The cost of implementing personal health budgets

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Personal Health Budgets Evaluation

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Contents

1 Executive Summary

This third interim report explores the implementation process for personal health budgets by examining the financial costs. As the introduction of personal health budgets is likely to necessitate a major cultural change in the organisation and provision of health care, it is important to understand the costs involved to be able to inform the more general roll-out of the initiative after 2012.

Information was gathered to be able to provide an indication of likely implementation costs following national roll-out of the initiative. Information was collected on the following:

- Costs associated with the project management structure (for example, number of people involved on the board).
- Additional costs, coming from:
    - *Designing systems* (e.g. design of assessment and budget-setting);
    - *Workforce training* (e.g. initial training/involvement in design);
    - *Developing and supporting planning/brokerage (*for example, developing a private/voluntary sector role and developing marketing materials);
    - *Managing the market* (for example, developing a procurement and commissioning strategy, contract renegotiation, transitional arrangements).
- Ongoing costs and anticipated cost reductions as a result of implementing personal health budgets.
- Potential displacement of other activities as a result of the introduction of personal health budgets. To obtain this information, pilot sites were asked to report whether the level of resource was in addition to what would have been incurred without implementing personal health budgets.

In summary, pilot sites reported:

- After discounting costs that would have been incurred without personal health budgets and the resource associated with the pilot process (for example advertising the piloting of the personal health budget process) it was found that:
    - An overall average cost of £93,280 (median £81,680) within the first year would be required to implement the initiative. Following previous studies, such as the evaluation of partnerships for older people projects (Windle et al., 2009) it is assumed that as personal health budgets become more mainstream the level of resource required will be reduced.
    - The average cost of the project board was £52,760 (median £47,170) with an additional cost of £19,150 (median £9,220) for direct expenditure. The additional cost was associated with purchasing a brokerage service and setting up a direct payment service.

- Taking account of the project management board activities, an average additional cost of £45,660 (median £33,570) was reported to be required during the first year among 13 pilot sites. Within this additional resource, pilot sites reported on average[1]:
  - £37,600 (median £37,200) would be required to develop local systems;
  - £15,880 (median £9,220) to develop the workforce;
  - £21,850 (median £21,380) to develop the support planning process;
  - £13,550 for developing the market reported by one pilot site.

- Among pilot sites focusing on implementing personal health budgets among two or fewer health conditions was £95,290 (median £80,690), while the average cost among sites concentrating on more health conditions was £91,640 (median £82,670).

- London pilot sites reported that on average £111,570 (median £97,140) would be required during the first year, while sites within Metropolitan areas reported a lower overall average cost of £48,950 (median £44,440).

- Pilot sites anticipated ongoing costs associated with staff time, advocacy and the review panel. One site thought that the implementation of personal health budgets would lead to cost reductions within the project management structure, due to collaborative working with the local authority. Potentially, over time the process would be more efficient as staff become more familiar with the process as the use of personal health budgets is expanded.

- Twelve of the 18 pilot sites[2] thought that the project management resource would be required for two years to ensure successful implementation. Based on this assumption and timescale, taking account of the level of resource that would be incurred without implementing personal health budgets, an average cost of £146,040 would be required to implement the initiative within a two year time period. As personal health budgets become more mainstream, it is assumed that the level of resource required will be reduced.

The full evaluation will explore the effectiveness of the models and approaches used within the time-frame of the pilot. Specifically, it will explore whether there is a relationship between the reported set-up costs, outlined in this report, and changes in

[1] The costs below are an average for those sites that reported costs in these areas.
[2] Two pilot sites did not report the length of time required to implement personal health budgets.

outcomes for those receiving personal health budgets between baseline and 12 months. One hypothesis could be that pilot sites reporting higher set-up costs have better systems in place to support individuals through the personal health budget process. Furthermore, we would expect variations in reported costs according to the number of personal health budgets allocated (with reducing costs per budget).

