Direct payments for healthcare

A consultation on updated policy for regulations

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Direct payments for healthcare

A consultation on updated policy for regulations

Prepared by the Department of Health

Contents

Summary

National rollout of personal health budgets

1. Personal health budgets were piloted in over 60 sites across England from 2009 to 2012. As with personal budgets in social care, people with a personal health budget can choose how their budget is spent to meet their individual needs, in line with a care plan that they agree with the NHS.

2. A personal health budget is a way of giving patients more choice (if they want it) about how NHS money is spent on their care, not of giving them extra money. The budget often only covers part of their care; for example, it would not normally pay for hospital care, medication or GP services.

3. The pilot programme looked at conditions and services such as NHS Continuing Healthcare, diabetes, multiple sclerosis, mental health and many more. There was an independent evaluation, led by the University of Kent, and the final evaluation report was published on 30 November 2012.

4. In light of the positive evidence from the evaluation, the Government wants personal health budgets to become an option for patients across the country. This is one of the ambitions we have set in our first mandate to the NHS Commissioning Board (the Board). The evaluation report suggests that achieving this on a large scale will take time. But as a first step, we have said that from April 2014, all patients receiving NHS Continuing Healthcare will have the right to ask for a personal health budget. Clinical commissioning groups (CCGs) and in some cases, the Board, will also be able to offer them to other people who they think may benefit, where the benefits outweigh any potential additional costs.

Direct payments for healthcare

5. It is already legally possible to offer patients a personal health budget where the money is held by the NHS or by a third party. Pilot sites authorised by the Department of Health also have the option of offering personal health budget in the form of a cash direct payment. Direct payments for healthcare are not yet allowed in areas outside the pilot programme.

6. We now want to give all parts of the country the power to offer direct payments for healthcare. We aim to do this in the summer by making a Parliamentary order which will amend primary legislation by removing the pilot site restriction. This needs to be approved by both Houses of Parliament. In light of the pilots, we also intend to make some relatively minor changes to the rules for how direct payment for healthcare work (the rules are set out in regulations). Our proposed changes are described fully below, but they include:
   - defining more clearly what services must not be paid for with a direct payment for healthcare (like most hospital care, and prescription charges);
   - explaining what kind of information, advice and support the NHS can give people with a direct payment for healthcare; and

- relaxing the rule that patients have to set up a separate bank account to receive a direct payment for healthcare if they are only receiving one-off payment.

7. This document is a consultation seeking views on the proposed changes.

Background

8. Since the 1970s, there has been a drive towards personalisation of health and social care services. Personalisation allows users of NHS and social care services to access services in a way that fits them as an individual, and enables the services to be tailored to their particular needs.

9. Personal health budgets are not unique; the policy fits in with a number of similar initiatives both in health and across government that aim to create more personalised public services, give people more choice and control and improve their experience of the public services they receive. Within health, links to personal health budgets include the Year of Care Partnership[1] and the updated National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care[2]. Across government, similar initiatives are being tested through the Department for Education's Special Educational Needs and Disability (SEND) pathfinder programme[3] and the Department for Work and Pensions' Right to Control trailblazers[4].

10. 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. The person with a personal health budget (or their representative) should 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 to achieve the agreed health outcomes;
    - create their own care plan, with support from their CCG, health professional, or a third party organisation if they want it and have the information they need to make informed decisions;
    - choose how their budget is held and managed, including whether it should be in the form of a direct payment for healthcare;
    - spend the money in ways and at times that make sense to them, as agreed in their care plan.

11. Personal health budgets have the core principles and values of the NHS at their heart. Whether or not someone has a personal health budget, their healthcare will always be free at the point of delivery, based on clinical need and not ability to pay.

12. Personal health budgets should be available to anyone who is eligible and where it may be cost effective to do so. Organisations must not assume that some groups of people can't

[1] http://healthandcare.dh.gov.uk/year-of-care/
[2] https://www.wp.dh.gov.uk/publications/files/2012/11/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf
[3] http://www.education.gov.uk/childrenandyoungpeople/strategy/laupdates/a0075365/support-and-aspiration-a-new-approach-to-special-educational-needs-and-disability-a-consultation
[4] http://www.dwp.gov.uk/newsroom/press-releases/2010/dec-2010/dwp177-10-131210.shtml

benefit from a personal health budget. Personal health budgets should also be entirely voluntary – nobody can be forced to have a personal health budget, including a direct payment for healthcare, if they do not wish to have one. Nor should anyone be denied essential treatment as a result of having a personal health budget. With good implementation, personal health budgets can offer opportunities for much more tailored support for people who may otherwise have a poor experience of the NHS.

