Birmingham CrossCity Clinical Commissioning Group

Personal Health Budgets for fully funded NHS Continuing Healthcare (adults) and NHS Continuing care for children

Policy & Practice Guidance

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1. Purpose & Introduction

This document sets out the policy and practice guidance developed to ensure the consistent and transparent delivery of Personal Health Budgets ("PHBs") for Eligible Persons (see section 3.1 for definition). This policy will run from October 2014. The Policy has been revised in readiness for the "right to have a PHB" that Eligible Persons will be afforded from October 2014. National policy in this area is still developing and the CCGs will review this paper when new guidance, regulations or national policy is published.

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

1.1 Scope

This policy applies to all employees of the Midlands & Lancashire Commissioning Support Unit, and NHS Birmingham CrossCity, NHS South Birmingham and NHS Solihull CCGs and all PHBs administered by those CCGs.

1.2 Other relevant legislation

- National Health Service (Direct Payments) Regulations 2013
- **Human Rights Act 1998,** including the Article 8 Right to respect for private and family life, and Article 14 Prohibition of discrimination
- The **Data Protection Act 1998**
- The **Carers (Equal Opportunities) Act 2004** provides carers with the right to receive assessment for support and a duty on various public authorities to give due consideration to a request to provide services to carers.
- **The Mental Capacity Act 2005 ("MCA")**. The Mental Capacity Act provides a framework for decision making applicable where people lack capacity to make a decision for themselves. The overriding principles of the Mental Capacity Act are set out in section 1 and include a requirement to ensure that all practicable steps are taken to seek to enable a person to make a decision for himself. Where a person is unable to make a decision, any decision made on their behalf must be made in accordance with his/her best interests and must be the least restrictive of the person's rights and freedom of action. A person is not to be treated as unable to make a decision simply because he makes an unwise decision.

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

- The **Children and Families Act 2014**, 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).

2 Overview

2.1 History

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

This development mirrors other changes within the NHS, including the drive generally for greater patient choice, shared decision-making and innovation in managing funds. The Government has confirmed a commitment in the NHS mandate 2014-2015 that anyone with a long term condition, who can benefit from a PHB, should have the right to ask for one by April 2015.

2.2 What is a PHB?

PHBs 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[1] on CCGs to:

- Consider any request for a PHB;

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

- Inform them of their right to have a PHB (October 2014)

- Provide information, advice and support in relation to PHBs.

[1] By virtue of the *National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) Regulations 2013 & National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) (No. 3) Regulations 2014*

There are five essential characteristics of a PHB.

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

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

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

2.3 Principles

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

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

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

2. **Quality – safety, effectiveness and experience should be central.** The wellbeing of the individual is paramount. Access to a PHB will be dependent on professionals and the individual agreeing a care plan that is safe and will meet agreed health and wellbeing outcomes. There should be transparent arrangements for continued clinical oversight, proportionate to the needs of the individual and the risks associated with the care package.

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

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

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

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

2.4 Standards for self-directed health support

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

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

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

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

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

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

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

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

3 PHB eligibility

3.1 Who can have a PHB?

From 1 October 2014, all Eligible Persons acquired a 'right to have' a PHB including by way of a direct payment. This includes:

- People who are eligible for fully funded NHS continuing healthcare (adults), including fast track patients[2];
- Families of children eligible for Continuing Care[3]

In the case of children this refers to the element of their care package that would normally be provided by the NHS once they become continuing care eligible and not the element of their care package provided by social care or education.

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

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

3.2 Exclusions for PHBs

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

'*There may be some exceptional circumstances when a CCG considers a personal health budget to be an impracticable or inappropriate way of securing NHS care for an individual.*

[2] as defined by the *National Framework for Continuing Healthcare and NHS-funded Nursing Care*, November 2012 (revised): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213137/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf

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

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

This could be due to the specialised clinical care required or because a personal health budget would not represent value for money as any additional benefits to the individual would not outweigh the extra cost to the NHS.'

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

3.3 PHBs for people in nursing or residential care home settings

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

4 Options for managing PHBs

The most appropriate way to manage a PHB should be discussed and agreed with the person, their representative or nominee as part of the care planning process. PHBs can now[5] be received and managed in the following ways, or a combination of them:

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

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

c) **Direct payments:**

- **Direct payments for people with capacity** – where the individual receives the funding that is available to them and they purchase the services and support they want in accordance with the agreed care plan (with or without assistance). The individual can elect to receive and manage the payment themselves or decide for it to be received and managed by a person of their choosing (a nominee). If the individual chooses a nominee, that nominee

[5] 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.

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. 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, direct payments can be received by their parents or those with parental responsibility for that child.

The CCG will set up a Cashplus Prepaid MasterCard account with associated debit card for recipients of direct payments (with the exception of one off payments). This will be loaded with the regular amounts as agreed In your care plan. Payments from the account can be made via BACS, direct debit or standing order or by debit card. The CCG has access to statements of these accounts for monitoring and auditing purposes.

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

5 How do PHBs work?

5.1 Informing people about PHBs

All policies relating to NHS Continuing Healthcare and Continuing Care continue to apply alongside the new law and guidance on PHBs. From October 2014 the named health professional will inform Eligible Persons of their right to have a PHB (including by way of direct payments) at the initial assessment, the 12 week review and or annual review. See exclusions in Section 3.2 and 6.4. The PHB pathway is shown in Appendix A.

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

PHBs are entirely voluntary and there is no obligation for a patient to accept the offer. Patients and their families will need to be provided with the CCG PHB Leaflet, a copy of which is at Appendix B.

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

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

Patients and families who wish to consider and explore PHBs further will be able to self-refer to their choice of provider for the information, advice and guidance. This will require the named health professional to complete a PHB self-referral form with the individual, as well as a PHB support plan (a copy of which is at Appendix C) which includes recording the clinical needs of the individual. This will begin the process of identifying risks so the care / support planning process can commence. Enquiries should be made to the care-coordinator. The care co-ordinator (see section 5.5) will be supported by the Commissioning Support Officers within the CCG, CSU and Joint Commissioning team (as appropriate) to progress the request.

5.2 Budget Setting

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

The CCGs are using a budget setting tool 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.

The PHB amount is therefore based on:

- The money that would otherwise be spent on meeting the fully funded NHS continuing healthcare needs or continuing care needs for Eligible Persons
- An hourly rate will be used to set the amount of PHB for each hour of care the patient is assessed as needing. The rate is set as the average cost of current home care packages and will be reviewed as part of the annual policy review process.

Once a person is assessed / reviewed and is identified or re-confirmed as an Eligible Person the indicative budget will be agreed. See section 6 for additional information.

In principle, the amount of money that would have been spent on NHS Services as part of an individual's Continuing Healthcare or Continuing care package could be available to use as a PHB. As much of this budget as possible should be included in a PHB. Where it is not possible to do so (for example, where the money currently being used to commission

services cannot be released immediately for use under a PHB), CCGs will work with the patient to tailor services as best as possible until this service can be provided under the PHB arrangement (where appropriate).

5.3 PHB care planning

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

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

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

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

The NHS (Direct Payments) Regulations 2013 and associated guidance set out what direct payments (using NHS money) can and cannot be used for, and how they should be administered. The CCGs will apply the regulations to all forms of PHB as far as possible,

whether it is by way of direct payments or another type of PHB. How a PHB will be used (however it is managed) must be set out in the PHB Care Plan. Please see section 6 of this Policy which is to be applied, as far as possible, to all PHBs.

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

5.4 Representatives for children and people who lack capacity

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

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

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

In the case of adults who lack capacity, 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 PHB.

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

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

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

5.5 Named Care Coordinator

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

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

5.6 Approval of Care Plan

PHB Care Plans are agreed in principle by the named health professional. However, all PHB Care Plans will also need to be signed off by the appropriate Continuing Healthcare panel (either at the CSU or in The Joint Commissioning Team). This process includes reviewing, agreeing and signing off the Care Plan which includes a risk identification and management plan. Terms of references have been developed to ensure consistency and adherence to the law and guidance. A copy of the terms of references for the panel are in Appendix E.

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

If a service named in the Care Plan is not agreed, the clinician will provide the individual, representative or nominee the reasons why this decision has been reached. The individual, their representative or nominee may ask the clinician to reconsider their decision and provide additional evidence or information to inform that decision. The clinician must reconsider their decision in 28 working days upon such a request being made. The clinician will notify and explain the outcome in writing to the individual. See sections 6.7 & 6.8 for further detail on the process to be followed.

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

5.7 PHB Agreement

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

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

5.8 Assistance to manage PHBs

As outlined at section [5.1] above, the CCGs will signpost to a choice of support services to provide support to individuals in receipt of PHBs. It is envisaged that over time a wider range of organisations will become available to offer support and that this will be reflected in the choices available to PHB recipients. These arrangements will be reviewed from October April 2015 onwards.

The costs associated with utilising support services are met as part of the PHB.

5.9 Monitoring and Review

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

For continuing healthcare for adults, this review is carried out in line with the continuing healthcare national service framework, i.e. three months after patients become eligible for continuing healthcare and annually thereafter. Reviews will also confirm whether or not the patient still has continuing healthcare needs.

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

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

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

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

5.10 Stopping or reclaiming PHBs

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

6 Direct Payments

The *National Health Service (Direct Payments) Regulations 2013*[6] set out how direct payments should be administered and on what they can be spent. The regulations are similar to the regulations and guidance for social care direct payments. PHB Guidance on the new direct payments for healthcare regulations was published in March 2014[7]. Although the NHS (Direct Payments) Regulations 2013 apply to direct payment PHBs, as noted above the CCGs have agreed to apply these regulations, as far as possible, to all forms of PHB to ensure transparency, fairness and best practice. References in this section to "direct payments" should therefore be treated as referring to all forms of PHB.

6.1 Who can receive a direct payment PHB?

A direct payment PHB can be made to any Eligible Person, where they are:

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

and where:

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

[6] *National Health Service (Direct Payments) Regulations 2013* and *National Health Service (Direct Payments) (Amendment) 2013*

[7] *Guidance on Direct Payments for Healthcare: Understanding the Regulations*, DH, March 2014 http://www.personalhealthbudgets.england.nhs.uk/_library/Resources/Personalhealthbudgets/2014/Guidance_on_Direct_Payments_for_Healthcare_Understanding_the_Regulations_March_2014.pdf

- The person is not subject to certain criminal justice orders for alcohol or drug misuse (see Section 6.4). However, such a person may be able to use another form of PHB to personalise their care.

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

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

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

6.2 Considerations when deciding whether to make a direct payment

The CCG will contact a range of people for information to help make the decision whether a direct payment may be suitable, e.g. a personal assistant, occupational therapist, community mental health nurse or social care team. The CCG will also consider whether the individual will be able to manage the direct payment (see section 6.3 below).

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

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

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

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

6.3 Ability to manage direct payments

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

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

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

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

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

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

6.4 Who cannot receive a direct payment?

There are some people to whom the duty to make direct payments does not apply[8]. This includes those:

[8] 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

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

6.5 Deciding not to offer a direct payment

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

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

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

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

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

6.6 Decision Making

Where there is a recommendation to accept or reject a request for a direct payment, the CCG will use an appropriately constituted Panel to consider this recommendation.

The Panel will consult the appropriate CCG's Terms of Reference (Appendix E) when making its decisions.

6.7 Request for review of a decision

Where the CCG decide that a direct payment would be inappropriate, the patient or representative may require the CCG to reconsider the decision, 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.

Should an individual not agree with the decision and place a complaint the CCGs will use their Complaints Appeals Panel to make a decision regarding a request for reconsideration of a refusal to provide a direct payment. The membership and terms of reference of the Complaints Panel should be in accordance with the requirements of the relevant CCG.

6.8 Representatives and direct payments

Information surrounding the appointment of Representatives is set out earlier in this Policy. When the use of direct payments is being considered, the CCG must be satisfied that a person agreeing to act as a representative understands what is involved, and has provided their informed consent, before going ahead and providing direct payments. They should be informed of the restrictions surrounding employment of a family member or person living in the same household to provide care (see section 7.1).

Full advice, support and information should be 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.

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

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

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

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

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

6.9 Nominees

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

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

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

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

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

The CCG must be satisfied that a person agreeing to act as a nominee understands what is involved, and has provided their informed consent, before going ahead and providing direct payments. Full advice, support and information 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.

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

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

If the proposed nominee is not a close family member of the person, 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[9] 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[10].

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

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

6.10 What can and cannot be bought with direct payments

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

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

[9] This is an enhanced DBS check including suitability information relating to vulnerable adults.

[10] 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.

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

Direct payments cannot be used to pay for the following[11]:

- alcohol
- tobacco
- gambling
- debt repayment (other than for a service specified in the care/support plan)
- core GP services
- planned surgical interventions
- prescriptions
- services provided through vaccination or immunisation programmes
- any service provided under the NHS healthcheck or National Child Measurement Programme
- NHS dentist and opticians.

For the CCGs involved, the above restrictions will be applied to all forms of PHB as far as possible.

In addition, pending the outcome of a further pilot scheme[12], caution should be had when considering the use of direct payments for those in nursing/residential care home settings. Where a request for a direct payment for healthcare is made for a person living in a residential setting the CCG must be certain that providing care in this way adds value to the person's overall care. Generally, direct payments should not be used to pay for care and support services being commissioned by the NHS that a person will continue to access in the same way whether they have a PHB or not. In such instances, where no additional choice or flexibility has been achieved by giving someone a PHB, then allocating a direct payment only adds an additional financial step and layer of bureaucracy into the commissioning of the care. CCGs need to be clear that the use of a direct payment in such settings is cost effective and is a sensible way to provide care to meet or improve the individual's agreed outcomes. Other types of PHB, for example notional budgets, can be used where direct payments are not a practical route and many people may find great benefit in planning their care using the personalised care planning process associated with developing a PHB.

