Explanatory Memorandum to the National Health Service (Direct Payments) (Wales) Regulations 2026 and the Local Health Boards (Directed Functions) (Wales) (Amendment) Regulations 2026.

This Explanatory Memorandum has been prepared by the Health, Social Care and Early Years Group and is laid before Senedd Cymru in conjunction with the above subordinate legislation and in accordance with Standing Order 27.1.

Minister's Declaration

In my view, this Explanatory Memorandum gives a fair and reasonable view of the expected impact of the National Health Service (Direct Payments) (Wales) Regulations 2026 and the Local Health Boards (Directed Functions) (Wales) (Amendment) Regulations 2026. I am satisfied that the benefits justify the likely costs.

Dawn Bowden MS
Minister for Children and Social Care
20 January 2026

PART 1 – EXPLANATORY MEMORANDUM

1. Description

1.1. The Health and Social Care (Wales) Act 2025 ("the 2025 Act") received Royal Assent on 24 March 2025. It contains provisions to (amongst other things) enable introduction of Direct Payments for NHS Continuing Healthcare (CHC).

1.2. Through the 2025 Act, the NHS (Wales) Act 2006 ('the 2006 Act') now includes provisions, which when commenced, enable the introduction of direct payments for health care in Wales.

2. Matters of special interest to the Legislation, Justice and Constitution Committee

2.1 None.

3. Legislative Background

3.1. Part 2 of the 2025 Act (health care) makes amendments to the 2006 Act which, when commenced by Order of the Welsh Ministers, will enable the making of payments for CHC in lieu of the receipt of services directly provided or commissioned by the NHS (see new section 10B – direct payments for health care, inserted into Part 1 of the 2006 Act by section 24(2) of the 2025 Act).

3.2. The proposed NHS (Direct Payments) (Wales) Regulations 2026 will be made under powers in the new provision in Part 1 of the 2006 Act (see new section 10C of the 2006 Act (regulations about direct payments), also inserted by section 24(2) of the 2025 Act). These Regulations will be made under the Senedd Approval (affirmative) procedure.

3.3. The proposed Local Health Board (Directed Functions) (Wales) (Amendment) Regulations 2026 will be made under existing powers in the 2006 Act (section 12) to delegate the exercise of the Welsh Ministers' functions relating to direct payments to Local Health Boards, by making amendments to the Local Health Boards (Directed Functions) (Wales) Regulations 2009. These Regulations will be made under the Senedd Annulment (negative) procedure.

3.4. Together the regulations set out how Local Health Boards will manage and deliver direct payments for health care. The policy intention is for these Regulations to be used to enable introduction of direct payments for NHS Continuing Healthcare (CHC), specifically for adults who are eligible for CHC.

4. Purpose and intended effect of the legislation

4.1. The Programme for Government contains the commitment to 'Improve the interface between continuing health care and Direct Payments'.

4.2. Continuing Health Care (CHC) is provided when an individual has a primary health need which outweighs their needs for other care and support, and is subject to regular reassessment. The health and care needs are paid for wholly by the NHS in accordance with duties under the NHS (Wales) Act 2006 ("the 2006 Act"), without any charge for the person receiving the care as, subject to limited exceptions, health care must be provided free at the point of delivery. Direct payments are not possible under the 2006 Act at present.

4.3. For social care, legislation enabling a local authority to make direct payments is already in place. Direct payments within social care are payments made by local authorities in accordance with duties in Part 4 of the 2014 Act, which are paid to individuals, or, in appropriate cases, their representative, to enable them to secure services to meet their eligible needs for care and support, or support needs in the case of a carer. Direct payments allow people to exercise voice and control; that is, to decide how, when and by whom their eligible care and support needs are met.

4.4. There is evidence that some people with complex health conditions are refusing CHC assessments. This can be for a number of reasons but these reasons often include:

- not wanting to lose the voice and control they have through local authority direct payments and the further feeling of loss of independence;
- concern that there may be fluctuation in CHC eligibility that could interrupt their stable package of care.
- concern that they may have to let one or more trusted and familiar Personal Assistants go because traditionally commissioned CHC offers less flexibility and choice in terms of the care provider.

4.5. Some people will therefore continue to contribute to their social care costs, with the local authority also contributing, depending on the financial assessment, where this would otherwise be fully funded by the NHS under CHC.

4.6. If a person is assessed as eligible for CHC but refuses a CHC package, it will not automatically mean that the status quo can be maintained and that the local authority retains responsibility for meeting their care and support needs. A local authority is not under a duty to meet needs for care and support which can be provided by other means (in this case by the NHS via a package of care to meet a need for primary health care via entitlement to CHC). Furthermore, section 47 of the 2014 Act sets out the limits of a local

authority's power to provide services which are required to be provided under a health enactment, such as the 2006 Act.

4.7. Over a number of years, stakeholders have raised the issues around this interface and the compromise of people's voice and control when transferring from local authority provided care (with direct payments), to CHC (where that option is lost).

4.8. In England, direct payments have been permissible under CHC, via Personal Health Budgets (PHBs), since 2014. PHBs can be used to meet a person's needs as set out in their care plan and are available for adults' and children's CHC. PHB provision also covers other areas including after-care in mental health (under section 117 of the Mental Health Act 1983) and wheelchairs.

4.9. There are three types of PHB in England: a notional budget where the money is held by the NHS; a third party budget; and direct payments. The first two types are already permissible in Wales under current legislation (the second option in the form of an Independent User Trust), however the third type – direct payments – is not yet possible in Wales. There are a number of types of service that may be required by an individual under the 2006 Act for which direct payments are not available to a person entitled to CHC under arrangements made in England, including primary and general medical services, drugs, medicines, appliances, dental charges, planned surgery, vaccination, NHS Health Checks, and alcohol, tobacco, and gambling services.

Change to legislation

4.10. In order to address the issues, the 2025 Act amended the 2006 Act to allow the Welsh Ministers to make direct payments to individual patients; this will enable them to secure services to meet their assessed needs for health care in lieu of receiving services provided or commissioned by the NHS in Wales.

4.11. The policy intention is to use this power to enable direct payments to be made to persons who have been assessed as having a primary health need and are therefore entitled to receive CHC. The draft regulations described within this explanatory memorandum fulfil this policy intention.

4.12. The demand for a policy change in this area has been growing to address concerns of unfairness and lack of voice and control faced by disabled and seriously ill people. LHBs currently commission a significant portion of most CHC packages from private sector care home providers and domiciliary care agencies, who in turn may purchase or commission health care such as nursing. The introduction of direct payments will therefore improve voice and control for individuals by allowing them more of a choice in how, and by whom, their care is delivered. Currently individuals have limited control over how their care is delivered under CHC.

Policy principles

4.13. The objectives are to ensure fairness and equality for disabled and seriously ill people, ensuring they do not lose voice and control over their care, when receiving CHC. Initially the provision of direct payments within CHC will be focused on adults receiving CHC in their own homes only, as this is where stakeholder feedback has indicated the most demand for increased voice and control exists currently.

4.14. This is in keeping with the principles of voice and control, person-centred care, equality and the Social Model of Disability. The approach should also support the principle of partnership working and integration, therefore allowing an improved interface between the delivery of local authority direct payments and direct payments made by the NHS in Wales.

4.15. We are also following the principle of co-production in working with stakeholders, including disabled people and people with lived experience, to refine how the proposals should be implemented.

Intended effect

4.16. The proposed changes are intended to ensure individuals have a strong voice and control over their care, whether responsibility for the provision of that care rests with a local authority or a local health board. The changes should potentially lead to more individuals agreeing to undergo CHC assessments, without fear of losing an entitlement to direct payments, and therefore having their complex health needs better managed as a result of having their full package of healthcare and care funded by the NHS.

4.17. The evaluation of the PHBs three-year pilot in England[1] found that use of personal health budgets was associated with a significant improvement in quality of life and psychological well-being. There is also evidence to show that better health outcomes are achieved when someone has a greater say in their own care. Direct payments support the provision of care in a person's own home and studies in England have shown that this can provide better value for the public purse.

Timelines

4.18. The intention is for the Regulations to come into effect on 1 April 2026.

5. Consultation

5.1. A public consultation to inform the development of Regulations ran for a 12-week period from 16 July to 8 October 2025. The consultation received 57 formal responses from a wide range of stakeholders, including

[1] Forder_et_al_2012_PHBE_final_report_nov_2012.pdf (kcl.ac.uk)

individuals, Local Health Boards (LHBs) and local authorities, care providers, academic institutions, Disabled People's Organisations and third-sector organisations. Respondents included Disability Wales, All Wales Forum of Parents and Carers for People with Learning Disabilities, Age Cymru, Dewis Centre for Independent Living, Ty Hafan, the Older People's Commissioner for Wales and ADSS Cymru. LHBs provided a joint response and five also responded individually.

5.2. The original consultation, the summary of responses, and the full responses, are all available at the following link: Proposed regulations for direct payments in health and social care | GOV.WALES

5.3. Key themes emerging from the analysis are as follows:

Proposal to delegate to LHBs the function of making direct payments

a) There was broad support across all sectors for the overarching proposal to delegate to LHBs the function of making direct payments for healthcare. Many respondents strongly agreed, and another large proportion agreed in principle, but had reservations about certain operational aspects. This is in line with the responses to the 2022 consultation on the primary legislation: Proposed changes to legislation on social care and continuing health care | GOV.WALES.

b) The overarching message was that while the proposal is welcomed, respondents emphasised that success depends on a variety of factors such as robust statutory frameworks, adequate resourcing, and clear implementation guidance.

Circumstances for offering a direct payment

c) In terms of the circumstances in which direct payments might be offered, there were strong contrasts of emphasis between different sectors. Disabled individuals and their representative bodies stressed the importance of ensuring broad access to direct payments, backed up by flexibility of approach and family support. Local authorities and other public bodies also advocated a person-centred approach with strong support mechanisms. LHBs and care sector providers, however, emphasised the importance of clinical factors, risk-based governance, and adequate skills and training in determining when direct payments should be offered.

d) On the issue of assessment by LHBs before offering direct payments, there was broad support for person-centred, enabling, and co-produced assessments, leading to robust care and support plans. The

main differences of opinion lay in the balance between flexibility and safeguarding and the associated levels of bureaucracy. Individuals and the third sector prioritised autonomy and empowerment, while statutory and provider sectors put more emphasis on governance and risk management. This was similar for the responses on conditions to be complied with by those in receipt of direct payments. Record keeping and audit processes were strong themes on all sides, but whereas LHBs see them as essential for managing risks and ensuring safety, individuals and disability organisations said they can be overly complex and punitive.

e) There was support for clearly identifiable, accountable care co-ordinators, and for the availability of flexible, well-defined one-off direct payments as an additional option in some circumstances.

Information, advice and support

f) As was seen during the Bill scrutiny period, information, advice and support were seen as essential. Key themes were clarity and consistency across Wales**,** accessible formats**,** as well as tools, templates, and real-life examples to help families and professionals navigate the system. There is strong encouragement for LHBs to work with local authorities and third-sector organisations, especially as doubts were expressed about the level of knowledge, infrastructure and resources that LHBs have to deliver this aspect.

g) In terms of the payments themselves, there were calls from service users and their advocates for the financial support to be adequate, responsive to changes in individuals' needs and with supportive rather than burdensome monitoring. LHBs on the other hand highlighted the need for clear protocols and regular financial monitoring and raised concerns about capacity, training, and the complexity of managing direct payments. Local authorities stressed the robustness of their existing systems for monitoring and review; they advocated alignment with current social care practices and offered to share their expertise.

Repayment and cessation of direct payments

h) In respect of repayment or cessation of direct payments, clear, fair and well communicated processes were called for by all sectors. LHBs again raised concerns about their capacity to carry out financial and administrative aspects of direct payments, and individuals called for processes to be proportionate, with good support and clear

communication. They emphasised the need for robust appeal mechanisms and transitional support in cases of cessation.

Guidance

i) There was a wide range of recommendations regarding the content of guidance to accompany the proposed Regulations, covering all of the areas outlined above. Disabled respondents highlighted the principle of “Nothing About Us Without Us”, and for guidance to be rooted in the social model of disability, promoting voice, choice, and control for recipients.

j) Access to practical advice on the role and responsibilities of an employer were stressed as well as how to access training, and on the delegation of clinical tasks.

k) Explicit lists of permitted and excluded uses of funding were frequently called for, however conversely, flexibility and broad options for usage were also considered crucial by service users, going beyond purely clinical needs. There were calls for parity in terms of the guidance between health and social care direct payments.

l) Finally, in response to the questions around how direct payments can support equalities and the Welsh language, there was a positive assessment of their potential, due to the option for care to be tailored to individual needs and preferences.

PART 2 – REGULATORY IMPACT ASSESSMENT

6. Regulatory Impact Assessment (RIA) summary

6.1. A Regulatory Impact Assessment has been completed for the Local Health Boards (Directed Functions) (Wales) (Amendment) Regulations 2026 and the National Health Service (Direct Payments) (Wales) Regulations 2026, both of which relate to the policy intention to introduce direct payments for adults eligible for CHC. The Regulatory Impact Assessment follows below.

Options, costs and benefits

<u>Continuing Health Care (CHC) and Direct Payments</u>

7.1 The options are:

- **Option one:** business as usual: do not introduce subordinate legislation to permit the provision of direct payments as an option for NHS CHC.
- **Option two:** introduce subordinate legislation (the Local Health Boards (Directed Functions) (Wales) (Amendment) Regulations 2026 and the National Health Service (Direct Payments) (Wales) Regulations 2026), to allow the Welsh Ministers to make direct payments to individuals entitled to receive Continuing Health Care (CHC).

Option one: business as usual

7.2 Under this option, direct payments for CHC will not be possible, as subordinate legislation is needed to allow the Welsh Ministers (or health boards acting on their behalf) to make direct payments. Currently only local authorities are able to make direct payments to individuals or their representatives to enable them to meet their needs for social care and support under the Social Services and Well-being (Wales) Act 2014 (“the 2014 Act”).

7.3 When individuals are having their social care and support needs met by local authorities’ duties under the 2014 Act, they have the option of accessing direct payments, enabling them to exercise voice and control; that is, to decide how, when and by whom their eligible care and support needs are met. When transferring from local authority provided social care to CHC, individuals who are receiving care in their own homes cannot access direct payments and therefore lose the independence to exercise voice and control over their eligible care and support needs.

7.4 There is evidence that some people with complex health conditions are refusing CHC assessments. This can be for a number of reasons but these reasons often include:

- not wanting to lose the voice and control they have through direct payments and the further feeling of loss of independence;
- concern that there may be fluctuation in CHC eligibility that could interrupt their stable package of care.
- concern that they may have to let one or more trusted and familiar Personal Assistants go because traditionally commissioned CHC offers less flexibility and choice in terms of the care provider.

