Title:
Direct payments for healthcare
IA No: 6103

Lead department or agency:
Department of Health

Other departments or agencies:
N/A

Impact Assessment (IA)

Date: 27/06/2013

Stage: Final

Source of intervention: Domestic

Type of measure: Secondary legislation

Summary: Intervention and Options

RPC Opinion: Not Applicable

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, Two-Out?**	**Measure qualifies as**
£271.5m	£0m	£0m	No	NA

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.
Personal health budgets (including direct payments) have been piloted, with a full academic evaluation of their impact, which was broadly positive. Legislation is needed to enable direct payments to continue in pilot sites and to be rolled out across the country.

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: (0) do nothing; and (1) extend the direct payments regulations, so that direct payments for healthcare can continue in pilot sites and be rolled out across the country.
Option 1 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.
Further non-legslative options were considered in the consultation, but these do not enable individuals to continue to receive direct payments for healthcare, so have not been pursued.
This IA only assess the impact of rolling out direct payments, as this is the direct effect of the legislation. Other forms of personal health budget (i.e. not direct payments) can continue under the 'do nothing' option.

Will the policy be reviewed? It will not be reviewed. **If applicable, set review date:** Month/Year

Does implementation go beyond minimum EU requirements?			N/A			
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 (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) that the benefits justify the costs.

Signed by the responsible Minister: Date: 2/7/13

Summary: Analysis & Evidence

Policy Option 1

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

FULL ECONOMIC ASSESSMENT

Price Base Year 2013	PV Base Year 2013	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: 97.2	**High:** 446.5	**Best Estimate:** 271.5

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	7.3*	2	2.3	**23.4**
High	1.3*		9.1	**65.9**
Best Estimate	4.3		5.7	**44.6**

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. *Higher transition costs are associated with lower ongoing costs, hence are included in the 'low estimate' and vice-versa.

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. There are likely to be additional time costs to budget-holders and clinicians in setting up and monitoring budgets. However, these are not expected to be substantial, particularly in Continuing Healthcare.

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	0	N/A	15.5	**120.5**
High	0		63.1	**512.4**
Best Estimate	0		42.7	**316.1**

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. These savings would accrue to commissioners, who can then spend this on commissioning additional services. This is estimated at £3,100 of cost savings (i.e. individuals needing less resource to manage their condition), and £1,920 of quality of life gains, which applies to people receiving high-value budgets.

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

There are likely to be additional benefits if commissioners expand personal health budgets to different patient groups. There are likely to be improvements in quality of life for carers, set out in the report. It is 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. However, this IA focuses on the effects of extending direct payments in Continuing Healthcare.

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

This assumes that 85% of NHS Continuing Healthcare individuals are likely to be eligible (i.e. not on a 'fast track'), of which 50% are likely to take up the option after two years. 36% of these individuals are assumed to receive direct payments, based on the evaluation. It assumes 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 1)

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

Evidence Base (for summary sheets)

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. Legislation to introduce direct payments in social care 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.
3. Within healthcare, 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.
4. 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,[2] as set out in the regulations. This will continue with the revised regulations.
5. However, personal health budgets (or at least direct payments) were not legally possible until the passage of the 2009 Health Act,[3] which meant there was a disconnect for some people when they moved from social care (where they may have already received a direct payment) into healthcare. Where this was the case, people often lost choice and control when the NHS took over funding of their care.
6. The personal health budgets pilot programme was announced within the 2008 report High Quality Care for All.[4] 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. 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.
7. The pilot programme was independently evaluated. This report is now in the public domain,[5] and is broadly positive about the effects of personal health budgets. This impact assessment is published alongside the response to the consultation on extending direct payments, which set out next steps for the policy and the long-term intention around personal health budgets. This is predominantly based on the evaluation, and the experience within the pilot programme.
8. While the consultation stage Impact Assessment covered the whole range of personal health budgets for comprehensiveness, this IA focusses on the effects of the legislative change of expanding the scope for direct payments.

Policy overview and description

9. 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 clinical commissioning groups; previously PCTs) agrees a care or support

[1] www.legislation.gov.uk/ukpga/1996/30/contents
[2] 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.
[3] www.legislation.gov.uk/ukpga/2009/21/contents
[4] www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825
[5] www.phbe.org.uk

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.

10. 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.

11. 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.

12. 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.

13. As with other personalisation initiatives, the aim is not just to introduce personal health budgets. There are two main benefits: 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 what services they offer.

