Nottingham North and East
Clinical Commissioning Group

Update on Personal Health Budgets and Integrated Personal Commissioning

Purpose of the report

The purpose of this report is to:

- Provide an update on personal health budgets (PHBs) and the progress to date
- Notify Governing Body about Integrated Personal Commissioning, its implications and gain support on implementation
- Gain sign off for support plan approval guidance

Update on Personal Health Budgets (PHBs)

PHBs are an amount of money to support a person's identified health and wellbeing needs, planned and agreed between the person and their local NHS team. A personal health budget is not new money, but rather enables people to use funding in different ways, in ways that work for them.

PHBs are a key delivery within the five year forward view. The 2020 goal for PHBs described in the Government's mandate to NHS England 2016/17 is for 50-100,000 to have a personal health budget or integrated personal budget. The NHSE Markers of Progress data published in November 2016 has demonstrated an increase nationally from 4,000 to 10,000 PHBs.

In Nottinghamshire, the five Clinical Commissioning Groups: Mansfield & Ashfield, Newark and Sherwood, Nottingham North & East, Nottingham West and Rushcliffe joined together to deliver the Personal Health Budget (PHB) mandate set out in the Five Year Forward View. The local offer was published in March 2016 and a PHB Manager was appointed in May 2016 to support the roll out. Rushcliffe CCG is the lead CCG for personalisation on behalf of the County CCGs.

For Nottinghamshire CCGs to meet the National NHS mandate of 0.1 – 0.2% per population on a PHB by 2021, we need to have between 705 and 1410 patient on a PHB.

Where we are now?

As of November 2016, there are 53 people across all five CCGs on a PHB. Table 1 below shows the breakdown for each CCG.

Where we need to be?

The two year NHS Planning guidance submitted in November 2016 required that CCGs published a trajectory of how many PHBs will be reached by year end 18 and 19.

This trajectory represents a significant change in expectation for PHB numbers. Whereas previously the NHSE mandate set was to be reached by 2021, the planning guidance clearly set out that PHBs by the end of 2018 must increase to 0.04% per 100,000 populations and by 0.1% by 2019. These trajectories are set out in the table below, along with current numbers per CCG.

Table 1 – PHB numbers and trajectories for next 2 years

	Current PHBs October 2016	By March 2018 (0.04%)	By March 2019 (0.10%)	IPC Target By March 2018 (0.10%)
Mansfield and Ashfield	10	77	193	193
Newark and Sherwood	12	54	134	134
Nottingham North and East	13	61	153	153
Nottingham West	8	39	97	97
Rushcliffe	10	51	127	127
Total	53	282	705	705

Integrated Personal Commissioning (IPC)

Through the Sustainability and Transformation Plan (STP) both Nottinghamshire and Nottingham City was successful in bidding to NHSE to become early adopters of Integrated Personal Commissioning. Both the County and City will be developing separate plans to develop and roll-out IPC.

What is IPC?

IPC is one of the pillars of the Five Year Forward View. It empowers people and communities to take an active role in their health and wellbeing with greater choice and control over the care they need. It supports the improvement, integration and personalisation of services, building on learning from personal budgets in social care and driving bold expansion plans for personal health budgets.

In future, IPC and personal health budgets will provide essential counterbalances to whole population commissioning models. Within or alongside overarching place-based models of care, they will enable people who need a more personalised

approach to opt out of their local provider for particular services where appropriate, and take increased charge of decision making around their care.

The IPC Programme is expanding in 2016-17 through early adoption of the model by other sites, representing the first stage of national roll-out. Learning from the demonstrator sites so far indicates that IPC could be the mainstream model of community based care for around 5% of the population, including people with multiple long term conditions, people with severe and enduring mental health problems, and children and adults with complex learning disabilities and autism. By 2020, the model will be in place in every locality, planned and delivered in partnership with social care and the voluntary, community and social enterprise (VCSE) sector. For more information on the IPC see NHSE website

How does this fit other models?

New Care Models
New Care Models, IPC and PHBs have similar aims around improving the outcomes for people through more coordinated and integrated care, and through reducing the costs of delivering that care. This includes through increasing self-care and moving care from hospitals into the community.

The Multispecialty Community Provider (MCP) Contract Framework makes it clear that MCPs should:

- fully implement the IPC model for people with complex, on-going health and care needs; and
- Contribute towards the national ambition that 100,000 people will be have a personal health budget by 2020.

Under a fully integrated MCP or Primary and Acute Care System (PACS), NHSE see IPC and PHBs being managed and delivered by the MCP/PACS, specified in the contract, rather than held by commissioners. CCGs will need to assure themselves that MCP/PACS are offering genuine choice, and to appropriately incentivise the introduction of IPC and PHBs within the contract.