2 Introduction

The piloting of personal health budgets is seen as a key feature of the personalisation agenda for health care in England, with the ethos around creating a more patient-centred, responsive NHS (Department of Health, 2009). The potential of personal health budgets was reinforced in the 2010 White Paper *Equity and Excellence – Liberating the NHS* which highlighted that the initiative would promote patient involvement and choice. This emphasis was reaffirmed by Paul Burstow, Minister of State for Care Services, at a personal health budgets conference in 2010:

"Personal budgets encapsulate what we represent. Our single, radical aim. To change the relationship between the citizen and the state. To do less to people, and more with them. And to ensure Government steps back, making the space for people to lead the lives they want, how they want to. In health and social care, that means giving people real choice over their treatment; real control over how money is spent; and real power to hold services to account. Put the patient first. Spend less time looking upwards to Whitehall, and much more looking outwards to the people you serve. And deliver what they need as people not just as patients. The human side, not just the clinical side. Personal health budgets can help us achieve this".

The Government response to the NHS Future Forum report reiterated support for the concept of personal health budgets:

"We will extend personal health budgets as a priority, subject to evidence from the current pilots".

The personal health budget pilot will give individuals more choice about the care and services they receive, through giving them more control over the money that is spent on their health care needs. After an initial assessment, an individual is given a transparent resource to purchase services and care that meets their desired outcomes. There are three different ways that this resource can be delivered (or potentially a combination of them): a notional budget; a third-party budget; a direct payment (in approved pilot sites, once local processes are in place).

The introduction of personal health budgets is likely to necessitate a major cultural change in the organisation and provision of health care, and it is important to understand the costs involved. The 2010 White Paper *Equity and Excellence – Liberating the NHS*, and the Government response to the NHS Future Forum report, outlined that the Government will use the results from the evaluation of the personal health budget pilot programme to inform a wider, more general roll-out of the initiative after 2012. However, for a national roll-out to be successful, it is essential that adequate funding is made available.

2.1 Personal health budget pilot programme

In 2009 the Department of Health invited PCTs to become pilot sites and to join a three-year programme which will explore the opportunities offered by personal health budgets; and an independent evaluation was commissioned. The evaluation runs alongside the pilot programme to provide information on how personal health budgets are best implemented, where and when they are most appropriate and what support is required for individuals. In addition, the wider organisational impact on the health system of personal health budgets will be explored.

Sixty-four PCTs are currently involved in piloting personal health budgets and are contributing to the evaluation. Twenty sites from all the pilots were selected to be in-depth evaluation sites, with the remainder being wider cohort sites. The twenty in-depth pilot sites each receives funding of £100,000 per year (three years in total) to ensure that the requirements of the evaluation are met. The wider cohort receive lower levels of funding per year as the evaluation demands are less onerous to them.

2.2 The national evaluation

The in-depth evaluation across the 20 selected sites focuses on individuals with the following health conditions: long-term conditions (including chronic obstructive pulmonary disease (COPD), diabetes and long-term neurological conditions); mental ill-health issues; NHS Continuing Healthcare; and stroke. In addition, the evaluation will explore whether personal health budgets have an impact on two specialist services: maternity and end of life care.

The over-arching aim of the evaluation is to identify whether personal health budgets ensure better health and social care outcomes when compared to conventional service delivery and, if so, the best way they should be implemented (for full details go to www.phbe.org.uk). Part of this evaluation is to inform the national roll-out of personal health budgets, by identifying the conditions for which personal health budgets are most appropriate and how they should be implemented. This particular report analyses the level of resource used by the pilot sites, to give an indication as to what would be needed by another authority to implement personal health budgets in their locality.

This report describes our best estimates of the cost of implementing personal health budgets across the twenty in-depth pilot sites. The report begins by outlining the approach adopted to estimate set-up costs, followed by a description of the results for the first year of implementation and likely subsequent set-up costs. We end by discussing the anticipated cost implications for mainstream implementation of personal health budgets after 2012.

