Provide a robust project governance structure with all decisions to go through CHC Reference group and, as necessary, the Surrey CCG Collaborative
- Provide Project and Change Management support
- Identify Health and Social Care integration opportunities

9 What Can Governing Bodies Do in Support of Personal Health Budgets?

- Ensure that you are aware of timelines
- Know who your champions are within your CCG and support them
- Work to understand how this will impact on the wider commissioning function
- Understand opportunities for strategic operational planning
- Encourage cultural change within commissioning teams and your wider healthcare economy
- Ensure that your finance teams are fully engaged

10 December Task & Finish Group Deliverables

- CHC budget impact assessment
- CHC nurse champions training begun
- Care planning template agreed and in use
- First patients' budgets set and communicated to them
- Contract in place with phase 1 brokerage and advocacy provider(s)
- Phase 1 key performance indicators (KPIs) locked and phase 2 KPI proposal
- Phase 1 project plan locked and phase 2 project plan recommendation

Appendix 1

1 Project Governance Structure

See Table 1 for the full governance structure.

Task & Finish group membership:

NAME	ROLE	ORG.	WORKSTREAM LEAD?
Nicola Airey (Chair)	Director of Operations	Surrey Heath CCG	
Jo-anne Alner	Director of Quality & Innovation	NW Surrey CCG	
Denise Crone	Governing Body Lay Member PPE	Surrey Downs CCG	
Caroline Lovis	Finance Manager	Surrey Heath CCG	Joint Budget Setting and Payment Mechanisms lead
Rod Hunter	Finance	Guildford and Waverley CCG	
Mary Goward	Interim Assistant Director for Safeguarding	Guildford and Waverley CCG	
Gill Dodds	CHC Lead Nurse	Surrey Downs CCG	Personal Care Planning Lead
Andrew Simmonds	Finance Manager (MH/LD /Continuing Care)	South CSU	Joint Budget Setting and Payment Mechanisms Lead
Tony Deadman	Contract Manager (NHS Continuing Health Care)	Surrey Downs CCG	
Jean Boddy	Senior Manager Commissioning	Surrey County Council	
Emma Parkinson	Personal Health Budgets Project Manager	Surrey Downs CCG	Project and Change Manager, and Stakeholder, Change and Communications Lead
Sian Carter	Clinical Lead Manager NHS Funded Healthcare Team	Surrey Downs CCG	
Chris Costa	Complex Needs Manager (Children's) Surrey Children's Commissioning Team	Guildford & Waverley CCG	
Jonathan Perrott	Transition Manager	Surrey Downs CCG	
Mabel Wu	Quality and Performance Lead	Surrey Downs CCG	Systems, Key Performance Indicators and Reporting Lead
Suzi Shettle	Head of Communication and Engagement	Surrey Downs CCG	