When operating at scale, these approaches will also provide necessary challenge to the quality of mainstream care and provide an invaluable evidence base for improving population based commissioning through shaping trends in service use. There is also strong evidence that, by supporting people to manage their health better in the community PHBs can reduce the need for unplanned care, therefore bending the demand curve further up-stream and supporting a financially sustainable NHS.

Transforming Care
Transforming Care aims to move more services to community settings and closer to people's homes, and give individuals more choice and say in their care. IPC and PHBs will make a significant contribution to making this a reality, putting people and

families at the centre of planning better support for better lives in their communities. Transforming Care partnerships (which include CCGs and local authorities) were asked to produce local plans by **March 2016**. Building the Right Support makes clear that personalisation is a key part of the new approach:

"People … should have choice and control over how their health and care needs are met – with information about care and support in formats people can understand, the expansion of personal budgets, personal health budgets and integrated personal budgets, and strong independent advocacy".

All IPC sites are being asked to include people with learning disabilities or autism (children and adults) in their IPC cohort, so that IPC becomes the mainstream approach for everyone. This means that people moving out of inpatient accommodation and people already living in the community will have a personalised approach and the option of a personal budget, which may include health, social care or education funding. For more information and stories about people with learning disabilities see the NHS England website

What this means in Nottinghamshire

The intention to join the IPC programme is embedded in the STP, which identified five high impact areas to focus on. The IPC is located in the primary and community care high impact area of the STP and the programme will report into this board.

Within the STP in Nottinghamshire there are three planning areas that have a blueprint for integrating services. These identify a localised model of delivering the STP. The IPC approach will be built and designed within the context of these as follows:

- Integrated Local Care Team models
- Mid-Nottinghamshire – Better Together programme
- Greater Nottingham Health and Care Partners – We Care

The IPC requires CCGs to identify groups or cohorts of people who may be suitable for and benefit from IPC approach. A cohort is defined as a subset of the whole population, within a given area. The aim is that IPC will be adopted as the operating model for people with complex health and social care needs in Nottinghamshire.

Targets set by NHSE

In order to become an early adopter, the CCGs must sign a Memorandum of Understanding which sets out the targets and expectations by NHSE (see Appendix 1).

IPC needs to be introduced at pace and scale - cohort by cohort with goals to scale personalised care planning to 1% of the population, and personal budgets with NHS funding to a minimum 1 in a 1000 by March 2018. This means reaching the NHS

planning trajectories for year end 2019 by March 2018, as indicated on the right hand column of Table 1.

How we will achieve this?

The increase in PHB figures over the next two years will be achieved in two key areas and with the following cohorts:

1) PHBs will be the default mechanism for all Children and Adults eligible for NHS Continuing Healthcare

2) All people who are eligible for joint health and social care funding will have an integrated budget. This includes:

- Adults with learning disabilities and autism, including Transforming care and S117
- Children transitioning to adult services
- Patients with physical disabilities.

Under the IPC, the first priority group will be Transforming Care - learning disability and autism. They represent the largest group of joint funded patients, as they present with the most complex needs. This means the packages are high cost to both health and social care.

The intention is for the IPC operating model to be adopted within the Care Delivery Groups for people with long term conditions in South Nottinghamshire.

Delivering on IPC requires scoping and planning; to ensure that expectations are managed and the culture change is promoted at all levels in both commissioner and provider organisations. Strong leadership and project management discipline is essential to the overall project's success.

What might prevent us from achieving this?

Lack of Partner commitment to the Integration agenda and the culture change required: this is needed to maintain long term sustained multi-organisational focus to achieve maximum increase in integrated budgets. Strong relationships will be important to withstand the changes and to manage competing priorities and a coherent approach to the delivery of multiple concurrent programmes on integration.

Resources: there may be insufficient resources to invest in new delivery models, new approaches or to build capacity or capability. In addition, the staffing resource may be inadequate to realise the full potential of the programme.

Workforce Capacity and Capability: a different culture and relationship with the

users of services and a different way of working across organisations is required. This will require buy in from all organisations involved and commitment from staff.

ICT Systems & Processes: systems for effective information sharing across organisations may be difficult due to technical difficulties, governance/confidential issues and/or investment.

Supporting the financial challenges

A priority of the IPC and PHB will be to ensure it supports the financial challenges of the CCGs. Therefore, a key element in the development of PHBs is to understand how much they cost. It is essential that PHBs represent value for money and that they do not cost more than a commissioned service.

A study comparing the cost of a PHB compared to a commissioned service was undertaken in November 2016. This involved a sample of 10 adult patients on a PHB, representing 20% of the total number of PHB recipients. The sample included two patients per CCG, from a range of patient groups including: physical disability; learning disability and older adults.

The report indicates that in the majority of the cases the actual spend of a PHB is cheaper than a commissioned service. In total, across the 10 cases £5,137.04 per week was saved with commissioned being higher than actuals.

From evaluating data from all 10 cases, the average saving between Commissioned and a Personal health budget is £498.75; this represents a 17% saving in PHB cases compared to a commissioned service. Further data will be added to over time and reviewed in March 2017, with a wider data set understood; the true cost benefits can be better predicted. However, the evidence from the case study of North West Devon corroborates our local findings as follows:

- Northern, Eastern and Western Devon have approximately 100 PHBs for those eligible for CHC
- Traditional package costs are estimated at £7.3m
- A PHB approach has saved £1.3m with administrative costs of £180,000 – 15% net saving
- Savings have been achieved through reduced costs of personal care (direct employment rather than agency) and a more proactive approach to delivering care when it is needed, rather than when scheduled. This is led by the person, and has tended to reduce the amount of care they receive.

What impact does this approach have for patients?

Case Study 1

Mr W is 66 years old man. Currently, he lives at home with his wife, who is his main carer. He has a diagnosis of epilepsy, which occurred following treatment of non-Hodgkin's lymphoma. His complex health needs fluctuate and can be unpredictable from day to day

with a steady deterioration. His condition results in regular hospital admissions.

Mr and Mrs W opted for a personal health budget which he takes as a direct payment. This puts them in control of organising the necessary care and support, following the setting up of a support plan, which is agreed by the NHS. The PHB is used for the following:

- Helping hands agency 5 x a week
- Helping hands cover 2:1 for 3 weeks to be used to support Mr W following a hospital admission to enable him to return home
- Personal assistant employed for support 20 hours a week
- Dove Cottage hospice once a week
- Specialist Neuro physiotherapy 4 x a month
- Powered wheelchair with an E stop wireless emergency stop button.

The flexibility offered with the PHB means Mrs W is able to arrange an increase in care and support quickly, with the money accrued in the direct payment account. This has resulted in both speedy discharges from hospital and has aided Mr W's quicker recovery. Mrs W allows for these circumstances and ensures that the couple are in control and can avoid crisis episodes.

The couple feel that the PHB has been of great benefit. It removes the anxiety of "what if", which has been really beneficial. It gives Mr W some freedom. The wheelchair gives him the opportunity to "drive" again, which he loved to do prior to his illness.

Mrs W reported of the personal health budget:
"he (Personal health budget co-ordinator) asked the right questions and really listened to what we said; to help us find the right solutions….Being in control makes you feel better and takes a lot of the worry about money away."

Lesson learned: The process of opting for a direct payment allows for flexible planning and puts people in control of organising their care and support as and when they need it. In this case resulting in a speedy discharge from hospital,

Case Study 2
Jack lives at home with his parents and twin sister. He is disabled and has multiple healthcare needs. During the transition of care from Children to Adult Services, the Jack and his family was offered a Personal health budget (PHB). The family took the PHB, opting for a mixed PHB. A mixed budget means they receive a proportion of the budget as a direct payment: to employ a PA; purchase a mobile hoist; participate in community and sport activities and a proportion of the budget is commission by health for day care.

Lesley, Jacks mother says:
"***Having a PHB has opened up a whole new world for my family. You can spend the budget in many different ways, including for the sports that Jack loves, enabling him to socialise and be involved in the community. Life was more difficult before having a PHB."***

Lesson learned: A PHB can provide better targeting of resources, less waste and duplication and improved patient outcomes and satisfaction. Employing Personal assistants means people are not reliant on agencies to provide all of their care; rather they gain

stability, consistency and familiarity.

Case Study 3
Mrs A is a 40 year old woman, who lives with her husband and two young children. She is at end of life care and is receiving fast track funding. She does not want the traditional offer of an agency to support her. Rather her parents have been driving an hour every day. They are working with her husband to ensure all her care and support needs are met. They are also offering invaluable support to their grandchildren. A PHB means that she can have a direct payment to meet her outcomes in a way that makes sense for her. The budget has been used to pay for her parents travel expenses, to enable them to continue to support her on a daily basis.

Lesson learned: A PHB can support people with creative solutions that work positively for them and their family at the end of life.

Support plan approval guidance

The County CCGs need guidance in the use of PHBs. The purpose of the support plan approval guidance is to set out the recommended framework for the process of approving support plans for patients opting to receive their eligible Continuing healthcare support or health care needs via a personal health budget.

The aim is to ensure that a consistent, cost effective and transparent approach is applied to the approval of all support plans and that care commissioned using a PHB is appropriate to meet a person's health needs and desired outcomes. The document is in Appendix 2 and requires sign off by the Governing Body.

RECOMMENDATION/S
The Governing Body is requested to:

- Note the update on personal health budgets (PHBs) and the need to increase the numbers of people on PHBs in the next 2 years by expanding the use of PHBs within CHC and joint funded budgets
- Support and drive forward the implementation of IPC across the key identified areas
- Approve the support plan approval guidance

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