3 Caveat

We must stress that there are caveats to all the presented cost estimates. We have identified the range of factors that might affect costs but readers must be careful in making

interpretations, owing to the limited number of cases that can be drawn on. In addition, we would expect the set-up costs of introducing personal health budgets will vary. Some areas will have information and administrative systems that are more easily adapted to the needs of personal health budgets than others. Where pilot sites have been approved to offer the direct payment deployment option, the reported costs would be dependent on the degree to which support processes can be easily adapted and, to the extent that they draw on partnership arrangements with their local authority. It is assumed that lower costs may be reported if there is full 'back-office' integration between health and social care processes.

4 Methods

A set-up cost template was circulated to each project lead in the 20 in-depth pilot sites in November 2010, 12 months after the start of the evaluation. Such timing of the data collection allowed pilot sites to sufficiently adjust their internal systems to be able to estimate resources required for national roll-out. To ensure an adequate reflection on the resource associated with implementing personal health budget, pilot sites were asked to provide costs associated with adapting and developing their internal systems rather than reporting on the resource associated with the pilot process. Table 4-1 describes the 20 pilot sites.

Table 4-1. Characteristics of pilot sites

PCT	Type of local authority	Health condition initially chosen for the personal health pilot
1	Metropolitan	Mental health; NHS Continuing Healthcare
2	London	COPD; Diabetes
3	Unitary	COPD; Diabetes; Long-term neurological; NHS Continuing Healthcare; End of Life
4	Unitary	COPD; Diabetes; Mental Health
5	Shire	NHS Continuing Healthcare
6	Shire	Mental Health; NHS Continuing Healthcare; End of life; Maternity
7	Shire	Long-term neurological; NHS Continuing healthcare; Stroke
8	London	COPD; Diabetes; Stroke
9	Shire	COPD; Long-term neurological; NHS Continuing Healthcare; End of Life
10	Unitary	COPD; Long-term neurological; Mental health; Stroke
11	Unitary	COPD; Long-term neurological; NHS Continuing Healthcare
12	Metropolitan	COPD; Diabetes
13	Unitary	Long-term neurological; Mental health; NHS Continuing Healthcare
14	Shire	COPD; Long-term neurological; Mental health; NHS Continuing Healthcare
15	Unitary	Long-term neurological; Mental health
16	Unitary	Stroke; NHS Continuing Healthcare
17	Metropolitan	Mental health
18	Metropolitan	NHS Continuing Healthcare
19	Unitary	Long-term neurological; Stroke
20	London	COPD; Diabetes; Long-term neurological; NHS Continuing Healthcare; Stroke

Following Knapp and Beecham, (1990) a bottom-up approach was used, to provide a detailed account of the resources associated with specific aspects of implementing personal health budgets.

Set-up costs

Participants were asked first to describe the overarching project-management structure required to implement personal health budgets. The following information was requested:

- Number of people and proportion of their time;
- Grade and/or salary level of these posts;
- Length of time for which the posts/time would be required (for example, six months, a year, two years);
- Where available, the cost of overheads to staff time (for example, human resource and finance departmental costs);
- Direct expenditure identified (for example, expenditure on IT equipment, training or contracting out such tasks).

The overall management costs would cover a variety of activities. In order to ensure that we had fully covered all set up costs, after accounting for the overall management structure, pilot sites were asked to identify any additional resources required to implement personal health budgets. Information about costs associated with the following areas was requested:

- *Designing systems* (for example, assessment, setting budgets, support planning, review, financial administration and information system set up);
- *Workforce training* (for example, initial training/involvement in design);
- *Developing support planning/brokerage* (for example, peer support, developing a private/voluntary sector role and developing marketing materials for in-house services);
- *Managing the market* (for example, developing a procurement and commissioning strategy, contract renegotiation, transitional arrangements).

Ongoing costs and cost reductions

It was very early for pilot sites to identify ongoing costs, and cost reductions, as a result of implementing personal health budgets, but they were best placed to speculate on the basis of their experience.

Pilot sites were asked whether their on-going costs were in addition to what would have been incurred without implementing personal health budgets. They were also asked to report on whether the implementation of the initiative had displaced other activities within their locality.

Displacement of activities

Activities outside of the pilot could potentially have been displaced and therefore the cost incurred would not be additional to what would have been incurred without personal health

budgets. Pilot sites were asked to provide information as to whether the costs reported would have been incurred without implementing the initiative.

All quantitative analysis was carried out by using STATA 10 statistical software package and descriptive results reported; parametric tests could not be performed owing to the small sample size. We initially report the overall average resource required to implement personal health budgets.

5 Results

5.1 Future roll-out of personal health budgets

Pilot sites were initially asked whether, based on their experience, they would offer personal health budgets to specific groups of patients, or roll-out wholesale across all patients. Fifteen sites reported that they would introduce the initiative to specific patient groups, whilst four reported that they would offer personal health budgets to all patients. While one pilot site did not know what approach they would use in the future, another area thought that the approach would be dependent on the operational guidance for implementing personal health budgets.

5.2 Overall costs

The majority of pilot sites reported that at least one year was required to implement personal health budgets. The average overhead cost, supplied by eight PCTs, was 23 per cent of salary costs among organisational representatives implementing personal health budgets. Where pilot sites did not report the percentage to cover overheads, 23 per cent was added to their reported costs.

Excluding costs that would have been incurred without personal health budgets and the resource associated with the pilot process, pilot sites reported an average implementation cost of £93,280 (median £81,680; standard deviation £42,760; range between £35,000 and £173,750). Fourteen pilot sites reported below £100,000 was required to implement personal health budgets, over and above what would have been incurred without piloting the initiative (range between £35,000 and £97,140). Following previous studies, such as the evaluation of partnerships for older people projects (Windle et al., 2009) it is assumed that as personal health budgets become more mainstream the level of resource required will be reduced. For example, Windle et al., (2009) reported a median cost in the first year of £62,638 per person which reduced to £170 in the third year. Initial work with pilot sites suggests that expansion to additional sites will be cheaper than the initial set-up.

5.3 Project Management Team

Table 5-1 shows that after discounting all costs that would have been incurred without personal health budgets and the resource associated with the pilot process, sites reported an average project management cost of £52,760 (median £47,170; standard deviation £33,720; ranging

from £0 to £128,180). Two pilot sites thought that the management structure was not in addition to what would have been incurred without personal health budgets.

Table 5-1. Overall direct expenditure from the project board

	Mean	Median	Standard deviation	Min	Max
Overall resource					
Overall cost	146,800	126,890	54,630	91,560	258,300
Project management	100,900	98,110	40,250	45,920	208,460
Costs associated with implementing personal health budgets					
Overall cost	93,280	81,680	42,760	35,000	173,750
Project management	52,760	47,170	33,720	0	128,180

Table 5-2 shows that once the salary costs had been taken into account, 12 pilot sites reported that on average, the project board spent an additional £19,150 (median £9,220; standard deviation £23,190; ranging from £580 to £75,500). All costs associated with the pilot process were removed. Owing to the large variation in costs, the median of £9,220 may be considered a more valid level of expenditure. The maximum additional cost of £75,500 included resources for a carer support service and direct payment service.

Table 5-2. Overall direct expenditure from the project board

	Obs	Mean	Median	Standard deviation	Min	Max
Overall additional expenditure	12	19,150	9,220	23,190	580	75,500
Specific activities						
Brokerage service	5	32,000	40,000	16,880	12,580	48,000
Direct payment service	4	4,090	3,520	2,050	2,500	6,820
Emergency carer support	1	22,500	-	-	-	-
Premises/office costs	9	3,600	3,750	2,230	580	6,500

Within the direct expenditure of the project board, five pilot sites reported that on average £32,000 (median £40,000; standard deviation £16,880; ranging from £12,580 to £48,000) was spent on a brokerage service, while four sites reported that £4,090 had been spent on a direct payment service (median £3,520; standard deviation £2,050; ranging from £2,500 to £6,820). Nine sites reported that on average £3,600 (median £3,750; standard deviation £2,230; ranging from £580 to £6,500) was spent on office related costs such as room hire, stationery and premises.

It was consistently reported that the project management boards would be involved in all four areas of adapting the systems and processes to implement personal health budgets:

- Design of system;
- Workforce development;
- Support planning/brokerage;
- Market development.

However, there was less consistency around the percentage of time the project board would spend on such activities which ranged from 2 to 100 per cent. As confidence and comfort with the process grows, the percentage of time required by the project board is likely to fall. Only five sites reported that the project board had displaced an existing resource in their PCT. One site reported that there would be a cost reduction as a result of the project board which was due to collaborative working with the local authority.

Once the cost of the project management team was taken into account and the resource associated with the pilot process, 16 pilot sites reported that an average additional resource of £53,070 (median £40,790; standard deviation £45,880; ranging from £390 to £150,000) was needed to implement personal health budgets during the first year. Some members of the project management board would have been moved from other activities and therefore their salary would not be an additional resource to the pilot site. Taking account of the level of resource that would be incurred without implementing personal health budgets, a mean cost of £45,660 (median £33,570) was reported among 13 pilot sites.

Within this resource there were four aspects of implementation: development of systems; workforce development; development of support planning and brokerage; and market management.

5.4 Development of systems

To be able to effectively implement the initiative, the local systems need to be adapted to the needs of personal health budgets. The project management teams undertook some development work, but often additional costs were incurred over and above the project management activity and what would have been incurred without personal health budgets.

Table 5-3 also shows that after pilot sites took account of what would have been incurred without implementing personal health budgets, the average cost reduced slightly to £37,600 (median £37,200). Within this sample, two pilot sites reported that £10,580 would be required to develop the assessment process. Five pilot sites reported that an additional £25,070 would be required for the development of the support planning process, while five sites indicated that an additional £5,540 would be needed to develop the financial process.

Table 5-3. Overall additional resource for the development of systems

	Overall resource						Costs associated with implementing personal health budgets					
	Obs	Mean	Median	SD	Min	Max	Obs	Mean	Median	SD	Min	Max
Overall additional expenditure	10	38,980	37,200	22,220	13,130	75,200	8	37,600	37,200	19,050	16,250	70,550
Specific development of:												
Assessment process	4	19,820	13,760	7,120	6,750	45,000	2	10,580	-	5,410	6750	14,400
Budget-setting	3	4,240	3,310	2,720	2,110	7,300	3	4,240	3,310	2,720	2,110	7,300
Support planning	6	21,310	13,880	24,280	2,530	67,940	5	25,070	21,000	25,360	5,520	67,940
Review process	4	5,300	5,880	2,040	2,530	6,930	3	6,230	6,750	1,070	5,000	6,930
Financial administration	7	6,110	5,050	5,420	390	15,000	5	5,540	1,860	6,290	390	15,000
Information set-up	6	6,870	2,570	8,220	580	18,500	5	7,640	2,110	8,940	580	18,500

5.5 Workforce development

Personal health budgets require a significant cultural change within the workforce that must go beyond simple training sessions and workshops. Consistently, such training and development activities were part of the responsibility of the management team in some areas, but pilot sites also reported a specific additional resource that would have incurred without personal health budgets. Eleven pilot sites reported that on average £13,050 would be required to meet the training needs of the workforce (median £7,400). Out of these 11 sites, eight reported an average mean cost of £15,880 that was additional to what would have incurred without personal health budgets (median £9,220).

5.6 Support planning and brokerage

An important element of implementing personal health budgets is to ensure that there is adequate support planning and brokerage. Where this works well, it enables individuals and their families to be more involved in planning the support that meets the needs identified in the support plan, rather than relying on the PCT's own local processes. This is clearly, therefore, key to the implementation of personalisation and personal health budgets. The reported costs are in addition to the resource reported for a brokerage service included in the direct expenditure of the project board. Table 5-4 indicates that six pilot sites reported a mean cost of £21,850 (median £21,380) to cover the development of support planning and brokerage that was in addition to what would have been incurred without personal health budgets. Two pilot sites reported a mean cost of £11,600 to publicise materials for in-house services, which was viewed as an additional cost that would have been incurred without personal health budgets.

Setting up a peer-support system was seen to be an important aspect of this process in three pilot sites which reported that on average £13,650 would be required, while four other sites reported that an additional £5,910 (median £5,500) would be needed to develop the private and voluntary sector. Both reported costs were viewed as additional to what would have been incurred without implementing personal health budgets.

Table 5-4. Additional resource for support planning

	Overall additional resource						Costs associated with implementing personal health budgets					
	Obs	Mean	Median	SD	Min	Max	Obs	Mean	Median	SD	Min	Max
Overall additional expenditure	8	18,470	13,450	15,770	2,220	43,330	6	21,850	21,380	16,730	2,220	43,330
Specific development of:												
Peer support	3	13,650	3,000	19,010	2,350	35,590	3	13,650	3,000	19,010	2,350	35,590
Private and voluntary sector	4	5,910	5,500	3,720	2,220	10,420	4	5,910	5,500	3,720	2,220	10,420
Marketing materials for in-house services	3	8,570	3,600	9,560	2,530	19,600	2	11,600	-	11,320	3,600	19,600

5.7 Market management

The implementation of personal health budgets may well result in additional costs being incurred by commissioning authorities, in order to change contracts and make necessary arrangements for the transitional process. However, only three pilot sites reported additional costs for this, with the average of the three being £5,750 (see Table 5-5). The few sites reporting this as a cost could be as a result of the timing of the information gathering, which is still relatively early within the pilot process. One pilot site reported the resource of £13,550 would be in addition to what would have been incurred without personal health budgets.

5.8 Variation in set-up costs

There are many factors that could have an impact on costs associated with implementing personal health budgets after removing all resources linked to the pilot process, such as the result of local implementation and sites' relative starting positions in instigating personalisation more generally in their locality. We would also expect that size, type and location of commissioning authorities would be influential, but owing to the small number of pilot sites and the variety of approaches being adopted, it was not possible to separate out such effects. However, Table 5-6 shows that the average set-up cost among pilot sites focusing on implementing personal health budgets among two or fewer health conditions was £95,290 (median £80,690), while the average cost among sites concentrating on more health conditions was £91,640 (median £82,670). This level of resource was in addition to what would have been incurred without personal health budgets.

When the resource that would have been incurred without implementing personal health budgets was taken into account, it was reported among pilot sites within London authorities that an additional £111,570 (median £97,140) would be required during the first year, while sites within Metropolitan areas reported a lower overall average cost (£48,950).

Table 5-5. Additional resource for market development

	Overall additional resource						Costs associated with implementing personal health budgets					
	Obs	Mean	Median	SD	Min	Max	Obs	Mean	Median	SD	Min	Max
Overall additional expenditure	3	5,750	2,190	6,770	1,500	13,550	1	13,550	-	-	-	-
Specific development of:												
Procurement	2	2,580	-	1,580	1,460	3,700	1	3,700	-	-	-	-
Contract re-negotiation	2	2,430	-	2,920	370	4,500	1	4,500	-	-	-	-
Transitional arrangements	2	2,860	-	3,530	370	5,350	1	5,350	-	-	-	-

Table 5-6. Variation in set-up costs

	Overall cost to implement personal health budgets						Costs associated with implementing personal health budgets					
	Obs	Mean	Median	SD	Min	Max	Obs	Mean	Median	SD	Min	Max
Number of health conditions												
2 or less	9	160,240	141,400	59,570	91,710	258,300	9	95,290	80,690	53,060	35,000	170,000
3 or more	11	135,810	119,070	50,360	96,560	248,100	11	91,640	82,670	34,670	45,660	173,750
Authority Type												
Metropolitan	4	118,700	120,850	20,750	91,710	141,400	4	48,950	44,440	16,890	35,000	71,960
Unitary	8	143,390	129,430	51,030	91,560	232,280	8	101,640	82,860	33,210	78,950	169,260
London	3	155,380	110,700	89,390	97,140	258,300	3	111,570	97,140	52,720	67,570	170,000
Shire	5	169,590	162,630	61,510	96,160	248,100	5	104,400	96,160	51,410	45,660	173,750

5.9 Ongoing costs or savings

It could be assumed that there will be on-going costs and cost reductions as a direct result of implementing personal health budgets. Four pilot sites reported that they anticipated a cost reduction in terms of assessment and support planning as a result of introducing personal health budgets in their locality. When people either manage their own support planning or go to external agencies, there is, at least theoretically, less demand on staff time, but it will take some time before such 'savings' could be realised in practice. One site thought that the implementation of personal health budgets would lead to cost reductions within the project management structure, due to collaborative working with the local authority.

Nine pilot sites reported on-going costs in terms of staff time, advocacy costs and the use of review panels. Potentially, the process would become more efficient over time as staff become more familiar with it.

5.10 Costs for the second year

Twelve of the 18 pilot sites thought that the project management resource would be required for two years to ensure successful implementation. Taking account of the level of resource of resource that would be incurred without implementing personal health budgets, an average cost of £146,040 would be required to implement the initiative within this two year period. As personal health budgets become more mainstream, it is assumed that the level of resource required will be reduced.

6 Conclusion

For the national roll-out of personal health budgets, outlined in both the 2010 White paper *Equity and Excellence-Liberating the NHS* and the Government response to the Future Forum report, it is essential to have an understanding of the costs associated with implementing the initiative. However, estimating set-up costs is always problematic, as the costs incurred rarely reflect the resource implications of implementing a previously piloted intervention. In addition, due to the small sample and the large variation in costs, care is required when interpreting the level of resource required. However, while there are caveats around the costs reported in this report, pilot sites are in the best position to provide estimates of the resource required to implement personal health budgets.

On average, sites reported that £93,280 would be required during the first year of the implementation of personal health budgets which was viewed as additional to what would have been incurred without being a pilot site. It was consistently reported that the project board would be required for two years in order to effectively introduce personal health budgets. Taking account of the activities within the PCT that would have been displaced, an average cost of £146,040 would be required to implement the initiative over a two year period. Following previous studies, such as the evaluation of partnerships for older people projects (Windle et al., 2009) it is assumed that as personal health budgets become more

mainstream the level of resource required will be reduced. It is planned to repeat the data collection in the evaluation of personal health budgets pilot programme in November 2011 to explore the accurate level of resource required during the second year of implementing personal health budgets. This additional data collection will also explore whether the level of integration of both social and health care systems would reduce the level of resource required for implementation. As reported earlier in the report, the implementation of personal health budgets may well result in additional costs being incurred to change existing contracts. However, within the current data collection very few sites reported additional costs for this aspect of implementation. The additional cost data collection could highlight a more accurate reflection of the resource required for this transitional process.

The full evaluation will explore the effectiveness of the models and approaches used within the time-frame of the pilot. Specifically, it will explore whether there is a relationship between the reported set-up costs, outlined in this report, and changes in outcomes for those receiving personal health budgets between baseline and 12 months. One hypothesis could be that pilot sites reporting higher set-up costs have better systems in place to support individuals through the personal health budget process. Furthermore, we would expect variations in reported costs according to the number of personal health budgets allocated (with reducing costs per budget).

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