



Briefing 09-20 April 2009

# Individual budgets in social care

This briefing provides an update on the state of play in regard to individualised budgets within social care. An initial pilot study was concluded in October 2008 with inconclusive results. This has prompted a second phase of pilots over an extended period. This briefing details the objectives for the further set of pilots, the outcomes from the first and attempts to interpret the lessons so far.

## Key finding from the initial pilots

- Individualised budgets are only of benefit to limited groups of users including people of working age with physical or sensory impairments.
- Net overall costs are set to increase to cover co-ordination and monitoring.
- Individualised budgets can adversely affect the wellbeing of the elderly.
- Funding streams are not integrated and hence implementation remains piecemeal

## Introduction

On April 1<sup>st</sup> 2009, the Government announced those 16 authorities who would take forward pilot schemes on independent care. The pilots are seeking to determine how health and social care services can work jointly to deliver a more integrated approach to the delivery of care services. A separate set of pilots is shortly to be announced under the guise of 'Personal health budgets: first steps', which should focus on the operation of Individual budgets. There appears to be significant cross-over between the 2 sets of pilots.

In regard to the Integrated pilots the press release states: *"The £4million scheme has been designed to look beyond traditional health and social care boundaries to explore how services for patients and service users can be improved. The scheme will then assess the benefits of different models of care and identify any best practice that could be used more widely.*

*Each site has developed new methods to help respond to particular local health needs. The health issues being tackled in each pilot include dementia, care for the elderly, substance misuse, chronic obstructive pulmonary disease and end of life care. The methods involved vary widely; they include partnerships, new systems and care pathways that span primary, community, secondary and social care".*

The PCTs selected are:

Bournemouth and Poole Teaching PCT Cambridge Assura Limited Liability Partnership Church View Medical Practice, Sunderland NHS Cumbria Durham Dales Integrated Care Organisation Nene Commissioning Community Interest Company Newcastle Hospitals NHS Foundation Trust Cornwall and Isles of Scilly PCT NHS Norfolk and Norfolk County Council	Northumbria Healthcare NHS Foundation Trust North Cornwall Practice-Based Commissioning Group Principia - Partners in Health, Nottinghamshire NHS Tameside and Glossop Torbay Care Trust Tower Hamlets PCT Wakefield Integrated Substance Misuse Service
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The pilots are scheduled to commence in the Summer of 2009 with direct payments in the Summer of 2010 with the evaluation period ending in the Summer of 2012. Given the services selected, the pilots are very much NHS driven.

The Government appears to be taking a more relaxed view of what constitutes a personal health budget:

*'A personal health budget helps people to get the services they need to achieve their health outcomes, by letting them take as much control over how money is spent on their care as is appropriate for them.'*

*It does not necessarily mean giving them the money itself. ...Personal health budgets could work in many ways, including:*

- *a notional budget held by the commissioner;*
- *a budget managed on the individual's behalf by a third party; and*
- *a cash payment to the individual (a 'healthcare direct payment').*

The healthcare direct payment is subject to the passage of legislation in the Health Bill 2009.

## **Desired outcomes of the pilot programme**

The pilots stated aim is to answer the following questions, at a local and national level:

- Is there a cultural shift towards personalisation?
- Are there improvements in:
  - quality, in terms of health and well-being outcomes and patient experience?
  - care planning?
  - partnerships in care provision and integration of care?
  - understanding of local needs and expectations, and therefore how resources can best be targeted at communities' needs?
- What is the impact on health inequalities?

- What is the impact of personal health budgets on the wider system, including:
  - costs?
  - equity of access and continued availability of services to non-budget holders?
  - staff?
- How and for whom should personal health budgets be implemented, including:
  - are there services and user groups for which this approach is particularly appropriate?
  - are there services where this approach is never appropriate?
  - what criteria should be used when deciding if a personal health budget is the right approach for an individual or a particular service?

## **Lesson learnt**

The previous 'Evaluation of the Individual Budgets Pilot Programme' by the Individual Budgets Evaluations Network (Ibsen) was published in October 2008 showed mixed results. Regrettably NHS funding was specifically excluded from these pilots.

The initial evaluation is guarded in its conclusions although does highlight the perceived benefits by the physically disabled and mental health users. The report detail is however more forthright about the significant problems that were uncovered during the exercise.

- Current funding streams (of which there are 6) are not integrated and hence implementation is piecemeal.
- There is potentially a major tension between volume discounts and delivering personalised services. Economies of scale are likely to be lost in the letting of contracts. Where payment was via the user, one provider had put in processes to deal with anticipated bad debts.
- There is no evidence of reductions in management and administrative time. Indeed the workload of care co-ordinators would appear to rise substantially the greater the service individualisation.
- Those with learning disabilities often receive care resources that reflect an allocation to group leisure and social participation activities. It is not clear that any benefit would arise from individual budgets in this case.
- Evidence from the initial pilots suggest that *'older people often approach services at a time of crisis when they feel vulnerable or unwell, find decision making difficult and hence likely to experience support planning as stressful'*

Many practitioners were concerned about the risks of physical or financial abuse especially if friends or relatives were employed without CRB checks. Monitoring to reduce the risk of abuse is likely to be required, further negating many savings.

The report concludes: *'More training and support will be needed for staff and organisations working with IBs, including more flexible approaches to deploying resources within care manager-purchased services and the development of specialist skills in support planning and brokerage'*. This obviously suggests that additional costs may be unavoidable to ensure that new system works.

## **APSE Comment**

The pilot schemes are to be welcomed as an opportunity to gain further evidence of how the application of individualised budgets might work in the field. The limited existing data shows that where the user has the mental capacity and capability to organise their care needs (some mental health service users and physically disabled) there is a greater feeling of control and service satisfaction

In terms of older people this is not however the case. The drive towards individualised budgets looks unlikely to produce a better outcome. The initial pilots revealed no significant cost savings and in fact standard care arrangements remained more cost effective and the users happier.

APSE has substantial reservations about the rationale for individualised budgets for the elderly operating in the same time frame as the drive towards commissioning by both the PCTs and local authorities. Commissioning in the vast majority of cases will fragment the provision of care services with the user having little option other than to deal with a multitude of service providers. The co-ordination of these services by a distant commissioning unit will necessarily depersonalise the service.

An older person is currently likely to be reliant on a paid carer who provides a multitude of tasks and co-ordination roles to ensure the wellbeing of the user. This added value is not reflected as a wage cost or saving and in the personalised budget/commissioning model is often ignored. Savings are therefore likely to be illusory as Councils find they have to implement a co-ordinating and monitoring regime to replace something that is currently inherent in the provision of direct social care. The wellbeing of the elderly is a combination of service delivery and psychological support, the latter of which appears to have been overlooked.

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For further information on the detail of the chosen pilots follow this link:

<http://nds.coi.gov.uk/environment/fullDetail.asp?ReleaseID=397405&NewsAreaID=2&NavigatedFromDepartment=False>