Personal Health Budgets

Governing Body meeting

Item 10d

6 November 2014

Author(s)	Chris Lomas, Quality Manager, Continuing Healthcare, Support at Home
Sponsor	Kevin Clifford, Chief Nurse

Is your report for Approval / Consideration / Noting

This report is to note the process for the implementation of Personal Health Budgets.

Are there any Resource Implications (including Financial, Staffing etc)?

There are costs that will be incurred through the contracts that will be entered into with partners in the CSU and the Local Authority. An estimate of these is detailed in the report and this will be financed from within the existing Continuing Healthcare budget.

Audit Requirement

CCG Objectives

2.1 Providers delivering poor quality care and not meeting quality targets (Domain 4)

This paper supports the CCG requirement to implement "Right to Have" Personal Health Budgets for all those in receipt of Continuing Healthcare from 1 October 2014.

Equality impact assessment

Have you carried out an Equality Impact Assessment and is it attached? YES

If not, why not?

PPE Activity

The implementation plan described in the paper details the level of support and information that will be available to patients, carers and the public.

Recommendations

The Governing Body is asked to note the recommendations made in this paper.

NHS
Sheffield
Clinical Commissioning Group

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1. Introduction / Background

1.1 This paper describes the proposed plan for implementing Personal Health Budgets (PHB) for patients eligible for Continuing Health Care (CHC), in accordance with the Clinical Commissioning Group (CCG) requirement to implement the "Right to Have" from the 1st October 2014.

1.2 The plan outlined in this paper will accord with the current principles set out in the CCG CHC Policy on the Commissioning of Care but this guidance will be updated to reflect the changes in practice required for the implementation of PHBs.

1.3 The plan is described in this paper as a model with various components and highlights the areas where an integrated approach and partnership working, with the Local Authority and the Commissioning Support Unit (CSU), is recommended.

1.4 Discussions with these partner agencies are still on-going around the potential costs that this integrated approach will incur to the CCG and contracts will be finalised once approval have been given. An estimated cost of procuring support through both the LA and CSU is £59,289.88 and £19,350 respectively, making a total estimate of £78,639.88 for the first year. These figures, based on assumptions around numbers of service users wanting PHBs, are explained further in sections 3.2 and 3.3.

1.5 The proposed model is for patients who indicate they would like a PHB in the form of a Direct Payment for Healthcare or a Managed Account. For patients who only express interest in a Notional Budget, a simple process for this is described in section 3.8 of this paper.

1.6 This paper focuses mainly on PHBs for adults eligible for CHC. The implementation plan for Children, who are eligible for continuing care, whose parents or carers have requested a personal budget, is outlined in section 3.11 to 3.18 of this paper.

1.7 The CHC nurses will continue to have lead responsibility for their patients eligible for CHC who wish to have a PHB, and will ensure that their care provision meets the individual's reasonable requirements. This principle of case management underpins every level of the proposed model.

2. The Model

2.1 **Patient Requests PHB** –

When a patient requests a PHB (in the form of a Direct Payment for Healthcare or a Managed Account) the CHC nurse will determine their suitability for this, in terms of whether they would benefit from this. PHBs will not be suitable for all CHC funded patients, however for the majority of patients receiving support at home it should be

possible for their health and well-being outcomes to be achieved through a PHB, if this is their choice.

2.2 There may be exceptional circumstances however where a PHB is considered to be an inappropriate way of securing NHS care for an individual. This could be because a PHB would not represent value for money as any additional benefits to the individual would not outweigh the extra cost to the NHS. PHBs are also unlikely to be suitable for patients requiring end-of-life care. A policy will be drafted and regularly updated to reflect the CCG's developing position and inform decisions on the use of PHBs and their suitability for different scenarios.

2.3 In cases where the CHC nurse feels a requested PHB is not appropriate and this may be contentious, the decision could be examined and endorsed if appropriate, through the current panel structure.

2.4 In cases where the CHC nurse supports the patient's request for a PHB, the nurse will ensure that the patient's immediate healthcare needs are appropriately met through our existing commissioned domiciliary care provision.

2.5 **Calculating the Indicative Budget**

The CHC nurse will then calculate the cost of this care using the existing process, which identifies the tasks and daily hours required to meet the individual's reasonable requirements. We propose to use this process as a recognised "ready-reckoner" model for calculating an indicative budget, and this information will be then shared with the patient and their chosen support planner. They will be advised that the CCG expects that their identified health and well-being outcomes will be met within this indicative budget.

