NHS
Nene Clinical Commissioning Group

Document Title: Personal health budgets for mental health

Subtitle: The experience in Northamptonshire

First published: July 2014

Prepared by: Vidhya Alakeson

Contents

To update the table of contents - right click on the contents table and select 'Update field', then 'update entire table'

Personal health budgets for mental health: The experience in Northamptonshire

Northamptonshire were one of the 'in depth' pilot sites in the original personal health budget evaluation programme (PHBE). As a site they had a strong interest in how this innovative approach could benefit people who used their mental health services. This paper gives an insight into their work over the last 5 years, with a particular focus in this service area. It provides learning for commissioners about the underpinning values and consequent implications of personal health budgets, the outcomes for patients, costs and financial benefits, and implementation strategy. It summarises approaches taken and lessons learnt so far, and plans and issues for the future. It is part of a growing body of knowledge from NHS England's 'Going Further Faster' programme about the potential for personal health budgets to address some of the challenges facing the health and social care system, and how they can best be implemented.

1.1.1 How do personal health budgets fit with 'recovery' in mental health?

In Northamptonshire a clear connection was made early on to one of the central strands of service transformation in mental health: recovery. Adopting a recovery focused approach to mental health services means moving beyond symptom and risk management to support people to re-establish a meaningful life for themselves with their mental health condition. Recovery requires services to look beyond treatment to consider wider issues such as housing, employment and family relationships. As a highly personal journey, recovery depends on services being able to develop individually tailored approaches. Personal health budgets were conceptualised in Northamptonshire as a tool to support more recovery focused services by allowing individuals to define their own outcomes and design their own packages of care and support.

1.2 How did Northamptonshire start to introduce personal health budgets?

Northamptonshire's application to become a personal health budget pilot site was driven by the Integrated Care Programme Board which had good support from health and social care organisations across the county. The personal health budget pilot in Northamptonshire led by Nene Practice-based Commissioning Group (now NHS Nene CCG) offered personal health budgets to 16 individuals in receipt of services from a community mental health team. The table below shows the clusters that each of the 16 individuals would have been assigned to if clusters had been in operation at the start of the pilot.

Table 1

Cluster Number	Cluster Description	Number of pilot participants
0	Definite mental health need but does not fit with other clusters (autism, aspergers)	2
1	Common mental health problems (low severity)	1
2	Common mental health problems (low severity with greater need)	1
3	Non-psychotic (moderate severity)	4
4	Non psychotic (severe)	1
7	Enduring non-psychotic disorders (high disability)	2
8	Non-psychotic chaotic and challenging disorders	2
11	Ongoing recurrent psychosis (low symptoms)	2
14	Psychotic crisis	1

The size of the personal health budget offered to each participant was based on the services individuals and their clinicians thought they required for the year rather than according to a needs-based formula. Commissioners worked with Northamptonshire Healthcare NHS Foundation Trust to identify the costs of clinical services for the purposes of calculating budgets. The following costs were used:

Table 2

Intervention	Price (£) per contact
Community mental health team, face to face contacts, any health professional	£202.04
Crisis face to face contact	£180.71
Inpatient bed stay	£481.18

As part of the planning process, individuals worked with their clinicians to decide whether their current use of clinical services was meeting their needs or whether a different pattern of service use was preferable in order to free up funding for other important activities. This is illustrated by the spending plan below.

For example, one participant wrote in his care plan:

> ***"Initially I still require fortnightly support from my care coordinator. I plan to review this on a quarterly basis with the aim of reducing contact when feeling more able. This will then allow me to purchase more personal assistant hours".***

Personal health budgets for the 16 pilot participants ranged from £1,820 to £29,093 a year. Since commissioners had already contracted with the Trust for the services that the participants would otherwise have been receiving, the cost of any clinical services that individuals chose to include was already covered by the contract. The Trust released any additional funding up to the full value of that individual's personal health budget back to commissioners to enable individuals to purchase the alternative goods and services that were part of their plan.

Personal health budgets and care planning

In Northamptonshire the care planning process, which is central to a personal health budget, gave individuals, together with their clinicians, the opportunity to think about what was important to them in their life, what was important for their health, what they would like to change about their current situation and how they were going to manage any risks. This conversation, or series of conversations, identified the objectives against which progress could be judged at the point of review.