14. **This impact assessment monetises the benefits and costs associated with expanding direct payments for people eligible for NHS Continuing Healthcare.** While individuals outside of NHS Continuing Healthcare will be able to receive direct payments as a result of the legislation, uptake is expected to be much lower, with the vast majority of recipients in NHS Continuing Healthcare. The quantified effects discussed below and included in the cover sheets are only for people eligible for NHS Continuing Healthcare. The consultation stage Impact Assessment has more detail on other options and their effects.[6]

Problem under consideration

15. 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.

16. 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. 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.

[6] www.gov.uk/government/consultations/changes-to-direct-payments-for-healthcare

17. 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.

Rationale for intervention

18. 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. These other models are outside the scope of this Impact Assessment, as they can continue without any change in legislation.
19. The evaluation found that individuals receiving direct payments tended to experience greater benefits that individuals receiving other forms of personal health budget. It also found that people had a clear preference for direct control over the money. Of those individuals who took part in the evaluation, around 36% received their personal health budget in the form of a direct payment.
20. Without intervention, direct payments will no longer be possible, and individuals who currently receive them will no longer be able to do so. If direct payments are not extended, this is also likely to reduce the take-up of other forms of personal health budget, as the impetus behind personal health budgets is reduced. This is supported by the fact that, while notional budgets and third party arrangements have been possible for some time, the best estimate is that there were fewer than 10 people in receipt of personal health budgets at the outset of the pilot programme.
21. 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.

Supporting evidence for personal health budgets

Personal health budgets evaluation – key evidence

22. The evaluation is the main source of evidence about personal health budgets. 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 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.[7]
23. 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.

[7] 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.

24. The evaluation found that individuals who received 'high value' personal health budgets (i.e. those over £1000 per year) tended to spend approximately £3,100 less in managing their condition per year than the control group. This was significant at the 10% level. 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. (It should be noted that this excluded the start-up costs of personal health budgets and ongoing costs of providing information, which are discussed below.)

25. These individuals experienced no significant difference from the control group in their health-related quality of life (as measures by the EQ5D). Other measures of quality of life suggested that high value personal health budget holders experienced an improvement in quality of life. Social-care related quality of life (as measured by the Adult Social Care Outcomes Toolkit, ASCOT) showed an improvement of 0.032 points, which was statistically significant at the 5% level. This is valued at the same rate as a Quality Adjusted Life Year (QALY), of £60,000. This suggests a monetised benefit of £1,920 per year. Overall, this implies a benefit (quality of life gain and cost saving) of £5,020 per year for each high value personal health budget.

Personal health budgets evaluation – wider learning

26. The evaluation found that personal health budgets had a net benefit for the whole sample, and that this was statistically significant at the 10% level, although the size of this benefit was less than for the high value budget group. Additionally, the evaluation looked specifically at the effects in Continuing Healthcare. They found a greater net benefit (also statistically significant at the 10% level) that for high value budgets. However, this figure is not used in the calculations below, as the sample focussed on individuals with much more complex needs and so is not likely to be representative of the NHS Continuing Healthcare group as a whole, to whom this rollout refers. Instead, the figures for high-value budgets are used as the most relevant source.
27. The evaluation team split the implementation models into four groups, as set out in table 1-2 of the final report. The models closest to the original policy intention had the largest and most significant positive outcomes. People aged under 75 benefited more, on average, from personal health budgets than people aged over 75, as measured by both ASCOT (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.
28. 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. 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.
29. Carers of people receiving personal health budgets are 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.
30. 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 for people receiving high value budgets. When personal health budgets are implemented as was originally intended they appear to be particularly beneficial, both in terms of outcomes and the effects on total costs for the individual.

Experience in social care

31. Overall, these findings mirror the experience of social care. 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.

32. 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

33. 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[8] 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 the original impact assessment for personal health budgets and from a review of direct payment programmes by Alakeson.[9]

34. There is no programme that is comparable with the personal health budgets pilots. There is some learning that can be drawn from other programmes. 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.

Description of options considered

35. There are a number 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 final stage Impact Assessment considers two main options: (0) do nothing, and (1) introduce legislation to extend the use of direct payments for healthcare. 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 of option 1.

Option 0: Do nothing

36. 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.

37. 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.

38. 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.

[8] www.health.org.uk/public/cms/75/76/313/2594/personal%20health%20budgets.pdf?realName=wiYPsk.pdf

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

39. 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 across personal health budgets more widely. .

