Title: Right to have a personal health budget in NHS Continuing Healthcare	Impact Assessment (IA)
IA No: 6119	Date: 16/06/2014
Lead department or agency: Department of Health	Stage: Final
Other departments or agencies: N/A	Source of intervention: Domestic
	Type of measure: Primary legislation
	Contact for enquiries: Anna Farley

Summary: Intervention and Options

RPC Opinion: Not Applicable

Cost of Preferred (or more likely) Option				
Total Net Present Value	**Business Net Present Value**	**Net cost to business per year** (EANCB on 2009 prices)	**In scope of One-In, Two-Out?**	**Measure qualifies as**
£316.3m	£0m	£0m	No	NA

What is the problem under consideration? Why is government intervention necessary?

By giving people more choice and control over the care they receive, outcomes and cost-effectiveness can be improved. People have valuable insight into what benefits them, which is not always taken into account at present. Personal health budgets (including direct payments) have been piloted, with a full academic evaluation of their impact, which was broadly positive. Existing rollout in NHS Continuing Healthcare (CHC) is slow, in part due to lack of engagement from commissioners. Legislation is needed (in addition to wider support) to raise the prominence of personal health budgets and ensure that CCGs give individuals' requests appropriate consideration.

What are the policy objectives and the intended effects?

Personal health budgets give the individual more choice and control over the money that is spent on their care. This aims to improve their outcomes and potentially to reduce total costs to the system, by helping people to self-direct towards services from which they experience greatest benefit, enabling them to better manage their health and reducing need for acute unplanned care. Personal health budgets have also been shown to improve people's satisfaction with the NHS.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

Options considered are: (0) do nothing; and (1) introduce a 'right to have' a personal health budget to individuals in receipt of NHS Continuing Healthcare, with exceptions.

Based on the independent evaluation, personal health budgets are beneficial, especially where people have higher levels of health need. However, personal health budgets are complex to introduce and require both cultural and system change. Doing nothing is likely to mean that the benefits of personal health budgets are not fully realised. Therefore option 1 is the preferred option.

Will the policy be reviewed? It will be reviewed. **If applicable, set review date:** 10/2014

Does implementation go beyond minimum EU requirements?			N/A		
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	**Micro** Yes/No	**< 20** Yes/No	**Small** Yes/No	**Medium** Yes/No	**Large** Yes/No
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			**Traded:** N/A	**Non-traded:** N/A	

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) that the benefits justify the costs.

Signed by the responsible Minister: Norman Lamb ***Date:*** 17/06/2014

Summary: Analysis & Evidence

Policy Option 1

Description: Introduce a right to have a personal health budget in NHS Continuing Healthcare

FULL ECONOMIC ASSESSMENT

Price Base Year 2014	PV Base Year 2014	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: 210.9	**High:** 421.7	**Best Estimate:** 316.3

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	0	N/A	5.2	**48.3**
High	0		10.3	**96.5**
Best Estimate	0		7.7	**72.4**

Description and scale of key monetised costs by 'main affected groups'

Costs are associated with support for patients and running of administrative support are estimated to be around £670 per patient. These are ongoing costs. High and low estimates are based on more or fewer patients receiving a personal health budget compared to the best estimate. The central financial cost estimate of c. £2.1m pa generates an opportunity cost of c. 140 QALYs pa (given that the NHS produces QALYs at an estimated £15k/QALY). These are valued in the table at £60k each.

Other key non-monetised costs by 'main affected groups'

People still wishing to access a particular service may experience a cost if that service becomes unviable as people opt away from it. There may be additional time costs to budget-holders and clinicians in setting up and monitoring budgets. However, these are not substantial, as individuals already agree personal care plans in NHS CHC.

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	0	N/A	27.7	**259.1**
High	0		55.4	**518.2**
Best Estimate	0		41.5	**388.7**

Description and scale of key monetised benefits by 'main affected groups'

There are cost savings of £3,100 per person in receipt of NHS CHC from reduced spend on services. This accrues to commissioners, who can then spend this on additional services. Savings presented here are opportunity cost savings, as described above. There are also quality of life gains for individuals in receipt of NHS CHC of 0.032 QALYs per person, monetised at £60,000 per QALY.

Other key non-monetised benefits by 'main affected groups'

There are likely to be improvements in quality of life for carers, set out in the independent evaluation. It is possible that by introducing personal health budgets, there are benefits beyond those receiving them as the NHS and other providers become more responsive to people's needs and preferences. However, this IA focuses on the effects of extending the 'right to have' a personal health budget in Continuing Healthcare.

