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.