Summary of learning from pilot programme

13. An independent research team led by the University of Kent looked at the effects of personal health budgets, in a study involving over 2,700 patients. They published five interim evaluation reports from 2010 to 2012[5], then a final report in November 2012[6].

14. These reports and the anecdotal evidence and practical experience from pilot sites are all contributing to our understanding of personal health budgets, how they affect people's health and wellbeing, and how they can be delivered effectively. Much of the learning from the pilots has been collated into an online toolkit[7] which can be used by the NHS or by personal health budget holders themselves.

15. In brief, the results in the final evaluation report show that personal health budgets:

- Are cost effective when implemented as the policy intended and patients have genuine control;
- Improve people's quality of life, well-being and feeling of being in control – but do not generally have any statistically significant effect on health status, or clinical measures such as a diabetic's blood sugar levels;
- May be more effective for people who are higher users of NHS services (such as people receiving NHS Continuing Healthcare), and those with long-term and substantial mental health needs;
- Worked best when there were fewer restrictions in place around what people could spend the money on;
- Worked best when people had choice of how to receive the budget, including the choice of a direct payment for healthcare; and
- May reduce use of NHS services indirectly - particularly by reducing hospital admissions.

16. These are positive findings, which provide proof of concept and support the rollout of personal health budgets, including direct payments, beyond the pilot programme. However, there is still much to learn about implementing personal health budgets for large numbers of people.

[5] https://www.phbe.org.uk/
[6] https://www.phbe.org.uk/
[7] http://www.personalhealthbudgets.dh.gov.uk/toolkit

Government Commitments

17. The Government has committed to extend personal health budgets, including direct payments for healthcare, beyond the pilot programme. Following the publication of the final evaluation report in November 2012, the Government:

    - confirmed the ambitious objective set in the Mandate to the Board, that "patients who could benefit will have the option to hold their own personal health budget, subject to the evaluation of the pilot programme, as a way to have even more control over their care";
    - reaffirmed the commitment to introduce a right, from April 2014, for people receiving NHS Continuing Healthcare to ask for a personal health budget, including a direct payment as the evaluation clearly suggests that personal health budgets have benefits for this group of people;
    - announced £1.5 million of funding to support early rollout of personal health budgets in the period until April 2013, when responsibility will transfer to the Board;
    - announced nine sites that are 'Going Further, Faster', pushing ahead with implementation on a larger scale and demonstrating how personal health budgets can be extended beyond NHS Continuing Healthcare; and
    - launched a toolkit which is available to everyone who has an interest in personal health budgets. It contains a wide range of learning from the pilot programme, including practical advice and information to support the implementation of personal health budgets. It also contains a range of individual's stories and experiences. This toolkit will evolve over time as we learn more about how best to deliver personal health budgets.

18. There is still much to learn about personal health budgets and implementation of the policy, including take-up of direct payments, is something that will take time and require a large degree of cultural change. The Government is taking a measured approach to rollout and is advocating a phased approach to implementation.

19. The responsibility for delivering personal health budgets will transfer to the Board in April 2013. We do not currently know enough about large-scale implementation to provide comprehensive guidance to CCGs. Full national guidance will be developed once more learning is gathered from the early implementers. Going Further Faster sites and regional networks will continue to explore many elements of personal health budgets, including where they have benefit, and will collate and spread this learning more widely. Policy decisions about the pace of subsequent rollout will only be made in light of future evidence.

20. It is also the Department's intention to work towards the provision of joint personal budgets across health and social care. Legally, the accountability for health will remain with CCGs or the Board, and accountability for social care will remain with local authorities. However, wherever possible, CCGs and where relevant, the Board, are expected to work collaboratively with local authorities to develop a single joined up plan incorporating health and social care.

