Policy

NHS
Cheshire
Clinical Commissioning Group

Personal Health Budget Policy

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This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request.

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1. Purpose and Introduction

1.1. This document sets out the policy and practice guidance developed to ensure the consistent and transparent delivery of personal health budgets for Eligible Persons. This Policy supports NHSE guidance for all individuals having the "right to have a personal health budget" afforded from October 2014. This policy has been developed in line with current legislation and the CCG will review policy guidance and practice when any new guidance, regulations or national policy is published.

1.2. The CCG will ensure that personal health budgets are value for money for patients and the CCGs. This will be done through the way in which personal health budgets are set up, through robust care & support planning and through effective monitoring of direct payments.

1.3. 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 with long term conditions and disabilities to have greater choice, flexibility and control over the health care and support they receive.

1.4. This policy outlines the principles for achieving the implementation of personal health budgets by balancing choice, risk, rights and responsibilities. It recognises that, in the right circumstances, risk can be managed so as to promote a culture of choice, and independence that encourages responsible, supported decision making.

2. Scope

2.1. This policy applies to all employees of:

- NHS Cheshire Clinical Commissioning Group

and where appropriate to all services implementing Personal Health Budgets on behalf of the above Clinical Commissioning Group

3. Legislation

3.1. The following legislation is relevant to this policy implementation:

- National Health Service (Direct Payments) Regulations 2013 Published March 2014
- Human Rights Act 1998, including the Article 8 Right to respect for private and family life, and Article 14 Prohibition of discrimination
- The Data Protection Act 1998
- The Carers (Equal Opportunities) Act 2004 provides carers with the right to receive assessment for support and a duty on various public authorities to give due consideration to a request to provide services to carers.
- The Mental Capacity Act 2005 ("MCA"). The Mental Capacity Act provides a framework for decision making applicable where people lack capacity to make a decision for themselves. The overriding principles of the Mental Capacity Act are set out and include a requirement to ensure that all practicable steps are taken to seek to enable a person to make a decision for himself. Where a person is unable to make a decision, any decision made on their behalf must be made in accordance with his/her best interests and must be the least restrictive of the person's rights and freedom of action. A person is not to be treated as unable to make a decision simply because he makes an unwise decision.
- The Equality Act 2010. The Equality Act brought together the various earlier discrimination laws under one statute. It is unlawful to act in a discriminatory manner against any "protected characteristics".
- The Children and Families Act 2014, which is partially in force and due to be fully in force by April 2015. This Act intends to improve services for key groups of vulnerable

children e.g., those in adoption and those with special educational needs and disabilities.

- The Fraud Act 2006: This sets out the general offence of fraud and is relevant to investigation of suspected fraudulent activities relating to the provision of PHBs. This is necessary to ensure the NHS Constitution principle 'The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources' is upheld.

4. History

4.1. Following a successful pilot programme by the Department of Health, which ended in October 2012, the Government announced that from April 2014, Eligible Persons would have the "right to ask" for a personal health budget, including by way of a direct payment. From October 2014, this right to ask was converted to a "right to have" a personal health budget.

4.2. This development mirrors other changes within the NHS, including the drive generally for greater patient choice, shared decision-making and innovation in managing funds. The Government confirmed a commitment to personalised care in the NHS mandate, 5 Year Forward View published in March 2014, this included identification of those with a Long term Condition who could benefit from a Personal Health Budget being given the "right to have" in April 2015.

4.3. The NHS Long Term Plan aims to expand personalised care and states *"Up to 200,000 people will benefit from a PHB by 2023/24. This will include provision of bespoke wheelchairs and community-based packages of personal and domestic support. We will also expand our offer in mental health services, for people with a learning disability, people receiving social care support and those receiving specialist end of life care."*

5. What is a personal health budget?

5.1. Personal health budgets are the allocation of NHS funding which patients, after an assessment and planning with their clinical team, are able to personally control and use for the services they choose to support their health needs. This enables them to manage identified risks and to live their lives in ways which best suit them. Enabling people to exercise choice and control over their lives is central to achieving better outcomes for individuals. For Eligible Persons there is a duty on CCGs to:

- Consider any request for a PHB
- Inform individuals of their right to have a PHB (established in October 2014)
- Provide information, advice and support in relation to PHBs

6. Principles

6.1. Increasing choice and achieving personalisation

The Clinical Commissioning Group is committed to offering opportunities for health care professionals and service users to work in partnership, making shared decisions and actively co-designing services and support. The introduction of personal health budgets is one way of doing this.

Personal health budgets give individuals more choice and control over how money is spent on meeting their health and wellbeing needs. A care and support plan is at the heart of a personal health budget that is developed through a combination of the healthcare professional's vital clinical expertise and knowledge, along with the person's expertise in their condition and their own ideas for how their needs can best be met.

The CCG is committed to promoting service user choice - where available, whilst supporting them to manage risk positively, proportionately and realistically. Good practice must support

choice. The attitude of the health care professional should be to support and encourage service user's choice as much as possible, and to keep the service user informed, in a positive way, of issues associated with those choices and how to take reasonable steps to manage them.

6.2. There are six key principles for personal health budgets and personalisation in health:

I. Upholding NHS principles and values.
The personalised approach must support the principles and values of the NHS as a comprehensive service which is free at the point of use, as set out in the NHS Constitution. It should remain consistent with existing NHS policy, including the following principles:

- Service users and their carers should be fully involved in discussions and decisions about their care using easily accessible, reliable and relevant information in a format that can be clearly understood;
- There should be clear accountability for the choices made;
- No one will ever be denied treatment as a result of having a personal health budget;
- Having a personal health budget does not entitle someone to additional or more expensive services, or to preferential access to NHS services;
- There should be efficient and appropriate use of current NHS resources.

II. Quality – safety, effectiveness and experience should be central.
The wellbeing of the individual is paramount. Access to a personal health budget will be dependent on professionals and the individual agreeing a support plan that is safe and will meet agreed health and wellbeing outcomes. There should be transparent arrangements for continued clinical oversight, proportionate to the needs of the individual and the risks associated with the care package. All care packages will be required to have a timely review with their allocated advisor, initial reviews being completed within a six week timeframe and then in line with the Continuing Healthcare / Continuing Care review.

III. Tackling inequalities and protecting equality.
Personal health budgets and the overall movement to personalise services could be a powerful tool to address inequalities in the health service. A personal health budget must not exacerbate inequalities or endanger equality. Lack of mental capacity should not be a factor. The decision to set up a personal health budget for an individual must be based on their needs, irrespective of race, age, gender, disability, sexual orientation, marital or civil partnership status, transgender, religion or beliefs.

IV. Personal health budgets are purely voluntary.
No one will ever be forced to take more control than they want.

V. Making decisions as close to the individual as possible.
Appropriate support should be available to help all those who might benefit from a more personalised approach, particularly those who may feel least well served by existing services / access, and who might benefit from managing their budget.

VI. Partnership.
Personalisation of healthcare embodies co-production. This means individuals working in partnership with their family, carers and professionals to plan, develop and procure the services and support that are appropriate for them. It also means CCGs, local authorities and healthcare providers working together to utilise personal health budgets so that health and social care work together as effectively as possible.

7. Standards for self-directed health support

7.1. The following standards for self-directed support are followed nationally and articulated as seven outcomes, which will be delivered through the implementation of this policy. These seven outcomes are:

Outcome 1 - Improved health and emotional well-being: To stay healthy and recover quickly from illness.

Outcome 2 - Improved quality of life: To have the best possible quality of life, including life with other family members supported in a caring role.

Outcome 3 - Making a positive contribution: To participate as an active citizen, increasing independence where possible.

Outcome 4 - Choice and control: To have maximum choice and control.

Outcome 5 - Freedom from discrimination, harassment and victimisation: To live free from discrimination, harassment and victimisation.

Outcome 6 - Economic well-being: To achieve economic well-being and have access to work and / or benefits as appropriate.

Outcome 7 - Personal dignity: To keep your personal dignity and be respected by others.

8. Who can have a personal health budget?

8.1. The individual must be registered with a GP within the CCG locality.

8.2. Adults who are eligible for NHS Continuing Healthcare funding and children and young people eligible for Continuing Care have had a legal right to a personal health budget since October 2014.

8.3. From 1 April 2019 it is expected that, unless there are exceptional circumstances, all individuals living in their own home in receipt of NHS Continuing Healthcare funding will have a personal health budget.

8.4. From 2 December 2019 the following groups of people will have a legal right to a personal health budget.

- People who are referred and meet the eligibility criteria of their local wheelchair service, and people already registered with the wheelchair service, when they require a new wheelchair either through a change in clinical needs or in the condition of the current chair. This group will have a right to a personal wheelchair budget to give them more choice and flexibility over the chair provided.
- People who are eligible for aftercare services under section 117 of the Mental Health Act, which is the provision or arrangement of help and support for people who have been detained in hospital under sections 3, 37, 45A, 47 or 48 of the Mental Health Act 1983, when they leave hospital. For this group, a personal health budget may be considered whenever planning is taking place for section 117 mental health aftercare needs during an admission to hospital, or at any assessment held to review the person's section 117 after-care package of support in the community.

8.5. The NHS will continue to explore further extension of legal rights to other groups which will support the NHS Long Term plan in delivering personalised care.

8.6. The CCG will also consider personal health budgets where:

- such an arrangement appears appropriate for an individual with regard to any particular condition they have and the impact of that condition on their life
- such an arrangement represents value for money
- where applicable, any additional cost is outweighed by the benefits to the individual

8.7. Declining involvement should not disadvantage the individual as in those cases normal routes to provision of a care package will apply. Should the individual wish to accept a personal health budget they are free to choose to resume a traditional care package at any time.

9. What a personal health budget can and cannot be used for

9.1. A personal health budget may only be spent on the services agreed between the service user, care manager and support planner in the care and support plan that will enable the service user to meet their agreed health and wellbeing outcomes. All agreements are confirmed and authorised within the support plan and are reviewed through the auditing process for compliance.

9.2. The Direct Payments for Healthcare: Understanding the Regulations March 2014, Paragraph 113 states "The care coordinator should normally be someone who has regular contact with both the individual receiving care, and their representative or nominee if they have one. They do not need to have 'care coordinator' in their job title - the important thing is that they fulfil the responsibilities above and that the direct payment recipient is aware of who they are and their role. While they are able to arrange with others to undertake actions, such as monitoring or review, the care coordinator should be the primary point of contact between the individual and the CCG. This is a similar role to the care coordinator in many mental health services and community matrons in NHS Continuing Healthcare."

9.3. A PHB cannot be used for:-

- Alcohol or tobacco products;
- Gambling services or facilities;
- Debt
- Core GP services
- Planned surgical interventions
- Prescriptions
- Services provided through vaccination or immunisation programmes
- Any service provided under the NHS health check or National Child Measurement Programme
- Primary medical services (such as diagnostic tests, vaccinations or medical treatment);
- Urgent or emergency treatment services (such as unplanned hospital admissions)
- NHS dentist or opticians

9.4. A personal health budget cannot be used for support or care provided by an individual living in the same household as the budget holder without the prior agreement of the CCG in accordance with paragraph 8(5A) of the Regulations. Agreement may only be obtained from the CCG if it considers that service is necessary to:

- Satisfactorily meet the service user's need for that service; or
- Promote the welfare of a service user who is a child.

The CCG will consider:

- The benefits that the service user and the proposed individual of the same of household may already be in receipt of; and
- The care that should naturally be expected from that of a family member/individual living in the same household.

9.5. An individual in receipt of a personal health budget and funded via the CCG is not allowed to contribute to or 'top-up' the cost of care as set out in the Care and Support plan from their own resources. If the budget holder considers that the direct payments are insufficient to meet his/her assessed needs then he or she should request a review of the care package by the CCG. The budget holder can purchase additional services from their own funds which are not identified in the care and support plan but this should take place separately with clear accountability.

9.6. The CCG will provide personal health budgets so that service users may use them to meet their identified health and well-being needs and outcomes. The use of such funding does not extend to the delivery of goods or services that would normally be the responsibility of other bodies (e.g. Local authority social services, housing authorities) or are covered by other existing contracts held by the CCG (e.g. community equipment via the Joint Integrated Community Equipment Service contract). However, in some cases, the CCG may agree a service which would normally be funded by another funding stream if that service is likely to meet someone's agreed health and wellbeing outcomes.

9.7. It should be noted that this list is not exhaustive and, if unsure, the service user should seek advice before expense is incurred.

10. Options for managing a personal health budget

10.1. On 1 August 2013, the National Health Service (Direct Payments) Regulations 2013 (subsequently amended by the National Health Service (Direct Payments) (Amendment) Regulations 2013) came into force across England, meaning that the NHS can lawfully offer direct payments for healthcare.

10.2. The most appropriate way to manage a personal health budget should be discussed and agreed with the person, their representative or nominee as part of the support planning process. There are three ways in which a person can receive a personal health budget:

a) Notional budget

Where an individual is informed of the amount of funding available to them and decides how the budget is used (by input into the support plan) but the CCG continues to commission services, manage contracts and make purchases etc. Notional budgets could be an option for individuals who want more choice and control over their healthcare but who do not feel able or willing to manage a budget.

b) Third party budget

A different organisation, legally independent of both the individual and the NHS, holds the money for the individual and arranges and pays for all of the services on behalf of the individual in accordance with the support plan. The third party will arrange to recruit and employ a team of Personal Assistants and manage all employment responsibilities making the care package bespoke to the individual's needs.

c) Direct payment

- **Direct payments for people with capacity**

  Where the individual receives the funding that is available to them and they purchase the services and support they want in accordance with the agreed

support plan (with or without assistance). The individual can elect to receive and manage the payment themselves or decide for it to be received and managed by a person of their choosing (a nominee). If the individual chooses a nominee, that nominee becomes responsible for managing the funds and services and accounting for expenditure.

- **Direct payments for people who lack capacity**
  Where the individual lacks capacity an 'authorised representative' receives the funding that is available to the individual as a direct payment. Alternatively the funding could be paid to a company on behalf of the individual and they will facilitate payment for all services, this will be classified as a "managed account". The authorised representative is responsible for managing the funds and services and accounting for expenditure. The 'authorised representative' must involve the individual as much as possible and act in their best interests, in accordance with the Mental Capacity Act 2005. In the case of children under 16, direct payments can be received by their parents or those with parental responsibility for that child.

10.3. A combination of the above may also be appropriate. The key principle is that the service user knows what their budget is, the treatment or care options and the financial implications of their choices, irrespective of the way the budget is actually managed.

11. How do Personal Health Budgets work?

11.1. Personal health budgets are entirely voluntary and there is no obligation for a patient to accept the offer. All individuals eligible for NHS Continuing Healthcare should be provided with a patient information leaflet explaining personal health budgets. The CHC Commissioning Practitioner can also provide further explanation as required.

11.2. The CCG websites also contain information relating to personal health budgets.

11.3. The CCGs will signpost individuals to choose a suitable organisation to provide information, advice and guidance to prospective and existing personal health budget recipients, and their families. The services provided by these organisations will include:

- Information on how a personal health budget can be used and managed
- Guidance on producing a personalised care / support plan
- Advice and support to manage a personal health budget
- Guidance on record keeping requirements
- Information about direct payments, including the responsibilities around financial monitoring that will need to be taken on by the recipient of the direct payments.

11.4. Patients and families who wish to consider and explore personal health budgets further will be supported by their Case Manager. Individuals will be supported to complete a personal health budget support plan which includes recording the clinical needs of the individual. This will begin the process of identifying risks so the care / support planning process can commence. All Commissioning Practitioners will receive the necessary training to advise on PHBs and will able to make the necessary referrals to support an individual to access personalised services. The initial information will be delivered by the care manager and will be supported by the CCG (as appropriate) to progress the request.

11.5. Following sign off by the CCG, where an individual or their representative requires further support on any element of the personal health budget, they will be able to contact their named Case Manager as detailed in the support plan.

12. Consent

12.1. Personal health budgets can only be arranged where appropriate consent has been provided by:

- A person aged 16 or over who has the capacity to consent to the arrangement
- The representative of a person aged 16 or over who lacks capacity to consent
- The representative of a child under the age of 16 (this can be those who have parental responsibility for the child)

12.2. The fact that an individual is a child or is an adult who lacks capacity to make a decision about a personal health budget does not prevent them from having one. In such cases, it will be necessary for those individuals to be appointed with a representative who is willing and able to act on the individual's behalf in relation to the personal health budget.

12.3. In order for a personal health budget arrangement to be put in place for a person who lacks capacity, a 'representative' will need to be appointed by the CCG. A representative is someone who agrees to act on behalf of someone who is otherwise eligible to receive a personal health budget but cannot do so because they do not have capacity to consent to receiving one or because they are a child.

12.4. An accepted 'representative' could be anyone deemed suitable by the CCG, and who would accept the role. Some examples of suitable representatives are:

- a friend, carer or family member;
- a deputy appointed by the Court of Protection;
- an attorney with health and welfare or finance decision-making powers created by a lasting power of attorney.

12.5. In the case of adults who lack capacity, the choice of the 'representative' must satisfy the best interest requirements of the Mental Capacity Act. This includes seeking the views of the Eligible Person, where possible, about who they would want to manage their personal health budget.

12.6. The decision making process for the appointment of the 'representative' must be documented and discussed as part of the support planning process, and agreed by the CCG.

12.7. The representative will take on the responsibilities associated with the personal health budget. Where it is believed to be appropriate to provide a personal health budget by way of direct payment, the representative must be fully informed about, and consent to accepting; the responsibilities relating to the receipt and management of the direct payment on the Eligible Person's behalf (see section 30).

12.8. The involvement of the representative should be reviewed if the Eligible Person regains capacity and/or reaches the age of 16.

13. Budget Setting

13.1. Under the traditional model of Continuing Healthcare, an assessment would be followed by the commissioning practitioner producing a support plan, i.e. a schedule prescribing episodes of care and defining specific tasks for the care worker. Under personal health budgets, after an assessment, annual review or 12 week review an 'indicative budget' is set. The indicative budget gives a financial envelope within which the personal health budget support plan is completed. The indicative budget is not a fixed amount, which cannot be exceeded, or a target to be reached, but a guide to make support planning more effective by giving an indication of how much money will be available.

13.2. The CCG implements a ready reckoner model to set the level of the PHB. This is where the decision support tool, alongside the continuing healthcare nurse assessment is used to calculate an indicative budget based on clinical need.

13.3. The personal health budget is therefore based on the money that would otherwise be spent on a service commissioned by the CCG to meet the fully funded / Joint Funded NHS Continuing Healthcare needs of the individual

13.4. For an individual whose offer of care from the CCG is domiciliary care, the indicative budget is calculated by the Commissioning Practitioner based on the requirements outlined in the support plan. The budget is calculated by identifying the hours of care an individual clinically requires and then calculating these hours against the appropriate provider rates against the level of health input. The CCG will use the CCG commissioned providers rates where more complex needs have been identified and full Continuing Healthcare eligibility has been confirmed. Where an individual has care commissioned jointly between the CCG and the Local Authority the indicative budget will be calculated by the allocated social worker using Local Authority commissioned care provider rates, where they could meet an individual's needs in their entirety. This will generate a provisional cost of care that the CCG would have paid, had it been commissioning the care on behalf of the individual. This cost will be the indicative budget.

13.5. Where an individual has an established package of care and uses Personal Assistants then the initial indicative budget will be calculated on the current cost of care. This is then open to review by the CCG. Where a package of care is transferring from a previous social care package with a previous direct payment being in place and where additional costs are identified, or if it identified that additional funding is required to strengthen the employment of Personal Assistants these costs will be included in the indicative budget.

13.6. In principle, the amount of money that would have been spent on NHS Services as part of an individual's Continuing Healthcare or Continuing Care package could be available to use as a personal health budget. As much of this budget as possible should be included in a personal health budget. Where it is not possible to do so (for example, where the money currently being used to commission services cannot be released immediately for use under a personal health budget), CCGs will work with the patient to tailor services as best as possible until this service can be provided under the personal health budget arrangement (where possible).

14. Support planning

14.1. Everyone who has a personal health budget will go through a support planning process, which leads to a person-centred support plan. Support planning for personal health budgets is fundamentally different from traditional care planning carried out for Continuing Healthcare / Continuing Care. Whereas a traditional care plan starts with the existing services, a personal health budget support plan has the indicative budget as the starting point.

14.2. A personal health budget support plan is developed jointly by the individual, (and where applicable their representative) and their case manager, and, as required, an independent broker.

14.3. Professionals involved in the support planning process should consider where collaborative working may be required. For example, children or young people may have in place or be eligible for an education, health and care plan. In such circumstances, case managers will need to work collaboratively with the social care and education professionals to ensure support planning is streamlined and to avoid duplication.

14.4. The process should be driven by the individual's choices and the support plan should clearly show how a personal health budget will be used to achieve the individual's identified health and care outcomes. This includes:

- the health needs of the individual and the desired outcomes;
- the amount of money available under the personal health budget;
- what the personal health budget will be used to purchase;
- how the personal health budget will be managed;
- who will be managing the budget;
- who will be providing each element of support;
- how the plan will meet the agreed outcomes and clinical needs;
- who is responsible for monitoring the health condition of the individual;
- who the individual should contact to discuss any changes in their needs;
- the anticipated date of the first review, including review of the outcomes;
- how the individual has been involved in the production of the plan;
- how any training needs will be met;
- identifying any risks, consequences and mitigating actions;
- contingency planning.

14.5. Good support planning involves looking holistically at the individual's life to improve their health, safety, independence and wellbeing. The individual should be supported throughout the support planning process.

14.6. The personal health budget support plan must detail how the personal health budget will be used. It is during the support planning phase that delegation of clinical tasks within personal health budgets will be considered for those wishing to receive a Direct Payment. Please see section 44 for further information.

14.7. When considering how and what care services can be commissioned, the CCG has a responsibility toward taxpayers to comply with its statutory duty to ensure that commissioning decisions take full account of the most cost effective options available, whilst also ensuring the assessed care needs of individuals are met.

14.8. Delay in arranging personal health budgets should be avoided. Where delay is unavoidable (for example, where circumstances make it difficult to plan for a person's on-going care), the reasons for it must be made clear to the individual. Regular review should take place so that a person's personal health budget can be put in place as soon as practicably possible. The CCG will make sure that this delay does not cause a delay in hospital discharges or in ensuring an appropriate package of care is in place pending finalisation of the personal health budget arrangements. An interim care package may be offered to avoid such delay.

14.9. A Care Coordinator will be named in an individual's support plan. This should be someone who has regular contact with the individual and their representative if they have one. It is likely that the named health professional will be the most appropriate person to undertake this role; this will usually be your Continuing Healthcare Commissioning Practitioner. The Care Coordinator is responsible for:

- Managing the assessment of the health needs of the individual as part of the support plan
- Ensuring that the individual, representative and relevant clinician have agreed the support plan
- Undertaking or arranging for the monitoring and review of the support plan and health of the person

- Liaising between the individual (or their representative or nominee) and the CCG as the primary point of contact

14.10. The CCG may agree to vary the support plan or the personal health budget if there is a change in circumstances. In the case of significant changes, this will take place following a review of the individual's needs. In the case of minor changes, the CCG may agree to a variation without a review being required.

14.11. The CCG may also agree to add to or amend a support plan and / or personal health budget that has previously been partially approved, once agreement has been reached on any outstanding elements. A variation may also be made following the outcome of an appeal. Irrespective of whether the change involved is major or minor, the support plan must be looked at as a whole in order to assess the full effect of the change and identify any changes in need.

15. Risk assessment

15.1. During the support planning process, the names care coordinator will have a detailed discussion with the individual and representative about potential risks, and how they can be managed.

15.2. The support plan will contain details of any proportionate means of mitigating the identified risks, and this will be informed by a discussion of the significant potential risks and their consequences. Examples of risks may include:

- Risk to the individual's health and wellbeing – clinical risk
- The individual's safety (including those around them) -safeguarding risk
- Those caring for the individual – employment risk
- The individual's budget – financial
- Purchasing services without appropriate indemnity cover

15.3. Provided the risks are clearly identified and addressed in the support plan, the plan will be considered.

15.4. No service should be included in the support plan if the CCG considers that the benefits of that service are outweighed by the possible damage to health. However, the CCG needs to ensure an appropriate balance is struck between empowerment and safeguarding.

15.5. An individual who has the mental capacity to make a decision, and chooses voluntarily to live with a level of risk, is entitled to do so. However, the CCG remains accountable for the proper use of public funds and whilst the individual is entitled to accept a degree of risk, the NHS is not obliged to fund it. In contentious cases, the process of approving support plans will need to address and resolve conflict about the treatment of risk.

15.6. Clinical governance should support flexibility and innovation where possible, so people can try alternative approaches to achieving their health goals providing all risks are identified and managed.

16. Safeguarding

16.1. The CCG has a duty of care to ensure that individuals are safeguarded and protected from harm. This is discharged through:

- Ensuring individuals and their carers are aware of how to obtain an assessment of need or carer's assessment. This would generally take place as part of the personalised care and support plans and review processes.
- Risk assessment forming part of the personal health budget assessment and approval process.
- Effective processes for the ongoing review of a personal health budget.
- Individuals and their carers being helped to understand the importance of safeguarding, and their role, including what to do if they have a concern.
- Ensuring the workforce that supports individuals and families or carers know, and can follow local and multi-agency safeguarding procedures for safeguarding children and safeguarding adults. Noting that in some cases where there are children under the age of 18, both the safeguarding children's procedures and the safeguarding adult's procedures will be working in tandem.
- Where a Personal Assistant is to be employed, all Personal Assistants must be subject to enhanced Disclosure and Barring Service (DBS) checks. Individuals cannot request DBS checks on other individuals. The CCG must therefore assist in arranging DBS checks. The CCG will not fund the cost of DBS checks. If the individual refuses, the CCG will not grant a direct payment, although other forms of personal health budget may still be made available. No DBS checks can be undertaken on close family members, members living in the same household as the individual or friends of an individual (please see section 35 which details the restrictions on employing such individuals as Personal Assistants)
- Where a Personal Assistant is already employed prior to the personal health budget (normally through Local Authority funding), the provider must check whether DBS (or CRB) checks were carried out at the time. If not, these will be required, as for a new employee

16.2. Where there are concerns about a change to an individual's capacity to consent, or manage their Personal Assistant, this must be assessed and appropriate steps taken by the CCG. Loss of capacity or ability to manage should not mean loss of a personal health budget or Personal Assistant.

16.3. That there is an acceptable level of training completed by Personal Assistant's to ensure that individual care needs can be met.

16.4. The CCG will work with the Local Authorities as lead agency should any safeguarding concerns arise concerning abuse and neglect or financial abuse of an individual receiving a personal health budget. Workers will follow the agreed local and multi-agency safeguarding procedures for safeguarding children and or, safeguarding adults, which may also require participating in strategy meetings, writing reports or attending conferences.

16.5. Cases involving allegations against workers (paid or unpaid) and or, those in a Position of Trust, multi-agency procedures should also be followed. Where children under the age of 18 are involved, seeking advice from the Local Authorities Designated Officers (LADOs) will also be required.

16.6. All safeguarding concerns will be reported and investigated accordingly, and the payment mechanism for the personal health budget may be reviewed if deemed appropriate by the CCG.

17. Approval of the Support Plan

17.1. All personal health budget support plans are submitted to the Case Manager for approval. The Case Manager will review the support plan against the criteria set out in 17.10 below.

This process includes full clinical oversight of the suggested package reviewing, agreeing and signing off the support plan which includes a risk identification and management plan.

17.2. The named health professional will not agree to any services named in the support plan if they believe that the potential health outcomes are outweighed by significant risks to the individual's health. However, the CCG will not impose blanket prohibitions and will remain open to considering different approaches to achieving outcomes other than those traditionally used, considering the particular circumstances of the individual and balancing the risks and benefits accordingly.

17.3. If the support plan proposed by the individual or the broker includes elements that are considered to be of an exceptional nature, i.e. are unusual / have unique features. The CCG has an exceptional circumstances panel in place to establish if exceptional circumstances exist that justify the options proposed. This may include one off purchases (e.g. specialist equipment) or the employment of Personal Assistants who are also family members.

17.4. The CCG will ensure that a quality monitoring process is introduced, involving sampling of cases, to confirm the quality and consistency of decision-making and ensure that the right criteria are being used effectively.

17.5. If a service named in the support plan is not agreed, the named health professional will provide the individual, representative or nominee the reasons why this decision has been reached. The individual, their representative or nominee may ask the clinician to reconsider their decision and provide additional evidence or information to inform that decision.

17.6. If a part of the support plan is refused, the CCG should make every effort to work in partnership with the individual, their representative or nominee to ensure their preferences are considered and taken into account.

17.7. If the support plan exceeds the indicative personal health budget but it is evident that this is due to additional needs that have been identified during support planning, then this should be reviewed with the individual, case manager and the independent broker to ensure that all eligible needs have been identified.

17.8. If the issue is not likely to be resolved quickly, the approver should consider whether the support plan can be partially approved to avoid any delay in meeting the individual's needs. If only one element of a support plan cannot be approved, which is not necessary to deliver the person's primary assessed needs, the CCG will approve the support plan with that specific exception, which will then be explored separately with the individual and their broker. In the interim, the personal health budget will be set at a level to meet the approved part of the plan. If this is not possible, a managed service should be put in place to ensure that the individual's needs are met while their support plan is under discussion. Where necessary the CCG will authorise a temporary support package to meet the assessed eligible needs while support planning proceeds. This will ensure that the individual's needs are met in line with the CCG's statutory duties but that they retain the freedom to plan their own support on a longer time scale.

17.9. When the support plan is approved, the final amount of the personal health budget will be set. The person, their representative or nominee (as applicable) and their broker will be notified and the commissioner will authorise the release of the money according to the delivery method selected.

17.10. While the individual, with access to an independent broker, will be responsible for developing their own support plan, the CCG retains its statutory duty to ensure that assessed eligible

needs are met. To discharge this responsibility, before approving the support plan, the CCG must ensure it is satisfied that the support plan is:

a) **Lawful** - the proposals must be lawful and meet all regulatory requirements. In deciding whether the support plan meets with legal requirements, it must show that:
    - Informed consent has been obtained
    - Legal responsibilities that an individual will incur under the personal health budget arrangement are clearly stated (e.g. employment law, health and safety)
    - The support plan sets out the assessed needs and desired outcomes of the individual and will meet those needs and outcomes
    - The measures within the support plan are lawful
    - The support plan is person-centred and led by the needs of the individual
    - It is well-balanced with the highest needs receiving priority
    - There is provision for appropriate reviews of the support plan
    - The CCG will ensure that any risks have been properly identified, discussed with the individual, their representative or nominee and properly addressed to ensure such risks are eliminated, reduced or managed. These include risks to the individual or anyone else but also risks to the service or to the CCG
    - Must demonstrate compliance with the Mental Capacity Act 2005. If the individual has been assessed as lacking capacity, the support plan must make it clear how their wishes have been ascertained and incorporated into the support plan
    - Where people lack capacity or are more vulnerable, procedures such as safeguarding, promoting liberty and if required, necessary restraint procedures have been included appropriately in the support plan and any necessary legal authorisations for those procedures have been obtained
    - Any service providers identified in the plan must meet applicable regulatory requirements. A regulated activity cannot be purchased from a non-registered service provider
    - The individual, their representative or nominee and, where applicable, their carers, must receive guidance on any health and safety issues or regulatory requirements in relation to any equipment to be used or any adaptations to their home
    - Where there is a carer, the carer's needs have been assessed and the proposals take account of their needs too

b) **Effective** - the CCG has a statutory duty to ensure funding is used effectively and in accordance with the principle of best value. The CCG will therefore make sure that the individual's needs and desired health outcomes are taken into account and that the measures proposed in the support plan represent an effective use of the personal health budget. In particular it must be satisfied that:
    - The support plan has been appropriately risk assessed
    - The support plan will be effective in meeting the individual's assessed needs and holistically supporting their independence, health and wellbeing
    - It takes account of the views and needs of carers
    - It is adaptable and flexible, so individuals can revise their plans as they learn what works best for them or as their circumstances change
    - Is reflective of the policy in the Commissioning Policy for Continuing Health Care ensuring that best value of public money has been achieved

c) **Affordable** - all costs have been identified and can realistically be met within the budget. In deciding whether the support plan is affordable, it must show that:

- In the case of support plans that exceed the indicative budget, the plan is thoroughly checked by commissioners before being sourced to ensure best value
- Where the support plan requires a budget that is lower than the indicative budget, the lower budget will be approved
- The use of existing universal services, community resources, informal support and assistive technology has been explored as a first-line, and clear rationale are given and agreed as to why these are not appropriate to meet the individual's assessed needs
- All relevant sources of funding (e.g. Local Authority provision) have been identified and utilised in conjunction with the personal health budget
- All costs have been identified and fall within the budget allocated
- A suitable contingency amount is included within the support plan
- The support plan fully meets the assessed, eligible needs in the most cost effective way possible
- The support plan's cost is not substantially disproportionate to the potential benefit
- Where NICE has concluded that a treatment is not cost effective, CCGs will apply their existing exceptions process before agreeing to such a service. However, where NICE has not ruled on the cost effectiveness or otherwise of a specific treatment, this will not be a barrier to people purchasing such services, if those services may meet the health and well-being needs identified

d) **Appropriate** - the support plan should not include the purchase of items or services that are excluded from personal health budget arrangements.

18. Calculating the final budget

18.1. The final budget will be shared with the individual in order for the necessary care and support to be arranged. Pay arrangements will differ dependent on the type of personal health budget chosen.

18.2. Personal health budgets will not be seen by the CCG as a cost-saving exercise but rather a way to get better health outcomes from the money the NHS already spends. The budget will therefore be calculated to ensure it is sufficient to meet each of the services and outcomes identified in the support plan.

18.3. The CCG will ensure that additional "hidden" costs are accounted for in the final budget. For example, where an individual uses a direct payment to employ staff to meet their care needs there will be additional costs to consider – National Insurance, PAYE, and liability insurance, pension but also potentially payroll services and other employment support. These costs will be covered in the personal health budget and will be detailed within the support plan.

18.4. The following costs will be considered when calculating the final budget:

- The direct cost of providing the service, including support service costs
- Start-up costs such as internal staff training
- Refresher training
- Pension costs
- Equipment costs (where equipment specifically forms part of the personal health budget and is not provided via the CCG's community equipment contract)
- Funding to cover the contingency plan (such as using an agency if a Personal Assistant is off sick)

- Equipment contingency (e.g. hire fee to cover breakdown not covered by insurance or by the CCG's community equipment contract)
- Additional elements may be required to be funded within the personal health budget such as the following (unplanned contingencies):
  - Redundancy costs when a service provided by a Personal Assistant ceases, if the Personal Assistant is entitled
  - Maternity pay, if the Personal Assistant is entitled
  - Long term sickness

18.5. The CCG may hold the above costs in a separate contingency fund until required by an actual liability.

18.6. The CCG is not obliged to fund particular costs associated with the individual's preferred method of securing a service. If the cost exceeds the 'reasonable cost' of securing it and the service can be secured more cost effectively (but still to the required standard) in another way, the CCG may insist on the more efficient option.

18.7. The CCG is not obliged to fund particular costs incurred by the individual, for example non-statutory liabilities such as ex gratia bonus payments.

18.8. If the individual incurs bank charges as a result of allowing a direct payment banking account to show a deficit without the agreement of the CCG, the individual will be responsible for meeting these charges from their own funds, and the CCG will not be liable for this payment.

18.9. Personal health budgets must be reviewed (section 22) and, if the budget is not set at a suitable level, adjusted accordingly.

19. Exceptional Circumstances

19.1. In line with the Commissioning Policy, an Exceptional Circumstances Panel is in place to ensure that where there are exceptional circumstances, decisions are made that are:

- Fair
- Reasonable
- Lawful
- Open to external scrutiny
- Evidenced
- Comply with Standing Financial Instructions

19.2. The Commissioner recognises that exceptional circumstances may require exceptional consideration but will retain its obligation to make best use of NHS resources to meet the needs of the whole population served. Where the package of care is defined as exceeding the normal level of expenditure or include unique features then the case may be referred to a Clinical Commissioning Group Exceptional Circumstances Consideration Panel to consider the suggested package and any exceptional circumstances that are pertinent to the individual that may indicate that the Clinical Commissioning Group is in agreement.

19.3. Exceptionality will be determined on a case by case basis and will require agreement by personnel at Director level or as determined by the Commissioner's Standing Rules and Financial Instruction.

20. Personal Health Budget Agreement

20.1. When taking up a personal health budget as a Direct Payment the individual or their representative must sign a 'Personal health budget direct payment agreement', which explains the responsibilities associated with the personal health budget and sets out the agreement that the personal health budget will be spent as set out in the support plan. More information on the Direct Payment Agreement can be found in section 34.

20.2. Where an individual receives a personal health budget as a notional budget a Direct Payment Agreement is not required with all care agreements being recorded by the named health professional.

20.3. An individual choosing to have a personal health budget as a Third Party Managed Account a contract will be arranged between the CCG and the agreed provider therefore again removing the need for a Direct Payment Agreement.

20.4. If the patient is receiving the personal health budget as a direct payment, the agreement will confirm that the personal health budget will be spent in accordance with the NHS (Direct Payments) Regulations 2013. If an individual chooses a package of care which includes both direct payment and notional support, all elements of the care will be included in the support plan however the notional proportion of the care will be retained by the CCG and paid upon request.

21. Assistance to manage personal health budgets

21.1. The CCG will signpost to a choice of support services to provide support to individuals in receipt of personal health budgets. It is envisaged that over time a wider range of organisations will become available to offer support and that this will be reflected in the choices available to personal health budget recipients. These arrangements will continue to be reviewed as the service develops.

21.2. The costs associated with utilising support services are met as part of the personal health budget

22. Monitoring and Review

22.1. Regular review is required in order to ensure that an individual's support plan continues to meet their needs.

22.2. In Continuing Healthcare, support plans and personal health budget packages will be reviewed three months following commencement and again in 12 months' time as a minimum. Intensity and frequency of review will be based on the risk assessment conducted for each individual.

22.3. Reviews may need to take place sooner or more frequently if the CCG becomes aware that:

- the health needs of the individual have changed significantly;
- if it becomes apparent that the support plan, care agreements or contractual arrangements are not being followed or expected health outcomes are not being met; or
- the individual or their representative requests it.

22.4. The support plan should state who the personal health budget holder should contact to discuss changes to their personal health budget should their needs change. In most cases this will be your Care Coordinator, usually your Continuing Healthcare practitioner.

22.5. For those with a direct payment arrangement, an audit of bank statements and expenditure and relevant employee documentation such as a contract, training certificates, insurance and DBS checks for Personal Assistants will be required.

22.6. The support plan will be reviewed against the following criteria:

- whether it meets personal health and well-being outcomes
- needs and risks
- cost neutrality or improved value for money
- level, use and management of direct payments (where applicable)
- the quality of support and service
- changes in needs and circumstances
- safeguarding and promotion of liberty

22.7. Outside of scheduled reviews, the individual may request a review of their needs or a review of the making of direct payments. It is at the CCG discretion as to whether a review will be carried out following such a request.

22.8. It is the individual's responsibility (or the representative or nominee) to inform the case manager if there is a change in residency, so that the needs of the individual can be reviewed if required. The personal health budget will continue until a review takes place. It is also the individual's responsibility to inform the new place of residence that they are in receipt of a personal health budget (and Continuing Healthcare funding if applicable).

22.9. If an individual moves permanent residency into a care home, the case manager should be notified in advance. The case manager will ensure that the move is to an appropriate care setting, if this is to a care home with nursing it is expected that a nursing assessment is completed prior to placement and that this includes a rationale for the placement. The case manager will then carry out a review within 12 weeks of the move to ensure that all nursing needs are being met. If the individual is moving into a care home for a temporary period of time, a review will be undertaken within 6 weeks. If an individual moves into a hospice the review will take place within 10 weeks, where appropriate.

22.10. If an individual is admitted to hospital the personal health budget will continue and will be reviewed by the CCG. Personal Assistants would be encouraged to take annual leave or to reduce their hours while the individual is under the care of the hospital unless in exceptional circumstances whereby the CCG must approve this. The CCG will suspend the personal health budget after 6 weeks in hospital if there is no imminent discharge date. This decision will be discussed with the service user, their representatives and the broker to ensure any staff, personal assistants or other providers involved are given the correct notices.

23. Stopping or reclaiming personal health budgets

23.1. Where it is identified that a personal health budget is not meeting need or felt to be inappropriate to continue arrangements under, the personal health budget can be stopped and, where applicable, money can be reclaimed. Personal health budgets regardless of payment method can be stopped at any time however initially a resolution to the identified problem will be sought. Where a solution cannot be identified the personal health budget will cease and a contracted provider for the CCG will be input to deliver care.

23.2. The CCG will terminate a personal health budget arrangement following notice to the individual or their representative if:

- The individual has deceased
- The terms and condition of the personal health budget agreement are not being met
- The individual or their representative spend money illegally
- The individual or their representative spend money not in accordance with the support plan agreed by the CCG
- The individual or their representative spend money not in the individual's best interest
- The individual's health or safety is at risk
- The individual or their representative are not able to provide the CCG with adequate records on spend for those with a direct payment arrangement
- The patient or their representative inform the CCG that they no longer wish to continue with their personal health budget arrangement
- The patient or their representative are no longer able to manage the personal health budget
- An individual with a personal health budget for NHS Continuing Healthcare is found no longer eligible

23.3. For notional and third party arrangements, the CCG will recover any payment made to providers from the date of death / transfer / other reason (as above) for stopping the personal health budget.

24. Direct Payments

24.1. The National Health Service (Direct Payments) Regulations 2013 set out how direct payments should be administered and on what they can be spent on. The regulations are similar to the regulations and guidance for social care direct payments. Personal health budget guidance on the new direct payments for healthcare regulations was published in March 2014. Although the NHS (Direct Payments) Regulations 2013 apply to direct payment personal health budgets, the CCGs agreed to apply these regulations, as far as possible, to all forms of personal health budget to ensure transparency, fairness and best practice.

24.2. Therefore all information in sections 24 to 48 relates in its entirety to those choosing to take a Direct Payment whether this be in the form of a Direct Payment to themselves or their representative, a managed account or a Third Party Account, it does not include those choosing a notional budget. Individuals choosing a Notional Budget will have all services delivered directly by the CCG commissioned providers however an individual can choose to transfer care to a Direct Payment where this is more suitable to meet need.

25. Who can receive a direct payment personal health budget?

25.1. A direct payment personal health budget can be made to any Eligible Person, where they are:

- A person aged 16 or over, who has the capacity to consent to receiving a personal health budget by way of a direct payment and consents to receive one;
- A child under 16 where they have a suitable representative who consents to a personal health budget by way of a direct payment;
- A person aged 16 or over who does not have the capacity to consent to receiving a personal health budget by way of a direct payment but has a suitable representative who consents to it.

And where:

- A direct payment personal health budget is appropriate for that individual with regard to any particular condition they may have and the impact of that condition on their life;
- A direct payment personal health budget represents value for money and, where applicable, any additional cost is outweighed by the benefits to the individual;

- The person is not subject to certain criminal justice orders for alcohol or drug misuse (see Section 27). However, such a person may be able to use another form of personal health budget to personalise their care.

25.2. The CCG will only provide direct payments if it is satisfied that the person receiving the direct payments (which may be the patient or representative) understands what is involved, and has given consent.

25.3. People aged 16 or over who have capacity, representatives of people aged 16 or over who lack capacity, and representatives of children can request that the direct payment is received and managed by a representative (see Section 30).

25.4. Decisions about providing direct payments for healthcare should be based around need rather than being based around a particular medical condition or severity of condition.

26. Ability to manage direct payments

26.1. The CCG will consider whether an individual (whether the patient or their representative) is able to manage direct payments by:

- Considering whether they would be able to make choices about, and manage the services they wish to purchase;
- Whether they have been unable to manage either a heath care or social care direct payment in the past, and whether their circumstances have changed;
- Whether they are able to take reasonable steps to prevent fraudulent use of the direct payment or identify a safeguarding risk and if they understand what to do and how to report it if necessary; and
- Considering any other factor which the CCG may consider is relevant.

26.2. If the CCG is concerned that an individual is not able to manage a direct payment they must consider:

- The individual's understanding of direct payments, including the actions and responsibilities on their part.
- Whether the individual understands the implications of receiving or not receiving direct payments.
- What kind of support the individual may need to manage a direct payment.
- What help is available to the individual, this may include a request for a managed account service to facilitate payments on the individual or representatives behalf.

26.3. Any decision that an individual is unable to manage a direct payment must be made on a case by case basis, taking into account the views of the individual, and the help they have available to them. The CCG will not make blanket assumptions that groups of people will or will not be capable of managing direct payments.

26.4. The CCG will inform the individual in writing if the decision has been made that they are not suitable for direct payments and whether an alternative method of receiving the personal health budget is considered to be suitable instead. See section 28 for further information.