Option 1: Extension of the regulations so that direct payments for healthcare can continue

40. Option 1 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.

41. 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.

42. Compared with option 0, 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.

43. Within option 1, there are sub-options about what 'rollout' of personal health budgets means. This includes sub-options about what is included within the regulations. 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.

44. **Care plan:** 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 which give the individual a high level of control, have much better outcomes than where pilot sites imposed restrictions. Therefore, the regulation will continue to stipulate that a direct payment must be based on a care or support plan.

45. **Patient groups:** It is clear from the evaluation that personal health budgets can be cost-effective and even cost-saving. They are more beneficial for people with higher levels of need; and appear to be more cost-effective for people eligible for NHS Continuing Healthcare. In NHS Continuing Healthcare there is already 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. For other patient groups, there are potential benefits, particularly for people with mental illnesses. At this stage, 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. It will be 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. Therefore, the regulations will not include specific conditions. Instead, they 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.

46. **Services that a personal health budget can be spent on:** 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. 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.

47. **Information, advice and support:** 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. 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. 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 that this will fall over time as staff and individuals get used to new ways of working. The regulations will set out in more detail what kind of information, advice and support the patient might be offered. The regulations will not be 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.

48. **Separate bank accounts:** The legislation will 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. However, 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. Having this possibility should help to reduce potentially unnecessary costs associated with a one-off payment will help to ensure that personal health budgets remain cost-effective.

49. **Safeguarding:** 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, 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 will not be 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.

50. **Budget setting:** 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. 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. 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 a particular method will not be included within the regulations.

Monetised and non-monetised benefits and costs of option 1: extend the regulations for direct payments for healthcare

51. This section makes estimates about the costs and benefits of option 1 – extending the regulations for direct payments for healthcare. This is 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. The costs and benefits are measures relative to the do nothing option (whose costs and benefits are defined to be zero).

Benefits of option 1

52. As set out above in the results of the evaluation, personal health budgets appear to be both cost-effective and cost-saving for the individual. Excluding set-up costs and the costs of providing information, individuals with high value budgets experienced a cost saving of around £3,100 per year, compared to the control group. This benefit accrues to commissioners, who are then able to spend this elsewhere. This is likely to generate an additional social benefit, which has not been monetised here. Budget-holders also experienced a social care-related quality of life improvement, monetised at £1,920 per individual per year. The total benefit (excluding set-up costs and the costs of providing information) is therefore approximately £5,020 per budget holder per year.

53. As of Q1 2012/13, there were 56,411 people currently eligible for NHS Continuing Healthcare, with a total spend of around £2.67bn.[10] 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.

54. Based on information about NHS Continuing Healthcare recipients in London, 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.

55. There is 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. The working assumption is that 50% of eligible people will take up the offer, i.e. 42.5% of people currently in receipt of NHS Continuing Healthcare.

56. This impact assessment focuses on the effects of extending the legislation on direct payments only, so the benefits will only be a subset of this. In the pilots, 36% of budgets were managed as a direct payment (298 out of the 828 responses that included deployment information). The analysis assumes that a similar proportion would seek direct payments on wider rollout. As a result, around 15% of people eligible for NHS Continuing Healthcare are likely to take up a personal health budget in the form of a direct payment.

57. The assumptions on take-up do not drive the overall results, as the benefits of personal health budgets are assumed to be scalable (see the risks section for more detail). However, given the existence of set-up costs, it is possible that very low take up may see costs outweigh benefits. Based on the central estimate, as long as more than 150 individuals take up personal health budgets in the form of direct payments, benefits are expected outweigh costs (this represents 0.3% of the Continuing Healthcare group). As a result, the broad conclusions of this analysis are robust to changes in this assumption. Further sensitivity analysis is investigated in annex A.

58. Table 1 summarises the benefits of introducing personal health budgets. This is based on the following assumptions:

    - Take-up of personal health budgets is assumed to be 15% of people eligible for NHS Continuing Healthcare (0% in year 0; 7.5% in year 1, 15% thereafter);
    - Excluding set-up and information provision costs, the cost saving is £3,100 per year and the monetised quality of life (QoL) gain is £1,920 per year, which are not assumed to vary as more people get a personal health budget; and
    - There is a 3.5% discount rate for costs and a 1.5% discount rate for quality of life improvements.

