Getting personal

HFMA ROUND TABLE

Personal health budgets have a big part to play in the personalisation agenda, and new targets signal a major expansion of the programme. NHS managers at a recent HFMA roundtable discussed progress to date and how the use of PHBs could be increased. Steve Brown listened in to the discussion

The delivery of more personalised care is one of five major changes set out in the *NHS long-term plan*. And personal health budgets (PHBs) are arguably the most visible mechanism for putting this into practice – in many cases giving people direct control over the care they receive and how it is delivered.

The government's commitment to personalisation is clear. From February, people have a legal right to have a PHB for wheelchairs and, if they are eligible, for section 117 mental health aftercare services. As of April, PHBs should be the default method of funding for those in receipt of continuing healthcare (CHC) in the community. But there is a clear desire to see PHBs move into other areas – perhaps particularly supporting people with long-term conditions

This has all been backed up with demanding targets to increase the number of people in receipt of a PHB to 200,000 within five years – a four-fold increase on the 54,000 already holding budgets.

While NHS England says the expansion is ahead of schedule, meeting the goal presents significant challenges for clinical commissioning groups as they look to manage risks and put the necessary processes in place to manage PHBs at scale.

At the end of May, the HFMA organised a roundtable discussion, bringing NHS managers together to share progress and plans to expand the use of PHBs in their local areas.

The roundtable was supported by the team behind PHBChoices, a financial management system incorporating a care marketplace provided by NHS Shared Business Services (NHS SBS). The system helps CCGs handle the


Steve Ham


James Rimmer


Sam Matthews

Participants

- Jon Baker, PHBChoices director
- Harry Bourton, Caretrack operations manager, CHS Healthcare
- Paul Brown, chief finance officer, North West London CCGs
- Sarah Day, policy and research manager, HFMA
- Clay Flattley, continuing healthcare business manager, Telford and Wrekin CCG
- Steve Ham, head of business services, Norfolk Continuing Care Partnership
- Jim Manton, senior contracts manager, East Leicestershire and Rutland CCG
- Sam Matthews, associate finance manager, South Warwickshire CCG
- John Ridler, deputy chief finance officer, Bath and North East Somerset CCG
- James Rimmer, chief finance officer, Southampton City CCG
- Tracey Simpson, deputy chief finance officer, Tameside and Glossop CCG

administration of providing PHBs and enables PHB holders to manage their budgets and source the services and goods they need.

NHS England suggested recently that PHBs were already being successful, with 86% of people saying their PHB had delivered the outcomes they were seeking, with costs 17% below conventional service packages (for CHC care). James Rimmer, chief finance officer of Southampton City CCG and chair for the roundtable, asked whether these improvements were also being demonstrated locally.

There was broad agreement that outcomes and patient satisfaction improve with the adoption of PHBs, but evidence remains anecdotal.

Steve Ham is head of business services at Norfolk Continuing Care Partnership, which oversees CHC for four Norfolk CCGs and currently runs 100 PHBs on a direct payment basis. He said the PHB process itself was an improvement on the way many services were co-ordinated as it provided the opportunity to sit down with an individual and work out what outcomes they wanted. And there were clear benefits in terms of greater flexibility for the service user and continuity of care – for example, where people directly employed personal assistants, rather than receiving their care from a range of different agency-provided carers.

'But one trouble is that it is difficult to prove if it has reduced GP or A&E visits – an indicator that their health and wellbeing is improving – with the data challenges we have,' he said.

Although this would not always be a good proxy for improving health, being able to link CHC data with data from the Secondary Uses Service would be a good step forward, he added. However, PHB holders' survey feedback was largely positive and even the act of holding a budget had proved to be an empowering experience for many.

Sam Matthews, associate finance manager for personalised care across three Coventry and Warwickshire CCGs, on a part-time secondment from Arden and Greater East Midlands Commissioning Support Unit, agreed there was a lack of hard data. But she also said there were good arguments for greater personalisation.

Having a personal assistant at a time that suits the patient, rather than at the time an agency could manage, might be what was enabling someone to stay at home rather than going into residential care. 'And the fact that they can choose and individualise their care, and that they and their relatives are involved, would hopefully help their wellbeing,' she said.

