NHS
Southport and Formby
Clinical Commissioning Group

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

Policy & Practice Guidance

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

Version Number	Type of Change	Date	Description of change

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1.0 Purpose & Introduction

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

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

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

1.1 Consultation

This policy was developed in consultation with:

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

1.2 Ratification

This policy and practice guidance will be ratified by NHS Southport and Formby CCG Governing Body.

1.3 Scope

This policy applies to all employees of NHS Southport and Formby / South Sefton CCG, Commissioning Support Unit, NHS Providers commissioned to deliver services by Southport and Formby CCG.

1.4 Other Relevant Legislation

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

- The Data Protection Act 1998

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

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

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

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

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

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

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

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

2.0 Overview

2.1 History

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

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

2.2 What is a PHB?

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

For Eligible Persons there is a duty on CCGs to:

- Consider any request for a PHB;
- Inform them of their right to ask for a PHB (April 2014);
- Inform them of their right to have a PHB (October 2014)
- Provide information, advice and support in relation to PHBs.

There are five essential characteristics of a PHB.

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

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

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

2.3 Principles

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

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

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

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

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

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

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

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

2.4 Standards for self-directed health support

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

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

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

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

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

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

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

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

3.0 PHB eligibility

3.1 Who can have a PHB?

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

For South Sefton CCG this includes:

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

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

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

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

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

3.2 Exclusions for PHBs

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

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

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

3.3 PHBs for people in nursing or residential care home settings

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

4.0 Options for managing PHBs

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

a) Notional budget – where an individual is informed of the amount of funding available to them and decides how the budget is used (by input into the care plan) but the CCG continues to commission services, manage contracts and make purchases etc. Notional budgets could be an option for individuals who want more

choice and control over their healthcare but who do not feel able or willing to manage a budget.

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

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

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

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

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

5.0 How do PHBs work?

5.1 Informing people about PHBs

All policies relating to NHS Continuing Healthcare and Continuing Care continue to apply alongside the new law and guidance on PHBs. From April 2014, the named health professional will inform Eligible Persons of their right to request a PHB (including by way of direct payments) at the initial assessment, the 12 week review or annual review. From October 2014 the named health professional will inform Eligible Persons of their right to have a PHB (including by way of direct payments) at

the initial assessment, the 12 week review and or annual review. See exclusions in Section 3.2 and 6.4. The Personal Health Budget pathway is outlined in Appendix 1.

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

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

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

The services provided by these organisations will include:

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

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

5.2 Budget Setting

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

set. The indicative budget gives a financial envelope within which the PHB Care Plan is completed.

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

The PHB amount is therefore based on:

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

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

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

5.3 PHB care planning

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

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

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

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

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

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

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

5.4 Representatives for children and people who lack capacity

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

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

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

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

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

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

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

5.5 Lead Health Professional

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

- Managing the assessment of the health needs of the individual as part of the care plan;

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

5.6 Approval of Care Plan

PHB Care Plans are agreed in principle by the named health professional. However, all PHB Care Plans will also need to be signed off by the appropriate CSU & CCG panel (which will include a relevant CCG representative). This process includes reviewing, agreeing and signing off the Care Plan which includes a risk identification and management plan. A PHB checklist has been developed to ensure consistency and adherence to the law and guidance. A copy of this checklist is at Appendix 5 of this Policy.

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

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

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

5.7 PHB Agreement

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

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

5.8 Assistance to manage PHBs

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

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

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

5.9 Monitoring and Review

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

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

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

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

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

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

5.10 Stopping or reclaiming PHBs

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

6.0 Direct Payments

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

6.1 Who can receive a direct payment PHB?

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

and where:

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

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

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

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

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

6.2 Considerations when deciding whether to make a direct payment

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

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

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

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

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

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

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

6.3 Ability to manage direct payments

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

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

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

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

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

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

6.4 Who cannot receive a direct payment?

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

a) subject to a drug rehabilitation requirement, as defined by section 209 of the Criminal Justice Act 2003 (drug rehabilitation requirement), imposed by a community order within the meaning of section 177 (community orders) of that Act, or by a suspended sentence of imprisonment within the meaning of section 189 of that Act (suspended sentences of imprisonment)
b) subject to an alcohol treatment requirement as defined by section 212 of the Criminal Justice Act 2003 (alcohol treatment requirement), imposed by a community order, within the meaning of section 177 of that Act, or by a suspended sentence of imprisonment, within the meaning of section 189 of that Act
c) released on licence under Part 2 of the Criminal Justice Act 1991 (early release of prisoners), Chapter 6 of Part 12 of the Criminal Justice Act 2003 (release on licence) or Chapter 2 of the Crime (Sentences) Act 1997 (life sentences) subject to a non-standard licence condition requiring the offender to undertake offending behaviour work to address drug or alcohol related behaviour
d) required to submit to treatment for their drug or alcohol dependency by virtue of a community rehabilitation order within the meaning of section 41 of the Powers of Criminal Courts (Sentencing) Act 2000 (community rehabilitation orders) or a community punishment and rehabilitation order within the meaning of section 51 of that Act (community punishment and rehabilitation orders)
e) subject to a drug treatment and testing order imposed under section 52 of the Powers of Criminal Courts (Sentencing) Act 2000 (drug treatment and testing orders)
f) subject to a youth rehabilitation order imposed in accordance with paragraph 22 (drug treatment requirement) of Schedule 1 to the Criminal Justice and Immigration Act 2008 (“the 2008 Act”) which requires the person to submit to treatment pursuant to a drug treatment requirement
g) subject to a youth rehabilitation order imposed in accordance with paragraph 23 of Schedule 1 to the 2008 Act (drug testing requirement) which includes a drug testing requirement
h) subject to a youth rehabilitation order imposed in accordance with paragraph 24 of Schedule 1 to the 2008 Act (intoxicating substance treatment requirement) which requires the person to submit to treatment pursuant to an intoxicating substance treatment requirement
i) required to submit to treatment for their drug or alcohol dependency by virtue of a requirement of a probation order within the meaning of sections 228 to 230 of the Criminal Procedure (Scotland) Act 1995 (probation orders) or

subject to a drug treatment and testing order within the meaning of section 234B of that Act (drug treatment and testing order)

j) released on licence under section 22 (release on licence of persons serving determinate sentences) or section 26 of the Prisons (Scotland) Act 1989 release on licence of persons sentenced to imprisonment for life, etc.) 34 or under section 1 (release of short-term, long term and life prisoners) or section 1AA of the Prisoners and Criminal Proceedings (Scotland) Act 1993 (release of certain sexual offenders) and subject to a condition that they submit to treatment for their drug or alcohol dependency

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

6.5 Deciding not to offer a direct payment

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

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

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

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

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

6.6 Decision Making

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

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

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

6.7 Request for review of a decision

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

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

No member will have had previous involvement in the case.