[10] www.dh.gov.uk/health/2012/09/continuing-healthcare-spreadsheet/ This is not an audited figure, and should be treated as an estimate.

Table 1: Benefits of option 1 (sensitivity analysis in annex A)

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	**Total**
Number of recipients	0	4250	8500	8500	8500	8500	8500	8500	8500	8500	**-**
Cost saving (£m)	0.0	13.2	26.4	26.4	26.4	26.4	26.4	26.4	26.4	26.4	**224.0**
QoL benefit (£m)	0.0	8.2	16.3	16.3	16.3	16.3	16.3	16.3	16.3	16.3	**138.7**
QoL benefit & cost saving (£m)	0.0	21.3	42.7	42.7	42.7	42.7	42.7	42.7	42.7	42.7	**362.7**
Cost saving, discounted (£m)	0.0	12.7	24.6	23.8	23.0	22.2	21.4	20.7	20.0	19.3	**187.7**
QoL benefit, discounted (£m)	0.0	8.0	15.8	15.6	15.4	15.1	14.9	14.7	14.5	14.3	**128.4**
QoL benefit & cost saving, discounted (£m)	**0.0**	**20.8**	**40.4**	**39.4**	**38.3**	**37.3**	**36.4**	**35.4**	**34.5**	**33.6**	**316.1**

59. The total discounted benefit for option 1 over the 10-year time horizon is £316m, while the total discounted cost-saving is estimated to be £188m.

60. Personal health budgets were also found to be beneficial, in general, for other patient groups as well, particularly people with mental health problems. While personal health budgets do seem to be generally beneficial, not all individuals will benefit. As a result, outside NHS Continuing Healthcare, personal health budgets are more likely to be suitable for introduction on a case-by-case basis.

Costs of option 1

61. Costs of the introduction of personal health budgets (excluding the costs of service provision, which have been incorporated in the benefits section above) 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 are 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.

62. The 3rd interim report[11] estimated all initial costs to be around £93,280 per year for each 'commissioning unit'. This is the combined total of set-up and ongoing costs. £18,470 of this was associated with information, advice and support, which would continue on an ongoing basis. Other costs were more difficult to classify, but are likely to have some ongoing element. As a result, this IA assumes that a lower estimate for ongoing costs is £20,000 per year, with an upper estimate of £80,000 per year. The central estimate is £50,000 per year. Set-up costs are assumed to be the remainder of the £93,280, and occur only in the first two years.

63. Ongoing costs will vary with the number of individuals who receive a personal health budget, while set-up costs will not vary in this way. Set-up costs relate to a 'commissioning unit', where clinical commissioning groups pool their expertise. It is assumed that there are around 50 of these, i.e. on average around four CCGs pool their expertise and resources to rollout direct payments (and personal health budgets more widely). This is likely to vary around the country, but has no substantial effect on the overall net benefit of rollout. As a result, the central estimate of set-up costs is £2.2m per year in the first two years (i.e. (£93,280 - £50,000) x 50). The cost information from pilot sites was based on an average of 75 individuals receiving a personal health budget. Therefore the central estimate of the ongoing cost per person is £667 per year (£50,000 ÷ 75). This cost will then vary by the number of individual receiving a personal health budget.

64. Table 2 summarises costs across a 10-year time horizon. This is based on the following assumptions:

[11] www.dh.gov.uk/health/2011/08/personal-health-budget-pilot/

- Take-up of personal health budgets is assumed to be 15% of people eligible for NHS Continuing Healthcare (0% in year 0; 7.5% in year 1, 15% thereafter);
- Set-up costs are incurred in years 0 and 1 only, at £2.2m per year;
- Ongoing costs are £50,000 per 75 people;
- There is a 3.5% discount rate

Table 2: Costs of option 1 (sensitivity analysis in Annex A)

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	**Total**
Number of recipients	0	4250	8500	8500	8500	8500	8500	8500	8500	8500	-
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 (£m)	0.0	2.8	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	48.2
Total costs (£m)	2.2	5.0	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	52.5
Total costs, discounted (£m)	**2.2**	**4.8**	**5.3**	**5.1**	**4.9**	**4.8**	**4.6**	**4.5**	**4.3**	**4.2**	**44.6**

65. There are likely to be additional time costs to budget-holders and clinicians in setting up and monitoring budgets. However, these are not expected to be substantial, particularly in Continuing Healthcare, where individuals and clinicians already spend time on managing their care package. This is through the Decision Support Tool, which – while nominally a needs assessment – has been developed to become a tool to inform budget-setting. This cost would exist under the do nothing option, so additional costs under option 1 are expected to be small.