21. Individuals currently in receipt of direct payments for healthcare as part of the pilot programme will be able to continue receiving them. All pilot sites with direct payment powers will continue to be able to offer them to individuals under the current regulations[8].

22. Although this consultation document relates specifically to direct payments for healthcare, the policy and proposals outlined will be relevant to personal health budgets more widely.

Details of the consultation

23. This consultation document is based on the original regulations for direct payments for healthcare, *The National Health Service (Direct payments) Regulations 2010*[9]. These regulations contain a number of provisions for making direct payments for healthcare as part of a pilot scheme. As Ministers have committed to personal health budgets being rolled out more widely, these regulations need to be updated to reflect the broader scope of the policy and the learning from the pilot programme.

24. The current regulations include sections specific to the pilot programme – see Annex A. Going forward the intention is for direct payments for healthcare to be made more widely available and so this section will be deleted.

25. Annex B outlines the changes to the direct payments for healthcare policy that the Department believes are necessary based on the learning from the pilot programme. The changes relate to:

- *Regulation 7* – who should be eligible for a direct payment for healthcare.
- *Regulation 8* – Separating out 'Direct payments for healthcare for children' and 'Direct payments for healthcare for people who lack capacity'.
- *Regulation 11* – care planning and what NHS services should be excluded from direct payments for healthcare.
- *Regulation 12* – information, advice or other support provided to individuals by a CCG or the Board.
- *Regulations 13 and 14* – conditions to be applied to making one-off payments.
- *New regulation* – remuneration for family members for administration of complex direct payments for healthcare .
- *New regulation* – that direct payments for healthcare could include some public health services.

26. Annex C describes the policy that the Department does not intend to change in substance (though consequential changes will be made in early 2013 to take account of the new NHS bodies and responsibilities). These are:

- *Regulation 9* – who should be eligible a direct payment for healthcare on someone's behalf.
- *Regulation 10* – decision to make a direct payment for healthcare.
- *Regulation 11* – the majority of care plan and care coordinator policy remains the same, with some changes to excluded services as described above.

[8] http://www.legislation.gov.uk/uksi/2010/1000/contents/made
[9] http://www.legislation.gov.uk/uksi/2010/1000/contents/made

- *Regulation 15* – information provided in relation to direct payments for healthcare.
- *Regulation 16* – amount of a direct payment for healthcare
- *Regulation 17* – review of care plan.
- *Regulations 18 and 19* – Repayment of a direct payment for healthcare.
- *Regulation 20* –stopping making a direct payment for healthcare.

27. Annex D contains a list of all the questions posed in the document. Annex E provides further detail about primary medical services and Annex F contains further detail about the consultation process.

Timetable for consultation and how to respond

28. The consultation will run for 8 weeks, starting from 1 March 2013 and running until 26 April 2013. An easy read version will be available online at: http://www.dh.gov.uk/health/category/publications/consultations/consultations-open/.

29. The consultation will inform the proposals for the updated regulations that we intend to put before Parliament in summer 2013. Subject to the approval of Parliament, these proposals would begin to take effect in summer 2013.

30. We welcome people's views online, by email or in hard copy. You can:

- respond online at http://consultations.dh.gov.uk/personal-health-budgets/directpaymentsforhealthcare/ ;
- email us at personalhealthbudgets@dh.gsi.gov.uk; or
- submit a written response to:

  Personal Health Budgets Team
  Department of Health
  Room 162
  Richmond House
  79 Whitehall
  London SW1A 2NS

Annex A - Regulations specific to pilot programme

31. As announced on 30 November 2012, personal health budgets will be rolled out more widely, which will include the option of a direct payment for healthcare. The regulations underpinning the use of direct payments for healthcare were developed for the pilot programme. Part 2 of these regulations concerns the pilot schemes, and will not be needed as direct payments for healthcare are rolled out.

32. The Health Act 2009 inserted sections 12A to 12D into the NHS Act 2006 providing PCTs with the power to give direct payments for healthcare. Section 12C(8) of the 2006 Act also allows the pilot schemes limitation to be removed by affirmative Parliamentary order, meaning it requires the positive approval of both Houses of Parliament to do so. The Parliamentary processes will be carried out in 2013.