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

6.8 Representatives and direct payments

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

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

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

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

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

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

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

6.9 Nominees

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

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

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

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

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

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

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

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

If the proposed nominee is not a close family member of the person (see Appendix 8), living in the same household as the person, or a friend involved in the person's care, then the CSU / CCG will require the nominee to apply for an enhanced Disclosure and Barring Service (DBS) certificate (formerly a CRB check) with a check of the 'adults barred' list and consider the information before giving their consent. If a proposed nominee in respect of a patient aged 18 or over is barred, the CCG must not give their consent. This is because the Safeguarding Vulnerable

Groups Act 2006 prohibits a barred person from engaging in the activities of managing the person's cash or paying the person's bills.

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

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

6.10 What can and cannot be bought with direct payments

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

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

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

Direct payments cannot be used to pay for the following:

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

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

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

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

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

6.11 Imposing conditions in connection with the making of direct payments

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

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

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

6.12 Assistance to manage a direct payment – Supported Managed Accounts

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

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

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

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

- Where the individual or representative feels assistance is required;
- Where mental capacity indicates; or

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

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

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

6.13 Receiving a direct payment

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

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

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

6.14 One-off payments

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

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

6.15 Monitoring and review of direct payments

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

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

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

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

6.16 Stopping or reducing direct payments

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

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

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

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

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

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

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

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

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

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

6.17 Reclaiming a direct payment

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

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

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

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

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

7.0 Using a direct payment to employ staff or buy services

7.1 Using a direct payment to employ staff

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

alternative agreed support service as a wider range or organisations become available) to ensure the legal responsibilities of being an employer are satisfied.

The costs associated with utilising a non NHS support service are met from the PHB allocation. This requires the PHB to be paid directly to these organisations so that their charges can be deducted. This cost should be factored in when setting the budget.

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

A direct payment can only be used to pay an individual living in the same household, a close family member (as defined in Appendix 8) or a friend if the CCG is satisfied that to secure a service from that person is necessary in order to satisfactorily meet the individual's need; or to promote the welfare of a child for who direct payments are being made. It is anticipated that this will be permitted in very limited circumstances. The CCGs must make judgements on a case by case basis.

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

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

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

7.3 Safeguarding and employment

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

The CSU and CCGs have made arrangements with non NHS support services to provide advice and accessible services in relation to the provision of DBS checks for individual employers.

Individuals cannot request DBS checks on other individuals. However, an individual or their nominee or representative may wish to ask the CCG or another Umbrella Organisation e.g. a non NHS support service, if it is possible to arrange for the prospective employee or contractor to apply for an enhanced DBS check with a check of the adult's (or children's if appropriate) barred lists when employing or

contracting with people who are not close family members or people living in the individual's household providing care to the individual but who are:

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

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

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

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

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

7.4 Indemnity

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

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

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

PAs employed via a direct payment do not need to comply with the legislation that will require them to have indemnity cover if practising unless they are a member of a regulated health profession (see Appendix 9), even if carrying out activities which might otherwise be performed by health professionals. Care co-ordinators, the CSU & CCGs will need to consider and discuss with the person, their nominee or representative, the potential risks associated with the clinical tasks being carried by the PAs on a case by case basis. This needs to form part of the risk assessment and care planning process and outcome recorded in the Care Plan.

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

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

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

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

7.5 Registration and regulated activities

If someone wishes to buy a service which is a regulated activity under the Health and Social Care Act 2008, they will need to inquire as to whether their preferred provider is registered with the Care Quality Commission (CQC). A direct payment cannot be used to purchase a regulated activity from a non-registered service provider.

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

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

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

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

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

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

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

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

In some circumstances, the provider may also need to be a registered member of a professional body affiliated with the Council for Healthcare Regulatory Excellence. If the Care Plan specifies that a task or tasks require a registered professional to undertake it, only a professional who is thus registered may be employed to perform that task or tasks. See Appendix 8.

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

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

8.0 Service User Evaluation

It is vital that CCG's have systems and processes in place to review the effectiveness of PHB's to provide assurance that the individual support plans are; clinically safe, effective and meeting individual needs and outcomes. To facilitate evaluation the CCG are utilising the Patient Experience Outcome Tool (POET), which was developed by Lancaster University. POET is designed specifically for PHB budget holders and family carers to provide insight into the experiences of personal health budget holders and their families. POET also aims to shows the impact having control over the budget has on their lives.

All PHB budget holders will be provided with an opportunity and or supported to complete the POET on an annual basis as part of their annual review. The results will be collated and reported to the CCG on an annual basis, as part of ongoing cycle of evaluation. The process of POET will be carried out by the CCG Commissioning Support Unit on behalf of the CCG.

9.0 Equal Opportunities / Equalities Impact Assessment

An Equality Impact Assessment has been completed and approved by the Equality & Inclusion Panel on 4th November 2015 for this policy and procedure and it does not marginalise or discriminate minority groups.

10.0 Review Date

This policy and procedure will be reviewed in April 2019 and will be reviewed and updated at the request of Southport & Formby CCG or earlier in light of any changes to legislation or National Guidance.

11.0 Further Information

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

www.personalhealthbudgets.england.nhs.uk

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

12.0 Appendices

Appendix 1 - Personal Health Budgets Pathway

Appendix 2 - PHB Care Plan

Appendix 3 – Capacity and Consent

Appendix 4 – PHB Checklist

Appendix 5 – Personal Health Budget Agreement (Adult)

Appendix 6 – Personal Health Budget Agreement (Child)

Appendix 7 – Close Family Members

Appendix 8 – Regulatory Bodies

Appendix 9 – Timescales for Appealing Personal Health Budgets Decisions

Appendix 1

Personal Health Budgets Pathway

1.0 Introduction

1.1 This procedure details the steps required from the agreement of a Personal Health Budget (PHB) to promptly expediting the first payment to the relevant organisation/individual.

1.2 Non-compliance with this procedure could cause delays to the commencement date of the PHB funded package of care resulting in dissatisfaction from families and direct payment support services and non NHS support services e.g. Salvere, Your Life Your Way and Solo (or an alternative agreed support service as a wider range or organisations become available).

2.0 Process

2.1 The CCG appropriate panel will approve a PHB for an individual. This will include the financial value of the PHB, specified as an annualised amount.

2.2 From the date of the Panel and the agreement for a PHB, the relevant direct payment support services and third party budget agencies are required to invoice the relevant CCG via SBS. On receipt of an invoice it can take up to 30 calendar days for the invoice to be paid. The invoice must state the correct Broadcare reference number. The value of the invoice should equate to 3 months (i.e. one quarter) of the annualised budget.

2.3 To facilitate this process the CSU are to complete a 'Financial Commitment Form' for all PHBs. The form will include the following details as agreed by the Panel:

- Broadcare reference number
- Type of PHB (notional payment, direct payment or third party budget)
- Type of package (adult, children's, complex mental health etc)
- Organisation/Individual to whom PHB invoices are to be paid.
- PHB start date (this must be at least 30 days, after the panel date)
- End Date (if applicable)
- Review Date (this must be within 12 weeks if it is a direct payment)
- Annualised value
- Forecast charge in current financial year
- Percentage of PHB to be funded by Local Authority (if applicable)
- Details (including telephone number) of a named CSU contact / DN (named health professional) and locality team contact number
- Space for the form to be signed by a CCG authorised signatory. It is acknowledged that each CCG will have its own Scheme of Delegation and authorisation limits.