7.5 Some people will therefore continue to contribute to their social care costs, with the local authority also contributing, depending on the financial assessment, whereas this would be fully funded by the NHS under CHC.

7.6 In England, direct payments have been permissible for CHC via Personal Health Budgets since 2014 (following amendments to the National Health Service Act 2006 which took effect in 2013).

7.7 Over a number of years, stakeholders have raised issues around the interface between CHC and direct payments in Wales, and the compromise of people's voice and control when transferring from local authority provided care, with direct payments, to CHC, where that option is lost.

7.8 This was discussed with the Petitions Committee in May 2022 through the Petition P-05-1106 - Introduce Personal Health Budgets and Personalised Care in Wales[2] and it is recommendation 8 in the Audit Wales report 'Direct Payments for Adult Social Care' that Welsh Government ensures that people who receive both NHS continuing healthcare and Direct Payments have greater voice, choice and control in decision making. [3]

7.9 As a first step in addressing this situation, the revised '*Continuing NHS Healthcare National Framework for implementation in Wales*', published in July 2021 and operational as of April 2022, contains an increased emphasis on enhancing voice and control for individuals in receipt of a package of care provided through CHC.[4] Welsh Ministers have undertaken to review the Framework within five years of implementation (i.e. by April 2027).

7.10 Under the revised framework, potential options for achieving improved voice and control were highlighted, one of these being the establishment of an Independent User Trust (IUT). This is an arrangement whereby a group of trustees can receive and administer CHC funds on behalf of an individual. It does not offer the same voice and control as direct payments, but is a step towards it.

[2] P-05-1106 Introduce Personal Health Budgets and Personalised Care in Wales (senedd.wales)
[3] Direct Payments for Adult Social Care (audit.wales), page 12
[4] National framework for Continuing NHS Healthcare | GOV.WALES

7.11 Work has been progressing on this option, to include the co-production of guidance and work to establish a pilot IUT in Betsi Cadwalader UHB. The complexities involved in this option mean that it would not be a route suitable for very many CHC recipients.

Option two: introduce the Local Health Boards (Directed Functions) (Wales) (Amendment) Regulations 2026 and the National Health Service (Direct Payments) (Wales) Regulations 2026, to allow the Welsh Ministers to make direct payments to individuals entitled to receive Continuing Health Care (CHC).

7.12 Under Option two, the Local Health Boards (Directed Functions) (Wales) (Amendment) Regulations 2026 and the National Health Service (Direct Payments) (Wales) Regulations 2026 will be introduced to allow the Welsh Ministers to make direct payments to individuals entitled to receive Continuing Health Care (CHC). The regulations set out details and conditions of when the direct payments could be made available.

7.13 This option will improve the interface between CHC and direct payments to address the issues raised and to enable individuals to retain independence and voice and control when transferring from local authority provided care to CHC. It would support improved fairness and equality for disabled and seriously ill people, whether receiving care from the local authority or the health board, and support the principles of person-centred care.

Costs and benefits

7.14 There is a degree of uncertainty around the costs for these regulations. In particular, the number of people who will opt to shift from receiving social care payments to a CHC direct payment is unknown. A best estimate for this number has been sourced from ADSS Cymru. The nature and cost of the care package received will depend on each individual's specific circumstances. Unless otherwise stated, the average cost of a social care package and CHC package has been used in the calculations.

7.15 Finally, the duration for which individuals continue to receive a CHC package varies from one case to the next, with people ceasing to receive payments for a variety of reasons. No data is available for the average length of time for which people receive CHC care packages. In the absence of this information and to enable costs to be estimated for the RIA, a simplifying assumption has been made that once an individual receives a CHC direct payment, they will continue to receive that payment for a five-year period.

7.16 The cost estimates underpinning this Regulatory Impact Assessment reflect those underpinning the Regulatory Impact Assessment for the 2025 Act. The figures for 2022–23 continue to represent the most robust and reliable data available. The average cost of a social care package

was derived from a specific study undertaken by Social Care Wales, and no more recent equivalent data has been published. In relation to Continuing Healthcare, while total expenditure figures for 2024–25 have been obtained, corresponding patient numbers are not available. As such, the 2022–23 estimates, developed with input from Local Health Boards and the National Care Commissioning Unit, remain the most consistent and credible basis for planning and assessment of cost impacts, as well as ensuring consistency with the original assessment and supporting a clear and transparent approach.

Option one – business as usual

Costs

7.17 This is the baseline option and as such the following is a summary of the baseline costs and is presented to enable a comparison to be made with the costs under Option two. Unless otherwise stated, cost figures have been rounded to the nearest £1,000.

Cost profile – current

7.18 In Wales, figures obtained by the health boards show that just over 10,000 people received CHC in financial year 2022-23. The total cost of CHC for that financial year was £448m, equating to an average cost of approximately £45,000 per person receiving CHC. There are caveats to the data however, because some cases counted relate to people receiving equipment, some relate to retrospective claims and some to costs joint-funded with local authorities.

7.19 As a comparator from England, we have obtained a range of average costings for PHBs paid via direct payments across various Integrated Care Boards. These range from £46,000 to £120,000, with a median example being £80,000. There will also of course be a variation across packages in Wales but as it is not possible to say what that variation will be we have used an exemplar cost of £50,000 at the lower end of the range obtained from England, as the figure accorded with the data and professional opinions we obtained.

7.20 To arrive at an exemplar cost of £50,000 for a CHC Package the total cost for CHC for 2022-23 was divided by the number of people in receipt of CHC that year as obtained from the LHBs (£449,000,000 divided by 10,106). This produced a figure of £44,429. Because of concerns over the consistency of the data between LHBs the National Care Commissioning Unit for Wales (NCCU) was also approached for their view on an illustrative package cost to use for planning purposes.

7.21 The NCCU suggested that an average band one care worker's hourly rate of pay for 2023-24 could be used to build a package cost. This was given as £18.15 and was based on an average of the care worker staff costs for 400 care homes. Assuming a typical package of 345 days' care

at 8 hours' care per day (2,760 hours per year) at the rate of £18.15 gives a total cost of £50,094 per year. After rounding to the nearest thousand, the package cost of £50,000 was therefore used as an illustrative figure in the calculations.

7.22 This figure does not include additional costs such as administration overheads, IT systems etc. which are accounted for elsewhere in these calculations under central administration costs subheadings.

7.23 Over the past ten years there has been a rise in spending on CHC, leading to an increasing focus on seeking value for money and on finding innovative commissioning and monitoring options to ensure sustainability. The rise in CHC costs is likely to be due to a number of factors, including an ageing population, increases in chronic disease, changes in lifestyle, and increases in health care costs.

Table 7.1 Expenditure on CHC – all LHBs over 10 years from 2013-14 to 2022-23

	Aneurin Bevan UHB	Betsi Cadwaladr UHB	Cardiff & Vale UHB	Cwm Taf Morgann-wg UHB	Hywel Dda UHB	Powys tHB	Swansea Bay UHB	TOTAL
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
2013-14	56,339	68,286	40,030	22,886	45,158	10,193	35,580	**278,472**
2014-15	66,973	72,253	42,089	27,606	43,809	12,076	41,443	**306,249**
2015-16	66,541	74,827	43,559	29,756	44,484	11,733	48,518	**319,418**
2016-17	68,123	76,848	47,414	30,465	45,499	12,964	50,553	**331,866**
2017-18	70,408	91,605	55,920	34,526	47,599	12,495	49,537	**362,090**
2018-19	71,481	99,032	57,757	33,298	47,012	11,508	52,076	**372,164**
2019-20	71,005	91,324	59,128	46,653	45,118	12,461	45,601	**371,290**
2020-21	81,347	106,173	62,120	46,093	49,440	15,055	55,606	**415,834**
2021-22	83,675	101,897	65,841	49,163	48,638	20,837	61,501	**431,552**
2022-23	86,006	99,614	73,113	55,798	49,203	23,667	60,703	**448,104**
	721,898	**881,859**	**546,971**	**376,244**	**465,960**	**142,989**	**501,118**	**3,637,039**

Source – LHBs' audited accounts

Cost profile – projected

7.24 Imputation work was carried out in early 2023 to project what the costs for CHC could be in 10 and 25 years' time, without the introduction of alternative models of delivery, of which direct payments is one. The estimates from this modelling work based on an average CHC cost of £50,000 per person per year are outlined in the table below:

Table 7.2 Projecting CHC for 10 and 25 years' time:

		Ten years time (FY 32-33)			25 years time (FY 47-48)		
	2022-23	**Low**	**High**	**At £50k (22-23 prices)**	**Low**	**High**	**At £50k (22-23 prices)**
Aneurin Bevan	1,783	2,094	2,399	£105m - £120m	2,197	2,716	£110m - £136m
CTM	1,129	1,415	1,568	£71m - £78m	1,475	1,784	£74m - £89m
Betsi	1,562	819	2,012	£41m - £101m	402	2,190	£20m - £110m
Hywel Dda	2,334	2,432	3,027	£122m - £151m	2,227	3,311	£111m - £167m
Powys	536	378	699	£19m - £35m	286	776	£14m - £39m
Swansea	1,630	1,821	2,269	£91m - £113m	1,762	2,666	£88m - £133m
Cardiff and Vale	1,564	1,514	2,129	£78m - £106m	1,372	2,249	£67m - £112m
			Total £527m - £704m			**Total £484m - £786m**	

7.25 The projection work does not take account of inflation, which will considerably add to the costings over time. It should be noted that healthcare inflation can be higher than general inflation, and can also vary between disciplines. The main point is that the costs trajectory for Option One – retaining only traditionally delivered CHC and not introducing direct payments – is rising year on year.

Benefits/disbenefits

7.26 Under this option, direct payments will not be possible for individuals eligible for CHC and will continue to be possible only for individuals receiving social care provided by the local authority. This option will not address the issues around the interface between CHC and direct payments. Individuals transferring from local authority provided care to CHC will not be able to retain the independence and voice and control from which they benefit as a result of direct payments.

7.27 If an individual is assessed as eligible for CHC but refuses to transfer from local authority provided social care, it will not automatically mean that the status quo can be maintained and that the local authority will continue to meet the individual's care and support needs, as a local authority is not under a duty to meet needs that can be met by other means.

7.28 If individuals should be receiving CHC, and are choosing not to because they don't want to lose direct payments, they are therefore not

having their health requirements met. This is acknowledged in the Audit Wales report which says: 'Direct Payment managers also noted instances where individuals with deteriorating health needs are refusing to access NHS continuing healthcare because of fear of losing the flexibility of Direct Payments and the wellbeing improvements it brings.'(page 34) This refusal of appropriate healthcare is clearly likely to negatively impact the individual's physical and mental health in the longer term.

Option two – introduce the Local Health Boards (Directed Functions) (Wales) (Amendment) Regulations 2026 and the National Health Service (Direct Payments) (Wales) Regulations 2026, to allow the Welsh Ministers to make direct payments to individuals entitled to receive Continuing Health Care (CHC).

Costs and savings

Individuals

7.29 As stated in Option one, there has been a rise in the demand for CHC packages over the past decade due to a number of factors. There is evidence that some people with complex health conditions are however refusing CHC assessments and preferring to retain their established social care packages. Unlike CHC, social care direct payments are subject to a charging or reimbursement policy, so some people are therefore continuing to contribute towards their care costs, with the local authority also contributing. A local authority is not under a duty to meet needs for care and support which can be provided by other means.

7.30 Without introducing the Regulations under Option two, individuals eligible to receive CHC but who do not want to lose direct payments are likely to continue to contribute to their social care costs, above what can be provided for by the local authority.

7.31 Having consulted ADSS Cymru contacts who lead in relation to CHC, it is estimated that approximately five individuals per local authority are delaying or refusing to transfer to CHC for the reasons outlined above. This cohort could transfer from receiving social care direct payments to receiving CHC in the first three years of direct payments for CHC being made possible. This equates to a maximum of 110 individuals across Wales, however it is possible that some local authorities will see fewer than five individuals transferring from social care to CHC. This would be a one-off transfer of a group of individuals who are in this set of circumstances. The first CHC direct payments are expected to be paid in 2026-27, following the coming into force of the Local Health Boards (Directed Functions) (Wales) (Amendment) Regulations 2026 and the National Health Service (Direct Payments) (Wales) Regulations 2026, with the 110 individuals all assumed to have moved to CHC payments by 2028-29. After this initial period, direct payments would be an option offered to people who are assessed as eligible for CHC and meet any

direct payments criteria, so they would move across in a more gradual way.

Savings

7.32 Under Option two there will be cost savings to individuals who are eligible for CHC but who currently refuse to be assessed, or are assessed and refuse CHC packages, as a result of not wanting to lose the direct payments they currently receive for local authority provided care. It is assumed ten people will switch from social care payments to CHC direct payments in 2026-27, 50 in 2027-28 and 50 in 2028-29. The maximum contribution for individuals to their social care is set at £100 per week, depending on means test. Therefore the maximum savings per individual per year, if they could transfer to CHC, would be £5,200. It should be noted that many individuals will not be contributing to their social care costs, or will be contributing less than £100 per week. It is not possible to determine the contributions currently made by the individuals who will switch from social care to CHC direct payments and so, for the purposes of this RIA, a range of £0 to £5,200 per annum has been used. This cost-saving range has been applied to the number of people who are expected to be in receipt of a CHC direct payment each year, having switched from a social care package. The table below shows the maximum saving to individuals for the period 2026-27 to 2032-33. At the lower end of the range, the saving will be £zero in each year. As explained above, each person is assumed to be in receipt of a CHC direct payment for a period of five years. We further assume that, in the absence of the regulations permitting direct payments for CHC, they would have continued to have received a social care package for the same period. As such, the cost-saving to the 110 individuals who switch from social care to a CHC direct payment is assumed to be £zero from 2033-34 onwards.

Table 7.3 – Maximum cost-saving to individuals from no longer having to contribute to the cost of their social care package.

£	2026-27	2027-28	2028-29	2029-30	2030-31	2031-32	2032-33
Recipients	10	60	110	110	110	100	50
Maximum cost-saving	52,000	312,000	572,000	572,000	572,000	520,000	260,000

Local authorities

Savings

7.33 Under Option two there would likely be some cost savings for local authorities when individuals who are eligible for CHC and wish to receive direct payments choose to transfer from local authority provided care to CHC provided by the local health board.

7.34 According to the Audit Wales report *Direct Payments for Adult Social Care,*[5] the average social care Direct Payment for adults in 2018-19 was £12,344, ranging from £6,033 in Ceredigion to £21,836 in Wrexham.[6] These figures have been uprated to 2022-23 prices using the GDP deflator series, giving a range of approximately £6,900 to £25,000 and an average of £14,100. Using these figures, it is estimated that the cost of social care packages to local authorities ranges from £130 to £480 per week, with an average of approximately £270 per week. Those individuals who need a CHC package are considered more likely to have complex care needs and to be at the upper end of the cost range for a social care package. For the purposes of the RIA then, we assume the average cost of a social care package for the relevant individuals is £480 per week.

7.35 It should be recognised that this savings estimate is based on the maximum projected number of recipients transferring away from social care, with packages at the highest average cost. The Audit Wales report identifies that there is a large degree of variation across local authorities in Wales, so in practice this variation would apply to the transferring of costs of care also. Cost savings to local authorities could be reduced further depending on how much the individuals contribute to their own care (as previously mentioned, this is currently a maximum limit of £100 per individual per week). If we assume all individuals contribute the maximum £100, this will leave a cost of £380 per week to local authorities.

7.36 The table below shows the estimated minimum and maximum cost-saving to local authorities, assuming they would otherwise have been paying £380 and £480 per week per resident respectively. As for the individual cost-savings calculated above, it is assumed local authority cost-savings will be £zero from 2033-34.

Table 7.4 – Estimated cost-savings to local authorities from no longer having to provide a social care package to those individuals who transfer to CHC direct payments

£	2026-27	2027-28	2028-29	2029-30	2030-31	2031-32	2032-33
Recipients	10	60	110	110	110	100	50
Minimum cost-saving	198,000	1,186,000	2,174,000	2,174,000	2,174,000	1,976,000	988,000
Maximum cost-saving	250,000	1,498,000	2,746,000	2,746,000	2,746,000	2,496,000	1,248,000

[5] Direct Payments for Adult Social Care (audit.wales) April 2022

[6] The report states that following the Welsh Government's decision to suspend data collection in response to the pandemic in 2020, no data on services other than expenditure had at the time of drafting been reported nationally since 2018-19. Figures do not include Caerphilly due to technical issues with their ICT systems when the data was being collected.

7.37 Without direct payments as proposed under Option two, the local authority will continue to incur these costs through providing social care to individuals who do not want to lose direct payments.

Local Health Boards

7.38 There will be additional costs to local health boards to establish the new approach of direct payments for CHC, as there were when they were introduced for social care. As the Audit Wales report into direct payments for adult social care states: 'There will be initial costs associated with setting up or commissioning an effective Direct Payment Support Service and training staff in Direct Payment processes. But once fully operational, Direct Payments should at least be cost neutral and should realise savings from, for instance, reduced administration, review and management of providers.'[7]

7.39 Requirements for training and support services will be addressed through appropriate guidance, similar to that developed for local authority direct payments. These transitional costs are expected to be met by Welsh Government and are considered further in the next section.

7.40 If this option were not to go ahead, local health boards would not incur additional costs for establishing direct payments for CHC nor for ongoing management. However, evidence from England shows that direct payments can reduce overall CHC costs over time. NHS England analysis entitled "2018-19 analysis of the impact of personal health budgets on spending on people eligible for NHS Continuing Healthcare" produced by the Personalised Care Group, for NHS England and NHS Improvement, (July 2019) has been obtained by the Welsh Government direct payments policy team. It looks at the difference between personal health budget (PHB) costs and conventional home care package costs for CHC, and shows the following key findings:

- For cases where there was no change in assessed needs, the aggregate cost reduction for PHB packages of care was 18%.
- Within this group, the aggregate cost reduction for PHBs delivered as direct payments was 22%. (PHB cases analysed were predominantly direct payments - 71%).[8]
- Cost reductions were evident across all age groups.
- 76% of all cases analysed stayed the same or decreased in cost following transition to a PHB.
- In total, the aggregate cost reduction for all PHB packages of care was 11%, which increased to 16% for direct payments.[9]

[7] Direct Payments for Adult Social Care (audit.wales) April 2022, p25

[8] PHBs in England can be one of 3 types – direct payments, 3rd party or notional (the latter closely resembles traditional CHC as the health board commissions the care but the budget amount is made known to the individual; 3rd party budgets involve having an independent organisation manage the care package, and are not widely used as yet).

[9] A caveat noted in the report is that conclusions were based on data from a small number of sites who are amongst the most mature in relation to PHB delivery. We asked NHS England

7.41 An increased demand for CHC is likely to partially offset cost savings from implementing the direct payments approach, especially initially. This will be due to a number of individuals agreeing to assessments for CHC when they have previously refused them. As estimated, this could be a maximum of five individuals per local authority, or 110 individuals across Wales. This is a very small percentage however, 1.1% of the total CHC cohort. There may also be more demand for CHC as time goes on, due to people not refusing assessments now that they can retain their Personal Assistants whilst in receipt of CHC.

7.42 The costs for some elements of Option two are expected to build each year for an initial period before a plateau of demand is likely to be reached. Therefore it is expected that the number of individuals choosing to receive direct payments for CHC will be comparatively low for the first year, and increase for some years thereafter. Anecdotal evidence from an ICB in England showed that the numbers of PHBs delivered as direct payments in their geographical area began relatively low and grew over time.

7.43 We have estimated growth in demand for direct payments for CHC – see table 7.5 below.

Table 7.5 – projected growth in demand for CHC direct payment packages

		Transfer from Social Care to CHC DP	**Transfer from traditional CHC to CHC DP**	**New CHC packages delivered via a DP**
2026-27	**Year 1**	10	5	0
2027-28	**Year 2**	50	30	0
2028-29	**Year 3**	50	30	55
2029-30	**Year 4**	0	10	55
2030-31	**Year 5**	0	10	70
2031-32	**Year 6**	0	10	70
2032-33	**Year 7**	0	10	70
2033-34	**Year 8**	0	10	140
2034-35	**Year 9**	0	10	140
2035-36	**Year 10**	0	10	140

7.44 There will be costs incurred to local health boards for the value of new CHC recipients who have previously refused a CHC assessment but have now transferred from local authority provided care, as well as the costs for

whether we could share the report however as they have not published it they asked that it remain with the Direct Payments policy team for information only. It is available to view on NHS England's Future NHS platform which requires a log in. We have used the findings of the report as they are a good source of information and help to build an indicative picture of cost savings seen in England, although they cannot be seen as definitive.

managing and administering direct payments. It is estimated that a maximum of five individuals per local authority, therefore a maximum of 110 individuals across Wales, will transfer from local authority provided care to CHC. The current estimated average cost of CHC packages in Wales is £50,000 per individual per year. Therefore, the maximum additional cost incurred to LHBs across Wales for 110 individuals transferring onto CHC (traditionally delivered) is estimated to be £5,500,000 per annum.[10]

7.45 This movement across from social care to CHC direct payments is likely to take some time. Only a small number is expected to transfer in the first year as this year will involve a good deal of preparation and set-up. The remainder are expected to move over in years two and three. Therefore, based on the cost of traditionally procured CHC packages, the additional cost for people switching from social care to CHC direct payments is projected to be £500,000 in 2026-27, £3,000,000 in 2027-28 and £5,500,000 from 2028-29 onwards. This cost is then expected to decline in 2031-32 and 2032-33 before reaching zero in 2033-34. It is important to recognise that this number of individuals, and therefore this overall cost, is the highest estimated point, and that local authorities suggest that there could be significantly fewer individuals transferring from social care to CHC.

7.46 The figures presented above are based on the cost of traditionally commissioned CHC care packages. However, as noted above, evidence from England indicates that the cost of CHC packages delivered by direct payments can be lower than traditionally commissioned packages of CHC.

7.47 As cited in the NHS England report on the impact of personal health budgets on spending on people eligible for NHS CHC, the aggregate cost reduction for all PHB care package was 11% and the average saving for PHB direct payment packages of care was 16%. Assuming the same reduction is achieved in Wales then the average cost per CHC direct payment package would be between £42,000 and £44,500 (a reduction of between £5,500 and £8,000 per package). Based on this amount, the cost to the LHBs for providing a Package of CHC to people switching from social care can be re-calculated as £420,000 - £445,000 in 2026-27, £2,520,000 - £2,670,000 in 2027-28 and £4,620,000 - £4,895,000 in 2028-29. As shown in Table 7.6 below, this cost is then expected to decline in 2031-32 and 2032-33 before reaching zero in 2033-34.

7.48 These additional costs are expected to be at least partially offset by a reduction in the cost of providing care to those individuals who currently receive traditional CHC but who will instead opt to receive a direct

[10] This figure is higher than the corresponding saving for LAs of up to £2.75m which reflects the fact that individuals will be moving from social care packages which do not meet their complex health needs to CHC care which is tailored to meet those complex needs and is therefore more expensive. However see below for cost savings which will offset some of these transferred costs.

payment in the future. As set out in Table 7.6, some future CHC recipients will, as a result of the proposed regulations, be able to choose direct payments (with a lower average cost) when they would otherwise have received a traditionally commissioned CHC package.

7.49 Table 7.6 below shows the range of costs and savings to LHBs for CHC direct payments. The table is based on the numbers of people taking up a CHC direct payment as shown in Table 7.5 and assumes the cost of a CHC package delivered through direct payments is 11-16% lower than a traditionally commissioned CHC package. Again, the calculations assume that once an individual receives a CHC package, they continue to receive that package for a five-year period.

Table 7.6 – costs and cost-savings to LHBs for CHC direct payment packages

		2026-27	2027-28	202829	2029-30	2030-31	2031-32	2032-33	2033-34	2034-35	2035-36
Additional cost for people switching from social care to CHC direct payments (average cost of £50,000 per CHC package)	**Number of people switching per year**	10	50	50	0	0	0	0	0	0	0
	Cumulative total additional cost of switching package at 11% (£44,500) saving rate	445,200	2,670,000	4,895,000	4,895,000	4,895,000	4,450,000	2,225,000	-	-	-
	Cumulative total additional cost of switching package at 16% (£42,000) saving rate	420,000	2,520,000	4,620,000	4,620,000	4,620,000	4,200,000	2,100,000	-	-	-
Cost-saving for current CHC recipients switching to direct payments	**Number of people switching per year**	5	30	30	10	10	10	10	10	10	10
	Cumulative savings (at 11%) from switching	27,500	192,500	357,500	412,500	467,500	495,500	385,500	275,000	275,000	275,000
	Cumulative savings (at 16%) from switching	40,000	280,000	520,000	600,000	680,000	720,000	560,000	400,000	400,000	400,000

		2026-27	2027-28	2028-29	2029-30	2030-31	2031-32	2032-33	2033-34	2034-35	2035-36
Cost-saving for new CHC recipients opting for direct payments	**Number of people switching per year**	0	0	55	55	70	70	70	140	140	140
	Cumulative total of people switched	0	0	55	110	180	250	320	460	600	740
	Cumulative savings (at 11%) from switching	-	-	302,500	605,000	990,000	1,375,000	1,760,000	2,227,500	2,695,000	3,080,000
	Cumulative savings (at 16%) from switching	-	-	440,000	880,000	1,440,000	2,000,000	2,560,000	3,240,000	3,920,0000	4,480,000
Net additional costs (a negative figure indicates a cost-saving)	**At 11% savings figure**	417,500	2,477,500	4,235,000	3,877,500	3,437,500	2,580,000	80,000	-2,502,500	-2,970,000	-3,355,000
	At 16% savings figure	380,000	2,240,000	3,660,000	3,140,000	2,500,000	1,480,000	-1,020,000	-3,640,000	-4,320,000	-4,880,000

Welsh Government

7.50 There will be a number of administrative costs incurred to implement and administer CHC direct payments. A transitional period of three years (2026-27 to 2028-29) is envisaged during which Welsh Government will provide financial support to cover the costs. These administrative costs will cover setting up and funding staffing, training for both staff and personal assistants, employer support for those in receipt of direct payments plus setting up the technical side of the scheme (IT tools to support the costing of individual budgets, payment and audit tools for managing the expenditure, payroll systems etc). The costs should then be fully borne by local health boards after the three-year transitional period, at a point when some savings should begin to be realised which will be offset against the costs incurred by LHBs.

7.51 There are several potential models for implementation, however a central hub for some key administrative functions is proposed, in order to create a pool of specialised staff who can deal efficiently with management of the direct payments' elements. It will also ensure as far as possible a level playing field across Wales for those who access CHC via a direct payment. This model is based on a previous Welsh Government / NHS Wales project managing a large number of retrospective CHC claims across Wales via a single team. It is also in line with other centralised and standardised approaches being considered for data capture and financial management of CHC.

7.52 Based on other similar models, it has been assumed the central hub will need a permanent staff of 5.5 FTEs, with staff costs estimated to total £357,000 per annum. The other costs for the hub (including travel, training and office costs) have been estimated at £50,000 in 2026-27 and £47,000 in the following years. A further Welsh Government project management cost of £221,000 per annum is expected to be incurred in 2026-27 and 2027-28.

Table 7.7 – Staffing costs per year – central hub (funded by Welsh Government for years 1, 2 and 3)

	Cost			
Item	**2026-27**	**2027-28**	**2028-29**	**Total**
Centralised hub to co-ordinate delivery – 5.5 FTE staff	£357,000	£357,000	£357,000	**£1,071,000**
Travel	£10,000	£10,000	£10,000	**£30,000**
Training/induction	£10,000	£7,000	£7,000	**£24,000**
Office and overheads, supplies	£30,000	£30,000	£30,000	**£90,000**
Additional project management by core WG team	£221,000	£221,000	£0	**£442,000**
Total	**£628,000**	**£625,000**	**£404,000**	**£1,657,000**

**The proposed Centralised Hub staffing structure includes a Head of team, a senior manager, three project delivery managers and some administrative support.*

The cost of additional project management by Welsh Government is made up of a head of team, a senior manager and project manager. The travel, training/induction and office, overheads and supplies costs are based on information supplied by a local authority on their Direct Payment Team's costs.

We have estimated the office and overheads costs to be around 10% of the costs of staffing the Central Hub. As the options for a Hub are still under development this has been included as a working figure at this stage.

7.53 There will be IT costs to establish and maintain a payment platform for direct payments. The IT system will be time efficient, standardise the service across Wales and will allow accurate auditing of cashflow and expenditure. An allowance of £250,000 per annum has been made for IT costs. In line with the option to maintain maximum choice for the individual in receipt of direct payments, the option of them being able to handle their own payments, payroll etc. will be maintained as well, but in such cases full audit documentation will need to be supplied on request.

Table 7.8 – IT tools cost per year – potentially budgeting a direct payments package, payment platform and payroll function (funded by Welsh Government for years 1, 2 and 3)

	Cost			
Item	**2026-27**	**2027-28**	**2028-29**	**Total**
Includes license(s), installation, training and support (initial and ongoing) Likely to include budgeting/ care plan, secure payment platform and payroll-related tools	£250,000	£250,000	£250,000	£750,000

**IT tools may include those available to purchase for which licences are required, or they may be developed in-house within the hub where the option allows. An indicative cost has been included at this stage as it is anticipated that some licence fees may apply, and to cover costs of in-house development where appropriate. It is not possible to say definitively at this stage which IT tools and platforms may be used or developed.*

7.54 In addition, there will be direct costs for Welsh Government to commission work to monitor and evaluate the policy at a cost of £90,000 over three years (spread across 2026-27 to 2028-29). These costs are set out in table 7.9.

Table 7.9 – other/miscellaneous costs (borne by Welsh Government)

	Cost			
Item	**2026-27**	**2027-28**	**2028-29**	**Total**
Creating Guidance and other documentation and refreshing delegation guidance	£100,000	£25,000	£25,000	£150,000
Evaluation contract	£30,000	£30,000	£30,000	£90,000
Total	£130,000	£55,000	£55,000	£240,000

**The costs for creating guidance and other documentation are envisaged to include staff time, including specialist contractors' time, the creation and publication of accessible formats as well as promotion and communications, which may include events to support co-production.*

The evaluation cost is based on previous Welsh Government evaluations of a similar nature and the information has been gained through discussions with specialist evaluation teams.

7.55 Not all elements of implementation can be centralised and much will remain at a regional or local level. Assessment and review of CHC needs would still occur locally via the LHB CHC teams, who have the clinical skills to carry out that element in line with the National CHC Framework as they do for traditional CHC. Since this work already takes place at a regional or local level, this is not expected to generate an additional cost for LHBs.

7.56 Support services for those in receipt of CHC direct payments for elements such as employment support, recruitment etc. would also ideally be provided locally, with the proposal being to tap into existing services which support social care direct payment recipients. These implementation structures would need to be further developed via an Implementation Plan, but outline roles and costings are provided below.

7.57 Experience in England and Scotland has emphasised how essential providing support to direct payment recipients is to the success of the scheme. Support costs have been estimated on the basis of the cost being £500 per recipient year, with a one-off cost of £125 for new recipients.

Table 7.10 – Direct Payment support services (funded by Welsh Government for years 1, 2 and 3)

	Cost			
Item	**2026-27**	**2027-28**	**2028-29**	**Total**
Support for direct payment recipients (based regionally & sourced through approved list; likely to be existing providers of support to social care direct payments)	£9,000	£58,000	£132,000	£199,000

** There are various models and pricing structures for direct payments support. These would all need to be considered in detail and the best option identified for the selected implementation model. The costing used here is a median priced option based on costings provided by a third-party provider of support for direct payments,*

7.58 Personal Assistants (PAs) are a key element of a direct payment scheme. There are a number of additional costs associated with the increase in the number of PAs that will be needed to support the additional direct payment recipients in Wales. These costs are expected to include the training of PAs, national workshops to provide support for PAs and an opportunity to share best practice for PAs themselves and their employers and LHBs. There will also be insurance and enhanced Disclosure and Barring Service (DBS) checks' costs. These costs are set out in tables 7.11 and 7.12 below.

Table 7.11 - Training and support costs per year (funded by Welsh Government for years 1-3)

	Costs			
Item	**2026-27**	**2027-28**	**2028-29**	**Total**
Training for PAs including suite of core training modules and delegated healthcare tasks training as required by packages of care	£14,000	£74,000	£125,000	£213,000
National workshops and communications events – to promote personalised care approach, also to share guidance, progress and good practice (face to face and online)	£15,000	£15,000	£15,000	£45,000
Total	**£29,000**	**£89,000**	**£140,000**	**£258,000**

***** *Training for PAs costings are based on two models of training provided for PAs carrying out delegated healthcare tasks, offered by training providers in England. One involves provision of online training modules at an annual fee and the other provides in-person training for an hourly fee. It is assumed that a combination may be used, although with an emphasis on in-person for most tasks.*

The national workshop and communication event figures are based on information from a provider of similar services to Welsh Government, and include venue hire, speakers' fees, catering etc. The figure quoted allows for one to two regional workshops annually; along with local or online forums.

Table 7.12 – Additional cost items

	Cost			
	2026-27	**2027-28**	**2028-29**	**Total**
PA insurance	£3,000	£16,000	£39,000	£58,000
Enhanced DBS checks for PAs	£1,000	£6,000	£10,000	£18,000
TOTAL	**£4,000**	**£22,000**	**£49,000**	**£76,000**

** PA insurance costs are based on quotes from a specialist direct payments insurance provider, at the higher-level package rate which is suitable for healthcare work by PAs, currently approximately £150pp + £20 per extra PA on the policy.*

Enhanced DBS checks have been costed at currently advertised prices (currently £38 per check but due to rise.)

7.59 Totalling all of these elements, the cost to Welsh Government is expected to be a little over £1million per annum between 2026-27 and 2028-29.

Table 7.13 – Total Cost to Welsh Government, 2026-27 to 2028-29

	2026-27	**2027-28**	**2028-29**	**Total**
Costs	£1,049,000	£1,099,000	£1,030,000	£3,178,000

7.60 From 2029-30 onwards, the cost for administering direct payments is expected to transfer to the local health boards. With the exception of PA insurance and DBS checks, these administrative costs have been calculated on the same basis as above. It is envisaged that the costs associated with PA insurance and DBS checks will be incorporated by the health boards into the care package costs and therefore they are not shown separately in the table below.

7.61 It is envisaged that the totals shown below will be divided between the LHBs; they are not the sums each LHB will need to find individually.

Table 7.14 – Administrative costs to Local Health Boards, 2029-30 to 2035-36

£	**2029-30**	**2030-31**	**2031-32**	**2032-33**	**2033-34**	**2034-35**	**2035-36**
Central Hub	404,000	404,000	404,000	404,000	404,000	404,000	404,000
IT	250,000	250,000	250,000	250,000	250,000	250,000	250,000
Direct payment support services	131,000	198,000	235,000	260,000	296,000	314,000	324,000
PA training and support	75,000	89,000	89,000	89,000	154,000	154,000	154,000
Total	**860,000**	**941,000**	**978,000**	**1,003,000**	**1,104,000**	**1,122,000**	**1,132,000**

Table 7.15 – Summary of cost-savings

£		**2026-27**	**2027-28**	**2028-29**	**2029-30**	**2030-31**	**2031-32**	**2032-33**	**2033-34**	**2034-35**	**2035-36**
Individual cost-savings	Maximum	52,000	312,000	572,000	572,000	572,000	520,000	260,000			
	Minimum	0	0	0	0	0	0	0			
LA cost-savings	**Minimum**	198,000	1,186,000	2,174,000	2,174,000	2,174,000	1,976,000	988,000			
	Maximum	250,000	1,498,000	2,746,000	2,746,000	2,746,000	2,496,000	1,248,000			

Note. You cannot sum the maximum individual cost-savings and the maximum LA cost-savings. For LA cost-savings to be at the maximum level, individual cost-savings must be at the lower end of the range (i.e. zero) and vice versa.

Table 7.16 – Summary of costs

£		**2026-27**	**2027-28**	**2028-29**	**2029-30**	**2030-31**	**2031-32**	**2032-33**	**2033-34**	**2034-35**	**2035-36**
Welsh Government											
Administrative costs		1,049,000	1,099,000	1,030,000							
Local Health Board											
Administrative costs					860,000	940,000	978,000	1,003,000	1,104,000	1,121,000	1,131,000
Package costs	11% reduction	418,000	2,478,000	4,235,000	3,878,000	3,438,000	2,580,000	80,000	-2,503,000	-2,970,000	-3,355,000
	16% reduction	380,000	2,240,000	3,660,000	3,140,000	2,500,000	1,480,000	-1,020,000	-3,640,000	-4,320,000	-4,880,000
Total Cost	Minimum	1,429,000	3,339,000	4,690,000	4,000,000	3,440,000	2,458,000	-17,000	-2,536,000	-3,199,000	-3,749,000
	Maximum	1,467,000	3,576,000	5,265,000	4,737,000	4,378,000	3,558,000	1,083,000	-1,399,000	-1,849,000	-2,224,000

7.62 These summary tables show net cost-savings are only expected to be realised from year 7 or 8 of the appraisal period. The timing will depend on the level of saving from direct payments relative to traditionally commissioned CHC packages. Based on these figures, this option has a Net Present Value of between £-5.2million and £1.7million over the ten-year appraisal period. However, as set out in the next section, there are a number of unquantifiable benefits that should also be considered.

7.63 The evidence suggests that in the longer term, direct payments for CHC will be less expensive than conventional packages and will result in savings to the NHS, which can be offset against the costs that will be incurred. After a transitional phase evidence suggests there will be savings to local health boards for delivering CHC as direct payments.

7.64 An Integrated Care Board (ICB) in England told us that individuals managing their own CHC care through direct payments were typically very motivated to obtain better value for their direct payments budget than might be possible under traditional CHC. Being far closer to the care being purchased than an in-house LHB commissioning service, they are also able to monitor the full service is provided and pick up on any issues in terms of delivery.

7.65 The ICB told us that some services were being commissioned at a lower cost than the ICB is able to access. An example given was physiotherapy. It is likely that individuals are in some cases able to access services at a lower cost than the NHS as a result of procurement constraints on the NHS. Offset against this is the fact that ICBs or LHBs will have block commissioning capabilities for some services which might prove cheaper but may be less tailored to the personal preferences or needs of the individual receiving care. An evaluation of the PHB pilot programme in 2012 found that PHB holders were securing services from outside conventional NHS providers.[11]

7.66 NHS England also reported significantly fewer challenges (such as care package breakdown or crisis) when delivering PHBs as direct payments. Apart from financial considerations, evaluations from England report that direct payments for CHC are highly valued by those in receipt of them, and there are many case studies available demonstrating positive outcomes for both the CHC recipient and their families.[12]

Benefits/disbenefits

7.67 Under this option the Welsh Ministers will obtain powers to make regulations about direct payments, in order for them to enable local health boards to make direct payments to people for CHC. Welsh Ministers will be able to set out details and conditions of when the direct payments could be made available under the regulations.

7.68 This option provides the opportunity to improve the interface between CHC and direct payments, to address issues raised around the loss of independence and voice and control that individuals experience when transferring from local authority provided care to CHC. This option would support improved fairness and equality for disabled and seriously ill people, whether receiving care from the local authority or the health board, and supports the principles of person-centred care.

[11] PHBE pilot evaluation - Executive summary and report – paragraph 18
[12] NHS England » Evidence and case studies

7.69 This option would be beneficial for individuals who would be eligible for CHC if assessed but who have continued to receive local authority funded care due to fear of loss of independence, voice and control if not able to receive direct payments. It is likely that these individuals' needs will be better met by receiving CHC which may improve their health and wellbeing in the short, medium or long term. They are likely to be better able to access their local community as a result of an improvement to having their needs met.

7.70 Beyond the immediate costs of the CHC being offered via direct payments, there are longer term cost benefit implications to consider also. If individuals in Wales are not having their health needs met due to refusing CHC packages, it is likely to result in higher costs to local health boards and the NHS in the longer term, such as increased hospital admissions and increases in the duration of hospital stays.

7.71 The flexibility offered by direct payments can also be a factor in saving costs later down the line. In the English Personal Health Budgets evaluation report, clinical commissioning staff are positive about the flexibility and range of health and care services which an individual can access via a direct payment. In particular, they say that this has in their experience had a positive impact on reducing more expensive hospital service use. One commissioning manager stated "We've had ones where we've given alternative therapy, so Reiki, for example. A PHB paid for some Reiki and because of this Reiki, which was £800, the person who received the Reiki hasn't used Mental Health Services. The crisis team hasn't come out once since this Reiki happened and if you could unpick the contract and if you could break it down, you would see that that £800 as part of the personal health budget has paid as a positive that ten times over." [13]

7.72 Furthermore, English evaluations cite the opportunity offered by direct payments to deliver more self-directed, tailored and appropriate care to people as a reason for better health and wellbeing outcomes. The original personal health budget (PHB) independent 2012 evaluation, led by the Personal Social Services Research Unit at the University of Kent, showed improved quality of life and reduced reliance on unplanned care e.g. A&E admissions, as well as overall savings of £3,100 per person per year for CHC PHB holders. This included changes to direct and indirect costs and the majority of people were living in their own home.14

7.73 An evaluation of the PHB pilot programme in England found that access to direct payments for CHC was associated with improved care-related quality of life and psychological well-being.[15]

[13] https://www.pssru.ac.uk/pub/5331.pdf 2017, p11
[14] NHS England » Evidence and case studies
[15] PHBE pilot evaluation - Executive summary and report – paragraph 12

7.74 Some respondents to the consultation on the proposal to introduce direct payments for CHC in Wales highlighted likely benefits of this option alongside increased voice and control, including:

- Improved quality of care due to CHC packages being more appropriate for new recipients compared with local authority provided care;
- Improved continuity of care and a level playing field between social care and health care, and between England and Wales CHC recipients;
- Better partnership working e.g. between LAs and LHBs;
- More access to care in the language of choice e.g. Welsh, other languages

7.75 Some respondents to the consultation on the proposals highlighted some potential disbenefits, including:

- A potential worsening of the quality of care for CHC recipients when commissioning their own care using direct payments without the day-by-day regulation of the NHS, and the individuals experiencing adverse outcomes as a result;[16]
- capacity challenges in the social care system resulting in individuals not being able to source suitable services;
- a potential worsening of working conditions for PAs employed using direct payments, without the assurance of being employed directly by a large employer such as the NHS.

7.76 Other possible benefits have been identified since the consultation, including:

- Improved social value – i.e. the local pound remaining within local economies and not going out to large care providers not based locally.
- Alternative models of care reducing strain on current care workforce recruitment issues
- Patients remaining at home where they would prefer to be, and at less cost than a care home placement.

8. Competition Assessment

8.1 The proposed legislation is not intended to affect business, charities or the voluntary sector. Overall, the National Health Service (Direct Payments) (Wales) Regulations 2026 and the Local Health Boards (Directed Functions) (Wales) (Amendment) Regulations 2026 are not expected to have a negative impact on competition in Wales, or the competitiveness of most businesses.

9. Post implementation review

[16] This is a very valid concern but evidence from England has not borne out this concern, largely because of the structures, training and insurance mechanisms which are in place.

9.1 We will commission an independent evaluation. This evaluation will cover both the implementation and the impact of the introduction of direct payments for CHC. The implementation will be assessed through a process evaluation, which may include the development of a Theory of Change, which maps the inputs and activities undertaken into immediate outputs, then into longer term outcomes and impacts.

9.2 The process evaluation will also include interviews with those involved in implementing CHC direct payments to explore any barriers or issues which may have an impact on the effectiveness of the final implementation. This helps shape delivery in the future and makes sure that CHC direct payments are being delivered as intended.

9.3 The impact evaluation will then go onto test those outcomes and impacts with the intended recipients. This evaluation will make use of a variety of methods, such as using published datasets, a survey and/or in-depth interviews to explore the impact of the proposal. This will then help inform future policy development and assess the final effectiveness of CHC direct payments.

9.4 LHBs' own datasets will also be requested to provide a picture of take-up of direct payments for CHC across Wales, and this will be monitored over time to see if the option remains accessible and if, as was seen in England, demand for the option grows.