1.3 What was learnt from individual's care plans

Analysing the care plans developed by participants in the Northamptonshire pilot, several themes emerged:

- ***Health is integrated within a wider sense of individual well-being and purpose***

Care plans demonstrate that individuals want to manage their health as part of being able to make wider improvements in their lives, for example returning to work, maintaining an organised home, managing their finances, being an active part of the family and having a social life. Their mental health problems often get in the way of these wider goals and their motivation in meeting their health needs is to make other improvements in their life possible.

'Ideally I want independence, stability and control. Not to crumble to pieces when vulnerable or challenged. To acquire skills, resources and support that help to enrich my diminished existence

beyond limited interaction with medical or domestic support. In order to do this, I must have the means and the opportunities to make real choices at home and outside that improve both my symptomatic and social outcomes'.

- ***Where individuals are in contact with or live with family members, they tend to focus on their needs as well as the needs of wider family members***

Providing more support for family members or being less of a source of anxiety for family members was a common theme. While individuals want to see improvements for themselves, the plans highlight the fact that the impact of mental health problems goes beyond the lives of the individuals concerned and the positive changes that individuals hope to make are intend to benefit those close to them as well.

'I want to be able to feel safe when I am on my own. This will enable my wife to feel more comfortable when leaving me to pursue her own activities and allow us to be husband and wife again rather than husband and carer'.

- ***Individuals want to reduce their use of services***

The care plans highlight the fact that individuals are strongly motivated to reduce their use of mental health services. Nine of the 16 participants identified this as an outcome they wished to achieve with their personal health budget. There is little sense of people holding onto services that they no longer need, rather a desire to use fewer services as they recover.

"I will not need hospital admission or crisis team assessment and intervention. I will be able to gradually disengage from secondary mental health services".

"My aim is to avoid visits to the NHS (via GP) or OT as often and, therefore, save health and social care resources".

"This year you gave me £5000. Ideally next year I would like perhaps £4000 and the next perhaps £2000".

- ***Individuals do not reject clinical care but often do want to change its frequency or be able to choose who they receive care from***

There is clear recognition across all care plans of the value of some clinical intervention and the need to maintain contact with some existing clinical support. However, there is evidence of individuals wanting to be able to reduce the frequency of that support, focus it at points where they most need help and the desire for greater choice over whom they work with. In other words, the plans reveal a desire for greater flexibility in how clinical care is offered rather than a wholesale move away from traditional options.

"I will see my social worker on a regular basis. It is mainly once a week but this can change depending on how I feel and she will up my visits or decrease them as required"
"I wish to continue to have contacts with my care coordinator from the CMHT for support, guidance, reassurance, although I would like to arrange the frequency of these sessions in accordance with how I am feeling rather than at set times. This will allow me to access support more appropriately, increasing contacts at times when I may not feel well and supporting myself when I feel better".

- ***Plans can help mitigate risks***

The care planning process provides a clear opportunity for individuals to think about their risks and how they can be managed, as well as to identify what things will look like if the plan succeeds and what are the signs that it is not succeeding. This provides a positive approach to risk management and one that involves the individuals closely in identifying and managing risks. The planning process also requires individuals to identify how the plan will be put into place and the specific roles they will play in ensuring that the plan happens. This is in contrast to a more passive, traditional role for individuals within services.
"I want to continue with annual psychiatric review with Dr X plus additional contact and referrals if required. I will budget for this by keeping back an emergency fund until the last quarter'.

- ***Individuals gain experience and their choices change over time***

Interviews with participants highlight the fact that choices change as individuals gain more experience of what can improve their health and wellbeing and as their recovery progresses. This means that the planning process needs to remain flexible enough to accommodate changes and encourage individuals to learn from their experience and change their approach accordingly.
"Yes things change, they are supposed to, if things are working then things should change because I am changing for the better I hope".

1.4 Outcomes and purchases

The lead for the pilot programme found that those new to personal health budgets were very keen to understand the ways in which individuals chose to spend their money. This is because some of these choices are new and novel within the NHS. However she was clear that the important thing was the focus on the health and well-being objectives that personal health budgets were there to

achieve and how purchases can contribute to achieving those goals. The table below shows the outcomes identified by participants in the pilot in Northamptonshire.