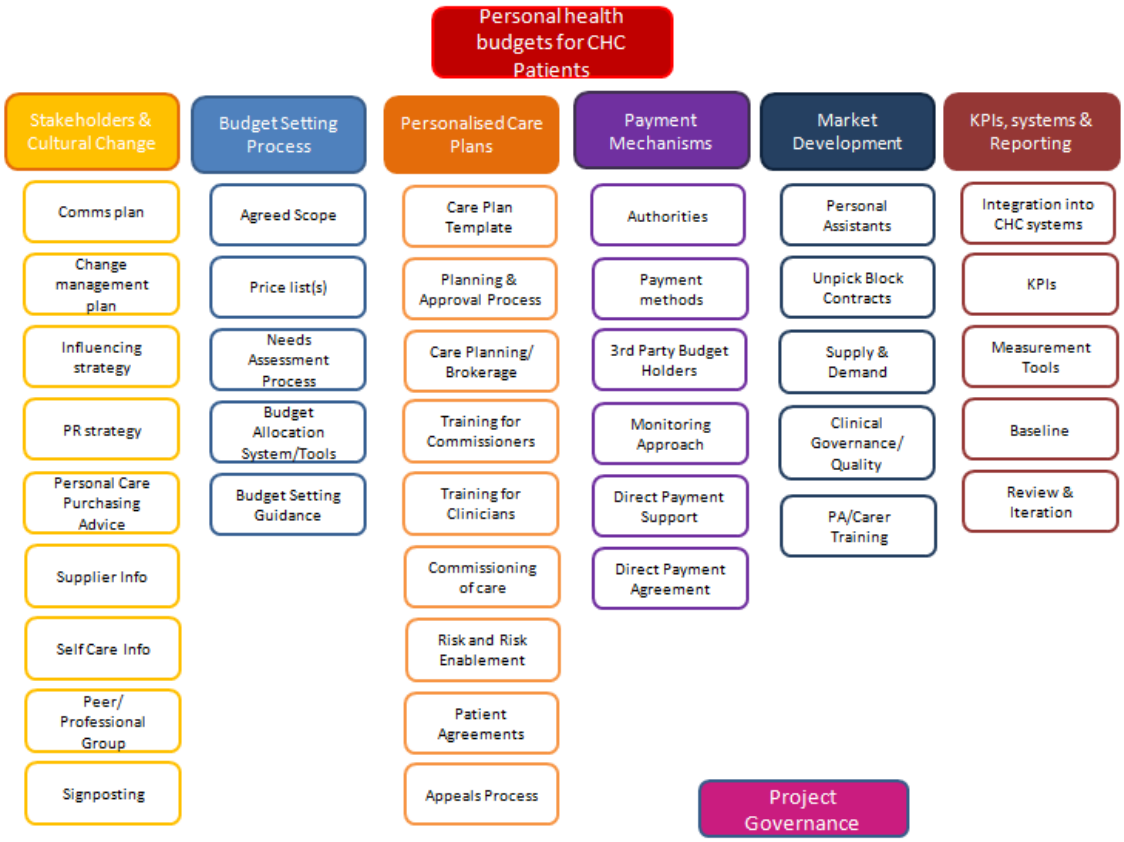
1.1 Table 1 – Governance structure

Body	PHB Project Role	Accountabilities	Frequency
Work stream Lead	To work with other members of the Task & Finish group and the wider local health economy to drive to recommendations of approach for their work stream	- Identify key decisions to be made for work stream - Gather information and make recommendations of approach to Task & Finish group for their work stream - Drive implementation of approved approaches across all Surrey CCGs	N/A
Task & Finish Group	Project group comprising health and social care members and patient representation collaborating to produce co-produced recommendations of approach and implement approved approaches of changes Guided by agreed Terms of Reference	- Make project recommendations to CHC Reference group for decision - Escalate risks to CHC Reference Group for solution	Meets once per month (2nd Thursday of the month)
CHC Reference Group	Group formed to oversee and make recommendations to the Surrey CCG Collaborative on the management of CHC (continuing health care) activities including the implementation of personal health budgets	- Making project decisions based on recommendations from Task & Finish Group - Escalating decisions to Surrey CCG Collaborative as necessary - Holding Task & Finish group to account - Communicating progress to all CCGs	Meets once per month
Surrey CCG Collaborative	Forum to make collective strategic decisions based on recommendations from the CHC Reference Group, and oversight of financial impact	- Accountable for overall service	Meets once per month

Appendix 2

2 Project Framework

As time is short and resources are few, we will break the project up into several parallel work streams and assign a work stream lead to each. The structure will be as follows:

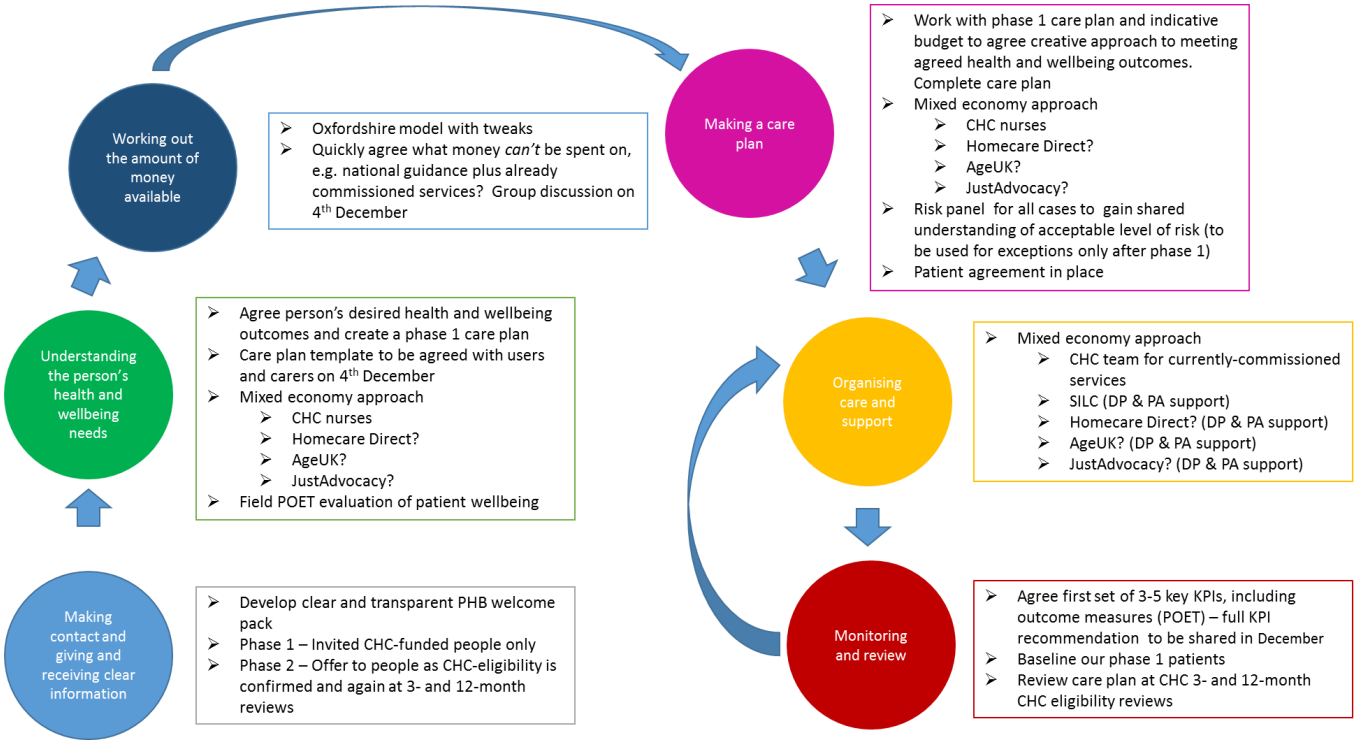


Each work group will comprise a multi-disciplinary team which will ideally include representatives from all stakeholder groups (patients, careers, clinical professionals, social services reps, provider reps, community group reps) in order that the personal health budgets service is truly co produced.

See Appendix 1 for workstream leads.

2.1 Phase 1 Approach (October to April)

Here are the task & finish group's key recommendations of approach for our phase 1 launch.



2.1.1 Communication, culture change and information

- Full communications plan to be in place – 30 November
- Co-design of entire solution from the start
- Stakeholder engagement event – 4th December
- Provider engagement event – January/February 2014
- 6 to 8-month culture change programme – January to August 2014

2.1.2 Working out the amount of money available (Indicative Budget Setting Process)

- We will use the tool used by Oxfordshire in the National Pilot with a few tweaks and assess through Phase 1
- We will co-create the guidelines for what a personal health budget can and cannot be spent on at the stakeholder event on 4th December

2.1.3 Personalised Care Planning

- We will work with 20 people in receipt of CHC funding between now and March. These people will be all those who had been referred to CHC from Social Services who were in receipt of a direct payment, along with a few of our more complex cases and any newly-eligible CHC patients who may benefit from a personal health budget
- We will gain experience quickly by designing a mixed-economy model for the provision of care planning. Care planning conversations will be carried out by CHC nurses and we will also approach Homecare Direct, AgeUK and JustAdvocacy to assess their services. It will be important to offer people choice and flexibility
    - We have identified 4 nurse champions who will work with our first patients
    - We will put a robust training plan in plan in place including shadowing and observation to ensure that everyone's first experience of care planning will be a good one. It's important that our first patients become our advocates
- The care plan template will be co-designed at the stakeholder event on 4th December

- Sign-off of care plans will happen as close to the patient as possible, usually by the lead nurse. We will create a risk panel which, during phase 1 only, will review all care packages (chiefly to ensure collective learning and understanding of the required risk enablement approach and challenge ourselves to think broadly). At the end of phase 1, we propose that the risk panel only be used on an exception basis to ensure quick decisions

2.1.4 How will we set up personal health budget payments?

- For phase 1 (December to March) we propose to manage personal health budget payments in house as it is unlikely to be possible to set up arrangements with SCC or SILC quickly. Direct payments and any 3rd party payments will therefore be made and managed directly by the CSU finance team
- We propose to work closely with SCC in the run up to phase 2 (April to September) to integrate direct payment facilities with their in-house solution. We will also work closely with them to jointly procure a pre-paid card solution for direct payments

2.1.5 Organising Care and Support (Market Development)

- Again, we propose to take a mixed-economy model in order to learn quickly and provide choice and flexibility to our patients
    - Where services are already procured by the NHS and we can commission them at preferential rates, the CHC team will continue to procure those services (placements team)
    - We will also approach organisations like Surrey Independent Living Council (who already provide 'brokerage' services for SCC), Homecare Direct, AgeUK and JustAdvocacy to assess the feasibility of working with them to procure the following services (areas in which it doesn't make sense for us to gain expertise in house):
        - PA recruitment
        - PA employment setup
        - Care Agency setup
        - Self employment setup
        - CRB check
        - Liability Insurance
        - Payroll
        - Risk Assessments
        - Specialist training
        - Ongoing support (PAs)
        - Supported managed account
- We will identify those phase 1 patients with existing PA arrangements and assess whether they would be able to take on some clinical tasks. We will devise a PA clinical training and accreditation approach and have a recommendation ready in December.
    - Where appropriate, we will go through a formal process to delegate clinical responsibility to the PA.
- We will work with our community service providers to obtain a clear directory of services available to CHC patients
- We will be holding a provider engagement event in the New Year to discuss the governance framework requirements for providers of PHB services and understand the market's

concerns and opportunities over the next few years. We will develop a plan to support our provider economy through this change

2.1.6 Monitoring and Review (Systems, KPIs and Reporting)

Recommended approach

- Keep reviews and monitoring light touch and focused on outcomes, rather than focused on the detail of how budgets have been used
- Put in place ways to measures outcomes and costs for individuals
- Check to see if some groups are being missed out or are not getting good results
- Listen to personal health budget holders and their families and learn from experience
- Where possible, use and leverage current systems, processes and measures
- Learn from other areas and use National tools, for example, the Personal Outcome Evaluation Tool (POET) where possible and appropriate

Appendix 3

3 Analysis of the financial impacts of personal health budgets from the National Pilot (see www.phbe.org.uk for full report).

1. The main findings of the National Pilot cost analysis were:
    a. The cost of inpatient care (an 'indirect' cost) was significantly lower for the personal health budget group compared to the control group after accounting for baseline differences.
    b. The ('direct') costs of well-being and other health services were both significantly higher for the personal health budget group compared to controls.
    c. Other categories of direct and indirect cost showed no difference between the groups.
    d. The difference in direct and indirect total costs between personal health budget and control groups after accounting for baseline differences were not statistically significant.
2. The cost analyses for the individual health condition groups were mostly inconclusive as a result of the modest sub-sample sizes. However, indirect costs were found to be lower for personal health budgetholders in the mental health and NHS Continuing Healthcare sub-groups (at the 90% confidence level).
3. Total costs were also lower in the group of people with high-value personal health budgets compared to the controls (significant at the 90% confidence level).
4. The change in the balance of services that budget-holders used also suggested that more of their services were secured from outside conventional NHS providers than the control group.
5. Personal health budgets were assessed to be cost-effective relative to conventional service delivery if they produced greater *net benefits* than this usual care comparator. Key findings were:
    a. Using care-related quality of life (ASCOT) measured net benefits, personal health budgets were cost-effective relative to conventional service delivery (at the 90% confidence level).
    b. There was no significant difference in the net benefit between the groups using health-related quality of life (EQ-5D) measured benefits.

c. Notwithstanding the small sample sizes in the sub-group analyses, personal health budgets showed higher ASCOT-measured net benefits than conventional services for the CHC and mental health sub-groups (at the 90% confidence level).
d. Personal health budgets implemented following the main ethos of the policy (greater choice and control) were cost-effective at the 95% confidence level, as were those with high-value budgets.

Appendix 4

4 High-level Risks & Mitigations

Risk	Score	Mitigation	Owner	Status
We may not be able to realise the opportunity for closer integration and efficiencies across health and social care due to lack of senior capacity within Surrey County Council	25	John Woods (AD Policy and former transition lead for Personal Budgets) will be our key contact	Nicola Airey	Resolved
Patient, carer and care worker representatives not yet identified	20	Emma working with community groups to engage users and invite them to December 4th event. Contacting potential Phase 1 patients and their carers to assess level of interest	Emma Parkinson	Open