2.4 Upon completion the form is to be:

- Retained by the CSU to hold on the individual's file and for entry into Broadcare.
- Sent to the relevant direct payment support service / third party budget agency in order for them to promptly raise an invoice to the CCG.

Sent to the relevant CCG so they can anticipate and approve the invoice from the third party agency, as well as incorporate the information into financial forecasts. If the invoice is consistent with the amount as specified in paragraph 2.2 then the CCG must not delay approving the payment on SBS. If there is a discrepancy the CCG is to contact the CSU to understand the reasons for this. If the issue is still unresolved then the CSU should query the invoice with the third party agency.

2.5 If the non NHS support service has not received payment by the agreed date then it should escalate the issue to the named contact on the Financial Commitment Form.

Appendix 2

Personal Health Budget Care & Support Plan for Southport and Formby CCG

Tables 1, 2 & 3 to be completed by NHS staff before submitting to the PHB Support Service, Table 3 must be signed by the patient or their representative. The Support Service and Patient complete the remainder of the Tables

Table 1 - To be completed by the NHS Named Health Professional (NHS)

Patients Name	Title	D.O.B (DD/MM/YYYY)
Address		Postcode
Home Telephone	Mobile	E-mail
Named Health Professional Name: Tel: E-mai	Request submitted to the following Support Service:	Indicative Budget amount: Annual £ Weekly £ Number of hours per week:

Table 2 - To be completed by the NHS Named Health Professional (NHS)

Patients Health Needs	Activities / Provisions	How the activities / provisions will meet my health and wellbeing needs
To be completed by the NHS Named Health Professional (NHS)	To be completed by the Support Service & Family	To be completed by the Support Service & Family
Add / delete rows as required		

Table 3 - To be completed by the NHS Named Health Professional (NHS) and patient

Declaration	
Please sign this document to show you give your consent (on the date of signing) that the details within this plan can be shared with the Support Service of your choice	
Signature of Patient	Date
Please provide the name of the chosen Support Service who will support you to develop a plan and a financial budget showing how you intend to meet your health and wellbeing needs	Name of chosen Support Service
If patient/ client is unable to sign, an appropriate adult representative with decision making responsibility OR consent from the patient / client should complete the fields below. This signature confirms that you give your consent to this document being shared with your chosen Support Service	
Name:	Relationship to patient:
Signature	Date

Table 4 - To be completed by the Support Service & Family

Significant People in your life In this section please include family and friends, health professionals, care agencies, carers, colleagues, neighbours and any others who play an important part of your life, even if they are not directly involved in your health care			
Name	Are they registered with CQC (Yes / No or N/A)	Contact Details	Do they help you make decisions?

Table 5 - To be completed by the Support Service & Family

Risk Assessment In this section please include any required risk assessments			
Type of risk assessment	Completed Yes / No / N/A	Proposed Risk Mitigation	Action taken / Agreed by Patient
Equipment (e.g. medical devices, consumables, therapy equipment etc.)			
Moving & Handling			
Environment			
Drug Management including covert medication policy if applicable			
Fire			
Managing Behaviour (Personal Intervention Plan)			
Nutritional (e.g. Malnutrition Universal Screening Tool)			
Pressure Area			

Others (add rows if applicable)			

Table 6 - To be completed by the Support Service & Family

Risks PAs do not need to comply with the legislation that will require them to have indemnity cover, unless they are a member of a regulated health profession, even if carrying out activities which might otherwise be performed by health professionals. The Support Service will need to consider and discuss with the person, their nominee or representative, the potential risks associated with the clinical tasks being carried out by the PAs on a case by case basis. This needs to form part of the risk assessment and care planning process and the outcome recorded in the care plan			
Identified Clinical Risk	Impact on Health & Wellbeing	Proposed / Advised Mitigation Action	Action Taken / Agreed by Patient
Identified Financial Risk	Impact on Health & Wellbeing	Proposed / Advised Mitigation Action	Action Taken / Agreed by Patient
Other Identified Risk	Impact on Health & Wellbeing	Proposed / Advised Mitigation	Action Taken / Agreed by

		Action	Patient

Table 7 - To be completed by the Support Service & Family

Support to Manage Personal Health Budget	How will this be managed and by who
Support for sourcing package of care for either agency or PA's	
Recruitment support - Tax, NI, Pension, Employment Rights / Law, Min Wage etc.	
DBS Checks (formerly CRB) and barred lists have been checked for all staff including nominees, representatives and family members (if applicable)	
Appropriate training and accountability measures including assessment of competencies are in place	
Insurance cover in place (employers and public liability etc.)	
Contracted Health professional(s) are registered with the appropriate body and have appropriate indemnity cover	
Identity, qualifications and professional registration checks for employees and the taking up of references has been explored and an approach to manage this agreed and recorded	

Management of the personal health budget	
Payment to staff i.e. Payroll (dependent on type of budget taken)	
Preparation and submission of financial monitoring information	
If any regulated activities are provided by agencies they must be registered with CQC	

Table 8 - To be completed by the Support Service & Family

Finally, your support plan must demonstrate how you have thought about and addressed any unforeseen or difficult times. To be completed by the Support Service & Family
What happens if something unforeseen happens? Please detail below
Add / delete rows as required

Table 9 - To be completed by the Support Service with the patient

Budget – How the Personal Health Budget will be spent		
Area:	Weekly Cost £	Yearly Total £
Staff: including NI, Pension, holiday pay, holiday cover		
Staff hours for shadow training		
DBS checks		
Redundancy		
Agency Fees		
Respite Costs		
Recruitment & Advertising		
Equipment		
Consumables – PPE; Printing		
Training: including clinical competencies / supervisions		
Transport		
Insurance		
Contingency costs; additional training for the new staff; emergency agency		

fees		
Support Service Charge		
List others costs as applicable		
Total		

Table 10 - To be completed by the Support Service with the patient

Declaration	
Please sign this document to show you agree (on the date of signing) that the details within this plan meet your Health and Wellbeing needs and that in your opinion you have been sufficiently involved in the putting together of your support plan. That you give your consent for the support planner to share this completed plan with appropriate persons involved in the PHB provision.	
Signature of Patient	**Date**
Name of Organisation Support Planning	
If patient / client is unable to sign, an appropriate adult representative with decision making responsibility OR consent from the	

patient /client should complete the fields below. That you give your consent for the support planner to share this completed plan with appropriate persons involved in the PHB provision.	
Name	**Relationship to patient**
Signature	**Date**

Appendix 3 Capacity & Consent

PHB arrangements can only be made where appropriate consent has been given by:

- a person aged 16 or over who has the capacity to consent to the making of direct payments to them;
- the suitable representative of a person aged 16 or over who lacks capacity to consent themselves to receipt of a PHB by way of a direct payment;
- the suitable representative of a child under 16.

Capacity

Under the MCA, there is a presumption that everyone over the age of 16 has capacity to make decision for themselves, unless they are assessed as lacking capacity.

When assessing a person's capacity to make a decision, the assessor should follow the two stage test set out under the MCA which asks:

1. Does the person have an impairment of the mind or brain, or is there some disturbance in the functioning of their mind or brain?

2. If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made? Are they able to:
    a. A Understand the issues relevant to the decision
    b. Retain the information relevant to the decision
    c. Weight up to the pros and cons of the decision
    d. Communicate their decision having done so

Capacity is time and issue specific. For example, a person may be able to make a decision about who they would like to support them, but not about how to manage a PHB. PHBs should remain an option for all eligible patients regardless of whether they are deemed to have capacity or not.

There are a number of important decision-making points in setting up and managing PHBs. Where a person lacks the capacity to make a particular decision, their views must still be sought to the extent possible.

Wherever possible a person should be supported to be as involved as possible in all aspects of their PHB including the support planning process. To enable a person to understand their options and to help them feel at ease, those supporting them in their decision making need to think about:

- using the person's preferred methods of communication
- a suitable location
- the persons' privacy and dignity
- letting the person make the decision at their own pace

The Best Interests Principle

Under the MCA, anyone making decisions or acting on behalf of someone who lacks capacity has a duty to act in that person's best interests. Therefore, people who lack the capacity to consent to and manage PHBs can still receive one, including by way of a direct payment, if this is believed to be in their best interests (in accordance with the MCA).

Section 4 of the Mental Capacity Act sets out a checklist of factors that must always be considered by anyone who needs to decide what is in the best interests of a person who lacks capacity in any particular situation. This checklist includes a duty to:

- encourage the person to participate or improve their ability to take part in making the decision
- identify all the relevant circumstances
- consider the person's views (past and present)
- avoid discrimination - not simply make assumptions about someone's 'best interests' on the basis of their age, appearance, condition or behaviour
- assess whether the person might regain capacity and whether the decision can wait until that time
- if the decision concerns life-sustaining treatment the decision maker should not be motivated in any way by a desire to bring about the person's death
- consult those close to the patient for their views about the person's 'best interests'
- avoid restricting the person's rights by seeing if there are other options that may be less restrictive of the person's rights
- weigh up all of the above factors in order to determine best interests

This is not an exhaustive list of factors and the decision maker is under a duty to take into account "all relevant circumstances".

Decisions about the treatment and care of a patient who lacks capacity should follow the same best interests framework as outlined above.

Fluctuating Capacity

Where a person who has agreed to a care plan and consented to the making of direct payments to them subsequently loses their capacity to consent, the CCG may, where it is satisfied that the loss of capacity is temporary, allow a representative to be appointed to receive direct payments on their behalf, or an existing nominee to continue to receive them, until they regain capacity. In these circumstances, the role will be similar to that of a representative for someone who has been assessed to lack capacity on an ongoing basis.
Where someone's capacity to consent fluctuates, for example where a person's mental illness is such that it impairs their capacity to make decisions at certain times but not others, it is important that there should be continuity of care, and any disruption should be as minimal as possible. It may be helpful to work with people with fluctuating conditions to draw up advance decisions under the MCA and contingency plans to ensure that their care in a crisis, better meets their wishes, including the identification of a nominee or representative who may take control of the direct payment at such times.

When a person with fluctuating capacity gains or regains their capacity to consent, their consent is needed to continue the direct payments. If they consent, the representative or nominee must agree to continue their role in respect of the direct payment until a review is held. This is because it is the representative, not the person who has gained or regained capacity who, consented to the arrangements. This allows direct payments to continue until the CCG can arrange a review, which it must do as soon as is reasonably possible. At this review, the CCG and the person receiving care will review and if necessary develop a new care plan. However, if the person who has gained or regained capacity, does not consent to the representative or their nominee continuing in that role until a review is held, or if the representative or nominee does not wish to continue in that role, then direct payments must stop. As in all circumstances when direct payments stop, alternative provision should be made to ensure continuity of care until the required review takes place and new arrangements, which may include direct payments, are put in place.

Appendix 4

PHB Care Plan Sign Off Sheet – Right to Have

To Be Completed by the Direct Payment / Third Party Support Service

Patient Details

About Whom?	Surname: …… First Name(s): …… Broadcare Number: …….. Responsible CCG: ……

Care Plan Checklist

Named Care Coordinator	Named care coordinator is recorded in the care plan	**Yes / No**	**N/A Please add explanatory text**
Review	Anticipated date of the first review (at least within three months of the person receiving a direct healthcare payment)	**DD/MM/YYYY**	
Risk Assessments Completed	Risk assessments included within the care plan and agreed as appropriate	**Yes / No**	**N/A**
Clinical risks recorded	Clinical risks recorded in the care plan including risk mitigation	**Yes / No**	**N/A**
Regulated activities must be carried out by CQC registered providers	Are or will any 'regulated activities' be commissioned from a provider?	**Yes / No**	**N/A**
Care Agencies	Is the provider CQC registered?	**Yes / No**	**N/A**
Meeting Health Needs	Does the Care Plan set out the health needs that the direct healthcare payment is to address?	**Yes / No**	**N/A**
	Is it clear to both CSU/CCG and the people involved what the direct healthcare payments are meant to achieve?	**Yes / No**	**N/A**
	Does the plan specify the services to be secured by the	**Yes / No**	**N/A**

	direct healthcare payment in order to achieve the health (and wellbeing) needs?		
	Is the budget sufficient to meet all of the above?	**Yes / No**	**N/A**
	Are the identified clinical tasks suitable for delegation, specified in the care plan, with appropriate training, development and assessment of competence in place and sufficient indemnity and insurance cover?	**Yes / No**	**N/A**
	Safeguarding has been considered by CSU/CCG?	**Yes / No**	**N/A**
	Is the liberty of the patient being promoted by the care plan? This is especially important where the patient lacks capacity, and or when there are safeguarding issues and /or the patient is in a vulnerable situation.	**Yes / No**	**N/A**
Provision of Information / Advice & Guidance	Has the person, their representative or nominee received information, advice and support from YLYW, SOLO Support Services or Salvere?	**Yes / No**	**N/A**
Are you satisfied that sufficient support has and will be provided to ensure:	The development and agreement from CSU / CCG of an appropriate care plan?	**Yes / No**	**N/A**
	Payroll, Tax and NI are managed effectively	**Yes / No**	**N/A**
	The direct healthcare payment will be managed appropriately?	**Yes / No**	**N/A**
	Monitoring, audit responsibilities and accountabilities are understood and can be adhered to?	**Yes / No**	**N/A**
	The employment of PAs & understanding of employer responsibilities is fully understood and will be adhered to?	**Yes / No**	**N/A**
	Regulated activities, will and are	**Yes / No**	**N/A**

	only commissioned from CQC registered providers?		
	Appropriate insurances are, and remain, in place for the employer?	**Yes / No**	**N/A**
	Appropriate registration is in place?	**Yes / No**	**N/A**
	Appropriate training & development, assessment of competence, sufficient indemnity and insurance cover is, and remains, in place for employed PAs and providers?	**Yes / No**	**N/A**
	The costs for this and ongoing support from YLYW / SOLO Support Services / Salvere are set out within the care plan?	**Yes / No**	**N/A**
	There are sufficient funds to meet the support service costs and meet all of the health needs safely?	**Yes / No**	**N/A**
	Family members, close relatives and people living in the same home as the patient or their partners will not be employed unless agreed by the CSU / CCG? **(If the CCG is considering such a request please complete appendix 1)**	**Yes / No**	**N/A**
Consent & Capacity	Does the patient or Person with Parental responsibility for a child 16 or under - have capacity to consent to a PHB / direct payment	**Yes / No**	**N/A**
	Has the patient / Person with Parental responsibility for a child 16 or under - consented to a PHB / direct payment **(if no Representatives and Nominees section below must be completed - see below)**	**Yes / No**	**N/A**
Representatives and Nominees	Any representative and / or nominee must be agreed by the CCG / CSU. Does the CCG approve the named representative and / or nominee **(When considering such a request please complete**	**Yes / No**	**N/A**

	appendix 2)		
PHB Start Date	The intended commencement date of the PHB:	**DD/MM/YYYY**	

Appendix 1
Employing family members, close relatives and/or people living in the same household as the patient or their partners
If family members, close relatives and/or people living in the same household as the patient or their partners will be employed using a direct healthcare payment the CCG / CSU must record this here. The CCG / CSU will need to confirm that this is necessary in order to satisfactorily meet the person receiving care's need for that service; or to promote the welfare of a child for whom direct healthcare payments are being made. **Name / Relationship** **……** Has the CCG / CSU agreed to any family members, close relatives, people living in the same household or their partners being employed? **Yes / No / N/A** Please include details below, the name of the person(s), relationship, what has been agreed and the reason for this, including the time period and review timeframe for this decision.

Appendix 2	
Capacity Does the patient have capacity?	**Yes / No**
Consent Has the patient (16+) consented to a PHB and / or direct healthcare payment or Have the child's (under 16) parent(s) / those with parental responsibility consented to a PHB and / or direct health care payment	**Yes / No** **Yes / No**
Has the Patient consented to receiving a PHB / direct healthcare payment and fulfilling all of the responsibilities of someone receiving a PHB / direct healthcare payment?	**Yes / No**

Representatives	**If No is used Representative do not complete**
For patients (16+) unable to consent to a PHB / direct healthcare payment a Representative can be appointed. For children (under 16) a parent or those with parental responsibility for the child must be appointed as a Representative.	
The CCG / CSU must ensure that the Representative has consented to	

receiving a direct healthcare payment and fulfilling all of the responsibilities of someone receiving direct healthcare payments.	
Name of agreed Representative:	
Has the Representative consented to receiving a direct healthcare payment and fulfilling all of the responsibilities of someone receiving a direct healthcare payment?	**Yes / No**
The CCG / CSU must give consent and consider whether the person is competent and able to manage direct healthcare payments.	
Does the CCG / CSU consent to the Representative? Does the CCG / CSU consider the representative is competent and able to manage direct healthcare payments?	**Yes / No** **Yes / No**
Has the Representative applied for an Enhanced DBS check? Parents or those with Parental responsibility for a child (under 16) do not ordinarily need to apply, neither do family members living in the same household	**Yes / No / N/A**
Has the Representative been checked against the Adults' / Children's Barred List? Parents or those with Parental responsibility for a child (under 16) do not ordinarily need to apply, neither do family members living in the same household	**Yes / No / N/A**
Are the results of both of these checks satisfactory?	**Yes / No / N/A**

Employing Relatives	
Will the Representative be paid or employed in any capacity using the direct healthcare payments?	**Yes / No**
Will / is the Representative paid or employed in any capacity by the PHB support service e.g. YLYW / SOLO Support Services or Salvere?	**Yes / No**
Will any partner, relative, friend or person living in the same household as the patient / their Representative be paid or employed in any capacity using the direct healthcare payment?	**Yes / No**

If the CCG / CSU cannot approve the proposed Representative or wishes to attach conditions to the PHB the reason / conditions must be recorded here:

Nominees	
Is a nominee being requested?	**Yes / No**
If yes please complete the remainder of this section	
A Representative or a person with capacity (16+) can choose a Nominee.	
Has the Nominee consented to receiving a PHB / direct healthcare payment and fulfilling all of the responsibilities of someone receiving a PHB / direct healthcare payment?	
Has the Nominee applied for an Enhanced DBS check?	**Yes / No**
Has the Nominee been checked against the adults'/children's barred list?	**Yes / No**
Are the results both of these checks satisfactory?	**Yes/No /N/A**
Will the Nominee be paid or employed in any capacity using the direct healthcare payments?	**Yes / No**
Will / is the Nominee paid or employed in any capacity by the PHB support service e.g. SOLO Support Services or Salvere?	**Yes / No**
Will any partner, relative, friend or person living in the same household as the patient / their nominee be paid or employed in any capacity using the direct healthcare payment?	**Yes / No**
Does the CCG / CSU consent to the Nominee?	**Yes / No**
Name of agreed Nominee	

If the CCG / CSU cannot approve the proposed Nominee or wishes to attach conditions to the PHB the reason / conditions must be recorded here:

Appendix 5

PERSONAL HEALTH BUDGET AGREEMENT (ADULT)

This document tells you about having a Personal Health Budget

1. Information about You and Community Services

This agreement is between:

[Enter name of relevant CCG here] Clinical Commissioning Group

_____

(Referred to in this agreement as ‘we’ or ‘us’)

and

Name and address of person receiving the Personal Health Budget

PLEASE PRINT:

First Name(s) _____

Surname _____

Address _____

_____

Post Code _____

(Referred to in this agreement as ‘you’)

In certain circumstances, including where you are under 16 or are unable to consent to your direct healthcare payment, someone else may legally consent to and manage your direct healthcare payments on your behalf. That person is called a ‘representative’. Your representative will sign and agree to the terms of this agreement, and any other obligations on them under the regulations.

Your representative, if applicable and agreed by us is:

Name and address of Representative* or chosen decision maker

PLEASE PRINT:

First Name(s) ___ _____

Surname _____ _____

Relationship to ‘you' _____

Address _____

_____

Post Code _____

*Referred to in this agreement as 'Representative' who has been appointed to arrange the services and manage the direct healthcare payment on behalf of the Patient who lacks capacity, and who has been agreed by 'Us'.

And, if applicable you or your representative is entitled to appoint a nominee to take on the contractual responsibilities including arranging the services and support detailed in your support plan, the nominee will also become responsible for how the money is spent. Where we agree to it your nominee will sign and agree to comply with the terms of this agreement and any other obligations on them under the regulations.

Name and address of Nominee

PLEASE PRINT:

First Name _____

Surname _____

Address _____

_____

_____

Post Code _____

(Referred to in this agreement as 'Nominee')

2. Basis of the Agreement

This agreement is made on the basis that:

- An assessment of your health needs has been completed with a health professional and it has been identified that you are eligible to receive health care funding.
- Your care plan will identify the care and / or support that you need to meet your assessed health care outcomes in order to maintain your independence.
- You are willing and able to secure the care / support detailed in your care plan yourself or with support**,** (from a Representative or Nominee) and we agree to make your Personal Health Budget available to you to purchase the support and / or care that you need.

Any payment made under this agreement will be subject to regular audit and monitoring by Salvere, Your Life Your Way or SOLO Support Services and us which may be reviewed by the Personal Health Budget Programme Board.

Further information about Your Life Your Way, SOLO Support Services and Salvere can be found at Appendix A.

3. Responsibilities of Your Nominated Representative (If you have one)

As part of the Clinical Commissioning Group agreeing to someone acting as your Representative, that person must be prepared to accept the following responsibilities:

- To involve you in decisions about your support
- To represent your best interests
- To consent to receiving and managing the direct healthcare payment, and
- Fulfilling all of the responsibilities of someone receiving direct healthcare payments

Even if you need a Representative you still have the right to be involved whenever possible. There is a duty placed on the Representative to involve you in all relevant decisions where possible.

If the Representative repeatedly fails to make decisions that reflect these key responsibilities, then their role as a Representative would need to be reconsidered.

Representatives are appointed only with the CCGs approval. Representatives can be appointed for individuals who do not have the capacity to consent to a direct healthcare payment or for a child under 16 when Representatives can include the parents of the child or those with parental responsibility for that child.

If you gain or regain capacity your consent is required to continue your direct healthcare payment.

Where an individual in receipt of a direct healthcare payment subsequently loses their capacity to consent, and the CCG is satisfied this is temporary, the CCG may allow a Representative to be appointed to manage the direct healthcare payments or allow a Nominee to continue to manage them until a review can be arranged.

4. Responsibilities of Your Nominee (If you or your Nominated Representative have one)

As part of the Clinical Commissioning Group agreeing to someone acting as your Nominee, that person must be prepared to accept the following responsibilities:

- To involve you in decisions about your support
- To represent your best interests
- To consent to receiving and managing the direct healthcare payment, and
- Fulfilling all of the responsibilities of someone receiving direct healthcare payments

Nominees must agree to act in the capacity of your Nominee and provide informed consent; the CCG must also consent to that Nominee acting in this capacity, and consider whether the Nominee is competent and able to manage direct healthcare payments with or without assistance.

You or your Representative may choose to elect a Nominee where you / your Representative wish to delegate all of the responsibilities of managing and receiving a direct healthcare payment.

5. About your Personal Health Budget

The amount of money you will receive

Start Date: _____
(Proposed) Breakdown of Payments:
Weekly (if applicable) £_____
One Off Value (if applicable) £ _____

The frequency of your payments will be discussed with you. However, payments are usually made to Solo Support Services / Salvere in advance on a three monthly basis and will be reviewed within the first 12 weeks and then annually, unless your health care needs change.

How you will receive your money

There are three main ways that you can receive your personal health budget:

1. A direct payment with support from Salvere
2. A cash budget held and managed by Your Life Your Way or SOLO Support Services
3. A 'Notional' budget

You will have all the options explained to you before you decide which is the best option for you. When you have decided which way you would like to receive your budget please mark your choice with an 'X' in the box.

√	**A Direct Healthcare Payment**

A direct healthcare payment is where we pay money to you. The money will be paid into a bank account set up for this purpose by Salvere.

- Your Personal Health Budget will be paid into a bank account, which will be opened by Salvere in your name / your Representative's name / your Nominee's name and managed by you or your nominated representative or nominee.

- You will need to sign this agreement

- You will need to sign an agreement with Salvere, this sets out the services they will provide to you, your Representative / Nominee and the charges they will deduct from your direct healthcare payment for these services. Salvere will advise you about this.

- You, your Representative or Nominee must take advice on becoming an employer from Salvere, as any employment, insurance, pension and tax issues will be the responsibility of the employer. You will be required to adhere to all aspects of employment law.

- You will be required to provide evidence of how you have spent the money for audit purposes. You will need to keep a record of your income and expenditure including receipts, invoices, timesheets, payslips and bank statements. Salvere can help you to manage this

- The bank account will be audited by Salvere and us and therefore it is important that you / Salvere submit all receipts and invoices for related expenditure.

- Salvere may make direct healthcare payments directly to you / your Representative or Nominee however the CCG will need to approve this.

- See Section 6. Employing your own Staff

√	**A 'cash budget' (third party arrangement) held and managed by SOLO / Your Life Your Way**

A cash budget is where the Clinical Commissioning Group pays your allocated budget to an organisation called either Your Life Your Way or SOLO Support Services, who hold the money for you and help you decide what you need. After you have agreed this with us, Your Life Your Way or SOLO Support Services will then buy and pay for the care and support you have chosen. Please note – Your Life Your Way or SOLO Support Services will employ your Personal Assistants if you choose to have a cash budget.

- The account is held and managed by Your Life Your Way or SOLO Support Services on your behalf

- Your Life Your Way or SOLO Support Services will buy the care and support you have chosen and take on the employment responsibilities

- You / your Representative / Nominee will need to sign an agreement with Your Life Your Way or SOLO Support Services; this sets out the services they will provide to you and the charges they will deduct from your Personal Health Budget for these services. Your Life Your Way or SOLO Support Services will advise you about this.

- You can request the balance of your bank account during working hours, Monday-Friday

- The bank account will be audited by Your Life Your Way or SOLO Support Services and us and therefore it is important that you / Your Life Your Way or SOLO Support Services submit all receipts and invoices for related expenditure.

√	**A Notional budget**

A Notional Budget enables you to be involved in planning your own care. The Clinical Commissioning Group will pay your service provider directly for any services that you have been assessed as needing. Please note - you cannot employ your own Personal Assistants if you choose to have a notional budget.

- The Clinical Commissioning Group will purchase and arrange the care and support from the provider(s) you have chosen

- The Clinical Commissioning Group will fund the care and support directly

- You will be involved in planning your care and support including developing your care plan

6. General Rules about How to Use the Money

Your Personal Health Budget enables you to buy the care, support or service that is detailed and agreed in your care plan.

The money cannot be spent on illegal services or activities, alcohol, tobacco, gambling or debt repayment.

You cannot use your Personal Health Budget to pay for primary or general medical services, for example GP services, vaccinations, dental charges, or optical appliances and hospital care.

If funds are used in this way the CCG may cease your Personal Health Budget and recover the inappropriately spent monies from you, your Representative / Nominee as appropriate.

Using a Care Agency

If you wish to use a care agency to provide a regulated activity you must purchase care from a provider who is registered with the Care Quality Commission, who regulate the standards of care agencies nationally. There is a list of registered providers available, please see www.cqc.org.uk for more information. Salvere / Your Life Your Way / SOLO Support Services or your named health professional can also advise you about choosing a care agency.

If you choose to purchase a service through a care agency then please be advised that the contract and agreed price is a private arrangement between you, your Representative or Nominee and the care agency. Should the care agency increase its prices in the future above the agreed personal health budget amount, or require you to give a period of notice, we recommend that you request a review of your care plan and budget by contacting your named health professional. It may be more cost effective for the CCG to commission the service directly from your preferred care agency and the CCG will provide you with the option of a notional budget to ensure value for money.

Employing your own staff

You may also use your Personal Health Budget to purchase a service from any willing trained provider. This may include employing a Personal Assistant. If a provider you choose requires training to enable them to carry out their role effectively, training must be undertaken to ensure that you receive a high quality service. Salvere can support you to access training as an employer and for your Personal Assistant(s).

We strongly recommend that a DBS check (Disclosure and Barring Service) is completed as part of the employment process. If you choose to employ your own staff you will have some legal responsibilities as an employer. These include but are not limited to providing:

- A statement of employment particulars including: providing a written contract; highlighting the location of the work; remuneration; period of notice etc. It is a legal requirement to have a written contract of employment between you and your member of staff

- Deducting Tax and National Insurance Contributions

- Adhering to Minimum Wage, Statutory Sick Pay and Maternity Entitlements and Responsibilities, Paternity leave and pay, Annual leave and pay, Adoption, Redundancy, Equal Opportunities, Unions and Health and Safety policies.

- You are legally required to take out Employers and Public Liability Insurance.

You will be responsible for all the employer responsibilities. Guidance can be obtained online at: www.direct.gov.uk: '*Employing a professional carer or personal assistant'* or www.hmrc.gov.uk

We recommend that you consult Salvere, who support people using direct healthcare payments for information and advice about becoming an employer. You cannot ordinarily employ family members or anyone who lives with you or the spouse / partner of a relative / anyone living in the same house as you*.

This will only be agreed if, the CCG is satisfied that to secure a service from that person is necessary to meet your needs or promote the welfare of a child. This will be detailed here if agreed by us.

The CCG has agreed that the following family members (detailed above*) are employed by you, your Representative / Nominee: N/A Full Name N/A _____ Relationship _____ Reason _____

Representatives and Nominees and their relatives and partners cannot be employed to avoid any conflict of interest.

7. Record Keeping and Audit

You are required to keep basic records.

Your bank account will be audited through Salvere, Your Life Your Life or SOLO Support Services. Salvere, Your Life Your Way and SOLO Support Services are only able to make payments that are agreed in your care plan. The records will be subject to audit arrangements and Salvere, Your Life Your Way and SOLO Support Services will be audited annually (as a minimum).

The balance of the bank account will be reviewed regularly and any money that has not been allocated to your care or support excluding your contingency funds will be returned to the Clinical Commissioning Group (unless a prior agreement has been made with your named health professional).

8. Review, Changed Needs, Contingency and Emergency Arrangements

The arrangements agreed within your care plan will be reviewed within the first 12 weeks and then at least annually. The review will determine if your health needs and your personal outcomes have been met or have changed, and to establish what has worked well or not worked well for you.

The Clinical Commissioning Group will arrange a review earlier or if we become aware that your health needs have changed and/or if your Personal Health Budget is insufficient to secure the services. You or your Representative can also ask for a review.

If your needs have changed during this period of time you may request an earlier review of your needs by contacting your named health professional.

You are required to make contingency arrangements within your care plan, which may include having a contingency fund. In crisis situations the Clinical Commissioning Group may, in the absence of alternative support, step in and help on an interim basis.

Primary care services, including access to your GP and emergency services, such as Accident and Emergency, will always be available to you regardless of having a Personal Health Budget. These services are not included in your budget.

If your needs change or something is not working, you or your Representative or Nominee, must contact your named health professional.

If you go into hospital, you or your Representative must inform us

9. Comments, Complaints and Compliments

You have a right to comment, complain or compliment through the Clinical Commissioning Group's complaints procedure about any action, decision or apparent failing of the Clinical Commissioning Group.

Contact the Customer Care Team:

by telephone: 0151 247 7000

by email: Southportandformbyccg.complaints@nhs.net

by post: NHS Southport and Formby CCG

3rd Floor Merton House,

Stanley Road,

Bootle.

L20 3DL.

10. Ending the Agreement

Either you, your Representative or we may end this agreement by giving one months' notice in writing to the other party.

We may end this agreement with immediate effect if, after investigation, it is found:

- You are using the money illegally
- You are not using it in your own best interests
- Your Nominated Representative is found to be acting in a way that is not in your best interests

Wherever possible, we will work with you and your Representative to find a resolution to the issues before ending the agreement.

At the point of ending the agreement, any funds paid to you by the Clinical Commissioning Group which covers the period after the termination date, must be paid back in full.

Following a review if we decide to reduce the amount of or stop making your direct healthcare payment you, your Representative or Nominee may ask us to reconsider this decision, and can provide evidence or relevant information to inform the reconsideration. We will inform you, your Representative or Nominee in writing of the decision following the reconsideration and state the reasons for the decision.

If this agreement ends for any reason and you continue to have health needs, the funding for your health needs will be provided by the CCG as part of the NHS in the usual way.

11. Data Protection and Use of Data

We may share information that we hold or become aware of with other statutory agencies for the prevention of fraud and abuse.

12. Signatures

This is where all parties are signing up to this agreement. This means that we will all work to what has been agreed in this document.

1st Party:

Us – Signature on behalf of the Clinical Commissioning Group:

Signature: _____

Date: _____

2nd Party:

You – The person receiving the Personal Health Budget

Signature: _____

Date: _____

3rd Party:

Representative – the person receiving and managing the Personal Health Budget on behalf of the above named person
Signature: _____

Date: _____

4th Party:

Nominee – the person receiving and managing the Personal Health Budget on behalf of the above named Representative or person

Signature: _____

Date: _____

13. Annex A
SOLO Support Services and Your Life Your Way

SOLO Support Services and Your Life Your Way are the CCGs approved providers for a personal health budget deployed as a 'cash budget' (third party arrangement). SOLO Support Services and Your Life Your Way are both Care Quality Commission (CQC) registered care agencies.

SOLO Support Services and Your Life Your Way work with families to build care plans and hold your personal health budget for you. SOLO and Your Life Your Way buy and pay for the care and support you have chosen. Please note – SOLO and Your Life Your Way will employ your Personal Assistants if you choose to have a 'cash budget' (third party arrangement). SOLO and Your Life Your Way will deduct their charges for their services from your Personal Health Budget. These charges have been agreed between yourself and Your Life your Way / SOLO Support Services as part of your care plan.

Salvere

Salvere are the CCGs approved provider for making direct healthcare payments for personal health budgets. Salvere are a Community Interest Company who support and assist families to organise, buy and manage their care, including building your own care plan using a direct healthcare payment.

Salvere will help you to manage all of your responsibilities as an employer and help you to employ personal assistants, arrange payroll, pay HMRC, provide staff handbooks, contracts of employment, risk assessment, help you make decisions about disclosure barring service checks, and ensure appropriate

training and competency checks are in place and ensure clinical tasks are delegated safely.

Salvere will hold your Personal Health Budget in a bank account, which will be opened in your name / your Representative's name / your Nominee's name and managed by you or your nominated representative or nominee. Salvere will deduct their charges for their services from your Personal Health Budget. These charges have been agreed between yourself and Salvere as part of your care plan.

Appendix 6

PERSONAL HEALTH BUDGET AGREEMENT (Children)

This document tells you about having a Personal Health Budget

14. Information about You and Community Services
15. Basis of the agreement
16. Responsibilities of a Nominated Representative
17. Responsibilities of your Nominee (if you have one)
18. About your Personal Health Budget
19. General Rules on How to Use the Money
20. Record Keeping and Audit
21. Review, Changed Needs, Contingent and Emergency Arrangements
22. Comments, Complaints and Compliments
23. Ending the Agreement
24. Data Protection and Use of Data
25. Signatures
26. Annex A

2. Information about You and Community Services

This agreement is between:

(Enter name of relevant CCG here) Clinical Commissioning Group (Referred to in this agreement as 'we' or 'us')

and

Name and address of the child for who the Personal Health Budget is being made PLEASE PRINT: **First Name(s)** : **Surname:** **Address**   **Post Code** (Referred to in this agreement as 'the child')

In certain circumstances, including for people who are under 16 or people who are unable to consent to a direct healthcare payment, someone else may legally consent to and manage the direct healthcare payments on their behalf. That person is called a 'representative'. The representative will sign and agree to the terms of this agreement, and any other obligations on them under the regulations.

Once the child reaches 16 they will be able to consent to and receive the direct healthcare payment in their own right. The CCG will discuss the options with the child and may discuss the options with a person with parental responsibility at this time.

Your representative, if applicable and agreed by us is:

Name and address of Representative* or chosen decision maker

PLEASE PRINT:

First Name(s) :

Surname:

Relationship to 'the child' : Parent or person with parental responsibility

Address

Post Code

*Referred to in this agreement as 'you' or 'Representative' who has been appointed to arrange the services and manage the direct healthcare payment on behalf of a child for whom they have parental responsibility, and who has been agreed by 'Us'.

A representative is entitled to appoint a nominee to take on the contractual responsibilities including arranging the services and support detailed in the child's support plan, the nominee will also become responsible for how the money is spent. Where we agree to it your nominee will sign and agree to comply with the terms of this agreement and any other obligations on them under the regulations.

Name and address of Nominee

PLEASE PRINT:

First Name Not Applicable

Surname _____

Address _____

_____

_____

Post Code _____

(Referred to in this agreement as 'Nominee')

2. Basis of the Agreement

This agreement is made on the basis that:

- An assessment of your child's health needs has been completed with a health professional and it has been identified that your child is eligible to receive health care funding.

- Your child's care plan will identify the care and / or support that your child needs to meet their assessed health care outcomes in order to maintain your child's' independence.

- You - The parent / person with parental responsibility (Representative) is willing and able to secure the care / support detailed in your child's care plan yourself or with support**,** (from a Nominee) and we agree to make your child's Personal Health Budget available to you as the Representative to purchase the support and / or care that your child needs.

Any payment made under this agreement will be subject to regular audit and monitoring by Salvere or Your Life Your Way / SOLO Support Services and us which may be reviewed by the Personal Health Budget Programme Board.

Further information about Your Life Your Way, SOLO Support Services and Salvere can be found at Appendix A.

3. Responsibilities of the Nominated Representative

As part of the Clinical Commissioning Group agreeing to someone acting as a Representative, that person must be prepared to accept the following responsibilities:

- To involve the child in decisions about their support

- To represent the child's best interests

- To consent to receiving and managing the direct healthcare payment, and

- Fulfilling all of the responsibilities of someone receiving direct healthcare payments

Even with a Representative a child still has the right to be involved whenever possible. There is a duty placed on the Representative to involve the child in all relevant decisions where possible.

If the Representative repeatedly fails to make decisions that reflect these key responsibilities, then their role as a Representative would need to be reconsidered.

Representatives are appointed only with the CCGs approval. Representatives can be appointed for individuals who do not have the capacity to consent to a direct healthcare payment or for a child under 16 when Representatives can include the parents of the child or those with parental responsibility for that child.

4. Responsibilities of Your Nominee (If you have one)

As part of the Clinical Commissioning Group agreeing to someone acting as your Nominee, that person must be prepared to accept the following responsibilities:

- To involve you and the child in decisions about the child's support
- To represent the child's best interests
- To consent to receiving and managing the direct healthcare payment, and
- Fulfilling all of the responsibilities of someone receiving direct healthcare payments

Nominees must agree to act in the capacity of your Nominee and provide informed consent; the CCG must also consent to that Nominee acting in this capacity, and consider whether the Nominee is competent and able to manage direct healthcare payments with or without assistance.

A Representative for the child may choose to elect a Nominee where the Representative wishes to delegate all of the responsibilities of managing and receiving a direct healthcare payment.

5. About your child's Personal Health Budget

<u>The amount of money you will receive</u>

Start Date: xx/xx/xx
(Proposed) Breakdown of Payments:
Weekly (if applicable) £
One Off Value (if applicable) £
NOT APPLICABLE

The frequency of the payments will be discussed with you. However, payments are usually made to Your Life Your Way / Solo Support Services / Salvere in advance on a three monthly basis and will be reviewed within the first 12 weeks and then annually, unless your health care needs change.

How you will receive the money

There are three main ways that you can receive the personal health budget:

4. A direct payment with support from Salvere
5. A cash budget held and managed by Your Life Your Way / SOLO Support Services
6. A 'Notional' budget

You will have all the options explained to you before you decide which is the best option for you. When you have decided which way you would like to receive the budget please mark your choice with an 'X' in the box.

√	**A Direct Healthcare Payment**

A direct healthcare payment is where we pay money to you. The money will be paid into a bank account set up for this purpose by Salvere.

- The Personal Health Budget will be paid into a bank account, which will be opened by Salvere in your name or the Nominee's name and managed by you or the Nominee.
- You will need to sign this agreement
- You will need to sign an agreement with Salvere, this sets out the services they will provide to you or your Nominee and the charges they will deduct from the direct healthcare payment for these services. