NHS Rotherham Clinical Commissioning Group

Personal Health Budgets

Lead Executive:	Keely Firth, Chief Finance Officer
Lead Officer	Sarah Lever, Head of Contracting and Service Improvement
Lead GP:	Richard Cullen

Purpose:

To update RCCG Governing Body on the CCG's readiness to offer personal health budgets (PHB) to patients in receipt of Continuing Healthcare (CHC) from 1 April 2014.

Background:

A PHB 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. The Government's 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.

From 1 April, 2014, CHC patients in the community will have a right to request a PHB and from 1 October 2014, the right to have a PHB. It is expected that the roll out of PHBs will be extended to all patients with a long term condition in future years.

There are a range of ways in which a PHB can be offered:

1. **Direct payment** – an amount of money calculated to meet patients' healthcare needs is transferred into a bank account set up specifically for the direct payment. Patients use this money to purchase care to meet their needs. Patients are responsible for the employment of staff.

2. **3rd party management** – An organisation legally independent of both the person and the NHS holds some or all of the money on the person's behalf, and supports the person to achieve the outcomes agreed in the plan.

3. **Notional budget** - Money is held by the NHS but the person has a clear understanding of the amount of money allocated for their care. The NHS arranges and pays for the services through its contracting processes with providers. There are key differences to the way in which CHC packages have historically been commissioned. The patient has knowledge of their budget and supported by a robust care planning process with specified outcomes, discussions take place with the patient and family around how they would like care to be commissioned to meet those needs.

A PHB cannot be used for:

- Tobacco, Alcohol, debt repayments or gambling
- Primary care services that can be provided by a GP
- Care services that can be provided by Commuinity Nursing services
- Acute Hospital care, including A&E

2013/14 pilot

The continuing healthcare service is delivered by the West Yorkshire and South Yorkshire and Bassetlaw Commissioning Support Unit (CSU). The CCG is working in partnership with the CSU and RMBC to implement PHBs. The CCG was granted pilot status by the Department of Health in 2013 to offer direct payments.

40 patients received a PHB via a direct payment/third part managed arrangement for Continuing Healthcare in 2013/14. 31 patients were in receipt of a direct payment at the end of January 2014, 18 of which were direct payments and 13 were via third party arrangements.

All patients use the majority of the budget to provide for their personal care needs and access to the community.

- 10 patients employ their own staff to assist with their need
- 12 patients employ the services of a care /nursing agency to meet their needs

- 9 patients use a combination of both personal assistants and agency.
- 3 patients utilise flexible respite care

The CCG has used the pilot to:

- Explore options for delivering PHBs
- Examine the risks and benefits to delivery including the financial implications

Analysis of key issues and of risks

1. Options for delivery

The CHC service is commissioned from the CSU. Where the NHS holds the budget for a patient (a notional budget), the PHB will be managed by the CHC team working collaboratively with a PHB advisor in the CSU. Where a patient is suitable for a direct payment/third party managed PHB, there are three options for the CCG:

1. To commission a PHB service from RMBC (preferred option)
2. To develop a service internally
3. To commission a service from an alternative provider

Commissioning this service from RMBC is the preferred option for 2014/15. RMBC has been offering its clients PHBs via direct payments and third party arrangements since 2008 and has 1000 service users. RMBC sets up, administers, arranges payments, monitors and audits utilisation. Lead officers for the CCG and the CSU have spent time working with RMBC to understand the systems and processes it has in place and are confident of the robustness of the systems and processes in place (presented to the governing body in October). There are also benefits for patients already in receipt of direct payments for social care when their eligibility changes to CHC and vice versa. We say more about the financial implications below.

2. Efficacy and Cost Effectiveness

Evidence from the Department of Health's evaluation showed that personal health budgets had a significant positive impact on care related quality of life and psychological wellbeing and this finding accords with several international studies. Personal health budgets have not been shown to have a significant impact on clinical outcomes or health related quality of life.

With respect to costs, the evaluation showed that A&E and inpatient costs were lower for patients in receipt of PHBs however total costs were not lower. This was in part due to the challenges around decommissioning services and PHBs were offered in addition to existing services. The CCG does not have the same information for Rotherham patients however the findings from the national evaluation contain important lessons for RCCG's commissioning strategy.

3. Embedding personalisation into practice

Training is required to ensure patients are informed of their right to request and have a PHB from 1 April. More work is needed to offer notional personal health budgets to CHC patients. A training schedule has been agreed with the CSU.

4. Governance

- *Policies and procedures*

RMBC has robust policies and procedures in place which were shared with the governing body in October:(http://www.rotherhamccg.nhs.uk/Downloads/Governing%20Body%20Papers/October%202013/Enc%206%20Personal%20Health%20Budgets.pdf.) Discussions are taking place between the CCG and RMBC as to how clinical oversight could be incorporated into the policies.

- *Safeguarding and risk*

There are concerns that PHBs place people at greater risk than conventionally commissioned services, in part as clinicians would be likely to make different decisions about patients care. All care plans are overseen by the Continuing Healthcare team to ensure that they are clinically and financially sound. It is also noted that where individuals employ their own staff, there tends to be a higher level of trust than conventional provision of care, thereby reducing risk.

The overall findings to date show that patient satisfaction of the pilot is high. There have been no safeguarding issues noted to date in the pilot cohort of patients.

- Fraud

  Drawing from evidence of personal budgets in social care, there is little evidence of fraud and abuse (Nuffield Trust, 2013). The specific controls which RMBC has in place to mitigate this risk were shared with governing body in October.

5. Contractual arrangements with providers

As the personalisation agenda is rolled out, the CCG will review its the payment mechanisms for community services to ensure that where patients choose alternative services over commissioned services, the CCG does not pay twice.

Where commissioned services are no longer required we will seek to decommission services without destabilising existing providers.

There is potential for a much wider range of providers which require the appropriate oversight to ensure quality requirements are being achieved.

6. Next steps

1. Roll out of training to offer PHBs to all patients in receipt of a domiciliary CHC package by 1 October, including notional budgets
2. Monitoring the impact of PHB roll out on expenditure
3. Stakeholder development sessions to build strong partnerships between RMBC, RCCG and CSU colleagues
4. Development of a SLA with RMBC, subject to agreement of a final price.

Patient, Public and Stakeholder Involvement:

Key stakeholders include CCG colleagues, RMBC and CSU and there is an acknowledgement that this is the required direction of travel.

RCCG has engaged with patients offered a PHB through the pilot to gather feedback. A survey was sent out in the late Autumn of 2013 and feedback is being collated.

Equality Impact:

A full equality diversity impact assessment was undertaken on 30 May 2012 in relation to this project.

Financial Implications:

From 1 April, in the region of £5,000,000 current CHC expenditure could be offered as a PHB The current pilot totals £1.4m pa.

The average monthly cost of these packages is £3,838. This compares to an average monthly cost of conventional CHC packages of £3,334 and £3,144 in 2012/13 and 2013/14 respectively however it is not possible to make a direct comparison as PHBs have been targeted at high cost packages of care.

Further work is required to develop the resource allocation system eg 24 hour grids to ensure that the indicative budget for the PHB is commensurate with need. This is a key action for controlling financial expenditure across continuing healthcare, not PHB alone.

Savings in care package costs

Lessons from the pilot health sites indicate that there is little or no change to the cost suggesting that the overall financial risk to the CCG will be low. It will be important to ensure that changes to contracts take place and appropriate resource allocation tools are employed.

Costs of external administration of the process

We are currently in discussions for the provision of the service with RMBC patients who would receive a PHB via a direct payment/third party arrangement. RCCG currently pays £30,000 for delivery of the service during the pilot period and costs to deliver the service long term are being negotiated. For RCCG to do this alone, it would require a much higher level of resource than currently being utilised as there would be infrastructure costs involved.

Potential liability for redundancy

There is a risk of employment liabilities to the CCG and this has been highlighted by a recent employment tribunal. To mitigate this risk, payments for insurance premiums to protect the patient from claims are incorporated into payment arrangements and monitored to ensure these are purchased by patients and service users. RMBC has audit processes in place to ensure compliance.

Human Resource Implications:

If the CCG procures a service from an external provider, there will be no HR implications.

Procurement:

There are no procurement requirements of the CCG. The CSU will be asked to sub contract the admin element to our preferred provider to optimise the opportunity to integrate with social care for the benefit of patients. The value is within delegated limits.

Recommendations:

1. Note the progress in establishing the systems and processes to implement personal health budgets and ongoing work to meet the CCG's obligations from 1 April 2014;
2. Approve the development of an SLA with RMBC to support the PHB agenda through direct payments, subject to agreement of a final price;
3. Note the financial implications in particular:
    - The costs of the service level agreement are to be determined
    - The low risk of increased expenditure for CHC packages and the controls in place to mitigate this
4. Note the controls in place to mitigate against the risk of probity issues;
5. Note the next steps.