Report to:	**SINGLE COMMISSIONING BOARD**
Date:	31 October 2017
Officer of Single Commissioning Board	Gill Gibson, Director of Quality and Safeguarding
Subject:	**PERSONAL HEALTH BUDGETS**
Report Summary:	A Personal Health Budget is an amount of money to support a person's identified health and wellbeing needs, planned and agreed between the person and their local NHS team. The vision for personal health budgets is to enable people who are frequent users of healthcare to services to have greater choice, flexibility and control. The expectation of Clinical Commissioning Groups to expand Personal Health Budgets was outlined in the Forward View into Action: Planning for 2015/16 and the NHS England mandate is that by 2020 0.1-0.2% of our population will hold a Personal Health Budget. In order to deliver the national mandate we have set local trajectories that seek to establish Personal Health Budgets for 99 patients by March 2018 rising to 153 by April 2019. Greater Manchester is establishing a Personalisation Programme in which we plan to actively engage. It is hoped that this will expand from a health focus to encompass the national drive towards Integrated Personal Commissioning, a nationally led, locally delivered programme that is supporting healthcare empowerment and the better integration of services across health, social care and the voluntary and community sector. The programme aims to ensure that services are tailored to people's individual needs, building on learning from personal budgets in social care and progress with personal health budgets. Through Integrated Personal Commissioning, people, carers and families with a range of long-term conditions and disabilities are supported to take a more active role in their health and wellbeing, with better information and access to support in their local community, and greater choice and control over their care. Despite having focused approaches to marketing Personal Health Budgets with frontline staff we have had very little update and currently have only 13 Personal Health Budgets awarded, the lowest rate in Greater Manchester. An analysis of our Personal Health Budget approach and process has raised a series of actions that are now being taken forward. It is recognised that if we are to increase numbers towards achieving the national target recurrent investment will be required, as well as the commitment to extract funding from block contracts to provide a viable budget to continue to expand Personal Health Budget numbers in the future. Due to the financial position, it is recommended that we work within existing resources rather than increase investment at this time.
Recommendations:	1. After assessing the risks, it is recommended that it would be better to delay the achievement of our local trajectories and agree a phased implementation plan for Personal Health Budgets. This would align more with the implementation of our transformation plans including the move towards a more

sophisticated contracting model and accountable care system.

2. To note that this will impact on the ability of the Clinical Commissioning Group to meet the Personal Health Budget target in 2017/8 and therefore the Improvement and Assessment Framework Standards, potentially resulting in reputational damage.
3. To escalate the risks associated with delay in achieving the Personal Health Budget target to the Clinical Commissioning Group Governing Body.
4. That the focus in 2017/8 is to expand the offer of Personal Health Budgets to patients who are already receiving individual packages of care, including Continuing Healthcare, Section 117 care and Transforming Care as this will be within existing resources.
5. That the Clinical Commissioning Group lead continues to work with Greater Manchester on the Personalisation agenda including taking developing Greater Manchester wide approaches to Personal Health Budgets (and integrated personal budgets) for other patient groups including, Personal Wheelchair Budgets, End of Life and Long Term Conditions.

Financial Implications:

(Authorised by the statutory Section 151 Officer & Chief Finance Officer)

Budget Allocation (if Investment Decision)	The report requested funding of £75k on a recurrent basis to fund administration costs associated with expanding PHB. Cost of the budgets themselves would need to be funded over and above this budget request (and could be significant). CCG currently has £50k committed in reserves on a non-recurrent basis to fund expansion of PHB.
CCG or TMBC Budget Allocation	CCG
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	S75
Decision Body – SCB, Executive Cabinet, CCG Governing Body	SCB
Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	Significant portion of historic healthcare costs (e.g. Pennine Care, ICFT) are paid via block contract. If patients with PHB's reduce use of traditional hospital services, we need to determine how costs from

	these traditional services can be reduced and funding transferred to PHB before making a value for money assessment.

Additional Comments Principles of Personal Health Budgets are firmly established at a national level, meaning that as a local economy we need to recognise the requirement to increase spend in this area. The national target is to increase the number of Personal Health Budget patients from 13 today to 153 by April 2019. Tameside and Glossop currently have the worst performance for take up of Personal Health Budgets across Greater Manchester.