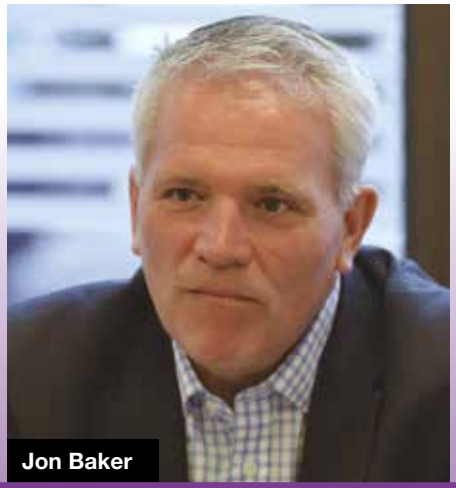
Blocking the way

The roundtable discussed current levels of PHBs and the blockages to making progress. There was concern that the current levels of reported PHBs – 54,000 or an average of just over 250 per CCG – seemed high compared with some participants' local experience, where levels were often measured in tens rather than hundreds.

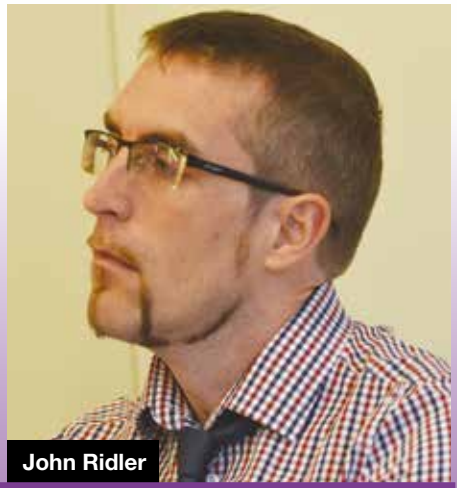
Jon Baker, director of PHBChoices, wondered whether all organisations counted in the same way. 'It is down to the interpretation of the definitions,' he said. 'Different CCGs may be counting in different ways – is someone in a care home being counted as a notional budget?'

Continuing healthcare could be an area

Sarah Day



Jon Baker



John Ridler

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for expansion, given the new requirement for PHBs to be the default funding mechanism – although this may well be in terms of increasing notional budgets rather than direct payments. But delegates said there was potential for rapid progress with wheelchair PHBs. Offering vouchers meant costs were tightly controlled and users could choose to supplement the specification if they wanted to customise the chair with extras.

Bath and North East Somerset CCG is arguably one of the more advanced commissioners in terms of personalisation, with more than 600 PHBs in place. However, deputy chief finance officer John Ridler said that even at this level, it did not yet feel as though PHBs had been mainstreamed. Again, it depended on what was currently being counted as PHBs.

The bulk of these PHBs are being delivered through a learning disabilities joint funding pool. Around 80% of these are on a notional budget basis – where the NHS continues to hold funds on behalf of the patient and purchases agreed care and support on their behalf.

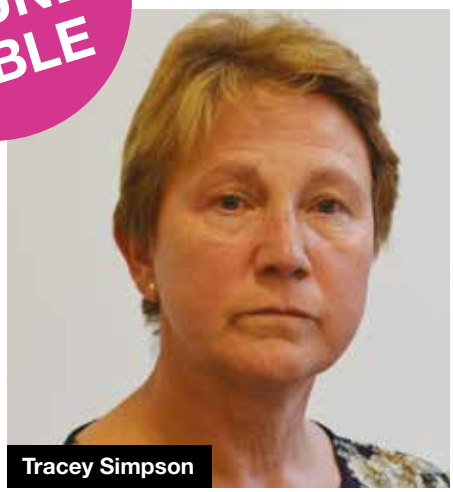
Moving towards other PHB options – involving a third-party budget or direct payments where these were found to be more appropriate – would present more challenges. However, the CCG does have 15 CHC patients on direct payment and direct payment is now the default position for all community packages not including residential homes.

The CCG, together with its local council, has commissioned Virgin Care to deliver a joined-up community health and care service, and CHC and learning disabilities – including the PHBs – are included in these arrangements.

CCGs on board?

Board commitment to PHBs was another concern. Most participants said their organisations were committed to personalisation in terms of integrating services and wrapping care around the patient – but PHBs specifically weren't always a priority for boards. The

Clay Flattley



Tracey Simpson

significant transformation agenda – with a move to integrated care systems – and the wider financial challenge meant that the focus was often elsewhere.

Tracey Simpson, deputy chief finance officer at Tameside and Glossop CCG, said Greater Manchester's city-wide devolution was focused on delivering place-based care. 'This is putting the patient at the heart of what we do, under an overarching aim of "starting well, living well, ageing well"', she said. But within this, PHBs were not currently the highest priority in all localities.

Existing contract arrangements and lack of funding were seen as obstacles by all participants. 'There is no money to pump prime – that's a major barrier to extending further,' said Mr Ham. 'Most people who would benefit from a PHB are under block contract arrangements and most providers are financially challenged.' This makes it difficult to discuss transferring funds out of the current block arrangements to create the PHBs.

Ms Simpson agreed. 'The reality of taking money out of budgets for PHBs is extremely difficult,' she said. Rather than trying to shoehorn personalisation into existing models of care, a 'major mindset change' was needed.

Jim Manton, senior contracts manager at East Leicestershire and Rutland CCG, but on secondment to NHS England working on personalisation, said the answer was to start small. 'If you have three people eligible for section 117 aftercare on PHBs, that's a good place to start. A provider won't be destabilised by this level of activity moving away. And you should work with the providers – what are the services that are difficult for them to deliver that they may be happy to release?'

Starting at the margins is exactly what Telford and Wrekin CCG has done, leaving existing CHC clients on current arrangements initially.

'We've started with the new CHC clients and we are making a PHB offer to them in the first instance,' said Clay Flattley, the CCG's continuing healthcare business manager. The CCG has small numbers of direct payment arrangements across adults' CHC and children's continuing care, with larger numbers of notional budgets.

Returning to concerns about destabilising existing providers, Mr Manton added that moving someone onto a PHB – whether direct payment or notional budget – didn't necessarily mean a provider would lose out. It might just mean they are paid directly by an individual rather than the commissioner.

'You need to challenge providers – they won't lose any business if they are the best option,' he said, adding there was an opportunity for providers to revise their service offerings to retain users. 'Most patients don't change their provider at all – they are happy with the service they are getting,' he said.

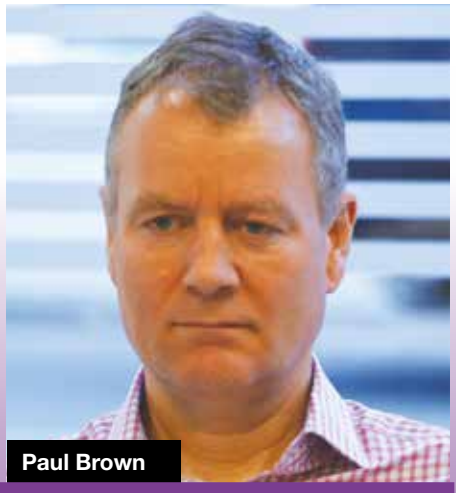
Paul Brown, chief finance officer of North West London CCGs, wondered whether empowering clinicians to personalise care might be a way around the need to move service users out of existing block contract arrangements.

'Perhaps capitation budgets can achieve the same thing for a volume of patients rather than a single patient, if the right partnerships are in place,' he said. 'That way you could make resource decisions around a cohort of patients but empower people to make individual care decisions around the patient.'

In some cases, PHBs will mean moving services away from current providers – perhaps recruiting personal assistants. 'But maybe the business model is to provide a service to source personal assistants rather than providing care,' Mr Baker said. 'Perhaps there's an opportunity to highlight the greater flexibility of being a personal assistant to former NHS nurses, who may wish to return to delivering care without being directly employed by the NHS.'

Addressing risk

The roundtable saw the biggest obstacle as the perceived risk of moving to PHBs. A large part of this is financial risk – would PHBs destabilise finances? Mr Rimmer said: 'This really feels



Paul Brown

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like a good thing to do, but we can't really evidence that it stacks up. We haven't quite got the business case yet,' he said. Mr Brown added that current pressures meant new approaches had to be affordable. 'We need to demonstrate there is money coming out,' he said. 'We can only do things if there is some payback.'

However, Mr Baker said evidence was beginning to emerge that the introduction of PHBs could not only be delivered within existing budgets but could lead to savings across systems.

'In North West London, there are three CCGs using PHBChoices which, combined with new ways of working, has enabled cash-releasing savings estimated to be between 20% and 30%, representing £680,000. We need to sit down with someone from finance to confirm the exact figures, but the potential savings are significant,' he said. However, he stressed that systems and standardised processes would be key to delivering at scale.

'At the moment, based on our experience, the ratio of PHB holders to a full-time equivalent member of staff within the CCG (including finance, administration and assurance staff) is approximately 10:1,' he said. He added that PHBChoices could help enable CCGs to get to the ratio of 50:1 or even greater.

While a business case demonstrating savings would be helpful, CCGs were also worried about the potential for overspends or funds in PHBs being spent on items and services not deemed as appropriate.

'CCGs are concerned about the financial risks on direct payments and the risk around allowing people to have their own personal assistants,' said Ms Matthews. 'Are the personal assistants appropriately trained or are the patients paying the employer's national insurance contributions for these personal assistants, for example.'

She said there needed to be good monitoring arrangements in place, with red flags raised as quickly as possible to identify any concerns.

There are ways to address this. For example, Telford and Wrekin uses a third-party organisation to handle all the payroll and employment issues for services commissioned through personal budgets. 'The provider then sends in clients' accounts every quarter, highlighting overspends and underspends,' said Mr Flattley.

He admitted this had pros and cons. It arguably provided some assurance that controls were in place and gave an audit trail, but the three-monthly submission of accounts meant that if issues did arise, they could carry on for longer before being spotted and addressed.

HFMA policy and research manager Sarah Day suggested that CCGs needed to think about proportionality when they considered the potential risks on PHBs. While individual CHC budgets might typically stretch into tens of thousands of pounds, lots of other budgets would be for hundreds of pounds, perhaps buying services alongside an existing CCG-commissioned package of care. 'The amounts involved are often very small compared with a CCG's overall budget,' she said.

Mr Rimmer agreed CCGs were approaching PHBs with excessive caution. 'We don't ask for payroll details of our acute providers,' he said. 'And on CHC we pay providers relatively happily when we receive invoices – but on PHBs the trust appears to be very low.'

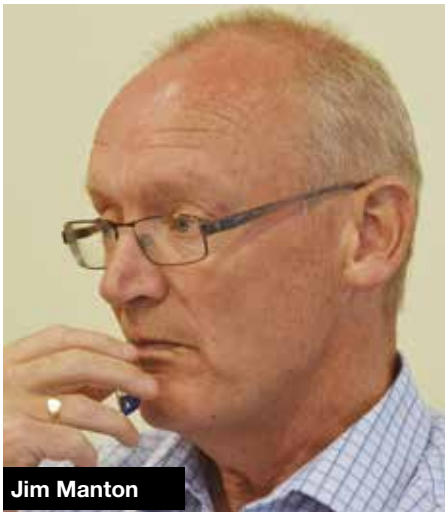
Harry Bourton is operations manager for CHS Healthcare, whose Caretrack software supports the management of people with CHC, funded nursing care and complex mental health funding. He believes people need to be helped to feel more comfortable with the new approach to personalisation. 'In some of our contracts we are the end-to-end CHC provider. We have some nurses who had to be taken on a journey to feel more confident about PHBs. They are also thinking about the clinical risks too.'

He underlined the importance of getting financial risks into proportion. 'We need to get on and let people have a go with PHBs,' he said.

However Mr Baker warned that PHB spend could become very significant over time and that CCGs would need to establish the right systems from the outset. In 2015, there were just 10,000 PHBs registered. 'With an average CHC budget of £70,000 in our experience, that is annual spend of £700m, which is relatively small compared with the £120bn NHS budget,' he said.

'But at 100,000 PHBs, it becomes £7bn. And 200,000 becomes £14bn. Without the right financial governance in place, there are greater risks around transparency, control and compliance as spend increases.'

In summary, the roundtable agreed that PHBs had real potential to deliver flexibility and improved outcomes for patients. There were perceived obstacles in the form of existing contracting arrangements and concerns about losing direct control of some parts of the budget – even though there was a recognition that the sums involved currently were small compared with overall spending.



Jim Manton

The targets were demanding, but there was recognition that issues would need to be addressed and more progress would need to be made quickly – with all parts of the service more focused on the agenda. Mr Bourton pointed out: 'There hasn't been the uptake we had been expecting and at some point there is likely to be more pressure on CCGs to increase the numbers.'

Perhaps more importantly, there was a concern that other pressures would distract CCGs from pursuing a key ingredient in delivering the personalisation agenda and helping to transform services in general.

Mr Ham expressed the views of the group when he highlighted a potential imbalance between the long-term plan and NHS England view of PHBs and the priority given to them so far locally. 'My concern is that we might find ourselves in five years' time not having done something really important – because it never quite got to the top of the pile,' he said.

For more information about PHBChoices, email jon.baker3@nhs.net or visit www.phbchoices.co.uk

Harry Bourton