Net benefit of option 1

66. Table 3 gives a net benefit, based on the best estimates of costs and benefits set out above.

Table 3: Net benefit of option 1

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	**Total**
Total set-up and ongoing costs (£m)	2.2	5.0	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	**52.5**
QoL benefit & cost saving (£m)	0.0	21.3	42.7	42.7	42.7	42.7	42.7	42.7	42.7	42.7	**362.7**
Total benefit (£m)	-2.2	16.3	37.0	37.0	37.0	37.0	37.0	37.0	37.0	37.0	**310.2**
Total set-up and ongoing costs, discounted (£m)	2.2	4.8	5.3	5.1	4.9	4.8	4.6	4.5	4.3	4.2	**44.6**
QoL benefit & cost saving, discounted (£m)	0.0	20.8	40.4	39.4	38.3	37.3	36.4	35.4	34.5	33.6	**316.1**
Total benefit, discounted (£m)	**-2.2**	**15.9**	**35.1**	**34.3**	**33.4**	**32.6**	**31.8**	**31.0**	**30.2**	**29.4**	**271.5**

67. This means that the net present value of option 1 over 10 years is £272m. The sensitivity analysis in annex A gives the 'high' and 'low' estimates in the summary sheets.
68. Therefore, as option 1 is estimated to deliver a positive net benefit, this is the preferred option. This 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 1 will remain the preferred option.

Rationale and evidence that justify the level of analysis used in the IA

69. 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 below, the effects of this are uncertain at this stage. 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.

70. 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 reasons that may or may not be entirely predictable. 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.

71. 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.[12] 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.

Risks and assumptions

72. The information above has demonstrated that there are some areas for rollout which would lead to a definite benefit (such as in NHS Continuing Healthcare), and other areas with a benefit that is less certain. However, there are a number of risks involved in the rollout of direct payments. None of these is insurmountable, and at worst are likely to delay implementation and realisation of the benefits rather than to pose specific risks to the policy.

73. **Risks to patients:** 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 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 defined through the EQ5D), there are also no negative impacts. Furthermore, in general there are benefits to an individual's quality of life, as measured by ASCOT. Any remaining risk will be mitigated by sharing practice from where the introduction of personal health budgets has been more beneficial.

74. **Risks to the wider system:** Personal health budgets are a major change to how the system operates. They give more control to the individual 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, if people are opting away from a particular service, there are clear implications for the long-term viability of that service. This is a risk that needs managing but not avoiding. It is not feasible to move away from previously-commissioned services immediately. The capacity in new services may not be immediately available, and funding may be tied up in a particular provider. Instead, this would be reduced over time. This risk will be mitigated by implementing personal health budgets slowly, and being clear about what individuals are choosing to do when they have more control and the implications on providers, and manage this accordingly.

75. **Fragmentation:** 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

[12] www.personalhealthbudgets.dh.gov.uk/News/item/?cid=8607

areas of expertise. This will be mitigated by ensuring that a care or support planner maintains oversight at the individual level as necessary; and that commissioners adapt over time.

76. **Increased costs to the system:** One of the issues raised 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. This has not proven to be a risk in practice – costs have been neutral or fallen. As a result, this needs no mitigating action.

77. **Fraud:** At the start of the pilot programme, it was thought that people may take the money and run away with it. This has proved unfounded, with no known examples of fraud by budget holders. Cases in social care are also very limited in number. As a result, this needs no mitigating action.

78. **Cultural change & transparency:** As a result of personal health budgets, there will be much greater transparency to the individual about costs of particular treatments. This presents 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). However, the evaluation found no evidence that these risks have materialised. Nevertheless, this will be mitigated by longer term monitoring.

79. **Cost minimisation, leading to lower benefits:** 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. This will be mitigated by emphasising the need to implement personal health budgets with regard to the findings of the evaluation, and also emphasise their cost-effectiveness.

80. **Implementation:** It is clear from the pilot programme and the evaluation that when personal health budgets are implemented well, they are beneficial. As the evaluation makes clear, one model 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. This will be mitigated by emphasising the learning from the pilot programme through the toolkit, and using the "Further, Faster" sites to investigate some of the remaining issues.