Table 3

Outcomes identified by individuals from personal health budget plans	No. of individuals
Reduce demand on health services – community and acute	9
Improve socialization	8
Gain employment or return to work	5
Maintain or achieve independence	4
Reduce number of overdoses or suicidal thoughts	4
To be able to help others	3
Reduce self-harming behaviour	3
Reduce medication	3
Improve confidence and self esteem	3
Improve body image	2
Alleviate pain	2
Stop smoking	1
Weight reduction	1
Manage and stabilize stress levels	1
Improve family relationships	1
Prevent mental health impacting on children	1

For many participants, these outcomes were achieved through a combination of traditional and alternative services. The table below identifies how individuals used alternative goods and services to achieve their outcomes and highlights the importance of seeing purchase in light of the outcome the individual intends to achieve.

1.5 Selected outcomes and purchases from the Northamptonshire personal health budget pilot

Table 4

Category	Non-traditional purchase	Outcomes
IT equipment	PDA 'tablet' organiser	To help me keep in touch with others, organize my diary and access information
	Sat nav	To feel in control, competent, useful and maintain my independence
	Dragon DSA	A laptop that I can talk to instead of type so I can engage with training/learning activities
Therapies	Physiotherapy	Reduce stiffness and protective tension due to pain – a side effect of my SSRI anti-depressant
	Massage/ Indian head massage	To compliment occupational therapy, understanding stress and anxiety and to have alternative ways to overcome stress
	Alexander technique	To prevent muscular pain and tension building up throughout my body
Education	Self-confidence course	To feel safe and confident on my own so my wife will not have to be a 24/7 carer and improve my ability to engage in social activities.
	Office Student Pro	To work and become part of society again. Long term aim, to live on my own independent from my family
	College course	Long term goal to be in employment and financially independent
Respite	Respite care home	To access respite/ crisis support so I will not need hospital admission and achieve long term well being
	Visiting family, travel costs	My moods will be manageable, less reliance on current services and less change of relapse

	Residential stay	Time to reflect and recuperate
Exercise	Gym membership	Increase healthy lifestyle, improve self esteem, gain confidence, reduce stress and anxiety
	Personal trainer	Increased strength and reduce pain
	Shiatsu sessions	Weight reduction, control or reverse diabetes type II diagnosis
Other support	Vehicle repair costs	Reduce isolation
	Costs towards clothing	I will feel comfortable and confident about my appearance which increases my self esteem and motivation
	Conversion of outhouse into playroom and storage units	To enable me to be more independent in my roles as wife and mother, to prevent my mental health impacting on my children

1.5.1 Managing a personal health budget

In the pilot, all personal health budgets were a mix of notional budgets (for the Trust provided clinical care) and direct payments (for the alternative services). Since the pilot Northamptonshire have developed a third party option as an alternative to direct payments – where the funding is held and spent on behalf of the person, and according to their care plan, by another organisation. Three people use this option and these are people considered a higher financial risk – because of past or current drug or alcohol dependency. Having this option in place has given care co-ordinators the confidence to promote personal health budgets and so opened up the possibility of personal health budgets for this small group.

1.6 What results were achieved?

1.6.1 Improved outcomes for patients

Interviews with personal health budget holder highlighted how they felt that alternative purchases had helped them achieve their outcomes and improve their health and wellbeing.

"The health budget and being able to buy technology has been so helpful. I bought a tablet to start with. I am a total dinosaur and since my stroke I

can't remember how to do anything so getting a tablet and messing around with that gave me a lot of confidence"

.

"At first I was really nervous (going to college) and staff came with me to settle me in but now I get a taxi in the morning and a bus back. That was something I could never do before. The thought of a bus just freaked me out, not now every Wednesday I get a bus back. I go over to [name of town] now to see my parents and my sister so they don't come over here and pick me up. So I have got more independence coming back and going when I want".

As part of a national research programme Northamptonshire were able to have their local data included in a national data set that backed up this anecdotal evidence of improved outcomes. The independent national evaluation showed that personal health budgets for mental health improve people's quality of life, well-being and feeling of being in control.