2.6 Where the indicative budget is higher than the current equivalent nursing home rate, in accordance with current practices, this will be referred to Resource panel for agreement in principle, before the individual is informed of the amount of indicative budget available to them.

2.7 Once agreed, the CHC nurse will make a referral to the PHB advisor in the CSU, to start the process of PHB implementation. The patient and the PHB advisor will be informed of the amount of indicative budget that is available to them by the CHC Nurse.

2.8 **Role of PHB Advisor – CSU**

CCGs must make arrangements to provide the person, their representative, family or carer with information, advice and other support, at every stage of the process. The evaluation of the NHS PHB pilot programme clearly demonstrated that having access to the right information and support is key to an individual being able to achieve good outcomes with a PHB.

2.9 The CSU have been working on pilot sites across the region undertaking this supportive role, and in April 2013 they established a PHB team who have developed expertise in this area through their work with 11 other regional CCGs. Although a Direct Payment Advisory team has agreement to be established in principle within the Local Authority, this will not be in place or operational until early 2015.

2.10 The CSU have PHB advisors already in place who would be able to start working with our patients immediately when the CHC nurse agrees that a PHB is suitable. We have developed a Flexible Support Service model, attached in appendix

1, to which the CSU is currently apportioning costs, which we can then enter into a formal contractual arrangement over.

2.11 The model has 3 levels, and it is envisaged that every patient requesting a PHB will receive an initial visit from the PHB advisor; unless the CHC nurse is satisfied that they already have access to other appropriate support through other means. Progression beyond level 1 of the model will be determined by the CHC nurse who will consider the appropriateness and necessity for this, following feedback from the PHB advisor's initial visit and in accordance with the individual's wishes. For some patients they may choose for their additional support to be provided from elsewhere, and we envisage that the PHB advisor will make the patient fully aware of all of their choices around the type of PHB they may wish to have, and then all of their options for further support. This will involve informing them and signposting where appropriate to the Local Authority's Recognised Provider List, which details all of the support planning organisations and money management agents in the locality. All of the organisations on the list are quality assured through Sheffield City Council's Contracts and Commissioning Service, and this advice and signposting will enable the patient to have choice and control over how they wish to proceed with their PHB.

2.12 If however, the patient chooses to proceed with a PHB and would like the CSU PHB advisor to continue to support them and assist them with developing their care plan (support plan), then they will progress to Level 2 of the model, after this has been agreed by the CHC nurse. If the patient wishes to only have a notional budget after the Level 1 visit, then there would no requirement for further support from CSU PHB advisor.

2.13 To complete Level 2 of the model the PHB advisor will have drafted the care plan, with clearly identified health and well-being outcomes, along with details and the various costings of how these will be met, and return it to the CHC nurse for the sign off process.

2.14 **Sign-Off Process**

The care plan is signed off from a financial and clinical point of view. The process for signing off care plans should remain proportionate to the clinical risks and costs involved in the care plan, and approval should be as close to the front line, as possible. Care plans should be approved on the basis that the services and support chosen will help meet the outcomes set out in the plan, do not exceed the value if the indicative budget, and do not put the individual or those working with them at an unacceptable level of risk.

2.15 Guidance will be developed to support a simple sign-off process, in order to remove as much of the subjectivity around approval as far as is possible. These may also include any local rules we may wish to make for how flexibly the money in a PHB can be used. These will need to be kept under review however, and may change over time as PHB's evolve.

2.16 For care plans within the cost of the indicative budget, and lower than the cost of equivalent care provided by a nursing home, the CHC nurse will be best placed and able to sign off the care plan.

2.17 For care plans over budget or with a higher cost than equivalent care provided by a nursing home, the care plan will be signed off at Resource panel, in accordance with current practices.

2.18 **Role of Social Care Accounts Service (SCAS) Sheffield City Council –**

SCAS already provide the CCG with a payments service for around 44 patients who previously had a direct payment in place, before becoming eligible for CHC funding.

In the current climate of developing more integrated services, it is proposed within this model that the agreement to undertake this work is extended with SCAS for them to take on new CHC patients with PHBs who require a direct payment to be administered.

2.19 SCAS have recently reviewed and updated their processes around the auditing of direct payments and we are satisfied that they have put in place a robust system to ensure direct payments are being appropriately managed and have measures in place to ensure early warning if this is not the case, so remedial action can be taken. They also ensure that where there may be a build-up of money, or money left un-spent at certain points of audit that this money is claimed back without delay. An arrangement will be put in place with the LA to facilitate the repayment of this money to the CCG. Although we have had some concerns previously around the ability of SCAS to monitor and audit some packages effectively, we believe the new Team's structure and management have appropriately addressed the issues and put in place satisfactory measures, and new practices, to improve the Team's performance. We will continue to monitor this, and should any issues or concerns arise in future, these will be raised immediately with the Team's senior management.

2.20 We are currently negotiating a new contract with them and ascertaining the costs to us, of increasing this support from them.

2.21 Case Management and Reviews

It is proposed that the CHC nurses continue with their existing case management role for patients who choose a PHB. They would be the first point of contact for patients who have any issues or concerns to do with their care, as is the current practice now.

2.22 The CHC nurses will continue to visit patients with PHBs to undertake review DSTs to determine eligibility for Continuing Health Care.

2.23 The CHC nurses will also review the patient's care plans in order to ensure that health outcomes are being appropriately met. This may be done at the point of DST review or may be scheduled to be undertaken on a different occasion.

2.24 SCAS, in the LA., will regularly run audits on all of the direct payments they administer on our behalf and will notify the CHC nurses immediately, should they come across any areas of concern or anomalies in the money management.

2.25 Where problems arise in the provision of care as a result of issues to do with the PHB, the CHC nurses will try to resolve this in the first instance, and consider alternative care or re-provision of care, if necessary.

2.26 For cases where the CHC nurses determine that a more intensive case-management intervention is required in connection with issues around the PHB, the CHC nurse may determine that the PHB advisor needs to continue with their involvement with the patient, or re-engage if their involvement had already ceased. This would be at Level 3 of the proposed Flexible Support Option and progression to this level must be agreed in advance by the CHC nurse.

3. Current position

3.1 **Contracts and Financial Implications** -

Work is still on-going with both the CSU and the LA on agreeing the details of their proposed support to the CCG within this recommended PHB model. Agreements have been reached in principle and the details are close to completion, which should enable the CCG to proceed with this implementation plan by the 1st October 2014.

3.2 A new contract will be entered into with the CSU to provide this new advisory support service, and they have advised the CCG that they have capacity within their current team to proceed with this PHB advisory role from the 1st October 2014. The cost quoted to the CCG for offering support to our patients; in accordance with the proposed Flexible support model is, £150 for Level 1 support, £415 for Level 2 support and £615 for Level 3 support, reducing to £415 in year 2. For most of our patients we envisage that support will be required at Level 1, or 2 of the proposed model.

3.3 Around 104 patients are currently receiving CHC funded domiciliary care and the CSU advise that take up rates of patients interested in PHBs in other CCG's has been around 40%. Assuming a similar take up rate here - 46 people may be offered support at Level 1, costing £6,900, and assuming 30 of those may proceed to Level 2 support, this would incur further costs of £12,450. This estimate totals £19,350.

3.4 A new contract will be entered into with SCAS to facilitate an extension to the current work they are undertaking on our behalf around the administration and auditing of direct payments. They have advised us that they currently have capacity within their existing resources to start this further work. They have quoted provisional costs to us, based on assumptions that every month they would set up 30 new packages, amend 10, close 30 and audit 30. For this level of service there would be an anticipated charge to us of £59,289.88, per year.

3.5 Final costs for both contracts will be forwarded for approval as soon as they have been received and it is hoped that work can commence with both of these partners, during the first 2 weeks of October 2014. There may be a slight delay with the Local Authority, depending on their internal approval routes to proceed with this new contract, but as the administration of the PHB is at the end of the process, any potential delays should not adversely affect our patients.

3.6 **Communication and Engagement with Service Users and other Stakeholders**

A list of priority patients who have requested advice and information about PHBs has been identified by the CHC team and these will be the target group to commence working with from the 1st October 2014.

3.7 It is proposed that a letter will be sent out to all other current patients, early October 2014, advising them of their "Right to Have a PHB "from 1st October 2014, and that this will be discussed further with them at their next scheduled review DST visit, unless they would like this discussion to happen sooner.

3.8 It is proposed for all new patients eligible for CHC from 1st October 2014, that they will be given basic information about PHBs when they have their eligibility decision confirmed to them. If they express interest in having a Managed Account or a Direct Payment for Healthcare, they will enter the process as described above.

3.9 It is proposed for all other patients receiving support at home, who choose for their service to be procured through existing commissioned provision, that an indicative budget is still calculated for them from the CHC 15 and they be advised that this is held as a notional budget by the CCG . This approach will assist with embedding personalisation within the CHC team and the CCG, which will support the further development of personal health budgets for other NHS patients in the future.

3.10 A strategy for briefing other stakeholders is being finalised and it is anticipated that internal briefings will take place and papers will be issued to CHC Operational Group in early October 2014. Arrangements will be made to ensure the CCG website is updated and communication will take place with the Complaints' Team. A report updating the CCG's position is scheduled for the Governing Body in November and a meeting is being scheduled to brief the Director of Social Care, in the Local Authority.

3.11 **Monitoring, Evaluation and Learning for Extending PHBs 2015**

It is proposed to set up processes for the monitoring and evaluation of PHBs, to gauge the effectiveness for patients, as well as looking at the roles and component parts of the model, particularly where contracts are entered into with partner agencies. Information sourced from the CSU, who are already working with 11 other CCGs , suggests that the take up rate of PHBs is higher than anticipated, and in some CCGs around 40% of patients have expressed an interest in having one.

3.12 Data will be gathered and analysed and we will continue to liaise with other CCG's through the PHB network, to share learning and best practice.

3.13 The monitoring and evaluation will include analysis of equality of access to PHBs, in accordance with The Equality Act 2010, to ensure that no groups have been disadvantaged.

3.14 The application of this knowledge and learning will not only help to help shape and inform future developments around PHBs for CHC, but will also be of value in the developmental work taking place around the extension of PHBs in April 2015 to other Long Term Conditions.

3.14 **PHB's for Children Eligible for Continuing Health Care**

The "Right to Have " a PHB from 1st October 2014 also applies to children who are eligible for continuing care and development work is on-going with the Senior Commissioning Manager for Children, in partnership with the Local Authority's Education and Social Care Services.

3.15 A Local Offer has been drawn up between the 3 services and was publicised on the 1st September 2014 on the Local Authority's website, to advise parents and carers about Personal Budgets. This offer details the types of personal budgets available to all children and the scope of services across the 3 areas that are currently available for personal budgets to be used for. This offer will also be publicised on the CCG's website in October 2014.

3.16 Many children's services are provided through block commissioned support and work is currently underway to develop unit costs for these services, to inform indicative budgets, and to develop ways of disaggregating these blocks over time, to free up funding for PHB's. Although the "Right to Have" PHBs exists for children, there is a risk of potential challenges from parents, should requests for PHBs not be agreed, whilst the potential funding for them remains committed to commissioned block services.

3.17 Further to the publication of the Local Offer, we propose to write to all parents/carers of children who are eligible for Continuing Care funding and who currently receive a package of care at home, to advise them to of their “Right to Have” a PHB.

It is proposed that letters are sent in early October 2014 and that the nurses who case-manage the children, at the Children’s Hospital ,will be the first point of contact for parents who express interest in having one. The nurses will then recommend the appropriateness of this for the individual child and this will be signed off and agreed at the Individual Funding Request, Children’s Continuing Care Panel before being referred for support with setting up the personal budget, if this required.

3.18 The process for children will be slightly different as many children receive tri-partite funding from health, social care and Education, to make up their package of care. For these children they will be referred to the Local Authority, who already have a Children’s Direct payments Advisor in post who will be able them advice and support with setting up their personal budget.

3.19 For children who are solely in receipt of continuing care funding, they may be referred to the LA’s Direct Payments Advisor, or could have the option of accessing the CSU PHB team, in accordance with the process for adults requesting PHBs. It is also envisaged that parents will be referred to, and use support agencies off the Recognised Provider List, if appropriate for their individual needs.

3.20 Where parents whose children are in receipt of block-commissioned services request PHBs this will be considered at the IFR panel but may have to be declined whilst the CCG is still commissioning this support through a block contract. Work will take place with providers and families in these situations to see if the commissioned support can be provided in a more personalised way to meet that child’s individual needs.

3.21 As block commissioned services become more flexible and disaggregated, these developments will be publicised through regular updating of the Local Offer.

4. Recommendations

The Governing Body is asked to note this paper which describes the PHB implementation plan and the processes to enter into contracts with the CSU / Local Authority and to procure their support as key partners in the plan.

Paper prepared by Chris Lomas, Quality Manager, Continuing Healthcare, Support at Home.

On behalf of Kevin Clifford, Chief Nurse

14 October 2014.

Appendix 1

CSU - Personal Health budget Team

Service Model - Flexible Support Option for Sheffield CCG

Level 1 – Standard Support for all patients requesting PHB.

