

PERSONAL HEALTH BUDGETS GUIDE

Integrating personal budgets – myths and misconceptions



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Personal health budgets

A personal health budget is 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. Our vision for personal health budgets is to enable people with long term conditions and disabilities to have greater choice, flexibility and control over the health care and support they receive.

What are the essential parts of a personal health budget?

The person with the personal health budget (or their representative) will:

- be able to choose the health and wellbeing outcomes they want to achieve, in agreement with a healthcare professional
- know how much money they have for their health care and support
- be enabled to create their own care plan, with support if they want it
- be able to choose how their budget is held and managed, including the right to ask for a direct payment
- be able to spend the money in ways and at times that make sense to them, as agreed in their plan.

How can a personal health budget be managed?

Personal health budgets can be managed in three ways, or a combination of them:

- notional budget: the money is held by the NHS
- third party budget: the money is paid to an organisation that holds the money on the person's behalf
- direct payment for health care: the money is paid to the person or their representative.

The NHS already has the necessary powers to offer personal health budgets, although only approved pilot sites can currently make direct payments for health care.

What are the stages of the personal health budgets process?

- Making contact and getting clear information.
- Understanding the person's health and wellbeing needs.
- Working out the amount of money available.
- Making a care plan.
- Organising care and support.
- Monitoring and review.

1 Introduction

This guide is one of two focusing on the integration of personal budgets across health and social care.¹ Improving the experience and quality of care for people and supporting them to achieve better health and social care outcomes are the most important aspects of integration work.

The two guides are aimed at health and social care staff involved in the implementation of personal budgets and personal health budgets, who want to develop local systems for people who would benefit from an integrated budget. They draw together learning from 14 of the pilot sites² that have been working in collaboration with the Department of Health to explore how best to integrate budgets across health and social care.

Integrating personal budgets presents major cultural, technical and structural challenges, and there are a number of genuine barriers to overcome to make them a success. However, some commonly identified barriers to progress are in fact myths resulting from misunderstandings or misconceptions. In many cases, the perceived barrier either is nonexistent or can be overcome through the right approach and effective partnership working at local level.

This guide is intended for local use by those delivering personal health budgets and personal budgets in social care, as a concise guide to current learning about integrating personal budgets, and as a prompt for local policy and practice development. It touches on issues relating to the wider challenge of integrating health and social care systems and services only as necessary context for its primary focus – integrating personal budgets.

The guide sets out the most common real and perceived barriers to personal budget integration as a series of myths. For each myth, a response explains the issue where necessary, refutes the myth where possible/appropriate, and presents a practical way forward. The myths were identified through consultation with pilot sites,² the peer network³ and the Department of Health. The responses reflect current policy and practice, and draw on the collective knowledge and experience of pilot sites that have been engaged and consulted throughout the production of this guide. Where possible, we include direct examples of how sites have addressed some of the issues and concerns thrown up by each myth. In all cases we include references for other publications and resources that people may find helpful.

The guide is divided into four sections:

- **Finance and legal** – Section 75, pooled budgets, VAT and accounting.
- **Culture change** – risk aversion, clinical engagement and the medical versus social models.
- **Workforce** – assessment, care and support planning, sign-off processes and joint teams.
- **Information and data** – strategic planning, data protection, IT and performance.

Resources

References refer to resources at the end of each section. Where no reference is given the resources listed in this guide accompany its online version at:

www.personalhealthbudgets.dh.gov.uk/toolkit

- 1 See also Department of Health. **Integrating personal budgets – early learning**. 2012
www.personalhealthbudgets.dh.gov.uk
- 2 Personal Health Budgets Website. **About the pilot programme**. 2009
www.personalhealthbudgets.dh.gov.uk
- 3 The national peer network is made up of people who have a personal health budget and family members. Some members have founded the **peoplehub** personal health budgets network www.peoplehub.org.uk



2 Finance and legal

LEGAL

Myth

We can't give the local authority money to pay on our behalf because that means they are providing NHS services, which is illegal

Response

It is not unlawful for local authorities to commission healthcare services so long as an appropriate joint funding agreement is in place.

NHS bodies and local authorities need to work in partnership to get better value from the resources available and to improve health and wellbeing outcomes across the system. There is a statutory duty of co-operation between NHS bodies and local authorities in Section 82 of the NHS Act 2006 (the 2006 Act),⁴ which states that when exercising their respective functions, NHS bodies and local authorities must co-operate to secure and advance the health and welfare of the people of England and Wales. This can include arrangements allowing for delegation of certain NHS and local authority health-related functions and/or an agreement for pooling

resources, delivered under a statutory agreement under Section 75 of the 2006 Act, or through payments made to a local authority under Section 256 of the 2006 Act. The Audit Commission has recognised that joint funding arrangements are often poorly understood and implemented in practice,^{5,6} and that the perceived complexity of requirements for pooled funds deters people from setting them up despite the benefits they can bring.

Background

- The statutory duty of partnership between NHS bodies and local authorities was established under the Health Act 1999 and the Health and Social Care (Community Health and Standards) Act 2003. Those provisions are replaced by sections 75 and 256 of the 2006 Act. The 2006 Act outlines measures to further enable Health Act flexibilities, including making it easier to delegate functions and create joint funding arrangements in pursuit of partnership objectives.
- The 2006 Act makes provision for the functions (statutory powers or duties) of one partner to be delivered day to day by another partner, subject to agreed terms of delegation.

Section 75

- Section 75 of the 2006 Act enables the delegation of functions and/or pooled funds to be spent on agreed objectives or specific services where each partner contributes. One party can take the lead role in commissioning, whereby partners agree to delegate commissioning of a service to a lead organisation that acts on behalf of the other party. For example, a primary care trust may manage a health budget and a local authority budget to achieve a jointly agreed set of aims, with the two budgets aligned under a single commissioning function. This may be a sensible option depending on the size and make up of the service to be commissioned.
- Section 75 also enables integration of provision, where resources and staff are combined to deliver a service from managerial level to the front line, with one party acting as the host. This allows the NHS to fund a local authority to carry out some or all of the duties associated with the delivery of personal health budgets.
- A pooled fund is a single, common fund set up to meet an agreed list of partnership objectives. It contains contributions towards expenditure on combined NHS and local authority functions to enable the shared responsibility of meeting specific local needs. Partners decide on a host body that will manage the pool through agreed delegation arrangements.⁷

- Audit Commission research found that pooled funds are most commonly in use for people whose needs cross the health and social care divide, most notably for learning disabilities, mental health and community equipment services. Formal joint expenditure accounts for a relatively small amount of total health and social care spend (3.4 percent in 2007/08). However, this varies considerably by location, so in the case of many NHS care trusts (eg Torbay and North East Lincolnshire) all NHS and social care funds are pooled under Section 75.
- Partners pooling funds must ensure that a signed agreement is in place along with arrangements to manage operation of the fund. The agreement should identify the host partner, functions, agreed aims and outcomes, levels of contributions, and relevant financial accountability and audit procedures.
- Partners can complete a single agreement covering multiple separate pooled funds where the details of each pool are set out within separate appendices.