2 Reduced service use

The PHBE evaluation found that personal health budget holders used fewer inpatient, A&E and GP services than those in the control group receiving care as usual by an average of £3050 a year. In Northamptonshire they kept careful records of service use for the individuals they were working with and results from the small local group of participants mirrored these national results. Overall, there was a 12 per cent increase in the costs of care for those in the local control group between 2010-11 and 2011-12 and a 54 per cent decrease in the costs of care for those with a personal health budget over the same period. This major reduction in costs was driven by those with personal health budgets who in 2010-11 had made significant use of inpatient and crisis services. In 2011-12 they saw a significant decrease in service use and, therefore, costs. By contrast, those in the control group who had accessed inpatient and crisis services in 2010-11 saw an increase in their costs. Those in the personal health budget group who had not made significant use of inpatient and crisis services in the previous year saw a reduction in their costs of care but a much less dramatic one. The tables in the appendix show the costs of control group and personal health budget participants split by whether or not they had accessed acute or crisis services in 2010-11.

While it is not possible to identify the causal relationships between access to a personal health budget and the reductions in service use and costs shown above, interviews with personal health budget holders highlight a set of things that appear to play a part:

- the sense of hope and renewed confidence that the personal health budget process offers
- the planning process itself and the ability for individuals to think about how they would like their life to be different.
- the ability to access alternative services and supports that can foster recovery in a different way from traditional clinical services, especially for those without the financial means to access these services privately, for example gym memberships
- the ability to alter the balance of clinical and alternative services to maximize the benefits of both
- the ability to choose professionals to work with, for example counsellors
- a different relationship with traditional, clinical services and professionals
- the sense of responsibility and renewed confidence that the personal health budget process offers by expecting individuals to participate in decisions and take on actions to implement their plan.

2.1.1 Participant views

Participants summed up the value of their personal health budget in the following way:

> **'*This (personal health budget) is the best thing that has ever happened. I don't think that I would have lived a lot longer, now I think I will. Before I didn't care, didn't want to live and now I think I want to live. I don't particularly want to die now which is different. It's because of [name of counsellor purchased with personal health budget]. It's amazing how she works but she says a lot of it is in the relationship between me and her'***

Personal health budget participant 8

> ***'Twelve months ago I couldn't really see a future, where now, life isn't great but it is not quite so depressing as it was. I am more involved in trying to help other people (one of the outcomes in his plan), someone less fortunate than me and that gives me a lot of inspiration to carry on. It is important. It is a reason to get up in the morning. My life is worthwhile'***

Personal health budget participant 1.

> ***'It has been absolutely fantastic to be given this opportunity to improve my life and I feel that it has, it's all been good. I was seeing [name of care coordinator] every two weeks and now it only every four, that must be a saving and I have not been in hospital for eight months. Every month I have tried to celebrate. It sounds really stupid but it's such an achievement for me not to be back in and now I really want to get to that one year in August'***

Personal health budget participant 9.

2.1.2 Beyond the pilot programme: rolling out personal health budgets

The Strategic Plan for Northamptonshire 'Healthier Northamptonshire' which includes all health, social care, statutory and voluntary sector organisations has personalisation and personal health budgets as a key work-stream. In addition to mental health, in Northamptonshire personal health budgets are available for adults eligible for Continuing Healthcare, children in receipt of continuing care and people who used a residential respite service which recently closed. In the next year they plan to increase uptake in existing areas, further develop work on integrated budgets with social care, and build the business case for wider roll out to people with long term conditions.
Offering personal health budgets as a mainstream part of the NHS raises two important questions: first, who should be eligible for a personal health budget; and second, how can the money to offer personal health budgets be freed up?

2.1.3 Using the Mental Health Payment System (formerly Payment by Results)

The current approach being taken by NHS Nene CCG is to base the value of a personal health budget on the community element of the care cluster costs developed for mental health. At present, most community mental health services continue to be block purchased. The introduction of cluster costs will create a set of tariffs within community mental health services similar to the acute sector, although tariffs will not be national but will be developed locally. Cluster costs are still being trialled within the NHS but they do provide one way of identifying the value of a personal health budget and moving money between providers.
In moving forward, Nene CCG is focusing on three clusters that address individuals with longer term mental health needs who would be expected to receive services over three or more years and have higher value cluster costs. Focusing on higher value clusters for the roll out of personal health budgets ties in with the finding from the national personal health budget evaluation that higher value personal health budgets lead to better results. The three clusters are:

- Cluster 8: personality disorder

- Cluster 10: first episode psychosis
- Cluster 17: severe engagement psychosis

Each of these three clusters relates to only one team within the CCG area, making the extension of personal health budgets less challenging from an organisational point of view. Staff training can be tightly focused on the teams involved and a personal health budget facilitator can be identified from within each team. The facilitator will follow each personal health budget holder throughout the process and will be responsible for signing off plans unless they are more than 15 per cent above the indicative budget.