81. **Scalability:** 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. This will be mitigated by ensuring ongoing monitoring, to assess whether this is arises as an issue.

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

82. 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.

Annex A: Sensitivity analysis for benefits and costs of option 1

83. 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 central estimates.

Sensitivity of benefits of introducing personal health budgets

84. 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.

85. 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. This means that:

    - The quality of life gain (excluding set-up and ongoing costs) ranges from £1,590 to £2,250
    - The cost-saving (excluding set-up and ongoing costs) ranges from £230 to £5,980

Table A1: Range in quality of life benefits and cost-savings (undiscounted)

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	**Total**
Cost-saving (low) (£m)	0.0	1.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	16.6
Cost saving (central) (£m)	0.0	13.2	26.4	26.4	26.4	26.4	26.4	26.4	26.4	26.4	224.0
Cost saving (high) (£m)	0.0	25.4	50.8	50.8	50.8	50.8	50.8	50.8	50.8	50.8	432.1
QoL benefit (low) (£m)	0.0	6.8	13.5	13.5	13.5	13.5	13.5	13.5	13.5	13.5	115.1
QoL benefit (central) (£m)	0.0	8.2	16.3	16.3	16.3	16.3	16.3	16.3	16.3	16.3	138.7
QoL benefit (high) (£m)	0.0	9.5	19.1	19.1	19.1	19.1	19.1	19.1	19.1	19.1	162.3
QoL benefit & cost saving (low) (£m)	**0.0**	**7.8**	**15.5**	**15.5**	**15.5**	**15.5**	**15.5**	**15.5**	**15.5**	**15.5**	**131.8**
QoL benefit & cost saving (central) (£m)	**0.0**	**21.3**	**42.7**	**42.7**	**42.7**	**42.7**	**42.7**	**42.7**	**42.7**	**42.7**	**362.7**
QoL benefit & cost saving (high) (£m)	**0.0**	**35.0**	**69.9**	**69.9**	**69.9**	**69.9**	**69.9**	**69.9**	**69.9**	**69.9**	**594.4**

86. When discounted (at 3.5% for cost savings and 1.5% for quality of life improvements), the total QoL benefit and cost saving ranges from £120m to £512m (with the central estimate at £316m). These figures are included in the cover sheets.

Sensitivity of benefits of introducing personal health budgets

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

    - Ongoing costs make up a central estimate of £50,000 per pilot site, ranging from £20,000 to £80,000

- This cost is assumed to be the cost of ongoing support for 75 personal health budget holders; the cost rises proportionally with the number of recipients
- Set-up costs are the residual of the £93,280 cost per pilot site, and are incurred in the first 2 years only, i.e. the central estimate is £43,280, ranging from £13,280 (in the case of high ongoing costs) to £73,280 (in the case of low ongoing costs),

Table A2: Range in cost estimates (undiscounted)

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	**Total**
Ongoing costs (low) (£m)	0.0	1.1	2.3	2.3	2.3	2.3	2.3	2.3	2.3	2.3	**19.3**
Ongoing costs (central) (£m)	0.0	2.8	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	**48.2**
Ongoing costs (high) (£m)	0.0	4.5	9.1	9.1	9.1	9.1	9.1	9.1	9.1	9.1	**77.1**
Set-up costs (low ongoing costs) (£m)	3.7	3.7	0	0	0	0	0	0	0	0	**7.3**
Set-up costs (central ongoing costs) (£m)	2.2	2.2	0	0	0	0	0	0	0	0	**4.3**
Set-up costs (high ongoing costs) (£m)	0.7	0.7	0	0	0	0	0	0	0	0	**1.3**
Total costs (low ongoing costs) (£m)	**3.7**	**4.8**	**2.3**	**2.3**	**2.3**	**2.3**	**2.3**	**2.3**	**2.3**	**2.3**	**26.6**
Total costs (central ongoing costs) (£m)	**2.2**	**5.0**	**5.7**	**5.7**	**5.7**	**5.7**	**5.7**	**5.7**	**5.7**	**5.7**	**52.5**
Total costs (high ongoing costs) (£m)	**0.7**	**5.2**	**9.1**	**9.1**	**9.1**	**9.1**	**9.1**	**9.1**	**9.1**	**9.1**	**78.4**

88. When discounted (at 3.5% for costs), the total cost ranges from £23m to £66m (with the central estimate at £45m). These figures are included in the cover sheets. These figures are included in the cover sheets.