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LSE THE LONDON SCHOOL OF ECONOMICS AND POLITICAL SCIENCE

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Evaluation of the personal health budget pilot programme

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Personal health budget programme

Personal health budgets are an important part of the personalisation agenda

The aim is to encourage NHS to be more responsive by promoting greater choice and control

First proposed in the 2008 NHS Next Stage Review and in 2009 DH invited PCTs to become pilots

The underlying principles of personal health budgets are:

- Know the level of resource available within the budget
- People being encouraged to develop a support plan that details how the resource will be used to meet outcomes
- Choice in how the budget will be managed

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Deployment options

Notional

Budget is held by the NHS and buys or provides the services

Managed by a third party organisation

Organisation independent of budget holder

Direct payment

Cash payment to the budget holder

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What can a personal health budget be used?

A range of services/help that can help meet identified goals

- Personal care
- Equipment
- Physiotherapies
- Complementary therapies

What is not covered by the personal health budget

- Emergency care
- Care normally received from a GP
- Gambling
- Debt repayment
- Alcohol or tobacco
- Anything that is unlawful

www.personalhealthbudgets.dh.gov.uk

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Evaluation of the Personal Health Budget Pilot Programme

Pilot programme was supported by a three-year evaluation (2009-2012)

Overall 64 pilot sites at outset

20 form the in-depth evaluation with the remainder forming the wider cohort

Overall aim of the evaluation was to provide information on:

- How personal health budgets are best implemented
- How well personal health budgets work
- Where and when they are most appropriate
- What support is required for individuals

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Research Team

PSSRU (University of Kent)

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Evaluation Design

Controlled trial with a pragmatic design

- Patient-level randomisation (whole site uptake)
- Between group comparison (selective PHB uptake)

The evaluation covered:

- NHS Continuing Healthcare
- Diabetes
- Mental health
- Chronic Obstructive Pulmonary Disease
- Stroke
- Long-term neurological conditions

1,000 people recruited to the PHB group
1,000 people recruited to the control group

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Quantitative data collection

Outcome interviews

- Care-related quality of life (ASCOT)
- Health-related quality of life (HRQOL) using the EQ5D scale
- Psychological health using GHQ12
- Subjective well-being

Primary care service use – GP medical records

- Service use for 12 months before and after consent date

Secondary care service use – Hospital Episodes Statistics

- Service use for 12 months before and after consent date

Analysis of PHB support/care plans – costing and service use

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Qualitative data collection

In-depth interviews: 3 and 9 months among budget holders and carers

Interviews with organisational representatives within the pilots.

- Month 3, 15 and 24

One aim of the interviews was to develop implementation models

- Whether pilot site informed the budget holder of the PHB amount
- Degree of flexibility in what services could be purchased
- Flexibility in deployment options

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Implementing Personal Health Budgets
Interviews with organisational Representatives

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Key Objectives

Interviews with organisational representatives

- Identify factors that have facilitated and inhibited the implementation process
- Identify effective strategies and approaches used to address challenges faced
- Collect information on peoples' experience of implementing personal health budget

Implementing personal health budgets

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Topics included:

- Personal health budget process and programme
  - Budget setting
  - Care planning
- Initial impact of personal health budgets
- Accountability and managing risk
- Cultural change
- Integration of the NHS and local authority
- Impact on the workplace
- The potential longer-term effects for national roll-out

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Views from Organisational Representatives

Positive views on the potential impact of personal health budgets

- Increasing choice and control over services
- Encouraging flexible and creative services
- Improving relations between the NHS and the budget holder

Key issues and challenges for implementation

- More time for support/care planning process
- Lack of choice of services, market development
- Challenges around the culture change required

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Implementation models

Model 1

- Personalised budget is known before support planning
- Flexibility in what help can be purchased
- Deployment choice (including DP)

Model 2

- Budget is known before support planning (but may not be personalised – a set amount)
- Service directory
- Deployment choice (including DP)

Model 3

Budget is known before support planning (but may not be personalised – a set amount)
Lack of flexibility with services
No deployment choice

Model 4

Budget is not known before support planning
Flexibility in what help can be purchased
Variation in the degree of deployment choice

Model 5

Models 1 and 2 combined

Summary

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Support from organisational representatives

- Personalised support planning increased choice and control
- Encouraged more creative services
- Improved relationship between the patient and the NHS

Implication for implementation

- Implementation models can be used to guide the national roll-out of personal health budgets
- Addressing cultural change central to implementing personal health budgets effectively
- Consistent, key members of staff required to drive implementation

Any questions?