On the basis of an initial assessment, individuals are assigned to a cluster. If that individual chooses to use traditional services, the cluster cost transfers to the Foundation Trust in its entirety. If the individual opts for a personal health budget, the Trust receives a part of the cluster cost that relates to the traditional services that individual wishes to continue to use. The remainder of the cluster cost is transferred to the individual as a direct payment or held by a third party on the individual's behalf for the purchase of alternative goods and services.

The thinking behind the development of cluster costs and personal health budgets is different: cluster costs relate to clinical needs only, while personal health budgets are intended to meet clinical needs within a wider context of health and wellbeing, However, under the current financial constraints of the NHS, it is important to be able to demonstrate that personal health budgets can be offered on a cost neutral basis and cluster costs offer a mechanism for being able to unlock money from existing providers without the need for double funding.

However, when comparing cluster costs and indicative personal health budget costs for the pilot population, Nene CCG did not find a close match. In some cases, the cluster cost was significantly higher and in others far lower (see table below). As a result, individuals who started in the pilot programme and have remained on a personal health budget will have to have their budget adjusted under the new system. For some, this will mean a reduction in their personal health budget.

Table 11: A comparison of cluster costs and indicative personal health budgets for individuals in the pilot programme

Cluster	Total annual cluster cost	Indicative personal health budget
1 – common mental health problems (low severity)	£ 5,475	£ 2,424.48

1 – common mental health problems (low severity)	£ 5,474	£ 6,061.20
8 – non-psychotic chaotic and challenging disorders	£12,045	£ 9,697.92
8 – non-psychotic chaotic and challenging disorders	£12,045	£ 4,848.96
11 – ongoing recurrent psychosis	£ 8,030	£ 4,848.96
11 – ongoing recurrent psychosis	£ 8,030	£16,971.36

It is too early to say whether cluster costs provide the best starting point for the allocation of resources for personal health budgets or whether the upfront availability of additional resources for some people would in the end save greater resources by having a greater impact on the use of hospital and other NHS services.

Northamptonshire are planning to calibrate and test the use of a commercially available 'Resource Allocation System' that is in use by the Local Authority. It is hoped that this will support the drive towards integrated health and social care budgets.

2.1.4 Workforce development

Frontline staff in Northamptonshire have worked hard to support the introduction of personal health budgets and help shape how they were designed. The idea of personal health budgets, when first discussed, raised concerns about risk and safeguarding. The care planning process that is at the heart of personal health budgets includes a full discussion of risk, and where people want to take some measured risk so that they can lead a full life, this can be discussed openly before the plan is agreed. While there is helpful guidance available through the personal health budget toolkit, in reality it has been the actual experience of clinicians working through the process with individuals, and then discussing this with their colleagues that has influenced them to feel more confident about this approach. The project manager invested time in working alongside those clinicians who took to the ideas earlier and were keen to explore them in practice. She gave them the opportunity to share their learning and stories with colleagues, rather than her trying to persuade all staff of the theory of personal health budgets at the outset. It has taken time to fully

appreciate the shift in relationship between the clinician and the person receiving services to a more equal partnership, accepting that the person themselves has expertise in their own condition.

> ***'It's giving our service users an awful lot of confidence, its decreasing social isolation. It stands a good chance of succeeding because they are in control of what they want, they are buying their own services, and because it's what they want, and are not being told it's what they've got to do, they stick with it.'***

> ***'The things that Mary is not using at the moment – she's not using the home treatment team, she's not using hospital services, and that has given Mary a real sense of achievement which has increased her confidence. Over the months when I saw how Mary's mental health improved how the other person that I've been working with, confidence grew, that they are actually achieving goals and aims in life that they have been struggling with over the last 5 years I couldn't believe it was possible, the strides that both of them have made and I'm so impressed.'***