Personal Health Budgets are high profile both nationally and in GM. We can assume that we would come under significant pressure and criticism at assurance meetings for not achieving targets or having credible plans in place for doing so. However there is no specific financial penalty or consequence in place should we fail against this target.

The Clinical Commissioning Group has non-recurrently committed £50k within reserves to fund the expansion of PHB in 2017/18. The report requested £75k to fund a band 7 post, a 0.5 X band 3 post and to provide a budget to support the work of this team. The band 7 will cost £46k and the band 3 £11k, leaving a residual £18k to fund the ancillary costs. While the part year effect of this in 2017/18 would be affordable from the £50k reserve, there would be a recurrent increase in administrative costs which will create a pressure for 2018/19 and beyond should this business case be approved.

However, the more significant funding pressure, would be the cost of the Personal Health Budgets themselves, which require funding over and above the administrative costs requested in the paper. Our understanding is that the next tranche of Personal Health Budget patients is focused on Continuing Healthcare, Section 117 patients, Transforming Care patients, people with long term conditions currently accessing acute hospital services and patients with mental illness using services at Pennine Care. The national theory around Personal Health Budgets for these patients is that they should be cost neutral to commissioners and funded from reductions in activity.

But as an economy Tameside and Glossop have moved away from traditional cost a volume PbR contracts. As such the key question for finance Task and Finish is how we maintain affordability as the number of Personal Health Budgets increases. Will the reduction in activity for the 153 patients be of sufficient scale to allow the provider to remove costs (e.g. by closing wards, reduce staffing rotas etc), which would in turn allow for a reduction in contract value to fund Personal Health Budgets. Or will the introduction of Personal Health Budgets result in an inevitable financial pressure for the economy. Which even using the 10% assumption in the paper, could be quite significant when multiplied up for high cost patients with long term conditions. By way of illustration,

the economy could be facing a pressure of £500k per year if the average value of new Personal Health Budgets was £3k and we were unable to reduce the cost base.

Therefore a key discussion point needs to be around the potential financial pressures associated with meeting the target, versus the regulatory and reputational damage that would result from failing to meet the target.

Legal Implications:

(Authorised by the Borough Solicitor)

Since October 2014 health bodies in England have been under a duty to provide personal budgets and pay direct payments along similar lines to those paid by social care in relation to adults and children eligible for Continuing Health Care (CHC).[1] The NHS mandate 2012 contained a commitment that from 2015 Personal health budgets for healthcare should be an option for people "who could benefit from one" ie including people using NHS services outside of CHC. There are regulations and detailed guidance governing personal health budgets and direct payments.[2] The following are the key legal issues:

- There is a presumption in favour of granting a Personal Health Budget and a direct payment and the policy governing this needs to clearly set out when a direct payment will not be given and what criteria will be used to exercise the discretion to grant one.
- The regulations provide that decisions must be based on need and that a direct payment must be appropriate for the individual concerned with regard to his/her condition and the impact of that condition on his/her life. The direct payment must represent value for money and, where applicable, any additional cost must be outweighed by the benefit to the individual.
- The policy will need to address issues such as the person's capacity to agree to a Personal Health Budget and direct payment and whether it is appropriate to involve a nominee or representative.

The decision making process will need to be clear and publicised. The decision when made must be clearly communicated to the person and/or their representative. Provision must be made for the decision to be reviewed if the person and/or their representative is not satisfied with it.

How do proposals align with Health & Wellbeing Strategy?

Personal Health Budgets align with the following Health and Wellbeing Board strategic priorities:

- Integration;
- Improve the health and wellbeing of local residents throughout life;
- support to those with poor health to enable their health to improve faster;
- Prevention and early intervention;
- Local action and responsibility for everyone;

[1] NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 SI. no 2996

[2] NHS (Direct Payments) Regulations 2013 and NHS (Direct Payments)(Amendment) Regulations 2013

- Public involvement in improving health and wellbeing.

How do proposals align with Locality Plan?

The service is consistent with the following priority transformation programmes:

- Healthy Lives (early intervention and prevention);
- Community development;
- Enabling self-care;

How do proposals align with the Commissioning Strategy?

The service contributes to the Commissioning Strategy by:

- Patients and communities being empowered to care for themselves and to work together to support local health and wellbeing;
- Identification and support of "at risk" people;
- Fewer overnight stays in hospital and more community based care.

Recommendations / views of the Professional Reference Group:

The Professional Reference Group recommends:

1. That due to impact on the financial position associated with investing resources to meet the Personal Health Budget target, an incremental approach is taken to improve our current position, focusing on offering Personal Health Budgets to patients who are already receiving individual packages of care, including Continuing Healthcare, Section 117 care and Transforming Care. This can be done within existing resources.
2. That the Clinical Commissioning Group lead continues to work with Greater Manchester on the Personalisation agenda including taking developing Greater Manchester wide approaches to Personal Health Budgets for other patients groups including, Personal Wheelchair Budgets, End of Life and Long Term Conditions.

Public and Patient Implications:

There are implications for patients of all ages.

Quality Implications:

There is evidence that Personal Health Budgets deliver the following patient outcomes

- **Better quality of life** and enhanced health and well-being;
- **Fewer crises** that lead to unplanned hospital and institution care;
- **Enhanced experience of care** through better coordination and personalisation of health, social care and other services.

How do the proposals help to reduce health inequalities?

By offering patients more choice, control and flexibility in relation to managing their own health.

What are the Equality and Diversity implications?

It is anticipated that the proposal will not have a negative effect on any of the protected characteristic group(s) within the Equality Act.

An Equality Impact assessment has been completed and is attached (**Appendix 1**)

What are the safeguarding implications?	Safeguarding assurance is integral within all personal plans.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	Information governance is a core element of the NHS. For reference a privacy impact assessment has been completed and has been signed off by the Clinical Commissioning Group's Governance Committee.
Risk Management:	The risks to not achieving Personal Health Budget numbers and risks of complaints are registered on the Clinical Commissioning Group Risk Matrix.
Access to Information :	The background papers relating to this report can be inspected by contacting Pat McKelvey, Head of Mental Health and Learning Disabilities: Telephone: e-mail: pat.mckelvey@nhs.net

1. BACKGROUND

1.1 The expectation of Clinical Commissioning Groups to expand Personal Health Budgets was outlined in the Forward View into Action: Planning for 2015/16.

1.2 The mandate to Clinical Commissioning Groups from NHS England is that by 2020 0.1- 0.2% of our population will hold a Personal Health Budget, which equates to 250-500 patients. In order to deliver the national mandate we have set local trajectories that seek 99 patients by March 2018. Our achievement of this is monitored through the mandatory personal budget data collection via NHS Digital and our progress features in the Clinical Commissioning Group Assurance process.

1.3 This year's planning guidance included requirements for Clinical Commissioning Groups to provide a challenging Personal Health Budget trajectory for 2017/9 (Table 1) and to outline in more detail the ambition set out in the Clinical Commissioning Group's Sustainability and Transformation Plans.

Table 1: NHSE Tameside and Glossop 2017/18 and 18/19 Planning Submission

PERSONAL HEALTH BUDGETS		Q1	Q2	Q3	Q4
2017/18 Plan	1) Personal health budgets in place at the beginning of quarter (total number per CCG)	26	36	52	74
	2) New personal health budgets that began during the quarter (total number per CCG)	10	16	22	25
	3) Total number of PHB in the quarter = sum of 1) and 2) (total number per CCG)	**36**	**52**	**74**	**99**
	4) GP registered population (total number per CCG)	246,637	246,637	246,637	246,637
		Q1	**Q2**	**Q3**	**Q4**
2018/19 Plan	1) Personal health budgets in place at the beginning of quarter (total number per CCG)	99	111	123	138
	2) New personal health budgets that began during the quarter (total number per CCG)	12	12	15	15
	3) Total number of PHB in the quarter = sum of 1) and 2) (total number per CCG)	**111**	**123**	**138**	**153**
	4) GP registered population (total number per CCG)	248,055	248,055	248,055	248,055

1.4 All requests for Personal Health Budgets are managed by a clinically led multi-agency risk panel, which meets monthly. The process followed can be found in **Appendix 2**.

2. CURRENT POSITION

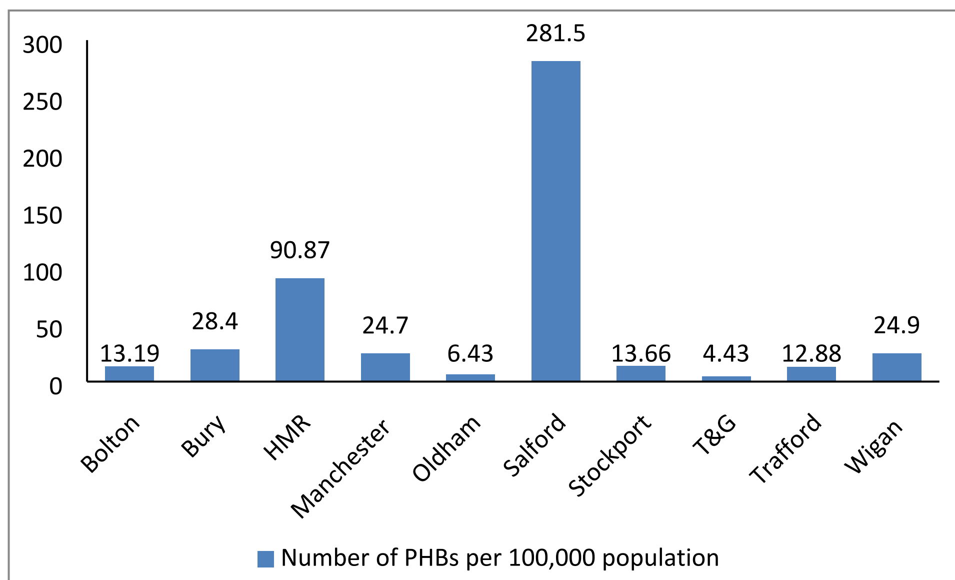
2.1. The Clinical Commissioning Group has been offering People who meet the Continuing Healthcare eligibility criteria the option of having a Personal Health Budget since 2014 and from December 2015 the Local Offer was developed to offer personal health budgets to people who **frequently use health services** such as:

- children with an Education Health and Care Plan;
- people needing long-term rehabilitation;
- people with long-term health conditions that use hospital services a lot;
- people with long term mental health needs;
- people with Learning Disability or Autism and Mental Health needs and/or who are at risk of hospital admission/are in hospital.

2.2. When developing the Local Offer the Clinical Commissioning Group agreed the principle that there would be no new funding for Personal Health Budgets but, in order to give time to move funding around the system based on the learning from Personal Health Budgets, a start-up budget of £150k was agreed for 2016/17 which included funding for a Personal health Budget Coordinator. This was later reduced to £75k and then £0 due to lack of demand.

2.3. The uptake of Personal Health Budgets in Tameside and Glossop for both Continuing Healthcare funded patients and the groups listed in 2.1 has been low despite a rolling staff training and marketing campaign. While there have been a number of people expressing an interest, few have been frequent users of health services and therefore they have not progressed.

2.4. At the present time we only have 13 Personal Health Budgets in place and therefore are not going to achieve the 99 in the trajectory this year. Although many Clinical Commissioning Groups report that they are struggling to increase their numbers, our current rate is the lowest in Greater Manchester:-



2.5. NHS England has established a mentoring programme to support Clinical Commissioning Groups to increase their rate and we are one of many who have signed up. We hope this will offer peer review of our approach and shared learning as we expand our programme.

2.6. An appraisal of this lack of progress has been done and the following issues identified:

(i) The approach to Personal Health Budgets requires reviewing in order to ensure that we are meeting the National Health Service (Direct Payments) Regulations 2013.
Action: - A member of the Legal team has been assigned to support this work.

(ii) Lack of a rigorous process and a protracted application process has meant that it has too long to get budgets in place. This has led to stress and potential complaints from patients.

Action: - A new time-focused process is in place and the Personal Health Budget Policy is currently being updated.

(iii) The Clinical Commissioning Group approach to budget setting has led to indicative budgets that are too small to implement change. The restrictions were agreed due to a request from the Personal Health Budget Panel for guidance on budget setting and the CCG Management Team agreed a paper that proposed that, for an individual who is a frequent user of healthcare services, the indicative budget be set at 10% or 15% of costs of the patients overall activity.
Action:- It is proposed that the Personal Health Budget Panel uses patient activity over the past 12 months to identify proactive positive care versus reactive/crisis care and from this identify with the patient and their healthcare worker which elements could be freed up to use in a Personal Health Budgets.

(iv) Direct Payment processes and support require strengthening – it is proposed to develop an integrated process within Tameside MBC to support Personal Health Budget Direct Payments for Tameside patients (Derbyshire County Council has established a process to support Direct Payments for all the Clinical Commissioning Groups). Additional Direct Payment capacity to ensure Care Act compliance has been agreed within the Adult Social Care Transformation Funding and it is proposed that this is developed further to support Integrated Personalised Budgets. The back office systems can support the development of Personal Health Budgets, joint marketing strategy, joint contract around payroll/pre-paid cards to provide more efficiency across the system.
Action:- A working group has been set up to take forward this work, including Legal support and internal audit as required.

(v) Stronger clinical leadership is required to support health professionals to engage in Personal Health Budgets as a solution rather than a threat and to support staff to undertake person centred personal support planning. As the Personal Health Budget Coordinator has returned to her substantive post it is proposed that the role is re-advertised with reviewed job description in order to cover all the requirements of the role. It is also proposed that leadership for Personal Health Budgets transfers from the Commissioning team to the Nursing and Quality team as in line with other individual commissioning.
Action:- The £75,000 Personal Health Budget is re-established to enable the recruitment of a full time Band 7 clinical Personal Health Budget Coordinator, and 0.5 whole time equivalent Band 3 administrator and to have a small working budget for the local Personal Health Budget Offer.

(vi) Greater emphasis on benefits of Personal Health Budget within Continuing Healthcare and more straightforward process for converting patients packages is required.
Action:- Continuing Healthcare and Personal Health Budgets paperwork is being reviewed so that Personal Health Budgets are offered as default for all community Continuing Healthcare cases and the process for converting is simplified.

(vii) Numbers taking up the offer of Personal Health Budgets is low in Tameside and Glossop so concerted effort is required to increase the numbers. It is proposed to focus on groups of patients who already have funded personalised healthcare packages including Continuing Healthcare, Section 117, and Transforming Care as a priority, including Integrated Personal Budgets for those in joint funded packages.
Action:- Nursing and Quality team are developing an action plan to increase the numbers.

(viii) Expansion of the offer to other areas such as Personal Wheelchair Budgets and End of Life planning can be supported through working with other Clinical Commissioning

Groups in the Greater Manchester Public Health Budget Working Group to develop a common approach across Greater Manchester. See 3.4 below.

(ix) To date there has been a lack of local partners with an interest in supporting Personal Health Budgets either though Support Planning or in provision of services (other localities have benefitted from having a strong voluntary and community sector interest e.g. Disability Derbyshire).
Action:- We are working with Greater Manchester leads to identify support available across Greater Manchester with the aim of having an approved list of providers and develop the support market.

3. GREATER MANCHESTER DEVELOPMENTS

3.1. Greater Manchester Health and Social Care Partnership have established a Personalisation programme which has been merged with a broader person and community centred approaches programme initiated through the population health plan. An Associate Lead for the programme (Giles Wilmore) is in place and a full programme is in development, on track for a September initiation. The scope of the programme includes person centred planning, community and asset based approaches; self-care and personal budgets. As part of the development of priorities Giles and colleagues are offering to visit each locality and meet with local leaders and stakeholder to understand programmes in this area, and discuss how we would work together productively and offer in useful support.

3.2. The programme is under development with both ‘programme’ and ‘campaign’ components spanning:
- Influence and Leadership;
- Partnership and co-production;
- Support and Delivery;
- Incentives and Enablers.

3.3. A call for people interested in being part of a core co-production group has been circulated and one of our Personal Health Budget patients is interested in joining. This is for people with lived experience (for themselves or a family member) of person and community centred approaches and/or personal budget approaches who would like to get involved in the programme and help shape and co-deliver it.

3.4. While the programme is still in a design phase, as committed to, certain elements of the programme are being established and set up ahead of initiation. These are summarised below:

- **Local innovation and change support using Rapid Results Methodologies.** We know that for real transform to happen, frontline staff and local communities need to own and drive the change. In partnership with NESTA we are working with Bolton, and Tameside and Glossop to launch 2 ‘100 Day Challenges’ in Autumn. These approaches will focus on the people, relationships and networks that make up health and care systems locally. Teams of front-line staff come together for 100 days to focus on highly ambitious goals, and are given the freedom to test and develop new ideas and approaches (some of which will work, others will not). Leaders shift their focus from “coming up with solutions” to “permissioning” and creating the space and confidence for teams to begin owning and experimenting around tricky issues. Both localities are using the 100 Day Challenge to explore and innovate around the establishment of integrated person and community centred approaches at a neighbourhood team level. It is hoped that similar offers can be made to all Greater Manchester localities following formal agreement of the programme and resourcing.
Action:- We need to include a wide range of partners in the 100 Day Challenge, including Community Mental Health Teams, District Nurses, Long Term Conditions and

REHAB staff. The NESTA projects for Tameside and Glossop have been agreed as Preventing Diabetes in Hyde/Denton and end of life care in Glossop. There is a wider piece of work underway around person centred care and support planning/asset based assessment/asset based approaches. Ashton/Dukinfield, Mossley, Stalybridge will be piloting the roll out of the PAM tool in addition to the NESTA work.

- The **personal health budget and integrated personal budget project.** This will aim to support localities to be in a position to scale Personal Health Budgets in Continuing Healthcare and beyond, and work with local authority colleagues to create integrated personal budget delivery systems. Priority themes from a workshop on 5 June are being woven into the overall programme design and are:
  - Development of support planning and brokerage services – including, potentially, collaboration across GM on specs, a framework approach and market development;
  - Awareness and skills training and coaching for staff on personal health budgets, and on broader person centred approaches and planning;
  - Delegation of clinical tasks to Personal Assistants;
  - Outcomes development and tracking;
  - Co-production and peer support;
  - Provider and market development, particularly around personalised provision such as 3rd party budgets/ISFs;
  - Collaboration on expansion of Personal Health Budgets for Continuing Healthcare and beyond.

  Action:- Personal Health Budget leads to actively support Greater Manchester work to reduce discrepancies in Greater Manchester, promote a more integrated approach and eliminate duplication of effort.

4. RECOMMENDATIONS

4.1 As set out on the front of the report.

APPENDIX 1

Subject / Title	**Tameside and Glossop CCG – Personal Health Budgets**

Team	**Department**	**Directorate**
Personal Health Budgets	MH and LD Commissioning Team	Commissioning

Start Date	**Completion Date**
April 2016	*June 2017*

Project Lead Officer	Pat McKelvey
Contract / Commissioning Manager	Pat McKelvey
Assistant Director/ Director	Clare Watson

EIA Group (lead contact first)	**Job title**	**Service**
Pat McKelvey	Head of MH and LD	Commissioning
Jayne Wilkinson	Individualised Commissioning Team Manager	Nursing and Quality Team
Julie Moore	Integrated Neighbourhood Manager	ICFT

PART 1 – INITIAL SCREENING

1a.	**What is the project, proposal or service / contract change?**	NHS Tameside & Glossop CCG (NHST&GCCG) have been given a mandate from NHS England (NHSE)to develop and expand personal health budgets (PHBs) outside of but not excluding Continuing Healthcare from 2016.
1b.	**What are the main aims of the project, proposal or service / contract change?**	A personal health budget is an amount of money to support a person's identified health and wellbeing needs, planned and agreed between the person and their local NHS team. Our vision for personal health budgets is to enable people with long term conditions and disabilities to have greater choice, flexibility and control over their health care and support they receive. From 2014 PHBs have been offered to people who meet the criteria for Continuing Healthcare (CHC). From 2016 the expectation from NHSE is for CCG's to expand the offer of PHBs locally outside of CHC. T&GCCGs local offer is offered to the following cohorts of people who **frequently use health services** such as:

		•Children with an Education Health and Care Plan •People needing long-term rehab •People with long-term health conditions who use hospital services a lot •People with long term mental health needs •People with Learning Disability or Autism and MH needs or at risk of hospital admission/are in hospital The mandate to NHSE is that the CCG will increase their PHBs from 9 to 30 by April 2017. The essential elements of a PHB are that the person with the PHB or their carer/representative will: • Be able to choose the health and wellbeing outcomes they want to achieve, in agreement with a healthcare professional • Know how much money they have for their health care and support • Be enabled to create their own care plan, with support if they want it • Be able to choose how their budget is held and managed, including the right to ask for a direct payment • Be able to spend the money in ways and at times that made sense to them, as agreed in their plan

1c. Will the project, proposal or service / contract change have either a direct or indirect impact on any groups of people with protected equality characteristics? Where a direct or indirect impact will occur as a result of the project, proposal or service / contract change please explain why and how that group of people will be affected.				
Protected Characteristic	**Direct Impact**	**Indirect Impact**	**Little / No Impact**	**Explanation**
Age	**x**			People of all ages are eligible to have a personal health budget including children. T&GCCG currently have 11 people with a personal health budget. 2 of the 11 are children with the remainder being adults under the age of 65 years. Early evidence suggests that younger patients might be more inclined to tailor make a service around their needs (a PHB) rather than those over the age of 65 who may be more inclined to choose a more traditionally commissioned service.

Disability	**x**			People with long term health conditions, long term rehabilitation needs, learning disabilities and physical disabilities will be impacted by personal health budgets, these are a cohort of patients identified in our local offer. We currently have 11 people with a personal health budget in T&G all of whom have some kind of learning disability and/or physical disability.
Ethnicity		**x**		PHBs are open to people of all ethnicity so there may be an indirect impact but no direct impact is anticipated in terms of ethnicity
Sex / Gender		**x**		PHBs are open to people of all sexes/genders so there may be an indirect impact but no direct impact is anticipated in terms of sex/gender
Religion or Belief			**x**	PHBs are open to people of all religion/beliefs so there may be an indirect impact but no direct impact is anticipated in terms of religion/belief
Sexual Orientation			**x**	PHBs are open to people of all sexual orientations so there may be an indirect impact but no direct impact is anticipated in terms of sexual orientation
Gender Reassignment			**x**	PHBs are open to everyone so there may be an indirect impact but no direct impact is anticipated in terms of gender reassignment
Pregnancy & Maternity			**x**	PHBs are open to everyone so there may be an indirect impact but no direct impact is anticipated in terms of pregnancy/maternity
Marriage & Civil Partnership			**x**	PHBs are open to everyone so there may be an indirect impact but no direct impact is anticipated for those who are married or who are in a civil partnership
NHS Tameside & Glossop Clinical Commissioning Group locally determined protected groups?				
Mental Health	**X**			People with mental health needs will be impacted by personal health budgets a cohort of patients identified in our local offer. From the 11 phbs we currently have in T&G over half have some kind of diagnosed mental health condition.
Carers		**x**		Personal health budgets can support carers. Early evidence suggests that carers benefit if the person being cared for opts for a personal health budget as the individual is choosing

				care tailored to their own needs. This means in some of our current live phb cases the personal health budget care plan has included more support from external agencies to enable more free time for the carer.
Military Veterans			x	PHBs are open to everyone so there may be an indirect impact but no direct impact is anticipated in relation to military veterans
Breast Feeding			X	PHBs are open to everyone there may be an indirect impact but no direct impact is anticipated in terms of this particular characteristic.
Are there any other groups who you feel may be impacted, directly or indirectly, by this project, proposal or service / contract change? (*e.g. vulnerable residents, isolated residents, low income households)*				
Group (*please state)*	**Direct Impact**	**Indirect Impact**	**Little / No Impact**	**Explanation**
Children with Education Health & Care Plans People with long-term rehab needs People with a long term condition People with long term mental health needs People who are at risk of hospital admissions	x			All of the groups stated are part of the CCGs local offer to expand personal health budgets so therefore all of these people will be directly affected. Personal Health Budgets does not exclude anyone who is vulnerable, isolated or from a low income household. Any of these people can apply and be deemed eligible to have a phb.

1d.	**Does the project, proposal or service / contract change require a full EIA?**	**Yes**	**No**
		x	
1e.	**What are your reasons for the decision made at 1d?**	The introduction of PHBs to a wider cohort of patients than those in receipt of Continuing Healthcare will potentially impact a number of protected characteristic groups either directly or indirectly (as outlined in table 1c). It is therefore necessary to undertake a full EIA to investigate these impacts further.	

PART 2 – FULL EQUALITY IMPACT ASSESSMENT

2a. Summary
On the completion of part 1, a need has been identified for a full Equality Impact Assessment (EIA) to be undertaken. The decision to complete a full EIA has been made because the project has been identified as having an impact on a number of protected characteristic groups. However, although some groups will be affected it is deemed that the affect will be mainly of a positive nature and will not negatively or adversely affect any of the above protected characteristic groups due to the nature of the project PHBs will be an enabler for local people to have more choice, control and flexibility over their own healthcare. For information the 5 key essential parts of a personal health budget to determine if a person is eligible are: • The person knows up front how much money they have to spend, so they can use that information to plan and budget in an ongoing way • The person chooses the personal health outcomes to be achieved, in agreement with their health professional • The person is enabled to create their own care plan, with whatever support they may want, to meet care planning process criteria • The person freely chooses the way in which their budget is held and managed (direct payment, notional budget or third party – or a combination of all three). • Whichever option is chosen by the person, the person must be able to spend it at times and in ways that is agreed in their care plan Nationally NHE's ambition for personal health budgets is that by March 2021, 1-2:1000 of the population will have a personal health budget in line with the national Mandate. Locally for Tameside and Glossop this equates to 250-500 people. The CCGs mandate to NHSE is by the end of April 2017 the CCG will have increased the number of Personal Health Budgets from 9 to 30. Personal Health Budgets (PHB) will allow people to move from a world where others know best to one where their input is valued above all others, but not in isolation from others. It is a way people can be at the heart of the planning process, identifying with key health professionals the things that really matter to them, and which allow them to lead a safe and fulfilling life. This will lead to available budgets being used in a more innovative and creative way, rather than reliance on traditional NHS services.

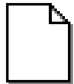
2b. Issues to Consider
• Raising expectations with potential reputational risk to the CCG/negative media coverage/complaints • Individuals consent to an element of risk in their personalised care plan • Governance of individuals personal information By offering a PHB outside of continuing healthcare the CCG must have clear and transparent PHB processes in place which all healthcare professionals can freely access. Healthcare professionals communicating the potential of having a PHB to an individual must first fully understand the concept of having a PHB. Without this initial understanding and an awareness of the process expectations could be raised inadvertently to individuals, which could lead to a complaint, legal implication and/or negative media coverage should the PHB not be agreed to.

Empowering individuals to take control of their own health can generate a perception of increased risk and adverse consequences. However, in reality there is likely to be a reduced risk because individuals have been consulted on their choices, are actively involved in the decision making process and take ownership of, and some pride in, the responsibility for achieving their own health outcomes. Again the CCG must clearly identify and be transparent in their systems and processes in terms of how they will manage risk and how they will monitor risk.

2c. Impact

The wider introduction of PHBs will ensure people will have more choice, control and flexibility over their own healthcare. Rather than traditionally commissioned services which in some cases may not be working for individuals, the option of having a PHB would act as an enabler to tailor make a care plan that could potentially meet a desired health need and meet an agreed health outcome.

2d. Mitigations *(Where you have identified an impact, what can be done to reduce or mitigate the impact?)*	
Raising expectations, negative media coverage/complaints	Clear communication to staff re the concept of PHBs along with current systems and processes via awareness raising to all staff A page dedicated to personal health budgets on the CCGs internet site. This includes a leaflet explaining the concept of a PHB, who can have one and who can apply for one
Regular Management and Monitoring of Risks	Personal Health Budget Panel meets monthly. This will ensure regular monitoring and monitoring of risks relating to PHBs. This will also help identify whether any protected characteristic groups in particular are accessing PHBs and help monitor support around these accordingly.
Ensure robust Information Governance arrangements are in place	Information governance is a core element of the NHS. For reference a data processing agreement is in place, signed off by the CCGs Governance Committee

2e. Evidence Sources – included in the box below are documents that are available to mitigate risks as explained in 2d
Existing documents – NB These will be reviewed in line with the actions outlined in this paper   Tameside and Glossop personal hea  leaflet--tameside-personal-health-budget-:   TOR_PHBpanel_August16_(ver3).doc   data_processing_agreement_for_phb_bet

2f. Monitoring progress		
Issue / Action	**Lead officer**	**Timescale**
EIA will be refreshed after the actions identified in the report have been completed.	Pat McKelvey	December 2017

Signature of Contract / Commissioning Manager	Date
Signature of Assistant Director / Director	**Date**

APPENDIX 2