27. Who cannot receive a direct payment?

27.1. There are some people to whom the duty to make direct payments does not apply. This includes those:

Schedule to NHS (Direct Payments) Regulations 2013

a) subject to a drug rehabilitation requirement, as defined by section 209 of the Criminal Justice Act 2003 (drug rehabilitation requirement), imposed by a community order

within the meaning of section 177 (community orders) of that Act, or by a suspended sentence of imprisonment within the meaning of section 189 of that Act (suspended sentences of imprisonment)

b) subject to an alcohol treatment requirement as defined by section 212 of the Criminal Justice Act 2003 (alcohol treatment requirement), imposed by a community order, within the meaning of section 177 of that Act, or by a suspended sentence of imprisonment, within the meaning of section 189 of that Act
c) released on licence under Part 2 of the Criminal Justice Act 1991 (early release of prisoners), Chapter 6 of Part 12 of the Criminal Justice Act 2003 (release on licence) or Chapter 2 of the Crime (Sentences) Act 1997 (life sentences) subject to a non-standard licence condition requiring the offender to undertake offending behaviour work to address drug or alcohol related behaviour
d) required to submit to treatment for their drug or alcohol dependency by virtue of a community rehabilitation order within the meaning of section 41 of the Powers of Criminal Courts (Sentencing) Act 2000 (community rehabilitation orders) or a community punishment and rehabilitation order within the meaning of section 51 of that Act (community punishment and rehabilitation orders)
e) subject to a drug treatment and testing order imposed under section 52 of the Powers of Criminal Courts (Sentencing) Act 2000 (drug treatment and testing orders)
f) subject to a youth rehabilitation order imposed in accordance with paragraph 22 (drug treatment requirement) of Schedule 1 to the Criminal Justice and Immigration Act 2008 ("the 2008 Act") which requires the person to submit to treatment pursuant to a drug treatment requirement
g) subject to a youth rehabilitation order imposed in accordance with paragraph 23 of Schedule 1 to the 2008 Act (drug testing requirement) which includes a drug testing requirement
h) subject to a youth rehabilitation order imposed in accordance with paragraph 24 of Schedule 1 to the 2008 Act (intoxicating substance treatment requirement) which requires the person to submit to treatment pursuant to an intoxicating substance treatment requirement
i) required to submit to treatment for their drug or alcohol dependency by virtue of a requirement of a probation order within the meaning of sections 228 to 230 of the Criminal Procedure (Scotland) Act 1995 (probation orders) or subject to a drug treatment and testing order within the meaning of section 234B of that Act (drug treatment and testing order)
j) released on licence under section 22 (release on licence of persons serving determinate sentences) or section 26 of the Prisons (Scotland) Act 1989 release on licence of persons sentenced to imprisonment for life, etc.) 34 or under section 1 (release of short-term, long term and life prisoners) or section 1AA of the Prisoners and Criminal Proceedings (Scotland) Act 1993 (release of certain sexual offenders) and subject to a condition that they submit to treatment for their drug or alcohol dependency

27.2. If the individual is subject to certain criminal justice orders for alcohol or drug misuse, then they will not receive a direct payment. However, they might be able to use another form of personal health budget to personalise their care and alternatives should be considered.

28. Deciding not to offer a direct payment

28.1. In addition to the above, a CCG may decide to refuse to make a direct payment if it believes it would be inappropriate to do so, for example:

- if there is significant doubt around an individual's or their representative's ability to manage a direct payment;
- if there is a high likelihood of a direct payment being abused;

- if the benefit to the particular individual of having a direct payment does not represent good value for money;
- if it considers that providing services in this way will not provide the same or improved outcomes.

28.2. Such a view may be formed from information gained from anyone known to be involved with the individual, including health professionals, social care professionals, the individual's family and close friends, and carers for the individual.

28.3. In all cases where a direct payment is refused, the Eligible Person and or representative will be informed in writing of the refusal and the grounds by which the request is declined. The individual or their representative has 28 days from receipt of this letter to request the CCG to reconsider this decision, in which case, the process set out in section 29 will be followed.

28.4. If a direct payment is refused, other options to personalise the package of care for the individual will be explored and facilitated as much as is possible, and other forms of personal health budget, such as a notional budget or third party budget, should be considered.

29. Request for review of Direct Payment refusal

29.1. Where the CCG decides that a direct payment would be inappropriate, the patient or representative may request the CCG to reconsider the decision within 28 days of receiving written notification of this, submitting additional information to support the deliberation. The CCG must reconsider its decision in a timely manner upon such a request being made but is not required to undertake more than one re-consideration in any six month period following the initial decision; a Clinical Lead within Continuing Healthcare will make this decision.

29.2. Should an individual not agree with the decision they may raise a complaint to the CCG. The Strategic Lead / Associate Director for Continuing Healthcare will make a decision regarding a request for reconsideration of a refusal to provide a direct payment. The decision will be reviewed in line with the CCG commissioning principles and will be considered on individual basis.

30. Representatives and direct payments

30.1. Information surrounding the appointment of Representatives is set out earlier in this Policy. When the use of direct payments is being considered, the CCG must be satisfied that a person agreeing to act as a representative understands what is involved, and has provided their informed consent, before going ahead and providing direct payments. They should be informed of the restrictions surrounding employment of a family member or person living in the same household to provide care (see section 40).

30.2. Full advice, support and information should be signposted so that people contemplating taking on the role of representative know what to expect. In addition, the CCG must provide its consent to the representative acting in this role, having duly considered whether the person is competent and able to manage direct payments, either on their own or with whatever assistance is available to them.

30.3. A representative may identify a nominee to receive and manage direct payments on their behalf, subject to the nominee's agreement and the approval of the CCG (see section 31 below).

30.4. A representative must (unless they have appointed a nominee to do so):

- act on behalf of the person, e.g. to help develop a personal health budget support plan and to hold the direct payment
- act in the best interests of the individual when securing the provision of services
- be the principal person for all contracts and agreements, e.g. as an employer
- use the personal health budget and direct payment in line with the agreed support plan
- comply with any other requirement that would normally be undertaken by the individual (e.g. participating in a review, providing information)

30.5. When considering whether to make direct payments to representatives, the CCG will consider:

- Whether the person receiving care had, when they had capacity, expressed a wish to receive direct payments
- Whether the person's beliefs or values would have influenced them to have consented or not consented to receiving a direct payment
- Any other factors that the person would be likely to take into account in deciding whether to consent or not to receiving direct payments
- As far as possible, the person's past and current wishes and feelings. This may be through their nominee, representative, family members, legal power of attorney or deputy as appointed by the Court of Protection.

31. Nominees

31.1. If a person aged 16 or over has capacity, but does not wish (for whatever reason) to receive direct payments themselves, they may nominate someone else (a nominee) to receive them on their behalf.

31.2. A representative (for a person aged 16 or over who does not have capacity or for a child) may also choose to nominate someone (a nominee) to hold and manage the direct payment on their behalf.

31.3. Where a nominee is appointed, they become responsible for managing the personal health budget and direct payment on behalf of the individual or the appointed representative (for individuals without capacity). They must:

- act on behalf of the person, e.g. to help develop a personal health budget support plan and to hold the direct payment
- act in the best interests of the individual when securing the provision of services
- be the principal person for all contracts and agreements, e.g. as an employer
- use the personal health budget and direct payment in line with the agreed support plan
- comply with any other requirement that would normally be undertaken by the individual (e.g. review, providing information)

31.4. It is important to note that the role of nominee for direct payments for healthcare is different from the role of nominee for direct payments for social care. For social care direct payments, a nominee does not have to take on all the responsibilities of someone receiving direct payments, but can simply carry out certain functions such as receiving or managing direct payments on behalf of the person receiving them. In direct payments for healthcare, however, the nominee is responsible for fulfilling all the responsibilities of someone receiving direct payments, as outlined above. Those receiving direct payments for healthcare and their nominees must be made fully aware of these responsibilities.

31.5. The CCG must be satisfied that a person agreeing to act as a nominee understands what is involved, and has provided their informed consent, before going ahead and providing direct payments. Full advice, support and information will be signposted so that people contemplating taking on the role of nominee know what to expect. In addition, the CCG must

provide its consent to the nominee acting in this role, having duly considered whether the person is competent and able to manage direct payments, either on their own or with whatever assistance is available to them.

31.6. Before the nominee receives the direct payment, the CCG must consent to the nomination. In reaching its decision, the CCG may:

- Consult with relevant people
- Require information from the person for whom the direct payments will be made on the state of health or any health condition they have which is included in the services for which direct payments are being considered
- Require the nominee to provide information relation to the account into which direct payments will be made.

31.7. If the proposed nominee is not a close family member of the person, living in the same household as the person, or a friend involved in the person's care, then the CCG will require the nominee to apply for an enhanced Disclosure and Barring Service (DBS) certificate (formerly a CRB check) with a check of the 'adults barred' list and consider the information before giving their consent. If a proposed nominee in respect of a patient aged 18 or over is barred, the CCG must not give their consent. This is because the Safeguarding Vulnerable Groups Act 2006 prohibits a barred person from engaging in the activities of managing the person's cash or paying the person's bills.

31.8. Such activities fall into "the provision of assistance in relation to general household matters to an adult who is in need of it by reason of age, illness or disability", which is a regulated activating relating to vulnerable adults under Part 2 of Schedule 4 to the Safeguarding Vulnerable Groups Act 2006.

31.9. If the proposed nominee is a close family member of the person, living in the same household as the person, or a friend involved in the person's care, the CCG cannot ask them to apply for a DBS certificate and has no legal power to request these checks.

31.10. The CCG must notify any person identified as a nominee where it has decided not to make a direct payment to them. The notification must be made in writing and state the reasons for the decision.

32. Imposing conditions in connection with the making of direct payments

32.1. The following conditions may be imposed on the individual, their representative or nominee in connection with the making of direct payments:

- the recipient must not secure a service from a particular person; and/or
- the individual, their representative or their nominee must provide information that the CCG considers necessary (other than information already covered by other regulations in the NHS (Direct Payment) Regulations 2013.

32.2. Conditions should only be imposed in exceptional circumstances. The reasons for the imposed conditions should be documented clearly.

33. Assistance to manage a direct payment – Supported Managed Accounts

33.1. The CCGs will signpost to a choice of support services to provide support to individuals in receipt of personal health budgets.

33.2. Where an individual chooses a direct payment there are extra responsibilities on the individual (or their appointed representative) to manage their care package. These are set out within the personal health budget Direct Payment Agreement.

33.3. It is essential that either the individual or their representative has the ability to consent to and manage their direct payment account. In certain circumstances, the option of a Supported Managed Account can be considered. These circumstances include:

- Where the individual or representative feels assistance is required;
- Where mental capacity indicates; or
- Where the individual may lack the skills to financially evidence spend for the audit.

33.4. For those in receipt of direct payments, Supported Managed Accounts can assist individuals in activities such as recruiting, employing staff and payroll. This option for support is open to people with personal health budgets and direct payments. However, in circumstances where Supported Managed Accounts are being considered, it may be more appropriate to consider the use of a notional budget. The respective benefits of each option should be discussed with the individual, their representative or nominee.

33.5. The costs of direct payment support services are met from the personal health budget allocation. This requires the personal health budget to be paid directly to the direct payment support service chosen so that its charges can be deducted. In certain circumstances the support service may make direct health care payments to patients, their representative or their nominee. This can only be carried out with the agreement of the CCG.

33.6. Individuals, representatives and appointed nominees employing staff are strongly recommended to utilise the information, advice, guidance and payroll and HR facilities of a direct payment support service to ensure the legal responsibilities of being an employer are satisfied. Should the individual, representative or nominee not wish to accept this recommendation the request for a direct payment may be refused because requirements of employment law will fall to the individual, their representative or their nominee as the employer. In such circumstances, the CCG would have to be satisfied that the individual, their representative or nominee are able to manage such responsibilities by other means.

34. Direct Payment agreement

34.1. All direct payments as agreed by the individual or their representative / nominee in the support plan will be made by the CCG as detailed in the Direct Payment Agreement.

34.2. The purpose of a Direct Payment Agreement is to ensure robust management of direct payments. The Direct Payment Agreement includes the following terms:

- the budget holder and case manager have to sign their understanding of the PHB, its purpose, funding arrangements and restrictions
- the budget holder must open a separate bank account solely for the purpose of the direct payment
- the budget holder has to provide evidence to the CCG of expenditure through bank statements, receipts etc.
- the budget holder must advise the CCG if there is slippage in the budget resulting in over eight weeks payments in their accounts
- the CCG will write to the budget holder to request the return of accumulated budgets of more than eight weeks payment
- records are retained by the budget holder and made available for audit by the CCG or representatives, this includes timesheets of Personal Assistants

- CCG has a right to carry out a financial audit of a PHB, irrespective of whether it is a direct payment, managed bank account or third party arrangement

34.3. In addition to the duty of the CCG to review the effectiveness of the support plan, it is the responsibility of the individual, or their nominee or representative, to inform the case manager as soon as they become aware of factors which may affect the cost to the CCG. The case manager will not automatically fund increased costs which have not been pre-approved through the support plan review process. Other benefits should also be taken into account to ensure that the personal health budget does not duplicate other sources of funding (e.g. winter fuel allowance, Motability allowance).

34.4. For individuals moving out of area, the CCG will pay according to the Responsible Commissioner guidelines.

35. Receiving a direct payment

35.1. Direct payments must be paid in advance. Under no circumstances should individuals have to pay for care and be reimbursed.

35.2. Direct payments must be made into a separate bank account used specifically for this purpose and held by the person receiving them. This account may also be used to receive money provided by the Government for other care or services. An exception to this is where an individual is receiving a one-off direct payment. A one-off payment can be made for no more than five items or services in the same financial year. Such payments can be made into the individual's ordinary bank account (or that of a nominee or representative). A record of how the one-off payment was spent will need to be kept for audit purposes. This can be in the form of receipts of items or services purchased.

35.3. The individual holding the account should keep a record of both the money going in and where it is spent.

35.4. Payments out of the account should only ever be to meet the needs and outcomes identified in the support plan. Payments out of the account should be made by bank transfer/cheque, not by cash. In any event, receipts, statements or payroll documentation should be available as requested by the CCG to substantiate all payments.

35.5. The CCG will hold a notional contingency equivalent to four week week's payments. This can be accessed via a same day payment agreed with the CCG in the event of an emergency.

35.6. With the exception of one-off direct payments (see below), direct payments must be paid into the personal health budget account used specifically for the direct payment. The account must be in the name of the person receiving the care, or their nominee or representative. The individual or their representative will be required to set up the personal health budget account and this account should not be used for any other funds to be paid into.

35.7. When receiving direct payments, the account holder should keep a record of both the money received and where it is spent. They are responsible for retaining statements and receipts for auditing.

36. Monitoring and review of direct payments

36.1. As a minimum, a clinical review of an individual's direct payments should be performed within three months of the first direct payment and then annually. Financial monitoring will take place

quarterly to check the allocated budget against the money spent, and then the money spent against the support plan.

36.2. There must be a review if the CCG become aware that direct payments have not been sufficient to secure the services specified in the support plan. If someone wishes to purchase additional care privately, they may do so, as long as it is additional to their assessed needs and it is a separate episode of care, with clearly separate lines of accountability and governance. They may not top up the direct payment with their own money to purchase more expensive care than that agreed in the support plan.

36.3. Where there are concerns regarding how the personal health budget is being spent, the CCG should be alerted to any concerns by the individual with the concerns, and the relevant continuing healthcare lead.

36.4. These considerations are in addition to those set out in section 36, which requires review of an individual's support plan to ensure it remains appropriate to meeting the individual's needs.

37. Stopping or reducing direct payments

37.1. There is an on-going duty to ensure that direct payments are reviewed. The amount provided under direct payments may be increased or decreased at any time, provided the new amount is sufficient to cover the full cost of the individual's support plan. Personal health budgets and direct payments are not a welfare benefit and do not represent an entitlement to a fixed amount of money. A surplus may indicate that the individual is not receiving the care they need or too much money has been allocated. It should be noted that a surplus is different to a contingency – it is permissible to include an amount for contingency in a personal health budget, for example, to cover where there is an increased care need in the case of an emergency. As part of the review process, the CCG should establish why the surplus has built up. Under these circumstances, a reduction in direct payment in any given period cannot be more than the amount that would have been paid to them in the same period.

37.2. Before making a decision to stop or reduce a direct payment, wherever possible and appropriate, the CCG should consult with the person receiving it to enable any inadvertent errors or misunderstandings to be addressed, and enable any alternatives to be made.

37.3. Where direct payments have been reduced, the individual, their representative may request that this decision be reconsidered, and may provide evidence or relevant information to be considered as part of that deliberation. Where this happens, the individual or representative must be informed in writing of the outcome of the reconsideration and the reasons for this decision. The CCG is not required to undertake more than one reconsideration of any such decision. If the individual remains unhappy with the CCG's decision, they should be referred to the local NHS complaints procedure.

37.4. The CCG will stop making direct payments where:

- A person with capacity to consent, withdraws their consent to receiving direct payments;
- A person who has recovered the capacity to consent, does not consent to the direct payments continuing; or
- A representative withdraws their consent to receive direct payments, and no other representative has been appointed.

37.5. The CCG may stop direct payments if it is satisfied that it is appropriate to do so. For example where:

- the money is being spent inappropriately (e.g. to buy something which is not specified in the care/ support plan);
- direct payments are no longer a suitable way of providing the person with care;
- a nominee withdraws their consent, and the person receiving care or their representative does not wish to receive the direct payment themselves;
- the CCG has reason to believe that a representative or nominee is no longer suitable to receive direct payments, and no other person has been appointed;
- where there has been theft, fraud or abuse of the direct payment; or
- if the patient's assessed needs are not being met or the person no longer requires care.
- where there are associated risks with continuing the direct payment

37.6. Where personal health budgets and direct payments are stopped, the CCG will give reasonable notice individual, their representative or nominee in writing, explaining the reasons behind the decision. It should be noted that, after a direct payment is stopped, all rights and liabilities acquired or incurred as a result of the service purchased, as according to the support plan, by direct payments will be transferred to the CCG. This should therefore be considered. However, in some cases, it may be necessary to stop the direct payment immediately, for example, if fraud or theft has occurred.

37.7. Where direct payments are to cease or be reduced, the CCG will give reasonable notice to the patient / representative / nominee or Third Party in writing in accordance with the terms of the Direct Payment Agreement. What will be considered "reasonable notice" will depend on the circumstances but generally this will not exceed three months. The CCG will explain its reasons for the decision.

37.8. In some cases, it may be necessary to stop the direct payment immediately, for example if fraud or theft has occurred. In such circumstances, CCGs must continue to provide healthcare if the individual requires it and should endeavour to provide a personalised service and to maintain continuity of care. The Clinical Commissioning Group will report any suspicion of fraud to the Clinical Commissioning Group's Anti-Fraud Specialist for investigation.

37.9. This section applies equally to personal health budgets delivered in the form of a Third Party arrangement.

38. Audit and record keeping for Direct Payments and Third Party Arrangements

38.1. The CCG's finance department is responsible for conducting audits on Direct Payment and Third Party personal health budgets.

38.2. The CCG will check at appropriate intervals (in Continuing Healthcare this will be line with three or 12 month reviews) how direct payments and third party budgets are being used. The recipient must provide the CCG with statements, receipts and invoices to enable an audit of the account.

38.3. The CCG will liaise with the personal health budget holder to conduct the financial audit.

38.4. The budget holder should retain the following information for audit purposes for 6 years after the CCG has paid the first direct payment:

- bank statements
- cheque and paying-in books
- invoices and receipts
- PAYE, N.I and other payroll records
- Any other information relating to the use of direct payments

38.5. The information stated above must be:
- legible
- accompanied with authorisation for the CCG to make copies or take extracts
- accompanied with an explanation of the information provided (if requested by the CCG)
- accompanied with a statement informing the CCG where information is held which the person has been unable to provide (if requested)

38.6. Documents submitted to the Clinical Commissioning Group for audit purposes could be subject to independent audit by the Clinical Commissioning Group's Internal Audit Team or Anti-Fraud Specialist.

39. Reclaiming a direct payment

39.1. The CCG can claim back personal health budgets and direct payments where:
- they have been used to purchase a service that was not agreed in the care package / support plan;
- there has been theft or fraud; or
- the money has not been used (e.g., as a result of a change in the support plan or the individual's circumstances have changed) and has accumulated.

39.2. If a decision to reclaim payments is made, reasonable notice must be given to the individual, their representative or nominee, in writing, stating:
- the reasons for the decision;
- the amount to be repaid;
- the time in which the money must be repaid; and
- the name of the person responsible for making the repayment.

39.3. The individual, their representative or nominee may request that this decision be reconsidered and provide additional information to the CCG for reconsideration. Notification of the outcome of this reconsideration must be provided in writing and an explanation provided. The CCGs are not required to undertake more than one reconsideration of any such decision. If the individual remains unhappy about the reduction, they will be referred to the local NHS complaints procedure.

40. Using a direct payment to employ staff or buy services

40.1. People may wish to use their direct payment to employ staff to provide them with care and support. In so doing, they will acquire responsibility as an employer and need to be aware of the legal responsibilities associated with this. An individual or their representative will be advised on this responsibility and confirmed in the Direct Payment Agreement. This should not discourage people who would otherwise be willing and able to manage a direct payment. In order to ensure that people are appropriately informed and supported in meeting their duties as an employer, the CCGs will signpost to a choice of providers to provide information, advice and support. The costs associated with utilising a direct payment support service are met from the personal health budget allocation. This cost will be factored in when setting the budget.

40.2. Personal Assistants will be paid at the agreed hourly rate with the CCG; this rate will include additional sundry costs such as uniforms, phones etc. The agreed rate will also be included in the Direct Payment Agreement.

40.3. Personal health budgets can include an element for "travel and subsistence" (food costs to cover refreshments and light snacks only but not meals), and not accommodation.

40.4. Further information around employing Personal Assistants and their employment status can be found at www.skillsforcare.org.uk.

41. Employing a family member or person living in the same household

41.1. A direct payment can only be used to pay an individual living in the same household, a close family member or a friend if the CCG is satisfied that to secure a service from that person is necessary in order to satisfactorily meet the Eligible Person's need; or to promote the welfare of a child for who direct payments are being made. It is anticipated that this will be permitted in very limited circumstances. The CCGs must make judgements on a case by case basis, as recommended by the NHS Direct Payment Guidance:

"*A direct payment can only be used to pay an individual living in the same household, a close family member or a friend if the CCG is satisfied that to secure a service from that person is necessary in order to satisfactorily meet the person receiving care's need for that service; or to promote the welfare of a child for whom direct payments are being made. CCGs will need to make these judgements on a case by case basis".*

41.2. Any arrangement of this nature will be formally considered by the CCG's Exceptional Circumstances Panel, and recorded in writing in both the support plan and the personal health budget agreement.

41.3. The suitability will be reviewed at least every three months, (following the existing pathways for complex, children's and adults). This process includes reviewing, agreeing and detailing in the support plan.

41.4. This restriction is not intended to prevent individuals from using direct payments to employ a live-in personal assistant. The restriction applies where the relationship between the two people is primarily personable rather than contractual (for example, if the people concerned would be living together in any case).

42. Safeguarding and employment

42.1. People may wish to use their direct payment to employ staff to provide them with care and support. When deciding whether or not to employ someone, patients and their families should follow best practice in relation to safeguarding, vetting and barring including satisfying themselves of a person's identity, their qualifications and professional registration if appropriate and taking up references.

42.2. Individuals cannot request DBS checks on other individuals. However, an individual, or their representative will be supported by the CCG to identify appropriate support services to arrange for the DBS to be completed. The prospective employee or contractor will be advised that prior to employment commencement an enhanced disclosure is required. This will be required for all individuals who are not close family members or living in the individual's household but providing care to the individual, these may be:

- regulated health care professionals – for example, nurses or physiotherapists
- people providing healthcare under the direction or supervision of a health care professional
- people providing personal care

42.3. These are examples of regulated activity relating to vulnerable adults and children within the meaning of Schedule 4 to the Safeguarding Vulnerable Groups Act 2006 ("regulated activity"). An enhanced Disclosure and Barring Service check including a barred list check may be

obtained to assess a person's suitability to engage in regulated activity. Refer to sections 113B, 113BA and 113BB of the Police Act 1997 (c.50) and S.I. 2002/233 and 2009/1882.

42.4. Alternatively, if the individual can satisfy the DBS that they have a legitimate interest in knowing if that person is barred, the DBS may supply this information.

42.5. If the potential employee is barred they must not be used to supply services as they pose an on-going risk to adults or children.

42.6. If the individual is contracting with a close family member or a person who is living in the individual's household or a friend it is not required to undertake any DBS checks although the CCG retain the right to ask for this information to ensure the support plan is achievable using the proposed employee.

42.7. The DBS has launched the Update Service. This is a service that allows people to reuse their certificate for multiple roles. If a potential employee or contractor has subscribed to the Update Service and has a check of the appropriate level, the individual should ensure they see the person's original certificate and use the free online portal to check for up to date information on that certificate. If the certificate is not up to date the individual should ask the potential employee or contractor to apply for a new certificate.

43. Indemnity

43.1. Direct payments can be used to pay for a Personal Assistant to carry out certain personal care and health tasks that might otherwise be carried out by qualified healthcare professionals such as nurses, physiotherapists or occupational therapists. In such cases the healthcare professional and CCG will need to be satisfied that the task is suitable for delegation, specify this in the support plan and ensure that the Personal Assistant is provided with the appropriate training and development, demonstration of competence and have sufficient indemnity and insurance cover.

43.2. Further assistance and guidance on this can be found at:
https://www.england.nhs.uk/wp-content/uploads/2017/06/516_Delegation-of-healthcare-tasks-to-personal-assistants_S7.pdf
https://www.gov.uk/government/publications/independent-review-of-the-requirement-to-have-insurance-or-indemnity-as-a-condition-of-registration-as-a-healthcare-professional

Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare -OJ L 88, 4.4.2011

43.3. Indemnity is a complex area for individual employers and one where sufficient support will need to be in place from the start to enable people to understand and be supported to meet any obligations they have.

43.4. Providers of some services may need to conform with prospective legislation which will implement the Finlay Scott Recommendations (June 2010)15 on indemnity cover and Article 4(2)(d) of Directive 2011/24/EC16. NHS England will provide further guidance on what this covers in due course.

43.5. Personal Assistants employed via a direct payment do not need to comply with the legislation that will require them to have indemnity cover if practising unless they are a member of a regulated health profession, even if carrying out activities which might otherwise be performed by health professionals. Care co-ordinators and CCGs will need to consider and discuss with the person, their nominee or representative, the potential risks associated with the clinical

tasks being carried by the Personal Assistants on a case by case basis. This needs to form part of the risk assessment and support planning process and outcome recorded in the support plan.

43.6. The person buying services needs to be aware of whether the provider needs to comply with prospective legislation discussed above. If the provider does not need to comply people may, if they wish, buy services from providers who have limited or no indemnity or insurance cover. Where an individual uses services without insurance is in place, the CCG will request that this is purchased directly by the individual and any additional identified risks are recorded in the support plan.

43.7. In the first instance, it will be the responsibility of the person buying the service to check the indemnity cover of the provider from which they are buying services. They must make enquiries to ascertain whether the provider has indemnity or insurance, and if so, whether it is proportionate to the risks involved, and otherwise appropriate.

43.8. If the person buying the service asks the CCG to undertake these checks on their behalf, the CCG must do so. Care managers and support planners should also ensure that people are aware that this is an option as part of the risk assessment and support planning process.

43.9. Regardless of who carries out the initial check, the CCG will review this as part of the first review, to ensure the checks have been made and are appropriate.

44. Registration, regulated activities and delegation of clinical tasks

44.1. If someone wishes to buy a service which is a regulated activity under the Health and Social Care Act 2008, they will need to inquire as to whether their preferred provider is registered with the Care Quality Commission (CQC). A direct payment cannot be used to purchase a regulated activity from a non-registered service provider.
The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, S.I 2010/781
http://www.cqc.org.uk/organisations-we-regulate/registering-first-time/regulated-activities

44.2. CQC guidance makes it clear that where a person, or a related third party on their behalf, makes their own arrangement for nursing care or personal care, and the nurse or carer works directly for them and under their control without an agency or employer involved in managing or directing the care provided, the nurse or carer does not need to register with the CQC for that regulated activity.

44.3. If a person or related third party employs a care worker directly, without the involvement of an agency or employer, the employee does not need to register with CQC. A related third party means:

a) an individual with parental responsibility for a child to whom personal care services are to be provided
b) an individual with power of attorney or other lawful authority to make arrangements on behalf of the person to whom personal care services are to be provided
c) a group or individuals mentioned in a) and b) making arrangements on behalf of one or more persons to whom personal care services are to be provided
d) a trust established for the purpose of providing services to meet the health or social care needs of a named individual

44.4. This means that where an individual has set up arrangements for nursing care or personal care on behalf of someone, they are exempt from the requirement to register with the CQC.

44.5. Also exempt are organisations that only help people find nurses or carers, such as employment agencies (sometimes known as introductory agencies), but who do not have any role in managing or directing the nursing or personal care that a nurse or carer provides.

44.6. If someone wishes to use a direct payment to purchase a service which is not a regulated activity, they may do so.

44.7. In some circumstances, the provider may also need to be a registered member of a professional body affiliated with the Council for Healthcare Regulatory Excellence. If the support plan specifies that a task or tasks require a registered professional to undertake it, only a professional who is thus registered may be employed to perform that task or tasks.

44.8. In the first instance it will be the responsibility of the person buying the service to check whether the provider they are purchasing from is appropriately registered. They can request the CCG investigate this, and if they ask, the CCG must do so. As with indemnity cover, the CCG must also review this as part of their assessment as to whether the direct payment is being effectively managed.

44.9. While some service providers, for example aroma-therapists, are not statutorily required to be registered, there are professional associations with voluntary registers that practitioners can choose to join. Typically, such practitioners can only join these associations or registers if they meet the standards of education, training, conduct and performance required by the professional body. However, there is no legal requirement to join these registers, and practitioners can still offer unregulated services without being a member of any organisation. If a provider is not registered with an appropriate body this should not automatically be a bar to purchasing from that provider but this should be included in the discussion around risks when developing the support plan.

44.10. Delegation of clinical tasks within personal health budgets where an NHS employee (CHC Practitioner) agrees, through the support planning process, to entrust authority and responsibility to a PA for a specific task, activity or role. Considering whether a task should be delegated involves reviewing not only the risks of delegation, but also the benefits that may come with delegation and the risks of not delegating. The Personal Assistant is often the person working most closely with the person requiring care and support; they are often able to respond quickly and in a timely manner. They may have developed a very good understanding of the person they care for, and have particular skills in communicating with them and it may make them ideally placed to carry out delegated tasks. There will also be tasks that are considered unsuitable for delegation, because of the nature of the task or the circumstances relating to it. Their skills, knowledge and availability may make them ideally placed to carry out delegated tasks. There will also be tasks that are considered unsuitable for delegation, because of the nature of the task or the circumstances relating to it.

44.11. When delegating a task, the following should be considered:

- Is delegation in the best interest of the person
- Does the personal health budget holder/ employer view the Personal Assistant as competent to carry out the task
- Does the registered practitioner view the Personal Assistant as competent to carry out the task
- Does the Personal Assistant consider him/herself to be competent to perform the activity
- Has the Personal Assistant been suitably trained and assessed as competent to perform the task, or is there a way to make this happen
- Are there opportunities for on-going development to ensure competency is maintained

- Is the task/ function/ health intervention within the remit of the Personal Assistant's job description
- Does the Personal Assistant recognise the limits of their competence and authority and know when to seek help

44.12. Regulated health professionals will also need to meet any standards for delegation set by their regulatory body (e.g. the Nursing and Midwifery Council for nurses, midwives and health visitors; the Health and Care Professions Council for physiotherapists, dieticians, and speech and language therapists).

45. Using a Direct Payment to purchase equipment

45.1. Personal health budgets will not be used to rent or purchase equipment that would have otherwise been provided by the NHS.

45.2. Personal health budgets can be used to purchase services or equipment for which the CCG has given clinically assessed agreement. The personal health budget holder shall ensure any equipment that is required will follow and evidence best value for money at all times.

45.3. If making a direct payment for the purchase or rent of equipment, the CCG will need to be satisfied that any equipment purchased with a direct payment is suitable for meeting the patient's needs. In particular, the CCG will wish to ensure that the direct payment recipient is adequately supported to ensure that items purchased are safe and appropriate. Support will also need to be provided for the recipient to ensure that those using the equipment are appropriately trained in its safe use.

45.4. Prior to any equipment being purchased or rented, the CCG will consider whether any adaptations to the individual's place of residence will be required to accommodate the equipment. The CCG, in consultation with its local partners, will consider how any such adaptations will be funded and arranged.

45.5. The personal health budget holder shall ensure any equipment they purchase ensures delivery, fitting, demonstration, collection, warranty claims, servicing, storage and recycling from the manufacturer is in place as required.

45.6. Disposables which are provided through an NHS contract (such as continence products) are not funded through a personal health budget to avoid double funding. However, if the local service is unable to supply to meet particular needs in either an appropriate or cost effective way, a personal health budget may be considered in the best interests of the individual.

45.7. NICE Technology Appraisals, Interventional Procedures, Clinical Guidelines, Public Health Guidance, Service user Safety Guidance and Cancer Manuals should be consulted when sourcing, procuring, storage, delivery, fitting, collection, decontamination, servicing and recycling of medical devices.

45.8. The personal health budget holder will ensure that if there is any increased fire risk arising from the supply of particular items of equipment, either by themselves or in combination that particular consideration is given to the impact of individual behaviour patterns e.g. smoking while using equipment such as pressure relieving mattresses. If the personal health budget holder has any concerns about the willingness or capacity of the individual members of the household to follow safety advice they will refer back to the relevant CCG for further advice as soon as possible.

46. Servicing and Maintenance of Equipment

46.1. The personal health budget holder shall satisfy themselves that they are competent to use the equipment for the purpose of assessed needs.

46.2. The personal health budget holder may, in some instances need to secure equipment to the fabric of premises. Anyone undertaking such work on behalf of the personal health budget holder shall be competent and trained to do so and have formal consent from the service user or premises landlord. Consent to be in writing and kept as a formal record.

46.3. The personal health budget holder may be required to ensure that on assessment of the site and the suitability of existing construction, as well as all subsequent work carried out by them, they ensure that all items are fitted safely and securely.

46.4. The personal budget holder will need to ensure they are able to produce and complete servicing/inspection certificates for their equipment. All certificates shall be kept as part of the equipment record and shall contain the certificate number, serial number(s) of the equipment, date of manufacture, date of service/inspection, summary of work undertaken and/or a checklist, signature of the individual carrying out work and the date that it was completed.

46.5. All equipment requiring maintenance/inspection/servicing shall be maintained, inspected and/or serviced in accordance with all legislation including, but not limited to, Lifting Operations Lifting Equipment Regulations 1998 [LOLER] and Portable Appliance Testing [PAT].

46.6. All maintenance and servicing records shall be kept up to date by the personal budget holder. The individual's support plan must include details regarding the safe use of any equipment required, including that any equipment in use is checked regularly ensuring it is fit for purpose and in full working order that the frequency and detail of what to check is included in the support plan and that checks are recorded. In the event of equipment failure, details of how to repair, replace or provide a suitable alternative should be included in the individuals support plan.

47. Using a Direct Payment to fund short breaks and holidays

47.1. There is no formal entitlement to holiday funding within a personal health budget, but for those individuals who do not benefit from carers' respite, the CCG recognises that a holiday or short break is beneficial to health and wellbeing. The CCG acknowledges that there may be additional staffing and equipment costs to support someone away from their home in an environment which may not be suitably adapted. In some instances 2 carers may be needed for safe care. In addition, people who do not normally require 24 hour care may need to take their own carers and require them to work longer hours.

47.2. The CCG will consider funding up to 14 days support plus appropriate equipment hire per annum to enable the chosen holiday or breaks to take place. The individual should discuss the clinical care implications of the break (including travel) with their health care professional and address this in their support plan, including the additional costs.

47.3. All funding requests for short breaks and holidays will be considered and agreed by the CCG's Exceptional Circumstances Panel. The CCG reserves the right to refuse to fund support or equipment over and above that required to meet assessed need. The personal health budget will not cover Personal Assistant's travel, meals, accommodation, or anything not related to the agreed support plan. The additional costs must be calculated and approved by the CCG (through submission of the support plan) before the holiday is booked.

47.4. Any other breaks or additional costs will need to be funded by the individual. The CCG acknowledges that there are times when flexibility for a support plan may be required and individuals may want to accumulate their personal health budget to allow for flexibility of a temporary change in circumstances. Any savings made via the personal health budget should not reduce the ability to meet agreed outcomes, or be made at the expense of health or wellbeing; this should be discussed with the case manager.

48. Using a Direct Payment to fund Travel and Mileage

48.1. A personal health budget may cover travel costs such as bus fares to activities which are fully documented in the support plan. When appropriate a personal health budget can provide a contribution towards the mileage at the NHS standard rate. However if the individual has a Motability Car, or higher rate Mobility Allowance, the CCG would not pay the full HMRC / NHS Mileage rate but only at the reduced mileage rate. The standing costs for running a car should be met from the Mobility Allowance as these costs would need to be met regardless. If the individual is not in receipt of Mobility Allowance at a higher rate, then the personal health budget would meet the HMRC / NHS rates of mileage. Calculations are based on the average distance between the individual's home and the activity.

48.2. The CCG would not normally expect to fund the purchase or lease of a car, unless there are exceptional circumstances to which the CCG agree.

49. Following death of an individual

49.1. In the event of the individual's death, the personal health budget does not form part of the estate.

49.2. Reclaiming any unused funds will be managed sensitively. Allowing for a period of grace (up to 6 weeks before funds must be returned), the CCG will liaise with those managing the Estate / responsible for managing the affairs of the budget holder following this period of time in order to close down the personal health budget.

49.3. For those with a direct payment or third party arrangement the individual responsible for managing the Estate / responsible for managing the affairs of the budget holder will forward the closing balance of the personal health budget account to the CCG along with the account's final statement.

49.4. The CCG maintains the right to lay claim to funds owed following ceasing of the personal health budget using the standard financial procedures for claims against an Estate.

49.5. The CCG acknowledges that if their individual (or their representative or nominees as applicable) was an employer, then they will have employment law responsibilities to fulfil.

50. Data reporting

50.1. Data reporting will be conducted in line with NHS England Personal Health Budgets Mandatory Data Collection Guidance, May 2018. Mandatory anonymised personal health budget data will be submitted quarterly via NHS Digital. Each CCG will identify an individual responsible for the mandatory data submission. Prior to data submission the NHS Continuing Healthcare Service's Performance and Business Team will provide a data extract to CCG identified individual for submission.

51. Equal Opportunities

51.1. All public bodies have a statutory duty under the Equality Act 2010 when exercising public functions to have due regard to the need to eliminate discrimination, advance equality, and foster good relations. The duty applies to the relevant protected characteristics – age, disability, gender reassignment, pregnancy and maternity, race, religion and belief, sex, sexual orientation and marriage and civil partnership.

51.2. Public authorities and other organisations when carrying out functions of a public nature have a duty under the Human Rights Act 1998 not to act incompatibly with rights under the European Convention for the Protection of Fundamental Rights and Freedoms. All health care providers are required to work within the NHS FREDA principles (Fairness, Respect, Equality, Dignity, and Autonomy).

51.3. The CCG endeavours to challenge discrimination, promote equality and respect human rights, and aims to design and implement services policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

51.4. All staff are expected to deliver services and provide care in a manner which respects the individuality of patients and their carers and as such treat them and members of the workforce respectfully, with dignity, and with regard for diversity of background and belief.

52. Equality and Quality Impact Assessment

52.1. An Equality Impact Assessment and Quality Impact Assessment has been completed for this policy. Upon evaluation, personal health budgets do not marginalise or discriminate minority groups; rather, they will be useful tool in the delivery of health equality.

52.2. The uptake of personal health budgets will be monitored at review, which will include the uptake by all groups considered in the Equality Analysis.

53. Review Date

53.1. This policy and procedure will be reviewed in 2023 or earlier in light of any changes to legislation or National Guidance.

54. More information

The NHS England website has a section dedicated to personal health budgets. This has information about national policy, the implementation toolkit, stories and other resources. www.personalhealthbudgets.england.nhs.uk

The Peer Network, a user-led organisation for PHBs, has its own website: www.peoplehub.org.uk

55. Glossary

Continuing Healthcare (CHC) is the name given to a package of care solely funded by the NHS or jointly funded between the NHS and Local Authority, for individuals who are not in hospital but have complex on-going care needs. The provision of Continuing Healthcare is set out in the National Framework for Continuing Healthcare and Funded Nursing Care.

Clinical Commissioning Group (CCG) the statutory body responsible for the effective application of the National Framework for Continuing Healthcare and Funded Nursing Care for its registered population. In this instance the CCG includes any person or organisation authorised to exercise any of its functions in relation to Continuing Healthcare.

“budget holder" and **“service user”** mean the individual who receives the personal health budget for NHS Continuing Healthcare/Continuing Care funding.

"Care Co-ordinator" and **“case manager”** means the representative from the Clinical Commissioning Group who will manage the assessment of the budget holder's health needs for the care and support plan, ensure those health needs continue to be met, and otherwise oversee the arrangements as set out in the Regulations. The care co-ordinator / case manager will be commissioned by the Clinical Commissioning Group from existing commissioned services or an appropriate external partner.

“Support Plan” is the Continuing Healthcare overview support plan developed by the budget holder, care manager and PHB advisor / Support Service which has been agreed by the Clinical Commissioning Group. It sets out the budget holder's health needs and health and wellbeing outcomes, the amount of money in the personal health budget and how the money will be used. It includes a risk assessment and contingency and respite plans for managing any significant potential risks.

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“Indicative budget” – An indicative budget is calculated so that the service user can begin to develop an individual care and support plan to meet their holistic needs including health and well-being.

“Nominated Person” is the person chosen by the Budget Holder to receive and manage the personal health budget on their behalf in circumstances where the Budget Holder has mental capacity to make that decision.

“Representative” means the person who receives and manages direct payments on behalf of the Budget Holder (e.g. deputy, attorney or person with parental responsibility). Where there is no such person, any person appointed by the Clinical Commissioning Group to receive and manage the direct payments on behalf of the Budget Holder.

“Provider” will be commissioned by the Clinical Commissioning Group from existing commissioned services or an appropriate external partner.

“Personal Budget” is the amount of social care money (means tested) that is available from the Local Authority to pay for support.
21 National Framework for Continuing Healthcare and Funded Nursing Care (Department of Health) November 2012 (Revised)

Family Member - A person’s close family members are described in the regulations (Box 3 of the Direct Payment Guidance) as

- The spouse or civil partner of the person receiving care;
- Someone who lives with the person as if their spouse or civil partner;
- Their parent or parent-in-law;
- Their son or daughter;
- Son- in- law or daughter- in- law;
- Stepson or stepdaughter;
- Brother or sister;
- Aunt or uncle;
- Grandparent; or
- The spouse or civil partners of (c)- (i), or someone who lives with them as if their spouse or civil partner.

http://www.personalhealthbudgets.england.nhs.uk/_library/Resources/Personalhealthbudgets/2014/Guidance_on_Direct_Payments_for_Healthcare_Understanding_the_Regulations_March_2014.pdf

Personalisation a social care approach described by the Department of Health and Social Care as meaning that "every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the shape of that support in all care settings". This approach is now being adopted in some areas of healthcare.

Notional Budget the budget is held by the NHS and no money changes hands. The NHS Commissions the services on an individual's behalf.

Third Party Budget the money is paid to an organisation that holds the money on the individuals' behalf and helps them decide what they need. The company will arrange to recruit and employ a team of Personal Assistants to work directly for the individual and the care package will be made bespoke to the individual's needs.

Direct Payment cash payments made to individuals who need care (following an assessment) by a local authority or NHS organisation to enable them to buy their own care or support services.

Direct Payment Legal Agreement - The Agreement is a template for use by NHS CCGs (CCG) in entering into direct payment agreements with individuals in accordance with the CCG's powers and duties under Section 12A NHS Act 2006, the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 as amended (Rules), and the NHS (Direct Payment) Regulations 2013 (Regulations), all as amended from time to time.

Supported Managed Account - The money is paid into the account of a named individual or organisation that manages the money and pays for the support on behalf of the individual. A Supported Managed Account allows the same flexibility and control as the individual receiving a direct payment. The control remains with the individual.

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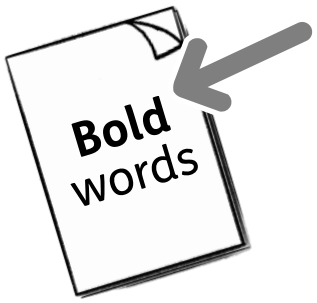
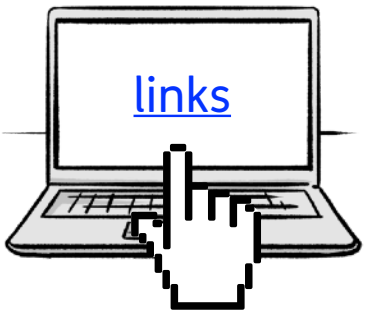
Personal health budgets

easy read

Contents



In this Easy Read document, difficult words are in **bold**. We explain what these words mean in the sentence after they have been used.



Some words are blue and underlined. These are links which will go to another website which has more information.

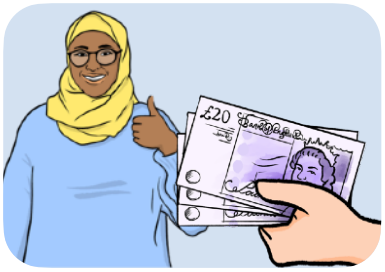
Introduction

The NHS in Liverpool have written this information about **personal health budgets**.

A **personal health budget** is money the NHS can give you to support your health and care needs.

This information explains:

- how we decide who gets a personal health budget.



- how we give people their personal health budget.

- what is good about getting a personal health budget.

- what you can and can't spend your personal health budget on.

Why we use personal health budgets

We want people to have more choice over their care and support.

Personal health budgets are a good way of people choosing what is best for them.

They are also a good way of using money, because people only spend money on the services they need.

You do not have to have a personal health budget.

You can choose to mix a personal health budget with other NHS care.

Personal health budgets should not be used for health care that is not to do with your long term care needs. For example, A&E or your doctor (GP).

Who can get a personal health budget

If you have health and care needs, you can ask for a personal health budget to pay for your support.

If you ask for a personal health budget, we will try to give you one.

This depends on:

- whether a personal health budget would help you.

- if the rules say you can have one.

The rules for people who can apply to get a personal health budget

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You must have a doctor (GP) in Liverpool to get a personal health budget from Liverpool NHS.

You also need to be 1 of:

- an adult who can get **NHS Continuing Healthcare**.

  NHS Continuing Healthcare is care for adults that is arranged and paid for by the NHS.

- a child or young person who can get **Continuing Care**.

  Continuing Care is care for children that is arranged and paid for by the NHS.

- a long term wheelchair user.

- someone who has stayed in hospital because of their mental health needs.

We want everyone who can get a personal health budget to get one.

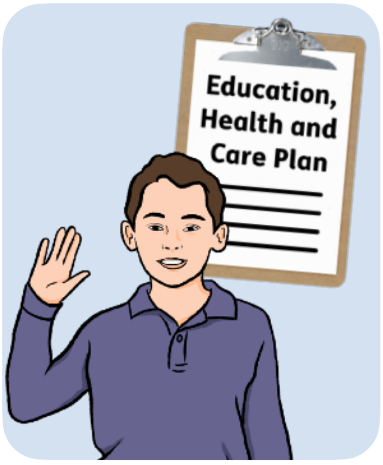
If the rules say you cannot have a personal health budget, we might still think about giving you one if you ask.

We will think about giving you a personal health budget if:

- you already receive a **direct payment**.