Advice/ information/support /signpost – Referral made to PHB team requesting initial visit to patient, deemed suitable for PHB.
Feedback/discussion with CHC nurse re. outcome of visit.
If external support planner to be used – end of PHB advisor intervention .

Level 2 – Comprehensive Support for patients, as agreed with CHC nurse.

Support plan and co-produce care package - Visits to patients to draft support plan, refer back to CCG for sign off, assist with setting up care package, advice and support around how to manage budget, liaise with other stakeholders ie LA families, carers. Hand back to CHC team for on-going case-management

Level 3 – Enhanced Case Management

Additional/on-going support/advice – to be discussed and agreed by CHC nurse and PHB advisor, in exceptional circumstances on a case by case basis, where patient needs more intensive or on-going case management support in relation to PHB, and achieving health outcomes.

NHS Sheffield Clinical Commissioning Group

NHS Sheffield CCG Equality Impact Assessment 2013

Title of policy or service	Personal Health budgets (PHBs)	
Name and role of officers completing the assessment	Chris Lomas	
Date assessment started/completed	13/10/2014	

1. Outline	
Give a brief summary of your policy or service • Aims • Objectives • Links to other policies, including partners, national or regional	• The CCG is required to implement Personal Health Budgets, in accordance with the NHS "Right to Have" mandate from 1st October 2014. • Personal Health Budgets will give patients greater choice and control over how their care is provided which may lead to improved health and well-being outcomes for them. . • Patients eligible for Continuing Healthcare funding in receipt of domiciliary care packages and children receiving Continuing care funding will be offered PHBs. • The implementation plan involves partnership working with the Local Authority, the CSU and the voluntary sector.

2. Gathering of Information This is the core of the analysis; what information do you have that indicates the policy or service might *impact on protected groups, with consideration of the General Equality Duty*.					
	What key impact have you identified?			**What action do you need to take to address these issues?**	**What difference will this make?**
	Positive Impact	**Neutral impact**	**Negative impact**		
Human rights	/			See below	Overall the initial screening shows that the personal healthcare budgets will have a positive impact across the protected characteristics. This is aligned with the national policy on Personal Health Budgets with NHS Continuing health care individual being prioritised.
Age	/				
Carers	/				
Disability	/				
Sex					
Race	/				
Religion or belief	/				
Sexual orientation	/				
Gender reassignment	/				
Pregnancy and maternity	/				
Marriage and civil partnership (only eliminating discrimination)		/			
Other relevant group	/				

/

Please provide details on the actions you need to take below.

3. Action plan				
Issues identified	**Actions required**	**How will you measure impact/progress**	**Timescale**	**Officer responsible**
Evaluation of pilot sites has evidenced that patients report better health and well-being outcomes from having a PHB, as they can tailor their care to meet their individual needs.	Regular monitoring of PHB's implemented and analysis of information relating to individuals health and well-being outcomes.	Evaluation of effectiveness of PHB's for patients by gathering data from CHC team and feedback from patients.	Quarterly – February 2015	Chris Lomas
CCG will develop a policy for PHB's which will inform decisions on the use of PHBs and their suitability for different scenarios.	Monitoring the uptake of PHBs, and the different types and situations they are used in,	Evaluations of PHBs agreed and refused, and review of policy to identify any areas for improvement and inform future roll out, paying particular attention to whether any groups appear to have been disadvantaged in accessing a PHB.	Quarterly – February 2015	Chris Lomas
Guidance will be developed to provide a local framework for signing off care plans for PHBs to assist with consistency and to promote fairness, equality and transparency in decision making.	Monitoring of quality of decisions made around signing off care plans, and data to be gathered from reviewing health and well-being outcomes.	Analysis of data to determine if the right decisions are being made at the correct level, in a timely way.	Quarterly – February 2015	Chris Lomas
CSU to offer effective support and guidance for all service users deemed suitable for a PHB, in order to ensure equality of access for all.	Quality monitoring of contract with CSU.	Feedback from CSU and patients to be gathered to inform evaluation of support.	Quarterly – February 2015	Chris Lomas

4. Monitoring, Review and Publication			
When will the proposal be reviewed and by whom?	**Quarterly reviews to be undertaken.**		
Lead Officer	**Chris Lomas**	**Review date:**	**February 2015**

Once complete please forward to your Equality & Diversity lead Elaine Barnes via email elaine.barnes3@nhs.net for Quality Assurance

Quality Assured by Elaine Barnes, Equality & Diversity Manager 14 October 2014