Key assumptions/sensitivities/risks — **Discount rate (%)** 1.5

This assumes that around 10% of individuals in receipt of NHS Continuing Healthcare are likely to receive a personal health budget. This IA assumes it will take apround two years to reach this state. It assumes gains in cost-effectiveness per person remain constant as more people access personal health budgets.It also assumes there are no wider costs to the system incurred as a result of the introduction of a 'right to have' in NHS CHC.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			In scope of OITO?	Measure qualifies as
Costs: 0	**Benefits:** 0	**Net:** 0	No	NA

Evidence Base (for summary sheets)

Policy background and wider context

1. A personal health budget is an amount of money which the individual has control over and is there to meet their agreed health and wellbeing needs. It is not additional money – it is a different way of commissioning NHS services, which enables individuals to meet their needs in different ways, ways which work for them. The individual, in conjunction with a representative of the commissioner (currently clinical commissioning groups) agrees a care or support plan that sets out the health and care needs of the individual, the amount of money in the budget and how they will be met. The budget is then used to pay for these services.
2. Personal health budgets aim to give the individual more choice and control over the services they receive. This is done by giving them direct control over the money, which is either i) held by the commissioner (notional budgets), ii) by an independent third party (third party arrangements) or iii) by the individuals themselves (direct payments). This is one part of the overall personalisation work within healthcare. The overriding aim is to improve individual outcomes, quality of life and satisfaction.
3. Within healthcare, people with long-term conditions are getting the opportunity to take more control over their care, through personalised care planning. A care plan sets out the health and wellbeing needs of the individual, their goals and preferences, and how they will be met, taking a holistic more than medicines approach. The aim is to enable patients to be able to take more control over their care, enabling them to better manage their health and reducing the need for unplanned care. Personal health budgets are closely linked to personalised care planning – people can only get a personal health budget if they have a care or support plan.
4. The personal health budgets pilot programme was announced within the 2008 report *High Quality Care for All*.[1] Pilots included personal health budgets for people eligible for NHS Continuing Healthcare, who have some of the highest levels of need in the population. The pilot programme was independently evaluated and the final report was published in November 2012.[2] The evaluation identified that those with the highest level of need were most likely to benefit from personal health budgets. Following this, a 'right to ask' for a personal health budget in NHS Continuing Healthcare was introduced in regulations in April 2014.
5. This impact assessment outlines the next steps for the policy. The evidence for further rolling out personal health budgets is predominantly based on the evaluation, the experience within the pilot programme and NHS England intelligence since introduction of the 'right to ask' for a personal health budget for those eligible for NHS Continuing Healthcare. This Impact Assessment builds on previous IAs, including the IA for the pilots[3] and the IA introducing the 'right to ask' for a personal health budget for people in receipt of NHS Continuing Healthcare.[4]

Rationale for intervention

6. People would often like to have more control over decision about their care than they currently have. This can improve outcomes by helping people access services that are more appropriate for them. This is particularly relevant to people with ongoing health and care needs. Relying on the health system alone to make decisions about people's care misses potentially beneficial opportunities to involve the patient and offer more appropriate services.
7. Without intervention, the current system of the 'right to ask' for a personal health budget will continue. However, take-up of personal health budgets, particularly in NHS Continuing Healthcare

[1] https://www.gov.uk/government/publications/high-quality-care-for-all-nhs-next-stage-review-final-report
[2] www.phbe.org.uk
[3] http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_099759.pdf
[4] http://www.legislation.gov.uk/ukia/2013/58

has been slower than expected (and slower than that projected under the previous Impact Assessment). Intelligence from NHS England suggests a number of reasons for this.

a. Firstly, there is a lack of awareness among CCGs and GPs of the potential benefits to the wider system and are likely to focus on the immediate and direct costs of personal health budgets (e.g. community care), which are even more transparent with direct payments. The independent evaluation shows such concerns to be ill-founded: although direct costs did increase amongst budget holders (compared to base year), this occurred at a slower rate than non-budget holders, yielding net cost-savings. Furthermore, indirect costs (e.g. hospital costs) were substantially lower under personal health budgets, leading to an overall substantial cost-saving within the same year. However, this indirect cost saving is not immediately observable to CCGs, as hospital costs do not form part of the personal health budget, and can be difficult for CCGs to attribute to a personal health budget.

b. Secondly, there is a reluctance to change given the complexity of implementing personal health budgets, particularly where money is currently tied to contracts. Commissioners may be risk averse in moving away from existing block contracts, even if they do not represent value for money or provide the services required to meet individuals' needs. This risk aversion may be exacerbated due to current financial constraints.

c. Thirdly, personal health budgets, especially direct payments, represent a change in culture for GPs and commissioners. Intelligence from NHS England suggests that many clinicians have a paternalistic approach; treatment planning is often focused on symptoms and diagnosis rather than taking a holistic view of needs. This is beginning to change and personal health budgets are helping to drive this change towards a more personalised integrated approach.

8. Therefore, while individuals request a personal health budgets under the existing 'right to ask', they might be refused, even though the individual may benefit. There is a real risk in some areas that when people ask about personal health budgets they are given excuses. By implementing the 'right to have', the aim is to shift the burden of proof to CCGs as to why a personal health budget should not be given.

9. NHS England has implemented the national support programme to address these factors and raise awareness among commissioners, and has seen good progress across CCGs. However, while all 211 CCGs have joined the programme, 77 of them have still not provided evidence that they are offering or are capable of offering personal health budgets. By introducing a 'right to have', CCGs will have to give greater consideration to individuals' requests for a personal health budget, increasing the expected number of personal health budgets. While expanding the rights to a personal health budgets for individuals on NHS Continuing healthcare from a 'right to ask' to a 'right to have' brings risks, this has been mitigated by allowing for exceptions (see the risks section).

Evidence from pilots

10. The evaluation is the main source of evidence about personal health budgets with the impact assessment investigating the 'right to ask' for direct payments discussing its broadly positive results. It also found that personal health budgets are more suitable for people with high levels of need and may be more cost-effective for particular conditions.

11. Outside of the evaluation, the average budget for individuals in receipt of NHS Continuing healthcare is approximately £46,000 per year.[5] The evaluation looked specifically at the effect of personal health budgets on 155 individuals in receipt of NHS Continuing Healthcare. However, their average budget was significantly higher than the average for the general NHS Continuing Healthcare population, so not representative of them. The most representative group was the set of 546 individuals receiving 'high-value' personal health budgets[6] and whose average budget was around £38,000. The 155 individuals on NHS Continuing Healthcare are likely to be within these

[5] www.dh.gov.uk/health/2012/09/continuing-healthcare-spreadsheet/ This is not an audited figure, and should be treated as an estimate

[6] Defined as a budget of at least £1,000, and likely to include practically all people in receipt of NHS Continuing Healthcare in the pilot

high-value budget receivers due to the nature of their healthcare costs; however this is not by definition. This Impact Assessment therefore uses the findings among the 'high value' group.[7]

12. From the evaluation, individuals in receipt of 'high value' personal health budgets on average spent £3,100 per year less on managing their condition than those in the control group, significant to the 10% level. Quality of life (as measures by the Adult Social Care Outcomes Toolkit) showed an improvement of 0.032 on average compared to the control group, which was significant at the 5% level.
13. Personal health budgets were also found to have a net benefit for the whole sample in the evaluation, significant at the 10% level. While the small sample size made it difficult to identify which subgroups benefitted most from personal health budgets, the evaluation identified relatively higher benefits for individuals in receipt of NHS Continuing Healthcare, those receiving budgets for mental health conditions, and among those aged over 75.

Current provision under 'right to ask' in NHS Continuing Healthcare

14. In the run up to the introduction of the 'right to ask' for personal health budgets in NHS Continuing Healthcare, NHS England has implemented the national support programme, which aims to help CCGs meet the deadlines required. They have seen good progress since September 2013 with most CCGs now in a good position to offer a personal health budget.
15. The numbers of people receiving personal health budgets is being collected as part of the NHS Continuing Healthcare national data set and this will give us accurate information on take-up across the country. Early indications from the NHS support programme for personal health budget implementation suggest around 1,000 people in receipt of NHS Continuing Healthcare have a personal health budget.
16. As of March 2014, two thirds of CCGs (134) were providing personal health budgets to individuals with all types of conditions. More than 40 CCGs are currently delivering ten or more personal health budgets although almost a third provide between one and five. Over time, the NHS England support programme aims to improve provision across the remaining CCGs who, at present, do not or are unable to provide for personal health budgets. The variation in provision by CCG suggests that weak uptake is attributable to the CCG factors listed above (paragraph 7) rather than to patient reluctance or inappropriateness.

International evidence and experience

17. Many countries continue to experiment with personal budgets in social care including France, Germany, the Netherlands, Austria, US, Canada, Australia, Sweden and Finland, however evidence so far is inconclusive and was discussed in the previous impact assessment. There is no programme comparable with the pilot programmes and the UK has been one of the world's leaders in the introduction of personal health budgets to date.

Description of options considered

18. This Impact Assessment considers options for expanding provision of personal health budgets for patients in receipt of NHS Continuing Healthcare. Its focus is narrow to reflect the incremental approach to rolling out personal health budgets. While the evaluation found evidence that personal health budgets had the potential to benefit a wide range of patients, it also pointed to risks, for example around disruption to existing service provision (see risks section). As a result, this IA investigates the next stage of rollout to individuals where the evidence is strongest – those on NHS Continuing Healthcare.
19. This Impact Assessment considers two options; (0) do nothing, and (1) move from the current 'right to ask' for a personal health budget for people in receipt on NHS Continuing Healthcare to a 'right to have'. Under option 1, CCGs will need to give greater consideration to requests from individuals for a personal health budget. Option 1 also includes individuals transitioning into NHS Continuing

[7] This may be an underestimate of the benefits, as the evaluation found higher benefits in the NHS Continuing Healthcare group

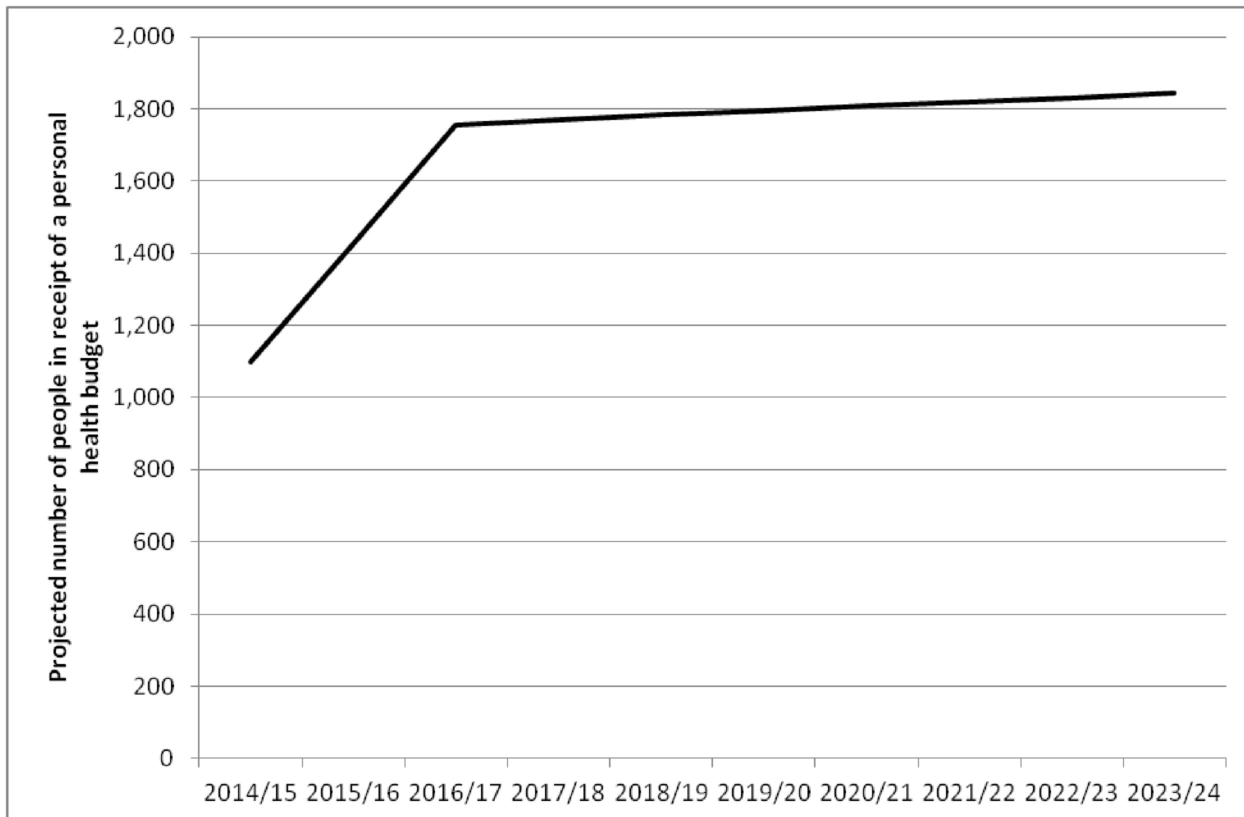
Healthcare. Other non-regulatory options have been considered, and are being pursued independently of this IA, including NHS England's national support programme. However, the evidence from existing rollout suggests that while beneficial, this is not sufficient.

20. Individuals have been able to ask for a personal health budget in the form of a notional budget or third-party payment since before the pilots in 2008. However, the possibility of holding a personal health budget in the form of a direct payment was only possible from June 2010 (and initially only in pilot sites). Therefore, previous changes in legislation (in 2008 and 2013) have only directly affected the rollout of direct payments. However, the legislatory changes in option 1 affect all forms of personal health budget, as they shift the burden of evidence onto the CCG. Now under all forms of personal health budget, the CCG will have to provide a robust rationale for any request it rejects. This is expected to increase the number of all forms of personal health budgets – notional budgets, third party budgets and direct payments.
21. In the future, it may be cost-effective to roll out personal health budgets to further patient groups. This will be subject to a future Impact Assessment if appropriate.

Option 0: Do nothing

22. The base case is the 'do nothing' scenario. Here, the 'right to have' will not be implemented in October 2014. The 'right to ask' for a personal health budget will remain.
23. Without the 'right to have', engagement with personal health budgets may decline and lose momentum. As a result, people who have the potential to benefit from a personal health budget may not be able to receive one. There is currently variable provision of personal health budgets around the country, and this is likely to continue under the do nothing option.
24. As is currently the case, this option would give no guarantee for continuity of services for people transitioning into NHS Continuing Healthcare from social care or children's services where they may have had personal budgets or direct payments.
25. Assuming a similar proportion of those in receipt of NHS Continuing Healthcare take up a personal health budget, after two years, around 1750 people will have a PHB. This represents 3% of all people in receipt of NHS Continuing Healthcare, and is lower than the number assumed in the previous Impact Assessment.
26. Through NHS England's support programme, it is known that not all CCGs currently offer personal health budgets. This IA assumes that with no intervention, uptake will increase so that all CCGs offer personal health budgets, of a similar number to those that currently do. As a result, uptake will increase by approximately 60%. This is assumed to take place over two years, so that the steady state is reached in 2016/17.
27. Chart 1 shows the potential uptake of all forms of personal health budgets in NHS Continuing Healthcare under the 'do nothing' option. The number of people on NHS Continuing Healthcare is assumed to increase in proportion to overall population growth.

Chart 1: Graph showing the predicted uptake of personal health budgets among patients in receipt of NHS Continuing Healthcare



Option 1: Introduce a ‘right to have’ a personal health budget for individuals in receipt of NHS Continuing Healthcare

28. Option 1 is to amend the regulations to give NHS Continuing Healthcare patients the ‘right to have’ a personal health budget, with exceptions (see risks section for more detail). The usage of personal health budgets would remain the same, i.e. they can be used for anything that may improve care and wellbeing excluding alcohol, tobacco, drugs or anything illegal. They also cannot be used for acute care or GP services.
29. As identified above, there is evidence that not all CCGs are offering personal health budgets to their local populations under the existing ‘right to ask’ in NHS Continuing Healthcare. While it is expected that the number of people receiving a PHB will continue to grow under the do nothing option, progress may be slow, with projection outlined in chart 1. Under option 1, progress is expected to be faster, as CCGs have fewer reasons for declining a personal health budget (though exceptions remain to ensure that people only receive a personal health budget if appropriate).

Benefits of Option 1

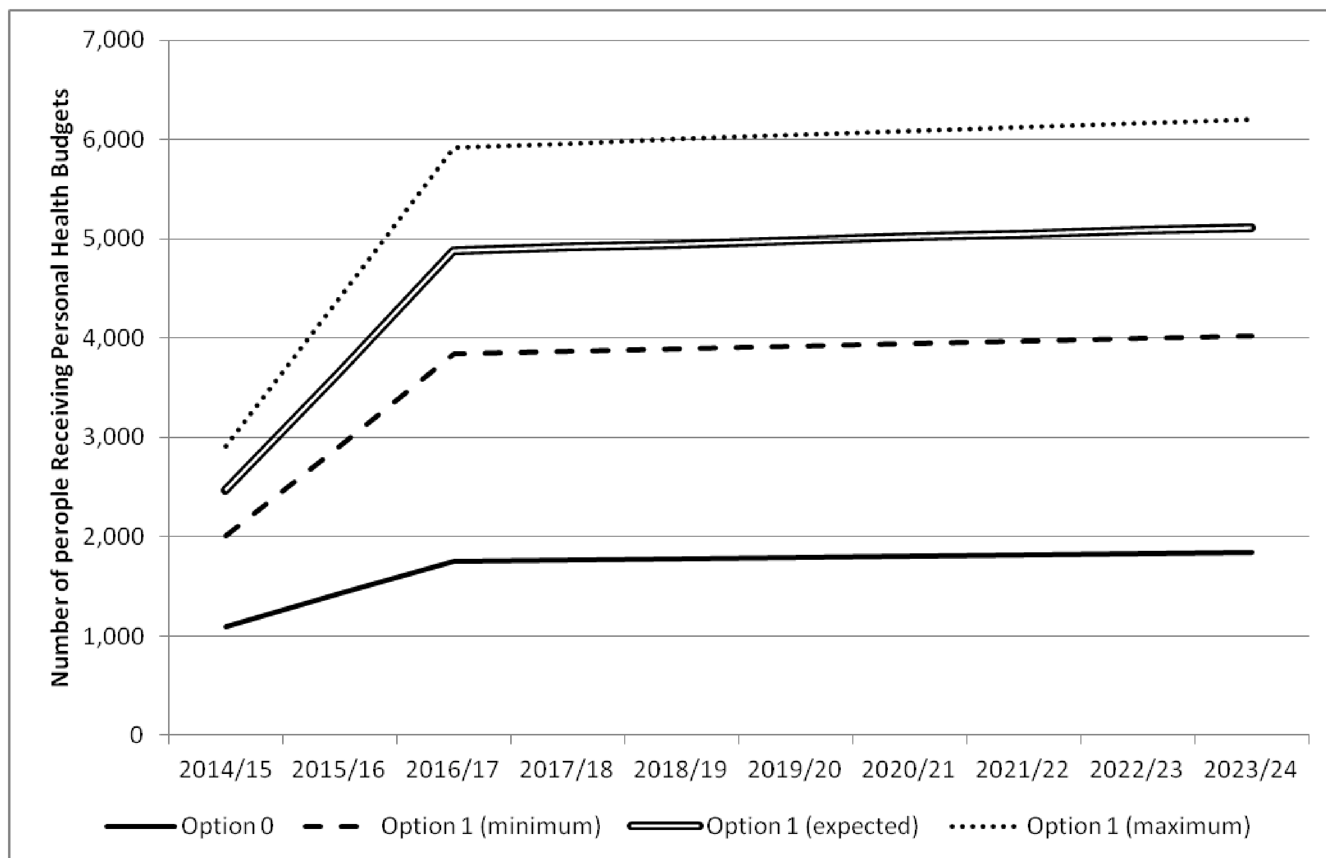
30. The ‘right to have’ is stronger than the ‘right to ask’ and shifts the burden of evidence onto CCGs – they will need to agree to individuals’ requests unless they fall under an exception. The ‘right to have’ clarifies the position for CCGs and motivates them to focus their attention on developing the capacity and capability to deliver personal health budgets.
31. As a result, more people receiving NHS Continuing Healthcare are expected to receive a personal health budget. Currently 58,340 people receive NHS Continuing Healthcare. This number is expected to grow, assumed to be in proportion to the rate of population growth projected by the Office of National Statistics.
32. 63% of people in receipt of NHS Continuing Healthcare are in residential care. These individuals are not expected to benefit significantly from personal health budgets, as there is no additional benefit to moving the money around the system via a direct payment if the package of care the person

receives remains unchanged. A further 27% are 'fast track' recipients, who are nearing the end of life. These individuals are also unlikely to benefit from a personal health budget, due to the timescales involved. Therefore, this IA assumes that a maximum people in receipt of NHS Continuing Healthcare that are likely to receive a personal health budget is the remainder, i.e. 10% (or 5,800 people). This may be a conservative assumption. However, if take-up increases, the benefits and costs are expected to increase proportionately (see the risks section for more detail).

33. This is assumed to be a maximum number of people who would receive a personal health budget in NHS Continuing Healthcare. As a result, the maximum incremental effect of option 1 is an additional 4,200 people with a personal health budget. This IA assumes that the minimum incremental number of people with a personal health budget in NHS Continuing Healthcare is half of this, i.e. 2,100. The expected number is halfway between, i.e. 3,200. It is assumed to take two years to reach this steady state.

34. Chart 2 shows the total projected number of people receiving a personal health budget under option 0 and the minimum, expected and maximum number of people under option 1. The incremental effect is the gap between the option 0 line and the different option 1 lines.

Chart 2: Graph showing the potential uptake of personal health budgets for those eligible for NHS Continuing Healthcare under the 'right to ask' and the 'right to have'.



35. Receipt of personal health budgets generates two main benefits: (i) improvements in quality of life, and (ii) reduction in the cost of service usage, leading to cost savings for commissioners.

36. The evaluation showed that personal health budgets are both cost-saving and cost-effective for individuals in the NHS Continuing Healthcare group. For high value budget holders, individuals experienced a cost saving of £3,100 per year compared to the control group (£1,220 on direct costs, £1,880 on indirect costs).[8] This Impact Assessment assumes that the full £50,000 average budget of a person in receipt of NHS Continuing Healthcare is at not risk. The recipient must agree a care plan

[8] Direct costs are for those services included in the personal health budget, and include social care, well-being, nursing & therapy and other health costs. Indirect costs are for services outside the personal health budget, and include primary care, inpatient care, A&E and outpatient services.

with a CCG that sets out how the money will be used to meet their needs. While there is a risk that some of this money may be used in ways that are ineffective in meeting their needs, this risk already exists, even among individuals without personal health budgets who are accessing traditional services. This is further mitigated by the fact that individuals' health needs and service usage are regularly monitored, with an in-depth review after three months.

37. Budget holders also experienced an average quality of life improvement (as measured through the Adult Social Care Outcomes Toolkit) of 0.032. Monetised at £60,000 for a year in perfect health, this translates into an average benefit of £1,920 per individual per year.

38. Table 1 outlines the expected benefits for the further roll out of personal health budgets. Cost savings have been translated into an opportunity cost saving of additional QALYs, at a rate of £15,000 per QALY. QALYs are then discounted at 1.5% per year. The value of a QALY is assumed to be £60,000. The discounted expected benefit is around £42m per year in the steady state, totalling £389m over ten years.

Table 1. Discounted benefits and opportunity cost savings of option 1

Year	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Total
Additional number of people receiving a PHB	1,400	2,200	3,100	3,100	3,200	3,200	3,200	3,200	3,300	3,300	-
Quality of life gain (QALYs)	44	72	100	101	101	102	103	103	104	105	**934**
Discounted quality of life gain (QALYs)	44	70	97	96	95	95	94	93	92	92	**869**
Financial cost saving (£m)	4.4	6.9	9.7	9.7	9.8	9.9	10.0	10.0	10.1	10.1	**90.5**
Opportunity cost saving (QALYs)	282	462	645	650	654	659	663	668	672	677	**6,032**
Discounted opportunity cost saving (QALYs)	282	455	626	621	617	612	607	602	597	592	**5,609**
Total discounted benefit (QALYs)	325	526	723	718	712	706	701	695	689	683	**6,478**
Total discounted benefit (£m)	19.5	31.5	43.4	43.1	42.7	42.4	42.0	41.7	41.4	41.0	**388.7**

Cost of Option 1

39. There are not expected to be any additional set-up costs under option 1 that are not covered in option 0. All CCGs are expected to be able to offer personal health budgets under option 0 with the help of NHS England's support programme, so will have the infrastructure in place. The only additional costs of the rollout of the 'right to have' are increased ongoing costs from providing support and information to people receiving personal health budgets.

40. The third interim report estimated all initial costs to be around £93,280 per year for each 'commissioning unit'.[9] This is the combined total of set-up and ongoing costs. £18,470 of this was associated with information, advice and support, which would continue on an ongoing basis. Other costs were more difficult to classify, but are likely to have some ongoing element. As a result, this IA assumes that the best estimate for ongoing costs is £50,000 per year.[10]

41. The cost information from the pilot sites was based on an average of 75 individuals receiving a personal health budget. Therefore, the central estimate of the ongoing financial cost per person is

[9] www.phbe.org.uk

[10] Set-up costs are covered in option 0 but these are assumed to be the remainder of the £93,280, which only occur in the first two years

approximately £670 per year. The cost will then vary by the number of individuals receiving a personal health budget.

42. Table 2 shows opportunity costs, estimated assuming a QALY is displaced for every £15,000 of Department of Health spending, and that QALYs are valued by the public at £60,000. Assuming the expected incremental number of people receiving a personal health budget as outlined above, the total cost is expected to be around £8m per year, or £72m discounted over ten years.

Table 2. Discounted opportunity costs of option 1

Year	**2014/ 15**	**2015/ 16**	**2016/ 17**	**2017/ 18**	**2018/ 19**	**2019/ 20**	**2020/ 21**	**2021/ 22**	**2022/ 23**	**2023/ 24**	**Total**
Additional number of people receiving a PHB	1,400	2,200	3,100	3,100	3,200	3,200	3,200	3,200	3,300	3,300	
Undiscounted financial cost (£m)	0.9	1.5	2.1	2.1	2.1	2.1	2.1	2.2	2.2	2.2	**19.5**
Undiscounted opportunity cost (QALYs)	61	99	139	140	141	142	143	144	145	146	**1,297**
Discounted opportunity cost (QALYs)	61	98	135	134	133	132	130	129	128	127	**1,206**
Total Cost (£m)	3.6	5.9	8.1	8.0	8.0	7.9	7.8	7.8	7.7	7.6	**72.4**

Net Benefit of Option 1

43. The discounted net benefit of option 1 is expected to be £316m over ten years. Table 3 gives the net benefit based on the best estimate of costs and benefits set out above.

Table 3. Discounted net benefit of option 1

Year	**2014/ 15**	**2015/ 16**	**2016/ 17**	**2017/ 18**	**2018/ 19**	**2019/ 20**	**2020/ 21**	**2021/ 22**	**2022/ 23**	**2023/ 24**	**Total**
Additional number of people receiving a PHB	1,400	2,200	3,100	3,100	3,200	3,200	3,200	3,200	3,300	3,300	
Total discounted benefit (£m)	19.5	31.5	43.4	43.1	42.7	42.4	42.0	41.7	41.4	41.0	**388.7**
Total discounted cost (£m)	3.6	5.9	8.1	8.0	8.0	7.9	7.8	7.8	7.7	7.6	**72.4**
Discounted net benefit (£m)	15.9	25.7	35.3	35.0	34.8	34.5	34.2	33.9	33.7	33.4	**316.3**

Sensitivity analysis

44. As described above, the incremental number of people receiving a direct personal health budget may be higher or lower than this. Based on the assumptions outlined in paragraph 33, the discounted net benefit over ten years may range from £211m to £422m.

Rationale and evidence that justify the level of analysis used in the impact assessment

45. This Impact Assessment builds on previous IAs, including the IA for the pilots and the IA introducing the ‘right to ask’ for a direct payment personal health budget for people in receipt of NHS Continuing

Healthcare. While it is likely to affect only a small number of people (i.e. a proportion of those on NHS Continuing Healthcare), the evidence suggests it could have substantial benefits, though carrying risks. As a result, it has been based on the rigorous independent evaluation of the personal health budget pilots and intelligence from NHS England on current rollout and capability. Given the uncertainties, it may be necessary to gather further information about both methods of implementation and effects of personal health budgets for rollout beyond NHS Continuing Healthcare.

Risks and assumptions

46. The information laid out above has demonstrated that there are areas where the ‘right to have’ a personal health budget will lead to significant benefits, beyond those available under the ‘right to ask’ for NHS Continuing Healthcare. There are also risks involved with this further rollout.
47. **Risks to patients:** At the outset of the pilot programme, this was raised as a risk. It was assumed that people, when given more control, would make decisions that were not in their long term interests and would result in worse health outcomes. This has not proven to be the case, and while there are no benefits to an individual’s health status (as defined through the EQ5D); there are also no negative impacts and the reduction in unplanned care suggests people are managing their health better. Furthermore, in general there are benefits to an individual’s quality of life, as measured by ASCOT. Any remaining risk will be mitigated by sharing practice from where the introduction of personal health budgets has been more successful.
48. **Inequality risks:** The evaluation collected information across a range of areas including age, gender, disability, ethnicity, socioeconomic status, sexual orientation, marital status and religion. There was some evidence that personal health budgets may be more beneficial and cost-effective for those over 75. No other differences in outcomes, cost or cost effectiveness were found across the other groups, though sample sizes were often small. Based on the evaluation of pilot sites, there is no evidence that personal health budgets for healthcare lead to deterioration in equalities. In areas where personal health budgets for healthcare were implemented well, the beneficial effects were greater.
49. **Risks to the wider system:** Personal health budgets are a major change to how the system operates. They give more control to the individual and mean that there could be significant changes in commissioning patterns. This is to be welcomed – as seen in the evaluation, patients do make choices that benefit them and are cost-effective. However, if people are opting away from a particular service, there are clear implications for the long-term viability of that service. This is a risk that needs managing but not avoiding. It is not feasible to move away from previously-commissioned services immediately. The capacity in new services may not be immediately available, and funding may be tied up in a particular provider. Instead, this would be reduced over time. This risk will be mitigated by implementing personal health budgets slowly, and being clear about what individuals are choosing to do when they have more control and the implications on providers, and manage this accordingly.
50. **Increased costs to the system:** One of the issues raised at the outset of the pilot programme was that personal health budgets would result in greater costs to the system. This could be through increased costs associated with care or support planning, or through people selecting inappropriate services and requiring expensive inpatient treatments as a result, or through people wilfully misspending their budget and the NHS being required to pick up the bill. This has not proven to be a risk in practice – costs have been neutral or fallen. Good quality care planning, a key part of the personal health budget process, mitigates this risk.
51. **Number receiving personal health budgets:** This IA has assumed that the likely maximum number of personal health budgets as a result of option 1 is around 10% of all people on NHS Continuing Healthcare.
    a. If individuals in residential care or on ‘fast track’ also receive a significant number of personal health budgets, the associated costs and benefits will increase. However, these increases are likely to be proportionate, so that the benefits will continue to outweigh the costs. The exceptions laid out in the regulations ensure that commissioners only offer personal health budgets where the benefit is likely to outweigh the cost and so are appropriate.

b. It is possible that personal health budget will be lower than expected. In this scenario, potential cost savings would be missed that could be spend elsewhere in the system. In order to prevent this, NHS England's support programme is working closely with CCGs to ensure they are engaged with the roll out.

52. **Risks of a 'right to have':** Personal health budgets may not be suitable for everyone, and introducing a 'right to have' could lead to inappropriate expansion in personal health budgets. To mitigate this risk, an exception clause has been drawn up and included in the regulations, based on an extensive period of engagement with clinicians, service users, existing budget-holders and lawyers. It states that a request for a personal health budget must be granted "unless it is not appropriate in the circumstances, and extend the appeal right to the type of personal health budget granted".

53. **Top-ups and personal health budgets:** Given the greater transparency associated with personal health budgets, and potentially exacerbated by potential restrictions on funding, there may be more of a pressure to allow top-ups in personal health budgets. This was seen in one case in the pilot programme, when an individual was directly asked to top up their budget. However, top-ups are unlawful except when specific patient charges are required by legislation, and they go directly against the NHS Constitution, which is clear that the NHS treats people on the basis of need and not ability to pay. A personal health budget is there in lieu of NHS services so is subject to the same rules.

Direct costs and benefits to business

54. The regulations that are introduced affect commissioners, and are therefore for public sector organisations only. The only impact on the voluntary sector or the private sector is that following the introduction of personal health budgets, it may be easier for them to provide NHS-commissioned services (either directly or via the individual), if they are providing services that the individual wants and this is agreed as part of the care plan. While this may mean that voluntary and private sector providers are required to comply with particular regulations, it is then their choice whether they decide to provide services are not, and therefore this is not imposed specifically on them.

Summary and preferred option

55. The preferred option is option 1: introduce a 'right to have' a personal health budget for individuals in receipt of (and those transitioning into) NHS Continuing Healthcare. This is likely to result in greater numbers of people accessing personal health budgets. Based on the independent evaluation, personal health budgets are beneficial, especially where people have higher levels of health need. Further non-legislative options were considered and these are being pursued independently. However, additional changes to legislation are necessary, to expand provision.