33. The Health Act 2009 provided direct payment for healthcare powers to PCTs, not CCGs, the Board or local authorities. These bodies will need to have direct payment for healthcare powers from when they take on their new roles and responsibilities on April 1, 2013. Therefore we will be updating the current regulations to ensure that the Board, CCGs and local authorities will have the powers they need when their new roles take effect. These changes are purely consequential and will allow the provision of direct payments for healthcare and personal health budgets to continue until the new regulations take effect.

34. **The limitation on pilot sites in the NHS Act 2006 needs to be removed by affirmative order requiring the approval of both Houses of Parliament. If Parliament approves these changes, the current regulations will be revoked and new regulations drafted to replace them. Part 2 of the current regulations will be removed.**

Annex B - Proposals for changes to direct payments for healthcare policy

35. Part 3 of the current regulations deals with a number of elements relating to direct payments for healthcare, including who is able to have a direct payment for healthcare, rules around the care plan and what the direct payment for healthcare may not be spent on.

36. The Department is proposing to keep the majority of the regulations the same, with only a few changes based on the evaluation of, and the wider learning from, the pilot programme. Each of the changes proposed is discussed individually below.

Eligibility for direct payments for healthcare; Persons to whom a direct payment may be made (Regulation 7)

37. Regulation 7 sets out who is eligible to receive a direct payment for healthcare as part of a personal health budget. At the moment, the regulations say that eligibility is to be determined locally, by the pilot area. The evaluation of the pilot programme suggests that eligibility for a personal health budget should be based on the level of need rather than having a particular long term condition or diagnosis.

38. The Department wishes eligibility criteria to be broad to enable CCGs and the Board to offer direct payments for healthcare to patients who might benefit. As a direct payment for healthcare is money given to someone in lieu of NHS services, only people eligible for NHS services will be eligible for direct payments for healthcare.

39. The Government has announced that anyone in receipt of NHS Continuing Healthcare will be able to ask for a direct payment for healthcare. However we do not wish to restrict the use of direct payments for healthcare to this group as others could benefit. Therefore we propose that eligibility should be determined at a local level by the CCG (or where relevant, the Board) on a case by case basis, but at the very least we propose that regulations will make clear:

    a. The individual would need to have a health need that the NHS would normally meet; and
    b. The potential benefit of having a direct payment for healthcare outweighs the additional costs (e.g. administrative), so is value for money.

40. Deciding whether the benefit of having a direct payment for healthcare outweighs any additional costs is complex and will vary depending on individual's needs and the local circumstance. We do not yet know enough about how to deliver direct payments for healthcare at scale to be able to develop complete national guidance, although there is some early learning available on the learning network including an Audit Commission report "making personal health budgets sustainable"[10]. Initial guidance will be published alongside

[10] http://www.personalhealthbudgets.dh.gov.uk/Topics/Toolkit/MakingPHBshappen/FinanciallySustainable/

these regulations, and this guidance will be updated and expanded as lessons are learned from early rollout. This guidance would include more detail on some of the fundamental considerations when determining whether to allocate a direct payment. These may include:

- the benefits to the individual of having a direct payment for healthcare in both the short and longer term;
- whether they represent good value for money in the longer term (beyond one year);
- what strategies are in place to release funding from existing systems including block contracts to fund direct payments;
- whether the direct payment for healthcare would align with local plans for outcome based commissioning and other innovation (eg Payment by Results);
- the effects on the local health economy of potentially reducing funding for existing providers. While this may well be necessary in the longer term to improve service provision, and is in line with other service developments, commissioners will need to manage the risk of destabilisation in the short term.

Question 1. Do you agree that these are the right criteria to be used to determine eligibility for a personal health budget? Should they be prescribed in regulations?

Direct payments in respect of children and persons who lack capacity (Regulation 8)

41. This regulation currently sets out what must happen in the case where the potential direct payment for healthcare recipient is a child or an adult who lacks capacity (as defined by the Mental Capacity Act 2005). This includes provisions for having a representative who will receive and manage the budget on their behalf.

42. Categorising these two groups of people together is inconsistent with the other health legislation. Therefore, while the policy of each will stay the same and be in line with other legislation, the Department wishes to make separate clauses for children and people who lack capacity.