6.11 Imposing conditions in connection with the making of direct payments

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

[11] *The National Health Service (Direct payments) Regulations,* 2013, Regulation 8(5)

[12] See NHS England guidance: *Guidance on the "right to have" a Personal Health Budget in Adult NHS Continuing Healthcare and Children and Young People's Continuing Care* (September 2014), page 17

- 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.

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

6.12 Assistance to manage a direct payment – Supported Managed Accounts

As outlined at section 5.1 above, the CCGs will signpost to a choice of support services to provide support to individuals in receipt of PHBs.

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

It is essential that either the individual or their representative has the ability to consent to and manage both their direct payment and the Cashplus Prepaid MasterCard 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.

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

The costs of direct payment support services are met from the PHB allocation. This requires the PHB 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.

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.

6.13 Receiving a direct payment

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

With the exception of one-off direct payments (see below), direct payments must be paid into the Cashplus Prepaid MasterCard account used specifically for the direct payment. The Cashplus Prepaid MasterCard account must be in the name of the person receiving the care, or their nominee or representative. The CCG will set up a Cashplus Prepaid MasterCard account on behalf of the individual with a payment solutions provider and the individual will be sent all the details, including a debit card and bank account details.

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. The CCG has access to online statements for monitoring and auditing purposes.

6.14 One-off payments

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

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

6.15 Monitoring and review of direct payments

As a minimum, a clinical review of an individual's direct payments should be performed within three months of the first direct payment and then annually. Financial monitoring will take place quarterly to check the allocated budget against the money spent, and then the money spent against the support plan.

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

Where there are concerns regarding how the PHB is being spent, the CCG should be alerted to any concerns by the individual with the concerns, and the relevant continuing healthcare / continuing care lead.

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

6.16 Stopping or reducing direct payments

There is an 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 care plan. PHBs and direct payments are not a welfare benefit and do not represent an entitlement to a fixed amount of money. A surplus may indicate that the individual is not receiving the care they need or too much money has been allocated. It should be noted that a surplus is different to a contingency – it is permissible to include an amount for contingency in a PHB, for example, to cover employment costs such as redundancy. As part of the review process, the CCG should establish why the surplus has built up. Under these circumstances, a reduction in direct payment in any given period cannot be more than the amount that would have been paid to them in the same period.

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

Where direct payments have been reduced, the individual, their representative 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 CCGs are not required to undertake more than one reconsideration of any such decision. If the individual remains unhappy about the reduction, they should be referred to the local NHS complaints procedure.

The 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.

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

Where PHBs and direct payments are stopped, the CCG will give reasonable notice of not less than 4 weeks to the patient, 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.

6.17 Reclaiming a direct payment

The CCG can claim back PHBs and direct payments where:

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

If a decision to reclaim payments is made, 28 working days' notice must be given to the individual, their representative or nominee, in writing, stating:

- the reasons for the decision;
- the amount to be repaid;
- the time in which the money must be repaid; and
- the name of the person responsible for making the repayment.

The individual, their representative or nominee may request that this decision be reconsidered and provide additional information to the 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 should be referred to the local NHS complaints procedure.

7 Using a direct payment to employ staff or buy services

7.1 Using a direct payment to employ staff

People may wish to use their direct payment to employ staff to provide them with care and support. In so doing, they will acquire responsibility as an employer and need to be aware of the legal responsibilities associated with this. This should not discourage people who would otherwise be willing and able to manage a direct payment. In order to ensure that people are appropriately informed and supported in meeting their duties as an employer, the CCGs will signpost to a choice of providers to provide information, advice and support. This includes support in relation to payroll, Human Resources and other employment related services. People should be made aware of the availability of these services, along with any others which may become available. Individuals, representatives and appointed nominees employing staff are strongly recommended to utilise the information, advice, guidance and payroll and HR facilities of a direct payment support service (or an alternative agreed support service as a wider range or organisations become available) to ensure the legal responsibilities of being an employer are satisfied.

The costs associated with utilising a direct payment support service are met from the PHB allocation. This cost should be factored in when setting the budget.

7.2 Employing a family member or person living in the same household

A direct payment can only be used to pay an individual living in the same household, a close family member 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[6]:

"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".

Any arrangement of this nature must be formally agreed by the CCG, and recorded in writing in both the care plan and the PHB agreement.

The suitability will be reviewed at least every three months, (following the existing pathways for complex, children's and adults). This process includes reviewing, agreeing and signing off the risk identification and mitigation tool.

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

7.3 Safeguarding and employment

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

Individuals cannot request DBS checks on other individuals. However, an individual or their nominee or representative may wish to ask the CCG to signpost them to appropriate support for them to arrange for the prospective employee or contractor to apply for an enhanced DBS check with a check of the adult's (or children's if appropriate) barred lists when employing or contracting with people who are not close family members or people living in the individual's household providing care to the individual but who are:

- regulated health care professionals – for example, nurses or physiotherapists
- people providing healthcare under the direction or supervision of a health care professional
- people providing personal care[13]

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

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

If the individual is contracting with a close family member or a person who is living in the individual's household or a friend it is not required to undertake any DBS checks.

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

[13] 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.

7.4 Indemnity

Direct payments can be used to pay for a personal assistant (PA) to carry out certain personal care and health tasks that might otherwise be carried out by qualified healthcare professionals such as nurses, physiotherapists or occupational therapists. In such cases the healthcare professional and CCG will need to be satisfied that the task is suitable for delegation, specify this in the Care Plan and ensure that the PA is provided with the appropriate training and development, demonstration of competence and have sufficient indemnity and insurance cover. More information on this can be found in the 'Personal assistants - delegation, training and accountability' document in the toolkit[14].

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

Providers of some services may need to conform with prospective legislation which will implement the Finlay Scott Recommendations (June 2010)[15] on indemnity cover and Article 4(2)(d) of Directive 2011/24/EC[16]. NHS England will provide further guidance on what this covers in due course[17].

PAs employed via a direct payment do not need to comply with the legislation that will require them to have indemnity cover if practising unless they are a member of a regulated health profession (see Appendix F), 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 PAs on a case by case basis. This needs to form part of the risk assessment and care planning process and outcome recorded in the Care Plan.

The person buying services needs to be aware of whether the provider needs to comply with prospective legislation discussed above. If the provider does not need to comply people may, if they wish, buy services from providers who have limited or no indemnity or insurance cover. So long as the person buying the service is aware of the potential risks and implications, limited or no indemnity should not automatically be a bar to purchasing from a provider. This should be included in the discussion around risks when developing the Care Plan.

In the first instance, it will be the responsibility of the person buying the service to check the indemnity cover of the provider from which they are buying services. They must make

[14] http://www.personalhealthbudgets.england.nhs.uk/_library/Resources/Personalhealthbudgets/Toolkit/MakingPHBHappen/TrainingandDeveloping/PersonalAssistantsSummary.pdf
[15] 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
[16] 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
[17] This will be available in the toolkit.

enquiries to ascertain whether the provider has indemnity or insurance, and if so, whether it is proportionate to the risks involved, and otherwise appropriate.

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

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

7.5 Registration, regulated activities and delegation of clinical tasks

If someone wishes to buy a service which is a regulated activity[18] 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[19].

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[20]. A related third party means:

a. an individual with parental responsibility for a child to whom personal care services are to be provided

b. an individual with power of attorney or other lawful authority to make arrangements on behalf of the person to whom personal care services are to be provided

c. a group or individuals mentioned in a) and b) making arrangements on behalf of one or more persons to whom personal care services are to be provided

d. a trust established for the purpose of providing services to meet the health or social care needs of a named individual

This means that individual user trusts, set up to make arrangements for nursing care or personal care on behalf of someone, are exempt from the requirement to register with the CQC.

[18] The *Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, S.I 2010/781*
[19] http://www.cqc.org.uk/organisations-we-regulate/registering-first-time/regulated-activities
[20] 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.

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

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

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

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

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

Delegation of clinical tasks within personal health budgets where an NHS employee (CHC Nurse) agrees, through the care 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.

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 PA as competent to carry out the task
- Does the registered practitioner view the PA as competent to carry out the task
- Does the PA consider him/herself to be competent to perform the activity
- Has the PA 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 PA's job description
- Does the PA recognise the limits of their competence and authority and know when to seek help

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, speech and language therapists).

Appendix G outlines The Framework for Delegation of Clinical Procedures, Training and Accountability Issues to PA's for Adults with a Personal Health Budget.

8 Equal Opportunities / Equalities Impact Assessment

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.

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).

BCC 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.

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.

An Equality Analysis Form has been completed and approved by the Equality & Inclusion Panel on 17 April 2015 for this policy and procedure and it does not marginalise or discriminate minority groups (see Appendix H).

The uptake of Personal Health Budgets will be monitored at review, which will include the uptake by all groups considered in the Equality Analysis.

9 Review Date

This policy and procedure will be reviewed in April 2016 and will be reviewed and updated at the request of the PHB Panel or earlier in light of any changes to legislation or National Guidance.

10 More Information

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

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

11 Glossary

Continuing Healthcare (CHC) **-** is the name given to a package of care solely funded by the NHS 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[21]

Commissioning Support Unit (CSU) **-** A Commissioning Support Unit (CSU) is an organisation. Commissioning Support Units are hosted within NHS England. Commissioning Support Units provide Clinical Commissioning Groups with external support, specialist skills and knowledge to support them in their role as commissioners.

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.

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

[21] National Framework for Continuing Healthcare and Funded Nursing Care (Department of Health) November 2012 (Revised)

- 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 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.

Personal Health Budgets (PHB) **-** a Personal Health Budget in an amount of money to support a person's individual healthcare and wellbeing needs, planned and agreed between the individual and their local NHS team.

Personal Budgets **-** a sum of money allocated by a local council as a result of an assessment of an individual's needs. The amount of money awarded is based on the 'eligible needs' the individual may have at that time. Eligible needs are those which the local council's policy says it has a duty to support the individual with.

Cashplus Prepaid MasterCard **–** an account set up by the CCG with Advanced Payment Solutions in order to for individuals to receive direct payments (excluding one off payments). The account operates similar to a telephone & online bank account. Amounts of money, as agreed in the support plan, are loaded onto the card by the CCG. The individual can make payments for their support needs by BACS, direct debit, standing order or using the debit card. The CCG has access to statements of the account for monitoring and auditing purposes.

Self-directed Care **-** allows people to choose how their support is provided, and gives them as much control as they want of their individual budget, to meet agreed health and social care outcomes.

Personal Support/Care Plan **-** an agreement between an individual and their health professional (and/or social services) to help them manage their health day-to-day. It can be a written document or something recorded in patient notes.

Notional Budget - 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 patients' behalf and helps them decide what they need.

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.

Resource Allocation System/Tool - set of rules that allow fair allocations to be made to people who need extra support. The development of Personal health Budgets depended upon the use of a RAS that enabled such an allocation to be made before the person had to decide how to spend their allocation.

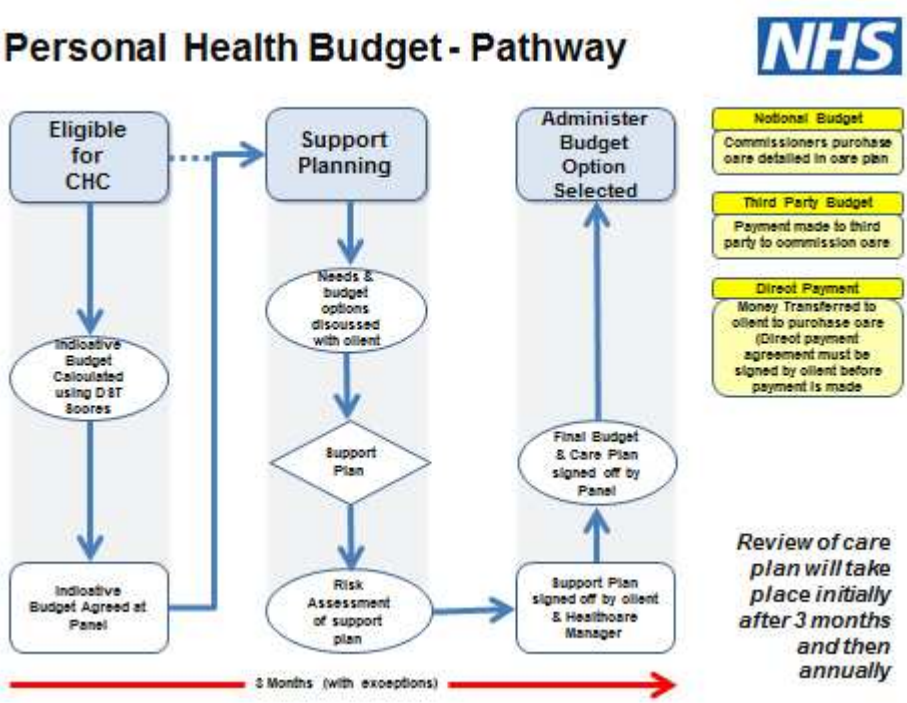
Direct Payment Legal Agreement - The Agreement is a template for use by NHS CCGs (CCG) in entering into direct payment agreements with individuals in accordance with the CCG's powers and duties under Section 12A NHS Act 2006, the National Health Service Commissioning Board and Clinical Commissioning 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.

Payment Solutions Provider – a service for accepting electronic payments by a variety of payment methods including credit card, bank-based payments such as direct debit, bank transfer, and real-time bank transfer based on online banking.

Appendices

Appendix A - PHB Pathway



Personal Health Budget: Support Plan

Section 1: My Details

Name:		**Date of Birth:**	
Address:		**Contact Number:**	
		Emergency contact number:	
NHS Number:		**E-mail address:**	
What I like to be called?			
My first language is?			
My communication needs are?			
I have an advocate, their name is?			
Important information relating to my beliefs and culture			

Next of Kin & Closest Relatives

Name	Relationship	Contact Details

Main Carer and others involved in care

Name	**Relationship** (please state if paid or unpaid carer)	Contact Details	If the carer is unpaid, has a carers assessment been completed?

Professional Contact Details

Person Involved	Job Title	Contact details	Lead clinician coordinating? (please tick)

Section 2: About me

This section is about you, what matters to you and what makes you content and fulfilled. Thinking about your past experiences can help to think about what is important to you, what you want for your future, and how you want to be supported.

How did I get where I am today?

What is important to me?

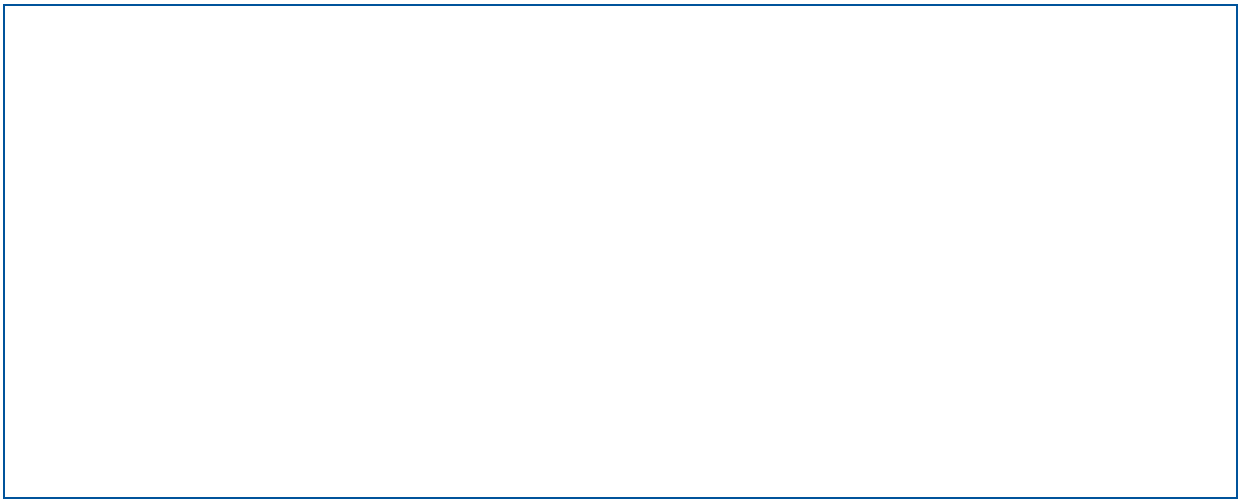
What are my goals and aspirations for now and the future?

Section 3: My Health Journey

In this section you can record information about you health condition/s and how it/they affect you on a day-to-day basis. Think about physical symptoms, how it affects your independence, side effects of treatment, any family or social issues, and how it affects you emotionally. You can also record information about the current treatment or support you receive and your wishes and preferences about your treatment or support.

My Health Condition/s

How my condition/s affect me?



The current treatment for my health condition/s
My wishes and preferences for my treatment and support

Section 4: Things I want to change or achieve – my outcomes

In this section you can describe the things that work well for you that you what to keep or maintain and the things that aren't working well that you wish to change. It's helpful to first look at what is important to you and what the best support is for you, and then consider what is working, or what is not working about those areas, from your own and other people's perspectives.

What is working and I want to keep the same	What is not working that I want to change

It is really important to record the outcomes that you wish to achieve and your ideas for achieving these outcomes. It is also important that these outcomes are linked to your assessed health needs. You should consider what your priority issues are and order your outcomes according to their importance to you.

When thinking about how to achieve your outcomes you should consider what you could do yourself, what family and friends could do for you, what free resources you could access within the community, what other public sector services or funding you could access and finally how you might use your Personal Health Budget.

	Outcome	My ideas for achieving this outcome
1		

2		
3		
4		
5		
6		
7		

8		

Section 5: My Action Plan

This is the section where you plan how to meet your outcomes; this is about making it happen and identifying who will arrange it. Look at each of your outcomes and decide what you need to do to achieve this: What will you do, specifically?, When will you have done it?, Who will do it?

What	By when	Who

Section 6: How will my support be managed?

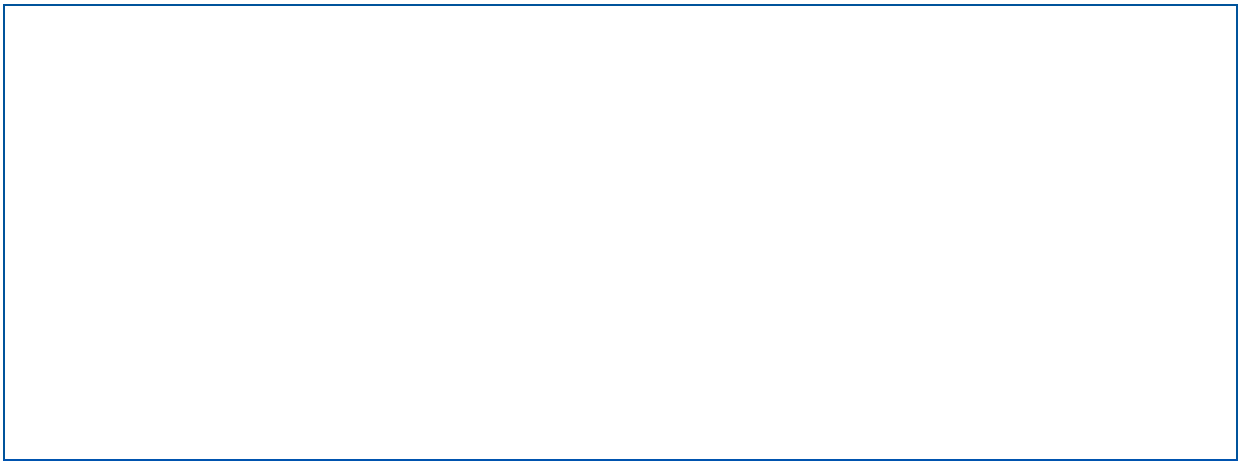
Who will manage your support? Who will manage your personal health budget? Will you access your personal health budget as a Direct Payment, Notional Budget or Third Party Budget?

Contingency plans

How will you deal with anything that changes and how will you manage any risks. It is important to plan for any sudden changes that may happen which will require you to have more support or if your regular support is not available.

If you are going to employ your own staff what will you do when they are on annual leave or off sick?

Are there periods of time when your health condition is worse? At these times do you need more support? How will you get this support?



Risks

It is important to describe any risks that may have been identified in what you are planning to do and how these risks will be managed. It is good to explore this with your health practitioner.

Identified risks	What I will do to manage these risks

How will your support be organised?

In this section you need to describe the support you require to stay healthy and safe and achieve the outcomes you have described. The timetable will show how you spend your time, or would like to spend your time and how much support you need. This does not mean that you have to do the same thing every week - you can change what you do to ensure you get the support to do the things that give your life meaning.

Day of week	Morning (8am-1pm)	Afternoon (1pm – 6pm)	Evening (6pm – 11pm)	Night (11pm – 8am)
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

Who will support me? (i.e. I am employing 3 PA's or I will be using an agency)
What equipment do I use for my support? (hoists, beds etc)

The training my PA's / Carers will require

It is important that any staff you employ directly or through an agency or provider organisation have specific training required to support you. It is good to explore this with your health practitioner.

Statutory or mandatory required (i.e. moving and handling, food hygiene etc)	**Specialist training required to meet your specific needs** (i.e. tracheotomy care, pressure care etc)

• Basic Life Support / First Aid • Moving & Handling • Falls Prevention • Infection Control • Health & Safety (including Risk Management) • Fire Safety • Safeguarding Adults / Children • If dealing with food preparation they will also need – Food Safety • If dealing with medicines they will also need – Medicines Management	

How will I use my personal health budget and other resources

Money in		**Weekly £**	**Yearly £**
Personal Health Budget			
Money out	**The outcome this will achieve, or help to achieve**	**Weekly £**	**Yearly £**
		£	£
		£	£
		£	£
		£	£
		£	£
		£	£
		£	£
		£	£
		£	£

		£	£
		£	£
		£	£
		£	£
		£	£
		£	£
		£	£
		£	£
		£	£
		£	£
Total money out			£
Does the budget balance? (do you have enough money?)			

How will I stay in control of decision making

It is important to record how you make decisions and stay in control of decision making about your life. The grid below can show how you have made the decisions recorded in this plan. You may also wish to record if you have any advance directives in place and where they are kept.

Important decisions in my life	**Who will help me with these decisions –** how will I be involved and what would it look like?	**Who will make the final decision**

How and when this plan will be reviewed

Who will review the plan	**When the plan will be reviewed**

Patient agreement

I agree with the contents of this support plan and understand that relevant assessments carried out by NHS Central Midlands CSU and information from my support plan will be shared with providers of my support.

Signature:	
Name:	
Date	

NHS Central Midlands CSU: Support Plan approval

Name of Approver:	
Job Title:	
Signature:	
Date:	

Appendix C – PHB Direct Payment Agreement

Direct Payment Agreement Template

Note 1: *This Agreement is a template for use by NHS Birmingham Crosscity CCG (**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.*

Note 2: *The Agreement should only be used for individuals who the CCG has assessed as eligible for direct payments in accordance with the Rules and Regulations, as amended from time to time. The Agreement does not set out all of the CCG's obligations in relation to direct payments which the CCG will need to consider before entering into this Agreement. The Agreement should be read in conjunction with NHS England's 'Guidance on Direct Payments for Healthcare Understanding the Regulations' (20 March 2014), as updated or replaced from time to time.*

Note 3: *This Agreement and the laws and regulations cited in it are correct as of the date of the draft of this Agreement but may be subject to change.*

Note 4: *This is a template Agreement and before using it you should consider the applicability of its terms to the individual in question and any requirements of the CCG's governance framework.*

Note 5: *The Agreement will need to be amended on a case by case basis including, in particular, in relation to any square bracketed sections or clauses. Please see notes highlighted in yellow throughout which will need consideration.*

Note 6: *Legal advice should be sought when amending this Agreement.*

NHS Birmingham Crosscity Clinical Commissioning Group
Agreement for direct payments in relation to Personal Health Budget for

……insert name of patient……..

This is an agreement between NHS Birmingham Crosscity Clinical Commissioning Group and the Patient or their representative or their nominee relating to direct payments for health care. NHS Birmingham Crosscity Clinical Commissioning Group encourages you to take independent advice before signing this agreement.

Parties

This Agreement is between:-

(1) **NHS Birmingham CrossCity Clinical Commissioning Group** of Bartholomew House, 142 Hagley Road, Edgbaston, Birmingham, B16 9PA the ”CCG”)

And

2 [Name of Patient “the Patient”) Address – insert Patients address)]

OR

Name of Rep of (insert representatives address (“the Representative”)

Relationship to the Patient:

as representative of (Name of Patient) of (insert patients address)

---

1. The Agreement

1.1 This is an agreement between **NHS Birmingham CrossCity CCG** and **the Patient or their Representative** which is made pursuant to the National Health Service Act 2006 and the National Health Service (Direct Payments) Regulations 2013.

1.2 Defined terms have the meaning given in Clause 1.7 of this Agreement.

1.3 The CCG has assessed your need for Support and is satisfied that you are capable of managing by yourself or with such assistance as may be available to you to receive your Personal Health Budget as a Direct Payment from the CCG to your Cashplus Prepaid MasterCard account, as defined in section 1.6. The Direct Payment will be made by the CCG in accordance with this Agreement and any other applicable terms and conditions referred to in this Agreement.

1.4 Your Cashplus Prepaid MasterCard Account into which Direct Payments under this Agreement are paid by the CCG will be used by the Patient, Patient Representative or Nominee only for the purposes of securing Support as agreed with the CCG in the Patients Personal Health Budget Plan and for no other purpose. You agree not to pay into the Cashplus Prepaid MasterCard Account any monies which are not Direct Payments monies. You agree that only payments associated with your care plan will be made from the Cashplus Prepaid MasterCard account.

1.5 This Agreement will come to an end with immediate effect upon any change in the law which will make it unlawful for the Patient or their Representative or the CCG to carry out their respective obligations under this Agreement.

1.6 Upon termination of this Agreement all monies held by the Patient, or their Representative shall be repaid to the CCG immediately or as directed by the CCG. Any misuse of unspent monies will be investigated by the CCG.

1.7 The following defined terms are used in this Agreement:

Agreement means this agreement between the Patient or their Representative and/or Nominee and the CCG to use your Cashplus Prepaid MasterCard Account to receive the Patient's Personal Health Budget as a Direct Payment from the CCG and incorporates the terms and conditions referred to in Schedule 1.

Cashplus Prepaid MasterCard Account means the Cashplus Prepaid MasterCard account held by the Patient or their Representative and approved by the CCG into which Direct Payments are paid under the terms of this Agreement.

Capacity has meaning in accordance with the Mental Capacity Act 2005.