Section 256

- Section 256 of the 2006 Act enables primary care trusts to make payments (service revenue or capital) to local authorities to support specific services. This is a grant for additional local authority spending, not a transfer of health functions

to the local authority. The provision can be used to create joint budgets for integrated services so long as the NHS ensures the arrangement represents a more efficient use of resources than if an equivalent amount was used directly for NHS services.

- Section 256 payments do not constitute a delegation of responsibilities to provide healthcare. Primary care trusts that use them are required independently to account for the delivery of any functions relating to health needs.

Resources

- 4 Sections 75 and 256 of the NHS Act 2006
www.legislation.gov.uk
- 5 Audit Commission. **Clarifying joint financing arrangements: a briefing paper for health bodies and local authorities.** 2008 www.auditcommission.gov.uk
- 6 Audit Commission. **Means to an end: joint financing across health and social care.** 2009 www.auditcommission.gov.uk
- 7 CIPFA. **Pooled budgets: a practical guide for local authorities and the National Health Service (second edition).** Chartered Institute of Public Financing and Accountancy. 2009 www.cipfa.org

POOLED BUDGETS

Myth

Pooled budgets are the only way to provide integrated personal budgets

Response

A pooled budget is not a prerequisite to delivering integrated personal budgets.

While a pooled fund agreed under Section 75 can make things easier, it is not strictly necessary and there is much that can be achieved without one. Services can be jointly funded through an aligned budget to meet agreed outcomes where funding streams remain separately managed. This requires neither a Section 75 agreement nor a payment made under Section 256. Under such arrangements, there is no delegation of functions and no host partner, and therefore each party's statutory duties remain their own. However, such options are often considered useful given the perceived complexity and technical requirements of entering into formal pooled fund arrangements.⁸

For NHS care trusts, the legal basis for joint working is a Section 75 arrangement of primary care trust and local authority funding. The exact basis of joint funding arrangements is unlikely to be the most important thing affecting people's experience of personal budgets.

Access to a seamless process and an integrated personalised experience has more to do with coherent communication and good partnership working than with the formal or informal agreements that may be in place. For example, work done by pilot sites² suggests that a shared approach to agreeing an estimated budget or to care and support planning has a positive impact on people's experience regardless of the separate back-office processes that make them possible.

It will be important for health agencies to build their local systems and processes so as to deliver the best possible experience for personal budget holders, rather than forcing people to fit with what is easiest for local services and their existing respective funding arrangements. This may ultimately

involve formal budget pooling, but the absence of such arrangements should not preclude efforts to integrate people's experience. Integration is not an end in itself, but a means of improving services and outcomes, so if there are simpler ways of achieving the same goals these should not be overlooked.⁹

Resources

- 8 Audit Commission. **Financial management of personal budgets: challenges and opportunities for councils**. 2011 www.audit-commission.gov.uk
- 9 NHS Confederation. **Where next for health and social care integration?** Discussion Paper. 2012 www.nhsconfed.org

Example: Both NHS Oxfordshire and NHS Kent and Medway use pooled budgets. This is working well and makes the financial process of delivering joint budgets easier and less bureaucratic. They have found that this allows time and energy to be dedicated to care and support planning, arranging services and outcome-focused reviews rather than managing day-to-day discussions about who pays for what. Similarly, NHS Nottingham City is currently working towards a Section 75 agreement with Nottingham City Council.

VAT

Myth

Different rules regarding VAT get in the way of integrating personal health budgets

Response

While it is clearly important to be aware of VAT rules and liabilities, these should not prevent personal budgets integration.

Issues regarding integration, personal budgets and VAT generally fall into two categories: those relating to the different VAT regimes that apply to NHS bodies as opposed to local authorities; and those relating to the different VAT regimes that potentially apply to individual personal budget holders as opposed to the funding bodies.

The NHS and local authorities

- NHS bodies and local authorities are subject to different VAT regimes. NHS bodies cannot reclaim VAT as they are deemed to be compensated through their funding, whereas local authorities can reclaim VAT on goods and services purchased because care services are not VAT rated. This has implications for integrated personal budgets in terms of understanding tax liability and where this lies, and ensuring the cost effectiveness of arrangements for budget holders.
- Where a pooled fund is in place under a Section 75 agreement, the host party's VAT regime applies. This would apply to pooled funds entered into to facilitate the delivery of integrated personal budgets. This means that when a local authority delegates functions to the NHS, it cannot recover VAT, whereas local authorities can recoup VAT incurred when undertaking the functions of an NHS body.
- When an NHS host acts as an agent for the local authority purchasing services on behalf of the partnership, VAT can be reclaimed so long as the invoice or financial report to the local authority clearly shows the proportion of VAT relating to expenditure to meet local authority objectives. In all such instances, partner agencies should clarify how VAT will be accounted for as part of the agreement and should be careful not to design partnership arrangements so as to avoid tax.

Personal budget holders

- When budgets are transferred to people as direct payments to procure goods and services previously purchased or provided by the NHS or the local authority, this can have implications for the recovery of VAT and for the personal budget holder.
- Concern has been raised that tax rules disadvantage direct payment holders because local authorities can reclaim VAT on care services, whereas budget holders cannot. This can reduce their purchasing power by 20 percent as compared with the local authority, and may act as a disincentive to taking up direct payments.

- HMRC has stated that this should not happen in most cases as the majority of goods and services purchased through direct payments would be categorised as welfare services and therefore exempt from VAT.¹⁰ This can include personal care, support to live independently, and help with domestic tasks.¹¹ Education and vocational training may also be exempt.¹¹ Personal assistants do not incur VAT as they are employees.
- VAT would still apply to those who take their personal budget as a direct payment for use on services that are not exempt from VAT, such as some day centres. Experience from social care shows that in these situations, the person can choose to continue to have that part of their package purchased directly by the council, who can then reclaim the VAT.

Resources

- 10 HMRC. **Notice 701/2 Welfare.** 2011
www.hmrc.gov.uk
- 11 HMRC. **Notice 701/30 Education and vocational training.** 2011
www.hmrc.gov.uk

ACCOUNTING

Myth

It's not worth it – different accounting and financial governance requirements for statutory partners make budget pooling just too difficult

Response

There are some different accounting and financial governance requirements for the NHS and local government relevant to pooled budgets, but the numerous instances of these operating across health and social care show that they can be overcome through good planning, communication and partnership working.

The Audit Commission reported mixed views about the complexities and benefits of implementing Section 75 legislation, highlighting the technical and accounting challenges.^{5,6} A good experience of integrated personal budgets does not necessarily depend on a pooled budget being in place. Where a pooled budget is the chosen local approach, it is important to understand the implications of different accounting regimes, as well as the challenges that personal budgets and personalisation bring to existing accounting practice.

Difference and convergence

- Relevant financial reporting guidance for the UK public sector is set out in the 'NHS manual for accounts',¹² the 'NHS Foundation Trust annual reporting manual'¹³ and the 'Code of practice for local authority accounting' in the UK.¹⁴ Each sets out the principles and practices of accounting required to prepare a statement of account to give a true and fair view of the relevant organisation's financial position and transactions.
- The code for local government is produced by the Chartered Institute of Public Finance and Accountancy (CIPFA) and the Local Authority (Scotland) Accounts Advisory Committee. The 'NHS manual for accounts' is published by the Department of Health.
- There are differences in VAT regimes; charging; financial planning and budget-setting timetables; financial reporting arrangements; and accountability and governance arrangements. Many of these are driven by national requirements.
- Differences arise because the legislative framework for local government has not previously allowed for the adoption of generally accepted accounting practice in a number of areas (eg fixed asset accounting).
- Fortunately, these differences are being eroded in a number of ways:
 - from April 2010, both the NHS and local authorities came under the international

financial reporting standards

- in May 2012, a memorandum of understanding prepared by the Financial Reporting Advisory Board, which includes HM Treasury, CIPFA, the Department of Health and Monitor, set out the arrangements for developing financial reporting guidance for the UK public sector; a working group is considering proposals for greater consistency across the sector and any amendments needed to relevant guidance
 - the NHS Commissioning Board has recently confirmed the use of a common integrated finance and accountancy system for use by the Board and clinical commissioning groups, the use of which will be a condition of authorisation.
- Clearly, many differences remain, and partner agencies should seek to clarify how these will affect the partnership in each instance.

Accounting for pooled budgets

- For accounting purposes, a pooled budget is described as a joint agreement that is not an entity, the reporting requirements for which are currently set out in the UK financial reporting standards.
- The host party is responsible for the accounts and arranging the audit of the pooled fund. A memorandum account prepared by the host can be used to ensure accountability and transparency by

explaining the purpose of the partnership and each party's contribution and gross income and expenditure, although this is now discretionary.

- Partners must also agree on the process for reporting and managing surpluses and deficits and any subsequent responsibilities. The pooled fund cannot be used to carry forward surpluses or deficits over the year end, and each party must account for its own share of the assets, liabilities and cash flows arising from the pool.
- The technical and accounting requirements for pooled funds are set out in Financial Reporting Standard 9. This stipulates that partners to pooled funds must report their share of assets and liabilities in their respective financial statements at the end of the year. This may cause problems because of differences between NHS and local government accounting schedules (NHS bodies' annual accounts are audited earlier in the year) and the availability of financial information at the right time.

Resources

- 12 Department of Health. **NHS manual for accounts 2011–12** www.dh.gov.uk
- 13 Monitor. **NHS Foundation Trust annual reporting manual 2011–12** www.monitor-nhsft.gov.uk
- 14 CIPFA. **Code of practice for local authority accounting 2011–12**. The Chartered Institute of Public Financing and Accountancy www.cipfa.org

DIFFERENT FUNDING STREAMS

Myth

You cannot have a joint personal budget for health and social care because there are different rules on how the money can be used

Response

While different regimes govern the use of health and social care funding, consistent principles should be applied within local policies for personal budget expenditure that support people to make decisions that are right for them.

A personal budget can be used to pay for care, items and/or services set out and agreed in a care and support plan, which meet an assessed health or social care need. Regardless of whether the budget comes from health, social care or a combination of the two, subject to any relevant legislation, it is good

practice for funding authorities to support people to make decisions about their care that make sense to them, with as few restrictions as possible. The social care experience indicates that greater value for money and potential savings can result from people's creative choices of products and services that may be cheaper than formal service alternatives. An example might be the cost of personal assistance to attend a sporting or cultural event as opposed to the cost of a traditional day service placement.

There are a few things a personal health budget cannot be spent on, for example, to buy emergency care.¹⁵ Equally, a personal health budget cannot be used to buy GP services such as a medical consultation. However services recommended by GPs can be included (eg physiotherapy).

Resources

- 15 Department of Health. **Understanding personal health budgets**. 2012
www.dh.gov.uk

MEANS TESTED VERSUS FREE AT THE POINT OF DELIVERY

Myth

You cannot have a joint personal budget for health and social care because social care is means tested and the NHS is free at the point of delivery

Response

It is possible to integrate personal budgets across health and social care in line with their respective eligibility and funding models, including recognition of the fact that social care is means tested and provision of NHS services is free at the point of delivery.

This does not mean that doing so in practice is straightforward. This fundamental difference between health and social care means the different components of the budget need to be dealt with separately so that fairer charging can be applied to the social care element. This means being clear and upfront with people early in the process so that everyone involved understands how their estimated budget is calculated, what proportion of an integrated personal budget will be subject to means testing, and how much they will be expected to contribute.

Different systems

- When the NHS was founded in 1948, the principle that it would be free at the point of delivery, and based on clinical need, not ability to pay, was a central component of a system designed to ensure that good healthcare was available to everyone, regardless of wealth or standing.¹⁶ These principles have guided the development of the NHS over more than 60 years and remain at its core. Personal health budgets do not change this.
- Section 1 (3) of the 1948 Act provides that services must be provided free of charge except in so far as the making and recovery of charges are expressly provided for by or under any other enactment. This prevents NHS bodies recovering charges for NHS services, unless specifically provided for in legislation such as the regulations that enable prescription charges (Section 172 of the 2006 Act) or charges for dental and optical care.
- Unlike healthcare, social care services are subject to means testing and charging. Under the current system, people pay all their care costs unless they have assets of less than £23,250 or are in receipt of NHS Continuing Healthcare, in which case all the person's assessed needs are provided free of charge by the NHS.
- The regimes under which means testing occurs differ between residential and nonresidential services. Statutory national rules govern means testing for residential care;¹⁷ local discretion is applied to means testing and charging for nonresidential services, within DH fairer charging guidelines.¹⁸

The future

- There is general recognition that the current resources for care and support will not be adequate within the existing system in future as a result of demographic change, earlier diagnosis and people living longer with long term conditions.
- Options for the future funding of care and support are currently under consideration by the government and the outcome could have a considerable impact on current means testing regimes.^{19,20}

Resources

- 16 Department of Health. **The NHS Constitution: the NHS belongs to us all**. 2012 www.nhs.uk
- 17 Department of Health. **Charging for residential accommodation guide (CRAG)**. 2011 2012 www.dh.gov.uk
- 18 Department of Health. **Fairer charging policies for homecare and other non-residential social services**. 2003 2012 www.dh.gov.uk
- 19 Department of Health. **Fairer contributions guidance 2010: calculating an individual's contribution to their personal budget**. 2010 www.dh.gov.uk
- 20 Dilnot, A. et al. **Fairer care funding: the report of the Commission on Funding of Care and Support**. 2011 www.dilnotcommission.dh.gov.uk

Example: Many of the complexities of dealing with different funding streams and charging policies can be overcome by good partnership arrangements and ensuring that clear procedures are in place.

- A number of pilot sites have delivered integrated personal budgets, including Kent, which found that joint health and social care assessment helped with early identification of cases where joint funding is likely.
- During the pilot, panel decisions have proved helpful to agree the funding split for each person and therefore the chargeable component. In Nottingham, this has meant identifying a percentage split at the outset. In Oxfordshire, it has meant identifying units of costed health time and totting them up as a proportion of the overall budget. The split of health and social care funding should then be detailed in the care and support plan – including any contribution from people themselves.
- When opting for a direct payment, a personal budget holder should ideally receive one payment into their direct payment bank account to pay for their health and social care needs (adjusted to reflect any contribution). This activity can be delegated to a lead party under a Section 75 pooled fund.

3 Culture change

RISK AVERSION

Myth

Approaches to risk between health and social care are very different and it isn't possible to bring them together

Response

It is important that health and social care staff work together to understand what risks are relevant to each person to ensure the co-ordination of good safeguarding practice and promote a risk-enabling approach wherever possible. This could improve people's safety as a single holistic appraisal will mean fewer gaps between health and social care services.

A variety of potential risks need to be taken into account when supporting people with health and social care needs, including financial, clinical and personal risks. A shared understanding of risks and a co-ordinated plan for managing them is an essential part of good safeguarding practice and should not be considered a barrier to integrated personal health budgets. Rather, there needs to be a shared responsibility for working jointly and consistently with people with health and social care needs to identify risks and manage them in ways that make sense to them.

Department of Health guidance emphasises the need for a joined-up approach:

Developing multi agency policies can help ensure that there is a positive and joined-up approach to risk across the whole community.²¹

Example: Many personal health budget pilot areas have taken steps to enhance and improve joint management of risks. North East Lincolnshire Care Trust has developed shared documentation for health and social care staff to use in assessing risk, and has established a joint panel to review care and support plans where specific risks are identified.

In 2011, the Social Care Institute for Excellence together with NHS London, the Metropolitan Police and the Association of Directors of Adult Social Services published a pan-London, multi-agency policy for protecting adults at risk,²² which highlights the need for a collective approach that needs to be seen as everyone's business. The foreword states:

*In London, as elsewhere, the main statutory agencies, local councils, the police and NHS organisations – need to work together **both** to promote safer communities to prevent harm and abuse **and** to deal well with suspected or actual cases...It is our firm belief that adults at risk are best protected when procedures between statutory agencies are consistent...*

Resources

- 21 Department of Health. **Practical approaches to safeguarding and personalisation**. 2010
www.thinklocalactpersonal.org.uk
- 22 Social Care Institute for Excellence. **Protecting adults at risk: London multiagency policy and procedures to safeguard adults from abuse**. 2011
www.scie.org.uk

CLINICAL EVIDENCE

Myth

NHS money can't be used for treatments and services not endorsed by NICE, and integrated personal health budgets make this more difficult

Response

There is no prohibition on using personal health budgets for treatments and services not endorsed by the National Institute for Health and Clinical Excellence (NICE),²³ although these should be agreed with a clinician. Where health and social care staff are working together effectively, integrated personal health budgets should not make this process more difficult.

Personal health budgets can be used for treatments that have not been reviewed by NICE. Indeed not all services currently commissioned by the NHS have been considered by NICE. People will need to have the right information to enable them to make informed decisions about what to use their budgets for. Where NICE has reviewed a treatment and concluded it is not cost effective, but someone wants to use their personal health budget to buy the treatment, the request would need to go through existing local exception processes.

In circumstances where the planned use of a budget is not approved, the health organisation should clearly communicate the reasons for refusal, for instance if a chosen provider is not a member of relevant regulatory bodies.

Where people have personal budgets to meet health and social care needs the same principles should apply. In such instances, care and support planners have an important role to ensure they provide correct advice and guidance, help to manage people's expectations about what is possible, and direct people to more specialist advice where needed. Care and support planners should know who to involve in the planning process and should take care to engage with the lead clinician – particularly around complementary therapies and where there is little experience of people using alternative treatments or provisions. Where people are using nontraditional services and treatments,

it is particularly important that reviews are used to check outcomes are being met and funds are being used appropriately. Many pilot areas that have built up experience of people using budgets in nontraditional ways emphasise the importance of sharing people's stories with clinicians and frontline staff, as this helps to build confidence in permitting people to use their budgets in ways that might seem unusual but ultimately could improve people's health and wellbeing outcomes. The Department of Health is currently working with NICE to look at this area in more detail and expects to make more information available to support the NHS with these issues.

Resources

23 NICE guidance www.nice.org.uk

EQUALITIES

Myth

Personal budgets for health and social care will work only for people who understand the system and have the time and skills to navigate it to get what they want

Response

It is imperative that those tasked with implementing personal budgets across health and social care do so in a way that ensures equal access and opportunity for everyone who might benefit, regardless of background, age or condition. Learning from personal budgets in social care suggests this is possible with the right approach.²⁴

The requirements on public bodies in England, Scotland and Wales in relation to equalities and human rights that are applicable to the implementation of personal budgets are set out in the Equality Act 2010.²⁵ The Act includes a new public sector equality duty, Section 149, which came into force in April 2011.^{26,27} The public bodies to which the duty applies including health bodies and local authorities, are set out in Schedule 19 of the Act. Part of the general duty sets out that public authorities must, in the exercise of their functions, advance equality of opportunity by:

- removing or minimising disadvantages
- taking steps to meet the needs of people where these are different from the needs of other people
- encourage people to participate where their participation is disproportionately low.

In particular, the duty states that meeting different needs includes (among other things) taking steps to take account of needs of older people and people with a disability. The duty also relates to equalities in terms of age, gender, race, religion and sexuality. To have due regard to the aims of the equality duty, public bodies need to understand the potential impact of their decisions and identify mitigating steps to reduce or remove any potentially adverse impacts for different groups of people. Personal budgets for social care are intended to be universally available to everyone who is eligible who could benefit from them.

Personal health budgets have been tested through the pilot programme² for a broad range of healthcare needs and long term conditions. However, many people struggle to understand and navigate the health and social care system, and without the right information, advice and advocacy, accessing and making good use of personal health and care budgets can be difficult.

The largest ever survey of people using personal budgets, conducted in 2011 (the POET survey),^{28,29} found that most people experienced significant benefits over and above those attributable to traditional

services. It found that the benefits offered were fairly universal, stating that in terms of equalities monitoring there are no differences in outcomes according to gender, ethnicity or religion. In particular, the survey noted that older people received the same benefits as others from personal budgets and direct payments, so long as the right information and support was available. This is reflected in the experience of the Oxfordshire personal health budgets pilot, where older people receiving NHS Continuing Healthcare have been supported to recruit personal assistants using direct payments.

There is also evidence that personal budgets can work well for people with a mental health difficulty. The individual budgets pilot evaluation report of 2008³⁰ compared the experiences of people using individual budgets with those using traditional services, and found that *mental health service users in the individual budgets group reported significantly higher quality of life than those in the comparison group.*

Research by the Social Care Institute for Excellence³¹ shares a wealth of learning from the experience of older people and those with mental health problems about personal budgets and direct payments. This illustrates that although older people and mental health service users are likely to benefit greatly from personal budgets, there can be attitudinal and cultural obstacles to people from both groups being offered different ways to manage personal budgets, in particular direct

payments. In response to such findings, recent guidance from Think Local Act Personal³² recommends that to make personal budgets and direct payments more universal, action needs to be taken in the following main areas:

- reducing unnecessary process and restrictions and increasing flexibility
- improving equality of access
- providing good information and advice about personal budgets and how they can be used
- improving delivery of both direct payments and managed personal budgets
- developing and engaging the provider market.

Resources

- 24 Department of Health. **Personal budgets for older people – making it happen.** 2010 www.thinklocalactpersonal.org.uk
- 25 **Equality Act 2010** www.legislation.gov.uk
- 26 Equality and Human Rights Commission. **The essential guide to the public sector equality duty.** 2012 www.equalityhumanrights.com
- 27 Equality and Human Rights Commission. **Meeting the equality duty in policy and decision making.** 2012 www.equalityhumanrights.com
- 28 In Control and Centre for Disability Research, Lancaster University. **POET – the Personal Budgets Outcomes and Evaluation Tool.** 2011 www.incontrol.org.uk

- 29 Hatton, C. and Waters, J. **The national personal budget survey**. Think Local Act Personal. 2011 www.incontrol.org.uk
- 30 Social Policy Research Unit, University of York. **Evaluation of the individual budgets pilot programme**. 2008 www.dh.gov.uk
- 31 Social Care Institute for Excellence. **Keeping personal budgets personal: learning from the experiences of older people, people with mental health problems and their carers**. 2011 www.scie.org.uk
- 32 Routledge, M. and Lewis, J. **Personal budgets: taking stock, moving forward**. Think Local Act Personal. 2012 www.thinklocalactpersonal.org.uk

MEDICAL MODEL

Myth

There is an unbridgeable gap between the medical and social models of care which makes integration impossible

Response

In the social model of disability, disability is defined as the disadvantage experienced by a person as a result of a broad range of external barriers. These can range from inaccessible public spaces and transport to segregation in education, all of which make inclusion more difficult for people with impairments and/or ill health. The medical model of disability sees disability as a functional deficit – either physical or psychological, which resides in the person and requires them to adapt as best as they can to their environment. Adopting and embedding an understanding of the social model of disability continues to be an integral part of the modernisation agenda within the NHS.³³

The social model of disability is an important thread running through many other aspects of government policy on health and social care, and is central to personal health budgets.³⁴

People with health needs should always remain at the centre of decision making about how resources can best be used to maintain and improve their health and wellbeing. Personal health budgets allow a more flexible approach, where health professionals can support people to use resources in ways that make the most sense to them and give them the best chance of maximising the benefits from the treatments and services they receive.

There are many instances where people can meet their health needs using approaches that might not look anything like traditional health services. Allowing people to try new things that might better meet their health and wellbeing outcomes is vital to the success of any local personal health budgets programme. Health and social care professionals should be engaged throughout the development of personal health budgets to ensure they understand the importance of enabling people to take more control over their health and wellbeing and are confident in the systems and checks in place to ensure people can use personal health budgets safely.

Resources

- 33 PM Strategy Unit. **Improving the life chances of disabled people**. 2005. p. 88
www.cabinetoffice.gov.uk
- 34 Office for Disability Issues. **The social model of disability**. 2010
odi.dwp.gov.uk



CLINICAL ENGAGEMENT

Myth

Personal health budgets will fail because they are not supported by health clinicians

Response

Many of the values underpinning personal health budgets mirror the professional codes of ethics and standards that drove many to enter their chosen profession within the health service, and there are many examples of health professionals who are supportive of them.

For example, the College of Occupational Therapy code of standards³⁵ makes explicit reference to the need for practitioners to enable people to optimise their independence, focus on outcomes and promote choice and control for people with support needs – principles that are also central to personal health budgets.

Developing the infrastructure to deliver personal health budgets and integrated personal budgets across health and social care is central to

government policy. By April 2014, people eligible for NHS Continuing Healthcare will have the right to ask for a personal health budget, including a direct payment for healthcare. The NHS will also be able to offer personal health budgets more widely – for example to people with long term health conditions or people with mental health problems who could benefit.

Laying the future foundations for this should be a strategic priority for all primary care trusts and clinical commissioning groups through their transition planning, even where there are concerns among clinicians.

Evidence suggests that the issues that most concern frontline staff and clinicians who have not yet worked with personal health budgets are not shared by people who have had direct experience of working with them. A report by the NHS Confederation in March 2011³⁶ found that the main concerns of staff who had yet to work with personal health budgets were that bureaucracy would subsume the potential benefits, and that enabling people to have additional choice could serve to undermine good clinical judgment. Early evidence from pilot sites suggests that such concerns are not borne out in practice and that the positive impact felt by people using personal health budgets serves to

Example: At the South London and Maudsley (SLAM) NHS Foundation Trust, it became clear that it is important to engage commissioners and clinicians early in the development of systems to deliver personal health budgets. The Trust has found that co-production and relationship building is the key to success, and has appointed a dedicated champion to lead the agenda and bring people together.

increase staff engagement and confidence in them over time. Personal health budgets can enable health professionals to support and empower people to take more control over their health and wellbeing without compromising good clinical judgment. There are many examples of people using personal health budgets to great effect, in some cases leading to significant improvements to health and wellbeing. The joint working needed to deliver integrated personal budgets will enable health professionals to benefit from the experience of social care staff who have been through a similar progress through uncertainty to greater confidence in how personal budgets can work for people.

All primary care trusts and clinical commissioning groups should ensure that clinicians and commissioners, along with frontline staff and people using health services, understand the benefits that personal health budgets can offer people and play an active role in developing the systems for ensuring they are made available safely to people.

Resources

- 35 College of Occupational Therapists. **Professional standards for occupational therapy practice**. 2011 www.cot.co.uk
- 36 NHS Confederation and National Mental Health Development Unit. **Facing up to the challenge of personal health budgets**. 2011 www.nhsconfed.org

CO-PRODUCTION

Myth

Meaningful engagement with people is easier in social care – people using health services are often ill and do not want to engage in this way

Response

Many pilot sites have found ways successfully to engage people with health needs and their carers – while the language of co-production is less common in health than in social care, there are many examples of how this is working in practice.

From 2013, as part of the Health and Social Care Bill proposals, all clinical commissioning groups must be able to demonstrate they have appropriate mechanisms in place to involve people with healthcare needs and their wider communities before they can attain authorisation. Commissioners need to get better at capturing the experiences of people using health services and using that information to drive the way the system works to support them. Health and wellbeing boards also have responsibilities in this area.³⁷

In November 2011 the NHS Confederation³⁸ published a brief discussion paper about public and patient engagement in the new commissioning environment, which many people have found useful. In relation to personal health budgets, developing ways to capture, understand and harness information

Example: Many of the personal health budget pilot sites have involved people with health needs in the governance of local pilots alongside clinicians and social and healthcare managers. In Teesside the NHS has used a best practice methodology for engaging people, using aggregated and person-centred information from people with health needs to influence strategic decision making. The process, called ‘Working together for change’, has been adopted with support from local authority partners who have worked with health colleagues to develop their expertise in using this methodology routinely to improve services.³⁹

from people using budgets about what is and isn't working for them will be vital to their success. That is not to say that people should be forced to engage, but they should have a range of options to do so, and health organisations should make it clear that they value the information people share about their experiences and are committed to using it to improve services.

Resources

- 37 NHS Confederation et al. **Operating principles for health and wellbeing boards: laying the foundations for healthier places.** 2011
www.nhsconfed.org
- 38 NHS Confederation. **Patient and public engagement in the new commissioning system.** Discussion paper 11. 2011
www.nhsconfed.org
- 39 Think Local Act Personal. **Working together for change: using person-centred information for commissioning.** 2009
www.thinklocalactpersonal.org.uk

4 Workforce

ASSESSMENT AND CARE AND SUPPORT PLANNING

Myth

Health and social care professionals don't have the skills needed or the training available to provide an integrated approach to assessment or care and support planning

Response

Developing the workforce to be able to deliver an integrated approach to assessment and care and support planning should be a core part of any local workforce development strategy.

Many pilot areas, including NHS Kent and Medway, have engaged people using budgets in training frontline staff. They have found this an effective way of communicating the importance of personal health budgets and

gaining buy in from staff to new ways of working. Such an approach can sit well alongside other training to help staff learn new skills.

Not all tasks involved in delivering personal health budgets will necessarily fall to frontline staff. In particular, developing a care and support plan is not a task that health and social care staff are required to do. Experience has shown that often community-based organisations are much better placed to help people develop a care and support plan. This is because good care and support planning requires a set of skills and competencies that are about working with people holistically to meet their needs and aspirations, skills that are not exclusive to health and social care professionals. Some professionals will already have these skills. However, there is much evidence from social care that people often prefer to get the support they require from independent people and organisations rather than from health or social care professionals. As a result, a number of councils have begun to outsource care and support planning to their local voluntary sector and to build

Example: As part of workforce development planning, NHS Kent and Medway held a half-day workshop that brought together health and social care staff to look at integrated budgets. During the session, staff had the opportunity to work together to complete case studies and complete a self assessment to look at training and development priorities. Using this information, a joint health and social care steering group was set up to deliver integrated training sessions.

greater capacity for peer support. Depending on health and social care need, further professional input and expertise will continue to be part of the care planning process.

Statutory duties require health and social care bodies to conduct relevant assessments of need and to set a clear framework for delivering a care and support plan. Beyond that, there should ideally be a range of care and support planning options available to people. Once the care and support plan is complete, it is for health and social care professionals to ensure conditions have been met to enable plans to be signed off. Where local decisions are made to involve health and social care staff in care and support planning, it will be important to complete a workforce development plan, looking at what skills they will need to be able to do this well.

Staff can also use other ways to support their own learning and development. In setting their yearly action plans, staff should aim to identify ongoing development opportunities around health and social care integration. Regular supervision is equally essential to provide ongoing support to staff. Helping staff to be clear about their roles and responsibilities is also central. In some cases, this may mean reviewing existing job descriptions.

Examples

- **Joint care and support plan** (Doncaster)
- **Care and support planning guide** (Nottingham City)

RESOURCE ALLOCATION

Myth

Joint personal budgets for health and social care need an integrated approach to budget setting, which is way too complicated

Response

It would be ideal to have a single approach to budget setting, but this is by no means necessary to deliver integrated personal budgets.

Experience so far suggests that an integrated budget-setting system is very difficult to achieve and would require a significant amount of time and effort. So far this has not been felt to be a worthwhile endeavour.

Most pilot sites have been using parallel systems for setting budgets, and working hard to make them work as seamlessly as possible. In Doncaster the primary care trust uses an indicative budget-setting tool for fully funded NHS Continuing Healthcare. For people with only social care needs, the local authority has its own resource allocation system, and where there is a joint responsibility to meet needs, staff from both organisations work out how best to meet their respective responsibilities and the most appropriate split of funding in order to provide as seamless a service as possible.

When a patient becomes eligible for fully funded NHS Continuing Healthcare, although the funding stream changes, the delivery of care is still progressed by the joint health and social care team.⁴⁰ This ensures mainstream social care is provided in addition to any identified health needs.

Experience more generally from the pilot sites seems to confirm that the most important factor for any local system is the person's experience of how simple and seamless the overall process is.

Resources

40 Department of Health. **Setting budgets for NHS Continuing Healthcare**. 2012
www.personalhealthbudgets.dh.gov.uk

SIGN OFF

Myth

An individual worker can't sign off an integrated package. They will have a good understanding of only one aspect – health or social care

Response

Many pilot sites are already empowering frontline staff to sign off integrated budgets for people whose needs are not highly complex. With the right training and support, it is possible – and preferable – for a single practitioner to sign off an integrated budget, with input from colleagues where necessary.

Developing such an approach can be a difficult undertaking – people's needs are diverse and some health needs are very specific and complex, especially where there are multiple conditions. A clear understanding of where decisions can safely be made by a single practitioner is an essential prerequisite for making this possible.

Example: NHS Kent and Medway is moving forward with its integration programme, and has appointed a single manager for health and community services. This has helped to integrate the decision making process and makes it easier to devolve decision making where appropriate.

Staff need training in the care and support planning process to build confidence, and should be supported to understand the requirements across both systems to enable an integrated approach to sign off. It is neither effective nor efficient to involve too many people in the sign-off process. Some areas use joint panels as a means to ensure joint sign off, although this can lead to increased bureaucracy and delays. Panels are only necessary and useful when considering complex cases where there may be some significant issues that need to be understood and accommodated before a decision can be made. In most cases, sign off should be a simple decision taken at practitioner level – though in health there will always need to be clinical governance of the process in some capacity, which can be defined locally.

Empowering staff to make such decisions in all but high-risk cases is likely to be a more effective and less resource-intensive solution. Frontline staff need to understand the whole process, from assessment to budget setting through to care planning and outcomes monitoring, so that they feel comfortable with making decisions. Where people are not confident to do this, it should be possible to take a plan to a team meeting and talk it through. Clear exception processes are needed to ensure that where more input is needed, this can be clearly identified and additional expertise brought in swiftly to assist decision making.

Example

- Support plan review template (Tees)

PANELS

Myth

Joint personal budgets for health and social care will mean more time spent at panel meetings

Response

Panels are not a prerequisite for signing off integrated personal budgets. Experience from the pilot programme and social care suggests they should be used in limited circumstances rather than as a core part of the process.

It is important to have a robust process in place to sign off of care and support plans, whether these are for health, social care or integrated personal budgets. In health, there is an additional requirement to ensure

adherence to clinical governance. While health and social care bodies commonly use panels, they are rarely the most efficient or effective way of supporting local decision making around sign off.

In some cases, the costs and staff time associated with running and attending panel meetings can far outweigh the value of the personal budgets under scrutiny. Panel decisions take time, and the deference to professional opinion, while justifiable in some circumstances, can undermine the personal choice and control that personal health budgets are intended to uphold. Experience from social care shows that panel meetings and their outcomes are a source of considerable anxiety for personal budget holders, who are usually excluded from their deliberations and find their judgments difficult to understand. Panels should be used only when strictly necessary, and other more proportionate methods of signing off personal budgets should be explored.

Example: NHS Norfolk has decided that panel meetings are not the most efficient method of sign off for integrated budgets in most instances. Instead, responsibility is devolved to key workers. NHS Doncaster has produced guidance for staff that allows robust initial decision making, which helps to minimise process and reduce unnecessary bureaucracy. Experience has shown that personal health budgets often result in more holistic packages of care and better outcomes. This has boosted confidence in delegated decision making and reduced the use of panels.

One way of doing this is by giving a social worker, health professional or other staff member the authority to approve plans. Where a joint sign off is needed, this can be done via email or by two people meeting face to face, but the bulk of the work can still be done individually rather than in a panel meeting. Where a key worker has the authority to sign off plans, clinical governance can be done behind the scenes, rather than taking the personal health budget holder through a drawn out decision making process. This has the dual benefit of giving people the choice and freedom to meet their needs and enabling the key worker to support them in doing so without recourse to too much process. This helps to change the dynamic from having the key worker acting as a barrier to care, to actively working to help meet someone's care needs with the budget provided. A reduction in using panels should also speed up the process of getting a personal budget – an important consideration as research in social care shows that the delays and difficulties people experience in accessing personal budgets have had a significantly negative impact on people's experience and outcomes.

JOINT WORKING

Myth

Joint teams are needed to provide integrated personal budgets, which is complicated and time consuming

Response

While delivering integrated personal budgets inevitably involves health and social care staff working together more closely, many areas have succeeded in doing so without creating joint teams.

Delivering integrated personal budgets can feel like a complicated undertaking, and there are many challenges to overcome in addressing fragmentation between health and social care services. There are strong established traditions of integrated working across different organisational boundaries to develop integrated pathways in areas such as long term conditions and rehabilitation, where commissioners and providers work together successfully to deliver good outcomes for people.

Joint teams are one approach people have tried, but they are not the only way – a lot can be achieved through good communication, openness and the commitment and enthusiasm of staff, regardless of where they are sitting. While it can be time consuming initially to establish the mechanisms and understanding through which joint working can happen, this

should not be an ongoing requirement once the customer journey and associated processes have been mapped and agreed.

In practical terms, health and social care staff can be brought together through meetings and workshops to discuss the best approach to developing and delivering integrated personal budgets. Staff will need support to understand the roles they will play and how they can best work together. They will also need time and support to familiarise themselves with each other's systems and processes. This can be done through joint training, backed up by clear guidance and procedures.

Health and social care professionals often need to contribute jointly to assessing a person's needs, and should continue to liaise

throughout the process until the personal budget is set up and running well. Joint working at the assessment and planning phases should result in people receiving more joined-up, holistic support. Accountability and risk should be shared across both organisations, and process and governance applied in a similar way. The goal is to provide a seamless service, which can empower people to take more control in managing their health and wellbeing, regardless of whether joint teams are in place behind the scenes.

Example

- **Joint self-assessment questionnaire**
(Doncaster)



5 Information and data

PLANNING AND REPORTING

Myth

The differences in strategic and financial planning cycles and priorities make integration difficult

Response

Although there are many differences, health and social care organisations have similar cycles and processes for strategic and financial planning, and their priorities often converge. These synergies will strengthen as health and wellbeing boards take on their new roles and responsibilities.

There are some specific differences relating to financial governance and accounting cycles that are outlined in the section on accounting (page 10). Health and social care services have shared responsibility for delivering better health and wellbeing outcomes for people with care and support needs, and for improving the quality and continuity of services. These shared responsibilities are true, irrespective of whether formal pooled funding arrangements are in place.

Integration is driven by the recognition that health and social care outcomes are interdependent. In the current financial environment, it is even more important that partnerships across health and social care help to target resources better and prevent duplication. From 2013, health and wellbeing boards³⁷ will become a focal point for local decision making, with the responsibility for facilitating joint working between clinical commissioning groups, local authorities and other stakeholders. These new arrangements present new opportunities for system-wide leadership to improve health outcomes and health and care services, as well as links to the wider determinants of health, including housing, leisure, transport, education and employment.^{41,42} Boards will have an explicit duty to promote integrated working, and their main purpose is to drive improvements in health and wellbeing by promoting joint commissioning and integrated delivery. The role of health and wellbeing boards in carrying out joint strategic needs assessments will enable a direct route into strategic planning through joint health and wellbeing strategies. The new boards can best be seen as a forum for shared leadership that places equal responsibilities on councils and the NHS to work towards shared priorities, including the delivery of integrated personal budgets.

Resources

- 41 Local Government Association. **New partnership, new opportunities: a resource to assist setting up and running health and wellbeing boards.** 2011 www.idea.gov.uk
- 42 Department of Health. **Joint strategic needs assessment and joint health and wellbeing strategies explained.** 2011 www.dh.gov.uk

CONFIDENTIALITY

Myth

Sharing information between health and social care is difficult and this undermines integration

Response

It is not unduly difficult to share information between health and social care organisations so long as agreements and processes are in place to share data safely and appropriately within the legislative safeguards provided by the **Data Protection Act 1998**.⁴³

Sharing information effectively in health and social care is a critical building block towards integration. Without data sharing, people are forced to grapple with a system that duplicates processes and misses opportunities to improve the co-ordination, delivery and experience of care and support services. There are important legislative safeguards in place to ensure people's rights are protected, and local processes must be robust to ensure information is shared safely and compliantly. The Data Protection Act 1998 is the main piece of legislation governing the protection of personal data in the UK, and any organisation holding personal information must comply with the 1998 Act.

The need to facilitate better information sharing is at the centre of a number of recent developments in policy and practice. In 2012, the DH published a new information strategy,⁴⁴



Example: A good example of a local process is Devon’s protocol for sharing person-identifiable information between health and social care organisations, available online at: www.devon.gov.uk/index/socialcare/policies-procedures-guidance/organisationalprocesses/info-sharing-protocol.htm A consortium of ten health and social care organisations across Hampshire, Portsmouth and Southampton has produced a pan-Hampshire information-sharing protocol. This commits each organisation to share information, so that people using health and social care services experience a more joined-up approach and are not asked for the same information by each organisation separately.

which sets out a ten-year framework and route map to lead a transformation in the way information is collected and used. The strategy sets out the ambition that information be used to drive integrated care across the health and social care sector, underpinned by systems that ensure information is recorded once at first contact, then shared securely between those providing care while keeping confidential information safe and secure. The strategy also describes the important role of culture change and IT, including electronic care records. In parallel, a three-year common assessment framework programme⁴⁵ is drawing to a close, where a number of sites have been testing and refining systems to facilitate better information sharing between health and social care IT systems.

Defined protocols can be used to improve the communication between organisations and to facilitate a more seamless and integrated care and support experience. Explicit and informed consent needs to be sought early on in the assessment process to ensure people understand why and how data might be

shared, and with whom. Where there are capacity issues affecting people’s ability to consent, relevant guidance derived from the Mental Capacity Act 2005⁴⁶ (including the code of practice) should be followed to determine whether the person is able to make the decision and that appropriate steps are taken to protect their best interests.

Resources

43 Data Protection Act 1998

www.legislation.gov.uk

44 Department of Health. **The power of information: putting us all in control of the health and care information we need.** 2012 informationstrategy.dh.gov.uk

45 NHS Networks. **Common assessment framework lessons learnt – overview.** 2012 www.networks.nhs.uk

46 Mental Capacity Act 2005

www.legislation.gov.uk

IT SYSTEMS

Myth

It's pointless trying to offer joint personal budgets for health and social care because our IT systems don't speak to one another

Response

Integrating personal budgets is certainly made more difficult when local IT systems do not talk to each other, but there are plenty of ways of making progress without waiting for the ideal IT solution.

IT plays a critical role in enabling health and social care systems to run smoothly, and fragmented information systems can result in delays, duplication and extra costs. Ensuring that IT systems are well aligned is a central part of the government's plans for integrating health and social care services and is central to the recent information strategy published by the Department of Health.⁴⁴

There are a host of different IT systems in use in health and social care, from internal case management and client data systems, through to outward-facing information systems and web portals. Lining these up so that information moves in a timely and secure way around the system and is available when and where it is needed is a massive challenge.

Systems often work in isolation and are not designed to interact with other systems; data tend to be entered multiple times; and in many cases IT systems have their own standards that may not work with other systems. A report from the Audit Commission⁴⁷ notes that local authorities often do not have the capability to use the data they have and highlights resulting inefficiencies and impacts on service quality and user experience.

There are also numerous examples where organisations are breaking new ground in terms of IT and effective information use. The common assessment framework for adults demonstrator programme⁴⁵ has seen a number of sites test new approaches to information sharing to ensure that common data follows a person through the system. This includes a range of approaches, from using secure email to linking local health and social care IT systems via the NHS spine and the development of shared customer portals. The learning from the programme is available on the NHS Networks website.

While significant progress can take time, much can be done to work around issues in the short term. Integration between systems on a particular issue (with specific workflow and data requirements) is not as difficult as creating a new or merged system. With a clear vision of the information you want to share, there are plenty of ways to work together to ensure data sharing happens safely and effectively. There are a range of

options, from simple solutions using existing technology (eg secure email) through to secure portals to allow different organisations to access each other's information, to fully standardised solutions such as the NHS interoperability toolkit.⁴⁸ Local information-sharing protocols are particularly helpful.

Resources

- 47 Audit Commission. *Is there something I should know? Making the most of your information to improve services.* 2009 www.audit-commission.gov.uk
- 48 NHS Interoperability Toolkit www.connectingforhealth.nhs.uk

PERFORMANCE

Myth

The quality and performance regimes in health and social care are different, which makes integration difficult

Response

Health and social care do have different performance regimes, but this does not have to hinder integrated working given the shared responsibility to improve health and wellbeing and the recent shift towards systems that measure outcomes.

There have been a number of important developments in recent times that should help bring health and social care closer together, including the development by the Department of Health of outcomes frameworks for the NHS, public health and adult social care.⁴⁹ These frameworks use outcome measures rather than inputs and outputs to determine the outcomes for people and communities of health and social care interventions. Together, the three frameworks are designed to provide local people and organisations with evidence-based measures to help judge the success of services across the health and social care system.

While the frameworks are different, they are intended to work together to enable health and social care systems to be held to account for the outcomes delivered and to reflect the collective effort needed to deliver improved health and wellbeing. The NHS outcomes framework is a tool through which the Department of Health can hold the NHS Commissioning Board to account for the outcomes delivered in the NHS. The adult social care outcomes framework comprises a set of outcome measures, which have been agreed to be of value both nationally and locally for demonstrating achievements in adult social care. Similarly, as part of the wide-ranging changes to the health service, the new NHS Commissioning Board will be agreeing a commissioning outcomes framework. This is a lever between the Board and clinical commissioning groups by which health outcomes can be measured and priorities set. The framework will be used to hold clinical commissioning groups to account for the health outcomes and quality of care they achieve (including patient-reported outcome measures and patient experience), and will be operational from April 2013.

At a local level, good joint working and a person-centred approach, which focuses on the person's needs rather than those of the organisations involved, can go a long way to ensuring good practice. Developments such as the outcomes star in mental health have proved useful, and tools such as POET²⁸ and 'Working together for change'³⁹ can help capture and use vital information about how well services are working.

Resources

- 49 Department of Health. **Transparency in outcomes: a framework for quality in adult social care**. 2011 www.dh.gov.uk



OUTCOMES

Myth

Health outcomes are often very specific and can't be integrated with other health outcomes or with social care

Response

An integrated approach to outcomes is an important component of the shift towards integration in health and social care. When a holistic approach is taken to a person's outcomes, all their outcomes become linked.

The lack of a shared view of outcomes across the system currently causes confusion and can create disincentives. For example, public health expenditure on a stop smoking service can accrue benefits to the NHS budget (eg if it leads to a person not contracting lung cancer), despite the origin of the initial expenditure. One of the main drivers for integrated personal budgets lies in the potential to remove this divide by putting the person at the centre. By taking a holistic view of people's lives, we can avoid imposing categories that are meaningless to people on their needs and aspirations.⁵⁰

The NHS Future Forum report recommends pulling together a basket of indicators from across the three outcomes frameworks (see above) to be used by health and wellbeing boards.⁵¹ At the level of individual outcomes,

a number of pilot sites have developed integrated approaches to personal care and support planning so that people don't have to create separate plans for the health and social care components of their budget. This involves people identifying the outcomes that are right for them with the support they need, regardless of whether they relate to health or social care. There will inevitably be overlaps, and good personal care and support planning should help identify these. Working from a single plan where people identify their own outcomes will help bring different parts of the system closer together.

Several pilot sites have been working alongside In Control to develop a process for understanding outcomes for personal health budget holders as an equivalent to the personal outcomes evaluation tool (POET) used in social care.^{28,29} It is striking that when starting from the person rather than the service, the information needed to understand people's outcomes is remarkably similar.

While some outcomes may require very specific measures that are not jointly owned, the more we can do to foster a shared understanding of outcomes across the system, the more effective integrated personal budgets will be.

Resources

- 50 Think Local Act Personal. **Changing lives together: using person-centred outcomes to measure results in social care.** 2010 www.thinklocalactpersonal.org.uk
- 51 NHS Future Forum. **Integration.** 2012 www.dh.gov.uk

Gateway Ref No. 18286

Personal health budgets team

Websites: www.personalhealthbudgets.dh.gov.uk/toolkit
www.nhs.uk/personalhealthbudgets

Email: personalhealthbudgets@dh.gsi.gov.uk

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