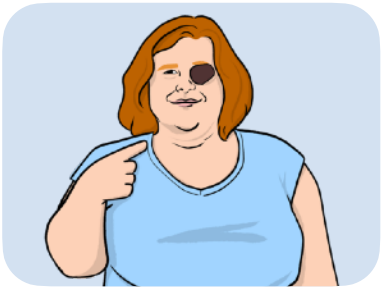
  Direct Payments are money paid to you by the council or NHS so that you can pay for your own care.

- if you already have a personal assistant or carer that you want to carry on using.



- you are a child or young adult with an **Education, Health and Care** plan and can't get Continuing Care.

  An **Education, Health and Care (EHC)** plan says what your health and care needs are.



- you need care that is designed for you.

A personal health budget should help people who may not always get the best out of the NHS to get a better service.

In the future, more people will be able to have a personal health budget.

Deciding not to give you a personal health budget

Some people might be turned down for a personal health budget.

This could be because:

- they need a special type of care that can only be done in one place.

- a personal health budget would not be a good use of money.

If we decide not to give you a personal health budget, you can complain.

We will let you know how to complain.

If you live in a care home

If you live in a nursing home or care home you can have a personal health budget if it would help you.

We will need to make sure that a personal health budget:

- doesn't cost too much money.

- is a good way to give you the care you need.

- gives you a choice about how to pay for your care.

Letting you know about personal health budgets

The **Nurse Assessor** will let people know if they can have a personal health budget.

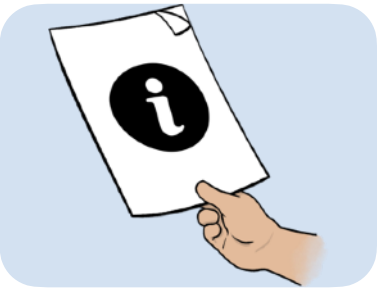
A **Nurse Assessor** is someone who decides what health and care needs a person has.

Health staff will also look for other patients who would get more suitable care if they had a personal health budget.

They will give out information about personal health budgets.

If a patient's health and care staff think they should have a personal health budget, they will discuss it with the person.

If the Nurse Assessor thinks you should have a personal health budget, they will:



- give you information about getting a personal health budget.

- tell you about other organisations that can help you learn more about personal health budgets.

These organisations will:

- explain how a personal health budget can be used.

- support you to look after your personal health budget.

- help with keeping notes on your personal health budget.

- give you information about using your personal health budget in the right way.

- help with paying back or spending left over money.

Your care support plan

When you get a personal health budget, you will need to write a care and support plan.

Your Nurse Assessor will write this with you.

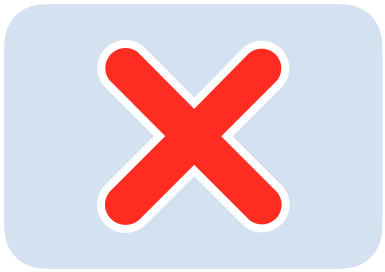
It will be checked to make sure it meets all of your care needs.

Your plan must:

- follow the law around keeping you safe and meeting your needs.

- use money in a good way and not cost too much.

- meet all of your health and care needs.



- not include things that are not allowed.

- show that you and the Nurse Assessor have thought about things that might go wrong with your safety and health, and how you can stop them.

Changes

Sometimes you might need to make changes to your care support plan.

You can save up your personal health budget so that you can cope with any changes in your life.

If you are saving money, you must still get all the care you need.

You must agree with us that you are saving money, and it will need to be written in your care and support plan.

Looking after your personal budget

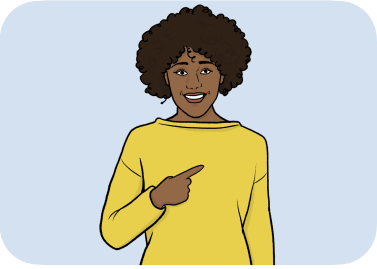
We will talk to you about the best way to look after your personal health budget.

You can receive and look after your personal health budget in 3 ways:

Notional budget

A **notional budget** means that:

- we tell you how much money you can use.



- you choose how the money is used.

- we buy the services you need.

Notional budgets are good for people who want more choice but don't want to look after money themselves.

Third party budget

A **third party budget** means that:

- your money is paid to an organisation, and

- this organisation arranges and pays for all of the services that you need.

Direct payments

A **direct payment** means that your personal health budget is paid into a special bank account that you will use to pay for your care.

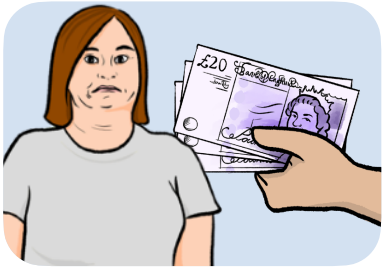
The bank account will need to be set up. You can get support to do this.

Direct payments will be paid into your bank account in advance. For example, your June payment would be paid into your account at the end of May.

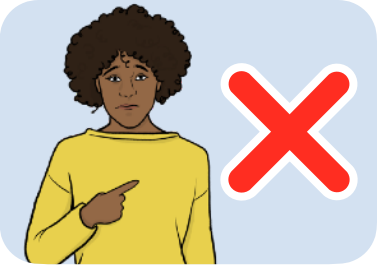
If you get a direct payment, you must sign an agreement that says you will follow your plan.

We may decide not to give you a direct payment.

This would be because:



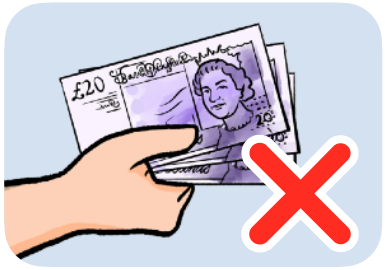
- we do not think you would be able to look after a direct payment.



- it would not be good for you to have a direct payment.

- it would not be a good use of money.

- your care would not be better if you got a direct payment.



- we think you would not use the direct payment for the things we agreed.

You cannot use a direct payment to pay for:

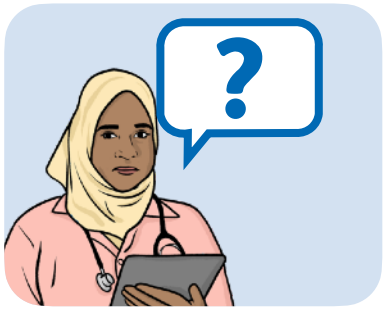
- alcohol.

- tobacco.

- gambling or paying off debts.

- anything illegal.

Individual Funding Requests



An **Individual Funding Request** is when a doctor or health professional asks for money for special care for a patient.

A personal health budget gives that money straight to the patient to let them choose how to spend it.

Your doctor can still make an Individual Funding Request if you have a personal health budget.

Short breaks and holidays

Sometimes it is helpful to have a short break or holiday.

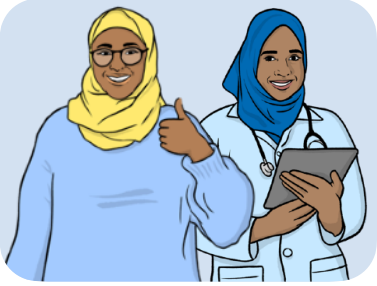
Short breaks

Short breaks are sometimes called respite care.

They are when you get care from someone else for a short time to give your usual carer a break.

You will have a certain number of hours of respite care every year.

This will be explained in your care and support plan.



Your health professional can help you to find a short break service.

Holidays

Holidays can be good for your health.

You might need more care than usual if you are going somewhere you do not normally live.

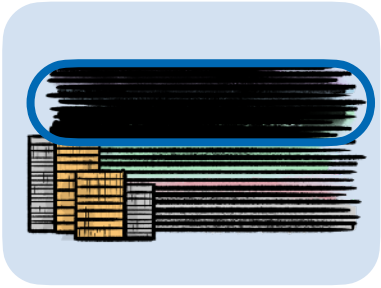
You might need 2 carers.

You might need to take your own carer and pay them to work for longer.

We know that this will cost more money.

Your nurse assessor will help you put everything you will need in your care support plan.

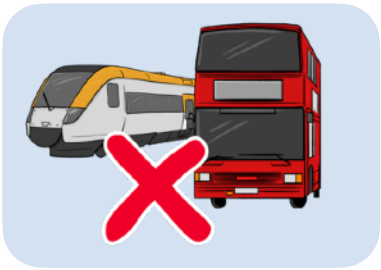
It shouldn't cost more money than you have to spend.



Your personal health budget might only cover some of what you need to spend.

You cannot use your personal health budget to pay for:

- places to stay, like hotels or B&Bs.



- transport, like trains or planes.

- **insurance**.

  Insurance is protection for when something goes wrong. You pay money to an insurance company and they pay out if things get lost, stolen or broken.

For more information

You can find out more about personal health budgets here:
www.england.nhs.uk/healthbudgets

You can read more about personal health budgets here:

www.personalhealthbudgets.england.nhs.uk

The Peer Network is an organisation for people with personal health budgets. You can find out more here:
www.peoplehub.org.uk

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NHS
Liverpool
Clinical Commissioning Group

NHS Liverpool Clinical Commissioning Group
Policy for Personal Health Budgets
December 2021

Title:	National Health Service (NHS) Liverpool Clinical Commissioning Group (CCG) Policy for Personal Health Budgets
Version:	2.0
Ratified by:	NHS Liverpool CCG Governing Body
Date ratified:	21 December 2021
Name of originator/author:	Ruth Hunter Senior Personalised Care Manager
Name of Lead:	Jane Lunt – Director of Quality, Outcomes and Improvement/ Chief Nurse
Date issued:	21 December 2021
Review date:	December 2022
Target audience:	People in receipt of personal health budgets Carers for people in receipt of personal health budgets Liverpool CCG Midlands and Lancashire Commissioning Support Unit NHS Providers Liverpool City Council

In the event of any changes to relevant legislation or statutory procedures this policy will be automatically updated to ensure compliancy without consultation. Such changes will be communicated.

Version Number	Type of Change	Date	Description of change
V2.0	Edit	19.04.2022	Change to the payment process under paragraph 89.
V2.0	Edit	26.04.2022	Removal of paragraph relating to The Mental Capacity (Amendment) Act 2019 on page 4.

Contents

The following document should be read in conjunction with the Mental Capacity Act 2005 (MCA) including Deprivation of Liberty Safeguards (DoLS), the Mental Health Act 1983, amended 2007 (MHA), the Equality Act 2010, The Children and Families Act 2014, The National Health Service (Direct Payments) Regulations 2013 (SI 2013, No.1617), The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) Regulations 2013, The Care Act (2014), The NHS 10 Year Plan 2019, Guidance for Personal Health Budgets for Liverpool CCG, and NHS England (NHSE) guidance relating to personal health budgets (PHBs).

Introduction and background

1. This policy document sets out Liverpool CCG's intentions on what its personal health budget (PHB) offer is.

2. This policy applies to people who are registered with a Liverpool General Practitioner (GP)

3. A PHB is a sum of money provided by the NHS to meet the health and wellbeing needs of individuals with serious long-term illness or health conditions. The PHB is spent on things that have been agreed between the person, named health professional, and the CCG. People who request a PHB can choose to receive it in one of three ways (See paragraph 66-69).

4. The aim of a PHB is to promote person-centred care and support and to give greater choice and control to the recipient. The aim in implementing these policies and systems should be to keep things as simple and flexible as possible whilst meeting legal and audit requirements.

5. Over the past decade personalisation has become an important strand of public service reform. There is now considerable activity across government to introduce PHBs, along with integrated PHBs between health, social care and, where appropriate, education. The NHS 10 Year Plan (2019) demonstrates a strong intent to increase personalised care to 2.5 million people by 2023/2024[i], and specifically to implement PHBs to 200,000 individuals nationally[ii].

6. A number of individuals currently have the 'right to have' a PHB as set out in national guidance. The Department of Health have set out intentions to extend this category of individuals. Liverpool CCG supports the intention to extend PHBs to further patient cohorts over the coming years.

Policy Statement

7. This policy sets out the principles for the ongoing rollout of PHBs by the CCG and focuses on PHBs for the following patient groups:

- Adults eligible for, or in receipt of, NHS Continuing Healthcare (CHC).
- Children eligible for, or in receipt of, Continuing Care (CC).
- Individuals who access wheelchair services whose posture and mobility needs impact their wider health and social care needs.
- Individuals eligible for Section 117 aftercare following inpatient admission under Sections 3, 37, 47, 48 or 45A of the Mental Health Act (1983, amended 2007).
- Individuals who have a long term condition who may benefit from a personal health budget and are not in receipt of NHS funded packages of care

8. These principles are to be applied by the CCG strategic partners which have a role in implementing PHBs for the CCG, and Liverpool City Council. This is an evolving policy that will be reviewed as national guidance and relevant legislation around PHBs develops.

9. This policy document sets out Liverpool CCG's intentions to ensure that all patients meeting the criteria for a PHB have the opportunity to be offered and/or receive a PHB in line with

national guidance and where possible, that PHBs are considered in other cases where there is a benefit for the individual. A key aim of this policy is to ensure that a consistent and transparent approach is applied to the development and approval of all support plans and budgets. (See appendix 1 for the support plan template)

10. Liverpool CCG will work in conjunction with its partner organisations to deliver an integrated PHB offer through the Personalised Care Commissioning Team. Whilst an initial financial offer is made at the indicative budget setting stage, a fully integrated PHB is achieved through a system of support planning for patients who have chosen to develop a PHB in response to their health and social outcomes. This document operates within wider guidance as stipulated at the beginning of the policy.

11. The CCG will ensure that PHBs achieve value for money for both the individual in receipt of one and the CCG. This will be done through the way in which PHBs are set up, through robust care & support planning, through effective monitoring of direct payments and clearly defined outcomes being agreed between all parties at the start of the process.

12. Following assessment of needs by a Nurse Assessor on behalf of the CCG, any support planning will assure the CCG that the patient has ownership throughout the process. The patient will lead the development of the support plan, with assistance from the Nurse Assessor if required. This is determined through patient choice. If the patient is unable to prepare their own support plan, their contribution should guide the preparation of the support plan as much as possible. Support planning will allow the identification of desired health and wellbeing outcomes and related goals which can be referred to by the patient, family/carer and health and social care professionals to promote improved health and wellbeing. In the case of children and young people with Special Educational Needs and Disabilities (SEND) and in receipt of an Education, Health and Care (EHC) Plan, assessment of need and support planning will be led by the Local Authority through this process, supported by clinicians and the CCG as set out in national guidance.

Principles of a Personal Health Budget

13. Liverpool CCG's underpinning principles for providing PHBs are:

- Patients and their carers will be central to all processes;
- Services will be personalised whether the care is provided by a statutory or private provider;
- The delivery of PHBs will be managed within the agreed budget;
- Patients have a right to request a PHB. The CCG will try to achieve this and need to ensure it is lawful, affordable, effective and appropriate
- The budget setting process will be based on the cost of provision of traditional services to meet the health and wellbeing outcomes identified and agreed;
- The CCG will ensure patients are supported throughout the PHB process

Due Regard and Equality

14. The CCG aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others or that some receive an advantage over others.

15. All policies and procedures are developed in line with the CCG Equality and Diversity Policy and need to take into account the diverse needs of the community that is served. The CCG will endeavour to make sure this policy supports its diverse workforce and look after the information the organisation needs to conduct its business. It will also endeavour to ensure that this information is protected on behalf of patients regardless of race, social exclusion, gender, disability, age, sexual orientation or religion/belief. Where it is identified that statements in this policy have an adverse impact for particular equality groups, this will be

raised with the Governance Manager (Compliance) and with the Head of Corporate Governance and Legal Affairs and solutions sought.

16. A full Quality Impact Assessment, Equality Impact Assessment and Financial Impact Assessment has been undertaken by the CCG in relation to PHBs.

Scope

17. The scope of this policy covers:

- All patients assessed as eligible for NHS CHC or CC for children and young people.
- Nominated[iii] PHB holder individuals.
- All staff irrespective of organisation that deliver PHBs on behalf of the CCG.
- CCG teams involved with the commissioning, contract management and governance of PHBs.

18. This policy document will act as a guide to support the process of planning, placing emphasis on ownership, co-production, transparency and support as and when required.

19. This policy document will compliment detailed guidance documents.

20. This policy promotes patient choice and control of services received within CHC and CC for children and will extend this choice to other cohorts such as S117 aftercare patients and long term wheelchair users. The aim is that there is an opportunity for patients and their families and carers to be proactive partners in agreeing the services which will meet their needs.

21. This document sets out the policy and practice guidance developed to ensure the consistent and transparent delivery of PHBs for Eligible Persons (see section 13 “Who can have a PHB” for definition). National policy in this area is still developing and the CCG will review this policy when new guidance, regulations, national policy is published or local offers reviewed.

Definitions

22. Agreement means either:

- the agreement between the CCG and the person receiving the direct payment agreement or the individual and the Third Party to receive the individual’s PHB payments.
  Or
- the agreement between the CCG and the Third Party which will receive the person’s payment from the CCG. (See appendix 2 for the agreement template)

23. Bank Account means the bank account held by the individual or Third Party as agreed by the individual and approved by the CCG into which PHB payments are paid under the terms of this agreement. This is a dedicated bank account used only for the purposes of the PHB.

24. Capacity refers to the ability of an individual to take valid autonomous decisions. Young children may lack capacity because of their age alone; adults may lack the mental capacity to take decisions for themselves in relation to a PHB because, for example, of a cognitive deficit. Every adult must be presumed to have mental capacity in relation to a particular issue unless it is established that they lack capacity, ie. that they are unable to:

- Understand the information relevant to the decision;
- Retain that information;
- Use or weigh that information as part of the decision-making process; or
- Communicate their decision (whether by talking, using sign language or any other means).

It is important to note that whether someone has capacity or not should be determined on a decision-specific basis but in accordance with the MCA (2005) and any future amendments to this act.

25. **Nurse Assessor** means the person nominated by LCCG to establish and monitor PHBs.

26. **Clinical Commissioning Group (CCG)** commissions the provision of healthcare services in a specific area and will work with local authorities and other agencies that provide health and social care locally to make sure that the local community's needs are being met.

27. **DBS** means the Disclosure and Barring Service or any replacement or successor service to it.

28. **Employment Costs** means costs associated with the employment of staff by the Third Party or the Individual for the purpose of (but not limited to) wages, DBS checks, national insurance, training, payroll, insurance and emergency cover, tax and any other costs.

29. **Eligible persons – and Right to Have -** Patients assessed as eligible for NHS CHC or CC for children and young people, have a Right to Have a PHB as defined the NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules Regulations) 2013 and by guidance[1]. From the 1st April 2019, a PHB is now the default offer for CHC and CC funding for those living at home. Patients eligible for Section 117 Aftercare and patients accessing wheelchair services also have a Right to Have a PHB from 2/12/19 (see paragraph 49). The CCG will also consider on a case by case basis those individuals who express an interest in PHB.

30. I**ndividual** means the person who will receive the care.

31. **Personal Health Budget** means the budget for provision of healthcare services to the individual made by way of PHB payments in accordance with the agreed support plan.

32. **Personal Health Budget Payments** means the payments made to the Third Party on behalf of the Individual or their Representative and paid into the bank account by the CCG.

33. **Representative** is a person who is appointed to manage a direct payment where an individual lacks capacity. A Representative may be:

- Someone who holds an enduring or lasting power of attorney;
- A Deputy appointed by the Court of Protection;
- Someone with parental responsibility for a child or someone with parental responsibility for a 16 or 17 year old who lacks capacity; or
- Someone appointed by the CCG.

34. **Support Plan** means the plan the individual or their Representative develops with appropriate personalised assistance, which describes the health and wellbeing outcomes they want to achieve and the services to be secured by means of PHB payments to achieve the health outcomes. This plan is agreed by the individual or their Representative and the CCG. The support plan may also be termed care plan.

35. **Support** means the arrangements made to meet the individual's health and personal care needs as specified in the PHB support plan.

[1] Guidance on the "right to have" a Personal Health Budget in Adult NHS Continuing Healthcare and Children and Young People's Continuing Care www.england.nhs.uk/publication/guidance-on-the-right-to-have-a-personal-health-budget-in-adult-nhs-continuing-healthcare-and-children-and-young-peoples-continuing-care/

36. SEND Reforms refers to the Special Educational Needs and Disabilities (SEND) Reforms that came into force on 1st September 2014, and which are legislated under Part 3 of the Children and Families Act 2014. These reforms and the underpinning Code of Practice relate to children and young people aged 0-25 with special educational needs or disability.

37. Education, Health and Care Plan/Process refers to the multiagency assessment and planning process and the resultant support plan produced under the SEND Reforms.

38. Safeguarding is about safety and wellbeing of patients and providing additional measures for those least able to protect themselves from harm and abuse. Staff should familiarise and be aware of their responsibilities around this agenda by accessing the CCG Safeguarding Adults and Children policy.

Responsibilities

39. The Accountable Officer takes the ultimate responsibility for this policy and must ensure that:

a. They discharge their duties as required by legislation in relation to PHBs;
b. The CCG complies with this policy. This includes their role to ensure effective implementation of this policy.

40. The CCG Chief Nurse must ensure that:

a. Quality assurance of PHBs is a standing agenda item at monthly Individual Patient Activity Clinical Quality and Performance meetings between the CCG and any CHC provider organisations.
b. There is an opportunity for the provider to discuss any quality or concerns related to PHBs with the CCG as and when required
c. The Joint Funding Steering Group between the CCG and Liverpool City Council works to its terms of reference in relation to quality, and feeds back any concerns with regard to PHBs to the appropriate governance groups.

41. The CCG Chief Finance Officer must ensure that:

a. There are procedures in place for receiving financial assurance in relation to PHBs

42. The CCG Team must:

a. Ensure that PHB projects are delivered consistently across the CCG, Local Authority and partner organisations.
b. Attend relevant local meetings and produce and present reports to project boards, forums and stakeholders as required.
c. Raise the profile of PHBs across the city.
d. Support the development of contracts that reflect the aims of the PHBs.
e. Assist the CCG in the interpretation of national and local policy and planning initiatives.

43. Patients, representatives and/or their nominated individuals must ensure that:

- They are active participants in the PHB process.
- They use their budget in the spirit of PHBs.
- They follow the legislative requirements of PHBs and follow the Direct Payment Agreement as appropriate.

44. PHB Providers

All providers of PHBs will:

a. Ensure they follow the PHB processes in line with national and local guidance.
b. Capture all relevant data to enable a response to information requests as required.
c. Engage with their users to improve their PHB offering, in line with national guidance.
d. Engage with the Personalised Care Team to ensure compliance with the PHB standards.

Capacity and Consent

45. This section applies to those being considered for a PHB and those who already have one. In line with the MCA (2005), patients with a PHB will be empowered to make independent decisions wherever possible and where they lack capacity over certain decisions, this will be managed in line with the MCA (2005) and any future amendments to this act.

46. The MCA (2005) including Deprivation of Liberty Safeguards (DoLS) Policy must be followed and there are specific requirements for how direct payments are managed for those with and without capacity. See below:

a. **Direct payments for people with capacity** – The individual receives the funding that is available to them and they purchase the services and support they want in accordance with the agreed care plan. The individual can elect to receive and manage the payment themselves or decide for it to be received and managed by a person of their choosing (a nominee). If the individual chooses a nominee, that nominee becomes responsible for managing the funds and services and accounting for expenditure.

b. **Direct payments for people who lack capacity** – Where the individual lacks capacity, an agreed representative receives the funding that is available to the individual as a direct payment. The representative is responsible for managing the funds and services and accounting for expenditure. The representative takes full legal responsibility of having a direct payment and of being an employer. They can identify someone else to support them in managing the direct payment. The representative will be required to sign the direct payment agreement. The representative must involve the individual as much as possible and act in their best interests, in accordance with the MCA (2005) and any amendments. In the case of children a representative may be appointed to receive the direct payments on the child's behalf. The representative may be the child's parents or those with parental responsibility for that child or anyone else the CCG agrees to appoint in compliance with the relevant regulations. The employer cannot also be an employee with the exception of a 3rd party holding the budget.

Who can have a Personal Health Budget?

47. The following groups have a 'right to have' a PHB:

a. People who are eligible for NHS CHC (adults)[2];
b. Children and Young People eligible for CC[3]. In the case of children and young people this refers to the element of additional health need that cannot be provided by NHS commissioned services.
c. Patients in receipt of Section 117 aftercare;
d. Patients with a long term wheelchair need.

48. In accordance with the overall drive towards greater patient choice and control, PHBs for patients other than those listed above can still be offered a PHB and the benefit of personalised care plans for patients with long term conditions should be borne in mind, even though the "right to have" does not currently extend to those patients.

[2] National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care October 2018 (Revised). www.events.england.nhs.uk/upload/entity/30215/national-framework-for-chc-and-fnc-october-2018-revised.pdf
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213137/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf

[3] as defined by the National Framework for Children and Young People's Continuing Care http://www.nhs.uk/CarersDirect/guide/practicalsupport/Documents/National-framework-for-continuing-care-england.pdf

49. The Department of Health and Social Care and NHS England have extended the Right to Have to those in receipt of Section 117 aftercare and long term wheelchair users and have a broader programme to extend this further in subsequent years.

50. As part of the CCG's commitment to PHBs – the CCG will consider if a PHB may be available to the following groups. The CCG will consider applications on a case by case basis:

a. Joint funded packages. The CCG will especially consider cases where the individual is already in receipt of a direct payment from social care or through the fairer funding charge do not qualify for social care funding but already have personal assistants/agency that they wish to continue using;
b. Children or young adults with an EHC plan who do not qualify for CC;
c. Those who require a bespoke package of care as outlined by the Transforming Care agenda;
d. Other individuals on a case-by-case basis where the CCG considers the individual would benefit from a PHB rather than a traditionally commissioned service.

Informing people about Personal Health Budgets

51. All CCG policies relating to NHS CHC and CC continue to apply when an individual has a PHB. The Nurse Assessor will inform those individuals of their right to have a PHB (see paragraph 6 above). This will include information about the option of a direct payment. For point of clarity, any patients who relocate into the Liverpool CCG footprint that are eligible for a PHB will have it discussed at review stage.

52. Health professionals will also seek to identify other patients who do not fall within the current scope of the "right to have" a PHB but who may benefit from the provision of a PHB. PHBs are not restricted to those currently eligible and the CCG can seek to offer PHBs on a voluntary basis to a wider cohort. Where such patients are identified, the health professionals involved in their care will provide them with information about PHBs (including directing them to the CCG website) and the case will be discussed with the CCG as to the appropriateness of the request.

53. The Nurse Assessor will offer information or signpost individuals to a suitable organisation who can provide information, advice and guidance to prospective and existing PHB recipients and their families. The services provided by these organisations will include:

a. How a PHB can be used and managed.
b. Guidance on producing a personalised care support plan.
c. Advice and support to manage a PHB, including a direct payment.
d. Guidance on record keeping requirements.
e. Information about direct payments, including the responsibilities around financial monitoring that will need to be taken on by the recipient of the direct payments.
f. Procedures around payback or any surplus funds.

Short breaks and holidays

54. Short breaks are also referred to as respite care. The agreed number of respite hours per year will be detailed in the support plan. The named health professional will assist in finding a suitable short break service to build into the PHB.

55. Holidays - Although there is no formal entitlement to holiday funding within a PHB, the CCG recognises that a holiday can be beneficial to health and wellbeing. The CCG acknowledges that there may be additional staffing and equipment costs to support someone away from their home in an environment which may not be suitably adapted. In some instances two carers may be needed for safe care. In addition, people who do not normally require 24 hour care may need to take their own carers and require them to work longer hours. All of this should be

outlined in the support plan and come within the indicative budget allocation. If someone wishes to take a holiday, this is allowed within a PHB but as outlined above other needs may need to be met by alternative arrangements. The number of care hours will be agreed on an individual basis however the PHB cannot be used to fund the following: PA - accommodation, transport and insurance.

56. Flexibility - the CCG acknowledges that there are times when flexibility for a support plan may be required and individuals may want to accumulate their PHB to allow for flexibility of a temporary change in circumstances. Any savings made via the PHB should not reduce the ability to meet agreed outcomes, or be made at the expense of health or wellbeing. If flexibility of this nature is requested by the individual, it must be agreed by the CCG and reflected in the support plan. The CCG must be assured that the individuals needs continue to be met.

Exclusions for Personal Health Budgets

57. If an individual comes within the scope of the "Right to Have" a PHB, then the expectation is that one will be provided. However, the NHS England guidance[4] states:

- '*There may be some exceptional circumstances when a CCG considers a personal health budget to be an impracticable or inappropriate way of securing NHS care for an individual. This could be due to the specialised clinical care required or because a personal health budget would not represent value for money as any additional benefits to the individual would not outweigh the extra cost to the NHS.*'

58. The CCG will comply with NHS England guidance and where applications are declined individuals will be advised of the CCG's complaints process should they wish to use this.

59. A PHB cannot be used to pay for alcohol, tobacco, gambling or debt repayment, or anything that is illegal.

60. NHS England has also provided guidance on the circumstances a CCG may decide not to provide someone with a direct payment (Guidance on Direct Payments for Healthcare; Understanding the Regulations, March 2014). The CCG may decide not to offer a direct payment if, for example, it considers:

a. That the individual (or their representative) would not be able to manage a direct payment;
b. That it is inappropriate for that individual as a result of their condition or other circumstances;
c. That the benefit to the individual does not represent value for money for the CCG;
d. That providing services by way of a direct payment will not provide the same or improved outcomes;
e. That the direct payment will not be used for the agreed purposes.

[4]http://www.personalhealthbudgets.england.nhs.uk/_library/Resources/Personalhealthbudgets/2014/Personal_health_budgets_right_to_have_guidance.pdf

PHBs and Individual Funding requests[5]

61. A PHB is an amount of money to support the planned healthcare and wellbeing needs of an individual, which should be agreed by their named health professional. PHBs, therefore, give people more independence over how money for their healthcare is spent. For more on the operation of PHBs see: www.england.nhs.uk/healthbudgets/.

62. Individual Funding Requests are applications by clinicians on behalf of their patients relating to funding for treatment that is not routinely commissioned by NHS England, based on clinical exceptionality. PHBs by contrast are a different way to meet assessed needs that services are routinely commissioned to meet.

63. The CCG would not expect the IFR process to be used to agree services agreed as part of a PHB. However, having a PHB in place for some aspects of a patient's care would not exclude the patient's clinician from making an IFR request to meet needs that are not routinely met via commissioned services.

PHBs for people in nursing or residential care home settings

64. The Government's intention is for all Eligible Persons to have the "Right to Have" a PHB where they would benefit. Therefore, where Eligible Persons living in nursing or residential care may benefit from receiving care via a PHB, the option should be considered and discussed. However, CCG needs to be satisfied that the use of a PHB in such settings:

a. Is cost effective and;
b. Is a sensible way to provide care to meet or improve the individual's agreed outcomes and;
c. Gives patient choice of payment method.

65. PHBs should not generally be used to pay for care and support services being funded through NHS core commissioned services that a person will continue to access in the same way whether they have a PHB or not, for example GP services or A&E.

Options for Managing a Personal Health Budget

66. The most appropriate way to manage a PHB should be discussed and agreed with the individual, their representative or nominee as part of the care planning process.

67. PHBs can now be received and managed in the following ways, or a combination of them in some circumstances:

a. **Notional budget** – where an individual is informed of the amount of funding available to them and decides how the budget is used (by input into the care plan) but the CCG continues to commission services, manage contracts and make purchases etc. Notional budgets could be an option for individuals who want more choice and control over their healthcare but who do not feel able or willing to manage a budget.
b. **Third party budget** – A different organisation, legally independent of both the individual and the NHS, holds the money for the individual and arranges and pays for all of the services on behalf of the individual in accordance with the care plan.
c. **Direct payments** – The PHB is paid directly to the individual and their nominated bank account. The CCG will comply with the National Health Service (Direct Payments) Regulations 2013 when dealing with direct payments.

68. An individual does not have to receive their care through a PHB but can opt for a traditional package of support or mix the two approaches if this option is available.

[5] NHS England 2017. Commissioning Policy: Individual Funding Requests

69. Direct payments will be paid via Shared Business Service in advance on account i.e. for the month of June the payment will be received by the end of May. Payment by arrears is not best practice, however under exceptional circumstances this may occur as a one-off, i.e. on the set up of a PHB. The set up of a PHB within the finance system can take up to two weeks to ensure all validation checks are complete. This will be set up by the CCG finance department.

The Personal Health Budget proposal and support plan

70. The support plan is the central part of the management of PHBs. A good support plan is at the heart of a PHB. Although the support plan is written by an individual with the support of the Nurse Assessor, it is the responsibility of the CCG to ensure that an approved support plan is fit for purpose following the subsequent directions on lawfulness, affordability, effectiveness and contains all health and social care needs

The Personal Health Budget proposal and support plan

Lawful

71. The proposals must be lawful and meet all regulatory requirements where relevant. In deciding whether the support plan meets with legal requirements. It should show for example that:

a. Informed consent has been obtained;
b. Any legal responsibilities that an individual will incur under the PHB arrangement (eg. employment law, health and safety, HMRC regulations and monitoring information);
c. The assessed needs and desired outcomes of the individual and that the PHB will be able to meet those needs and outcomes;
d. It is person-centred and led by the needs of the individual;
e. It is well-balanced with the highest needs receiving priority;
f. There is provision for appropriate reviews of the care plan;
g. Risks have been properly identified and discussed with the individual, their representative or nominee and properly addressed to ensure such risks are eliminated, reduced or managed. These include risks to the individual or anyone else but also risks to the service or to the CCG.
h. Compliance with the MCA (2005) can be clearly demonstrated, and that the appropriate deprivation of liberty authorisation has been applied for if relevant. If the individual has been assessed as lacking capacity, the support plan must make it clear how their wishes have been ascertained and incorporated into the care and support plan;
i. Where people lack capacity or are more vulnerable, procedures such as safeguarding, promoting liberty and necessary restraint procedures (if required) have been included appropriately in the care plan and any necessary legal authorisations for those procedures have been obtained;
j. Any service providers identified in the plan must meet applicable regulatory requirements. A regulated activity cannot be purchased from a service provider that is not registered with CQC;
k. The individual, their representative or nominee and, where applicable, their carers, have received guidance on any health and safety issues or regulatory requirements in relation to any equipment to be used or any adaptations to their home;
l. A legally binding agreement or contract is in place;
m. Where a direct payment is used, The National Health Service (Direct Payments) Regulations 2013 are complied with.

Affordable

72. The CCG has a responsibility to meet all statutory obligations, which include manage its finances appropriately and ensure value for money. The CCG reviews and aligns its PHB rates with Liverpool City Council on an annual basis.

73. Whilst the CCG wants to maximise flexibility, it may decide to avoid using PHBs to commission packages of care which are being provided under existing NHS contracts, as long as they are able to meet an individual's needs.

74. Individuals with a PHB should not be unfairly advantaged when compared with those who do not have a PHB. Where the CCG already has a commissioned service under a block contract, this service must be investigated first. This may mean that a direct payment may not cover all of the budget requirements, and a notional budget is also required to cover those services already commissioned under the NHS standard contract. Where the commissioned service cannot deliver the care because it is outside the scope of its specification then a direct payment could be considered. However, where there is a capacity issue within the commissioned service a PHB cannot be used to 'jump the queue'. Where capacity problems exist they must be reported to the CCG.

In deciding whether the support plan is affordable, it must show that:

a. Where the support plan requires a budget that is lower than the indicative budget, the lower budget will be approved as the assessed needs are able to be met for this lower sum;
b. Where the support plan exceeds the indicative budget, the plan is thoroughly checked by the Nurse Assessor before being sourced to ensure best value;
c. Is reflective of the CCGs relevant policies, ensuring that best value of public money has been achieved;
d. The use of existing universal services, community resources, informal support and assistive technology has been explored as a first-line, and clear rationale are given and agreed as to why these **are not** appropriate to meet the individual's assessed needs;
e. All relevant sources of funding (eg. local authority provision) have been identified and utilised in conjunction with the PHB;
f. All costs have been identified and fall within the budget allocated;
g. The support plan fully meets the assessed, eligible needs in the most cost effective way possible;
h. Where NICE has concluded that a treatment is not cost effective, the CCG will apply its existing exceptions process before agreeing to such a service. However, when NICE has not ruled on the cost effectiveness or otherwise of a specific treatment, the CCG will not use this as a barrier to people purchasing the service, if it could meet the individual's health and wellbeing needs. NICE provide a lay version of their guidance that can help people make decisions about this type of healthcare.
i. All PHB final budgets must be authorised by the CCG prior to commencement of the PHB.

Effective

75. The CCG has a statutory duty to ensure funding is used effectively and in accordance with the principle of best value. The CCG will therefore make sure that the individual's needs and desired health outcomes are taken into account and that the measures proposed in the support plan represent an effective use of the PHB. In particular the CCG must be satisfied that:

a. The support plan has been appropriately risk assessed;
b. The support plan will be effective in meeting the individual's assessed needs and holistically supporting their health and wellbeing;
c. The support plan takes account of the views and needs of carers;
d. The support plan is adaptable and flexible, so individuals can revise their plans as they learn what works best for them or as their circumstances change;
e. The support plan has tangible outcomes and reviews are arranged at least annually;
f. Where outcomes are not being met, the review will ascertain the reason behind this and whether it is reasonable to continue with the PHB in its current format.

Appropriate

76. The support plan should not include the purchase of items or services that are excluded from PHBs as set out in Section 59.

The CCG recognises that:

a. Some measures that involve the CCG in an outlay of a significant short term cost can contribute to increased independence in the future and thereby reduce support needs or avoid further costs in the long term. In these circumstances the CCG will expect the Nurse Assessor to justify how short term measures will yield longer term benefits. Where longer term benefits are not met, the CCG will ensure that the support plan will be reviewed and, if necessary, the PHB will be changed.
b. Prioritising prevention and early intervention promotes greater wellbeing and independence and can reduce the need for ongoing support.
c. Full consideration needs to be given to the different kinds of health, care and support individuals will request. Some individuals will want to keep their existing support, but have it tailored better to their needs. Others will choose to spend their budget differently, on every day and community-based support not currently available from the NHS.
d. Unusual requests will not be excluded without examining the proposal on a case-by- case basis as these may have significant benefits for people's health and wellbeing. These requests will be considered taking into account the health outcomes to be achieved by the proposal.
e. Where an individual chooses to use their PHB flexibly to pay a PA differing amounts than that those traditionally commissioned by the CCG, they are able to do so as long the PHB remains in budget.

Managing the risk

77. Individuals should be supported to make fully informed choices about the risks they may be taking. Where risks are identified, a 'risk enablement' approach will be employed to mitigate all risks. During the care planning process, Nurse Assessor will have a detailed discussion with the individual, representative or nominee about potential risks, and how to manage them and the consequences of them. This should be part of an ongoing dialogue between all parties on how to effectively manage risk.

78. Examples of possible risks relating to PHBs are as follows:

a. The individual's health and wellbeing: clinical risk
b. The Individual's safety (or those around them): safeguarding risk
c. Those that are caring for the patient: employment risk
d. The individual's budget: financial risk
e. The Individual’s personal information: information governance risk
f. The availability/capability of providers to deliver PHBs across Liverpool: corporate risk

79. The support plan must contain details of the risks discussed and any proportionate means of eliminating, reducing or managing the risks agreed with the individual about managing the potential risk.

80. Where identified risk incidents occur, (eg. safeguarding, financial abuse etc.) the CCG’s reporting procedures should be followed. The Nurse Assessor is responsible for ensuring that the individual is aware of what constitutes risk incidents; knows the correct pathways for reporting them if they arise, and is furnished with the appropriate contact details.

81. Risks should be discussed between the CCG and provider through the CCG’s contract management process.

Complaint process

82. If the individual is dissatisfied with the process and/or final outcome decision, they have the right to complain to the CCG via the normal NHS Complaints procedure.

Assistance to manage Personal Health Budgets

83. Individuals in receipt of PHBs, and who require support, will be signposted by the Nurse Assessor to a choice of support services.

84. The costs associated with utilising support services are met as part of the PHB as long as they are agreed as part of the support plan.

Personal Health Budget Agreement and contracts

85. When taking up a PHB, there must be a contract or agreement in place.

86. For notional budgets, the provider will be issued with the NHS standard contract and the support plan will become the service specification of the contract.

87. For third party budgets, the agreement is tripartite between the CCG, the provider and the service user/budget holder. This agreement is made using an PHB agreement and NHS standard contract, as other agreements do not have measures to monitor quality of provision. The provider will be expected to furnish the CCG with a bank form that allows for the setting-up of an account for the individual ahead of the commencement of the PHB

88. For direct payment budgets, the individual or their representative must sign a PHB Agreement, which explains the responsibilities associated with the PHB and sets out the agreement that the PHB will be spent as set out in the support plan. If the patient is receiving the PHB as a direct payment, the PHB agreement will confirm that the PHB will be spent in accordance with the NHS (Direct Payments) Regulations 2013.

Payments of Personal Health Budgets

89. PHBs will be paid as outlined in the agreement or contract. For direct payments this will be made in advance. The overall budget will be split into 12 monthly parts and the individual or provider will receive a monthly payment. For third party or notional budgets, these will be paid on invoice in accordance with standard NHS terms.

Contingency will be paid in line with the contract/agreement.

Reconciliation of Funds

90. It is advisable for the CCG to review spend on a regular basis through out the year. Any unspent funds which are not identified for future use; *per* the support plan; will be reclaimed back in consultation with the individual or their representative.

Audit and Financial review

91. It is the responsibility of the patient / representative to maintain and retain proper accounting records. The CCG will request these records including bank account statements, payslips, timesheets and receipts and expect the patient/representative to provide explanation for spend. If the individual is unable to provide the appropriate audit evidence this may result in the PHB being changed or stopped and the monies paid being fully recovered.

92. It is expected that minimal spend will be made by Cash. If this is not possible all cash payments must be accounted for with a receipt. Cash may be paid to an employee as long as a payslip has been provided and the appropriate tax and NI has been withheld to be paid on to Her Majesty's Revenue and Customs.

93. Once the audit has been completed if the budget has been inappropriately used, the value would be required to be refunded to the CCG and may result in the PHB being changed or stopped.

Monitoring and review of this policy

94. A financial audit of the PHB will be undertaken by the CCG finance department on an annual basis to assess performance against this policy. A letter will be sent to the individual / representative to inform them of the audit evidence required. The CCG will allow sufficient time for the information to be gathered and sent as appropriate. The letter will outline the period under review, the information required and where this should be sent.

95. It may be appropriate to send original copies of receipts and payslips. Should this take place the CCG will take copies and return the originals as required. It would be more advantageous for the information to be sent electronically if possible. This will speed up the audit process and allow review by managers to occur effectively. The audit will follow the Liverpool CCGs PHB audit procedures which have been developed in line with the NHS England "Guidance on Direct Payments for Healthcare: Understanding the Regulations" and updates.

96. It is the responsibility of the representative to provide the information in a timely manner, recognising that not doing so may impact on the CCGs view on their ability to maintain the PHB budget in the future.

97. Should the financial information not be received by the agreed time set out in the letter, a second letter would be sent as approved by the Deputy Chief Finance Officer with a new agreed date (preferably no longer than one week).

98. If no information / contact is received following the deadline date set out on the second letter, a third letter would be drafted and approved by the Chief Nurse, a copy would be sent to the Nurse Assessor to inform them of the difficulty and to request assistance. It would be anticipated that by this stage a very small number, if any would not produce the financial information, however, should this occur, this should be reported through the provider contract management process and the CCG and provider team would seek to contact the patient / representative and review their ability to manage the PHB in the future.

Conducting the audit

99. It should be the intention of the CCG to conduct the audit no more than one month after the evidence for the financial audit is received. The audit will review the patient's / representative's ability to maintain and manage the PHB budget. The audit may reveal some minor issues that can be easily resolved with additional questions and further advice and help in managing the finances may be provided. The audit may however also reveal issues such as inappropriate spending, or under / over spending. Should this be the case, the finance team must immediately notify the Nurse Assessor to discuss the issues identified, so that any impact on the individuals care can be assessed.

100. The audit may result in an urgent review of the care to ensure that the PHB is still a viable option.

101. On a periodic basis, the CCG will update the PHB team on the progress of the PHB audits and any issues identified which may require updates and improvements to the policy and processes.

Audit process on Death of an individual

102. At times the CCG is notified of an individual's death. When this occurs, the financial accounts department and the Nurse Assessor must be informed.

103. If the Nurse Assessor confirms it is appropriate to do so, the financial accounts team will contact the patient representative / Next of Kin to discuss any return of unspent funds and a closure audit being conducted.

104. As a guide a grace period of 2-4 weeks would be given to the representative / Next of Kin if appropriate (this may be longer due to circumstances, each case would be assessed individually), to provide all audit documents from the date of the previous audit to present. A final Closure audit will be conducted to ensure that the PHB was used appropriately during this period. The representative would continue to be responsible to answer queries if required. If the patient managed their own budget, it may mean that the next of kin and executor of the will are required to help in answering queries. Every effort should be made to ensure that a thorough closure audit is conducted.

105. In situations where a death has occurred, it may be that it takes some time before all final bills are received and paid before a PHB bank account can be closed and any surplus funds be returned to the CCG. The CCG would in this instance maintain contact with the representative / next of kin to agree a sufficient time scale for the return of funds.

106. If any issues have been identified, the CCG should still inform the Nurse Assessor of this for lessons learnt.

107. Where necessary a remedial action plan will be produced.

Policy update

108. This policy will be reviewed and updated every three years or earlier in accordance with any of the following:

a. Legislative changes;
b. Good practice guidance;
c. Case law;
d. Significant incidents reported;
e. New vulnerabilities;
f. Changes to organisational infrastructure.

Legislation

a. National Health Service (Direct Payments) Regulations 2013 as amended by the National Health Service (Direct Payments) (Amendment) Regulations 2013).
b. Human Rights Act 1998, including the Article 8 Right to respect for private and family life, and Article 14 Prohibition of discrimination.
c. The Data Protection Act 2018.
d. The Carers (Equal Opportunities) Act 2004 provides carers with the right to receive assessment for support and a duty on various public authorities to give due consideration to a request to provide services to carers.
e. The Mental Capacity Act 2005. The MCA provides a framework for decision making applicable where people lack capacity to make a decision for themselves. The overriding principles of

the MCA are set out in section 46 and include a requirement to ensure that all practicable steps are taken to seek to enable a person to make a decision for himself. Where a person is unable to make a decision, any decision made on their behalf must be made in accordance with his/her best interests and must be the least restrictive of the person's rights and freedom of action. A person is not to be treated as unable to make a decision simply because he makes an unwise decision.

f. The Equality Act 2010. The Equality Act brought together the various earlier discrimination laws under one statute. It is unlawful to act in a discriminatory manner against any "protected characteristics", including race, sex and disability.

g. The Children and Families Act 2014, which is partially in force and due to be fully in force by April 2015. This Act intends to improve services for key groups of vulnerable children (e.g., those in adoption and those with special educational needs and disabilities).

More Information

The NHS England website has a section dedicated to PHBs. This has information about national policy, the implementation toolkit, stories and other resources. www.personalhealthbudgets.england.nhs.uk

The Peer Network, a user-led organisation for PHBs, has its own website: www.peoplehub.org.uk

Appendices

Appendix 1 - Support Plan Template

Support Plan Template.doc

Appendix 2 – Personal Health Budget Agreement Template

Personal Health Budget Agreement.do

[i] NHS Long Term Plan 2019; section 1.39 www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf
[ii] NHS Long Term Plan 2019; section 1.41. www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf
[iii] A person who you nominate to receive and manage your direct payment

NHS
South Sefton
Clinical Commissioning Group

NHS South Sefton Clinical Commissioning Group

Personal Health Budgets for NHS Funded Packages of Care for Adults and Children

Policy & Practice Guidance

Title:	NHS South Sefton Clinical Commissioning Group Personal Health Budgets for NHS Funded Packages of Care for Adults and Children Policy & Practice Guidance
Version:	1.0
Ratified by:	NHS South Sefton CCG Governing Body
Date ratified:	23rd March 2016
Name of originator/author:	Katy Murray, Interim PHB Project Manager. Midlands and Lancashire Commissioning Support Unit Tracey Forshaw Head of Vulnerable People
Name of Lead:	Chief Nurse
Date issued:	23rd March 2016
Review date:	March 2019
Target audience:	CCG, CSU, NHS Community Providers, NHS Mental Health Providers

In the event of any changes to relevant legislation or statutory procedures this policy will be automatically updated to ensure compliancy without consultation. Such changes will be communicated.

Version Number	Type of Change	Date	Description of change

Table of Contents

1.0 Purpose & Introduction

This document sets out the policy and practice guidance developed to ensure the consistent and transparent delivery of Personal Health Budgets ("PHBs") for Eligible Persons (see section 3.1 for definition). This policy took effect from April 2014. The policy has been prepared to take account of the "right to have a PHB" for Eligible Persons from October 2014, and the wider expansion of PHBs at the CCGs discretion from April 2015 onwards. National policy in this area is still developing and the CCGs will review this paper when new guidance, regulations or national policy is published.

NHS South Sefton CCG (CCG) will ensure that PHBs are value for money for patients and the CCG. This will be done though the way in which PHBs are set up, through robust support planning and through effective monitoring of direct payments.

NHS South Sefton CCG would like to acknowledge Midlands and Lancashire Commissioning Support Unit, for the development of this policy, practice guidance and supporting documentation.

1.1 Consultation

This policy was developed in consultation with:

- NHS South Sefton CCG: Lead Commissioner – Learning Diversity, Children and Mental Health, Head of Finance, Head of Communications, Senior Governance Manager (Equality and Diversity), Head of Contracts.
- NHS South Sefton CCG meetings: Corporate Governance Support, Clinical Quality Committee, Evaluation and Patient Experience Group, NHS South Sefton Governing Body, Corporate Governance Meeting and CCG / CSU CHC Steering Group.
- CCG Legal Representation – Hill Dickinson
- Sefton Metropolitan County Council: Dwayne Johnson, Tina Wilkins, Nick Roberts, Margaret Milne, Carol Cater, Mark Waterhouse, Lauren Sadler, Lesley McCann, Mike McSorely.
- North West Commissioning Support Unit (NW CSU) – Continuing Health Care / Complex Care and Quality Team: Lorraine Norfolk, Jo Ryder, Margie Learie, Lead for Children, Mental Health and Learning Disability,
- Service user / Patient Consultation and Engagement: Commissioned and delivered by Sefton Carers Centre, Sefton MBC Consultation and Engagement Panel
- Personal Health Budget Brokerage: Salvere, Your Life Your Way, SOLO Support Services
- Third Sector Organisations: Sefton Carers Centre, Sefton Council for Voluntary Services, HealthWatch Sefton
- NHS Community Providers: Director of Nursing: Southport and Formby NHS Trust, Liverpool Community Health NHS Trust and Merseycare NHS Trust.

1.2 Ratification

This policy and practice guidance will be ratified by NHS South Sefton CCG Governing Body.

1.3 Scope

This policy applies to all employees of the South Sefton CCG, the CCG Commissioning Support Unit, NHS Providers commissioned to deliver services for South Sefton CCG.

1.4 Other Relevant Legislation

- Care Act 2014, HM Government. London

- Human Rights Act 1998, including the Article 8 Right to respect for private and family life, and Article 14 Prohibition of discrimination

- The Data Protection Act 1998

- The Carers (Equal Opportunities) Act 2004 provides carers with the right to receive assessment for support and a duty on various public authorities to give due consideration to a request to provide services to carers.

- The Mental Capacity Act 2005 ("MCA"). The Mental Capacity Act provides a framework for decision making applicable where people lack capacity to make a decision for themselves. The overriding principles of the Mental Capacity Act are set out in section 1 and include a requirement to ensure that all practicable steps are taken to seek to enable a person to make a decision for himself. Where a person is unable to make a decision, any decision made on their behalf must be made in accordance with his/her best interests and must be the least restrictive of the person's rights and freedom of action. A person is not to be treated as unable to make a decision simply because he makes an unwise decision.

- The Equality Act 2010. The Equality Act brought together the various earlier discrimination laws under one statute. It is unlawful to act in a discriminatory manner against any "protected characteristics", including race, sex and disability.

- The Children and Families Act 2014. This Act intends to improve services for key groups of vulnerable children (e.g. those in adoption and those with special educational needs and disabilities).

- The National Health Service (Direct Payments) Regulations 2013 (SI 2013 No.1617)

- The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) Regulations 2013. These Regulations set out the duties of CCG's relating to NHS Continuing Healthcare rights and personal health budgets.

- NHS England – The Forward View into action: Planning for 2015 / 2016

- Department of Heath The Government's Mandate to NHS England 2016 / 2017

2.0 Overview

2.1 History

Following a successful pilot programme by the Department of Health, which ended in October 2012, the Government announced that from April 2014, Eligible Persons will have the "right to ask" for a PHB, including by way of a direct payment. From October 2014, this right to ask was converted to a "right to have" a PHB, specifically for Continuing Health Care (CHC) and Continuing Care (CC) for children with complex care needs.

This development mirrors other changes within the NHS, including the drive generally for greater patient choice, shared decision-making and innovation in managing funds. The Government has confirmed a commitment in the Mandate to NHS England 2016-2017 that PHB's including direct payments, should be an option extended to anyone who could benefit from a PHB from April 2015. The Mandate requires the consideration of more personalised care, including variant forms of PHBs even when a person is not suitable to receive a direct payment, with the emphasis on identifying any way in which the person's care could be personalised.

2.2 What is a PHB?

PHBs are the allocation of NHS funding which patients, after an assessment and planning with their NHS clinical team, are able to personally control and use the services they choose to support their health needs. This enables them to manage identified risks and to live their lives in ways which best suit them. Enabling people to exercise choice and control over their lives is central to achieving better outcomes for individuals.

For Eligible Persons there is a duty on CCGs to:

- Consider any request for a PHB;
- Inform them of their right to ask for a PHB (April 2014);

- Inform them of their right to have a PHB (October 2014)
- Provide information, advice and support in relation to PHBs.

There are five essential characteristics of a PHB.

The person with the PHB (or their representative) must:

1. be able to choose the health outcomes they want to achieve
2. know how much money they have for their healthcare and support
3. be enabled to create their own care plan, with support if they want it
4. be able to choose how their budget is held and managed
5. be able to spend the money in ways and at times that make sense to them, as agreed in their plan.

The CCG is committed to promoting service user choice, where available, while supporting them to manage risk positively, proportionately and realistically. As part of good practice, health care professionals should support and encourage service users' choices as much as possible, and keep them informed, in a positive way, of issues associated with those choices and how to take reasonable steps to manage them.

2.3 Principles

There are six key principles for PHBs and personalisation in health:

1. *Upholding NHS principles and values* - The personalised approach must support the principles and values of the NHS as a comprehensive service which is free at the point of use, as set out in the NHS Constitution. It should remain consistent with existing NHS policy, including the following principles:

- Service users and their carers should be fully involved in discussions and decisions about their care using easily accessible, reliable and relevant information in a format that can be clearly understood;
- There should be clear accountability for the choices made;
- No one will ever be denied treatment as a result of having a PHB;
- Having a PHB does not entitle someone to additional or more expensive services, or to preferential access to NHS services;
- There should be efficient and appropriate use of current NHS resources.

2. *Quality* – safety, effectiveness and experience should be central. The wellbeing of the individual is paramount. Access to a PHB will be dependent on

professionals and the individual agreeing a care plan that is safe and will meet agreed health and wellbeing outcomes. There should be transparent arrangements for continued clinical oversight, proportionate to the needs of the individual and the risks associated with the care package.

3. *Tackling inequalities and protecting equality* – PHBs and the overall movement to personalise services could be a powerful tool to address inequalities in the health service. A PHB must not exacerbate inequalities or endanger equality. The decision to set up a PHB for an individual must be based on their needs, irrespective of race, age, gender, disability, sexual orientation, marital or civil partnership status, transgender, religion, beliefs or their lack of the requisite mental capacity to make decisions regarding their care.

4. *PHBs are purely voluntary* - No one will ever be forced to take more control than they want.

5. *Making decisions as close to the individual as possible* - Appropriate support should be available to help all those who might benefit from a more personalised approach, particularly those who may feel least well served by existing services / access, and who might benefit from managing their budget.

6. *Partnership* - Personalisation of healthcare embodies co-production. This means individuals working in partnership with their family, carers and professionals to plan, develop and procure the services and support that are appropriate for them. It also means CCGs, local authorities and healthcare providers working together to utilise PHBs so that health, education and social care work together as effectively as possible.

2.4 Standards for self-directed health support

The following standards for self-directed support are followed nationally and articulated as seven outcomes, which will be delivered through the implementation of this policy. These seven outcomes are:

Outcome 1 - Improved health and emotional well-being: To stay healthy and recover quickly from illness.

Outcome 2 - Improved quality of life: To have the best possible quality of life, including life with other family members supported in a caring role.

Outcome 3 - Making a positive contribution: To participate as an active citizen, increasing independence where possible.

Outcome 4 - Choice and control: To have maximum choice and control.

Outcome 5 - Freedom from discrimination, harassment and victimisation: To live free from discrimination, harassment and victimisation.

Outcome 6 - Economic well-being: To achieve economic well-being and have access to work and / or benefits as appropriate.

Outcome 7 - Personal dignity: To keep your personal dignity and be respected by others.

3.0 PHB eligibility

3.1 Who can have a PHB?

From 1 October 2014, all Eligible Persons acquired a 'right to have' a PHB including by way of a direct payment. Whilst the offer was initially only for CHC and CC, CCG's can at their discretion now offer this to a wider group of people who may benefit from a PHB. This is related to the NHS commitment and mandate to support individuals with long term conditions. This provision has been extended as part of the NHS England 'Moving Forward with Personal Health Budgets' development programme.

For South Sefton CCG this includes:

- People who are eligible for fully funded NHS continuing healthcare (adults), including people with a learning disability, mental health difficulties who have complex health needs and or challenging behaviour, and long term conditions (refer to 3.1.1)
- Families of children eligible for Continuing Care (refer to 3.1.2)
- Individuals who have a long term condition who may benefit from personal health budget who are not in receipt of NHS funded packages of care.

3.1.1 Adults who have learning disabilities and mental health with complex health needs or challenging behaviour, who are in receipt of a joint funding arrangement with South Sefton CCG and Sefton MBC, have the right to explore whether their needs can be met by utilising a personal budget. The integrated personal budgets under joint funding arrangements for South Sefton CCG will be managed by Sefton MBC, this includes access to a direct payment. Adults with a learning disability and or mental health difficulty, who are in receipt of a joint funded package of care, and receiving a direct payment, will by nature already be in receipt of an integrated PHB.

3.1.2 Children Complex Care - In the case of children where continuing care is being received, the child and or family will have an, education, health and social care plan in place (EHC) or will be in the process of transferring over to an EHC. For children, personal health budgets can contribute to some or all of the social, health and educational elements of this plan. Within South Sefton CCG this will be provided by the SEND 'local offer', the joint funding arrangements will be managed via by Sefton Metropolitan Council (MBC) as a direct payment. Children across South Sefton CCG who are already in receipt of a direct payment, will by nature already be in receipt of an integrated PHB.

Individuals and their representatives already in receipt of CHC or CC may take up their right for a personal health budget at any time and CCGs must give due consideration to any request made. Individuals and families assessed as eligible for CHC or CC from October 2014 should be informed of their "right to have" their NHS care delivered in this way (see section 5.1 below).

In accordance with the overall drive towards greater patient choice and control, PHBs for patients other than those listed above, can still be considered and offered the benefit of a personalised care plans. In line with the NHS England 'Moving Forward with Personal Health Budget' development programme agenda this will form the basis of the CCG Local Offer which will be published on the CCG website from April 2016.

3.2 Exclusions for PHBs

If an individual comes within the scope of the "right to have" a PHB, then the expectation is that one will be provided. However, the NHS England guidance states:

"There may be some exceptional circumstances when a CCG considers a personal health budget to be an impracticable or inappropriate way of securing NHS care for an individual. This could be due to the specialised clinical care required or because a personal health budget would not represent value for money as any additional benefits to the individual would not outweigh the extra cost to the NHS."

Where a PHB by way of a direct payment is being considered, please also see exclusions listed at section 6.4.

3.3 PHBs for people in nursing or residential care home settings

The Government's intention is for all Eligible Persons to have the "right to have" a PHB where they would benefit from personalised care. Therefore, such Eligible Persons living in nursing or residential care who may benefit from receiving care via a PHB, ought to be offered this option. However, CCGs need to be satisfied that the use of a PHB in such settings is cost effective and is a sensible way to provide care to meet or improve the individual's agreed outcomes. PHBs should not generally be used to pay for care and support services being commissioned by the NHS that a person will continue to access in the same way whether they have a PHB or not. See section 6.10 for further detail relating to direct payments for those in nursing / residential care home settings.

4.0 Options for managing PHBs

The most appropriate way to manage a PHB should be discussed and agreed with the person, their representative or nominee as part of the care planning process. PHBs can now be received and managed in the following ways, or a combination of them:

a) Notional budget – where an individual is informed of the amount of funding available to them and decides how the budget is used (by input into the care plan) but the CCG continues to commission services, manage contracts and make purchases etc. Notional budgets could be an option for individuals who want more choice and control over their healthcare but who do not feel able or willing to manage a budget.

b) Third party budget – A non NHS support service organisation, legally independent of both the individual and the NHS, holds the money for the individual and arranges and pays for all of the services on behalf of the individual in accordance with the care plan.

c) Direct payments: Can differ whether a person lacks or retains capacity:

i. Direct payments for people *with capacity* – where the individual receives the funding that is available to them and they purchase the services and support they want in accordance with the agreed care plan (with or without assistance). The individual can elect to receive and manage the payment themselves or decide for it to be received and managed by a person of their choosing (a nominee). If the individual chooses a nominee, that nominee becomes responsible for managing the funds and services and accounting for expenditure. Support from CCG recommended support services are available for all direct payment recipients.

ii. Direct payments for people who lack capacity – where the individual lacks capacity, an 'authorised representative' (agreed by the CCG – see 5.4 for further detail) receives the funding that is available to the individual as a direct payment. The authorised representative is responsible for managing the funds and services and accounting for expenditure. The 'authorised representative' must involve the individual as much as possible and all decision making must be in line with the individual's best interests, in accordance with s.4 Mental Capacity Act 2005. Support from a CCG recommended support services (a direct payment support service) are available for all direct payment recipients. In the case of children, direct payments can be received by their parents or those with parental responsibility for that child.

Further detail on Direct Payments is set out in Section 6 of this Policy.

5.0 How do PHBs work?

5.1 Informing people about PHBs

All policies relating to NHS Continuing Healthcare and Continuing Care continue to apply alongside the new law and guidance on PHBs. From April 2014, the named health professional will inform Eligible Persons of their right to request a PHB

(including by way of direct payments) at the initial assessment, the 12 week review or annual review. From October 2014 the named health professional will inform Eligible Persons of their right to have a PHB (including by way of direct payments) at the initial assessment, the 12 week review and or annual review. See exclusions in Section 3.2 and 6.4. The Personal Health Budget pathway is outlined in Appendix 1.

Health professionals will also seek to identify other patients who do not fall within the scope of the "right to have" but who may benefit from the provision of a PHB. PHBs are not restricted to Eligible Persons and CCGs will seek to offer PHBs on a voluntary basis to those patients with long term conditions for whom it would be appropriate. Where such patients are identified, the health professionals involved in their care will provide them with information about PHBs.

PHBs are entirely voluntary and there is no obligation for a patient to accept the offer. Patients and their families will be provided with a CCG PHB standard leaflet or where appropriate an Easy Read leaflet.

The CCGs have made arrangements for non NHS support services for example: Salvere (a direct payment support service), SOLO Support Services and Your Life Your Way (third party budget support services) to provide information, advice and guidance to prospective and existing PHB recipients, and their families.
The list of non NHS support services above will be subject to change and extension subject CSU / CCG 3rd Party Assurance Process.

The services provided by these organisations will include:

- Information on how a PHB can be used and managed
- Guidance on producing a personalised care / support plan
- Advice and support to manage a PHB, including a direct payment
- Guidance on record keeping requirements
- Information about direct payments, including the responsibilities around financial monitoring that will need to be taken on by the recipient of the direct payments.

Patients and families who wish to consider and explore PHBs further will be offered a referral to a non NHS support service by the lead health professional. This will require the lead health professional to complete a PHB enquiry form, as well as a PHB care plan (a copy of which is at Appendix 2) which includes recording the clinical needs of the individual. This will begin the process of identifying risks so the care / support planning process can commence. Enquiries should be made to CMCSU.Care@nhs.net The lead health professional (see section 5.5) will be supported by the CSU to progress the request.

5.2 Budget Setting

Under the traditional model of CHC / CC, an assessment would be followed by the named health professional producing a care plan, i.e. a schedule prescribing episodes of care and defining specific tasks for the care worker. Under PHBs, after an assessment, a 12 week review and or an annual review an 'indicative budget' is set. The indicative budget gives a financial envelope within which the PHB Care Plan is completed.

The CSU and CCGs are using a 'ready reckoner' approach to set the level of the PHB. This approach uses an existing care plan / package of support to calculate an *indicative budget.* Where there is no existing care plan or package of support already in place, the budget will be based on a standard hourly rate (see below). Whilst the 'ready reckoner' approach is based on existing services, it can be simpler to use, more transparent and easier to understand.

The PHB amount is therefore based on:

- 90% of the money that would otherwise be spent on meeting the fully funded NHS continuing healthcare needs or continuing care needs for Eligible Persons.
- If no package of care is in place an hourly rate of £13.50 will be used to set as a baseline amount of PHB for each hour of care the patient is assessed as needing.
- In the case of individuals with long term conditions, who are not in receipt of a health funded package of care. The CCG will need to work out the indicative budget in terms of the overall cost of NHS Services used, and determine which elements cannot be utilised e.g. regular routine hospital consultant appointments and which elements could form the basis of the indicative budget as part of the PHB, with the emphasis of reducing overall NHS expenditure.

Following a person being assessed / reviewed and identified or re-confirmed as an individual entitled to receive a PHB, the indicative budget will be agreed by CSU / CCG. See section 6 for additional information.

In principle, the amount of money that would have been spent on NHS Services as part of an individual's CHC, CC and or long term conditions could be available to use as a PHB. As much of this budget as possible should be included in a PHB. Where it is not possible to do so (for example, where money currently being used to commission services cannot be released immediately for use under a PHB), CCGs will work with the patient to tailor services as best as possible until this service can be provided under the PHB arrangement (where appropriate).

5.3 PHB care planning

Everyone who has a PHB will go through a care planning process, which leads to a person-centred Care Plan. Care planning for PHBs is fundamentally different from traditional care planning carried out for CHC / CC for children patients. Whereas a traditional care plan starts with the existing services, the starting point for a PHB Care Plan is the agreement of an indicative budget.

A PHB Care Plan is developed jointly by the individual, their family (if appropriate), a non NHS support services planner, and the individual's lead health professional. The process should be driven by the individual's choices and the Care Plan should clearly show how a PHB will be used to achieve the individual's identified health and care outcomes. This includes:

- the health needs of the individual and the desired outcomes;
- the amount of money available under the PHB;
- what the PHB will be used to purchase;
- how the PHB will be managed;
- who will be managing the budget;
- who will be providing each element of support;
- how the plan will meet the agreed outcomes and clinical needs;
- who is responsible for monitoring the health condition of the individual;
- who the individual should contact to discuss any changes in their needs;
- the anticipated date of the first review;
- how the individual has been involved in the production of the plan;
- how any training needs will be met;
- identifying any risks, consequences and mitigating actions;
- contingency planning.

Good care planning involves looking holistically at the individual's life to improve their health, safety, independence and wellbeing. The individual should be supported throughout the care planning process.

The NHS (Direct Payments) Regulations 2013 ("the regulations") and associated guidance set out what direct payments (using NHS money) can and cannot be used for, and how they should be administered. The CSU / CCGs will apply the regulations to all forms of PHB as far as possible, whether it is received/managed by way of direct payments or otherwise (as detailed at section 4). How a PHB will be used (however it is received / managed) must be set out in the PHB Care Plan. Please see section 6 of this Policy which is to be applied, as far as possible, to all PHBs.

Delay in arranging PHBs should be avoided. Where delay is unavoidable (for example, where circumstances make it difficult to plan for a person's ongoing care), the reasons for it must be made clear to the individual. Regular review should take place so that a person's PHB can be put in place as soon as practicably possible.

The CSU and CCGs will make sure that this delay does not cause a delay in hospital discharges, or in ensuring an appropriate package of care is in place pending finalisation of the PHB arrangements. An interim care package may be offered to avoid such delay.

5.4 Representatives for children and people who lack capacity

A PHB arrangement for a person who lacks capacity will require the appointment of a 'representative' by the appropriate CCG. A representative is someone who agrees to act on behalf of someone who is otherwise eligible to receive a PHB but cannot do so because they do not have capacity to consent to receiving one (see Appendix 4) or because they are a child.

An appointed 'representative' could be anyone deemed suitable by the CCG, and who would accept the role. The representative can be:

- a friend, carer or family member;
- a deputy appointed by the Court of Protection;
- an attorney with health and welfare or finance decision-making powers created by a lasting power of attorney;
- someone appointed by the CCG.

In the case of adults who lack capacity, when choosing the 'representative' the CCG must adopt a decision making process in line with the requirements of the MCA and within the context of the individual's best interests as per the checklist at s.4 of the Act. This includes seeking the views of the individual, where possible, about who they would want to manage their PHB.

The decision making process for the appointment of the 'representative' must be documented and discussed as part of care planning process, and agreed by the CSU / CCG.

The representative will take on the responsibilities associated with the PHB. Where it is believed to be appropriate to provide a PHB by way of direct payments, the representative must be fully informed about, and consent to accepting, the responsibilities relating to the receipt and management of the direct payment on the individual's behalf (see section [6.8] below).

The involvement of the representative should be reviewed if the individual regains capacity and/or reaches the age of 16.

5.5 Lead Health Professional

A lead health professional will be named in an individual's Care Plan. This should be someone who has regular contact with the individual and their representative or nominee if they have one. It is likely that the lead health professional will be the

most appropriate person to undertake this role. The lead health professional is responsible for:

- Managing the assessment of the health needs of the individual as part of the care plan;
- Ensuring that the individual, representative and CSU / CCG clinician have agreed the care plan;
- Undertaking or arranging for the monitoring and review of the care plan and health of the person;
- Liaising between the individual (or their representative or nominee) and the CCG as the primary point of contact.

5.6 Approval of Care Plan

PHB Care Plans are agreed in principle by the named health professional. However, all PHB Care Plans will also need to be signed off by the appropriate CSU & CCG panel (which will include a relevant CCG representative). The purpose of the panel is to provide robust governance processes, to ensure that the PHB support plans are clinically safe and meet the needs of the individual. This process includes reviewing, agreeing and signing off the Care Plan which includes a risk identification and management plan. A PHB checklist has been developed to ensure consistency and adherence to the law and guidance. A copy of this checklist is at Appendix 4 of this Policy.

The CSU / CCG clinician will not agree to any services named in the Care Plan if they believe that the potential health outcomes are outweighed by significant risks to the individual's health. However, the CCGs will not impose blanket prohibitions and will remain open to considering different approaches to achieving outcomes other than those traditionally used, considering the particular circumstances of the individual and balancing the risks and benefits accordingly.

If a service named in the Care Plan is not agreed, the CSU / CCG clinician will provide the individual, representative or nominee the reasons why this decision has been reached. The individual, their representative or nominee may ask the CSU / CCG clinician to reconsider their decision and provide additional evidence or information to inform that decision. The CSU / CCG clinician must reconsider their decision in a timely manner upon such a request being made. The CSU / CCG clinician will notify and explain the outcome in writing to the individual. See sections 6.7 & 6.8 for further detail on the process to be followed.

If a part of the Care Plan is refused, the CCG should make every effort to work in partnership with the individual, their representative or nominee to ensure their preferences are considered and taken into account.

5.7 PHB Agreement

When taking up a PHB, the patient, their representative and / or their nominee must sign a 'PHB agreement', which explains the responsibilities associated with the PHB and sets out the agreement that the PHB will be spent as set out in the Care Plan.

If the patient is receiving the PHB as a direct payment, the PHB agreement will confirm that the PHB will be spent in accordance with the NHS (Direct Payments) Regulations 2013. A copy of this Agreement is at Appendix 5 for an adult and Appendix 6 for children of this Policy.

5.8 Assistance to manage PHBs

The CCGs have arranged for non NHS support services e.g. Salvere, Your Life Your Way and SOLO Support Services to provide support to individuals in receipt of PHBs. It is envisaged that over time a wider range of organisations will become available to offer support and that this will be reflected in the choices available to PHB recipients, this will be subject to CSU / CCG 3rd Party Assurance Process. Salvere offers support services for those in receipt of direct payments. It can also support individuals in activities such as recruiting, employing staff and payroll. Further detail on these services can be found at section 6.12.

SOLO Support Services and Your Life Your Way offer services for those with third party budgets, including options where they become the employer and manage the PHB on an individual's behalf.

The costs associated with utilising a non NHS support service will be met from the PHB allocation. This requires the PHB to be paid directly to these organisations so that their charges can be deducted.

5.9 Monitoring and Review

Regular review is required in order to ensure that an individual's Care Plan continues to meet their needs.

In respect of CHC for adults, this review is carried out in line with the continuing healthcare national service framework, i.e. three months after patients become eligible for CHC and annually thereafter. Reviews will also confirm whether or not the patient remains eligible and in need of CHC.

In respect of continuing care for children, the care package should be reviewed after three months and then at least every six months to ensure it continues to meet the child or young person's needs. Reviews will also confirm whether or not the child or young person still has continuing care needs.

Reviews may need to take place sooner or more frequently if the CCG or CSU become aware that:

- the health needs of the individual have changed significantly;
- the care plan is not being followed or expected health outcomes are not being met; or
- the individual, their representative or their nominee requests it.

It should be made clear under the Care Plan who the PHB holder should contact to discuss changes to their PHB should their needs change. In most cases, the Care Coordinator will be best placed to undertake this role.

5.10 Stopping or reclaiming PHBs

Arrangements under PHBs can be stopped and, where applicable, money can be reclaimed. The details of this are set out at section 6.16 and 6.17 but, to the extent possible, this applies to all types of PHB.

6.0 Direct Payments

The National Health Service (Direct Payments) Regulations 2013 set out how direct payments should be administered and on what they can be spent. The regulations are similar to the regulations and guidance for social care direct payments. PHB Guidance on the new direct payments for healthcare regulations was published in March 2014. Although the NHS (Direct Payments) Regulations 2013 apply to direct payment PHBs, as noted above the CCG has agreed to apply these regulations, as far as possible, to all forms of PHB to ensure transparency, fairness and best practice. References in this section to “direct payments” should therefore be treated as referring to all forms of PHB.

6.1 Who can receive a direct payment PHB?

- A direct payment PHB can be made to any Eligible Person, where they are:
- In receipt of any benefit that may or must be provided or arranged by a health body under the NHS Act 2006 or under any other enactment and;
- A person aged 16 or over, who has the capacity to consent to receiving a PHB by way of a direct payment and consents to receive one (please see Appendix 4 in relation to capacity);
- A child under 16 where they have a suitable representative who consents to a PHB by way of a direct payment;
- A person aged 16 or over who does not have the capacity to consent to receiving a PHB by way of a direct payment but has a suitable representative who consents to it.

and where:

- A direct payment PHB is appropriate for that individual with regard to any particular condition they may have and the impact of that condition on their life;

- A direct payment PHB represents value for money and, where applicable, any additional cost is outweighed by the benefits to the individual;
- The person is not subject to certain criminal justice orders for alcohol or drug misuse (see Section 6.4). However, such a person may be able to use another form of PHB to personalise their care.

The CCG will only provide direct payments if it is satisfied that the person receiving the direct payments (which may be the patient, a nominee or representative) understands what is involved, and has given consent.

People aged 16 or over who have capacity, representatives of people aged 16 or over who lack capacity, and representatives of children can request that the direct payment is received and managed by a nominee (see Section 6).

Decisions about providing direct payments for healthcare should be based around need rather than being based around a particular medical condition or severity of condition.

Health professionals will also seek to identify other patients who do not fall within the scope of the “right to have” but who may benefit from the provision of a PHB. PHBs are not restricted to Eligible Persons and CCGs will seek to offer PHBs on a voluntary basis to those patients with long term conditions for whom it would be appropriate. Where such patients are identified, the health professionals involved in their care will provide them with information about PHBs.

6.2 Considerations when deciding whether to make a direct payment

The CCG will adhere to the requirements as detailed at Regulation 7 of the NHS (Direct Payments) Regulations 2013 when deciding whether to make a direct payment. In doing so the CCG will contact a range of people for information to help make the decision whether a direct payment may be suitable. From this range will be any health or social care professional involved in the provision of care/treatment to the individual e.g. a personal assistant, occupational therapist, community mental health nurse or social care team. The CCG will also consult:

- anyone identified by the individual as a person to be consulted for this purpose.
- If the individual is a person aged 16 or over but under the age of 18, a person with parental responsibility for the individual.
- The person primarily involved in the care for the individual
- Any other person who provides care for the patient
- Any Independent Mental Capacity Advocate (IMCA) or Independent Mental Health Advocate (IMHA) appointed for the individual

The CCG will consider whether the individual will be able to manage the direct payment (see section 6.3 below).

If the person is aged between 16 and 18, a parent or guardian with parental responsibility will be assessed, to look at whether they could manage a direct payment.

If the individual has a deputy appointed by the Court of Protection in relation to matters about which direct payments may be made, this will be considered and the CCG may consult the appointed person to help decide whether or not the person would want to receive direct payments.

In considering whether to provide direct payments, the CCG may ask the individual or their representative for information about:

- Their overall health;
- The details of their condition in respect of which they would receive direct payments;
- Any bank, building society, Post Office or other account into which direct payments would be paid; and
- Anything else which appears relevant.

6.3 Ability to manage direct payments

The CCG will consider whether an individual (whether the patient or their representative) is able to manage direct payments by:

- Considering whether they would be able to make choices about, and manage the services they wish to purchase;
- Whether they have been unable to manage either a heath care or social care direct payment in the past, and whether their circumstances have changed;
- Whether they are able to take reasonable steps to prevent fraudulent use of the direct payment or identify a safeguarding risk and if they understand what to do and how to report it if necessary; and
- Considering any other factor which the CCG may consider is relevant.

If the CCG is concerned that an individual is not able to manage a direct payment they must consider:

- The individual's understanding of direct payments, including the actions and responsibilities on their part.
- Whether the person understands the implications of receiving or not receiving direct payments.
- What kind of support the individual may need to manage a direct payment.
- What help is available to the individual.

Any decision that an individual is unable to manage a direct payment must be made on a case by case basis, taking into account the views of the individual, and the help

they have available to them. The CCG will not make blanket assumptions that groups of people will or will not be capable of managing direct payments.

The CCG will inform the individual in writing if the decision has been made that they are not suitable for direct payments and whether an alternative method of receiving the PHB is considered to be suitable instead. See section 6.5 for further information.

6.4 Who cannot receive a direct payment?

There are some people to whom the duty to make direct payments does not apply. This includes those:

a) subject to a drug rehabilitation requirement, as defined by section 209 of the Criminal Justice Act 2003 (drug rehabilitation requirement), imposed by a community order within the meaning of section 177 (community orders) of that Act, or by a suspended sentence of imprisonment within the meaning of section 189 of that Act (suspended sentences of imprisonment)
b) subject to an alcohol treatment requirement as defined by section 212 of the Criminal Justice Act 2003 (alcohol treatment requirement), imposed by a community order, within the meaning of section 177 of that Act, or by a suspended sentence of imprisonment, within the meaning of section 189 of that Act
c) released on licence under Part 2 of the Criminal Justice Act 1991 (early release of prisoners), Chapter 6 of Part 12 of the Criminal Justice Act 2003 (release on licence) or Chapter 2 of the Crime (Sentences) Act 1997 (life sentences) subject to a non-standard licence condition requiring the offender to undertake offending behaviour work to address drug or alcohol related behaviour
d) required to submit to treatment for their drug or alcohol dependency by virtue of a community rehabilitation order within the meaning of section 41 of the Powers of Criminal Courts (Sentencing) Act 2000 (community rehabilitation orders) or a community punishment and rehabilitation order within the meaning of section 51 of that Act (community punishment and rehabilitation orders)
e) subject to a drug treatment and testing order imposed under section 52 of the Powers of Criminal Courts (Sentencing) Act 2000 (drug treatment and testing orders)
f) subject to a youth rehabilitation order imposed in accordance with paragraph 22 (drug treatment requirement) of Schedule 1 to the Criminal Justice and Immigration Act 2008 (“the 2008 Act”) which requires the person to submit to treatment pursuant to a drug treatment requirement
g) subject to a youth rehabilitation order imposed in accordance with paragraph 23 of Schedule 1 to the 2008 Act (drug testing requirement) which includes a drug testing requirement

h) subject to a youth rehabilitation order imposed in accordance with paragraph 24 of Schedule 1 to the 2008 Act (intoxicating substance treatment requirement) which requires the person to submit to treatment pursuant to an intoxicating substance treatment requirement
i) required to submit to treatment for their drug or alcohol dependency by virtue of a requirement of a probation order within the meaning of sections 228 to 230 of the Criminal Procedure (Scotland) Act 1995 (probation orders) or subject to a drug treatment and testing order within the meaning of section 234B of that Act (drug treatment and testing order)
j) released on licence under section 22 (release on licence of persons serving determinate sentences) or section 26 of the Prisons (Scotland) Act 1989 release on licence of persons sentenced to imprisonment for life, etc.) 34 or under section 1 (release of short-term, long term and life prisoners) or section 1AA of the Prisoners and Criminal Proceedings (Scotland) Act 1993 (release of certain sexual offenders) and subject to a condition that they submit to treatment for their drug or alcohol dependency
k) If the individual is subject to certain criminal justice orders for alcohol or drug misuse, then they will not receive a direct payment. However, they might be able to use another form of PHB to personalise their care and alternatives should be considered.

6.5 Deciding not to offer a direct payment

In addition to section 6.4 above, a CCG may decide to refuse to make a direct payment if it believes it would be inappropriate to do so, for example:

- if there is significant doubt around an individual's or their representative's ability to manage a direct payment;
- if there is a high likelihood of a direct payment being abused;
- if the benefit to the particular individual of having a direct payment does not represent good value for money;
- if it considers that providing services in this way will not provide the same or improved outcomes.

Such a view may be formed from information gained from anyone known to be involved with the individual, including health professionals, social care professionals, the individual's family and close friends, and carers for the individual.

In all cases where a direct payment is refused, the Eligible Person and any nominee or representative will be informed in writing of the refusal and the grounds by which the request is declined. The individual or their representative may request a review of this decision, in which case, the process set out at section 6.7 will be followed.

If a direct payment is refused, other options to personalise the package of care for the individual will be explored and facilitated as much as is possible, and other forms of PHB, such as a notional budget or third party budget, should be considered.

6.6 Decision Making

Where there is a recommendation to accept or reject a request for a direct payment, the CCG will use a Panel to consider this recommendation. This Panel will consist of:

- Senior Nurse CCG (Chair)
- Senior Nurse CSU (Chair) under delegated responsibilities
- CSU Representatives individual commissioning nurse (CHC, CC, Mental Health, LD) – appropriate to individuals needs
- CCG GP representative
- Lead Health Professional
- Co-opted Members as appropriate this may include; medicines management, Sefton MBC representative (this list is not exhaustive)

The Panel will consult the appropriate Terms of Reference when making its decisions.

6.7 Request for review of a decision

Where the CSU / CCG decide that a direct payment would be inappropriate, the patient, their representative or nominee may require the CSU / CCG to reconsider the decision, submitting additional information to support the deliberation. The CSU / CCG must reconsider its decision in a timely manner upon such a request being made but is not required to undertake more than one re-consideration in any six month period following the initial decision.

The CCGs will use an Appeals Panel to make a decision regarding a request for reconsideration of a refusal to provide a direct payment. The membership and terms of reference of the Appeals Panel should be in accordance with the requirements of the relevant CCG. However, with regards to timeframe for the Appeals process, the Panel should seek to follow the recommended timescales set out under national guidance. Details of these timescales are set out at Appendix 9.

No member will have had previous involvement in the case.

The patient, representative or nominee must be informed in writing of the outcome of the review and the reasons for the decision. If the refusal is upheld, other options to personalise the package of care for the individual will be explored and facilitated as much as is possible, and other forms of PHB, such as a notional budget or third party budget, should be considered (refer to section 4.0).

6.8 Representatives and direct payments

Information surrounding the appointment of Representatives is set out earlier in this Policy. When the use of direct payments is being considered, the CCG must be satisfied that a person agreeing to act as a representative understands what is

involved, and has provided their informed consent, before going ahead and providing direct payments. They should be informed of the restrictions surrounding employment of a family member or person living in the same household to provide care (see section 7.1).

Full advice, support and information should be provided so that people contemplating taking on the role of representative know what to expect. In addition, the CCG must provide its consent to the representative acting in this role, having duly considered whether the person is competent and able to manage direct payments, either on their own or with whatever assistance is available to them.

A representative may identify a nominee to receive and manage direct payments on their behalf, subject to the nominee's agreement and the approval of the CCG (see section 6.9 below).

A representative must (unless they have appointed a nominee to do so):

- act on behalf of the person, e.g. to help develop a PHB Care Plan and to hold the direct payment
- act in the best interests of the individual when securing the provision of services
- be the principal person for all contracts and agreements, e.g. as an employer;
- use the PHB and direct payment in line with the agreed Care / Support Plan
- comply with any other requirement that would normally be undertaken by the individual (e.g. participating in a review, providing information)

When considering whether to make direct payments to representatives, the CCG will consider:

- Whether the person receiving care had, when they had capacity, expressed a wish to receive direct payments;
- Whether the person's beliefs or values would have influenced them to have consented or not consented to receiving a direct payment;
- Any other factors that the person would be likely to take into account in deciding whether to consent or not to receiving direct payments;
- As far as possible, the person's past and current wishes and feelings.

6.9 Nominees

If a person aged 16 or over has capacity, but does not wish (for whatever reason) to receive direct payments themselves, they may nominate someone else (a nominee) to receive them on their behalf.

A representative (for a person aged 16 or over who does not have capacity or for a child) may also choose to nominate someone (a nominee) to hold and manage the direct payment on their behalf.

Where a nominee is appointed, they become responsible for managing the PHB and direct payment on behalf of the individual or the appointed representative (for individuals without capacity). They must:

- act on behalf of the person, e.g. to help develop a PHB Care / Support plan(s) and to hold the direct payment
- act in the best interests of the individual when securing the provision of services
- be the principal person for all contracts and agreements, e.g. as an employer;
- use the PHB and direct payment in line with the agreed Care / Support Plan
- comply with any other requirement that would normally be undertaken by the individual (e.g. review, providing information)

It is important to note that the role of nominee for direct payments for healthcare is different from the role of nominee for direct payments for social care. For social care direct payments, a nominee does not have to take on all the responsibilities of someone receiving direct payments, but can simply carry out certain functions such as receiving or managing direct payments on behalf of the person receiving them. In direct payments for healthcare, however, the nominee is responsible for fulfilling all the responsibilities of someone receiving direct payments, as outlined above. Those receiving direct payments for healthcare and their nominees must be made fully aware of these responsibilities.

The CCG must be satisfied that a person agreeing to act as a nominee understands what is involved, and has provided their informed consent, before going ahead and providing direct payments. Full advice, support and information should be provided so that people contemplating taking on the role of nominee know what to expect. In addition, the CCG must provide its consent to the nominee acting in this role, having duly considered whether the person is competent and able to manage direct payments, either on their own or with whatever assistance is available to them.

Before the nominee receives the direct payment, the CCG must consent to the nomination. In reaching its decision, the CCG may:

- Consult with relevant people;
- Require information from the person for whom the direct payments will be made on the state of health or any health condition they have which is included in the services for which direct payments are being considered;
- Require the nominee to provide information relation to the account into which direct payments will be made.

If the proposed nominee is not a close family member of the person (see Appendix 7), living in the same household as the person, or a friend involved in the person's care, then the CSU / CCG will require the nominee to apply for an enhanced Disclosure and Barring Service (DBS) certificate (formerly a CRB check) with a check of the 'adults barred' list and consider the information before giving their

consent. If a proposed nominee in respect of a patient aged 18 or over is barred, the CCG must not give their consent. This is because the Safeguarding Vulnerable Groups Act 2006 prohibits a barred person from engaging in the activities of managing the person's cash or paying the person's bills.

If the proposed nominee is a close family member of the person, living in the same household as the person, or a friend involved in the person's care, the CCG cannot ask them to apply for a DBS certificate and has no legal power to request these checks.

The CCG must notify any person identified as a nominee where it has decided not to make a direct payment to them. The notification must be made in writing and state the reasons for the decision.

6.10 What can and cannot be bought with direct payments

The NHS direct payments regulations and associated guidance set out what direct payments (using NHS money) can and cannot be used for, and how they should be administered.

A direct payment can be spent on a range of services and equipment that will lead to health outcomes, but only if they have been agreed in the Care Plan (see Appendix 3). The person receiving the direct payment (whether it is the individual requiring support, their nominee or a representative) is responsible for ensuring that it is only used as specified in the care plan. If it is not, the direct payment may have to be stopped and the law allows for certain payments which have been mis-spent to be reclaimed. Please see section 6.17 below.

There are some restrictions on how PHBs can be used. These are not intended to reduce choice and control for individuals, but to ensure that PHBs are used for maximum benefit and to ensure they are administered consistently and fairly for everyone.

Direct payments cannot be used to pay for the following:

- alcohol
- tobacco
- gambling
- debt repayment (other than for a service specified in the support plan)
- core GP services
- planned surgical interventions
- pharmaceutical charges
- services provided through vaccination or immunisation programmes
- any service provided under the NHS health check or National Child Measurement Programme
- Urgent or emergency treatment services.

For the avoidance of doubt, as South Sefton CCG will apply the regulations to any form of PHB insofar as it is possible, the above restrictions will equally be applied to all forms of PHB insofar as it is possible.

In addition, pending the outcome of a further pilot scheme, caution should be had when considering the use of direct payments for those in nursing/residential care home settings.

Where a request for a direct payment for healthcare is made for a person living in a residential setting the CCG must be certain that providing care in this way adds value to the person's overall care. Generally, direct payments should not be used to pay for care and support services being commissioned by the NHS that a person will continue to access in the same way whether they have a PHB or not. In such instances, where no additional choice or flexibility has been achieved by giving someone a PHB, then allocating a direct payment only adds an additional financial step and layer of bureaucracy into the commissioning of the care. CCGs need to be clear that the use of a direct payment in such settings is cost effective and is a sensible way to provide care to meet or improve the individual's agreed outcomes.

Other types of PHB, for example notional budgets, can be used where direct payments are not a practical route and many people may find great benefit in planning their care using the personalised care planning process associated with developing a PHB.

6.11 Imposing conditions in connection with the making of direct payments

The following conditions may be imposed on the individual, their representative or nominee in connection with the making of direct payments:

- the recipient must not secure a service from a particular person; and/or
- the individual, their representative or their nominee must provide information that the CSU / CCG considers necessary (other than information already covered by other regulations in the NHS (Direct Payment) Regulations 2013.

Conditions should only be imposed in exceptional circumstances. The reasons for the imposed conditions should be documented clearly.

6.12 Assistance to manage a direct payment – Supported Managed Accounts

As outlined at section 5.1 above, the CCGs have arranged for non NHS support services to provide support to individuals in receipt of PHBs.

Where an individual chooses a direct payment there are extra responsibilities on the individual (or their appointed representative and / or nominee) to manage their care package. These are set out within the PHB Agreement – see Appendix 5 and 6.

It is essential that either the individual or their representative has the ability to consent to and manage both their direct payment and the dedicated bank account.

In certain circumstances, the option of a Supported Managed Account can be considered. These circumstances include:

- Where the individual or representative feels assistance is required;
- Where mental capacity indicates; or
- Where financial audit skills in managing finances are high risk.

For those in receipt of direct payments, the non NHS support services offer Supported Managed Accounts and can support individuals in activities such as recruiting, employing staff and payroll. This option for support is open to people with PHBs and direct payments. However, in circumstances where Supported Managed Accounts are being considered, it may be more appropriate to consider the use of a notional budget. The respective benefits of each option should be discussed with the individual, their representative or nominee.

The costs of the non NHS support service are met from the PHB allocation. This requires the PHB to be paid directly to the non NHS support service so that its charges can be deducted. In certain circumstances the non NHS support service may make direct health care payments to patients, their representative or their nominee. This can only be carried out with the agreement of the CSU / CCG.

Individuals, representatives and appointed nominees employing staff are strongly recommended to utilise the information, advice, guidance and payroll and HR facilities of the non NHS support services e.g. Salvere, Your Life Your Way or SOLO (or, as the range of organisations offering such services widens, an alternative agreed support service) to ensure the legal responsibilities of being an employer are satisfied. Should the individual, representative or nominee not wish to accept this recommendation the request for a direct payment may be refused because requirements of employment law will fall to the individual, their representative or their nominee as the employer. In such circumstances, the CCG would have to be satisfied that the individual, their representative or nominee are able to manage such responsibilities by other means.

6.13 Receiving a direct payment

Direct payments will be paid in advance on the 15th day of the month, and where this day falls on the weekend, it will be paid on the Friday before. Under no circumstances should individuals have to pay for care and be reimbursed.

With the exception of one-off direct payments (see below), direct payments must be paid into a separate bank account used specifically for the direct payment. The bank account must be in the name of the person receiving the care, or their nominee or representative.

When receiving direct payments, the account holder should keep a record of both the money received and where it is spent. They are responsible for keeping hold of statements and receipts for auditing.

6.14 One-off payments

A one-off payment is used to buy a single item or service, or a single payment for no more than five items or services, where the individual is not expected to receive another direct payment in the same financial year.

When someone is receiving a one-off direct payment, it can be paid into the individual's ordinary bank account (or that of a nominee or representative). Individuals will need to provide evidence that the direct payment was used as agreed in the Care Plan, for example, by producing receipts of items/services purchased.

6.15 Monitoring and review of direct payments

As a minimum, a clinical review of an individual's direct payments should be performed within three months of the first direct payment and then annually. Financial monitoring will take place quarterly. Financial reviews will be completed by the non NHS support service.

There must be a review if the CCG or CSU become aware that direct payments have not been sufficient to secure the services specified in the care plan. If someone wishes to purchase additional care privately, they may do so, as long as it is additional to their assessed needs and it is a separate episode of care, with clearly separate lines of accountability and governance. They may not top up the direct payment with their own money to purchase more expensive care than that agreed in the Care Plan.

Where concerns are raised regarding how the PHB is being spent, the non NHS support service will inform the CCG to alert them to any concerns, and the CHC / CC lead at the Commissioning Support Unit.

These considerations are in addition to those set out at section [5.9] above, which requires review of an individual's Care Plan to ensure it remains appropriate to meeting the individual's needs.

6.16 Stopping or reducing direct payments

There is an ongoing duty to ensure that direct payments are reviewed by CSU / CCG. The amount provided under direct payments may be increased or decreased at any time, provided the new amount is sufficient to cover the full cost of the individual's care plan. PHBs and direct payments are not a welfare benefit and do not represent an entitlement to a fixed amount of money. A surplus may indicate that the individual is not receiving the care they need or too much money has been allocated. It should be noted that a surplus is different to a contingency – it is permissible to include an amount for contingency in a PHB, for example, to cover employment costs such as redundancy. As part of the review process, the CSU / CCG should establish why the surplus has built up. Under these circumstances, a

reduction in direct payment in any given period cannot be more than the amount that would have been paid to them in the same period.

Before making a decision to stop or reduce a direct payment, wherever possible and appropriate, the CSU / CCG should consult with the person receiving it to enable any inadvertent errors or misunderstandings to be addressed, and enable any alternatives to be made.

Where direct payments have been reduced, the individual, their representative or nominee may request that this decision be reconsidered, and may provide evidence or relevant information to be considered as part of that deliberation. Where this happens, the individual, representative or nominee must be informed in writing of the outcome of the reconsideration and the reasons for this decision. The CSU / CCGs are not required to undertake more than one reconsideration of any such decision. If the individual remains unhappy about the reduction, they should be referred to the local NHS complaints procedure.

The CSU will stop making direct payments on behalf of the CCGs where:

- A person with capacity to consent, withdraws their consent to receiving direct payments;
- A person who has recovered the capacity to consent, does not consent to the direct payments continuing; or
- A representative withdraws their consent to receive direct payments, and no other representative has been appointed.

The CSU may stop direct payments if it is satisfied that it is appropriate to do so. For example where:

- the money is being spent inappropriately (e.g. to buy something which is not specified in the support plan);
- direct payments are no longer a suitable way of providing the person with care;
- a nominee withdraws their consent, and the person receiving care or their representative does not wish to receive the direct payment themselves;
- the CSU / CCG has reason to believe that a representative or nominee is no longer suitable to receive direct payments, and no other person has been appointed;
- where there has been theft, fraud or abuse of the direct payment; or
- if the patient's assessed needs are not being met or the person no longer requires care.

Where PHBs and direct payments are stopped, the CSU / CCG will give reasonable notice to the patient, their representative or nominee in writing, explaining the reasons behind the decision. There is no definition as to what constitutes "reasonable notice". It should be noted that, after a direct payment is stopped, all

rights and liabilities acquired or incurred as a result of the service purchased by direct payments will be transferred to the CCG. This should therefore be considered. However, in some cases, it may be necessary to stop the direct payment immediately, for example, if fraud or theft has occurred.

6.17 Reclaiming a direct payment

The CSU can claim back PHBs and direct payments on behalf of the CCGs where:

- they have been used to purchase a service that was not agreed in the care plan;
- there has been theft or fraud; or
- the money has not been used (e.g. as a result of a change in the care plan or the individual's circumstances have changed) and has accumulated.

If a decision to reclaim payments is made, reasonable notice must be given to the individual, their representative or nominee, in writing, stating:

- the reasons for the decision;
- the amount to be repaid;
- the time in which the money must be repaid; and
- the name of the person responsible for making the repayment.

The individual, their representative or nominee may request that this decision be reconsidered and provide additional information to the CSU / CCG for reconsideration. Notification of the outcome of this reconsideration must be provided in writing and an explanation provided. The CSU / CCGs are not required to undertake more than one reconsideration of any such decision. If the individual remains unhappy about the reduction, they should be referred to the local NHS complaints procedure.

7.0 Using a direct payment to employ staff or buy services

7.1 Using a direct payment to employ staff

People may wish to use their direct payment to employ staff to provide them with care and support. In so doing, they will acquire responsibility as an employer and need to be aware of the legal responsibilities associated with this. This should not discourage people who would otherwise be willing and able to manage a direct payment. In order to ensure that people are appropriately informed and supported in meeting their duties as an employer, the CCGs have arranged for non NHS support services e.g. Salvere to provide information, advice and support. This includes support in relation to payroll, Human Resources and other employment related services. People should be made aware of the availability of this service, along with any others which may become available. Individuals, representatives and appointed nominees employing staff are strongly recommended to utilise the information, advice, guidance and payroll and HR facilities of non NHS support services (or an

alternative agreed support service as a wider range or organisations become available) to ensure the legal responsibilities of being an employer are satisfied.

The costs associated with utilising a non NHS support service are met from the PHB allocation. This requires the PHB to be paid directly to these organisations so that their charges can be deducted. This cost should be factored in when setting the budget.

7.2 Employing a family member or person living in the same household

A direct payment can only be used to pay an individual living in the same household, a close family member (as defined in Appendix 8) or a friend if the CCG is satisfied that to secure a service from that person is necessary in order to satisfactorily meet the individual's need; or to promote the welfare of a child for who direct payments are being made. It is anticipated that this will be permitted in very limited circumstances. The CCGs must make judgements on a case by case basis.

Any arrangement of this nature must be formally agreed by the CSU / CCG, and recorded in writing in both the care plan and the PHB agreement.

The suitability will be reviewed at least every three months, (following the existing pathways for complex, children's and adults). This process includes reviewing, agreeing and signing off the risk identification and mitigation tool.

This restriction is not intended to prevent individuals from using direct payments to employ a live-in personal assistant. The restriction applies where the relationship between the two people is primarily person rather than contractual (for example, if the people concerned would be living together in any case).

7.3 Safeguarding and employment

People may wish to use their direct payment to employ staff to provide them with care and support. When deciding whether or not to employ someone, patients and their families should follow best practice in relation to safeguarding, vetting and barring including satisfying themselves of a person's identity, their qualifications and professional registration if appropriate and taking up references.

The CSU and CCGs have made arrangements with non NHS support services to provide advice and accessible services in relation to the provision of DBS checks for individual employers.

Individuals cannot request DBS checks on other individuals. However, an individual or their nominee or representative may wish to ask the CCG or another Umbrella Organisation e.g. a non NHS support service, if it is possible to arrange for the prospective employee or contractor to apply for an enhanced DBS check with a check of the adult's (or children's if appropriate) barred lists when employing or

contracting with people who are not close family members or people living in the individual's household providing care to the individual but who are:

- regulated health care professionals – for example, nurses or physiotherapists
- people providing healthcare under the direction or supervision of a health care professional
- people providing personal care

Alternatively, if the individual can satisfy the DBS that they have a legitimate interest in knowing if that person is barred, the DBS may supply this information.

If the potential employee is barred they must not be used to supply services as they pose an ongoing risk to adults or children.

If the individual is contracting with a close family member or a person who is living in the individual's household or a friend it is not possible to undertake any DBS checks.

The DBS has recently launched the Update Service. This is a service that allows people to reuse their certificate for multiple roles. If a potential employee or contractor has subscribed to the Update Service and has a check of the appropriate level, the individual should ensure they see the person's original certificate and use the free online portal to check for up to date information on that certificate. If the certificate is not up to date the individual should ask the potential employee or contractor to apply for a new certificate.

7.4 Indemnity

Direct payments can be used to pay for a personal assistant (PA) to carry out certain personal care and health tasks that might otherwise be carried out by qualified healthcare professionals such as nurses, physiotherapists or occupational therapists. In such cases the healthcare professional and CSU / CCG will need to be satisfied that the task is suitable for delegation, specify this in the Care Plan and ensure that the PA is provided with the appropriate training and development, assessment of competence and have sufficient indemnity and insurance cover. More information on this can be found in the 'Personal assistants - delegation, training and accountability' document in the toolkit.

Indemnity is a complex area for individual employers, and one where sufficient support will need to be in place from the start to enable people to understand and be supported to meet any obligations they have.

Providers of some services may need to conform with prospective legislation which will implement the Finlay Scott Recommendations (June 2010) on indemnity cover and Article 4(2)(d) of Directive 2011/24/EC . NHS England will provide further guidance on what this covers in due course.

PAs employed via a direct payment do not need to comply with the legislation that will require them to have indemnity cover if practising unless they are a member of a regulated health profession (see Appendix 8), even if carrying out activities which might otherwise be performed by health professionals. Lead health professionals, the CSU & CCGs will need to consider and discuss with the person, their nominee or representative, the potential risks associated with the clinical tasks being carried by the PAs on a case by case basis. This needs to form part of the risk assessment and care planning process and outcome recorded in the Care Plan.

The person buying services needs to be aware of whether the provider needs to comply with prospective legislation discussed above. If the provider does not need to comply people may, if they wish, buy services from providers who have limited or no indemnity or insurance cover. So long as the person buying the service is aware of the potential risks and implications, limited or no indemnity should not automatically be a bar to purchasing from a provider. This should be included in the discussion around risks when developing the Care Plan.

In the first instance, it will be the responsibility of the person buying the service to check the indemnity cover of the provider from which they are buying services. They must make enquiries to ascertain whether the provider has indemnity or insurance, and if so, whether it is proportionate to the risks involved, and otherwise appropriate.

If the person buying the service asks the CCG to undertake these checks on their behalf, the CCG must do so. Care co-ordinators and care planners should also ensure that people are aware that this is an option, and may wish to offer this as part of the risk assessment and care planning process.

Regardless of who carries out the initial check, the CCG will review this as part of the first review, to ensure the checks have been made and are appropriate.

7.5 Registration and regulated activities

If someone wishes to buy a service which is a regulated activity under the Health and Social Care Act 2008, they will need to inquire as to whether their preferred provider is registered with the Care Quality Commission (CQC). A direct payment cannot be used to purchase a regulated activity from a non-registered service provider.

If a person or related third party employs a care worker directly, without the involvement of an agency or employer, the employee does not need to register with CQC. A related third party means:

(a) an individual with parental responsibility for a child to whom personal care services are to be provided

(b) an individual with power of attorney or other lawful authority to make arrangements on behalf of the person to whom personal care services are to be provided

(c) a group or individuals mentioned in a) and b) making arrangements on behalf of one or more persons to whom personal care services are to be provided

(d) a trust established for the purpose of providing services to meet the health or social care needs of a named individual

This means that individual user trusts, set up to make arrangements for nursing care or personal care on behalf of someone, are exempt from the requirement to register with the CQC.

Also exempt are organisations that only help people find nurses or carers, such as employment agencies (sometimes known as introductory agencies), but who do not have any role in managing or directing the nursing or personal care that a nurse or carer provides.

If someone wishes to use a direct payment to purchase a service which is not a regulated activity, they may do so.

In some circumstances, the provider may also need to be a registered member of a professional body affiliated with the Council for Healthcare Regulatory Excellence. If the Care Plan specifies that a task or tasks require a registered professional to undertake it, only a professional who is thus registered may be employed to perform that task or tasks. See Appendix 8.

In the first instance it will be the responsibility of the person buying the service to check whether the provider they are purchasing from is appropriately registered. They can request the CCG investigate this, and if they ask, the CCG must do so. As with indemnity cover, the CCG must also review this as part of their assessment as to whether the direct payment is being effectively managed.

While some service providers, for example aromatherapists, are not statutorily required to be registered, there are professional associations with voluntary registers that practitioners can choose to join. Typically, such practitioners can only join these associations or registers if they meet the standards of education, training, conduct and performance required by the professional body. However, there is no legal requirement to join these registers, and practitioners can still offer unregulated services without being a member of any organisation. If a provider is not registered with an appropriate body this should not automatically be a bar to purchasing from that provider but this should be included in the discussion around risks when developing the Care Plan.

8.0 Service User Evaluation

It is vital that CCG's have systems and processes in place to review the effectiveness of PHB's to provide assurance that the individual support plans are; clinically safe, effective and meeting individual needs and outcomes. To facilitate evaluation the CCG are utilising the Patient Experience Outcome Tool (POET), which was developed by Lancaster University. POET is designed specifically for PHB budget holders and family carers to provide insight into the experiences of personal health budget holders and their families. POET also aims to shows the impact having control over the budget has on their lives.

All PHB budget holders will be provided with an opportunity and or supported to complete the POET on an annual basis as part of their annual review. The results will be collated and reported to the CCG on an annual basis, as part of ongoing cycle of evaluation. The process of POET will be carried out by the CCG Commissioning Support Unit on behalf of the CCG.

9.0 Equal Opportunities / Equalities Impact Assessment

An Equality Impact Assessment has been completed and approved by the Equality & Inclusion Panel on 4th November 2015 for this policy and procedure and it does not marginalise or discriminate minority groups.

10.0 Review Date

This policy and procedure will be reviewed in April 2019 and will be reviewed and updated at the request of South Sefton CCG or earlier in light of any changes to legislation or National Guidance.

11.0 Further Information

The NHS England website has a section dedicated to PHBs. This has information about national policy, the implementation toolkit, stories and other resources.

www.personalhealthbudgets.england.nhs.uk

The Peer Network, a user-led organisation for PHBs, has its own website: www.peoplehub.org.uk

12.0 Appendices

Appendix 1 - Personal Health Budgets Pathway

Appendix 2 - PHB Care Plan

Appendix 3 – Capacity and Consent

Appendix 4 – PHB Checklist

Appendix 5 – Personal Health Budget Agreement (Adult)

Appendix 6 – Personal Health Budget Agreement (Child)

Appendix 7 – Close Family Members

Appendix 8 – Regulatory Bodies

Appendix 9 – Timescales for Appealing Personal Health Budgets Decisions

Appendix 1

Personal Health Budgets Pathway

1.0 Introduction

1.1 This procedure details the steps required from the agreement of a Personal Health Budget (PHB) to promptly expediting the first payment to the relevant organisation/individual.

1.2 Non-compliance with this procedure could cause delays to the commencement date of the PHB funded package of care resulting in dissatisfaction from families and direct payment support services and non NHS support services e.g. Salvere, Your Life Your Way and Solo (or an alternative agreed support service as a wider range or organisations become available).

2.0 Process

2.1 The CCG appropriate panel will approve a PHB for an individual. This will include the financial value of the PHB, specified as an annualised amount.

2.2 From the date of the Panel and the agreement for a PHB, the relevant direct payment support services and non NHS support service are required to invoice the relevant CCG via SBS. On receipt of an invoice it can take up to 30 calendar days for the invoice to be paid. The invoice must state the correct Broadcare reference number. The value of the invoice should equate to 3 months (i.e. one quarter) of the annualised budget.

2.3 To facilitate this process the CSU are to complete a 'Financial Commitment Form' for all PHBs. The form will include the following details as agreed by the Panel:

- Broadcare reference number
- Type of PHB (notional payment, direct payment or third party budget)
- Type of package (adult, children's, complex mental health etc)
- Organisation/Individual to whom PHB invoices are to be paid.
- PHB start date (this must be at least 30 days, after the panel date)
- End Date (if applicable)
- Review Date (this must be within 12 weeks if it is a direct payment)
- Annualised value
- Forecast charge in current financial year
- Percentage of PHB to be funded by Local Authority (if applicable)
- Details (including telephone number) of a named CSU contact / DN (named health professional) and locality team contact number
- Space for the form to be signed by a CCG authorised signatory. It is acknowledged that each CCG will have its own Scheme of Delegation and authorisation limits.

2.4 Upon completion the form is to be:

- Retained by the CSU to hold on the individual's file and for entry into Broadcare.
- Sent to the relevant direct payment non NHS support service in order for them to promptly raise an invoice to the CCG.

Sent to the relevant CCG so they can anticipate and approve the invoice from the non NHS support service, as well as incorporate the information into financial forecasts. If the invoice is consistent with the amount as specified in paragraph 2.2 then the CCG must not delay approving the payment on SBS. If there is a discrepancy the CCG is to contact the CSU to understand the reasons for this. If the issue is still unresolved then the CSU should query the invoice with the third party agency.

2.5 If the non NHS support service has not received payment by the agreed date then it should escalate the issue to the named contact on the Financial Commitment Form.

Appendix 2

Personal Health Budget Care & Support Plan for South Sefton and Southport and Formby CCG

Tables 1, 2 & 3 to be completed by NHS staff before submitting to the PHB Support Service, Table 3 must be signed by the patient or their representative. The Support Service and Patient complete the remainder of the Tables

Table 1 - To be completed by the NHS Named Health Professional (NHS)

Patients Name	Title	D.O.B (DD/MM/YYYY)
Address		Postcode
Home Telephone	Mobile	E-mail
Named Health Professional Name: Tel: E-mail:	Request submitted to the following Support Service:	Indicative Budget amount: Annual £ Weekly £ Number of hours per week:

Table 2 - To be completed by the NHS Named Health Professional (NHS)

Patients Health Needs	Activities / Provisions	How the activities / provisions will meet my health and wellbeing needs
To be completed by the NHS Named Health Professional (NHS)	To be completed by the Support Service & Family	To be completed by the Support Service & Family
Add / delete rows as required		

Table 3 - To be completed by the NHS Named Health Professional (NHS) and patient

Declaration	
Please sign this document to show you give your consent (on the date of signing) that the details within this plan can be shared with the Support Service of your choice	
Signature of Patient	Date
Please provide the name of the chosen Support Service who will support you to develop a plan and a financial budget showing how you intend to meet your health and wellbeing needs	Name of chosen Support Service
If patient/ client is unable to sign, an appropriate adult representative with decision making responsibility OR consent from the patient / client should complete the fields below. This signature confirms that you give your consent to this document being shared with your chosen Support Service	
Name:	Relationship to patient:
Signature	Date

Table 4 - To be completed by the Support Service & Family

Significant People in your life In this section please include family and friends, health professionals, care agencies, carers, colleagues, neighbours and any others who play an important part of your life, even if they are not directly involved in your health care			
Name	Are they registered with CQC (Yes / No or N/A)	Contact Details	Do they help you make decisions?

Table 5 - To be completed by the Support Service & Family

Risk Assessment In this section please include any required risk assessments			
Type of risk assessment	Completed Yes / No / N/A	Proposed Risk Mitigation	Action taken / Agreed by Patient
Equipment (e.g. medical devices, consumables, therapy equipment etc.)			
Moving & Handling			
Environment			
Drug Management including covert medication policy if applicable			
Fire			
Managing Behaviour (Personal Intervention Plan)			
Nutritional (e.g. Malnutrition Universal Screening Tool)			
Pressure Area			
Others (add rows if applicable)			

Table 6 - To be completed by the Support Service & Family

Risks PAs do not need to comply with the legislation that will require them to have indemnity cover, unless they are a member of a regulated health profession, even if carrying out activities which might otherwise be performed by health professionals. The Support Service will need to consider and discuss with the person, their nominee or representative, the potential risks associated with the clinical tasks being carried out by the PAs on a case by case basis. This needs to form part of the risk assessment and care planning process and the outcome recorded in the care plan			
Identified Clinical Risk	Impact on Health & Wellbeing	Proposed / Advised Mitigation Action	Action Taken / Agreed by Patient
Identified Financial Risk	Impact on Health & Wellbeing	Proposed / Advised Mitigation Action	Action Taken / Agreed by Patient
Other Identified Risk	Impact on Health & Wellbeing	Proposed / Advised Mitigation Action	Action Taken / Agreed by Patient

Table 7 - To be completed by the Support Service & Family

Support to Manage Personal Health Budget	How will this be managed and by who
Support for sourcing package of care for either agency or PA's	
Recruitment support - Tax, NI, Pension, Employment Rights / Law, Min Wage etc.	
DBS Checks (formerly CRB) and barred lists have been checked for all staff including nominees, representatives and family members (if applicable)	
Appropriate training and accountability measures including assessment of competencies are in place	
Insurance cover in place (employers and public liability etc.)	
Contracted Health professional(s) are registered with the appropriate body and have appropriate indemnity cover	
Identity, qualifications and professional registration checks for employees and the taking up of references has been explored and an approach to manage this agreed and recorded	
Management of the personal health budget	

Payment to staff i.e. Payroll (dependent on type of budget taken)	
Preparation and submission of financial monitoring information	
If any regulated activities are provided by agencies they must be registered with CQC	

Table 8 - To be completed by the Support Service & Family

Finally, your support plan must demonstrate how you have thought about and addressed any unforeseen or difficult times. To be completed by the Support Service & Family
What happens if something unforeseen happens? Please detail below
Add / delete rows as required

Table 9 - To be completed by the Support Service with the patient

Budget – How the Personal Health Budget will be spent		
Area:	Weekly Cost £	Yearly Total £

Staff: including NI, Pension, holiday pay, holiday cover		
Staff hours for shadow training		
DBS checks		
Redundancy		
Agency Fees		
Respite Costs		
Recruitment & Advertising		
Equipment		
Consumables – PPE; Printing		
Training: including clinical competencies / supervisions		
Transport		
Insurance		
Contingency costs; additional training for the new staff; emergency agency fees		
Support Service Charge		
List others costs as applicable		

Total		

Table 10 - To be completed by the Support Service with the patient

Declaration	
Please sign this document to show you agree (on the date of signing) that the details within this plan meet your Health and Wellbeing needs and that in your opinion you have been sufficiently involved in the putting together of your support plan. That you give your consent for the support planner to share this completed plan with appropriate persons involved in the PHB provision.	
Signature of Patient	**Date**
Name of Organisation Support Planning	
If patient / client is unable to sign, an appropriate adult representative with decision making responsibility OR consent from the patient /client should complete the fields below. That you give your consent for the support planner to share this completed plan with appropriate persons involved in the PHB provision.	
Name	**Relationship to patient**

Signature	**Date**

Appendix 3 Capacity & Consent

PHB arrangements can only be made where appropriate consent has been given by:

- a person aged 16 or over who has the capacity to consent to the making of direct payments to them;

- the suitable representative of a person aged 16 or over who lacks capacity to consent themselves to receipt of a PHB by way of a direct payment;

- the suitable representative of a child under 16.

Capacity

Under the MCA, there is a presumption that everyone over the age of 16 has capacity to make decisions for themselves, unless they are assessed as lacking capacity.

When assessing a person's capacity to make a decision, the assessor should follow the two stage test set out under the MCA which asks:

1. Does the person have an impairment of the mind or brain, or is there some disturbance in the functioning of their mind or brain?

2. If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made? Are they able to:
    a. A Understand the issues relevant to the decision
    b. Retain the information relevant to the decision
    c. Weight up to the pros and cons of the decision
    d. Communicate their decision having done so

Capacity is time and issue specific. For example, a person may be able to make a decision about who they would like to support them, but not about how to manage a PHB. PHBs should remain an option for all eligible patients regardless of whether they are deemed to have capacity or not.

There are a number of important decision-making points in setting up and managing PHBs. Where a person lacks the capacity to make a particular decision, their views must still be sought to the extent possible.

Wherever possible a person should be supported to be as involved as possible in all aspects of their PHB including the support planning process. To enable a person to understand their options and to help them feel at ease, those supporting them in their decision making need to think about:

- using the person's preferred methods of communication
- a suitable location
- the persons' privacy and dignity
- letting the person make the decision at their own pace

The Best Interests Principle

Under the MCA, anyone making decisions or acting on behalf of someone who lacks capacity has a duty to act in that person's best interests. Therefore, people who lack the capacity to consent to and manage PHBs can still receive one, including by way of a direct payment, if this is believed to be in their best interests (in accordance with the MCA).

Section 4 of the Mental Capacity Act sets out a checklist of factors that must always be considered by anyone who needs to decide what is in the best interests of a person who lacks capacity in any particular situation. This checklist includes a duty to:

- encourage the person to participate or improve their ability to take part in making the decision
- identify all the relevant circumstances
- consider the person's views (past and present)
- avoid discrimination - not simply make assumptions about someone's 'best interests' on the basis of their age, appearance, condition or behaviour
- assess whether the person might regain capacity and whether the decision can wait until that time
- if the decision concerns life-sustaining treatment the decision maker should not be motivated in any way by a desire to bring about the person's death
- consult those close to the patient for their views about the person's 'best interests'
- avoid restricting the person's rights by seeing if there are other options that may be less restrictive of the person's rights
- weigh up all of the above factors in order to determine best interests

This is not an exhaustive list of factors and the decision maker is under a duty to take into account "all relevant circumstances".

Decisions about the treatment and care of a patient who lacks capacity should follow the same best interests framework as outlined above.

Fluctuating Capacity

Where a person who has agreed to a care plan and consented to the making of direct payments to them subsequently loses their capacity to consent, the CCG may, where it is satisfied that the loss of capacity is temporary, allow a representative to be appointed to receive direct payments on their behalf, or an existing nominee to continue to receive them, until they regain capacity. In these circumstances, the role will be similar to that of a representative for someone who has been assessed to lack capacity on an ongoing basis.
Where someone's capacity to consent fluctuates, for example where a person's mental illness is such that it impairs their capacity to make decisions at certain times but not others, it is important that there should be continuity of care, and any disruption should be as minimal as possible. It may be helpful to work with people with fluctuating conditions to draw up advance decisions under the MCA and contingency plans to ensure that their care in a crisis, better meets their wishes, including the identification of a nominee or representative who may take control of the direct payment at such times.

When a person with fluctuating capacity gains or regains their capacity to consent, their consent is needed to continue the direct payments. If they consent, the representative or nominee must agree to continue their role in respect of the direct payment until a review is held. This is because it is the representative, not the person who has gained or regained capacity who, consented to the arrangements. This allows direct payments to continue until the CCG can arrange a review, which it must do as soon as is reasonably possible. At this review, the CCG and the person receiving care will review and if necessary develop a new care plan. However, if the person who has gained or regained capacity, does not consent to the representative or their nominee continuing in that role until a review is held, or if the representative or nominee does not wish to continue in that role, then direct payments must stop. As in all circumstances when direct payments stop, alternative provision should be made to ensure continuity of care until the required review takes place and new arrangements, which may include direct payments, are put in place.

Appendix 4

PHB Care Plan Sign Off Sheet – Right to Have

To Be Completed by the Direct Payment / Third Party Support Service

Patient Details

About Whom?	Surname: …… First Name(s): …… Broadcare Number: …….. Responsible CCG: ……

Care Plan Checklist

Named Care Coordinator	Named care coordinator is recorded in the care plan	**Yes / No**	**N/A Please add explanatory text**
Review	Anticipated date of the first review (at least within three months of the person receiving a direct healthcare payment)	**DD/MM/YYYY**	
Risk Assessments Completed	Risk assessments included within the care plan and agreed as appropriate	**Yes / No**	**N/A**
Clinical risks recorded	Clinical risks recorded in the care plan including risk mitigation	**Yes / No**	**N/A**
Regulated activities must be carried out by CQC registered providers	Are or will any 'regulated activities' be commissioned from a provider?	**Yes / No**	**N/A**
Care Agencies	Is the provider CQC registered?	**Yes / No**	**N/A**
Meeting Health Needs	Does the Care Plan set out the health needs that the direct healthcare payment is to address?	**Yes / No**	**N/A**
	Is it clear to both CSU/CCG and the people involved what the direct healthcare payments are meant to achieve?	**Yes / No**	**N/A**
	Does the plan specify the services to be secured by the	**Yes / No**	**N/A**

	direct healthcare payment in order to achieve the health (and wellbeing) needs?		
	Is the budget sufficient to meet all of the above?	**Yes / No**	**N/A**
	Are the identified clinical tasks suitable for delegation, specified in the care plan, with appropriate training, development and assessment of competence in place and sufficient indemnity and insurance cover?	**Yes / No**	**N/A**
	Safeguarding has been considered by CSU/CCG?	**Yes / No**	**N/A**
	Is the liberty of the patient being promoted by the care plan? This is especially important where the patient lacks capacity, and or when there are safeguarding issues and /or the patient is in a vulnerable situation.	**Yes / No**	**N/A**
Provision of Information / Advice & Guidance	Has the person, their representative or nominee received information, advice and support from the non NHS Support Service?	**Yes / No**	**N/A**
Are you satisfied that sufficient support has and will be provided to ensure:	The development and agreement from CSU / CCG of an appropriate care plan?	**Yes / No**	**N/A**
	Payroll, Tax and NI are managed effectively	**Yes / No**	**N/A**
	The direct healthcare payment will be managed appropriately?	**Yes / No**	**N/A**
	Monitoring, audit responsibilities and accountabilities are understood and can be adhered to?	**Yes / No**	**N/A**
	The employment of PAs & understanding of employer responsibilities is fully understood and will be adhered to?	**Yes / No**	**N/A**
	Regulated activities, will and are	**Yes / No**	**N/A**

	only commissioned from CQC registered providers?		
	Appropriate insurances are, and remain, in place for the employer?	**Yes / No**	**N/A**
	Appropriate registration is in place?	**Yes / No**	**N/A**
	Appropriate training & development, assessment of competence, sufficient indemnity and insurance cover is, and remains, in place for employed PAs and providers?	**Yes / No**	**N/A**
	The costs for this and ongoing support from the non NHS support service are set out within the care plan?	**Yes / No**	**N/A**
	There are sufficient funds to meet the support service costs and meet all of the health needs safely?	**Yes / No**	**N/A**
	Family members, close relatives and people living in the same home as the patient or their partners will not be employed unless agreed by the CSU / CCG? **(If the CCG is considering such a request please complete appendix 1)**	**Yes / No**	**N/A**
Consent & Capacity	Does the patient or Person with Parental responsibility for a child 16 or under - have capacity to consent to a PHB / direct payment	**Yes / No**	**N/A**
	Has the patient / Person with Parental responsibility for a child 16 or under - consented to a PHB / direct payment **(if no Representatives and Nominees section below must be completed - see below)**	**Yes / No**	**N/A**
Representatives and Nominees	Any representative and / or nominee must be agreed by the CCG / CSU. Does the CCG approve the named representative and / or nominee **(When considering such a request please complete**	**Yes / No**	**N/A**

	appendix 2)		
PHB Start Date	The intended commencement date of the PHB:	**DD/MM/YYYY**	

Appendix 1
Employing family members, close relatives and/or people living in the same household as the patient or their partners
If family members, close relatives and/or people living in the same household as the patient or their partners will be employed using a direct healthcare payment the CCG / CSU must record this here. The CCG / CSU will need to confirm that this is necessary in order to satisfactorily meet the person receiving care's need for that service; or to promote the welfare of a child for whom direct healthcare payments are being made. **Name / Relationship** **……** Has the CCG / CSU agreed to any family members, close relatives, people living in the same household or their partners being employed? **Yes / No / N/A** Please include details below, the name of the person(s), relationship, what has been agreed and the reason for this, including the time period and review timeframe for this decision.

Appendix 2	
Capacity Does the patient have capacity?	**Yes / No**
Consent Has the patient (16+) consented to a PHB and / or direct healthcare payment or Have the child's (under 16) parent(s) / those with parental responsibility consented to a PHB and / or direct health care payment	**Yes / No** **Yes / No**
Has the Patient consented to receiving a PHB / direct healthcare payment and fulfilling all of the responsibilities of someone receiving a PHB / direct healthcare payment?	**Yes / No**

Representatives	**If No is used Representative do not complete**
For patients (16+) unable to consent to a PHB / direct healthcare payment a Representative can be appointed. For children (under 16) a parent or those with parental responsibility for the child must be appointed as a Representative.	
The CCG / CSU must ensure that the Representative has consented to	

receiving a direct healthcare payment and fulfilling all of the responsibilities of someone receiving direct healthcare payments.	
Name of agreed Representative:	
Has the Representative consented to receiving a direct healthcare payment and fulfilling all of the responsibilities of someone receiving a direct healthcare payment?	**Yes / No**
The CCG / CSU must give consent and consider whether the person is competent and able to manage direct healthcare payments.	
Does the CCG / CSU consent to the Representative? Does the CCG / CSU consider the representative is competent and able to manage direct healthcare payments?	**Yes / No** **Yes / No**
Has the Representative applied for an Enhanced DBS check? Parents or those with Parental responsibility for a child (under 16) do not ordinarily need to apply, neither do family members living in the same household	**Yes / No / N/A**
Has the Representative been checked against the Adults' / Children's Barred List? Parents or those with Parental responsibility for a child (under 16) do not ordinarily need to apply, neither do family members living in the same household	**Yes / No / N/A**
Are the results of both of these checks satisfactory?	**Yes / No / N/A**

Employing Relatives	
Will the Representative be paid or employed in any capacity using the direct healthcare payments?	**Yes / No**
Will / is the Representative paid or employed in any capacity by the PHB support service e.g. YLYW / SOLO Support Services or Salvere?	**Yes / No**
Will any partner, relative, friend or person living in the same household as the patient / their Representative be paid or employed in any capacity using the direct healthcare payment?	**Yes / No**

If the CCG / CSU cannot approve the proposed Representative or wishes to attach conditions to the PHB the reason / conditions must be recorded here:

Nominees	
Is a nominee being requested?	**Yes / No**
If yes please complete the remainder of this section	
A Representative or a person with capacity (16+) can choose a Nominee.	
Has the Nominee consented to receiving a PHB / direct healthcare payment and fulfilling all of the responsibilities of someone receiving a PHB / direct healthcare payment?	
Has the Nominee applied for an Enhanced DBS check?	**Yes / No**
Has the Nominee been checked against the adults'/children's barred list?	**Yes / No**
Are the results both of these checks satisfactory?	**Yes/No /N/A**
Will the Nominee be paid or employed in any capacity using the direct healthcare payments?	**Yes / No**
Will / is the Nominee paid or employed in any capacity by the PHB support service e.g. SOLO Support Services or Salvere?	**Yes / No**
Will any partner, relative, friend or person living in the same household as the patient / their nominee be paid or employed in any capacity using the direct healthcare payment?	**Yes / No**
Does the CCG / CSU consent to the Nominee?	**Yes / No**
Name of agreed Nominee	

If the CCG / CSU cannot approve the proposed Nominee or wishes to attach conditions to the PHB the reason / conditions must be recorded here:

Appendix 5

PERSONAL HEALTH BUDGET AGREEMENT (ADULT)

This document tells you about having a Personal Health Budget

1. Information about You and Community Services

This agreement is between:

[Enter name of relevant CCG here] Clinical Commissioning Group

_____

(Referred to in this agreement as ‘we’ or ‘us’)

and

Name and address of person receiving the Personal Health Budget

PLEASE PRINT:

First Name(s) _____

Surname _____

Address _____

_____

Post Code _____

(Referred to in this agreement as ‘you’)

In certain circumstances, including where you are under 16 or are unable to consent to your direct healthcare payment, someone else may legally consent to and manage your direct healthcare payments on your behalf. That person is called a ‘representative’. Your representative will sign and agree to the terms of this agreement, and any other obligations on them under the regulations.

Your representative, if applicable and agreed by us is:

Name and address of Representative* or chosen decision maker

PLEASE PRINT:

First Name(s) ___ _____

Surname _____ _____

Relationship to ‘you' _____

Address _____

_____

Post Code _____

*Referred to in this agreement as 'Representative' who has been appointed to arrange the services and manage the direct healthcare payment on behalf of the Patient who lacks capacity, and who has been agreed by 'Us'.

And, if applicable you or your representative is entitled to appoint a nominee to take on the contractual responsibilities including arranging the services and support detailed in your support plan, the nominee will also become responsible for how the money is spent. Where we agree to it your nominee will sign and agree to comply with the terms of this agreement and any other obligations on them under the regulations.

Name and address of Nominee

PLEASE PRINT:

First Name _____

Surname _____

Address _____

_____

_____

Post Code _____

(Referred to in this agreement as 'Nominee')

2. Basis of the Agreement

This agreement is made on the basis that:

- An assessment of your health needs has been completed with a health professional and it has been identified that you are eligible to receive health care funding.

- Your care plan will identify the care and / or support that you need to meet your assessed health care outcomes in order to maintain your independence.

- You are willing and able to secure the care / support detailed in your care plan yourself or with support**,** (from a Representative or Nominee) and we agree to make your Personal Health Budget available to you to purchase the support and / or care that you need.

Any payment made under this agreement will be subject to regular audit and monitoring by the non NHS support service and us which may be reviewed by the Personal Health Budget Programme Board.

Further information about Your Life Your Way, SOLO Support Services and Salvere can be found at Appendix A.

3. Responsibilities of Your Nominated Representative (If you have one)

As part of the Clinical Commissioning Group agreeing to someone acting as your Representative, that person must be prepared to accept the following responsibilities:

- To involve you in decisions about your support
- To represent your best interests
- To consent to receiving and managing the direct healthcare payment, and
- Fulfilling all of the responsibilities of someone receiving direct healthcare payments

Even if you need a Representative you still have the right to be involved whenever possible. There is a duty placed on the Representative to involve you in all relevant decisions where possible.

If the Representative repeatedly fails to make decisions that reflect these key responsibilities, then their role as a Representative would need to be reconsidered.

Representatives are appointed only with the CCGs approval. Representatives can be appointed for individuals who do not have the capacity to consent to a direct healthcare payment or for a child under 16 when Representatives can include the parents of the child or those with parental responsibility for that child.

If you gain or regain capacity your consent is required to continue your direct healthcare payment.

Where an individual in receipt of a direct healthcare payment subsequently loses their capacity to consent, and the CCG is satisfied this is temporary, the CCG may allow a Representative to be appointed to manage the direct healthcare payments or allow a Nominee to continue to manage them until a review can be arranged.

4. Responsibilities of Your Nominee (If you or your Nominated Representative have one)

As part of the Clinical Commissioning Group agreeing to someone acting as your Nominee, that person must be prepared to accept the following responsibilities:

- To involve you in decisions about your support
- To represent your best interests
- To consent to receiving and managing the direct healthcare payment, and
- Fulfilling all of the responsibilities of someone receiving direct healthcare payments

Nominees must agree to act in the capacity of your Nominee and provide informed consent; the CCG must also consent to that Nominee acting in this capacity, and consider whether the Nominee is competent and able to manage direct healthcare payments with or without assistance.

You or your Representative may choose to elect a Nominee where you / your Representative wish to delegate all of the responsibilities of managing and receiving a direct healthcare payment.

5. About your Personal Health Budget

The amount of money you will receive

Start Date: _____
(Proposed) Breakdown of Payments:
Weekly (if applicable) £_____
One Off Value (if applicable) £ _____

The frequency of your payments will be discussed with you. However, payments are usually made to xxxxxxxxxxxxx in advance on a three monthly basis and will be reviewed within the first 12 weeks and then annually, unless your health care needs change.

How you will receive your money

There are three main ways that you can receive your personal health budget:

1. A direct payment with support from a non NHS support service who provides expertise in direct payments
2. A cash budget held and managed by a non NHS support service
3. A 'Notional' budget

You will have all the options explained to you before you decide which is the best option for you. When you have decided which way you would like to receive your budget please mark your choice with an 'X' in the box.

√	**A Direct Healthcare Payment**

A direct healthcare payment is where we pay money to you. The money will be paid into a bank account set up for this purpose by a non NHS support service who provides expertise in direct payments.

- Your Personal Health Budget will be paid into a bank account, which will be opened by xxxxxxxxxx in your name / your Representative's name / your Nominee's name and managed by you or your nominated representative or nominee.

- You will need to sign this agreement

- You will need to sign an agreement with xxxxxxxxxxx, this sets out the services they will provide to you, your Representative / Nominee and the charges they will deduct from your direct healthcare payment for these services. The non NHS support service will advise you about this.

- You, your Representative or Nominee must take advice on becoming an employer from xxxxxxxxxxxxx, as any employment, insurance, pension and tax issues will be the responsibility of the employer. You will be required to adhere to all aspects of employment law.

- You will be required to provide evidence of how you have spent the money for audit purposes. You will need to keep a record of your income and expenditure including receipts, invoices, timesheets, payslips and bank statements. xxxxxxxxxxxx can help you to manage this

- The bank account will be audited by xxxxxxxxxxx and us and therefore it is important that you / xxxxxxxxxxxxx submit all receipts and invoices for related expenditure.

- xxxxxxxxxxx may make direct healthcare payments directly to you / your Representative or Nominee however the CCG will need to approve this.

- See Section 6. Employing your own Staff

√	**A 'cash budget' (third party arrangement) held and managed by e.g SOLO / Your Life Your Way**

A cash budget is where the Clinical Commissioning Group pays your allocated budget to an organisation called either Your Life Your Way or SOLO Support Services, who hold the money for you and help you decide what you need. After you have agreed this with us, Your Life Your Way or SOLO Support Services will then buy and pay for the care and support you have chosen. Please note – Your Life Your Way or SOLO Support Services will employ your Personal Assistants if you choose to have a cash budget.

- The account is held and managed by Your Life Your Way or SOLO Support Services on your behalf

- Your Life Your Way or SOLO Support Services will buy the care and support you have chosen and take on the employment responsibilities

- You / your Representative / Nominee will need to sign an agreement with Your Life Your Way or SOLO Support Services; this sets out the services they will provide to you and the charges they will deduct from your Personal Health Budget for these services. Your Life Your Way or SOLO Support Services will advise you about this.

- You can request the balance of your bank account during working hours, Monday-Friday

- The bank account will be audited by Your Life Your Way or SOLO Support Services and us and therefore it is important that you / Your Life Your Way or SOLO Support Services submit all receipts and invoices for related expenditure.

√	**A Notional budget**

A Notional Budget enables you to be involved in planning your own care. The Clinical Commissioning Group will pay your service provider directly for any services that you have been assessed as needing. Please note - you cannot employ your own Personal Assistants if you choose to have a notional budget.

- The Clinical Commissioning Group will purchase and arrange the care and support from the provider(s) you have chosen

- The Clinical Commissioning Group will fund the care and support directly

- You will be involved in planning your care and support including developing your care plan

6. General Rules about How to Use the Money

Your Personal Health Budget enables you to buy the care, support or service that is detailed and agreed in your care plan.

The money cannot be spent on illegal services or activities, alcohol, tobacco, gambling or debt repayment.

You cannot use your Personal Health Budget to pay for primary or general medical services, for example GP services, vaccinations, dental charges, or optical appliances and hospital care.

If funds are used in this way the CCG may cease your Personal Health Budget and recover the inappropriately spent monies from you, your Representative / Nominee as appropriate.

Using a Care Agency

If you wish to use a care agency to provide a regulated activity you must purchase care from a provider who is registered with the Care Quality Commission, who regulate the standards of care agencies nationally. There is a list of registered providers available, please see www.cqc.org.uk for more information. The non NHS support service or your named health professional can also advise you about choosing a care agency.

If you choose to purchase a service through a care agency then please be advised that the contract and agreed price is a private arrangement between you, your Representative or Nominee and the care agency. Should the care agency increase its prices in the future above the agreed personal health budget amount, or require you to give a period of notice, we recommend that you request a review of your care plan and budget by contacting your named health professional. It may be more cost effective for the CCG to commission the service directly from your preferred care agency and the CCG will provide you with the option of a notional budget to ensure value for money.

Employing your own staff

You may also use your Personal Health Budget to purchase a service from any willing trained provider. This may include employing a Personal Assistant. If a provider you choose requires training to enable them to carry out their role effectively, training must be undertaken to ensure that you receive a high quality service. A non NHS support service e.g. Salvere can support you to access training as an employer and for your Personal Assistant(s).

We strongly recommend that a DBS check (Disclosure and Barring Service) is completed as part of the employment process. If you choose to employ your own staff you will have some legal responsibilities as an employer. These include but are not limited to providing:

- A statement of employment particulars including: providing a written contract; highlighting the location of the work; remuneration; period of notice etc. It is a legal requirement to have a written contract of employment between you and your member of staff

- Deducting Tax and National Insurance Contributions

- Adhering to Minimum Wage, Statutory Sick Pay and Maternity Entitlements and Responsibilities, Paternity leave and pay, Annual leave and pay, Adoption, Redundancy, Equal Opportunities, Unions and Health and Safety policies.

- You are legally required to take out Employers and Public Liability Insurance.

You will be responsible for all the employer responsibilities. Guidance can be obtained online at: www.direct.gov.uk: '*Employing a professional carer or personal assistant'* or www.hmrc.gov.uk

We recommend that you consult you non NHS support service, who support people using direct healthcare payments for information and advice about becoming an employer. You cannot ordinarily employ family members or anyone who lives with you or the spouse / partner of a relative / anyone living in the same house as you*.

This will only be agreed if, the CCG is satisfied that to secure a service from that person is necessary to meet your needs or promote the welfare of a child. This will be detailed here if agreed by us.

The CCG has agreed that the following family members (detailed above*) are employed by you, your Representative / Nominee: N/A Full Name N/A _____ Relationship _____ Reason _____

Representatives and Nominees and their relatives and partners cannot be employed to avoid any conflict of interest.

7. Record Keeping and Audit

You are required to keep basic records.

Your bank account will be audited through Salvere, Your Life Your Life or SOLO Support Services. Salvere, Your Life Your Way and SOLO Support Services are only able to make payments that are agreed in your care plan. The records will be subject to audit arrangements and Salvere, Your Life Your Way and SOLO Support Services will be audited annually (as a minimum).

The balance of the bank account will be reviewed regularly and any money that has not been allocated to your care or support excluding your contingency funds will be returned to the Clinical Commissioning Group (unless a prior agreement has been made with your named health professional).

8. Review, Changed Needs, Contingency and Emergency Arrangements

The arrangements agreed within your care plan will be reviewed within the first 12 weeks and then at least annually. The review will determine if your health needs and your personal outcomes have been met or have changed, and to establish what has worked well or not worked well for you.

The Clinical Commissioning Group will arrange a review earlier or if we become aware that your health needs have changed and/or if your Personal Health Budget is insufficient to secure the services. You or your Representative can also ask for a review.

If your needs have changed during this period of time you may request an earlier review of your needs by contacting your named health professional.

You are required to make contingency arrangements within your care plan, which may include having a contingency fund. In crisis situations the Clinical Commissioning Group may, in the absence of alternative support, step in and help on an interim basis.

Primary care services, including access to your GP and emergency services, such as Accident and Emergency, will always be available to you regardless of having a Personal Health Budget. These services are not included in your budget.

If your needs change or something is not working, you or your Representative or Nominee, must contact your named health professional.

If you go into hospital, you or your Representative must inform us

9. Comments, Complaints and Compliments

You have a right to comment, complain or compliment through the Clinical Commissioning Group's complaints procedure about any action, decision or apparent failing of the Clinical Commissioning Group.

Contact the Customer Care Team:

by telephone: 0151 247 700

by email: Southseftonccg.complaints@nhs.net

by post: NHS South Sefton CCG

3rd Floor Merton House,

Stanley Road,

Bootle.

L20 3DL.

10. Ending the Agreement

Either you, your Representative or we may end this agreement by giving one months' notice in writing to the other party.

We may end this agreement with immediate effect if, after investigation, it is found:

- You are using the money illegally
- You are not using it in your own best interests
- Your Nominated Representative is found to be acting in a way that is not in your best interests

Wherever possible, we will work with you and your Representative to find a resolution to the issues before ending the agreement.

At the point of ending the agreement, any funds paid to you by the Clinical Commissioning Group which covers the period after the termination date, must be paid back in full.

Following a review if we decide to reduce the amount of or stop making your direct healthcare payment you, your Representative or Nominee may ask us to reconsider this decision, and can provide evidence or relevant information to inform the reconsideration. We will inform you, your Representative or Nominee in writing of the decision following the reconsideration and state the reasons for the decision.

If this agreement ends for any reason and you continue to have health needs, the funding for your health needs will be provided by the CCG as part of the NHS in the usual way.

11. Data Protection and Use of Data

We may share information that we hold or become aware of with other statutory agencies for the prevention of fraud and abuse.

12. Signatures

This is where all parties are signing up to this agreement. This means that we will all work to what has been agreed in this document.

1st Party:

Us – Signature on behalf of the Clinical Commissioning Group:

Signature: _____

Date: _____

2nd Party:

You – The person receiving the Personal Health Budget

Signature: _____

Date: _____

3rd Party:

Representative – the person receiving and managing the Personal Health Budget on behalf of the above named person

Signature: _____

Date: _____

4th Party:

Nominee – the person receiving and managing the Personal Health Budget on behalf of the above named Representative or person

Signature: _____

Date: _____

13. Annex A
SOLO Support Services and Your Life Your Way

SOLO Support Services and Your Life Your Way are the CCGs approved providers for a personal health budget deployed as a 'cash budget' (third party arrangement). SOLO Support Services and Your Life Your Way are both Care Quality Commission (CQC) registered care agencies.

SOLO Support Services and Your Life Your Way work with families to build care plans and hold your personal health budget for you. SOLO and Your Life Your Way buy and pay for the care and support you have chosen. Please note – SOLO and Your Life Your Way will employ your Personal Assistants if you choose to have a 'cash budget' (third party arrangement). SOLO and Your Life Your Way will deduct their charges for their services from your Personal Health Budget. These charges have been agreed between yourself and Your Life your Way / SOLO Support Services as part of your care plan.

Salvere

Salvere are the CCGs approved provider for making direct healthcare payments for personal health budgets. Salvere are a Community Interest Company who support and assist families to organise, buy and manage their care, including building your own care plan using a direct healthcare payment.

Salvere will help you to manage all of your responsibilities as an employer and help you to employ personal assistants, arrange payroll, pay HMRC, provide staff handbooks, contracts of employment, risk assessment, help you make decisions about disclosure barring service checks, and ensure appropriate training and competency checks are in place and ensure clinical tasks are delegated safely.

Salvere will hold your Personal Health Budget in a bank account, which will be opened in your name / your Representative's name / your Nominee's name and managed by you or your nominated representative or nominee. Salvere will deduct their charges for their services from your Personal Health Budget. These charges have been agreed between yourself and Salvere as part of your care plan.

Appendix 6

PERSONAL HEALTH BUDGET AGREEMENT (Children)

This document tells you about having a Personal Health Budget

14. Information about You and Community Services
15. Basis of the agreement
16. Responsibilities of a Nominated Representative
17. Responsibilities of your Nominee (if you have one)
18. About your Personal Health Budget
19. General Rules on How to Use the Money
20. Record Keeping and Audit
21. Review, Changed Needs, Contingent and Emergency Arrangements
22. Comments, Complaints and Compliments
23. Ending the Agreement
24. Data Protection and Use of Data
25. Signatures
26. Annex A

2. Information about You and Community Services

This agreement is between:

(Enter name of relevant CCG here) Clinical Commissioning Group (Referred to in this agreement as 'we' or 'us')

and

Name and address of the child for who the Personal Health Budget is being made PLEASE PRINT: **First Name(s)** : **Surname:** **Address**   **Post Code** (Referred to in this agreement as 'the child')

In certain circumstances, including for people who are under 16 or people who are unable to consent to a direct healthcare payment, someone else may legally consent to and manage the direct healthcare payments on their behalf. That person is called a 'representative'. The representative will sign and agree to the terms of this agreement, and any other obligations on them under the regulations.

Once the child reaches 16 they will be able to consent to and receive the direct healthcare payment in their own right. The CCG will discuss the options with the child and may discuss the options with a person with parental responsibility at this time.

Your representative, if applicable and agreed by us is:

Name and address of Representative* or chosen decision maker

PLEASE PRINT:

First Name(s) :

Surname:

Relationship to 'the child' : Parent or person with parental responsibility

Address

Post Code

*Referred to in this agreement as 'you' or 'Representative' who has been appointed to arrange the services and manage the direct healthcare payment on behalf of a child for whom they have parental responsibility, and who has been agreed by 'Us'.

A representative is entitled to appoint a nominee to take on the contractual responsibilities including arranging the services and support detailed in the child's support plan, the nominee will also become responsible for how the money is spent. Where we agree to it your nominee will sign and agree to comply with the terms of this agreement and any other obligations on them under the regulations.

Name and address of Nominee

PLEASE PRINT:

First Name Not Applicable

Surname _____

Address _____

_____

_____

Post Code _____

(Referred to in this agreement as 'Nominee')

2. Basis of the Agreement

This agreement is made on the basis that:

- An assessment of your child's health needs has been completed with a health professional and it has been identified that your child is eligible to receive health care funding.

- Your child's care plan will identify the care and / or support that your child needs to meet their assessed health care outcomes in order to maintain your child's' independence.

- You - The parent / person with parental responsibility (Representative) is willing and able to secure the care / support detailed in your child's care plan yourself or with support**,** (from a Nominee) and we agree to make your child's Personal Health Budget available to you as the Representative to purchase the support and / or care that your child needs.

Any payment made under this agreement will be subject to regular audit and monitoring by Salvere or Your Life Your Way / SOLO Support Services and us which may be reviewed by the Personal Health Budget Programme Board.

Further information about Your Life Your Way, SOLO Support Services and Salvere can be found at Appendix A.

3. Responsibilities of the Nominated Representative

As part of the Clinical Commissioning Group agreeing to someone acting as a Representative, that person must be prepared to accept the following responsibilities:

- To involve the child in decisions about their support

- To represent the child's best interests

- To consent to receiving and managing the direct healthcare payment, and

- Fulfilling all of the responsibilities of someone receiving direct healthcare payments

Even with a Representative a child still has the right to be involved whenever possible. There is a duty placed on the Representative to involve the child in all relevant decisions where possible.

If the Representative repeatedly fails to make decisions that reflect these key responsibilities, then their role as a Representative would need to be reconsidered.

Representatives are appointed only with the CCGs approval. Representatives can be appointed for individuals who do not have the capacity to consent to a direct healthcare payment or for a child under 16 when Representatives can include the parents of the child or those with parental responsibility for that child.

4. Responsibilities of Your Nominee (If you have one)

As part of the Clinical Commissioning Group agreeing to someone acting as your Nominee, that person must be prepared to accept the following responsibilities:

- To involve you and the child in decisions about the child's support
- To represent the child's best interests
- To consent to receiving and managing the direct healthcare payment, and
- Fulfilling all of the responsibilities of someone receiving direct healthcare payments

Nominees must agree to act in the capacity of your Nominee and provide informed consent; the CCG must also consent to that Nominee acting in this capacity, and consider whether the Nominee is competent and able to manage direct healthcare payments with or without assistance.

A Representative for the child may choose to elect a Nominee where the Representative wishes to delegate all of the responsibilities of managing and receiving a direct healthcare payment.

5. About your child's Personal Health Budget

<u>The amount of money you will receive</u>

Start Date: xx/xx/xx
(Proposed) Breakdown of Payments:
Weekly (if applicable) £
One Off Value (if applicable) £
NOT APPLICABLE

The frequency of the payments will be discussed with you. However, payments are usually made to Your Life Your Way / Solo Support Services / Salvere in advance on a three monthly basis and will be reviewed within the first 12 weeks and then annually, unless your health care needs change.

How you will receive the money

There are three main ways that you can receive the personal health budget:

4. A direct payment with support from Salvere
5. A cash budget held and managed by Your Life Your Way / SOLO Support Services
6. A 'Notional' budget

You will have all the options explained to you before you decide which is the best option for you. When you have decided which way you would like to receive the budget please mark your choice with an 'X' in the box.

√	**A Direct Healthcare Payment**

A direct healthcare payment is where we pay money to you. The money will be paid into a bank account set up for this purpose by Salvere.

- The Personal Health Budget will be paid into a bank account, which will be opened by Salvere in your name or the Nominee's name and managed by you or the Nominee.
- You will need to sign this agreement
- You will need to sign an agreement with Salvere, this sets out the services they will provide to you or your Nominee and the charges they will deduct from the direct healthcare payment for these services. Salvere will advise you about this.
- You or your Nominee must take advice on becoming an employer from Salvere, as any employment, insurance, pension and tax issues will be the responsibility of the employer. You or your Nominee will be required to adhere to all aspects of employment law.
- You will be required to provide evidence of how you have spent the money for audit purposes. You will need to keep a record of all income and expenditure including receipts, invoices, timesheets, payslips and bank statements. Salvere can help you to manage this
- The bank account will be audited by Salvere and us and therefore it is important that you / Salvere submit all receipts and invoices for related expenditure.
- Salvere may make direct healthcare payments directly to you or your Nominee however the CCG will need to approve this.

- See Section 6. Employing your own Staff

√	**A 'cash budget' (third party arrangement) held and managed by SOLO or Your Life Your Way**

A cash budget is where the Clinical Commissioning Group pays the allocated budget to an organisation called Your Life Your Way, SOLO Support Services, who hold the money for you and help you decide what you and your child need. After you have agreed this with us, Your Life Your Way, SOLO Support Services will then buy and pay for the care and support you have chosen. Please note – Your Life Your Way, SOLO Support Services will employ your Personal Assistants if you choose to have a cash budget.

- The account is held and managed by Your Life Your Life or SOLO Support Services on your behalf
- Your Life Your Way or SOLO Support Services will buy the care and support you have chosen and take on the employment responsibilities
- You or your Nominee will need to sign an agreement with Your Life Your Way / SOLO Support Services; this sets out the services they will provide to you and the charges they will deduct from your Personal Health Budget for these services. Your Life Your Way / SOLO Support Services will advise you about this.
- You can request the balance of your bank account during working hours, Monday-Friday
- The bank account will be audited by Your Life Your Way / SOLO Support Services and us and therefore it is important that you / SOLO Support Services / Your Life Your Way submit all receipts and invoices for related expenditure.

√	**A Notional budget**

A Notional Budget enables you to be involved in planning your child's care. The Clinical Commissioning Group will pay your service provider directly for any services that your child has been assessed as needing. Please note - you cannot employ your own Personal Assistants if you choose to have a notional budget.

- The Clinical Commissioning Group will purchase and arrange the care and support from the provider(s) you have chosen
- The Clinical Commissioning Group will fund the care and support directly
- You will be involved in planning your childs' care and support including developing your childs' care plan

6. General Rules about How to Use the Money

The Personal Health Budget enables you to buy the care, support or service that is detailed and agreed in your childs' care plan.

The money cannot be spent on illegal services or activities, alcohol, tobacco, gambling or debt repayment.

You cannot use your Personal Health Budget to pay for primary or general medical services, for example GP services, vaccinations, dental charges, or optical appliances and hospital care.

If funds are used in this way the CCG may cease your Personal Health Budget and recover the inappropriately spent monies from you or your Nominee as appropriate.

Using a Care Agency

If you wish to use a care agency to provide a regulated activity you must purchase care from a provider who is registered with the Care Quality Commission, who regulate the standards of care agencies nationally. There is a list of registered providers available, please see www.cqc.org.uk for more information. Salvere / SOLO Support Services / Your Life Your Way or your child's named health professional can also advise you about choosing a care agency.

If you choose to purchase a service through a care agency then please be advised that the contract and agreed price is a private arrangement between you or your Nominee and the care agency. Should the care agency increase its prices in the future above the agreed personal health budget amount, or require you to give a period of notice, we recommend that you request a review of your child's care plan and budget by contacting your childs' named health professional. It may be more cost effective for the CCG to commission the service directly from your preferred care agency and the CCG will provide you with the option of a notional budget to ensure value for money.

Employing your own staff

You may also use your Personal Health Budget to purchase a service from any willing trained provider. This may include employing a Personal Assistant. If a provider you choose requires training to enable them to carry out their role effectively, training must be undertaken to ensure that your child receives a high quality service. Salvere can support you to access training as an employer and for your child's Personal Assistant(s).

We strongly recommend that a DBS check (Disclosure and Barring Service) is completed as part of the employment process. If you choose to employ your own staff you will have some legal responsibilities as an employer. These include but are not limited to providing:

- A statement of employment particulars including: providing a written contract; highlighting the location of the work; remuneration; period of notice etc. It is a legal requirement to have a written contract of employment between you and your member of staff

- Deducting Tax and National Insurance Contributions

- Adhering to Minimum Wage, Statutory Sick Pay and Maternity Entitlements and Responsibilities, Paternity leave and pay, Annual leave and pay, Adoption, Redundancy, Equal Opportunities, Unions and Health and Safety policies.

- You are legally required to take out Employers and Public Liability Insurance.

You will be responsible for all the employer responsibilities. Guidance can be obtained online at: www.direct.gov.uk: '*Employing a professional carer or personal assistant'* or www.hmrc.gov.uk

We recommend that you consult Salvere, who support people using direct healthcare payments for information and advice about becoming an employer. You cannot ordinarily employ family members or anyone who lives with you or the spouse / partner of a relative / anyone living in the same house as you*.

This will only be agreed if, the CCG is satisfied that to secure a service from that person is necessary to meet the child's needs or promote the welfare of the child.
This will be detailed here if agreed by us.

The CCG has agreed that the following family members (detailed above*) are employed by you or your Nominee: Not Applicable Full Name: _____Not Applicable_____ Relationship _____ Reason _____

Representatives and Nominees and their relatives and partners cannot be employed to avoid any conflict of interest.

7. Record Keeping and Audit

You are required to keep basic records.

Your bank account will be audited through Salvere, Your Life Your Way or SOLO Support Services. Salvere, Your Life Your Way and SOLO Support Services are only able to make payments that are agreed in your childs' care

plan. The records will be subject to audit arrangements and Salvere, Your Life Your Way and SOLO Support Services will be audited annually (as a minimum).

The balance of the bank account will be reviewed regularly and any money that has not been allocated to your childs' care or support excluding your contingency funds will be returned to the Clinical Commissioning Group (unless a prior agreement has been made with your named health professional).

8. Review, Changed Needs, Contingency and Emergency Arrangements

The arrangements agreed within your child's care plan will be reviewed within the first 12 weeks and then at least annually. The review will determine if your childs' health needs and personal outcomes have been met or have changed, and to establish what has worked well or not worked well for you and your child.

The Clinical Commissioning Group will arrange a review earlier if we become aware that your childs' health needs have changed and/or if the Personal Health Budget is insufficient to secure the services. You can also ask for a review if your childs' needs have changed during this period of time - you may request an earlier review of your childs' needs by contacting your childs' named health professional.

You are required to make contingency arrangements within your childs' care plan, which may include having a contingency fund. In crisis situations the Clinical Commissioning Group may, in the absence of alternative support, step in and help on an interim basis.

Primary care services, including access to your childs' GP and emergency services, such as Accident and Emergency, will always be available to your child regardless of having a Personal Health Budget. These services are not included in your budget.

If your child's needs change or something is not working, you or your Nominee, must contact your childs' named health professional. If your child goes into hospital, you must inform us so that we can consider whether an adjustment to the personal health budget is needed for services which are not provided while your child is in hospital.

9. Comments, Complaints and Compliments

You have a right to comment, complain or compliment through the Clinical Commissioning Group's complaints procedure about any action, decision or apparent failing of the Clinical Commissioning Group.

Contact the Customer Care Team:

by telephone: 0151 247 700

by email: Southseftonccg.complaints@nhs.net

by post: NHS South Sefton CCG

3rd Floor Merton House,
Stanley Road,
Bootle.
L20 3DL.

10. Ending the Agreement

Either you or we may end this agreement by giving one months' notice in writing to the other party.

We may end this agreement with immediate effect if, after investigation, it is found:

- You are using the money illegally or for any purpose which is not permitted in this Agreement or in the child's care plan
- You are not using the money in your childs' best interests or as agreed with us
- You are found to be acting in a way that is not in the childs' best interests

Wherever possible, we will work with you to find a resolution to the issues before ending the agreement.

At the point of ending the agreement, any funds paid to you by the Clinical Commissioning Group which covers the period after the termination date, must be paid back in full.

Following a review if we decide to reduce the amount of or stop making the direct healthcare payment you or your Nominee may ask us to reconsider this decision, and you may provide evidence or relevant information to inform the reconsideration. We will inform you or your Nominee in writing of the decision following the reconsideration and state the reasons for the decision.

If this agreement ends for any reason and your child continues to have health needs, the funding for your health needs will be provided by the CCG as part of the NHS in the usual way.

11. Data Protection and Use of Data

We may share information that we hold or become aware of with other statutory agencies for the prevention of fraud and abuse.

12. Signatures

This is where all parties are signing up to this agreement. This means that we will all work to what has been agreed in this document.

1st Party:

Us – Signature on behalf of the Clinical Commissioning Group:

Signature: _____

Date: _____

2nd Party:

You / The Representative– The person receiving the Personal Health Budget on behalf of a child for who you have parental responsibility

Signature: _____

Date: _____

3rd Party:

Nominee – the person receiving and managing the Personal Health Budget on behalf of the above named Representative

Signature: _Not Applicable_____

Date: _____

13. Annex A

SOLO Support Services & Your Life Your Way

SOLO Support Services & Your Life Your Way are the CCGs approved provider for a personal health budget deployed as a 'cash budget' (third party arrangement). SOLO Support Services & Your Life Your Way are Care Quality Commission (CQC) registered care agencies.

SOLO Support Services & Your Life Your Way work with families to build care plans and hold your personal health budget for you. SOLO & Your Life Your Way buy and pay for the care and support you have chosen. Please note – SOLO & Your Life Your Way will employ your Personal Assistants if you choose to have a 'cash budget' (third party arrangement). SOLO & Your Life Your Way will deduct their charges for their services from your Personal Health Budget. These charges have been agreed between yourself and SOLO Support Services & Your Life Your Way as part of your care plan.

Salvere

Salvere are the CCGs approved provider for making direct healthcare payments for personal health budgets. Salvere are a Community Interest Company who support and assist families to organise, buy and manage their care, including building your childs' own care plan using a direct healthcare payment.

Salvere will help you to manage all of your responsibilities as an employer and help you to employ personal assistants, arrange payroll, pay HMRC, provide staff handbooks, contracts of employment, risk assessment, help you make decisions about disclosure barring service checks, and ensure appropriate training and competency checks are in place and ensure clinical tasks are delegated safely.

Salvere will hold your Personal Health Budget in a bank account, which will be opened in your name / your child's name / your Nominee's name and managed by you or your nominee. Salvere will deduct their charges for their services from your Personal Health Budget. These charges have been agreed between yourself and Salvere as part of your childs' care plan.

Appendix 7 Close Family Members

Who is a close family member?

A person's close family members are described in the regulations as:

a. the spouse or civil partner of the person receiving care

b. someone who lives with the person as if their spouse or civil partner

c. their parent or parent-in-law

d. their son or daughter

e. son- in- law or daughter- in- law

f. stepson or stepdaughter

g. brother or sister

h. aunt or uncle

i. grandparent, or

j. the spouse or civil partners of (c)- (i), or someone who lives with them as if their spouse or civil partner

Appendix 8

Regulatory Bodies

Which are the statutory regulatory bodies?

- The General Chiropractic Council (GCC) regulates chiropractors.
- The General Dental Council (GDC) regulates dentists, dental nurses, dental technicians, dental hygienists, dental therapists, clinical dental technicians and orthodontic therapists.
- The General Medical Council (GMC) regulates doctors.
- The General Optical Council (GOC) regulates optometrists, dispensing opticians, student opticians and dispensing opticians, specialist practitioners and optical businesses.
- The General Osteopathic Council (GOsC) regulates osteopaths.
- The Health and Care Professions Council (HCPC) regulates the members of 15 health professions: arts therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dietitians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists/orthotists, radiographers, speech and language therapists, and social workers in England.
- The Nursing and Midwifery Council (NMC) regulates nurses and midwives.
- The Royal Pharmaceutical Society of Great Britain (RPSGB) regulates pharmacists, pharmacy technicians and pharmacy premises in Great Britain in England, Wales and Scotland.

Appendix 9

Timescales for Appealing Personal Health Budgets Decisions

1.0 Timescales:

1.1 The appeal must be made within 4 weeks of receiving the CCG's response to the PHB request. Appeals can be made by email, letter, by phone, either direct to the CCG, or via the CSU.

1.2 On receipt of an appeal, the CCG will respond within 10 working days confirming that a meeting will be convened.

1.3 The meeting should take place within 25 working days of the appeal being received.

1.4 The response of the panel will be confirmed to the service user in a letter within 28 working days of acknowledgement the original request meeting. The reasons for the decision will be set out in the decision letter, (together with an information leaflet on the NHS Complaints Procedure if the patient or their representative is not satisfied with the decision).

1.5 In the event of any timescales being exceeded, it is the responsibility of the CCG to keep the patient or their representative informed of reasons and progress.

1.6 Once the review is complete the CCG will inform the patient or their representative of its decision in writing, setting out the reasons for its decision within 28 working days of acknowledgement of the original request. If a patient or their representative is not satisfied that can pursue the matter via the local NHS complaints process.

1.7 If the internal process cannot resolve the concerns of the individual and/or their representative then the appellant can use the NHS Complaints Procedure.

NHS
Southport and Formby
Clinical Commissioning Group

NHS Southport and Formby Clinical Commissioning Group

Personal Health Budgets for NHS Funded Packages of Care for Adults and Children

Policy & Practice Guidance

Title:	NHS Southport and Formby Clinical Commissioning Group Personal Health Budgets for NHS Funded Packages of Care for Adults and Children Policy & Practice Guidance
Version:	1.0
Ratified by:	NHS Southport and Formby CCG Governing Body
Date ratified:	23rd March 2016
Name of originator/author:	Katy Murray, Interim PHB Project Manager. Midlands and Lancashire Commissioning Support Unit Tracey Forshaw Head of Vulnerable People
Name of Lead:	Chief Nurse
Date issued:	23rd March 2016
Review date:	March 2019
Target audience:	CCG, CSU, NHS Community Providers, NHS Mental Health Providers

In the event of any changes to relevant legislation or statutory procedures this policy will be automatically updated to ensure compliancy without consultation. Such changes will be communicated.

Version Number	Type of Change	Date	Description of change

Table of Contents

1.0 Purpose & Introduction

This document sets out the policy and practice guidance developed to ensure the consistent and transparent delivery of Personal Health Budgets ("PHBs") for Eligible Persons (see section 3.1 for definition). This policy took effect from April 2014. The policy has been revised for the "right to have a PHB" for Eligible Persons from October 2014, and the wider expansion of PHBs at the CCGs discretion from April 2015 onwards. National policy in this area is still developing and the CCGs will review this paper when new guidance, regulations or national policy is published.

NHS Southport and Formby CCG (CCG) will ensure that PHBs are value for money for patients and the CCG. This will be done though the way in which PHBs are set up, through robust support planning and through effective monitoring of direct payments.

NHS Southport and Formby CCG would like to acknowledge Midlands and Lancashire Commissioning Support Unit, for the development of this policy, practice guidance and supporting documentation.

1.1 Consultation

This policy was developed in consultation with:

- NHS South Sefton CCG: Lead Commissioner – Learning Diversity, Children and Mental Health, Head of Finance, Head of Communications, Senior Governance Manager (Equality and Diversity).
- NHS Southport and Formby CCG meetings: Corporate Governance Support, Clinical Quality Committee, Evaluation of Patient Experience Group, NHS South Sefton Governing Body, CCG / CSU CHC Steering Group.
- CCG Legal representation – Hill Dickinson
- Sefton Metropolitan County Council: Dwayne Johnson, Tina Wilkins, Nick Roberts, Margaret Milne, Carol Cater, Mark Waterhouse, Lauren Sadler, Lesley McCann, Mike McSorely.
- Commissioning Support Unit (CSU) – Continuing Health Care / Complex Care and Quality Team: Lorraine Norfolk, Jo Ryder, Margie Learie, Lead for Children, Mental Health and Learning Disability
- Service user / Patient consultation: Commissioned and delivered by Sefton Carers Centre,
- Personal Health Budget Brokerage: Salvere, Your Life Your Way, SOLO Support Services, Sefton MBC Consultation and Engagement Panel
- Third sector Organisations: Sefton Carers Centre, Sefton Council for Voluntary Services, HealthWatch Sefton
- NHS Community Provider: Director of Nursing: Southport and Formby NHS Trust, Liverpool Community Health NHS Trust and Merseycare NHS Trust.

1.2 Ratification

This policy and practice guidance will be ratified by NHS Southport and Formby CCG Governing Body.

1.3 Scope

This policy applies to all employees of NHS Southport and Formby / South Sefton CCG, Commissioning Support Unit, NHS Providers commissioned to deliver services by Southport and Formby CCG.

1.4 Other Relevant Legislation

- Human Rights Act 1998, including the Article 8 Right to respect for private and family life, and Article 14 Prohibition of discrimination

- The Data Protection Act 1998

- The Carers (Equal Opportunities) Act 2004 provides carers with the right to receive assessment for support and a duty on various public authorities to give due consideration to a request to provide services to carers.

- The Mental Capacity Act 2005 ("MCA"). The Mental Capacity Act provides a framework for decision making applicable where people lack capacity to make a decision for themselves. The overriding principles of the Mental Capacity Act are set out in section 1 and include a requirement to ensure that all practicable steps are taken to seek to enable a person to make a decision for himself. Where a person is unable to make a decision, any decision made on their behalf must be made in accordance with his/her best interests and must be the least restrictive of the person's rights and freedom of action. A person is not to be treated as unable to make a decision simply because he makes an unwise decision.

- The Equality Act 2010. The Equality Act brought together the various earlier discrimination laws under one statute. It is unlawful to act in a discriminatory manner against any "protected characteristics", including race, sex and disability.

- The Children and Families Act 2014. This Act intends to improve services for key groups of vulnerable children (e.g. those in adoption and those with special educational needs and disabilities).

- The National Health Service (Direct Payments) Regulations 2013 (SI 2013 No.1617)

- The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) Regulations 2013. These Regulations set out the duties of CCG's relating to NHS Continuing Healthcare rights and personal health budgets.

- NHS England – The Forward View into action: Planning for 2015 / 2016

- Department of Heath The Government's Mandate to NHS England 2016 / 2017

2.0 Overview

2.1 History

Following a successful pilot programme by the Department of Health, which ended in October 2012, the Government announced that from April 2014, Eligible Persons will have the "right to ask" for a PHB, including by way of a direct payment. From October 2014, this right to ask was converted to a "right to have" a PHB, specifically for Continuing Health Care (CHC) and Continuing Care (CC) for children with complex care needs.

This development mirrors other changes within the NHS, including the drive generally for greater patient choice, shared decision-making and innovation in managing funds. The Government has confirmed a commitment in the Mandate to NHS England 2016-2017 that PHB's including direct payments, should be an option extended to anyone who could benefit from a PHB from April 2015. The Mandate requires the consideration of more personalised care, including variant forms of PHBs even when a person is not suitable to receive a direct payment, with the emphasis on identifying any way in which the person's care could be personalised.

2.2 What is a PHB?

PHBs are the allocation of NHS funding which patients, after an assessment and planning with their NHS clinical team, are able to personally control and use the services they choose to support their health needs. This enables them to manage identified risks and to live their lives in ways which best suit them. Enabling people to exercise choice and control over their lives is central to achieving better outcomes for individuals.

For Eligible Persons there is a duty on CCGs to:

- Consider any request for a PHB;
- Inform them of their right to ask for a PHB (April 2014);
- Inform them of their right to have a PHB (October 2014)
- Provide information, advice and support in relation to PHBs.

There are five essential characteristics of a PHB.

The person with the PHB (or their representative) must:

1. be able to choose the health outcomes they want to achieve
2. know how much money they have for their healthcare and support
3. be enabled to create their own care plan, with support if they want it
4. be able to choose how their budget is held and managed
5. be able to spend the money in ways and at times that make sense to them, as agreed in their plan.

The CCG is committed to promoting service user choice, where available, while supporting them to manage risk positively, proportionately and realistically. As part of good practice, health care professionals should support and encourage service users' choices as much as possible, and keep them informed, in a positive way, of issues associated with those choices and how to take reasonable steps to manage them.

2.3 Principles

There are six key principles for PHBs and personalisation in health:

1. *Upholding NHS principles and values* - The personalised approach must support the principles and values of the NHS as a comprehensive service which is free at the point of use, as set out in the NHS Constitution. It should remain consistent with existing NHS policy, including the following principles:

- Service users and their carers should be fully involved in discussions and decisions about their care using easily accessible, reliable and relevant information in a format that can be clearly understood;
- There should be clear accountability for the choices made;
- No one will ever be denied treatment as a result of having a PHB;
- Having a PHB does not entitle someone to additional or more expensive services, or to preferential access to NHS services;
- There should be efficient and appropriate use of current NHS resources.

2. *Quality* – safety, effectiveness and experience should be central. The wellbeing of the individual is paramount. Access to a PHB will be dependent on professionals and the individual agreeing a care plan that is safe and will meet agreed health and wellbeing outcomes. There should be transparent arrangements for continued clinical oversight, proportionate to the needs of the individual and the risks associated with the care package.

3. *Tackling inequalities and protecting equality* – PHBs and the overall movement to personalise services could be a powerful tool to address inequalities in the health service. A PHB must not exacerbate inequalities or endanger equality. The decision to set up a PHB for an individual must be based on their needs, irrespective of race, age, gender, disability, sexual orientation, marital or civil partnership status, transgender, religion, beliefs or their lack of the requisite mental capacity to make decisions regarding their care.

4. *PHBs are purely voluntary* - No one will ever be forced to take more control than they want.

5. *Making decisions as close to the individual as possible* - Appropriate support should be available to help all those who might benefit from a more personalised approach, particularly those who may feel least well served by existing services / access, and who might benefit from managing their budget.

6. *Partnership* - Personalisation of healthcare embodies co-production. This means individuals working in partnership with their family, carers and professionals to plan, develop and procure the services and support that are appropriate for them. It also means CCGs, local authorities and healthcare providers working together to utilise PHBs so that health and social care work together as effectively as possible.

2.4 Standards for self-directed health support

The following standards for self-directed support are followed nationally and articulated as seven outcomes, which will be delivered through the implementation of this policy. These seven outcomes are:

Outcome 1 - Improved health and emotional well-being: To stay healthy and recover quickly from illness.

Outcome 2 - Improved quality of life: To have the best possible quality of life, including life with other family members supported in a caring role.

Outcome 3 - Making a positive contribution: To participate as an active citizen, increasing independence where possible.

Outcome 4 - Choice and control: To have maximum choice and control.

Outcome 5 - Freedom from discrimination, harassment and victimisation: To live free from discrimination, harassment and victimisation.

Outcome 6 - Economic well-being: To achieve economic well-being and have access to work and / or benefits as appropriate.

Outcome 7 - Personal dignity: To keep your personal dignity and be respected by others.

3.0 PHB eligibility

3.1 Who can have a PHB?

From 1 October 2014, all Eligible Persons acquired a 'right to have' a PHB including by way of a direct payment. Whilst the offer was initially only for CHC and CC, CCG's can at their discretion now offer this to a wider group of people who may benefit from a PHB. This is related to the NHS commitment and mandate to support individuals with long term conditions. This provision has been extended as part of the NHS England 'Moving Forward with Personal Health Budgets' development programme.

For South Sefton CCG this includes:

- People who are eligible for fully funded NHS continuing healthcare (adults), including people with a learning disability, mental health difficulties who have complex health needs and or challenging behaviour, and long term conditions (refer to 3.1.1)
- Families of children eligible for Continuing Care (refer to 3.1.2)
- Individuals who have a long term condition who may benefit from personal health budget who are not in receipt of NHS funded packages of care.

3.1.1 Adults who have learning disabilities and mental health with complex health needs or challenging behaviour, who are in receipt of a joint funding arrangement with Southport and Formby CCG and Sefton MBC, have the right to explore whether their needs can be met by utilising a personal budget. The personal budgets under joint funding arrangements for Southport and Formby CCG will be managed by Sefton MBC, this includes access to a direct payment. Adults with a learning disability and or mental health difficulty, who are in receipt of a joint funded package of care, and receiving a direct payment, will by nature already be in receipt of an integrated PHB.

3.1.2 Children Complex Care - In the case of children where continuing care is being received, the child and or family will have an, education, health and social care plan in place (EHC) or will be in the process of transferring over to an EHC. For children, personal health budgets can contribute to some or all of the social, health and educational elements of this plan. Within Southport and Formby CCG this will be provided by the SEND 'local offer', the joint funding arrangements will be managed via by Sefton Metropolitan Council (MBC) as a direct payment. Children across Southport and Formby CCG who are already in receipt of a direct payment, will by nature already be in receipt of an integrated PHB.

Individuals and their representatives already in receipt of CHC or CC may take up their right for a personal health budget at any time and CCGs must give due consideration to any request made. Individuals and families assessed as eligible for CHC or CC from October 2014 should be informed of their "right to have" their NHS care delivered in this way (see section 5.1 below).

In accordance with the overall drive towards greater patient choice and control, PHBs for patients other than those listed above, can still be considered and offered the benefit of a personalised care plans. In line with the NHS England 'Moving Forward with Personal Health Budget' development programme agenda this will form the basis of the CCG Local Offer which will be published on the CCG website from April 2016.

3.2 Exclusions for PHBs

If an individual comes within the scope of the "right to have" a PHB, then the expectation is that one will be provided. However, the NHS England guidance states:

"There may be some exceptional circumstances when a CCG considers a personal health budget to be an impracticable or inappropriate way of securing NHS care for an individual. This could be due to the specialised clinical care required or because a personal health budget would not represent value for money as any additional benefits to the individual would not outweigh the extra cost to the NHS."

Where a PHB by way of a direct payment is being considered, please also see exclusions listed at section 6.4.

3.3 PHBs for people in nursing or residential care home settings

The Government's intention is for all Eligible Persons to have the "right to have" a PHB where they would benefit from personalised care. Therefore, such Eligible Persons living in nursing or residential care who may benefit from receiving care via a PHB, ought to be offered this option. However, CCGs need to be satisfied that the use of a PHB in such settings is cost effective and is a sensible way to provide care to meet or improve the individual's agreed outcomes. PHBs should not generally be used to pay for care and support services being commissioned by the NHS that a person will continue to access in the same way whether they have a PHB or not. See section 6.10 for further detail relating to direct payments for those in nursing / residential care home settings.

4.0 Options for managing PHBs

The most appropriate way to manage a PHB should be discussed and agreed with the person, their representative or nominee as part of the care planning process. PHBs can now be received and managed in the following ways, or a combination of them:

a) Notional budget – where an individual is informed of the amount of funding available to them and decides how the budget is used (by input into the care plan) but the CCG continues to commission services, manage contracts and make purchases etc. Notional budgets could be an option for individuals who want more

choice and control over their healthcare but who do not feel able or willing to manage a budget.

b) Third party budget – A non NHS support service organisation, legally independent of both the individual and the NHS, holds the money for the individual and arranges and pays for all of the services on behalf of the individual in accordance with the care plan.

c) Direct payments: Can differ whether a person lacks or retains capacity :

i. Direct payments for people *with capacity* – where the individual receives the funding that is available to them and they purchase the services and support they want in accordance with the agreed care plan (with or without assistance). The individual can elect to receive and manage the payment themselves or decide for it to be received and managed by a person of their choosing (a nominee). If the individual chooses a nominee, that nominee becomes responsible for managing the funds and services and accounting for expenditure. Support from CCG recommended support services are available for all direct payment recipients.

ii. Direct payments for people who lack capacity – where the individual lacks capacity, an 'authorised representative' (agreed by the CCG – see 5.4 for further detail) receives the funding that is available to the individual as a direct payment. The authorised representative is responsible for managing the funds and services and accounting for expenditure. The 'authorised representative' must involve the individual as much as possible and all decision making must be in line with the individual's best interests, in accordance with s.4 Mental Capacity Act 2005. Support from a CCG recommended support services (a direct payment support service) are available for all direct payment recipients. In the case of children, direct payments can be received by their parents or those with parental responsibility for that child.

Further detail on Direct Payments is set out in Section 6 of this Policy.

5.0 How do PHBs work?

5.1 Informing people about PHBs

All policies relating to NHS Continuing Healthcare and Continuing Care continue to apply alongside the new law and guidance on PHBs. From April 2014, the named health professional will inform Eligible Persons of their right to request a PHB (including by way of direct payments) at the initial assessment, the 12 week review or annual review. From October 2014 the named health professional will inform Eligible Persons of their right to have a PHB (including by way of direct payments) at

the initial assessment, the 12 week review and or annual review. See exclusions in Section 3.2 and 6.4. The Personal Health Budget pathway is outlined in Appendix 1.

Health professionals will also seek to identify other patients who do not fall within the scope of the "right to have" but who may benefit from the provision of a PHB. PHBs are not restricted to Eligible Persons and CCGs will seek to offer PHBs on a voluntary basis to those patients with long term conditions for whom it would be appropriate. Where such patients are identified, the health professionals involved in their care will provide them with information about PHBs.

PHBs are entirely voluntary and there is no obligation for a patient to accept the offer. Patients and their families will need to be provided with the CCG PHB standard leaflet or where appropriate Easy Read leaflet.

The CCGs have made arrangements for non NHS support services for example: Salvere (a direct payment support service), SOLO Support Services and Your Life Your Way (third party budget support services) to provide information, advice and guidance to prospective and existing PHB recipients, and their families.
The list of non NHS support services above will be subject to change and extension subject CSU / CCG 3rd Party Assurance Process.

The services provided by these organisations will include:

- Information on how a PHB can be used and managed
- Guidance on producing a personalised care / support plan
- Advice and support to manage a PHB, including a direct payment
- Guidance on record keeping requirements
- Information about direct payments, including the responsibilities around financial monitoring that will need to be taken on by the recipient of the direct payments.

Patients and families who wish to consider and explore PHBs further will be offered a referral to a non NHS support service by the named health professional. This will require the named health professional to complete a PHB enquiry form, as well as a PHB care plan (a copy of which is at Appendix 2) which includes recording the clinical needs of the individual. This will begin the process of identifying risks so the care / support planning process can commence. Enquiries should be made to CMCSU.Care@nhs.net The lead health professional (see section 5.5) will be supported by the Commissioning Support Officers within the CCG and CSU to progress the request.

5.2 Budget Setting

Under the traditional model of CHC / CC, an assessment would be followed by the named health professional producing a care plan, i.e. a schedule prescribing episodes of care and defining specific tasks for the care worker. Under PHBs, after an assessment, a 12 week review and or an annual review an 'indicative budget' is

set. The indicative budget gives a financial envelope within which the PHB Care Plan is completed.

The CSU and CCGs are using a 'ready reckoner' approach to set the level of the PHB. This approach uses an existing care plan / package of support to calculate an *indicative budget.* Where there is no existing care plan or package of support already in place, the budget will be based on a standard hourly rate (see below). Whilst the 'ready reckoner' approach is based on existing services, it can be simpler to use, more transparent and easier to understand.

The PHB amount is therefore based on:

- 90% of the money that would otherwise be spent on meeting the fully funded NHS continuing healthcare needs or continuing care needs for Eligible Persons.
- If no package of care is in place an hourly rate of £13.50 will be used to set as a baseline amount of PHB for each hour of care the patient is assessed as needing.
- In the case of individuals with long term conditions, who are not in receipt of a health funded package of care. The CCG will need to work out the indicative budget in terms of the overall cost of NHS Services used, and determine which elements cannot be utilised e.g. regular routine hospital consultant appointments and which elements could form the basis of the indicative budget as part of the PHB, with the emphasis of reducing overall NHS expenditure.

Following a person being assessed / reviewed and identified or re-confirmed as an individual entitled to receive a PHB, the indicative budget will be agreed by CSU / CCG. See section 6 for additional information.

In principle, the amount of money that would have been spent on NHS Services as part of an individual's CHC, CC and or long term conditions could be available to use as a PHB. As much of this budget as possible should be included in a PHB. Where it is not possible to do so (for example, where money currently being used to commission services cannot be released immediately for use under a PHB), CCGs will work with the patient to tailor services as best as possible until this service can be provided under the PHB arrangement (where appropriate).

5.3 PHB care planning

Everyone who has a PHB will go through a care planning process, which leads to a person-centred Care Plan. Care planning for PHBs is fundamentally different from traditional care planning carried out for CHC / CC for children patients. Whereas a traditional care plan starts with the existing services, the starting point for a PHB Care Plan is the agreement of an indicative budget.

A PHB Care Plan is developed jointly by the individual, their family (if appropriate), a non NHS support services planner, and the individual's lead health professional. The process should be driven by the individual's choices and the Care Plan should clearly show how a PHB will be used to achieve the individual's identified health and care outcomes. This includes:

- the health needs of the individual and the desired outcomes;
- the amount of money available under the PHB;
- what the PHB will be used to purchase;
- how the PHB will be managed;
- who will be managing the budget;
- who will be providing each element of support;
- how the plan will meet the agreed outcomes and clinical needs;
- who is responsible for monitoring the health condition of the individual;
- who the individual should contact to discuss any changes in their needs;
- the anticipated date of the first review;
- how the individual has been involved in the production of the plan;
- how any training needs will be met;
- identifying any risks, consequences and mitigating actions;
- contingency planning.

Good care planning involves looking holistically at the individual's life to improve their health, safety, independence and wellbeing. The individual should be supported throughout the care planning process.

The NHS (Direct Payments) Regulations 2013 ("the regulations") and associated guidance set out what direct payments (using NHS money) can and cannot be used for, and how they should be administered. The CSU / CCGs will apply the regulations to all forms of PHB as far as possible, whether it is received/managed by way of direct payments or otherwise (as detailed at section 4). How a PHB will be used (however it is received / managed) must be set out in the PHB Care Plan. Please see section 6 of this Policy which is to be applied, as far as possible, to all PHBs.

Delay in arranging PHBs should be avoided. Where delay is unavoidable (for example, where circumstances make it difficult to plan for a person's ongoing care), the reasons for it must be made clear to the individual. Regular review should take place so that a person's PHB can be put in place as soon as practicably possible.

The CSU and CCGs will make sure that this delay does not cause a delay in hospital discharges or in ensuring an appropriate package of care is in place pending finalisation of the PHB arrangements. An interim care package may be offered to avoid such delay.

5.4 Representatives for children and people who lack capacity

A PHB arrangement for a person who lacks capacity will require the appointment of a 'representative' by the appropriate CCG. A representative is someone who agrees to act on behalf of someone who is otherwise eligible to receive a PHB but cannot do so because they do not have capacity to consent to receiving one (see Appendix 4) or because they are a child.

An appointed 'representative' could be anyone deemed suitable by the CCG, and who would accept the role. The representative can be:

- a friend, carer or family member;
- a deputy appointed by the Court of Protection;
- an attorney with health and welfare or finance decision-making powers created by a lasting power of attorney;
- someone appointed by the CCG.

In the case of adults who lack capacity, when choosing the 'representative' the CCG must adopt a decision making process in line with the requirements of the MCA and within the context of the individual's best interests as per the checklist at s.4 of the Act. This includes seeking the views of the individual, where possible, about who they would want to manage their PHB.

The decision making process for the appointment of the 'representative' must be documented and discussed as part of care planning process, and agreed by the CSU / CCG.

The representative will take on the responsibilities associated with the PHB. Where it is believed to be appropriate to provide a PHB by way of direct payments, the representative must be fully informed about, and consent to accepting, the responsibilities relating to the receipt and management of the direct payment on the individual's behalf (see section [6.8] below).

The involvement of the representative should be reviewed if the individual regains capacity and/or reaches the age of 16.

5.5 Lead Health Professional

A lead health professional will be named in an individual's Care Plan. This should be someone who has regular contact with the individual and their representative or nominee if they have one. It is likely that the lead health professional will be the most appropriate person to undertake this role. The Care Coordinator is responsible for:

- Managing the assessment of the health needs of the individual as part of the care plan;

- Ensuring that the individual, representative and CSU / CCG clinician have agreed the care plan;
- Undertaking or arranging for the monitoring and review of the care plan and health of the person;
- Liaising between the individual (or their representative or nominee) and the CCG as the primary point of contact.

5.6 Approval of Care Plan

PHB Care Plans are agreed in principle by the named health professional. However, all PHB Care Plans will also need to be signed off by the appropriate CSU & CCG panel (which will include a relevant CCG representative). This process includes reviewing, agreeing and signing off the Care Plan which includes a risk identification and management plan. A PHB checklist has been developed to ensure consistency and adherence to the law and guidance. A copy of this checklist is at Appendix 5 of this Policy.

The CSU / CCG clinician will not agree to any services named in the Care Plan if they believe that the potential health outcomes are outweighed by significant risks to the individual's health. However, the CCGs will not impose blanket prohibitions and will remain open to considering different approaches to achieving outcomes other than those traditionally used, considering the particular circumstances of the individual and balancing the risks and benefits accordingly.

If a service named in the Care Plan is not agreed, the CSU / CCG clinician will provide the individual, representative or nominee the reasons why this decision has been reached. The individual, their representative or nominee may ask the CSU / CCG clinician to reconsider their decision and provide additional evidence or information to inform that decision. The CSU / CCG clinician must reconsider their decision in a timely manner upon such a request being made. The CSU / CCG clinician will notify and explain the outcome in writing to the individual. See sections 6.7 & 6.8 for further detail on the process to be followed.

If a part of the Care Plan is refused, the CCG should make every effort to work in partnership with the individual, their representative or nominee to ensure their preferences are considered and taken into account.

5.7 PHB Agreement

When taking up a PHB, the patient, their representative and / or their nominee must sign a 'PHB agreement', which explains the responsibilities associated with the PHB and sets out the agreement that the PHB will be spent as set out in the Care Plan.

If the patient is receiving the PHB as a direct payment, the PHB agreement will confirm that the PHB will be spent in accordance with the NHS (Direct Payments) Regulations 2013. A copy of this Agreement is at Appendix 5 for an adult and Appendix 6 for children in this Policy.

5.8 Assistance to manage PHBs

The CCGs have arranged for non NHS support services e.g. Salvere, Your Life Your Way and SOLO Support Services to provide support to individuals in receipt of PHBs. It is envisaged that over time a wider range of organisations will become available to offer support and that this will be reflected in the choices available to PHB recipients, this will be subject to CSU / CCG 3rd Party Assurance Process. Salvere offers support services for those in receipt of direct payments. It can also support individuals in activities such as recruiting, employing staff and payroll. Further detail on these services can be found at section 6.12.

SOLO Support Services and Your Life Your Way offer services for those with third party budgets, including options where they become the employer and manage the PHB on an individual's behalf.

The costs associated with utilising a non NHS support service will be met from the PHB allocation. This requires the PHB to be paid directly to these organisations so that their charges can be deducted.

5.9 Monitoring and Review

Regular review is required in order to ensure that an individual's Care Plan continues to meet their needs.

In respect of continuing healthcare for adults, this review is carried out in line with the continuing healthcare national service framework, i.e. three months after patients become eligible for continuing healthcare and annually thereafter. Reviews will also confirm whether or not the patient remains eligible and in need continuing healthcare.

In respect of continuing care for children, the care package should be reviewed after three months and then at least every six months to ensure it continues to meet the child or young person's needs. Reviews will also confirm whether or not the child or young person still has continuing care needs.

Reviews may need to take place sooner or more frequently if the CCG or CSU become aware that:

- the health needs of the individual have changed significantly;
- the care plan is not being followed or expected health outcomes are not being met; or
- the individual, their representative or their nominee requests it.

It should be made clear under the Care Plan who the PHB holder should contact to discuss changes to their PHB should their needs change. In most cases, the Care Coordinator will be best placed to undertake this role.

5.10 Stopping or reclaiming PHBs

Arrangements under PHBs can be stopped and, where applicable, money can be reclaimed. The details of this are set out at section 6.16 and 6.17 but, to the extent possible, this applies to all types of PHB.

6.0 Direct Payments

The National Health Service (Direct Payments) Regulations 2013 set out how direct payments should be administered and on what they can be spent. The regulations are similar to the regulations and guidance for social care direct payments. PHB Guidance on the new direct payments for healthcare regulations was published in March 2014. Although the NHS (Direct Payments) Regulations 2013 apply to direct payment PHBs, as noted above the CCG has agreed to apply these regulations, as far as possible, to all forms of PHB to ensure transparency, fairness and best practice. References in this section to "direct payments" should therefore be treated as referring to all forms of PHB.

6.1 Who can receive a direct payment PHB?

- A direct payment PHB can be made to any Eligible Person, where they are:
- In receipt of any benefit that may or must be provided or arranged by a health body under the NHS Act 2006 or under any other enactment and;
- A person aged 16 or over, who has the capacity to consent to receiving a PHB by way of a direct payment and consents to receive one (please see Appendix 4 in relation to capacity);
- A child under 16 where they have a suitable representative who consents to a PHB by way of a direct payment;
- A person aged 16 or over who does not have the capacity to consent to receiving a PHB by way of a direct payment but has a suitable representative who consents to it.

and where:

- A direct payment PHB is appropriate for that individual with regard to any particular condition they may have and the impact of that condition on their life;
- A direct payment PHB represents value for money and, where applicable, any additional cost is outweighed by the benefits to the individual;
- The person is not subject to certain criminal justice orders for alcohol or drug misuse (see Section 6.4). However, such a person may be able to use another form of PHB to personalise their care

The CCG will only provide direct payments if it is satisfied that the person receiving the direct payments (which may be the patient, a nominee or representative) understands what is involved, and has given consent.

People aged 16 or over who have capacity, representatives of people aged 16 or over who lack capacity, and representatives of children can request that the direct payment is received and managed by a nominee (see Section 6).

Decisions about providing direct payments for healthcare should be based around need rather than being based around a particular medical condition or severity of condition.

Health professionals will also seek to identify other patients who do not fall within the scope of the "right to have" but who may benefit from the provision of a PHB. PHBs are not restricted to Eligible Persons and CCGs will seek to offer PHBs on a voluntary basis to those patients with long term conditions for whom it would be appropriate. Where such patients are identified, the health professionals involved in their care will provide them with information about PHBs.

6.2 Considerations when deciding whether to make a direct payment

The CCG will adhere to the requirements as detailed at Regulation 7 of the NHS (Direct Payments) Regulations 2013 when deciding whether to make a direct payment. In doing so the CCG will contact a range of people for information to help make the decision whether a direct payment may be suitable. From this range will be any health or social care professional involved in the provision of care/treatment to the individual e.g. a personal assistant, occupational therapist, community mental health nurse or social care team. The CCG will also consult:

- anyone identified by the individual as a person to be consulted for this purpose.
- If the individual is a person aged 16 or over but under the age of 18, a person with parental responsibility for the individual.
- The person primarily involved in the care for the individual
- Any other person who provides care for the patient
- Any Independent Mental Capacity Advocate (IMCA) or Independent Mental Health Advocate (IMHA) appointed for the individual

The CCG will consider whether the individual will be able to manage the direct payment (see section 6.3 below).

If the person is aged between 16 and 18, a parent or guardian with parental responsibility will be assessed, to look at whether they could manage a direct payment.

If the individual has a deputy appointed by the Court of Protection in relation to matters about which direct payments may be made, this will be considered and the CCG may consult the appointed person to help decide whether or not the person would want to receive direct payments.

In considering whether to provide direct payments, the CCG may ask the individual or their representative for information about:

- Their overall health;
- The details of their condition in respect of which they would receive direct payments;
- Any bank, building society, Post Office or other account into which direct payments would be paid; and
- Anything else which appears relevant.

6.3 Ability to manage direct payments

The CCG will consider whether an individual (whether the patient or their representative) is able to manage direct payments by:

- Considering whether they would be able to make choices about, and manage the services they wish to purchase;
- Whether they have been unable to manage either a heath care or social care direct payment in the past, and whether their circumstances have changed;
- Whether they are able to take reasonable steps to prevent fraudulent use of the direct payment or identify a safeguarding risk and if they understand what to do and how to report it if necessary; and
- Considering any other factor which the CCG may consider is relevant.

If the CCG is concerned that an individual is not able to manage a direct payment they must consider:

- The individual's understanding of direct payments, including the actions and responsibilities on their part.
- Whether the person understands the implications of receiving or not receiving direct payments.
- What kind of support the individual may need to manage a direct payment.
- What help is available to the individual.

Any decision that an individual is unable to manage a direct payment must be made on a case by case basis, taking into account the views of the individual, and the help they have available to them. The CCG will not make blanket assumptions that groups of people will or will not be capable of managing direct payments.

The CCG will inform the individual in writing if the decision has been made that they are not suitable for direct payments and whether an alternative method of receiving the PHB is considered to be suitable instead. See section 6.5 for further information.

6.4 Who cannot receive a direct payment?

There are some people to whom the duty to make direct payments does not apply . This includes those:

a) subject to a drug rehabilitation requirement, as defined by section 209 of the Criminal Justice Act 2003 (drug rehabilitation requirement), imposed by a community order within the meaning of section 177 (community orders) of that Act, or by a suspended sentence of imprisonment within the meaning of section 189 of that Act (suspended sentences of imprisonment)
b) subject to an alcohol treatment requirement as defined by section 212 of the Criminal Justice Act 2003 (alcohol treatment requirement), imposed by a community order, within the meaning of section 177 of that Act, or by a suspended sentence of imprisonment, within the meaning of section 189 of that Act
c) released on licence under Part 2 of the Criminal Justice Act 1991 (early release of prisoners), Chapter 6 of Part 12 of the Criminal Justice Act 2003 (release on licence) or Chapter 2 of the Crime (Sentences) Act 1997 (life sentences) subject to a non-standard licence condition requiring the offender to undertake offending behaviour work to address drug or alcohol related behaviour
d) required to submit to treatment for their drug or alcohol dependency by virtue of a community rehabilitation order within the meaning of section 41 of the Powers of Criminal Courts (Sentencing) Act 2000 (community rehabilitation orders) or a community punishment and rehabilitation order within the meaning of section 51 of that Act (community punishment and rehabilitation orders)
e) subject to a drug treatment and testing order imposed under section 52 of the Powers of Criminal Courts (Sentencing) Act 2000 (drug treatment and testing orders)
f) subject to a youth rehabilitation order imposed in accordance with paragraph 22 (drug treatment requirement) of Schedule 1 to the Criminal Justice and Immigration Act 2008 (“the 2008 Act”) which requires the person to submit to treatment pursuant to a drug treatment requirement
g) subject to a youth rehabilitation order imposed in accordance with paragraph 23 of Schedule 1 to the 2008 Act (drug testing requirement) which includes a drug testing requirement
h) subject to a youth rehabilitation order imposed in accordance with paragraph 24 of Schedule 1 to the 2008 Act (intoxicating substance treatment requirement) which requires the person to submit to treatment pursuant to an intoxicating substance treatment requirement
i) required to submit to treatment for their drug or alcohol dependency by virtue of a requirement of a probation order within the meaning of sections 228 to 230 of the Criminal Procedure (Scotland) Act 1995 (probation orders) or

subject to a drug treatment and testing order within the meaning of section 234B of that Act (drug treatment and testing order)

j) released on licence under section 22 (release on licence of persons serving determinate sentences) or section 26 of the Prisons (Scotland) Act 1989 release on licence of persons sentenced to imprisonment for life, etc.) 34 or under section 1 (release of short-term, long term and life prisoners) or section 1AA of the Prisoners and Criminal Proceedings (Scotland) Act 1993 (release of certain sexual offenders) and subject to a condition that they submit to treatment for their drug or alcohol dependency

k) If the individual is subject to certain criminal justice orders for alcohol or drug misuse, then they will not receive a direct payment. However, they might be able to use another form of PHB to personalise their care and alternatives should be considered.

6.5 Deciding not to offer a direct payment

In addition to section 6.4 above, a CCG may decide to refuse to make a direct payment if it believes it would be inappropriate to do so, for example:

- if there is significant doubt around an individual's or their representative's ability to manage a direct payment;
- if there is a high likelihood of a direct payment being abused;
- if the benefit to the particular individual of having a direct payment does not represent good value for money;
- if it considers that providing services in this way will not provide the same or improved outcomes.

Such a view may be formed from information gained from anyone known to be involved with the individual, including health professionals, social care professionals, the individual's family and close friends, and carers for the individual.

In all cases where a direct payment is refused, the Eligible Person and any nominee or representative will be informed in writing of the refusal and the grounds by which the request is declined. The individual or their representative may request a review of this decision, in which case, the process set out at section 6.7 will be followed.

If a direct payment is refused, other options to personalise the package of care for the individual will be explored and facilitated as much as is possible, and other forms of PHB, such as a notional budget or third party budget, should be considered.

6.6 Decision Making

Where there is a recommendation to accept or reject a request for a direct payment, the CCG will use a Panel to consider this recommendation. This Panel will consist of:

- Senior Nurse CCG (Chair)
- Senior Nurse CSU (Chair) under delegated responsibilities
- CSU Representatives individual commissioning nurse (CHC, CC, Mental Health, LD) – appropriate to individuals needs
- CCG GP representative
- Lead Health Professional
- Co-opted Members as appropriate this may include; medicines management, Sefton MBC representative (this list is not exhaustive)

The Panel will consult the appropriate Terms of Reference when making its decisions.

6.7 Request for review of a decision

Where the CSU / CCG decide that a direct payment would be inappropriate, the patient, their representative or nominee may require the CSU / CCG to reconsider the decision, submitting additional information to support the deliberation. The CSU / CCG must reconsider its decision in a timely manner upon such a request being made but is not required to undertake more than one re-consideration in any six month period following the initial decision.

The CCGs will use an Appeals Panel to make a decision regarding a request for reconsideration of a refusal to provide a direct payment. The membership and terms of reference of the Appeals Panel should be in accordance with the requirements of the relevant CCG. However, with regards to timeframe for the Appeals process, the Panel should seek to follow the recommended timescales set out under national guidance. Details of these timescales are set out at Appendix 9.

No member will have had previous involvement in the case.

The patient, representative or nominee must be informed in writing of the outcome of the review and the reasons for the decision. If the refusal is upheld, other options to personalise the package of care for the individual will be explored and facilitated as much as is possible, and other forms of PHB, such as a notional budget or third party budget, should be considered.

6.8 Representatives and direct payments

Information surrounding the appointment of Representatives is set out earlier in this Policy. When the use of direct payments is being considered, the CCG must be satisfied that a person agreeing to act as a representative understands what is involved, and has provided their informed consent, before going ahead and providing direct payments. They should be informed of the restrictions surrounding employment of a family member or person living in the same household to provide care (see section 7.1).

Full advice, support and information should be provided so that people contemplating taking on the role of representative know what to expect. In addition, the CCG must provide its consent to the representative acting in this role, having duly considered whether the person is competent and able to manage direct payments, either on their own or with whatever assistance is available to them.

A representative may identify a nominee to receive and manage direct payments on their behalf, subject to the nominee's agreement and the approval of the CCG (see section 6.9 below).

A representative must (unless they have appointed a nominee to do so):

- act on behalf of the person, e.g. to help develop a PHB Care Plan and to hold the direct payment
- act in the best interests of the individual when securing the provision of services
- be the principal person for all contracts and agreements, e.g. as an employer;
- use the PHB and direct payment in line with the agreed Care / Support Plan
- comply with any other requirement that would normally be undertaken by the individual (e.g. participating in a review, providing information)

When considering whether to make direct payments to representatives, the CCG will consider:

- Whether the person receiving care had, when they had capacity, expressed a wish to receive direct payments;
- Whether the person's beliefs or values would have influenced them to have consented or not consented to receiving a direct payment;
- Any other factors that the person would be likely to take into account in deciding whether to consent or not to receiving direct payments;
- As far as possible, the person's past and current wishes and feelings.

6.9 Nominees

If a person aged 16 or over has capacity, but does not wish (for whatever reason) to receive direct payments themselves, they may nominate someone else (a nominee) to receive them on their behalf.

A representative (for a person aged 16 or over who does not have capacity or for a child) may also choose to nominate someone (a nominee) to hold and manage the direct payment on their behalf.

Where a nominee is appointed, they become responsible for managing the PHB and direct payment on behalf of the individual or the appointed representative (for individuals without capacity). They must:

- act on behalf of the person, e.g. to help develop a PHB Care / Support plan(s) and to hold the direct payment
- act in the best interests of the individual when securing the provision of services
- be the principal person for all contracts and agreements, e.g. as an employer;
- use the PHB and direct payment in line with the agreed Care / Support Plan
- comply with any other requirement that would normally be undertaken by the individual (e.g. review, providing information)

It is important to note that the role of nominee for direct payments for healthcare is different from the role of nominee for direct payments for social care. For social care direct payments, a nominee does not have to take on all the responsibilities of someone receiving direct payments, but can simply carry out certain functions such as receiving or managing direct payments on behalf of the person receiving them. In direct payments for healthcare, however, the nominee is responsible for fulfilling all the responsibilities of someone receiving direct payments, as outlined above. Those receiving direct payments for healthcare and their nominees must be made fully aware of these responsibilities.

The CCG must be satisfied that a person agreeing to act as a nominee understands what is involved, and has provided their informed consent, before going ahead and providing direct payments. Full advice, support and information should be provided so that people contemplating taking on the role of nominee know what to expect. In addition, the CCG must provide its consent to the nominee acting in this role, having duly considered whether the person is competent and able to manage direct payments, either on their own or with whatever assistance is available to them.

Before the nominee receives the direct payment, the CCG must consent to the nomination. In reaching its decision, the CCG may:

- Consult with relevant people;
- Require information from the person for whom the direct payments will be made on the state of health or any health condition they have which is included in the services for which direct payments are being considered;
- Require the nominee to provide information relation to the account into which direct payments will be made.

If the proposed nominee is not a close family member of the person (see Appendix 8), living in the same household as the person, or a friend involved in the person's care, then the CSU / CCG will require the nominee to apply for an enhanced Disclosure and Barring Service (DBS) certificate (formerly a CRB check) with a check of the 'adults barred' list and consider the information before giving their consent. If a proposed nominee in respect of a patient aged 18 or over is barred, the CCG must not give their consent. This is because the Safeguarding Vulnerable

Groups Act 2006 prohibits a barred person from engaging in the activities of managing the person's cash or paying the person's bills.

If the proposed nominee is a close family member of the person, living in the same household as the person, or a friend involved in the person's care, the CCG cannot ask them to apply for a DBS certificate and has no legal power to request these checks.

The CCG must notify any person identified as a nominee where it has decided not to make a direct payment to them. The notification must be made in writing and state the reasons for the decision.

6.10 What can and cannot be bought with direct payments

The NHS direct payments regulations and associated guidance set out what direct payments (using NHS money) can and cannot be used for, and how they should be administered.

A direct payment can be spent on a range of services and equipment that will lead to health outcomes, but only if they have been agreed in the Care Plan (see Appendix 3). The person receiving the direct payment (whether it is the individual requiring support, their nominee or a representative) is responsible for ensuring that it is only used as specified in the care plan. If it is not, the direct payment may have to be stopped and the law allows for certain payments which have been mis-spent to be reclaimed. Please see section 6.17 below.

There are some restrictions on how PHBs can be used. These are not intended to reduce choice and control for individuals, but to ensure that PHBs are used for maximum benefit and to ensure they are administered consistently and fairly for everyone.

Direct payments cannot be used to pay for the following:

- alcohol
- tobacco
- gambling
- debt repayment (other than for a service specified in the support plan)
- core GP services
- planned surgical interventions
- pharmaceutical charges
- services provided through vaccination or immunisation programmes
- any service provided under the NHS health check or National Child Measurement Programme
- Urgent or emergency treatment services.

For the avoidance of doubt, as Southport and Formby CCG will apply the regulations to any form of PHB insofar as it is possible, the above restrictions will equally be applied to all forms of PHB insofar as it is possible.

In addition, pending the outcome of a further pilot scheme, caution should be had when considering the use of direct payments for those in nursing/residential care home settings.

Where a request for a direct payment for healthcare is made for a person living in a residential setting the CCG must be certain that providing care in this way adds value to the person's overall care. Generally, direct payments should not be used to pay for care and support services being commissioned by the NHS that a person will continue to access in the same way whether they have a PHB or not. In such instances, where no additional choice or flexibility has been achieved by giving someone a PHB, then allocating a direct payment only adds an additional financial step and layer of bureaucracy into the commissioning of the care. CCGs need to be clear that the use of a direct payment in such settings is cost effective and is a sensible way to provide care to meet or improve the individual's agreed outcomes.

Other types of PHB, for example notional budgets, can be used where direct payments are not a practical route and many people may find great benefit in planning their care using the personalised care planning process associated with developing a PHB.

6.11 Imposing conditions in connection with the making of direct payments

The following conditions may be imposed on the individual, their representative or nominee in connection with the making of direct payments:

- the recipient must not secure a service from a particular person; and/or
- the individual, their representative or their nominee must provide information that the CSU / CCG considers necessary (other than information already covered by other regulations in the NHS (Direct Payment) Regulations 2013.

Conditions should only be imposed in exceptional circumstances. The reasons for the imposed conditions should be documented clearly.

6.12 Assistance to manage a direct payment – Supported Managed Accounts

As outlined at section 5.1 above, the CCGs have arranged for non NHS support services to provide support to individuals in receipt of PHBs.

Where an individual chooses a direct payment there are extra responsibilities on the individual (or their appointed representative and / or nominee) to manage their care package. These are set out within the PHB Agreement – see Appendix 6.

It is essential that either the individual or their representative has the ability to consent to and manage both their direct payment and the dedicated bank account.

In certain circumstances, the option of a Supported Managed Account can be considered. These circumstances include:

- Where the individual or representative feels assistance is required;
- Where mental capacity indicates; or

For those in receipt of direct payments, the non NHS support services offer Supported Managed Accounts and can support individuals in activities such as recruiting, employing staff and payroll. This option for support is open to people with PHBs and direct payments. However, in circumstances where Supported Managed Accounts are being considered, it may be more appropriate to consider the use of a notional budget. The respective benefits of each option should be discussed with the individual, their representative or nominee.

The costs of the non NHS support service are met from the PHB allocation. This requires the PHB to be paid directly to the non NHS support service so that its charges can be deducted. In certain circumstances the non NHS support service may make direct health care payments to patients, their representative or their nominee. This can only be carried out with the agreement of the CSU / CCG.

Individuals, representatives and appointed nominees employing staff are strongly recommended to utilise the information, advice, guidance and payroll and HR facilities of the non NHS support services e.g. Salvere, Your Life Your Way or SOLO (or, as the range of organisations offering such services widens, an alternative agreed support service) to ensure the legal responsibilities of being an employer are satisfied. Should the individual, representative or nominee not wish to accept this recommendation the request for a direct payment may be refused because requirements of employment law will fall to the individual, their representative or their nominee as the employer. In such circumstances, the CCG would have to be satisfied that the individual, their representative or nominee are able to manage such responsibilities by other means.

6.13 Receiving a direct payment

Direct payments will be paid in advance on the 15th day of the month, and where this day falls on the weekend, it will be paid on the Friday before. Under no circumstances should individuals have to pay for care and be reimbursed.

With the exception of one-off direct payments (see below), direct payments must be paid into a separate bank account used specifically for the direct payment. The bank account must be in the name of the person receiving the care, or their nominee or representative.

When receiving direct payments, the account holder should keep a record of both the money received and where it is spent. They are responsible for keeping hold of statements and receipts for auditing.

6.14 One-off payments

A one-off payment is used to buy a single item or service, or a single payment for no more than five items or services, where the individual is not expected to receive another direct payment in the same financial year.

When someone is receiving a one-off direct payment, it can be paid into the individual's ordinary bank account (or that of a nominee or representative). Individuals will need to provide evidence that the direct payment was used as agreed in the Care Plan, for example, by producing receipts of items/services purchased.

6.15 Monitoring and review of direct payments

As a minimum, a clinical review of an individual's direct payments should be performed within three months of the first direct payment and then annually. Financial monitoring will take place quarterly. Financial reviews will be completed by the non NHS support service.

There must be a review if the CCG or CSU become aware that direct payments have not been sufficient to secure the services specified in the care plan. If someone wishes to purchase additional care privately, they may do so, as long as it is additional to their assessed needs and it is a separate episode of care, with clearly separate lines of accountability and governance. They may not top up the direct payment with their own money to purchase more expensive care than that agreed in the Care Plan.

Where concerns are raised regarding how the PHB is being spent, the non NHS support service will inform the CCG to alert them to any concerns, and the CHC / CC lead at the Commissioning Support Unit.

These considerations are in addition to those set out at section [5.9] above, which requires review of an individual's Care Plan to ensure it remains appropriate to meeting the individual's needs.

6.16 Stopping or reducing direct payments

There is an ongoing duty to ensure that direct payments are reviewed. The amount provided under direct payments may be increased or decreased at any time, provided the new amount is sufficient to cover the full cost of the individual's care plan. PHBs and direct payments are not a welfare benefit and do not represent an entitlement to a fixed amount of money. A surplus may indicate that the individual is not receiving the care they need or too much money has been allocated. It should be noted that a surplus is different to a contingency – it is permissible to include an amount for contingency in a PHB, for example, to cover employment costs such as redundancy. As part of the review process, the CSU / CCG should establish why the surplus has built up. Under these circumstances, a reduction in direct payment in

any given period cannot be more than the amount that would have been paid to them in the same period.

Before making a decision to stop or reduce a direct payment, wherever possible and appropriate, the CSU / CCG should consult with the person receiving it to enable any inadvertent errors or misunderstandings to be addressed, and enable any alternatives to be made.

Where direct payments have been reduced, the individual, their representative or nominee may request that this decision be reconsidered, and may provide evidence or relevant information to be considered as part of that deliberation. Where this happens, the individual, representative or nominee must be informed in writing of the outcome of the reconsideration and the reasons for this decision. The CSU / CCGs are not required to undertake more than one reconsideration of any such decision. If the individual remains unhappy about the reduction, they should be referred to the local NHS complaints procedure.

The CSU will stop making direct payments on behalf of the CCGs where:

- A person with capacity to consent, withdraws their consent to receiving direct payments;
- A person who has recovered the capacity to consent, does not consent to the direct payments continuing; or
- A representative withdraws their consent to receive direct payments, and no other representative has been appointed.

The CSU may stop direct payments if it is satisfied that it is appropriate to do so. For example where:

- the money is being spent inappropriately (e.g. to buy something which is not specified in the support plan);
- direct payments are no longer a suitable way of providing the person with care;
- a nominee withdraws their consent, and the person receiving care or their representative does not wish to receive the direct payment themselves;
- the CSU / CCG has reason to believe that a representative or nominee is no longer suitable to receive direct payments, and no other person has been appointed;
- where there has been theft, fraud or abuse of the direct payment; or
- if the patient's assessed needs are not being met or the person no longer requires care.

Where PHBs and direct payments are stopped, the CSU / CCG will give reasonable notice to the patient, their representative or nominee in writing, explaining the reasons behind the decision. There is no definition as to what constitutes "reasonable notice". It should be noted that, after a direct payment is stopped, all

rights and liabilities acquired or incurred as a result of the service purchased by direct payments will be transferred to the CCG. This should therefore be considered. However, in some cases, it may be necessary to stop the direct payment immediately, for example, if fraud or theft has occurred

6.17 Reclaiming a direct payment

The CSU can claim back PHBs and direct payments on behalf of the CCGs where:

- they have been used to purchase a service that was not agreed in the care plan;
- there has been theft or fraud; or
- the money has not been used (e.g. as a result of a change in the care plan or the individual's circumstances have changed) and has accumulated.

If a decision to reclaim payments is made, reasonable notice must be given to the individual, their representative or nominee, in writing, stating:

- the reasons for the decision;
- the amount to be repaid;
- the time in which the money must be repaid; and
- the name of the person responsible for making the repayment.

The individual, their representative or nominee may request that this decision be reconsidered and provide additional information to the CSU / CCG for reconsideration. Notification of the outcome of this reconsideration must be provided in writing and an explanation provided. The CSU / CCGs are not required to undertake more than one reconsideration of any such decision. If the individual remains unhappy about the reduction, they should be referred to the local NHS complaints procedure.

7.0 Using a direct payment to employ staff or buy services

7.1 Using a direct payment to employ staff

People may wish to use their direct payment to employ staff to provide them with care and support. In so doing, they will acquire responsibility as an employer and need to be aware of the legal responsibilities associated with this. This should not discourage people who would otherwise be willing and able to manage a direct payment. In order to ensure that people are appropriately informed and supported in meeting their duties as an employer, the CCGs have arranged for non NHS support services e.g. Salvere to provide information, advice and support. This includes support in relation to payroll, Human Resources and other employment related services. People should be made aware of the availability of this service, along with any others which may become available. Individuals, representatives and appointed nominees employing staff are strongly recommended to utilise the information, advice, guidance and payroll and HR facilities of non NHS support services (or an

alternative agreed support service as a wider range or organisations become available) to ensure the legal responsibilities of being an employer are satisfied.

The costs associated with utilising a non NHS support service are met from the PHB allocation. This requires the PHB to be paid directly to these organisations so that their charges can be deducted. This cost should be factored in when setting the budget.

7.2 Employing a family member or person living in the same household

A direct payment can only be used to pay an individual living in the same household, a close family member (as defined in Appendix 8) or a friend if the CCG is satisfied that to secure a service from that person is necessary in order to satisfactorily meet the individual's need; or to promote the welfare of a child for who direct payments are being made. It is anticipated that this will be permitted in very limited circumstances. The CCGs must make judgements on a case by case basis.

Any arrangement of this nature must be formally agreed by the CSU / CCG, and recorded in writing in both the care plan and the PHB agreement.

The suitability will be reviewed at least every three months, (following the existing pathways for complex, children's and adults). This process includes reviewing, agreeing and signing off the risk identification and mitigation tool.

This restriction is not intended to prevent individuals from using direct payments to employ a live-in personal assistant. The restriction applies where the relationship between the two people is primarily person rather than contractual (for example, if the people concerned would be living together in any case).

7.3 Safeguarding and employment

People may wish to use their direct payment to employ staff to provide them with care and support. When deciding whether or not to employ someone, patients and their families should follow best practice in relation to safeguarding, vetting and barring including satisfying themselves of a person's identity, their qualifications and professional registration if appropriate and taking up references.

The CSU and CCGs have made arrangements with non NHS support services to provide advice and accessible services in relation to the provision of DBS checks for individual employers.

Individuals cannot request DBS checks on other individuals. However, an individual or their nominee or representative may wish to ask the CCG or another Umbrella Organisation e.g. a non NHS support service, if it is possible to arrange for the prospective employee or contractor to apply for an enhanced DBS check with a check of the adult's (or children's if appropriate) barred lists when employing or

contracting with people who are not close family members or people living in the individual's household providing care to the individual but who are:

- regulated health care professionals – for example, nurses or physiotherapists
- people providing healthcare under the direction or supervision of a health care professional
- people providing personal care

Alternatively, if the individual can satisfy the DBS that they have a legitimate interest in knowing if that person is barred, the DBS may supply this information.

If the potential employee is barred they must not be used to supply services as they pose an ongoing risk to adults or children.

If the individual is contracting with a close family member or a person who is living in the individual's household or a friend it is not possible to undertake any DBS checks.

The DBS has recently launched the Update Service. This is a service that allows people to reuse their certificate for multiple roles. If a potential employee or contractor has subscribed to the Update Service and has a check of the appropriate level, the individual should ensure they see the person's original certificate and use the free online portal to check for up to date information on that certificate. If the certificate is not up to date the individual should ask the potential employee or contractor to apply for a new certificate.

7.4 Indemnity

Direct payments can be used to pay for a personal assistant (PA) to carry out certain personal care and health tasks that might otherwise be carried out by qualified healthcare professionals such as nurses, physiotherapists or occupational therapists. In such cases the healthcare professional and CSU / CCG will need to be satisfied that the task is suitable for delegation, specify this in the Care Plan and ensure that the PA is provided with the appropriate training and development, assessment of competence and have sufficient indemnity and insurance cover. More information on this can be found in the 'Personal assistants - delegation, training and accountability' document in the toolkit.

Indemnity is a complex area for individual employers, and one where sufficient support will need to be in place from the start to enable people to understand and be supported to meet any obligations they have.

Providers of some services may need to conform with prospective legislation which will implement the Finlay Scott Recommendations (June 2010) on indemnity cover and Article 4(2)(d) of Directive 2011/24/EC . NHS England will provide further guidance on what this covers in due course.

PAs employed via a direct payment do not need to comply with the legislation that will require them to have indemnity cover if practising unless they are a member of a regulated health profession (see Appendix 9), even if carrying out activities which might otherwise be performed by health professionals. Care co-ordinators, the CSU & CCGs will need to consider and discuss with the person, their nominee or representative, the potential risks associated with the clinical tasks being carried by the PAs on a case by case basis. This needs to form part of the risk assessment and care planning process and outcome recorded in the Care Plan.

The person buying services needs to be aware of whether the provider needs to comply with prospective legislation discussed above. If the provider does not need to comply people may, if they wish, buy services from providers who have limited or no indemnity or insurance cover. So long as the person buying the service is aware of the potential risks and implications, limited or no indemnity should not automatically be a bar to purchasing from a provider. This should be included in the discussion around risks when developing the Care Plan.

In the first instance, it will be the responsibility of the person buying the service to check the indemnity cover of the provider from which they are buying services. They must make enquiries to ascertain whether the provider has indemnity or insurance, and if so, whether it is proportionate to the risks involved, and otherwise appropriate.

If the person buying the service asks the CCG to undertake these checks on their behalf, the CCG must do so. Care co-ordinators and care planners should also ensure that people are aware that this is an option, and may wish to offer this as part of the risk assessment and care planning process.

Regardless of who carries out the initial check, the CCG will review this as part of the first review, to ensure the checks have been made and are appropriate.

7.5 Registration and regulated activities

If someone wishes to buy a service which is a regulated activity under the Health and Social Care Act 2008, they will need to inquire as to whether their preferred provider is registered with the Care Quality Commission (CQC). A direct payment cannot be used to purchase a regulated activity from a non-registered service provider.

If a person or related third party employs a care worker directly, without the involvement of an agency or employer, the employee does not need to register with CQC. A related third party means:

(a) an individual with parental responsibility for a child to whom personal care services are to be provided

(b) an individual with power of attorney or other lawful authority to make arrangements on behalf of the person to whom personal care services are to be provided

(c) a group or individuals mentioned in a) and b) making arrangements on behalf of one or more persons to whom personal care services are to be provided

(d) a trust established for the purpose of providing services to meet the health or social care needs of a named individual

This means that individual user trusts, set up to make arrangements for nursing care or personal care on behalf of someone, are exempt from the requirement to register with the CQC.

Also exempt are organisations that only help people find nurses or carers, such as employment agencies (sometimes known as introductory agencies), but who do not have any role in managing or directing the nursing or personal care that a nurse or carer provides.

If someone wishes to use a direct payment to purchase a service which is not a regulated activity, they may do so.

In some circumstances, the provider may also need to be a registered member of a professional body affiliated with the Council for Healthcare Regulatory Excellence. If the Care Plan specifies that a task or tasks require a registered professional to undertake it, only a professional who is thus registered may be employed to perform that task or tasks. See Appendix 8.

In the first instance it will be the responsibility of the person buying the service to check whether the provider they are purchasing from is appropriately registered. They can request the CCG investigate this, and if they ask, the CCG must do so. As with indemnity cover, the CCG must also review this as part of their assessment as to whether the direct payment is being effectively managed.

While some service providers, for example aroma therapists, are not statutorily required to be registered, there are professional associations with voluntary registers that practitioners can choose to join. Typically, such practitioners can only join these associations or registers if they meet the standards of education, training, conduct and performance required by the professional body. However, there is no legal requirement to join these registers, and practitioners can still offer unregulated services without being a member of any organisation. If a provider is not registered with an appropriate body this should not automatically be a bar to purchasing from that provider but this should be included in the discussion around risks when developing the Care Plan.

8.0 Service User Evaluation

It is vital that CCG's have systems and processes in place to review the effectiveness of PHB's to provide assurance that the individual support plans are; clinically safe, effective and meeting individual needs and outcomes. To facilitate evaluation the CCG are utilising the Patient Experience Outcome Tool (POET), which was developed by Lancaster University. POET is designed specifically for PHB budget holders and family carers to provide insight into the experiences of personal health budget holders and their families. POET also aims to shows the impact having control over the budget has on their lives.

All PHB budget holders will be provided with an opportunity and or supported to complete the POET on an annual basis as part of their annual review. The results will be collated and reported to the CCG on an annual basis, as part of ongoing cycle of evaluation. The process of POET will be carried out by the CCG Commissioning Support Unit on behalf of the CCG.

9.0 Equal Opportunities / Equalities Impact Assessment

An Equality Impact Assessment has been completed and approved by the Equality & Inclusion Panel on 4th November 2015 for this policy and procedure and it does not marginalise or discriminate minority groups.

10.0 Review Date

This policy and procedure will be reviewed in April 2016 and will be reviewed and updated at the request of Southport & Formby CCG or earlier in light of any changes to legislation or National Guidance.

11.0 Further Information

The NHS England website has a section dedicated to PHBs. This has information about national policy, the implementation toolkit, stories and other resources.

www.personalhealthbudgets.england.nhs.uk

The Peer Network, a user-led organisation for PHBs, has its own website: www.peoplehub.org.uk

12.0 Appendices

Appendix 1 - Personal Health Budgets Pathway

Appendix 2 - PHB Care Plan

Appendix 3 – Capacity and Consent

Appendix 4 – PHB Checklist

Appendix 5 – Personal Health Budget Agreement (Adult)

Appendix 6 – Personal Health Budget Agreement (Child)

Appendix 7 – Close Family Members

Appendix 8 – Regulatory Bodies

Appendix 9 – Timescales for Appealing Personal Health Budgets Decisions

Appendix 1

Personal Health Budgets Pathway

1.0 Introduction

1.1 This procedure details the steps required from the agreement of a Personal Health Budget (PHB) to promptly expediting the first payment to the relevant organisation/individual.

1.2 Non-compliance with this procedure could cause delays to the commencement date of the PHB funded package of care resulting in dissatisfaction from families and direct payment support services and non NHS support services e.g. Salvere, Your Life Your Way and Solo (or an alternative agreed support service as a wider range or organisations become available).

2.0 Process

2.1 The CCG appropriate panel will approve a PHB for an individual. This will include the financial value of the PHB, specified as an annualised amount.

2.2 From the date of the Panel and the agreement for a PHB, the relevant direct payment support services and third party budget agencies are required to invoice the relevant CCG via SBS. On receipt of an invoice it can take up to 30 calendar days for the invoice to be paid. The invoice must state the correct Broadcare reference number. The value of the invoice should equate to 3 months (i.e. one quarter) of the annualised budget.

2.3 To facilitate this process the CSU are to complete a 'Financial Commitment Form' for all PHBs. The form will include the following details as agreed by the Panel:

- Broadcare reference number
- Type of PHB (notional payment, direct payment or third party budget)
- Type of package (adult, children's, complex mental health etc)
- Organisation/Individual to whom PHB invoices are to be paid.
- PHB start date (this must be at least 30 days, after the panel date)
- End Date (if applicable)
- Review Date (this must be within 12 weeks if it is a direct payment)
- Annualised value
- Forecast charge in current financial year
- Percentage of PHB to be funded by Local Authority (if applicable)
- Details (including telephone number) of a named CSU contact / DN (named health professional) and locality team contact number
- Space for the form to be signed by a CCG authorised signatory. It is acknowledged that each CCG will have its own Scheme of Delegation and authorisation limits.

2.4 Upon completion the form is to be:

- Retained by the CSU to hold on the individual's file and for entry into Broadcare.
- Sent to the relevant direct payment support service / third party budget agency in order for them to promptly raise an invoice to the CCG.

Sent to the relevant CCG so they can anticipate and approve the invoice from the third party agency, as well as incorporate the information into financial forecasts. If the invoice is consistent with the amount as specified in paragraph 2.2 then the CCG must not delay approving the payment on SBS. If there is a discrepancy the CCG is to contact the CSU to understand the reasons for this. If the issue is still unresolved then the CSU should query the invoice with the third party agency.

2.5 If the non NHS support service has not received payment by the agreed date then it should escalate the issue to the named contact on the Financial Commitment Form.

Appendix 2

Personal Health Budget Care & Support Plan for Southport and Formby CCG

Tables 1, 2 & 3 to be completed by NHS staff before submitting to the PHB Support Service, Table 3 must be signed by the patient or their representative. The Support Service and Patient complete the remainder of the Tables

Table 1 - To be completed by the NHS Named Health Professional (NHS)

Patients Name	Title	D.O.B (DD/MM/YYYY)
Address		Postcode
Home Telephone	Mobile	E-mail
Named Health Professional Name: Tel: E-mai	Request submitted to the following Support Service:	Indicative Budget amount: Annual £ Weekly £ Number of hours per week:

Table 2 - To be completed by the NHS Named Health Professional (NHS)

Patients Health Needs	Activities / Provisions	How the activities / provisions will meet my health and wellbeing needs
To be completed by the NHS Named Health Professional (NHS)	To be completed by the Support Service & Family	To be completed by the Support Service & Family
Add / delete rows as required		

Table 3 - To be completed by the NHS Named Health Professional (NHS) and patient

Declaration	
Please sign this document to show you give your consent (on the date of signing) that the details within this plan can be shared with the Support Service of your choice	
Signature of Patient	Date
Please provide the name of the chosen Support Service who will support you to develop a plan and a financial budget showing how you intend to meet your health and wellbeing needs	Name of chosen Support Service
If patient/ client is unable to sign, an appropriate adult representative with decision making responsibility OR consent from the patient / client should complete the fields below. This signature confirms that you give your consent to this document being shared with your chosen Support Service	
Name:	Relationship to patient:
Signature	Date

Table 4 - To be completed by the Support Service & Family

Significant People in your life In this section please include family and friends, health professionals, care agencies, carers, colleagues, neighbours and any others who play an important part of your life, even if they are not directly involved in your health care			
Name	Are they registered with CQC (Yes / No or N/A)	Contact Details	Do they help you make decisions?

Table 5 - To be completed by the Support Service & Family

Risk Assessment In this section please include any required risk assessments			
Type of risk assessment	Completed Yes / No / N/A	Proposed Risk Mitigation	Action taken / Agreed by Patient
Equipment (e.g. medical devices, consumables, therapy equipment etc.)			
Moving & Handling			
Environment			
Drug Management including covert medication policy if applicable			
Fire			
Managing Behaviour (Personal Intervention Plan)			
Nutritional (e.g. Malnutrition Universal Screening Tool)			
Pressure Area			
Others (add rows if applicable)			

Table 6 - To be completed by the Support Service & Family

Risks PAs do not need to comply with the legislation that will require them to have indemnity cover, unless they are a member of a regulated health profession, even if carrying out activities which might otherwise be performed by health professionals. The Support Service will need to consider and discuss with the person, their nominee or representative, the potential risks associated with the clinical tasks being carried out by the PAs on a case by case basis. This needs to form part of the risk assessment and care planning process and the outcome recorded in the care plan			
Identified Clinical Risk	Impact on Health & Wellbeing	Proposed / Advised Mitigation Action	Action Taken / Agreed by Patient
Identified Financial Risk	Impact on Health & Wellbeing	Proposed / Advised Mitigation Action	Action Taken / Agreed by Patient
Other Identified Risk	Impact on Health & Wellbeing	Proposed / Advised Mitigation Action	Action Taken / Agreed by Patient

Table 7 - To be completed by the Support Service & Family

Support to Manage Personal Health Budget	How will this be managed and by who
Support for sourcing package of care for either agency or PA's	
Recruitment support - Tax, NI, Pension, Employment Rights / Law, Min Wage etc.	
DBS Checks (formerly CRB) and barred lists have been checked for all staff including nominees, representatives and family members (if applicable)	
Appropriate training and accountability measures including assessment of competencies are in place	
Insurance cover in place (employers and public liability etc.)	
Contracted Health professional(s) are registered with the appropriate body and have appropriate indemnity cover	
Identity, qualifications and professional registration checks for employees and the taking up of references has been explored and an approach to manage this agreed and recorded	
Management of the personal health budget	

Payment to staff i.e. Payroll (dependent on type of budget taken)	
Preparation and submission of financial monitoring information	
If any regulated activities are provided by agencies they must be registered with CQC	

Table 8 - To be completed by the Support Service & Family

Finally, your support plan must demonstrate how you have thought about and addressed any unforeseen or difficult times. To be completed by the Support Service & Family
What happens if something unforeseen happens? Please detail below
Add / delete rows as required

Table 9 - To be completed by the Support Service with the patient

Budget – How the Personal Health Budget will be spent		
Area:	Weekly Cost £	Yearly Total £
Staff: including NI, Pension, holiday pay, holiday cover		
Staff hours for shadow training		
DBS checks		
Redundancy		
Agency Fees		
Respite Costs		
Recruitment & Advertising		
Equipment		
Consumables – PPE; Printing		
Training: including clinical competencies / supervisions		
Transport		
Insurance		
Contingency costs; additional training for the new staff; emergency agency fees		

Support Service Charge		
List others costs as applicable		
Total		

Table 10 - To be completed by the Support Service with the patient

Declaration	
Please sign this document to show you agree (on the date of signing) that the details within this plan meet your Health and Wellbeing needs and that in your opinion you have been sufficiently involved in the putting together of your support plan. That you give your consent for the support planner to share this completed plan with appropriate persons involved in the PHB provision.	
Signature of Patient	**Date**
Name of Organisation Support Planning	
If patient / client is unable to sign, an appropriate adult representative with decision making responsibility OR consent from the patient /client should complete the fields below. That you give your consent for the support planner to share this completed plan	

with appropriate persons involved in the PHB provision.	
Name	**Relationship to patient**
Signature	**Date**

Appendix 3 Capacity & Consent

PHB arrangements can only be made where appropriate consent has been given by:

- a person aged 16 or over who has the capacity to consent to the making of direct payments to them;
- the suitable representative of a person aged 16 or over who lacks capacity to consent themselves to receipt of a PHB by way of a direct payment;
- the suitable representative of a child under 16.

Capacity

Under the MCA, there is a presumption that everyone over the age of 16 has capacity to make decision for themselves, unless they are assessed as lacking capacity.

When assessing a person's capacity to make a decision, the assessor should follow the two stage test set out under the MCA which asks:

1. Does the person have an impairment of the mind or brain, or is there some disturbance in the functioning of their mind or brain?

2. If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made? Are they able to:
    a. A Understand the issues relevant to the decision
    b. Retain the information relevant to the decision
    c. Weight up to the pros and cons of the decision
    d. Communicate their decision having done so

Capacity is time and issue specific. For example, a person may be able to make a decision about who they would like to support them, but not about how to manage a PHB. PHBs should remain an option for all eligible patients regardless of whether they are deemed to have capacity or not.

There are a number of important decision-making points in setting up and managing PHBs. Where a person lacks the capacity to make a particular decision, their views must still be sought to the extent possible.

Wherever possible a person should be supported to be as involved as possible in all aspects of their PHB including the support planning process. To enable a person to understand their options and to help them feel at ease, those supporting them in their decision making need to think about:

- using the person's preferred methods of communication
- a suitable location
- the persons' privacy and dignity
- letting the person make the decision at their own pace

The Best Interests Principle

Under the MCA, anyone making decisions or acting on behalf of someone who lacks capacity has a duty to act in that person's best interests. Therefore, people who lack the capacity to consent to and manage PHBs can still receive one, including by way of a direct payment, if this is believed to be in their best interests (in accordance with the MCA).

Section 4 of the Mental Capacity Act sets out a checklist of factors that must always be considered by anyone who needs to decide what is in the best interests of a person who lacks capacity in any particular situation. This checklist includes a duty to:

- encourage the person to participate or improve their ability to take part in making the decision
- identify all the relevant circumstances
- consider the person's views (past and present)
- avoid discrimination - not simply make assumptions about someone's 'best interests' on the basis of their age, appearance, condition or behaviour
- assess whether the person might regain capacity and whether the decision can wait until that time
- if the decision concerns life-sustaining treatment the decision maker should not be motivated in any way by a desire to bring about the person's death
- consult those close to the patient for their views about the person's 'best interests'
- avoid restricting the person's rights by seeing if there are other options that may be less restrictive of the person's rights
- weigh up all of the above factors in order to determine best interests

This is not an exhaustive list of factors and the decision maker is under a duty to take into account "all relevant circumstances".

Decisions about the treatment and care of a patient who lacks capacity should follow the same best interests framework as outlined above.

Fluctuating Capacity

Where a person who has agreed to a care plan and consented to the making of direct payments to them subsequently loses their capacity to consent, the CCG may, where it is satisfied that the loss of capacity is temporary, allow a representative to be appointed to receive direct payments on their behalf, or an existing nominee to continue to receive them, until they regain capacity. In these circumstances, the role will be similar to that of a representative for someone who has been assessed to lack capacity on an ongoing basis.
Where someone's capacity to consent fluctuates, for example where a person's mental illness is such that it impairs their capacity to make decisions at certain times but not others, it is important that there should be continuity of care, and any disruption should be as minimal as possible. It may be helpful to work with people with fluctuating conditions to draw up advance decisions under the MCA and contingency plans to ensure that their care in a crisis, better meets their wishes, including the identification of a nominee or representative who may take control of the direct payment at such times.

When a person with fluctuating capacity gains or regains their capacity to consent, their consent is needed to continue the direct payments. If they consent, the representative or nominee must agree to continue their role in respect of the direct payment until a review is held. This is because it is the representative, not the person who has gained or regained capacity who, consented to the arrangements. This allows direct payments to continue until the CCG can arrange a review, which it must do as soon as is reasonably possible. At this review, the CCG and the person receiving care will review and if necessary develop a new care plan. However, if the person who has gained or regained capacity, does not consent to the representative or their nominee continuing in that role until a review is held, or if the representative or nominee does not wish to continue in that role, then direct payments must stop. As in all circumstances when direct payments stop, alternative provision should be made to ensure continuity of care until the required review takes place and new arrangements, which may include direct payments, are put in place.

Appendix 4

PHB Care Plan Sign Off Sheet – Right to Have

To Be Completed by the Direct Payment / Third Party Support Service

Patient Details

About Whom?	Surname: …… First Name(s): …… Broadcare Number: …….. Responsible CCG: ……

Care Plan Checklist

Named Care Coordinator	Named care coordinator is recorded in the care plan	**Yes / No**	**N/A Please add explanatory text**
Review	Anticipated date of the first review (at least within three months of the person receiving a direct healthcare payment)	**DD/MM/YYYY**	
Risk Assessments Completed	Risk assessments included within the care plan and agreed as appropriate	**Yes / No**	**N/A**
Clinical risks recorded	Clinical risks recorded in the care plan including risk mitigation	**Yes / No**	**N/A**
Regulated activities must be carried out by CQC registered providers	Are or will any 'regulated activities' be commissioned from a provider?	**Yes / No**	**N/A**
Care Agencies	Is the provider CQC registered?	**Yes / No**	**N/A**
Meeting Health Needs	Does the Care Plan set out the health needs that the direct healthcare payment is to address?	**Yes / No**	**N/A**
	Is it clear to both CSU/CCG and the people involved what the direct healthcare payments are meant to achieve?	**Yes / No**	**N/A**
	Does the plan specify the services to be secured by the	**Yes / No**	**N/A**

	direct healthcare payment in order to achieve the health (and wellbeing) needs?		
	Is the budget sufficient to meet all of the above?	**Yes / No**	**N/A**
	Are the identified clinical tasks suitable for delegation, specified in the care plan, with appropriate training, development and assessment of competence in place and sufficient indemnity and insurance cover?	**Yes / No**	**N/A**
	Safeguarding has been considered by CSU/CCG?	**Yes / No**	**N/A**
	Is the liberty of the patient being promoted by the care plan? This is especially important where the patient lacks capacity, and or when there are safeguarding issues and /or the patient is in a vulnerable situation.	**Yes / No**	**N/A**
Provision of Information / Advice & Guidance	Has the person, their representative or nominee received information, advice and support from YLYW, SOLO Support Services or Salvere?	**Yes / No**	**N/A**
Are you satisfied that sufficient support has and will be provided to ensure:	The development and agreement from CSU / CCG of an appropriate care plan?	**Yes / No**	**N/A**
	Payroll, Tax and NI are managed effectively	**Yes / No**	**N/A**
	The direct healthcare payment will be managed appropriately?	**Yes / No**	**N/A**
	Monitoring, audit responsibilities and accountabilities are understood and can be adhered to?	**Yes / No**	**N/A**
	The employment of PAs & understanding of employer responsibilities is fully understood and will be adhered to?	**Yes / No**	**N/A**
	Regulated activities, will and are	**Yes / No**	**N/A**

	only commissioned from CQC registered providers?		
	Appropriate insurances are, and remain, in place for the employer?	**Yes / No**	**N/A**
	Appropriate registration is in place?	**Yes / No**	**N/A**
	Appropriate training & development, assessment of competence, sufficient indemnity and insurance cover is, and remains, in place for employed PAs and providers?	**Yes / No**	**N/A**
	The costs for this and ongoing support from YLYW / SOLO Support Services / Salvere are set out within the care plan?	**Yes / No**	**N/A**
	There are sufficient funds to meet the support service costs and meet all of the health needs safely?	**Yes / No**	**N/A**
	Family members, close relatives and people living in the same home as the patient or their partners will not be employed unless agreed by the CSU / CCG? **(If the CCG is considering such a request please complete appendix 1)**	**Yes / No**	**N/A**
Consent & Capacity	Does the patient or Person with Parental responsibility for a child 16 or under - have capacity to consent to a PHB / direct payment	**Yes / No**	**N/A**
	Has the patient / Person with Parental responsibility for a child 16 or under - consented to a PHB / direct payment **(if no Representatives and Nominees section below must be completed - see below)**	**Yes / No**	**N/A**
Representatives and Nominees	Any representative and / or nominee must be agreed by the CCG / CSU. Does the CCG approve the named representative and / or nominee **(When considering such a request please complete**	**Yes / No**	**N/A**

	appendix 2)		
PHB Start Date	The intended commencement date of the PHB:	**DD/MM/YYYY**	

Appendix 1
Employing family members, close relatives and/or people living in the same household as the patient or their partners
If family members, close relatives and/or people living in the same household as the patient or their partners will be employed using a direct healthcare payment the CCG / CSU must record this here. The CCG / CSU will need to confirm that this is necessary in order to satisfactorily meet the person receiving care's need for that service; or to promote the welfare of a child for whom direct healthcare payments are being made. **Name / Relationship** **……** Has the CCG / CSU agreed to any family members, close relatives, people living in the same household or their partners being employed? **Yes / No / N/A** Please include details below, the name of the person(s), relationship, what has been agreed and the reason for this, including the time period and review timeframe for this decision.

Appendix 2	
Capacity Does the patient have capacity?	**Yes / No**
Consent Has the patient (16+) consented to a PHB and / or direct healthcare payment or Have the child's (under 16) parent(s) / those with parental responsibility consented to a PHB and / or direct health care payment	**Yes / No** **Yes / No**
Has the Patient consented to receiving a PHB / direct healthcare payment and fulfilling all of the responsibilities of someone receiving a PHB / direct healthcare payment?	**Yes / No**

Representatives	**If No is used Representative do not complete**
For patients (16+) unable to consent to a PHB / direct healthcare payment a Representative can be appointed. For children (under 16) a parent or those with parental responsibility for the child must be appointed as a Representative.	
The CCG / CSU must ensure that the Representative has consented to	

receiving a direct healthcare payment and fulfilling all of the responsibilities of someone receiving direct healthcare payments.	
Name of agreed Representative:	
Has the Representative consented to receiving a direct healthcare payment and fulfilling all of the responsibilities of someone receiving a direct healthcare payment?	**Yes / No**
The CCG / CSU must give consent and consider whether the person is competent and able to manage direct healthcare payments.	
Does the CCG / CSU consent to the Representative? Does the CCG / CSU consider the representative is competent and able to manage direct healthcare payments?	**Yes / No** **Yes / No**
Has the Representative applied for an Enhanced DBS check? Parents or those with Parental responsibility for a child (under 16) do not ordinarily need to apply, neither do family members living in the same household	**Yes / No / N/A**
Has the Representative been checked against the Adults' / Children's Barred List? Parents or those with Parental responsibility for a child (under 16) do not ordinarily need to apply, neither do family members living in the same household	**Yes / No / N/A**
Are the results of both of these checks satisfactory?	**Yes / No / N/A**

Employing Relatives	
Will the Representative be paid or employed in any capacity using the direct healthcare payments?	**Yes / No**
Will / is the Representative paid or employed in any capacity by the PHB support service e.g. YLYW / SOLO Support Services or Salvere?	**Yes / No**
Will any partner, relative, friend or person living in the same household as the patient / their Representative be paid or employed in any capacity using the direct healthcare payment?	**Yes / No**

If the CCG / CSU cannot approve the proposed Representative or wishes to attach conditions to the PHB the reason / conditions must be recorded here:

Nominees	
Is a nominee being requested?	**Yes / No**
If yes please complete the remainder of this section	
A Representative or a person with capacity (16+) can choose a Nominee.	
Has the Nominee consented to receiving a PHB / direct healthcare payment and fulfilling all of the responsibilities of someone receiving a PHB / direct healthcare payment?	
Has the Nominee applied for an Enhanced DBS check?	**Yes / No**
Has the Nominee been checked against the adults'/children's barred list?	**Yes / No**
Are the results both of these checks satisfactory?	**Yes/No /N/A**
Will the Nominee be paid or employed in any capacity using the direct healthcare payments?	**Yes / No**
Will / is the Nominee paid or employed in any capacity by the PHB support service e.g. SOLO Support Services or Salvere?	**Yes / No**
Will any partner, relative, friend or person living in the same household as the patient / their nominee be paid or employed in any capacity using the direct healthcare payment?	**Yes / No**
Does the CCG / CSU consent to the Nominee?	**Yes / No**
Name of agreed Nominee	

If the CCG / CSU cannot approve the proposed Nominee or wishes to attach conditions to the PHB the reason / conditions must be recorded here:

Appendix 5

PERSONAL HEALTH BUDGET AGREEMENT (ADULT)

This document tells you about having a Personal Health Budget

1. Information about You and Community Services

This agreement is between:

[Enter name of relevant CCG here] Clinical Commissioning Group

_____

(Referred to in this agreement as ‘we’ or ‘us’)

and

Name and address of person receiving the Personal Health Budget

PLEASE PRINT:

First Name(s) _____

Surname _____

Address _____

_____

Post Code _____

(Referred to in this agreement as ‘you’)

In certain circumstances, including where you are under 16 or are unable to consent to your direct healthcare payment, someone else may legally consent to and manage your direct healthcare payments on your behalf. That person is called a ‘representative’. Your representative will sign and agree to the terms of this agreement, and any other obligations on them under the regulations.

Your representative, if applicable and agreed by us is:

Name and address of Representative* or chosen decision maker

PLEASE PRINT:

First Name(s) ___ _____

Surname _____ _____

Relationship to ‘you' _____

Address _____

_____

Post Code _____

*Referred to in this agreement as 'Representative' who has been appointed to arrange the services and manage the direct healthcare payment on behalf of the Patient who lacks capacity, and who has been agreed by 'Us'.

And, if applicable you or your representative is entitled to appoint a nominee to take on the contractual responsibilities including arranging the services and support detailed in your support plan, the nominee will also become responsible for how the money is spent. Where we agree to it your nominee will sign and agree to comply with the terms of this agreement and any other obligations on them under the regulations.

Name and address of Nominee

PLEASE PRINT:

First Name _____

Surname _____

Address _____

_____

_____

Post Code _____

(Referred to in this agreement as 'Nominee')

2. Basis of the Agreement

This agreement is made on the basis that:

- An assessment of your health needs has been completed with a health professional and it has been identified that you are eligible to receive health care funding.

- Your care plan will identify the care and / or support that you need to meet your assessed health care outcomes in order to maintain your independence.

- You are willing and able to secure the care / support detailed in your care plan yourself or with support**,** (from a Representative or Nominee) and we agree to make your Personal Health Budget available to you to purchase the support and / or care that you need.

Any payment made under this agreement will be subject to regular audit and monitoring by Salvere, Your Life Your Way or SOLO Support Services and us which may be reviewed by the Personal Health Budget Programme Board.

Further information about Your Life Your Way, SOLO Support Services and Salvere can be found at Appendix A.

3. Responsibilities of Your Nominated Representative (If you have one)

As part of the Clinical Commissioning Group agreeing to someone acting as your Representative, that person must be prepared to accept the following responsibilities:

- To involve you in decisions about your support
- To represent your best interests
- To consent to receiving and managing the direct healthcare payment, and
- Fulfilling all of the responsibilities of someone receiving direct healthcare payments

Even if you need a Representative you still have the right to be involved whenever possible. There is a duty placed on the Representative to involve you in all relevant decisions where possible.

If the Representative repeatedly fails to make decisions that reflect these key responsibilities, then their role as a Representative would need to be reconsidered.

Representatives are appointed only with the CCGs approval. Representatives can be appointed for individuals who do not have the capacity to consent to a direct healthcare payment or for a child under 16 when Representatives can include the parents of the child or those with parental responsibility for that child.

If you gain or regain capacity your consent is required to continue your direct healthcare payment.

Where an individual in receipt of a direct healthcare payment subsequently loses their capacity to consent, and the CCG is satisfied this is temporary, the CCG may allow a Representative to be appointed to manage the direct healthcare payments or allow a Nominee to continue to manage them until a review can be arranged.

4. Responsibilities of Your Nominee (If you or your Nominated Representative have one)

As part of the Clinical Commissioning Group agreeing to someone acting as your Nominee, that person must be prepared to accept the following responsibilities:

- To involve you in decisions about your support
- To represent your best interests
- To consent to receiving and managing the direct healthcare payment, and
- Fulfilling all of the responsibilities of someone receiving direct healthcare payments

Nominees must agree to act in the capacity of your Nominee and provide informed consent; the CCG must also consent to that Nominee acting in this capacity, and consider whether the Nominee is competent and able to manage direct healthcare payments with or without assistance.

You or your Representative may choose to elect a Nominee where you / your Representative wish to delegate all of the responsibilities of managing and receiving a direct healthcare payment.

5. About your Personal Health Budget

The amount of money you will receive

Start Date: _____
(Proposed) Breakdown of Payments:
Weekly (if applicable) £_____
One Off Value (if applicable) £ _____

The frequency of your payments will be discussed with you. However, payments are usually made to Solo Support Services / Salvere in advance on a three monthly basis and will be reviewed within the first 12 weeks and then annually, unless your health care needs change.

How you will receive your money

There are three main ways that you can receive your personal health budget:

1. A direct payment with support from Salvere
2. A cash budget held and managed by Your Life Your Way or SOLO Support Services
3. A 'Notional' budget

You will have all the options explained to you before you decide which is the best option for you. When you have decided which way you would like to receive your budget please mark your choice with an 'X' in the box.

√	**A Direct Healthcare Payment**

A direct healthcare payment is where we pay money to you. The money will be paid into a bank account set up for this purpose by Salvere.

- Your Personal Health Budget will be paid into a bank account, which will be opened by Salvere in your name / your Representative's name / your Nominee's name and managed by you or your nominated representative or nominee.

- You will need to sign this agreement

- You will need to sign an agreement with Salvere, this sets out the services they will provide to you, your Representative / Nominee and the charges they will deduct from your direct healthcare payment for these services. Salvere will advise you about this.

- You, your Representative or Nominee must take advice on becoming an employer from Salvere, as any employment, insurance, pension and tax issues will be the responsibility of the employer. You will be required to adhere to all aspects of employment law.

- You will be required to provide evidence of how you have spent the money for audit purposes. You will need to keep a record of your income and expenditure including receipts, invoices, timesheets, payslips and bank statements. Salvere can help you to manage this

- The bank account will be audited by Salvere and us and therefore it is important that you / Salvere submit all receipts and invoices for related expenditure.

- Salvere may make direct healthcare payments directly to you / your Representative or Nominee however the CCG will need to approve this.

- See Section 6. Employing your own Staff

√	**A 'cash budget' (third party arrangement) held and managed by SOLO / Your Life Your Way**

A cash budget is where the Clinical Commissioning Group pays your allocated budget to an organisation called either Your Life Your Way or SOLO Support Services, who hold the money for you and help you decide what you need. After you have agreed this with us, Your Life Your Way or SOLO Support Services will then buy and pay for the care and support you have chosen. Please note – Your Life Your Way or SOLO Support Services will employ your Personal Assistants if you choose to have a cash budget.

- The account is held and managed by Your Life Your Way or SOLO Support Services on your behalf

- Your Life Your Way or SOLO Support Services will buy the care and support you have chosen and take on the employment responsibilities

- You / your Representative / Nominee will need to sign an agreement with Your Life Your Way or SOLO Support Services; this sets out the services they will provide to you and the charges they will deduct from your Personal Health Budget for these services. Your Life Your Way or SOLO Support Services will advise you about this.

- You can request the balance of your bank account during working hours, Monday-Friday

- The bank account will be audited by Your Life Your Way or SOLO Support Services and us and therefore it is important that you / Your Life Your Way or SOLO Support Services submit all receipts and invoices for related expenditure.

√	**A Notional budget**

A Notional Budget enables you to be involved in planning your own care. The Clinical Commissioning Group will pay your service provider directly for any services that you have been assessed as needing. Please note - you cannot employ your own Personal Assistants if you choose to have a notional budget.

- The Clinical Commissioning Group will purchase and arrange the care and support from the provider(s) you have chosen

- The Clinical Commissioning Group will fund the care and support directly

- You will be involved in planning your care and support including developing your care plan

6. General Rules about How to Use the Money

Your Personal Health Budget enables you to buy the care, support or service that is detailed and agreed in your care plan.

The money cannot be spent on illegal services or activities, alcohol, tobacco, gambling or debt repayment.

You cannot use your Personal Health Budget to pay for primary or general medical services, for example GP services, vaccinations, dental charges, or optical appliances and hospital care.

If funds are used in this way the CCG may cease your Personal Health Budget and recover the inappropriately spent monies from you, your Representative / Nominee as appropriate.

Using a Care Agency

If you wish to use a care agency to provide a regulated activity you must purchase care from a provider who is registered with the Care Quality Commission, who regulate the standards of care agencies nationally. There is a list of registered providers available, please see www.cqc.org.uk for more information. Salvere / Your Life Your Way / SOLO Support Services or your named health professional can also advise you about choosing a care agency.

If you choose to purchase a service through a care agency then please be advised that the contract and agreed price is a private arrangement between you, your Representative or Nominee and the care agency. Should the care agency increase its prices in the future above the agreed personal health budget amount, or require you to give a period of notice, we recommend that you request a review of your care plan and budget by contacting your named health professional. It may be more cost effective for the CCG to commission the service directly from your preferred care agency and the CCG will provide you with the option of a notional budget to ensure value for money.

Employing your own staff

You may also use your Personal Health Budget to purchase a service from any willing trained provider. This may include employing a Personal Assistant. If a provider you choose requires training to enable them to carry out their role effectively, training must be undertaken to ensure that you receive a high quality service. Salvere can support you to access training as an employer and for your Personal Assistant(s).

We strongly recommend that a DBS check (Disclosure and Barring Service) is completed as part of the employment process. If you choose to employ your own staff you will have some legal responsibilities as an employer. These include but are not limited to providing:

- A statement of employment particulars including: providing a written contract; highlighting the location of the work; remuneration; period of notice etc. It is a legal requirement to have a written contract of employment between you and your member of staff

- Deducting Tax and National Insurance Contributions

- Adhering to Minimum Wage, Statutory Sick Pay and Maternity Entitlements and Responsibilities, Paternity leave and pay, Annual leave and pay, Adoption, Redundancy, Equal Opportunities, Unions and Health and Safety policies.

- You are legally required to take out Employers and Public Liability Insurance.

You will be responsible for all the employer responsibilities. Guidance can be obtained online at: www.direct.gov.uk: '*Employing a professional carer or personal assistant'* or www.hmrc.gov.uk

We recommend that you consult Salvere, who support people using direct healthcare payments for information and advice about becoming an employer. You cannot ordinarily employ family members or anyone who lives with you or the spouse / partner of a relative / anyone living in the same house as you*.

This will only be agreed if, the CCG is satisfied that to secure a service from that person is necessary to meet your needs or promote the welfare of a child. This will be detailed here if agreed by us.

The CCG has agreed that the following family members (detailed above*) are employed by you, your Representative / Nominee: N/A Full Name N/A _____ Relationship _____ Reason _____

Representatives and Nominees and their relatives and partners cannot be employed to avoid any conflict of interest.

7. Record Keeping and Audit

You are required to keep basic records.

Your bank account will be audited through Salvere, Your Life Your Life or SOLO Support Services. Salvere, Your Life Your Way and SOLO Support Services are only able to make payments that are agreed in your care plan. The records will be subject to audit arrangements and Salvere, Your Life Your Way and SOLO Support Services will be audited annually (as a minimum).

The balance of the bank account will be reviewed regularly and any money that has not been allocated to your care or support excluding your contingency funds will be returned to the Clinical Commissioning Group (unless a prior agreement has been made with your named health professional).

8. Review, Changed Needs, Contingency and Emergency Arrangements

The arrangements agreed within your care plan will be reviewed within the first 12 weeks and then at least annually. The review will determine if your health needs and your personal outcomes have been met or have changed, and to establish what has worked well or not worked well for you.

The Clinical Commissioning Group will arrange a review earlier or if we become aware that your health needs have changed and/or if your Personal Health Budget is insufficient to secure the services. You or your Representative can also ask for a review.

If your needs have changed during this period of time you may request an earlier review of your needs by contacting your named health professional.

You are required to make contingency arrangements within your care plan, which may include having a contingency fund. In crisis situations the Clinical Commissioning Group may, in the absence of alternative support, step in and help on an interim basis.

Primary care services, including access to your GP and emergency services, such as Accident and Emergency, will always be available to you regardless of having a Personal Health Budget. These services are not included in your budget.

If your needs change or something is not working, you or your Representative or Nominee, must contact your named health professional.

If you go into hospital, you or your Representative must inform us

9. Comments, Complaints and Compliments

You have a right to comment, complain or compliment through the Clinical Commissioning Group's complaints procedure about any action, decision or apparent failing of the Clinical Commissioning Group.

Contact the Customer Care Team:

by telephone: 0151 247 700

by email: Southportandformbyccg.complaints@nhs.net

by post: NHS Southport and Formby CCG

3rd Floor Merton House,

Stanley Road,

Bootle.

L20 3DL.

10. Ending the Agreement

Either you, your Representative or we may end this agreement by giving one months' notice in writing to the other party.

We may end this agreement with immediate effect if, after investigation, it is found:

- You are using the money illegally
- You are not using it in your own best interests
- Your Nominated Representative is found to be acting in a way that is not in your best interests

Wherever possible, we will work with you and your Representative to find a resolution to the issues before ending the agreement.

At the point of ending the agreement, any funds paid to you by the Clinical Commissioning Group which covers the period after the termination date, must be paid back in full.

Following a review if we decide to reduce the amount of or stop making your direct healthcare payment you, your Representative or Nominee may ask us to reconsider this decision, and can provide evidence or relevant information to inform the reconsideration. We will inform you, your Representative or Nominee in writing of the decision following the reconsideration and state the reasons for the decision.

If this agreement ends for any reason and you continue to have health needs, the funding for your health needs will be provided by the CCG as part of the NHS in the usual way.

11. Data Protection and Use of Data

We may share information that we hold or become aware of with other statutory agencies for the prevention of fraud and abuse.

12. Signatures

This is where all parties are signing up to this agreement. This means that we will all work to what has been agreed in this document.

1st Party:

Us – Signature on behalf of the Clinical Commissioning Group:

Signature: _____

Date: _____

2nd Party:

You – The person receiving the Personal Health Budget

Signature: _____

Date: _____

3rd Party:

Representative – the person receiving and managing the Personal Health Budget on behalf of the above named person
Signature: _____

Date: _____

4th Party:

Nominee – the person receiving and managing the Personal Health Budget on behalf of the above named Representative or person

Signature: _____

Date: _____

13. Annex A
SOLO Support Services and Your Life Your Way

SOLO Support Services and Your Life Your Way are the CCGs approved providers for a personal health budget deployed as a 'cash budget' (third party arrangement). SOLO Support Services and Your Life Your Way are both Care Quality Commission (CQC) registered care agencies.

SOLO Support Services and Your Life Your Way work with families to build care plans and hold your personal health budget for you. SOLO and Your Life Your Way buy and pay for the care and support you have chosen. Please note – SOLO and Your Life Your Way will employ your Personal Assistants if you choose to have a 'cash budget' (third party arrangement). SOLO and Your Life Your Way will deduct their charges for their services from your Personal Health Budget. These charges have been agreed between yourself and Your Life your Way / SOLO Support Services as part of your care plan.

Salvere

Salvere are the CCGs approved provider for making direct healthcare payments for personal health budgets. Salvere are a Community Interest Company who support and assist families to organise, buy and manage their care, including building your own care plan using a direct healthcare payment.

Salvere will help you to manage all of your responsibilities as an employer and help you to employ personal assistants, arrange payroll, pay HMRC, provide staff handbooks, contracts of employment, risk assessment, help you make decisions about disclosure barring service checks, and ensure appropriate

training and competency checks are in place and ensure clinical tasks are delegated safely.

Salvere will hold your Personal Health Budget in a bank account, which will be opened in your name / your Representative's name / your Nominee's name and managed by you or your nominated representative or nominee. Salvere will deduct their charges for their services from your Personal Health Budget. These charges have been agreed between yourself and Salvere as part of your care plan.

Appendix 6

PERSONAL HEALTH BUDGET AGREEMENT (Children)

This document tells you about having a Personal Health Budget

2. Information about You and Community Services

This agreement is between:

(Enter name of relevant CCG here) Clinical Commissioning Group (Referred to in this agreement as 'we' or 'us')

and

Name and address of the child for who the Personal Health Budget is being made PLEASE PRINT: **First Name(s)** : **Surname:** **Address**   **Post Code** (Referred to in this agreement as 'the child')

In certain circumstances, including for people who are under 16 or people who are unable to consent to a direct healthcare payment, someone else may legally consent to and manage the direct healthcare payments on their behalf. That person is called a 'representative'. The representative will sign and agree to the terms of this agreement, and any other obligations on them under the regulations.

Once the child reaches 16 they will be able to consent to and receive the direct healthcare payment in their own right. The CCG will discuss the options with the child and may discuss the options with a person with parental responsibility at this time.

Your representative, if applicable and agreed by us is:

Name and address of Representative* or chosen decision maker

PLEASE PRINT:

First Name(s) :

Surname:

Relationship to 'the child' : Parent or person with parental responsibility

Address

Post Code

*Referred to in this agreement as 'you' or 'Representative' who has been appointed to arrange the services and manage the direct healthcare payment on behalf of a child for whom they have parental responsibility, and who has been agreed by 'Us'.

A representative is entitled to appoint a nominee to take on the contractual responsibilities including arranging the services and support detailed in the child's support plan, the nominee will also become responsible for how the money is spent. Where we agree to it your nominee will sign and agree to comply with the terms of this agreement and any other obligations on them under the regulations.

Name and address of Nominee

PLEASE PRINT:

First Name Not Applicable

Surname _____

Address _____

_____

_____

Post Code _____

(Referred to in this agreement as 'Nominee')

2. Basis of the Agreement

This agreement is made on the basis that:

- An assessment of your child's health needs has been completed with a health professional and it has been identified that your child is eligible to receive health care funding.

- Your child's care plan will identify the care and / or support that your child needs to meet their assessed health care outcomes in order to maintain your child's' independence.

- You - The parent / person with parental responsibility (Representative) is willing and able to secure the care / support detailed in your child's care plan yourself or with support**,** (from a Nominee) and we agree to make your child's Personal Health Budget available to you as the Representative to purchase the support and / or care that your child needs.

Any payment made under this agreement will be subject to regular audit and monitoring by Salvere or Your Life Your Way / SOLO Support Services and us which may be reviewed by the Personal Health Budget Programme Board.

Further information about Your Life Your Way, SOLO Support Services and Salvere can be found at Appendix A.

3. Responsibilities of the Nominated Representative

As part of the Clinical Commissioning Group agreeing to someone acting as a Representative, that person must be prepared to accept the following responsibilities:

- To involve the child in decisions about their support

- To represent the child's best interests

- To consent to receiving and managing the direct healthcare payment, and

- Fulfilling all of the responsibilities of someone receiving direct healthcare payments

Even with a Representative a child still has the right to be involved whenever possible. There is a duty placed on the Representative to involve the child in all relevant decisions where possible.

If the Representative repeatedly fails to make decisions that reflect these key responsibilities, then their role as a Representative would need to be reconsidered.

Representatives are appointed only with the CCGs approval. Representatives can be appointed for individuals who do not have the capacity to consent to a direct healthcare payment or for a child under 16 when Representatives can include the parents of the child or those with parental responsibility for that child.

4. Responsibilities of Your Nominee (If you have one)

As part of the Clinical Commissioning Group agreeing to someone acting as your Nominee, that person must be prepared to accept the following responsibilities:

- To involve you and the child in decisions about the child's support
- To represent the child's best interests
- To consent to receiving and managing the direct healthcare payment, and
- Fulfilling all of the responsibilities of someone receiving direct healthcare payments

Nominees must agree to act in the capacity of your Nominee and provide informed consent; the CCG must also consent to that Nominee acting in this capacity, and consider whether the Nominee is competent and able to manage direct healthcare payments with or without assistance.

A Representative for the child may choose to elect a Nominee where the Representative wishes to delegate all of the responsibilities of managing and receiving a direct healthcare payment.

5. About your child's Personal Health Budget

<u>The amount of money you will receive</u>

Start Date: xx/xx/xx
(Proposed) Breakdown of Payments:
Weekly (if applicable) £
One Off Value (if applicable) £
NOT APPLICABLE

The frequency of the payments will be discussed with you. However, payments are usually made to Your Life Your Way / Solo Support Services / Salvere in advance on a three monthly basis and will be reviewed within the first 12 weeks and then annually, unless your health care needs change.

How you will receive the money

There are three main ways that you can receive the personal health budget:

4. A direct payment with support from Salvere
5. A cash budget held and managed by Your Life Your Way / SOLO Support Services
6. A 'Notional' budget

You will have all the options explained to you before you decide which is the best option for you. When you have decided which way you would like to receive the budget please mark your choice with an 'X' in the box.

√	**A Direct Healthcare Payment**

A direct healthcare payment is where we pay money to you. The money will be paid into a bank account set up for this purpose by Salvere.

- The Personal Health Budget will be paid into a bank account, which will be opened by Salvere in your name or the Nominee's name and managed by you or the Nominee.
- You will need to sign this agreement
- You will need to sign an agreement with Salvere, this sets out the services they will provide to you or your Nominee and the charges they will deduct from the direct healthcare payment for these services. Salvere will advise you about this.
- You or your Nominee must take advice on becoming an employer from Salvere, as any employment, insurance, pension and tax issues will be the responsibility of the employer. You or your Nominee will be required to adhere to all aspects of employment law.
- You will be required to provide evidence of how you have spent the money for audit purposes. You will need to keep a record of all income and expenditure including receipts, invoices, timesheets, payslips and bank statements. Salvere can help you to manage this
- The bank account will be audited by Salvere and us and therefore it is important that you / Salvere submit all receipts and invoices for related expenditure.
- Salvere may make direct healthcare payments directly to you or your Nominee however the CCG will need to approve this.
- See Section 6. Employing your own Staff

√	**A 'cash budget' (third party arrangement) held and managed by SOLO or Your Life Your Way**

A cash budget is where the Clinical Commissioning Group pays the allocated budget to an organisation called Your Life Your Way, SOLO Support Services, who hold the money for you and help you decide what you and your child need. After you have agreed this with us, Your Life Your Way, SOLO Support Services will then buy and pay for the care and support you have chosen. Please note – Your Life Your Way, SOLO Support Services will employ your Personal Assistants if you choose to have a cash budget.

- The account is held and managed by Your Life Your Life or SOLO Support Services on your behalf
- Your Life Your Way or SOLO Support Services will buy the care and support you have chosen and take on the employment responsibilities
- You or your Nominee will need to sign an agreement with Your Life Your Way / SOLO Support Services; this sets out the services they will provide to you and the charges they will deduct from your Personal Health Budget for these services. Your Life Your Way / SOLO Support Services will advise you about this.
- You can request the balance of your bank account during working hours, Monday-Friday
- The bank account will be audited by Your Life Your Way / SOLO Support Services and us and therefore it is important that you / SOLO Support Services / Your Life Your Way submit all receipts and invoices for related expenditure.

√	**A Notional budget**

A Notional Budget enables you to be involved in planning your child's care. The Clinical Commissioning Group will pay your service provider directly for any services that your child has been assessed as needing. Please note - you cannot employ your own Personal Assistants if you choose to have a notional budget.

- The Clinical Commissioning Group will purchase and arrange the care and support from the provider(s) you have chosen
- The Clinical Commissioning Group will fund the care and support directly
- You will be involved in planning your childs' care and support including developing your childs' care plan.
-

6. General Rules about How to Use the Money

The Personal Health Budget enables you to buy the care, support or service that is detailed and agreed in your childs' care plan.

The money cannot be spent on illegal services or activities, alcohol, tobacco, gambling or debt repayment.

You cannot use your Personal Health Budget to pay for primary or general medical services, for example GP services, vaccinations, dental charges, or optical appliances and hospital care.

If funds are used in this way the CCG may cease your Personal Health Budget and recover the inappropriately spent monies from you or your Nominee as appropriate.

Using a Care Agency

If you wish to use a care agency to provide a regulated activity you must purchase care from a provider who is registered with the Care Quality Commission, who regulate the standards of care agencies nationally. There is a list of registered providers available, please see www.cqc.org.uk for more information. Salvere / SOLO Support Services / Your Life Your Way or your child's named health professional can also advise you about choosing a care agency.

If you choose to purchase a service through a care agency then please be advised that the contract and agreed price is a private arrangement between you or your Nominee and the care agency. Should the care agency increase its prices in the future above the agreed personal health budget amount, or require you to give a period of notice, we recommend that you request a review of your child's care plan and budget by contacting your childs' named health professional. It may be more cost effective for the CCG to commission the service directly from your preferred care agency and the CCG will provide you with the option of a notional budget to ensure value for money.

Employing your own staff

You may also use your Personal Health Budget to purchase a service from any willing trained provider. This may include employing a Personal Assistant. If a provider you choose requires training to enable them to carry out their role effectively, training must be undertaken to ensure that your child receives a high quality service. Salvere can support you to access training as an employer and for your child's Personal Assistant(s).

We strongly recommend that a DBS check (Disclosure and Barring Service) is completed as part of the employment process. If you choose to employ your own staff you will have some legal responsibilities as an employer. These include but are not limited to providing:

- A statement of employment particulars including: providing a written contract; highlighting the location of the work; remuneration; period of notice etc. It is a legal requirement to have a written contract of employment between you and your member of staff

- Deducting Tax and National Insurance Contributions

- Adhering to Minimum Wage, Statutory Sick Pay and Maternity Entitlements and Responsibilities, Paternity leave and pay, Annual leave and pay, Adoption, Redundancy, Equal Opportunities, Unions and Health and Safety policies.

- You are legally required to take out Employers and Public Liability Insurance.

You will be responsible for all the employer responsibilities. Guidance can be obtained online at: www.direct.gov.uk: '*Employing a professional carer or personal assistant'* or www.hmrc.gov.uk

We recommend that you consult Salvere, who support people using direct healthcare payments for information and advice about becoming an employer. You cannot ordinarily employ family members or anyone who lives with you or the spouse / partner of a relative / anyone living in the same house as you*.

This will only be agreed if, the CCG is satisfied that to secure a service from that person is necessary to meet the child's needs or promote the welfare of the child.
This will be detailed here if agreed by us.

The CCG has agreed that the following family members (detailed above*) are employed by you or your Nominee: Full Name: _____Not Applicable_____ Relationship _____ Reason _____

Representatives and Nominees and their relatives and partners cannot be employed to avoid any conflict of interest.

7. Record Keeping and Audit

You are required to keep basic records.

Your bank account will be audited through Salvere, Your Life Your Way or SOLO Support Services. Salvere, Your Life Your Way and SOLO Support Services are only able to make payments that are agreed in your childs' care plan. The records will be subject to audit arrangements and Salvere, Your Life Your Way and SOLO Support Services will be audited annually (as a minimum).

The balance of the bank account will be reviewed regularly and any money that has not been allocated to your childs' care or support excluding your contingency funds will be returned to the Clinical Commissioning Group (unless a prior agreement has been made with your named health professional).

8. Review, Changed Needs, Contingency and Emergency Arrangements

The arrangements agreed within your child's care plan will be reviewed within the first 12 weeks and then at least annually. The review will determine if your childs' health needs and personal outcomes have been met or have changed, and to establish what has worked well or not worked well for you and your child.

The Clinical Commissioning Group will arrange a review earlier if we become aware that your childs' health needs have changed and/or if the Personal Health Budget is insufficient to secure the services. You can also ask for a review if your childs' needs have changed during this period of time - you may request an earlier review of your childs' needs by contacting your childs' named health professional.

You are required to make contingency arrangements within your childs' care plan, which may include having a contingency fund. In crisis situations the Clinical Commissioning Group may, in the absence of alternative support, step in and help on an interim basis.

Primary care services, including access to your childs' GP and emergency services, such as Accident and Emergency, will always be available to your child regardless of having a Personal Health Budget. These services are not included in your budget.

If your child's needs change or something is not working, you or your Nominee, must contact your childs' named health professional. If your child goes into hospital, you must inform us so that we can consider whether an adjustment to the personal health budget is needed for services which are not provided while your child is in hospital.

9. Comments, Complaints and Compliments

You have a right to comment, complain or compliment through the Clinical Commissioning Group's complaints procedure about any action, decision or apparent failing of the Clinical Commissioning Group.

Contact the Customer Care Team:

by telephone: 0151 247 700

by email: Southport and formbyccg.complaints@nhs.net

by post: NHS Southport and Formby CCG

3rd Floor Merton House,
Stanley Road,

Bootle.
L20 3DL.

10. Ending the Agreement

Either you or we may end this agreement by giving one months' notice in writing to the other party.

We may end this agreement with immediate effect if, after investigation, it is found:

- You are using the money illegally or for any purpose which is not permitted in this Agreement or in the child's care plan
- You are not using the money in your childs' best interests or as agreed with us
- You are found to be acting in a way that is not in the childs' best interests

Wherever possible, we will work with you to find a resolution to the issues before ending the agreement.

At the point of ending the agreement, any funds paid to you by the Clinical Commissioning Group which covers the period after the termination date, must be paid back in full.

Following a review if we decide to reduce the amount of or stop making the direct healthcare payment you or your Nominee may ask us to reconsider this decision, and you may provide evidence or relevant information to inform the reconsideration. We will inform you or your Nominee in writing of the decision following the reconsideration and state the reasons for the decision.

If this agreement ends for any reason and your child continues to have health needs, the funding for your health needs will be provided by the CCG as part of the NHS in the usual way.

11. Data Protection and Use of Data

We may share information that we hold or become aware of with other statutory agencies for the prevention of fraud and abuse.

12. Signatures

This is where all parties are signing up to this agreement. This means that we will all work to what has been agreed in this document.

1st Party:

Us – Signature on behalf of the Clinical Commissioning Group:

Signature: _____

Date: _____

2nd Party:

You / The Representative– The person receiving the Personal Health Budget on behalf of a child for who you have parental responsibility

Signature: _____

Date: _____

3rd Party:

Nominee – the person receiving and managing the Personal Health Budget on behalf of the above named Representative

Signature: _Not Applicable_____

Date: _____

13. Annex A

SOLO Support Services & Your Life Your Way

SOLO Support Services & Your Life Your Way are the CCGs approved provider for a personal health budget deployed as a 'cash budget' (third party arrangement). SOLO Support Services & Your Life Your Way are Care Quality Commission (CQC) registered care agencies.

SOLO Support Services & Your Life Your Way work with families to build care plans and hold your personal health budget for you. SOLO & Your Life Your Way buy and pay for the care and support you have chosen. Please note – SOLO & Your Life Your Way will employ your Personal Assistants if you choose to have a 'cash budget' (third party arrangement). SOLO & Your Life Your Way will deduct their charges for their services from your Personal Health Budget. These charges have been agreed between yourself and SOLO Support Services & Your Life Your Way as part of your care plan.

Salvere

Salvere are the CCGs approved provider for making direct healthcare payments for personal health budgets. Salvere are a Community Interest Company who support and assist families to organise, buy and manage their care, including building your childs' own care plan using a direct healthcare payment.

Salvere will help you to manage all of your responsibilities as an employer and help you to employ personal assistants, arrange payroll, pay HMRC, provide staff handbooks, contracts of employment, risk assessment, help you make decisions about disclosure barring service checks, and ensure appropriate training and competency checks are in place and ensure clinical tasks are delegated safely.

Salvere will hold your Personal Health Budget in a bank account, which will be opened in your name / your child's name / your Nominee's name and managed by you or your nominee. Salvere will deduct their charges for their services from your Personal Health Budget. These charges have been agreed between yourself and Salvere as part of your childs' care plan.

Appendix 7

Close Family Members

Who is a close family member?

A person's close family members are described in the regulations as:

a. the spouse or civil partner of the person receiving care

b. someone who lives with the person as if their spouse or civil partner

c. their parent or parent-in-law

d. their son or daughter

e. son- in- law or daughter- in- law

f. stepson or stepdaughter

g. brother or sister

h. aunt or uncle

i. grandparent, or

j. the spouse or civil partners of (c)- (i), or someone who lives with them as if their spouse or civil partner

Appendix 8

Regulatory Bodies

Which are the statutory regulatory bodies?

- The General Chiropractic Council (GCC) regulates chiropractors.
- The General Dental Council (GDC) regulates dentists, dental nurses, dental technicians, dental hygienists, dental therapists, clinical dental technicians and orthodontic therapists.
- The General Medical Council (GMC) regulates doctors.
- The General Optical Council (GOC) regulates optometrists, dispensing opticians, student opticians and dispensing opticians, specialist practitioners and optical businesses.
- The General Osteopathic Council (GOsC) regulates osteopaths.
- The Health and Care Professions Council (HCPC) regulates the members of 15 health professions: arts therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dietitians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists/orthotists, radiographers, speech and language therapists, and social workers in England.
- The Nursing and Midwifery Council (NMC) regulates nurses and midwives.
- The Royal Pharmaceutical Society of Great Britain (RPSGB) regulates pharmacists, pharmacy technicians and pharmacy premises in Great Britain in England, Wales and Scotland.

Appendix 9

Timescales for Appealing Personal Health Budgets Decisions

1.0 Timescales:

1.1 The appeal must be made within 4 weeks of receiving the CCG's response to the PHB request. Appeals can be made by email, letter, by phone, either direct to the CCG, or via the CSU.

1.2 On receipt of an appeal, the CCG will respond within 10 working days confirming that a meeting will be convened.

1.3 The meeting should take place within 25 working days of the appeal being received.

1.4 The response of the panel will be confirmed to the service user in a letter within 28 working days of acknowledgement the original request meeting. The reasons for the decision will be set out in the decision letter, (together with an information leaflet on the NHS Complaints Procedure if the patient or their representative is not satisfied with the decision).

1.5 In the event of any timescales being exceeded, it is the responsibility of the CCG to keep the patient or their representative informed of reasons and progress.

1.6 Once the review is complete the CCG will inform the patient or their representative of its decision in writing, setting out the reasons for its decision within 28 working days of acknowledgement of the original request. If a patient or their representative is not satisfied that can pursue the matter via the local NHS complaints process.

1.7 If the internal process cannot resolve the concerns of the individual and/or their representative then the appellant can use the NHS Complaints Procedure.