Care Coordinator means the person nominated by the CCG to monitor and review the making of Direct Payments in accordance with Paragraph 2.1 of Schedule 1.

Care Plan means the plan prepared for you by the CCG and agreed by you in respect of the services to be secured by means of Direct Payments. It is found at Schedule 2 of this Agreement.

Clinical Commissioning Group (CCG) commissions the provision of primary care services in a specific area for their registered population.

DBS means Disclosure and Barring Service or any replacement or successor organisation to it.

Direct Payments means the payments made to you in accordance with Clause 4 of this Agreement and paid into the Cashplus Prepaid MasterCard Account by the CCG.

Employment Costs means the gross costs associated with the employment of staff by you, your Representative or Nominee for the purpose of this Agreement including (but not limited to) wages, DBS checks, national insurance, training, payroll, annual leave, sickness, insurance and emergency cover, tax and any other costs. It also includes any costs associated with addressing any employment/employer disputes that may arise.

Family Member means a spouse, civil partner or any of the other persons listed in regulation 7(8) of the Regulations.

Nominee means an individual nominated in accordance with Regulation 6(1) of the Regulations and such Nominee is included in the definition of and referred to as a Nominee within this this Agreement.

One-off Direct Payment means a payment made for a single item or service or a single payment made for no more than 5 items or services where that payment is the only payment you would receive from the CCG in any financial year.

Personal Health Budget means the budget for provision of health care services to the Patient made by way of Direct Payments in accordance with this Agreement.

Regulations means the National Health Service (Direct Payments) Regulations 2013 as amended or replaced by subsequent legislation.

Representative means a person who is a Court appointed deputy, an attorney, a person with parental responsibility and any other person which the CCG may consider appropriate to receive and manage Direct Payments on behalf of the Patient and named at Clause 2.2 of this Agreement.

Support means the arrangements made to meet the Patients health care needs as specified in your Personal Health Budget Support Plan.

2 Representative

2.1 Any Representative to whom the CCG is to make Direct Payments under the terms of this Agreement must:

a) agree to act on the Patients behalf in relation to the Direct Payments;

b) act in the Patients best interest when securing the provision of services in respect of which Direct Payments are made and at all other times;

c) be responsible as a principal for all contractual arrangements entered into for the Patients benefit and secured by means of Direct Payments;

d) use the Direct Payments in accordance with the Personal Health Budget Support Plan and the terms of this Agreement and the Regulations;

e) In the case of a Patient who lacks mental capacity as at the date of this Agreement, inform the CCG immediately if the Patient regains mental capacity and becomes able to manage the Direct Payments.

g) where required agree to have a DBS check.

f) you agree to notify the CCG if you wish to change or withdraw your Nominee. Following such a notification we may stop the making of Direct Payments, consider paying the Direct Payments to you directly or to a different nominee and as soon as reasonably possible review the Personal Health Budget and Care Plan in accordance with the Regulations.

2.2 The CCG will agree to the making of Direct Payments to the Representative on the Patients behalf subject to being satisfied that the Representative is capable of managing the Direct Payments by themselves or with such assistance as may be available to them. If the Representative is not one of the Patients close family members or a friend involved in their care, then the CCG will require the Representative to apply for an enhanced DBS certificate before giving its consent to making the Direct Payments to the Representative.

2.3 The Patient may notify the CCG if they wish to change or withdraw your Representative. Following such a notification the CCG may stop the making of Direct Payments, consider paying the Direct Payments to the Patient directly or to a different Representative of the Patient, within the meaning of Regulation 2(1), and may as soon as reasonably possible review the Personal Health Budget and Personal Health Budget Support Plan in accordance with the Regulations.

2.4 If Direct Payments to the Patient are stopped under Clause 2.3 it will be the Patient, or their Representative's responsibility to ensure that any surplus monies held by them under this Agreement are repaid to the CCG.

3. Payments

3.1 All Direct Payments as agreed by the Patient or their Representative in the Personal Health Budget Support Plan will be made by the CCG directly to the Patient or their Representative, as follows:

3.1.1 **One-off Direct Payments**

A one-off Direct payment of £ [ ] from which to purchase the following:

£ [ ] for _____
£ [ ] for _____
£ [ ] for _____
£ [ ] for _____
£ [ ] for _____]

.3.1.2 **Regular Payments**

a) Every calendar month the Patient, or their Representative, will receive in the Cashplus Prepaid MasterCard Account from the CCG £ ____as the regular Direct Payment.

b) This is equivalent to £ _____ per annum.

c)Payments will begin on _____]

In accordance with this Agreement, these payments should only be used to pay for care/items as specified in your Personal Health Budget support plan. Any misuse of the direct payment may result in the right to have a direct payment agreement being terminated and a full investigation will be carried out.

4. **General Provisions**

4.1 All amendments and variations of this Agreement must be agreed between the CCG and the Patient or their Representative and confirmed in writing, signed and dated by the Patient or their Representative and attached to this Agreement.

4.2 The CCG will give the Patient or their Representative not less than 4 weeks' notice of any proposed review, monitoring or changes to the Personal Health Budget that may require any amendment or variation to this Agreement.

4.3 Any notice to be given in connection with this Agreement will be in writing and may be delivered by hand, post, facsimile or email, addressed to the recipient at the address set out at the beginning of this Agreement or any other address notified to the other party in writing in accordance with this clause as the address to which notices and other documents may be sent:

_____

4.4 The notice, demand or communication will be deemed to have been duly served:

a) if delivered by hand, at the time of delivery;

b) if delivered by post, forty eight (48) hours after being posted (excluding Saturdays, Sundays and public holidays);

c) if delivered by email or facsimile or email, at the time of transmission.

4.5 This Agreement will be a legally binding contract made in England and Wales and will be subject to the laws of England and Wales.

4.6 This Agreement together with the Schedules constitutes the whole agreement between the Patient their Representative and the CCG and supersedes any previous arrangement, understanding or agreement between the Patient or their Representative relating to the subject matter of this Agreement.

4.7 If any provision of this Agreement (or part of any provision) is found by any court or other authority of competent jurisdiction to be invalid, illegal or unenforceable, that provision or part-provision will, to the extent required, be deemed not to form part of

the Agreement, and the validity and enforceability of the other provisions of the Agreement will not be affected.

4.8 The Patient or their Representative confirms that they have read and understood this Agreement including the terms and conditions set out in Schedule 1 and the Personal Health Budget Support Plan at Schedule 2.

The CCG and the Patient or their Representative agree to be bound by and to comply with the terms and conditions set out in Schedule 1 to this Agreement and any other applicable terms and conditions as referred to in this Agreement or as notified by the Patient or their Representative

Signed by the **Patient OR Representative (delete as necessary)**

……..

Name ……

Address ……

……..

……..

……..

Date ……....

Signed by the

Representative……

Signed on behalf of **NHS Birmingham CrossCity Clinical Commissioning Group**

Signature …….

Name ……..

Designation …….

Date ……

Address: Care of NHS Midlands and Lancashire Commissioning Support Unit, Continuing Healthcare, 3rd Floor Front, Kingston House, 438-450 High Street, West Bromwich, B70 9LD

SCHEDULE 1

RIGHTS AND RESPONSIBILITIES OF THE PARTIES

YOU AND NHS Birmingham Crosscity CCG - RIGHTS AND RESPONSIBILITIES

This document sets out the terms and conditions of the Agreement between the Patient or their Representative and the CCG

1. The Patients or the Representative's Rights and Responsibilities

1.1 The patient or their Representative agree that the Patient's health needs can be met by provision of the Support as identified in the Personal Health Budget Support Plan, as updated from time to time in accordance with this Agreement or as required by any relevant law and that the amount of the Direct Payments is sufficient to provide for the full cost of the Support identified in The Personal Health Budget Support Plan. The Patient or their Representative agree to use the Personal Health Budget made available to the Patient as Direct Payments for the purpose of securing healthcare services needed for your Support as agreed by you in your Care Plan from:

a) any service provider who meets the conditions set out at paragraph 1.9 of this Schedule and does not fall under paragraph 2.5 of this Schedule; and/or

1.2 The Patient or their Representative agree that the Direct Payments can only be used for items specified in the Personal Health Budget support plan and cannot be used for the purchase of the following:

a) Supply or procurement of alcohol or tobacco; or

b) Provision of gambling services or facilities; or

c) To repay a debt otherwise than in respect of a service specified in the Personal Health Budget Support Plan; or

d) Primary medical services provided by general practitioners as indicated in the Personal Health Budget Support Plan; or

e) Urgent or emergency treatment services (including any unplanned hospital admissions); or

f) Planned surgical procedures; or

g) Vaccination, immunisation or screening, including population-wide immunisation programmes; or

h) Services provided under the National Child Measurement Programme; or

i) Services provided under NHS Health Check; or

j) Prescription charges, dental charges or ophthalmic appliances.

1.3 The Patient or their Representative must use Direct Payments to cover the cost of your Support as agreed in your care plan and for no other purpose.

1.4 The Patient or their Representative agree to provide the CCG with a list detailing how you, your Representative or Nominee intend to spend your Personal Health Budget through the support plan attached and upon our request provide information or evidence relating to:

a) your state of health or any health condition and any changes relating to your health in respect of which Direct Payments are made;

b) the health outcomes expected from the provision of any service provided to you with your Direct Payments;

c) any other information as we may consider necessary.

1.5 The Patient or their Representative give permission to let the CCG examine, and where appropriate, take copies or make extracts of all information and documentation relating to the Personal Health Budget and the provision of the Support on a quarterly basis whenever the CCG requests the Patient or their Representative to do so. This information includes:

a) all financial records (that is, of income received and payments made through the Cashplus Prepaid MasterCard Account which show clearly the Direct Payments received from the CCG and details of how the Patient or their Representative has used the Direct Payments as agreed in the Personal Health Budget Support Plan);

b) The Cashplus Prepaid MasterCard Account Cashplus Prepaid MasterCard statements;

c) Invoices for payment of care;

d) Receipts for payments made

e) Payslips;

f) Confirmation of tax/government payments;

g) Agency invoices, and receipts (if applicable); and

h) Any other information as we may consider necessary.

Where the Patient or their Representative are to provide the CCG with information under this Agreement, such information shall be provided in a legible format, accompanied by authorisation for the CCG to take copies or extracts of the information, with an explanation of the information provided to the CCG or a statement to the best of the Patient or their Representative's knowledge and belief of where any information not provided to the CCG is held. Any information requested should be provided within 28 days of the request. Failure to provide requested information may result in the right to receive a direct payment being suspended/terminated.

1.6 The Patient or their Representative, must keep all supporting documents relating to the Personal Health Budget and the provision of the care for at least seven complete

financial years from the date of the Direct Payment, even if the Direct Payments have stopped. The Patient or their Representative agree to provide the CCG, upon our request, with an explanation of the information they provide to the CCG or a statement to the best of their knowledge and belief of where any information they fail to provide to the CCG.

1.7 The Patient or their Representative must keep a Financial Record which shows clearly:

a) Direct Payments they have received to meet the Patients assessed needs; and

b) details of how they have used Direct Payments made into the Cashplus Prepaid MasterCard Account,.

1.8 The Patient or their Representative must ensure that provisions are put in place for cover in emergency situations to ensure that the Patient has Support when they need it. The financial cost for this forms part of your regular monthly payment and no further liability will be borne by the CCG.

1.9 The Patient or their Representative must make enquiries to ensure that any service provider providing or to provide Support pursuant to paragraph 1.1 above:

a) is reputable and can meet the standards of quality expected by the CCG, as stated in the support plan;

b) has complied with all its registration obligations including with the Care Quality Commission if carrying out regulated activities;

c) has adequate insurance and indemnity cover for the services to be provided to the Patient, if it is ascertained that the provider must operate under insurance or indemnity cover;

d) has the right skills and resources in place to provide the type of services the Patient requires under the Personal Health Budget Support Plan;

e) has adequate complaints procedures in place; and

f) where applicable, is a registered member of a professional body affiliated with the Professional Standards Authority for Health and Social Care.

g) the CCG will not be liable for any liabilities associated with the failure in standards of care by a service provider selected and paid for by the Patient.

1.10 The Patient or their Representative may request the CCG to assist with their enquiries under paragraph 1.9(b), (c) and (f) in respect of any particular service provider organisation.

1.11 Within three months from the date you first receive your Personal Health Budget in the Cashplus Prepaid MasterCard Account there will be an initial review of the management of the Personal Health Budget by the CCG and the making of Direct Payments to you and a review and re-assessment of the Patients care needs (including a review of the quality of the Support arrangements the Patient or their Representative have made). Any proposed changes to the Personal Health Budget and / or the support arrangements will be the subject of discussions between the CCG and the Patient or their Representative.

1.12 Within twelve months of the date you first receive your Personal Health Budget in your Cashplus Prepaid MasterCard Account and more frequently if there is a change in circumstances, or where we become aware that the Direct Payment(s) have not been sufficient to secure your Support, or in any other circumstances where the CCG, at its discretion, considers it appropriate, there will be a review of the management of the Personal Health Budget, the appropriateness of the Patients Care Plan and the sufficiency of the Direct Payments. The CCG may also review and re-assess the Patients Support needs (including a review of the quality of the Support the Patient is receiving). Any proposed changes to the Personal Health Budget, Direct Payments and / or the Support will be the subject of discussions between the Patient or their Representative and the CCG. All transactions through the Cashplus Prepaid MasterCard account must be supported by documentation. The CCG reserve the right to request documents to support a transaction as it feels necessary.

1.13 If following a review of the Personal Health Budget under paragraphs 1.11 and 1.12 the CCG decides to reduce the amount or stop the making of Direct Payments we will give the Patient or their Representative 4 week's minimum notice in writing stating the reasons for the decision. Upon receipt of such notice the Patient or their Representative may require the CCG to undertake one further review and provide any relevant evidence or information to consider as part of this further review. The CCG will notify the Patient or their Representative in writing of its decision and the reasons for it.

1.14 The Patient or their Representative, agree to notify the CCG immediately of any substantial change of the Patients health conditions or the Personal Health Budget Support Plan or other relevant circumstances (including where the Patient is admitted to hospital, moves away from the area, moves to a different address, leaves the country for more than four weeks, no longer wish to receive the Direct Payment, or need help to comply with these terms and conditions).

1.15 Where the CCG is satisfied that the whole or any part of a Personal Health Budget has not been used to secure the Support to which it relates, the CCG reserves the right to:

a) demand repayment of the whole or part of the Direct Payment; or

b) withdraw your Direct Payment and transfer it onto a notional budget managed directly by the CCG; or

c) arrange for a third party or accountancy service approved by the CCG to take over the management of your Direct Payment.

1.16 If, for any reason, the CCG discovers that the Patient or their Representative are holding any of the Personal Health Budget in the Cashplus Prepaid MasterCard Account which is not necessary to enable them to secure the provision of Support as defined by this Agreement and/or the Personal Health Budget Support Plan then such Personal Health Budget must be repaid to the CCG in accordance with our instructions. Failure to do so could result in the matter being referred for formal investigation by the CCG Local Counter Fraud Specialist.

1.17 Subject to paragraph 2.7 of this Schedule, where we are satisfied that the Patient or their Representative have not complied with any term or condition of this Agreement then the Patient or their Representative must repay the whole or part of the Personal Health Budget if the CCG so request.

1.18 The Patient or their Representative, (if so directed by you) have the right to bring this Agreement to an end at any time by giving four weeks' written notice (or less by agreement) to your Care Coordinator.

1.19 If this Agreement is brought to an end by the Patient or their Representative or by the CCG, the CCG will be responsible for settling any outstanding payments due to a service provider organisation with whom the Patient or their Representative has made arrangements to provide Support. If there is a surplus Personal Health Budget held in the Cashplus Prepaid MasterCard Account under this Agreement it must be repaid to the CCG in accordance with the CCG's instructions (in order to settle any such outstanding payments).

1.20 Any repayment of the Direct Payments, in part or in whole, to the CCG under the terms of this Agreement shall be in the form of a Cashplus Prepaid MasterCard transfer made payable to NHS Birmingham Crosscity CCG. The CCG reserves the right to request any repayment of the Direct Payments to be made in accordance with any other instructions, as it thinks appropriate.

1.21 No transfer of Direct Payments monies to any Cashplus Prepaid MasterCard account (other than the Cashplus Prepaid MasterCard Account) held by the Patient or their Representative is permitted under the terms of this Agreement. All monies must be held in the Cashplus Prepaid MasterCard account and any payments for services/goods detailed in the Patient's care plan should be paid from it.

1.22 The Patient or their Representative may at any time during the term of this Agreement request us to undertake a review of the Personal Health Budget and Direct Payments. Upon receipt of such a request the CCG shall decide whether to undertake such a review and will notify the Patient or their Representative of the decision and the reasons for it. Following a review the CCG may amend the Personal Health Budget Support Plan or make any other changes as required and considered appropriate by us.

a. If the Patient or their Representative intend to employ staff directly, the Patient or their Representative must request these staff to undertake DBS checks and satisfy themselves as to their suitability for employment in light of the information revealed. When the Patient or their Representative intends to employ or contract with persons known to them (such as family or friends) will have discretion as to whether to request them to undertake an enhanced DBS check to ensure that the person has no relevant criminal convictions which would preclude them from being employed in such a role. If the Patient or their Representative intends to employ a person unknown to the Patient but known to their Representative, they shall require such person to undertake an enhanced DBS check.

b. The Patient or their Representative must fulfil all legal requirements as an employer. You will be required to comply with all relevant employment legislation – the CCG will not be liable for any failure on your part to comply with this legislation.

1.23 If the Patient or their Representative directly employ staff they are required to have in force appropriate employers liability insurance which includes public liability insurance. This must be with reputable insurers or underwriters with a minimum limit for any one claim (the limit to be increased from time to time as reasonably required

by the CCG). The relevant insurance policy and premium receipts must be produced as and when required by the CCG. An allowance for these insurance policies is included within the Personal Health Budget

1.24 If the Patient or their Representative intend to employ staff directly, all employment related costs such as tax and national insurance must be paid within the required timescales and you may use an accredited/reputable payroll services to pay your personal assistants or employees, as approved by the CCG.

1.25 Anyone employed by the Patient or their Representative using the Personal Health Budget will not be considered as one of the CCG's employees or agents.

1.26 All Employment Costs associated with the employment of any staff by the Patient or their Representative under this Agreement shall be included within the Personal Health Budget as indicated in the Personal Health Budget Support Plan. The CCG will not be liable for any additional employment costs outside of that which is included within Personal Health Budget Support Plan.

1.27 In the event of the Patients death the CCG will assess the outstanding contractual responsibilities incurred by the Patient or their Representative in respect of the use of the Direct Payments for the purpose of determining whether any amount shall be repaid to the CCG.

1.28 The Patient or their Representative agree that the purchase of equipment with the Personal Health Budget and no longer required by the Patient will be returned to the CCG at the end of this Agreement in a good condition except reasonable wear and tear.

2. The CCG's Rights and Responsibilities

2.1 The CCG will prepare the Care Plan for you and advise you, your Representative or Nominee of significant potential risks arising in relation to the making of Direct Payments and the means of mitigating those risks. Any amendments made to the Care Plan are to be approved in advance in writing by the CCG.

2.2 The CCG retains responsibility to review the Patients health care needs and will therefore appoint a Care Coordinator to assess that the needs as agreed in the Personal Health Budget Support Plan are being met. The Care Coordinator will be responsible for reviewing the Personal Health Budget Support Plan and:

a) Monitoring the Patients health needs and health conditions and the making of Direct Payments to the Patient or their Representative.

b) Arranging for the review of Direct Payments under the terms of this Agreement;

c) Liaising between the Patient, their Representative and the CCG.

2.3 The sum of the Personal Health Budget the CCG has agreed it will pay for 'start up' costs for the regular provision of Support will be paid by the CCG into the Cashplus Prepaid MasterCard Account as a Direct Payment.

2.4 Every month the Personal Health Budget in the form of Direct Payments will be paid by the CCG into the Cashplus Prepaid MasterCard Account for the purpose of

receiving payments to meet the full cost of the Support which the CCG have assessed is needed by the Patient as included in their Personal Health Budget Support Plan. The CCG may increase or reduce Direct Payments as required to meet the full cost of the services specified in the Patients Personal Health Budget Support Plan.

2.5 The CCG reserves the right to require that the Patient or their Representative do not secure Support from a particular service provider as indicated by the CCG in this Agreement or otherwise notified to the Patient or their Representative by the CCG.

2.6 The CCG may suspend or discontinue making payments to the Patient or their Representative if it becomes aware or is notified that the Personal Health Budget is not needed for a period exceeding 28 days but before doing so it will discuss the matter with the Patient or their Representative and take into account any contractual agreements and continuing needs the Patient may have.

2.7 Where CCG is satisfied that the whole or any part of the Personal Health Budget has not been used to secure the provision of the care to which it relates or the Personal Health Budget Support Plan has changed substantially then it may suspend, discontinue, reduce or offset against outstanding amounts of Direct Payments due to the Patient but before doing so it will discuss the matter with the Patient or their Representative and take into account any contractual agreements and continuing needs they may have. If no contact can be made with the Patient or their Representative for a period of four weeks the CCG reserve the right to suspend or withdraw the Direct Payment.

2.8 Where the CCG is satisfied that the Patient or their Representative have not complied with any term or condition of this Agreement then it may require the Patient or their Representative to repay the CCG the whole or part of the Personal Health Budget it has made. It may also be necessary to terminate the Patients ability to receive direct payments and care facilitated through a different means.

2.9 If the CCG is satisfied that theft, fraud or another offence has occurred in connection with the Direct Payments it may terminate this Agreement with immediate effect and require the Patient or their Representative to repay the CGG the whole or part of the Personal Health Budget payments made. In any instance the matter will be referred to the CCG Local Counter Fraud Specialist for investigation.

2.10 If the CCG decides that a sum must be reduced or repaid under paragraphs 1.15, 1.16, 2.7, 2.8 and 2.9 it will notify the Patient or their Representative within 28 working days of making the decision and provide reasons for making the decision and specifying the amount to be reduced or repaid.

2.11 Upon receipt of a notice to repay the whole or part of the Direct Payments served under paragraph 2.10 the Patient or their Representative may require the CCG to re-consider the decision and provide evidence or information for the CCG to consider as part of the deliberation. The CCG will notify the Patient or their Representative in writing of their decision and the reasons for it.

2.12 The CCG has the right to bring this Agreement to an end by giving the Patient or their Representative 28 working days' notice **in writing stating the reasons for the decision** if it appears to the CCG that the Patient or their Representative is no longer capable of managing a Personal Health Budget by themselves or with such assistance as may be available to them or the Patient is a person whose ability to

arrange their Support is restricted by certain mental health or criminal justice legislation (details of which the CCG will give to the Patient or their Representative).

2.13 Even if the Patient appears to be no longer capable of managing a Personal Health Budget by themselves the CCG may continue to make such payments if it is reasonably satisfied that the Patients inability will be temporary and a Representative is prepared to accept and manage the Direct Payments on the Patients behalf and the Representative allows the Patient to manage Direct Payments by themselves for any period for which the CCG is satisfied that the Patient has capacity to do so.

2.14 The CCG may bring this Agreement to an end by giving the Patient or their Representative 28 working days' notice in writing stating the reasons for the decision if it appears to the CCG that the Patients needs for care can no longer be met by means of a Personal Health Budget or if the Patient is no longer a resident registered with a member GP practice of the CCG as defined by the Responsible Commissioner Guidance (2014) or if the Patient no longer meets the criteria for NHS Continuing Health Care.

2.15 The CCG may bring this Agreement to an end by giving the Patient or their Representative 28 working days' notice **in writing stating the reasons for the decision** if the Patient or their Representative have not complied with any term or condition of this Agreement.

2.16 the CCG may bring this Agreement to an end with immediate effect and arrange appropriate service if:

a) the patient or Representative refuses to receive Direct Payments; or

b) the CCG considers that the patient or Representative is no longer suitable to receive Direct Payments.

2.17 Upon receipt of a notice served under paragraph 2.16 the Patient or Representative may require the CCG to re-consider the decision and may provide evidence or information for the CCG to consider as part of the deliberation. The CCG will notify the Patient or their Representative in writing of its decision and the reasons for it.

2.18 Any right or liability of the Patient or their Representative (or personal representatives of the Patient in case of their death) to a third party acquired or incurred in respect of a Support secured by means of a Direct Payment shall transfer to the CCG when the CCG stops making Direct Payments to the Patient or their Representative pursuant to termination of this Agreement for whatever reason.

2.19 Throughout the duration of this Agreement the CCG will provide information, advice and support to the Patient or their Representative as may be necessary.

2.20 The NHS complaints procedure will apply to any decision by the CCG in relation to a complaint brought by the Patient or their Representative. The CCG will ensure that the Patient or their Representative is aware of the process for accessing that procedure. We will also ensure that the Patient or their Representative are aware of the procedure for escalating a complaint to the Parliamentary Health Service Ombudsman should the Patient or their Representative feel that it is necessary to do so.

3 Termination

3.1 The CCG will terminate this Agreement in the following circumstances:

a) where the Patient no longer consents to, or have withdrawn, their consent to the making of the Direct Payments;

b) where the Patients Representative has withdrawn their consent to the making of the Direct Payments and there is no other representative who consents to the making of the Direct Payments in respect of the Patient; or

c) Where the patient reaches the age of 16 and does not consent to the continued making of Direct Payments to their Representative.

d) Non-compliance with the conditions of this agreement and misuse of the direct payment.

e) Belief that the Cashplus Prepaid MasterCard account or payments have been the subject of fraud.

3.2 The CCG may terminate this Agreement if satisfied it is appropriate to do so and in the following circumstances:

a) if a person in respect of whom a Direct Payment is made is not a patient;

b) the patient has died; or

c) pursuant to Schedule 1 Clauses included in section 2 of this Agreement.

3.3 Where the CCG terminates this Agreement under this Clause 3, it will give 28 working says notice in writing to the Patient or their Representative or stating reasons for the decision.

3.4 In the case of a patient who has died, reasonable notice mentioned in Clause 3.3 will be given to the personal representatives of the patient.

3.5 Where a notice is served on the CCG to reconsider its decision pursuant to Schedule 1, Clause 2.17 of this Agreement, the CCG may not be required to undertake more than one re-consideration following its decision under Clauses 3.1 and 3.2 above.

3.6 The CCG may terminate this agreement following reasonable notice even though a decision under Clauses 3.1 and 3.2 above are being re-considered.

4 The Cashplus Prepaid MasterCard Account

4.1 The Cashplus Prepaid MasterCard Account will be held by the Patient or their Representative for the purpose of using the Direct Payments under the terms of this Agreement and the Regulations.

4.2 The Cashplus Prepaid MasterCard Account will be operated by Advance Payment Solutions and the Direct Payments under this Agreement will be paid into the Cashplus Prepaid MasterCard Account by the CCG.

4.3 No monies, other than Direct Payments monies under this Agreement, can be paid into the Cashplus Prepaid MasterCard Account by you, your Representative or Nominee.

4.4 Advance Payment Solution's terms and conditions and any variations, additions, or amendments as notified to you, your Representative or Nominee by the Advanced Payment Solution will apply to your Cashplus Prepaid MasterCard Account.

4.5 By providing your personal information to the NHS you consent to the NHS using it to apply for a Cashplus Prepaid MasterCard and understand that the information will be used by the NHS's Pre Payment Card Provider ("Advanced Payment Solutions Limited") in the following ways:

- Advanced Payment Solutions Limited will be the data controller of personal data given to or received by them in connection with your Account. They may use third parties to process your personal data on their behalf.
- They will process and retain personal data in order to open, administer and run your Account and to deal with any enquiries you have about it.
- If they suspect that they have been given false or inaccurate information, they may record their suspicion together with any other relevant information.
- If false or inaccurate information is provided and fraud is identified, they may pass details to Fraud Prevention Agencies to prevent fraud and money laundering.
- If your Account goes overdrawn and you do not pay back the money owed when asked they may provide information about you to credit reference agencies.
- Personal data may also be transferred confidentially to other organisations within Advanced Payment Solutions Limited's group of companies and to third parties so that they can run your Account.
- Your personal data in relation to transactions made with your Card will be made available to the NHS and our duly authorised agents at our request.
- They will reserve the right to process data in countries outside the European Union, including the United States of America, however they will ensure adequate protection for personal data transferred to countries outside the European Union and in the case of the United States of America they will only use processors who adhere to the 'Safe Harbor' Privacy Principles issued by the US Department of Commerce.

SCHEDULE 2

YOUR CARE PLAN

Appendix D – Panel Terms of References

Personal Health Budgets (PHB) Panel

Terms of Reference

Draft Version 3.1

Introduction

NHS Birmingham Cross City CCG alongside the Central Midlands and Lancashire Commissioning Support Unit (CSU) Continuing Healthcare (CHC) Team / The Joint Commissioning Team recognises that risk is an inevitable consequence of people managing their own care. These terms of references highlight the arrangements the CCG will put in place to manage situations that are high risk or complex.

To make good choices, people need to understand the consequences of their decisions and take some responsibility for them. NHS Birmingham Cross City CCG want to promote a culture of choice and flexibility that includes responsible, reasonable, supported and shared decision making (including management of risk). Reasonable risk is the balance between empowering individuals to make decisions about their healthcare, whilst supporting them to take informed everyday risks.

The PHB Panel shares this decision making process to enable an effective, transparent and safe way to reach the best decision based on the information available and to ensure corporate responsibility. The PHB Panel will provide a forum to consider the PHB care plans for an individual and identify the risks and mitigating actions. Cases may be presented to the Panel during the assessment process, support planning or review of a care plan.

Purpose

The purpose of the PHB Panel is to:

- Guide, advise and support staff to ensure risks and high repercussions are minimised and managed to protect staff and individuals using the CHC service. The Panel has been designed to be a safe and supportive environment for both the individual and staff.
- Ensure a consistent approach to managing risk enablement decisions, where the risk to independence is balanced with the risk of ‘not supporting choice’.

- To provide positive solutions and outcomes for individuals and resolve issues regarding the sharing of risk between individuals, third parties and the organisation.
- To ensure that no individual is left to make a difficult decision without support and that the CCG can demonstrate it has fulfilled its duty of care around the support of service users.
- To provide a forum where staff at all levels of the organisation can share risk decision making where there is concern about the level of risk
- To take the final decision on issues involving high or complex care risks to ensure the risks are accepted at a corporate level
- To promote a consistent approach to managing complex risk decision making.
- To ensure there is evidence that a person centred assessment and support plan have been developed and that the support plan reflects the views of the individual
- To determine whether the agreed outcomes will meet the needs identified in the Continuing Healthcare Assessment and to decide if the support plan will deliver the agreed outcomes
- To decide if the proposed personal health budget is the most appropriate way to meet those outcomes
- To be assured that safeguarding provisions are in place
- To be assured that contingency plans are in place
- To ensure no-one is exposed to unacceptable risk
- To ensure the affordability of the support plan and the equitable use of public funds

Scope of Responsibility

The PHB Panel will review all support plans and risk enablement forms as completed by the individual and case manager (may also involve external brokers). The Panel will act as a decision maker and offer advice and guidance on risk enablement and complex or high risk cases. The responsibility will then lie with the relevant senior/service manager and team to support the individual with their PHB and put the advice into action. *All agreed actions for each support plan must be recorded.*

Some examples of issues the Panel may need to consider:

- Can the risks in a care plan be managed within reason
- Could any risks cause endangerment to other people (third parties)
- Could the risk expose the CCG to political or reputational risk
- Legal and regulatory issues
- Possibility of fraud
- Risks arising from availability of services or facilities
- Financial risks that cannot be resolved through the validation process
- If a direct payment has been requested, is it in line with the regulations and is it appropriate
- Is the delegation of tasks appropriate and have all training needs been identified and secured

- Consideration of those to be employed, are agencies applicably registered, have relevant checks been carried out, do they have contracts of employment, has the status on anyone self-employed been checked
- Determine if the final budget is the right amount to deliver the support plan and is within 10% of the indicative budget or have the reasons why not clearly indicated and relevant
- The proposal represents best value

Please note this is a guide and not a closed list and the PHB Panel is to address all PHB related issues.

Criteria for approval of CHC Personal Health Budget Support Plans

The proposals for meeting the patients assessed eligible needs, as set out in the support plan, must be:

a. Lawful
b. Effective
c. Affordable
d. Appropriate

Lawful – the proposals should be legitimately within the scope of the funds and resources that will be used. The proposals must be lawful and regulatory requirements relating to specific measures proposed must be addressed.

In deciding whether the support plan meets with legal requirements it must show that:

1. The support plan will fulfil the CCG's statutory duty to meet the patients assessed, eligible needs.
2. The measures proposed in the support plan must in all cases be lawful.
3. In line with the Mental Capacity Act 2005, if the person appears to lack capacity, the support plan must make clear how their wishes have been ascertained and incorporated into the support plan.
4. The patient has been made aware of any legal responsibilities they will incur as a result of measures proposed in the support plan (e.g. employment law, health and safety)
5. Contracts of employment are or will be in place if necessary
6. If they are self-employed their status has been checked
7. Any service providers identified in the plan must meet applicable regulatory requirements.
8. Disclosure and barring service checks have been carried out on individuals unless they are a close family member of the person, living in the same household as the person or a friend involved in the person's care.

9. The patient and carers have received guidance on any health and safety issues or regulatory requirements in relation to any equipment to be used or any adaptations to their home.

Effective – the proposals must meet the patient's assessed eligible needs and support the patient's independence, health and wellbeing. A risk assessment must be carried out and any risks identified that might jeopardise the effectiveness of the plan or threaten the safety or wellbeing of the patient or others must be addressed. The proposals must make effective use of the funds and resources available in accordance with the principle of best value.

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

1. The support plan meets all the assessed eligible needs
2. The proposed measures will be effective in supporting the patients independence, health and wellbeing
3. Where there is a carer, the carer's needs have been assessed and the proposals take account of their needs too.
4. The proposals represent the most effective use of the resources and funds available
5. A risk assessment has been carried out and any risks identified in the plan have been addressed.
6. The support plan includes measures to address outcomes that will help the patient develop their independence or independent living skills and will enhance their health and wellbeing.
7. The support plan demonstrates due regard to the need to safeguard the patient and their carers.
8. Individuals have been advised to carry out DBS checks on staff they are employing or if they do not wish to do so, sign a disclaimer to this effect.
9. Any clinical tasks have been appropriately delegated and all training needs for identified and competencies checked and certified.

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:

1. The support plan is within the indicative budget or if the indicative budget is exceeded a clear and reasoned explanation is provided to justify the additional spend.
2. In the case of support plans that exceed the indicative budget, the plan is thoroughly reviewed to ensure best value.
3. The use of universal services, community resources, informal support and assistive technology has been explored.

4. All relevant sources of funding have been identified and utilised.
5. The support plan does not include anything for which the individual is already receiving benefits or that an alternative agency would traditionally fund or is already funding.
6. All costs have been identified and fall within the indicative budget allocated or within 10%.
7. A suitable contingency amount is included within the support plan.
8. Appropriate insurances have been included and proposed providers/employed carers have the appropriate indemnity cover.
9. The proposals represent the most effective use of the resources and funds available.
10. The support plan meets the assessed, eligible needs in the most cost effective way possible.
11. Where the support plan requires a budget that is lower than the indicative budget, the lower budget will be approved.
12. The support plans cost is not substantially disproportionate to the potential benefit.

Appropriate – the support plan should not detail the purchase of items or services that are inappropriate for the state to fund or that would bring the NHS into disrepute. The support plan must have clear and strong links to a health or social care outcome. The following items are deemed as inappropriate spend.

1. Emergency or acute hospital services, such as unplanned in-person admissions to hospital.
2. primary medical services provided by GPs, such as diagnostic tests, basic medical treatment or vaccinations
3. Alcohol
4. Tobacco
5. Gambling
6. Debt repayment
7. Treatments (like medicines) that the NHS would not normally fund because they are not shown to be cost effective
8. To pay a close family carer living in the same household except in circumstances when ‘it is necessary to meet satisfactorily the person’s need for that service; or to promote the welfare of a person who is a child’.
9. The employment of people in ways which breach national employment regulations.

Appeals and Disputes

Challenge to a change in the budget

A Budget Holder, Representative or Nominated Person can ask the CCG to re-consider its decision to:

- change the amount of the Personal Health Budget;
- repay all or part of the Personal Health Budget;
- suspend the Personal Health Budget; or
- terminate the Personal Health Budget.

Evidence or relevant information can be provided for the CCG to re-consider. The CCG will then write to the Budget Holder, Representative or Nominated Person to tell them:

- what has been decided as a result of the re-consideration; and
- why this has been decided.

The CCG is not required to undertake more than one re-consideration in these circumstances.

Management of Disputes

Where the dispute relates to the CHC eligibility decision, the disputes procedure as set out in the Continuing Healthcare Local Review Policy should be followed.

Where the dispute relates to:

- repayment of a direct payment;
- suspension of a direct payment;
- termination of a direct payment; or
- challenge to a change in the budget.

The re-consideration procedure as set out earlier in this document should be followed. Where the complainant remains dissatisfied, they should be signposted to the CCGs complaints procedure.

Decisions relating to the:

- Refusal of a PHB application;
- Refusal of budget to be received by a direct payment/third party managed account;
- Refusal of proposed use of budget
- Outcome of review;
- Outcome of PHB appeals;

will be communicated in writing to individuals, or their Representative or Nominated Person, (together with copies of the minutes of the PHB Panel where involved) with rationale for the decision within 28 working days of the decision being made.

Where the complainant remains dissatisfied, the individual, and/or their Representative or Nominated Person will be invited to resolve the matter informally through discussion with the Care Co-ordinator and then through CCGs local resolution procedure.

Membership

The PHB Panel shall consist of no less than 3 members of staff, including the following:

- CSU/JCT Representatives:
  - Clinical Lead for Quality Assurance and CHC or Clinical Operational Lead for CHC (Chair)
  - Senior CHC Nurse
  - Senior CHC Business and Commissioning Manager

- The Panel may reserve the right to invite the following individuals to support the decision making:

  - CCG Representative

  - Borough Council or Local Authority Representatives as appropriate

  - Case Manager as appropriate

  - Service User/representative as appropriate

  - Co-opted Members as appropriate

There should be a minimum of 3 members present (excluding CHC Project Assistant), this must include a chair, case manager and at least one other member of staff from the above list (both a commissioner and a clinician in addition to the case manager must be present).

A representative from communications, finance and clinical areas will need to attend where risk has been identified to that particular area. Where a member cannot attend they should nominate an appropriate deputy or submit written comments.

Each meeting will have a designated Chair to ensure that there is accountability, continuity and commitment.

Frequency and Format of Meetings

Panels will meet as appropriate to the needs of the PHB agenda. Thus, a meeting will be called as and when cases arise requiring approval. There is not set frequency for these meetings; however this will be periodically reviewed to ensure appropriateness. Cases for discussion should be submitted at least one week on advance of the Panel meeting.

It is essential that the meeting is well documented, with outcomes and actions demonstrably followed up. Therefore all Panel meetings will be accurately recorded.

Panel members will endeavour to facilitate the meeting in an informative, supportive and sensitive manner. Consideration will be given to any access and support needs of the service user. The case manager will present the case at the Panel meeting.

The review date for each case will be agreed and recorded upon agreement of each care plan.

Secretariat

Papers relating to each case, including support plans and risk enablement forms, will be prepared in advance of each PHB Panel. Each Panel will also be minuted with detailed action points, to be followed up at the following meeting.

Appendix E – Statutory & Regulatory Bodies

Statutory and Regulatory Bodies

Which are the statutory regulatory bodies?

- The General Chiropractic Council (GCC) regulates chiropractors.
- The General Dental Council (GDC) regulates dentists, dental nurses, dental technicians, dental hygienists, dental therapists, clinical dental technicians and orthodontic therapists.
- The General Medical Council (GMC) regulates doctors.
- The General Optical Council (GOC) regulates optometrists, dispensing opticians, student opticians and dispensing opticians, specialist practitioners and optical businesses.

- The General Osteopathic Council (GOsC) regulates osteopaths.
- The Health and Care Professions Council (HCPC) regulates the members of 15 health professions: arts therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dietitians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists/orthotists, radiographers, speech and language therapists, and social workers in England.
- The Nursing and Midwifery Council (NMC) regulates nurses and midwives.
- The Royal Pharmaceutical Society of Great Britain (RPSGB) regulates pharmacists, pharmacy technicians and pharmacy premises in Great Britain in England, Wales and Scotland.

Appendix F – The Framework for Delegation of Clinical Procedures, Training and Accountability Issues to PA's for Adults with a Personal Health Budget

FRAMEWORK FOR DELEGATION OF CLINICAL PROCEDURES, TRAINING AND ACCOUNTABILITY ISSUES TO PA'S, FOR ADULTS WITH A PHB

Clinical procedures which might be undertaken by non-health qualified staff

In order to safely and effectively support the care needs of adults requiring these procedures, comprehensive training needs to be in place and delivered by appropriately qualified nursing staff.

Underpinning principles

1.The training programme must be designed to enable carers to

- Care for an adult who is medically stable, but may have complex, intense or unpredictable health care needs.
- Recognise signs of when the adult is becoming unwell.
- Know how to seek appropriate help.

NB. If the adult becomes unwell they need to be seen by appropriate clinical staff and cared for by appropriately qualified staff (Registered nursing care may be required at such times).

2. Non-health qualified staff should be trained to deliver care according to set protocols and guidelines and would not be expected to make independent decisions about an adults care, but refer these to either a relative, appropriate representative or a health professional.

The permitted tasks for non-health qualified staff and focus of training for these tasks must be on the care as it applies to a **named adult**. The individual carer will require specific training and assessment in order to participate in the care of another adult.

The following advisory list of procedures may be safely taught and delegated to non-health qualified staff following a specific assessment of clinical risk and as specified in individualised care plans.

- Bolus or continuous feeds via a nasogastric tube
- Bolus or continuous feeds using a pump via a gastrostomy tube
- Tracheostomy care including suction using a suction catheter

Emergency change of tracheostomy tube. Routine tracheostomy changes provide an opportunity for a registered practitioner to assess carer competency while also undertaking an assessment of the tracheostomy site
The first time replacement must be undertaken by an appropriately qualified nurse or qualified medical practitioner.

- Oral suction with a yanker sucker
- Administration of oral medications as prescribed by an appropriate practitioner.
- Administration of medications via nasogastric tube or gastrostomy tube as prescribed by an appropriate practitioner.
- Injections (intramuscular or subcutaneous). These may be single dose or multiple dose devices which are pre-assembled with pre-determined amounts of medication to be administered as documented in the individual care plan (preloaded devices should be marked when to be administered e.g. for diabetes where the dose might be different am or pm. In many circumstances there may be two different pens, one with short-acting insulin to be administered at specified times during the day and another for administration at night with long acting insulin).
- Intermittent catheterisation.
- Catheter care, to include urethral and suprapubic catheters.
- Stoma care including maintenance of patency of a stoma in an emergency situation using for example the tip of a soft foley catheter and replacement of button devises once stoma has been well established for more than 6 months and there have been no problems with the stoma.
- Inserting suppositories or pessaries with a pre-packaged dose of a prescribed medicine.
- Manual Evacuation.
- Rectal medication with a pre-packaged dose i.e. rectal diazepam to treat seizures.
- Administration of buccal or intra-nasal medication as prescribed for treatment of specific symptoms, to include treatment of Hypoglycaemia, Autonomic Dysreflexia.
- Emergency treatments covered in basic first aid training including airway management.
- Assistance with inhalers, cartridges and nebulisers.
- Assistance with prescribed oxygen administration including oxygen saturation monitoring where required.
- Blood Glucose monitoring as agreed by the diabetes nurse specialist
- Ventilation care for an adult with a predictable medical condition and stable ventilation requirements (both invasive and non-invasive ventilation). NB. Stability of ventilation requirements should be determined by the adults respiratory physician and will include consideration of the predictability of the adults ventilation needs to enable the key tasks to be clearly learnt.

Staff and carers should only agree to undertake these tasks if they feel competent and confident to do so.

The following tasks should **not** be undertaken by non-health qualified carers:

- Assessment of care needs, planning a programme of care or evaluating outcomes of a programme of care.
- Re-insertion of nasogastric tube.
- Re-insertion of PEG's or other gastrostomy tubes.

- Intramuscular and sub-cutaneous injections involving assembling syringe or intravenous, administration.
- Programming of syringe drivers.
- Deep Suctioning (oral suctioning tube beyond back of mouth or tracheal suctioning beyond the end of the tracheostomy tube).
- Siting of indwelling catheters.
- Medicine not prescribed or included in the care plan.
- Ventilation care for an unstable and unpredictable adult.

DELAGATION AND ACCOUNTABILITY

Nursing involves complex tasks and procedures and even though health care support staff may have been trained to provide certain aspects of care to specific adults, they may not necessarily be competent in all circumstances to do so. The NMC code states:

4.6 You remain accountable for the appropriateness of the delegation, for ensuring that the person who does the work is able to do it and that adequate supervision and support is provided.

When delegating any aspect of care the NMC states that each adult should be clinically assessed and the most appropriate person appointed to deliver any subsequent care. If this is a health care support worker then the registered nurse delegating the care should ensure they are competent to undertake the task being requested of them. The NMC advises that if a registrant feels they have been asked to delegate care to a health care support worker who they believe does not have the required competency or it is an inappropriate delegation, then they should refuse the instruction. This should then be raised formally with their employers including the justification for taking such a decision. Clause 8.2 and 8.3 of the Code supports this:

8.2 You must act quickly to protect patients and clients from risk if you have good reason to believe that you or a colleague, from your own or another profession, may not be fit to practice for reasons of conduct, health or competence

8.3 Where you cannot remedy circumstances in the environment of care that could jeopardise standards of practice, you must report them to a senior person with sufficient authority to manage them and also, in the case of midwifery, to the supervisor of midwives. This must be supported by a written record.

A risk assessment will be carried out by an appropriate panel of clinicians, including a Community Continuing Health Care Nurse, before delegation of specific tasks is approved. Training of such staff will then be provided by external contracts, to the specifications below.

Any delegation of clinical tasks to non-health qualified staff must be undertaken within a robust governance framework which encompasses:

- Initial training and preparation
- Assessment and confirmation of competence
- Confirmation of arrangements for on-going support, updating of training and reassessment of competence

Training non health qualified staff

The aim of a training programme should be to provide information and learning about both theoretical and practical aspects of the carers role. Opportunities must be provided for supervised practice before an assessment of competence by a suitably qualified person. This process should take into account the views of the person being assessed, the views of the adult requiring the tasks to be completed, relatives or appropriate representative.

Training should take place at two levels:

- General training around complex health needs
- Training around a specific adult and the procedures or the care that adult will require

Key elements of a training programme are suggested as follows

- A competency-based approach
- Written goals for individuals
- Audit cycles (regular updating and reassessing of competence)
- Evaluation criteria
- Statements of accountability
- Confidentiality
- The care of the required equipment
- Care of the adults holistic care needs including social and developmental care
- Emergency management
- Risk assessment and when to get help

In the same way as information is shared on a need-to-know basis, training should be arranged on a general level for all staff working with a particular adult and specific training for staff who will be supporting an adult on a one-to-one basis.
The trainee must be assessed as competent to undertake the task and documentation signed by the health care professional to indicate this. At the time of assessment of competence, the monitoring and date of training update will be agreed and recorded.

Draft completed by Ann Carr on 11/8/2014

References

NMC (2007) Advice on delegation for NMC registrants, London: NMC

Appendix G – Equality Analysis Form

Step 1	Document Ownership

Name of document being analysed		Personal Health Budget Policy	
Person completing analysis		Personal Health Budget Project Manager	
Date of analysis		October 2014	
Function Area		**Clinical Reference**	
Is the document	**Proposal of new service or pathway**	**Strategy or Policy (or similar)**	**Review of existing service, pathway or**

			project
	YES	**YES**	**NO**

Step 2	**Establishing Relevance**

Public Sector Equality Duties

To ensure compliance with the Equality Act 2010, all strategies or policies, proposals for a new service or pathway, or changes to an existing service or pathway, should be assessed for their relevance to equality – for patients, the public, and for staff. The general equality duty requires that when exercising its functions that the NHS has due regard to the need to:

- Eliminate unlawful discrimination, harassment , victimisation and any other conduct prohibited by the Act;
- Advance equality of opportunity between people who share a protected characteristics and those who do not;
- Foster good relations between people who share a protected characteristic and those who do not.

Protected Characteristics

You need to analyse the effect on equality for all protected characteristics – namely: Age, Disability, Sex, Race, Gender reassignment, Sexual Orientation, Religion and Belief; Pregnancy and Maternity, Marriage and Civil Partnership. Please also consider other groups who are currently outside the scope of the Act, but who may have a significant relationship with NHS services (for example Carers, homeless people, travelling communities, sex-workers and migrant groups).

With reference to the Public Sector Equality Duties and the Protected Characteristics is an Equality Analysis required? YES

Please summarise your conclusion if an equality analysis is <u>not</u> required:

If you have concluded that the document **<u>is</u>** relevant please continue with your equality analysis below; otherwise please sent this part only to the Equality and Diversity Team together with a copy of your document.

Step 3	**Responsibility, Development, Aims and Purpose**

Who holds overall responsibility for the policy/ strategy/ service redesign etc.?	CCGs, Head of CHC CSU, Assistant Director Joint Commissioning Team
Who else has been involved in the development?	Birmingham City Council, NHSE

Purpose and aims: (briefly describe the overall purpose and aims of the service – for a new

service – describe the rationale and need for the proposal, referring to evidence sources. For a change in service or pathway – specify exactly what will change and the rationale/ evidence, including which CCG priority this will contribute to):

The overall aim of Personal Health Budgets (PHBs) is to bring better health and wellbeing outcomes for individuals who are eligible for NHS Continuing Healthcare.

Specific outcomes expected to be achieved are:

- Better quality health and well-being outcomes for patients and carers
- Improved quality of life for patients and carers
- Improved patient experience/satisfaction for patients and carers
- Reduced health inequalities
- Improved access to a wider range of support and services
- Positive shift of culture and behavioural change by staff and wider public
- Better use of NHS resources – indirect impact of personilisation improving wider NHS services plus traditional services being more focussed on those individuals using them
- Increased value for money – cost effectiveness

Who is intended to benefit from the implementation of this piece of work?	PHBs are available to all individuals found to be eligible for Continuing Healthcare funding. At present, it is envisaged PHBs will be aimed at those who receive a care package at home.
What are the key outcomes/ benefits for the groups identified above?	The evaluation of the three year National PHB Pilot Programme confirms the intended benefits for those opting to have a PHB are: • Outcomes focussed care • Control and flexibility over how their health conditions are managed • Improvement in health and wellbeing • Better quality of life • Improved well-being of carers • Mutually agreed outcomes with agreed interventions
Does it meet any statutory requirements, outcomes or targets?	In line with the Department of Health Policy, individuals eligible for CHC funding have 'the right to have' a PHB from October 2014.
Does it contribute to the Equality Delivery System Goals? (specify goals and related outcomes)*	Yes Goals 1 and Goals 2 of EDS

*Equality Delivery System goals are fully explained in the Equality analysis guidance notes

Step 4	**Protected Characteristics – analysis of impact**

Please provide analysis of both the positive and negative impacts of the proposal against each of the protected characteristics providing details on the evidence (both qualitative and quantitive) used. If the work is targeted towards a particular group (s) – provide justification e.g. women only services. Any gaps in evidence should be accounted for and included in your Action Plan.

Age
Impact and evidence: Consider and detail impact and evidence across all age groups. Department of Health Policy states that personal health budgets will be available to those eligible for CHC funding from 1 April 2014. This will include adults and children. Therefore there are age related issues that the implementation of this policy needs to recognise. People that are eligible for CHC funding are predominantly older people. Personal health budgets will provide the opportunity for older adults to become active participants in their care and support rather than passive recipients of services. Therefore understanding of how older people can best be supported to get the maximum benefits from a personal health budget is particularly important. The Department of Health's Equality Impact Assessment found that there were notable negative effects for older adults. They tended to have lower levels of wellbeing and higher levels of anxiety throughout implementation. However, by the end of the pilot older people reported higher levels of satisfaction with personal health budget provision than traditional models of service provision. Other pilot sites in local Equality Impact Assessments based on social care experience, identified the risk that older people may be reluctant to spend the money allocated to them through a personal budget as it is felt to be a lot of money.. This is likely to become more of an issue within health, as interventions will often cost more money and the commensurate cost of staff time is likely to be higher as well. It may also become more of an issue the more control the individual has over the funding, so it would represent the biggest risk when the individual receives a direct payment. With the above concerns raised, the report 'Making personal budgets work for older: developing experience' provides guidance on the way that personal health budgets can overcome these issues. ? Start from the person. ? Small things make a difference. ? Solutions need to be flexible and individual. ? There needs to be choice in how the money is managed. ? Good support is essential. The above guidance points raised will be imbedded in personal health budget training and literature provided to healthcare professionals who will be responsible for implementing personal health budgets.

A Brokerage Support Service will be available to all patients who wish to have a personal health budget. This service will be able to offer assistance with the administrative burden of having a direct payment e.g. provide payroll services. The Brokerage Support Service will also be able to assist those that may need some independent support to help them to make choices about their care, which is a concept they are not used to.

Another area of potential concern with regards to the age of recipients with a personal health budget is children. Children who are eligible for Continuing Healthcare funding and receive direct payments from the Local Authority are currently disadvantaged when they are found eligible for NHS Continuing Healthcare and go through the transition process. When they go through the transition process they are no longer able to receive direct payments for health services. This affects, their choice, continuity of care, quality of life and independence. Through the introduction of personal health budgets they will be able to continue to receive direct payments.

Disability

Impact and evidence: Consider and detail impact and evidence on disability (this includes physical, sensory, learning, long-term conditions and mental health) and if any **reasonable adjustments** may be required to avoid a disabled patient, or member of staff, from being disadvantaged by the proposal.

A – Physical Disability

CHC pays for all health and social care needs of an individual to maintain a reasonable supported life. Recipients of NHS Continuing Care funding have health needs often in conjunction with needs that are traditionally supported by social care services/education services. Evidence from the social care individual budgets pilot suggests that people with physical disabilities benefited from the additional control given to them through the use of a personal health budget.

Personal health budgets should have a positive impact on this group of people as it will give them greater control over their care. It will allow them to develop a care and support plan in partnership with a healthcare professional and to choose services that will best suit their individual needs. A Brokerage Support Service can support patients in making the most out of their personal health budget should the individual choose.

B – Mental Disability

Within this group of people there are likely to be a large number of patients suffering from Dementia. Personal health budgets aim to actively engage with this group of people and overcome barriers that are present when people lack capacity.

C – Learning Disability

Disability Rights Commission paper entitled ‘Equal Treatment: Closing the Gap’ identified that there is some evidence that people with learning disabilities have worse levels of

healthcare interventions than other groups. The aim is to overcome this by offering a brokerage support service to assist patients with implementing a personal health budget.

Learning disabled service users are currently disadvantaged during the transition from children's to adult services when can no longer receive direct payments for health services. This affects their choice, quality of life and independence. Through the availability of personal health budgets they will be able to continue to receive direct payments if they continue to be eligible for funding.

Sex

Impact and evidence: Consider and detail impact and evidence on both males and females

There is no real perceived difference in the benefits that people will receive from this policy based on gender.

The gender split for those found eligible for NHS Continuing Healthcare is 1006 males and 1378 females. Therefore it will be important for staff to monitor take up rates between men and women and the different levels of interest expressed in taking up personal health budgets as they are implemented. This data will be simple to collect as the personal health budget process makes provision for data systems to record the level of uptake which will include the gender of the recipient.

Race

Impact and evidence: Consider and detail impact and evidence on ethnic groups

There is weak evidence available from evaluation of personal budget implementation in social care that white recipients of budget recipients may have a higher level of satisfaction than black and ethnic minority groups.

Personal health budgets should help deliver more flexible care, which is sensitive to patient's needs and preferences. Overcoming cultural and language barriers are important to making sure that these communities are offered personal health budgets in a way that is meaningful to them. Translation and interpretation services are key to engaging and supporting patients to take up personal health budgets. A need for translation and interpretation services would be identified during the CHC assessment stages.

Religion or Belief

Impact and evidence: Consider and detail impact and evidence on people of different religions, beliefs (and those who may have no religion)

Eligibility for CHC funding is based on an individual's clinical needs, therefore it is not anticipated that this group of people will differ in the benefits that they can derive from this policy. However, personal health budgets may enable users to organise care that fits in with their cultural beliefs and customs as the pivotal point of personal health budgets is the imposition of a care and support plan that is person centred. This will allow a personal health budget recipient to organise care that fits their cultural beliefs/customs.

Sexual Orientation

Impact and evidence: Consider and detail impact and evidence on people of different sexual orientations

There is very little data available around this strand, often due to sensitivities around requesting the information and declaration. However Government estimates the figure for lesbian, gay and bisexual people in the UK's population is about 5% (Census 2011 Office of National Statistics).

Eligibility for CHC is based on an individual's clinical needs, therefore it is not anticipated that this group of people will differ in the benefits that they can derive from this policy. However, personal health budgets may offer this group of people greater choice in services to meet their health and wellbeing needs. By putting people at the centre of the care planning process this will enable them to choose the care that they receive and to organise care that considers their sexual orientation.

Gender Reassignment/ Transgender

Impact and evidence: Consider and detail impact and evidence on transgender people

Eligibility for CHC is based on an individual's clinical needs, therefore it is not anticipated that this group of people will differ in the benefits that they can derive from this policy. However, personal health budgets may offer this group of people greater choice in services to meet their health and wellbeing needs. By putting people at the centre of the care planning process this will enable them to choose the care that they receive and to organise care that they feel happy with.

Pregnancy and Maternity

Impact and evidence: Consider and detail impact and evidence on work arrangements, breastfeeding etc.

Eligibility for CHC funding is based on an individual's clinical needs, therefore it is not anticipated that this group of people will differ in the benefits that they can derive from this policy.

Marriage and Civil Partnership

Impact and evidence: Consider and detail impact and evidence on employees who are married or in a civil partnership

Eligibility for CHC funding is based on an individual's clinical needs, therefore it is not anticipated that this group of people will differ in the benefits that they can derive from this policy.

Other Excluded Groups/ Multiple and social deprivation

Impact and evidence: Consider and detail impact and evidence on groups that do not readily fall under the protected characteristics such as carers, transient communities, ex-offenders, asylum seekers, sex-workers, homeless people.

Eligibility for CHC funding is based upon the individual's clinical needs. However, criticism

has been levelled at personal health budgets in that it will tend to be of greater benefit to educated, informed and confident groups of people. It is recognised that different levels of education, articulacy, awareness and confidence are known to closely correlate with economic status and background. These factors may be important in securing a personal health budget and effectively meeting a patient's needs.

The challenge will be to ensure that patients who chose to have a personal health budget, regardless of socio/economic background, receive the same benefits from this policy. Without appropriate support this may limit the care choices made and thus fail to maximise the benefits that this policy could offer. By offering people appropriate support through a Brokerage Support Service, this group of people will have more of a voice and reduce some of the inequalities that are inherent in a system where better informed groups of people already tend to benefit from a more personalised service.

Carers - Having a personal health budget could have a large impact on carers as they may have a far greater role in administering a personal health budget, particularly if direct payments are used. However, a Brokerage Support Service can offer support with personal health budget administration. This will alleviate the impact on carers.

There is also the opportunity for carers to be involved throughout the process of care and support plan so that they are also considered. There is a provision for respite care and the associated costs built into the resource allocation tool that is used to assess the amount of money in the service user's budget.

Asylum seekers and refugees - Eligibility for CHC funding is based on an individual's clinical needs, therefore it is not anticipated that this group of people will differ in the benefits that they can derive from this policy. However, it will be important that service users can easily access translation services and that PHB literature can be made available in a different language or format.

Public Sector Equality Duty (PSED)

Please provide detail on how the proposal contributes to:

- Eliminating unlawful discrimination, harassment and victimisation;
- Advancing equality of opportunity between people who share a protected characteristic and those who do not;
- Fostering good relations between people who share a protected characteristic and those who do not.

Personal Health Budgets rely on the Personalised Support Plan, which highlights the needs and wellbeing of the individual, and planning care that meets the needs of the individuals taking any protected characteristics into consideration. As the uptake of PHBs increases, Peer networks will be formed allowing individuals to network and support each other.

A wider range of providers will be engaged through personal choice.

PHBs will encourage positive action to meet the needs of the individual.

Cumulative impact of this and other proposals? (Please consider whether this proposal, when combined with other decisions made by the CCG, might have a contributory positive or negative impact on the Public Sector Equality Duty.)

A positive impact will be made on PSED due to the personalised approach of PHBs.

Step 5	**NHS Constitution and Human Rights**

Checklist – how does this proposal affect the rights of patients set out in the NHS Constitution or their Human Rights?

	Constitutional Rights	**Yes/No**	**Please explain**
a	Could this result in a person being treated in an inhuman or degrading way?	No	Personal Health Budgets offers an individual more choice, control and flexibility over their own care.
b	Does the proposal respect a patient's dignity, confidentiality, and the requirement for their consent?	Yes	Personal Health Budgets offers an individual more choice, control and flexibility over their own care.
c	Do patients have the opportunity to be involved in discussions and decisions about their own healthcare arising from this proposal?	Yes	The support plan for a PHB is person centred and allows them to make decisions of the delivery of their own care.
d	Do patients and their families have an opportunity to be involved (directly or through representatives) in decisions made about the **planning** of healthcare services arising from this proposal?	Yes	The support plan clearly identifies who will be involved in the discussions and decision making alongside the individual.
	Constitutional Rights	**Yes/No**	**Please explain**
e	Will the person's right to respect for private and family life be interfered with?	No	The aim of PHBs is to enable an individual to remain within their own home wherever possible, and have maximum choice, control and flexibility. However there may be instances where

			the risks involved in this mean that this is not possible and alternative options for care may have to be considered.
f	Will it affect a person's right to life?	No	PHBs aim to give service users more of a voice and a say about their own care.
g	Will this affect a person's right not to be discriminated against?	No	The individual will have more choice, control and flexibility over the care they receive.
h	Will this affect a person's right to freedom of thought, conscience and religion?	No	PHBs aim to give service users a voice and freedom to express their preferences which should be catered for within the care environment

Step 6	**Engagement and Involvement (Duty to involve – s242 NHS Act 2006) Francis Recommendation 135**

How have you involved users, carers and community groups in developing this proposal? (Please give details of any research/consultation drawn on (desk reviews – including complaints, PALS, incidents, patient and community feedback, surveys etc)). **Also give details of any specific discussions or consultations you have carried out to develop this proposal** – with users, carers, protected characteristic groups and/or their representatives, other communities of interest (e.g. user groups, forums, workshops, focus groups, open days etc.). **How have you used this information to inform the proposal?**

Advised by NHSE not required – implementing legislation.

Have you involved any other partner agencies (such as Local Authorities, Health and Well-being boards, Health Scrutiny Committees, Local Healthwatch, Public Health, CSU or CCGs) **please give details of any involvement to date or planned:**

The PHB Steering Group procurement has representatives from CSU commissioners, clinicians, finance and communications and Birmingham City Council.

The policy will also be signed off by CCG Governance Boards/Committees.

Step 7	Including people who need to know

Please consider the way in which the proposal will be explained to a wider audience. (Will translation or interpretation materials be required (audio, pictorial, Braille as well as alternative languages); are there any particular approaches required for different cultures using outreach or advocacy support**;** is some targeted marketing required?

It is intended that patients and their families be provided with clear information about the expectations they should have with regard to the PHBs and patient and family experience. Information will be provided in different formats where required.

Step 8	Monitoring Arrangements

Please identify the monitoring arrangements that will be introduced to ensure that the effect of the proposal does not result in a disproportionate impact on any protected group (e.g. by creating an unintended barrier); For example, including contractual requirements to provide equality monitoring data on those accessing the service or making complaints.

Uptake of PHBs will be monitored via relevant data systems to ensure there is an equitable take up of PHBs across all groups. Please note, PHBs are a choice, so it will be relevant to note why someone may choose to not take up a PHB after requesting initial information. This information will be reviewed alongside the policy on an annual basis.

The policy will be reviewed on an annual basis, which includes the Equalities Impact Assessment.

Individuals may make appeals/complaints using the existing processes as set up by the CCGs.

Which committee or group will receive updates on the monitoring? (Include details of how often reports will be presented).

CCG Quality and Safety Committees, CHC Performance Group (Joint group across BXC, BSC and Solihull CCGs)

Step 9	Decision Making

Taking the equality analysis and the engagement into consideration, and the duties around the Public Sector Equality Duty, you should now identify what your next step will be for the proposal:

Decision steps available	Rationale for your decision
Continue unchanged	No potential negative impacts have been identified. Expectations relating to the fair and equitable treatment of all individuals are included in this service specification. We are also happy that the results of the consultation have not raised any concerns or unmet needs from service users, potential service users or their relatives.
Adjust the proposal (please detail the changes you will make in the Action Plan at **Step 10**)	N/A
Fundamental review of / stop the proposal	N/A

Step 10	Action Plan

Please reference all actions identified above & any additional actions required to ensure that this proposal can be implemented in compliance with Equality legislation, NHS Constitution and Human Rights requirements.

Action	What will it achieve or address?	Lead Person	Timescale
Ensure there is effective monitoring of the take up of Personal Health Budgets across all groups.	This action will assure the commissioners that service users are being treated equitably and their requirements are being taken into consideration and met.	Commissioners	Ongoing
Consider reasonable adjustments and have ensured these are in place e.g. communication adjustments	This action will assure the commissioners that service users disabilities such as communication issues, hearing, oral or learning impairments are taken into account and appropriate assistance and reasonable adjustments are made.	Commissioners	Ongoing

Review date for this equality analysis (when actions above and impacts of the proposal will be considered)	April 2015

Step 11	**Sign Off**

STAGE 6: SIGN OFF (you should arrange for an appropriate Chief Officer/ Governing Body Member to sign off this EA before sending it to the Manager for Equality & Diversity)			
ROLE	NAME	SIGNATURE	DATE
Manager for Equality & Diversity	Balvinder Everitt	Bal K Everitt	17 April 2015

Please return your completed and signed EA to the Manager for Equality and Diversity, together with a copy of the document to which it refers.

Guidance:

A summary guidance sheet can be found overleaf; for further advice or support please contact the Manager for Equality and Diversity on tel: 0121 255 0809 or email: Balvinder.Everitt@nhs.net