Principal social worker

2.1.5 Using CQUIN to drive workforce development

In 2013/4 Nene CCG used a CQUIN target to drive forward the roll out of personal health budgets. CQUIN targets are locally agreed between commissioner and provider and have been used effectively in several areas to accelerate personalisation. The one adopted in Northamptonshire focussed on training of care co-ordinators. Local evidence indicated the pivotal role of care-co-ordinators in helping people develop and put in place their plans. A target was set around the numbers of care co-ordinators new to personal health budgets who received awareness training, and the numbers who had a client who wanted a personal health budget who received more in depth training. The training was delivered with people who had personal health budgets. Other outputs and outcomes measured included results of a survey of mental health service users, and the numbers of agreed care plans that passed a best practice audit. Using the CQUIN in this way helped ensure support to workforce development, fund some of the costs of implementation of personal health budgets, and raise awareness of personal health budgets corporately.

Not all support for personal health budgets needs to be provided by NHS clinicians. Together with their peer network, Northamptonshire co-commissioned an AQP for support planning and brokerage. Four organisations are on the list, 2 from the voluntary sector and 2 independent providers. This means that clinicians time will not be taken up with helping people to write their plans, and it is hoped that the skills and experience of the new support planners may increase the creativity of the plans. The planners will act as advocates on the occasions needed. Clinicians will still play a pivotal role in the planning process, particularly around sign off of plans, including issues around risk and safeguarding.

2.1.6 Process redesign

Northamptonshire is also seeking to streamline the paperwork that supports personal health budgets to develop a more standardized set of documents, for example for review. This will be important in ensuring that the personal health budget process is able to accommodate higher numbers of people. However, given the importance of relationships in the personal health budget process, it will be critical to ensure that the process is not too driven by forms and that the change in conversation between individuals and clinicians that sits at the heart of personal health budgets does not get lost.

2.1.7 Support for commissioners and ensuring quality

Northamptonshire also set up a local peer network – a group of people with direct experience - as part of its approach to implementing personal health budgets. This is facilitated by peoplehub CIC who run the National Peer Network for personal health budgets. In the future it is anticipated that the the Northamptonshire Peer Network will run independently. The peer network has insured that the perspective of those who use personal health budgets is central to implementation and the evaluation of how well the programme is going locally. The Peer Network provide support to peers and people who are considering a personal health budget. They have worked in partnership with the CCG on the AQP procurement; helped develop and design the systems and processes for roll out, written the questions for a best practice audit and delivered personal health budget training for CMHT staff. They continue to share their stories and experience, which is recognised as being vital for communicating about personal health budgets across the county.

Northamptonshire, along with the other Gong Further Faster sites have used the POET (Personal Outcomes Evaluation Tool) to systematically measure the experiences and self-reported outcomes for personal health budget users and their carers. In addition they interview a random sample of people with budgets to gather qualitative date around service delivery.

2.1.8 Provider development and roles

Personal health budgets raise several issues for provider trusts. They are both a business opportunity as well as posing a financial risk if people choose to go elsewhere to receive services. This is a particular issue if some people continue to want a particular service but there is no longer a critical mass to offer that service efficiently. However in Northamptonshire the Trust chose to play a positive role in the programme from the outset. One benefit they anticipated was that they would gain a better understanding of the kind of services and support that people really wanted and were beneficial, so they could expand their market provision.

In Northamptonshire, Northamptonshire Healthcare NHS Foundation Trust manages the operational aspects of personal health budgets through its community-based teams now that the pilot is complete. In many ways this is appropriate, the trust has a long term relationship with many of the individuals who would receive personal health budgets. However, there is also a tension between the role of a trust as a facilitator of personal health budgets and as a provider. Where individuals choose to receive all of their services outside of the trust, there are issues about how to fund the Trust to facilitate personal health budgets given that there is no other revenue going to the Trust from that individual. In the medium term, it may be better to separate out these two roles and have a non-provider organisation facilitating budgets that can be used to purchase clinical services provided by the trust.

2.1.9 The primary and secondary care gap

One of the most significant issues that has arisen in moving forward with personal health budgets has been the inability to support people to stay well once they have been discharged from secondary care. This is an issue that goes beyond personal health budgets to the very nature of our mental health system. However, it has been made more pressing by the success that some individuals have had with a personal health budget.

Individuals who improve significantly towards recovery with a personal health budget can be discharged from secondary care. However, once they leave secondary care, they have no way of accessing a personal health budget, even a small one to maintain their health and well-being.

Without a personal health budget to stay well, they are at risk of becoming unwell and drifting back into secondary care. The alternative is for them to remain unnecessarily within secondary care simply to be able to access a personal health budget.

The experience of personal health budget holders has highlighted the need for primary care transformation as part of the longer term change that will sustain personal health budgets. Primary care based budgets for mental health and other long term conditions that stretch beyond prescribing need to be available to ensure that there is an effective bridge between specialist and primary care services rather than today's chasm.

2.1.10 Conclusions

The personal health budgets pilot programme addressed two critically important questions: do personal health budgets work to improve people's health and well-being and how can they best be implemented within the NHS. Northamptonshire's experience in the pilot programme highlights the positive impact that personal health budgets can have on people's lives and on the NHS in the context of mental health. Personal health budgets allow recovery to be taken to a deeper level than before by allowing services to respond to highly individual and personal approaches to recovery. This results in a reduction in use of hospital and crisis services.

The roll out of personal health budgets for mental health raises fresh challenges, notably how to release the funding to offer personal health budgets to large numbers of people a cost neutral basis and who should have the option of a personal health budget. There are no definitive answers to these complex questions. Northamptonshire's approach is presented here as an example of how one local area is moving forward with the intention of supporting other CCGs who also want to make progress. Other parts of the country will choose other, equally valid approaches from which we can all learn.

Underpinning both the pilot programme and roll out of personal health budgets is culture change. Personal health budgets require a significant culture change in the relationship that the NHS has with citizens. For the approach to work, individuals and families have to be real partners in decisions about their care and support, drawing on the expertise of clinical professionals. Whatever technical solution an area chooses for funding and offering personal health budgets, the need for culture change remains and is the most challenging aspect of implementing personal health budgets.

Appendix 1

An example personal health budget spending plan

Money In	**Per Week**	**Per Year**
Personal Health Budget		£4,800.00
Total Money In		

Money Out (help/service costs)	**Per Week**	**Per Year**
Time limited number of 4 sessions with CMHT		£808.16
1 Psychiatric Visit		
Respite Break		£202.04
A personal Assistant for 6 hrs contact per week		
Gym Membership		£500.00
		£2,184.00
		£580.00
Total		£4,274.20

Additional Items/costs Required		**Cost**
Personal Computer		£500.00
Total		**£500.00**

2.2 Control group costs – excluding individuals who accessed acute and/or crisis care

Table 5

Participant	Total costs of care (excluding medication) 2010-11	Total costs of care (excluding medication 2011-12
1	£ 2,020.40	£ 404.08
2	£ 6,039.87	£12,526.48
3	£ 6,869.36	£ 3,434,68
4	£ 6,082.24	£ 1,616.32
Total costs	**£21,011.87**	**£17,981.56**

2.3 Control group costs – excluding individuals who did not access acute and/or crisis care

Table 6

Participant	Total costs of care (excluding medication) 2010-11	Total costs of care (excluding medication 2011-12
5	£ 9,686.66	£ 4,242.84
6	£ 5,859.16	£11,186.26
7	£ 6,667.32	£10,867.50
8	£35,236.71	£45,062.04
Total costs	**£57,449.85**	**£71,358.64**

2.4 Personal health budget group costs – excluding individuals who accessed acute and/or crisis care

Table 7

Participant	Total costs of care (excluding medication) 2010-11	Total costs of care (excluding medication 2011-12
1	£ 7,475.48	£ 4,849.48
2	£20,001.96	£ 6,426.76
3	£ 2,626.52	£ 4,019.08
4	£10,506.08	£ 9.639.36
5	£ 4,444.88	£ 3,183.36
6	£10,506.08	£10,176.52
7	£ 5,051.00	£ 3,982.90
Total costs	**£60,612.00**	**£42,277.46**

2.5 Personal health budget group costs – excluding individuals who did not access acute and/or crisis care

Table 8

Participant	Total costs of care (excluding medication) 2010-11	Total costs of care (excluding medication 2011-12
8	£ 19,464.75	£14,207.36
9	£ 56,291.89	£16,903.11
10	£ 6,263.24	£11, 068.84
11	£ 40,934.71	£ 4,259.08
12	£ 15,527.88	£ 3,056.16
Total costs	**£138,482.47**	**£49,494.55**

Looking at the costs for two particular individuals with personal health budgets who used acute and crisis services in the previous year, it is possible to see how the savings are made from one year to the next through a significant reduction in contact with both acute and crisis services.

Table 9: Personal health budget group participant 8

Costs of care in 2010-11			£19,464.75
	CMHT contacts x49	£9,899.96	
	Crisis contacts x5	£ 903.55	
	Inpatient stays x18	£8,661.24	
Costs of care in 2011-12			£14,207.36
	PHB direct payment (for alternative services)	£3,800	
	CMHT contacts x 39	£7,879.56	
	Crisis contacts x 6	£1,084.26	
	Inpatient stays x 3	£1,443.54	

Table 10: Personal health budget group participant 11

Costs of care in 2010-11			£40,934.71
	CMHT contacts x 35	£ 7,071.40	
	Crisis contacts x 1	£ 180.71	
	Inpatient stays x 70	£33,682.60	
Costs of care in 2011-12			£14,207.36
	PHB direct payment (for alternative services)	£3,855	
	CMHT contacts x 2	£ 404.08	
	Crisis contacts x 0	£0	
	Inpatient stays x 0	£0	

It is worth noting that medication costs are not included in the costs shown above but from interviews with personal health budget holders, there is evidence that several saw a reduction in medication over the pilot period.

3 Table Template

You can adapt this generic table to insert your own headings and information into. You can also add more rows and columns. To add rows and columns please go to Word, Insert, Tables and follow the instructions there. The following text is inserted as an example of what you can do.

Category	Actions	Target date	Person responsible and their Directorate
Involvement and consultation			
Data collection and evidencing			
Analysis of evidence and assessment			
Monitoring, evaluating and reviewing			
Transparency (including publication)			

3.1.1 Case study: Ricky's story

The outcomes that Ricky wanted to achieve with his personal health budget are:

- To increase his understanding of his behaviour and learn to problem solve, to manage his thoughts and negative feelings
- To be able to give support to others
- To develop and maintain friendships and access social and leisure opportunities
- To regain confidence in him myself
- To regain employment and be self sufficient

This is how he describes his experience of having a personal health budget:

'What did I have before this house, this was my life. I had nothing. Sue would come and see how I was every two weeks and we would sit here for an hour that was my only interaction. She would go away and I would take all my medication and go back into depression my life was just meaningless. Since the PHB I have my computer, I can go on the internet and research my illness, I didn't know what bi-polar was to be honest, I didn't even know what I had. Being able to go on the bi-polar site it's helped me understand my illness and now I can manage it better.

I am not seeing Sue so frequently now, it used to be once a fortnight now its every two months, so there is a six weeks gap there, which is quite good. There are still times when I need to see Sue.

I am quite proud of myself to be honest. I am completing my Reiki Masters Degree this coming weekend and what that will allow me to do is I will be able to teach Reiki, not just give Reiki but teach. Then I will be able to earn an income from it. I have met some brilliant friends through it as well. Since I have been doing Reiki I go to a Reiki share group where I have met some beautiful people, its an opportunity to give something back for what has been given to me…life's pretty good.

With the budget things are just amazing. I have this cinema card. If I am feeling a bit down and I need to go away from the house, concentrate on something else I can, I have this little card and I can go to the cinema any time. With my illness I sometimes need to escape from what I am thinking, take myself away and the cinema does that and when I come back home it's not so bad and I can manage better, and it works! Having a carer two and a half hours a week helps. Sometimes with my bi-polar, when I'm really low, I don't eat and drink but having Denise coming in she prepares my

meals and then I freeze some so that I can just put them in the microwave. So my diet is looked after better than it was when I was on my own.
To be honest if anyone is considering a PHB I would say go for it because it has changed my life, I'm more confident, I have more self-esteem, I've made new friends, I've studied, all because of the PHB. I'm actually looking after myself a lot better than before I had this opportunity. People with bi-polar and mental illness just give it a chance, give it a try.
I can now help other people with mental illness, bi-polar… can share my story with them and show there is hope for them'.

More case studies can be found on Northamptonshire's website at http://www.neneccg.nhs.uk/personal-health-budgets/

There are also stories and case studies on the NHS England website at http://www.personalhealthbudgets.england.nhs.uk/About/Stories/