Question 2. Do you agree with our proposal to separate out clauses in respect of children and adults who lack capacity? Are there any other capacity related issues you would like to see addressed?

Care plan and co-ordinator (Regulation 11)

43. This regulation discusses the steps that the PCT (in future, a CCG or the Board) must follow during care planning with an individual who wishes to have a direct payment for

healthcare.

44. The majority of this will remain unchanged, however paragraph 5 of regulation 11 lists the things that a direct payment for healthcare cannot be spent on – including gambling, alcohol, tobacco or repaying debts. We propose to expand this section to include the services the direct payment for healthcare cannot be used for, these are:

    a. GP services: A direct payment for healthcare should not be spent on primary medical services which are provided by GPs as part of their primary medical services contractual terms and conditions. This is because the majority of GP services are already funded through such contracts, which means that GPs have already been paid to provide these services. We would not want to disrupt the holistic care provided to patients by their local family GP. People already have the ability to choose which GP practice to register with, within the area in which they reside (subject to possible list closure within particular areas).
    b. NHS charges: a direct payment for healthcare should not be used to pay for NHS charges, including prescription, dental, or wigs and fabric supports or to fund sight tests for which an individual would not be entitled under NHS arrangements. Direct payments for healthcare should not be a way of getting around the core policies on NHS charges and entitlements; they are there to support the existing policies in the NHS.
    c. Public health: We do not believe that a direct payment for healthcare should be used for:
        - vaccination/immunisation,
        - screening,
        - the National Child Measurement Programme,
        - NHS Health Checks,
        - population wide immunisation programmes, as these are centrally funded.
    d. Secondary care: Direct payments for healthcare should not be used to pay for A&E services and other unplanned care, or operations. Use of these services are typically unplanned and so not included in a care plan. In addition, nobody would be denied access to A&E or acute care if they needed it. If people need an operation, they already have the right to choose the hospital they attend and this will soon include the right to choose a consultant led team.

45. It is proposed that the cost of any equipment or service not on this list could be included in a direct payment for healthcare. The evidence from the evaluation suggests that while some people choose not to use traditional services to meet their health needs, they successfully met their agreed health and wellbeing outcomes. Examples of what people used their budgets on during the pilot included gym membership to aid weight loss, or singing lessons to improve breathing.

Question 3. Do you agree that personal health budgets should not be allowed to be spent on the services listed above? Are there any other services which should be excluded?

Information, advice and other support (Regulation 12)

46. Regulation 12 does not make the provision of information mandatory, however paragraph 2 indicates the types of information that may be provided to a patient by a healthcare professional. This currently includes:

    a. Advocacy services such as third party support to manage a care plan, contract or the personal budget;
    b. Assistance with buying healthcare services; or
    c. Information and assistance related to being an employer, for example payroll, training, sickness cover.

47. It is clear from the evaluation and wider learning from the pilot programme that having the right level of information, support and advice is key to the success of direct payments for healthcare and personal health budgets more widely. The evaluation also suggests that it is important for individuals to know the amount of money in their budget before they start care planning. We propose adding to the list of information that may be provided to include:

    a. The amount of money that will be in their budget and how this is calculated;
    b. Whether and how the patient can request a review of their budget and care plan if they believe either is insufficient;
    c. Circumstances in which a direct payment for healthcare may be withdrawn, e.g. if the patient's circumstances change in such a way that they are no longer eligible or if in practice the costs outweigh the benefits;
    d. Any restrictions on how the money may be spent;
    e. The process of signing off care plans and things that might be considered as part of this; and
    f. If the patient is also in receipt of a social care budget, how these could be integrated and how the respective health and social care bodies will work together.

48. It is good practice to provide the potential direct payment for healthcare recipient with as much relevant information as possible before they receive their direct payment, as well as providing them with information and support throughout the process.

Question 4. Do you agree that the list of information, support and advice that patients are entitled to ask their CCG or the Board for should be supplemented with the items above?

Conditions applying to the making of direct payments (Regulation 13), and Conditions to be complied with by the patient, representative or nominee (Regulation 14)

49. The majority of these sections of the regulations will remain unchanged. However, at present, a direct payment for healthcare must be paid into a separate bank account, regardless of the number of payments. This differs from direct payments in social care,

where one-off payments can be paid into an individual's own bank account. A one-off payment is a single instalment given for one item or a small number of items or services, that would be the only direct payment for healthcare the person would receive in that financial year.

50. Evidence from the pilot programme suggests that single, one-off payments are useful in healthcare, for example for a specific service or piece of equipment.

51. Setting up a separate bank account can be time consuming and bureaucratic, and for some individuals impossible to do. This can cause unnecessary delays to the payment and consequently, treatment or service.

52. Therefore, the Department proposes to update these two regulations so that a one-off direct payment for healthcare can be paid into an individual's personal bank account (where they do not already have a separate bank account for other direct payments). Provision of receipts can be used to review how the money was spent.

Question 5. Do you agree that there should be the option of paying one-off direct payments for healthcare into an individual's personal bank account?

Direct payments for healthcare and public health (new provision)

53. The Health and Social Care Act 2012 made a number of changes to the NHS Act 2006 and consequently to the health service, many of which are due to take effect on 1 April 2013. One such change is the abolition of PCTs. Some legal duties and responsibilities of PCTs will transfer to CCGs, and in some cases, to the Board or Local Authorities.

54. Local authorities will have new public health responsibility to improve the health of people in their area. These functions include services to help people make lifestyle changes such as stopping smoking or losing weight, where the option of a direct payment for healthcare may be useful.

55. Local authorities already make direct payments for social care and we wish to give them the powers, to fund part of a person's direct payment for healthcare where treatment includes public health services and it is appropriate to do so.

Question 6. Do you agree that local authorities should be included in the scope of the regulations for direct payments for healthcare?

Administration of direct payments for healthcare (new provision)

56. Current regulations for direct payments for healthcare prevent close friends or family members (living in the same household) being paid to provide care other than in exceptional circumstances (Regulation 14, paragraph 4). We do not intend to change this as it is in line with other government policies.

57. Local authorities have a responsibility carry out carers' assessments for support if someone is providing care on a substantial and regular basis. There are provisions in the draft Care and Support Bill to simplify the process of carers' assessments and for the first time to place a duty on local authorities to meet carers' eligible needs for support. This should not have any impact on this proposal.

58. A recurring issue raised during the pilot programme was that close family members of people with large direct payments for healthcare often undertook complex administration tasks which went beyond the traditional role of a family carer. These tasks could include things such as managing the payroll for personal assistants, recruiting staff, managing shifts and arranging cover for absences. This constituted a large amount of work for the friend/family member, for which they received no remuneration.

59. For example, Margaret manages a direct payment for healthcare for her 23 year old daughter, Sam, who needs 24 hour care following a brain injury seven years ago. Margaret organises Sam's complex package of care, she employs 10 personal assistants, organising their rota depending on what Sam is doing and carrying out administrative tasks related to employing staff (e.g. payroll, tax and national insurance). One of Sam's carers recently left to pursue their ambition to be a nurse, and Margaret has to find a new carer for Sam. Margaret also has to work out how to ensure Sam receives the right level of support while she recruits a new carer.

60. During the pilot programme, some stakeholders proposed that close family members or friends should be paid for managing or administrating complex care packages which are on a par with providing business support to a small business employing a similar number of people. Some felt that recognition and remuneration were important as this took significant amounts time and third parties would be paid to manage or carry out the same activities. They suggested that a set level of remuneration could be agreed that was dependent on the size of the package of care. They felt that while it would not be appropriate for everyone managing a direct payment for healthcare to receive remuneration, but it should be an option for CCGs or the Board, if they feel it is appropriate.

61. However, not everyone supported this proposal. Some felt it would be difficult to draw a line between where the 'traditional family carer' role separated from this management role. They felt that organising care and support was something you did as you wanted the best for your loved one, it was not a job. Some were concerned that getting paid to manage a care package may result in people taking on the task when they were not competent or appropriately trained to do so. They suggested it would be difficult to monitor their success or the number of hours it took– both of which they felt would be important.

62. Before coming to a decision on whether to give CCGs (or where relevant, the Board) the option to pay close friends/family members to manage complex care packages we would like your views on this.

Question 7. What are your views on friends or family members being paid for managing complex or large healthcare packages? How should this be defined, for example should it be linked to the size of the direct payment?

Annex C - Areas of the direct payments for healthcare policy set in the regulations that we propose keeping the same

Nominated person (Regulation 9)

63. This section allows a patient to nominate someone else to receive a direct payment for healthcare on their behalf. This person will be responsible for buying the services that are set out in the person's care plan and that the regulations apply in full to the nominee just as they would to the person who was managing their own budget. If someone lacks capacity a representative can be appointed to manage a direct payment on their behalf; this is included in regulation 8. This gives people flexibility around how they can manage their direct payment for healthcare and the Department does not propose to change this regulation.

Decision to make a direct payment (Regulation 10)

64. This regulation outlines the steps that a PCT (or in future, a CCG or the Board) may take when deciding whether a patient (or their nominee) is a suitable person to have a direct payment for healthcare. It provides options relating to:

    a. Who they may consult, including family members, carers, independent mental health or mental capacity advocates or local authorities; or
    b. What information they may request, including information about the patient's health, mental capacity, their bank accounts or other relevant information.

65. Based on the experience from the pilot programme, these appear to be reasonable measures for a CCG or the Board to take when considering whether someone could have a direct payment for healthcare. The Department believes that these measures should be the minimum set out in law.

Care plan and co-ordinator (Regulation 11)

66. Before a direct payment for healthcare can be given, the individual needs to have a care plan. This regulation sets out what needs to be included in this plan, including the desired outcomes, the money available and how this will be used. This regulation also sets out the responsibilities of the care coordinator. The plan is agreed between the NHS and the individual or their representative. As discussed in Annex B we wish to revise the list of services and treatments which cannot be included in a care plan. However the other sections of this regulation will remain unchanged.

Provision of information (Regulation 15)

67. This regulation states that any information provided to a PCT must be legible and that the PCT must be able to take copies of it. There is no evidence to show that these provisions are not appropriate, therefore this regulation will remain unchanged.

Amount of direct payment (Regulation 16)

68. This regulation sets out that the PCT must ensure that the direct payment for healthcare allocated is enough to cover all the services that have been agreed in their care plan. It also requires that the level of budget should be adjusted as the individual's condition changes.

69. This provision is important to ensure that direct payments for healthcare comply with the core principles of the NHS – free, comprehensive care at the point of delivery.

Monitoring and review of direct payments (Regulation 17)

70. This regulation sets out that the PCT must regularly review the direct payment for healthcare with the individual (within three months of them first receiving a budget and subsequently at least once a year). The review should include whether the direct payment for healthcare is working and remains cost-effective and whether the money is being used as agreed in the care plan. Following review, the care plan or direct payment for healthcare may be modified.

71. We believe reviews are important and based on the learning from the pilots, the frequency of reviews and details of the reviews are sufficient; therefore this regulation will remain unchanged.

Repayment of direct payment & Recovery of amounts due as civil debt (Regulations 18 & 19)

72. These regulations state that the recipient of a direct payment for healthcare or their representative may have to pay back all or some of their personal health budget money if:
    a. Their care plan changes;
    b. Their circumstances change;
    c. They are not using all the money that has been allocated to them (in which case only part would have to be paid back);
    d. The money has been spent on things they were not allowed to spend it on;
    e. There has been other fraud in connection with the budget; or
    f. The patient has died.

73. If, as in point e, there has been fraud, the regulation 'recovery of amounts due as civil debt' is a technical provision that allows the PCT to reclaim the relevant portion of the budget as civil debt.

74. The Department is not aware of any cases of fraud taking place during the pilot. Learning from the pilots has not indicated that any of the other provisions in this regulation were insufficient or problematic, therefore we do not propose to amend these regulations.

Stopping a direct payment (Regulation 20)

75. This regulation allows the PCT to stop making a direct payment for healthcare for a variety of reasons. This could include the patient no longer wishing to receive a direct payment for healthcare, the patient no longer being a suitable candidate for a direct payment for healthcare, or the money not having been used appropriately.

76. The Department believes that this provides an appropriate range of options for protecting NHS money from fraudulent uses and does not intend to amend this regulation.

Question 8. Do you agree that these regulations should remain the same? If not, what would you like to see changed?

Question 9. Are there other areas that you would wish to see in regulations? If so, what are they?

Question 10. Could the proposals have any perceived or potential impact on equality including people sharing protected characteristics under the Equality Act 2010?

Annex D - Full list of consultation questions

We would welcome responses to the following questions on the regulations as well as any additional comments that you would like to make:

Question 1. Do you agree that these are the right criteria to be used to determine eligibility for a personal health budget? Should they be prescribed in regulations?

Question 2. Do you agree with our proposal to separate out clauses in respect of children and adults who lack capacity? Are there any other capacity related issues you would like to see addressed?

Question 3. Do you agree that personal health budgets should not be allowed to be spent on the following services? Are there any other services which should be excluded?

- Primary medical services provided by GPs;
- Prescription charges (including pre-payment certificates);
- Dental charges;
- Charges for wigs and fabric supports;
- Vaccination and immunisation;
- Screening;
- The National Child Measurement Programme;
- NHS Health Checks;
- A&E services;
- Other unplanned care or elective surgery.

Question 4. Do you agree that the list of information, support and advice that patients are entitled to ask their CCG or the Board for should be supplemented with the following items?

- The amount of money that will be in their budget and how this is calculated;
- Whether and how the patient can request a review of their budget and care plan if they believe either is insufficient;
- Circumstances in which a patient may no longer qualify for a PHB;
- Any restrictions on how the money may be spent;
- The process of signing off care plans and things that might be considered as part of this; and
- If the patient is also in receipt of a social care budget, how these could be integrated and how the respective health and social care bodies will work together.

Question 5. Do you agree that there should be the option of paying one-off direct payments for healthcare into an individual's personal bank account?

Question 6. Do you agree that local authorities should be included in the scope of the direct payments for healthcare regulations?

Question 7. What are your views on friends or family members being paid for managing complex or large healthcare packages? How should this be defined, for example should it be linked to the size of the direct payment ?

Question 8. Do you agree that the regulations described in Annex C should remain the same? If not, what would you like to see changed?

Question 9. Are there other areas that you would wish to see in regulations? If so, what are they?

Question 10. Could the proposals have any perceived or potential impact on equality including people sharing protected characteristics under the Equality Act 2010?

Annex E - Primary Medical Services

1. Essential and additional GP services are set out in the National Health Service (General Medical Services Contracts) Regulations 2004 at regulations 15 and 16[11]. In addition to essential and additional services, GPs may also provide services including the following.

2. Nationally Enhanced Services:

   Anti-coagulation monitoring
   Enhanced care of the homeless
   Intra Partum care
   Intra-uterine contraceptive device fittings
   Minor injury services
   More specialised services for patients with multiple sclerosis
   More specialised sexual health services
   Patients who are alcohol misusers
   Patients suffering from drug misuse
   Provision of near-patient testing
   Provision of immediate care and first response care
   Specialised care of patients with depression

3. Directed Enhanced Services:

   Extended hours access scheme
   Alcohol Related Risk Reduction Scheme
   Learning Disabilities Health Check Scheme
   Childhood Immunisation Scheme
   Influenza and Pneumococcal Immunisation Scheme
   Violent Patients Scheme
   Minor Surgery Scheme
   Patient Participation Scheme
   Promoting Quality and Innovation Scheme (new scheme to be introduced from 1 April 2013)

[11] http://www.legislation.gov.uk/uksi/2004/291/regulation/15/made

Annex F - The Consultation Process

Criteria for consultation

This consultation follows the 'Government Code of Practice', in particular we aim to:

- formally consult at a stage where there is scope to influence the policy outcome;
- be clear bout the consultations process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach;
- keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' 'buy-in' to the process;
- analyse responses carefully and give clear feedback to participants following the consultation;
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

The full text of the code of practice is on the Better Regulation website at:

Link to consultation Code of Practice

Comments on the consultation process itself

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please

contact Consultations Coordinator
Department of Health
3E48, Quarry House
Leeds
LS2 7UE

e-mail consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Confidentiality of information

We manage the information you provide in response to this consultation in accordance with the Department of Health's **Information Charter.**

Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

Summary of the consultation

A summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the Consultations website at http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm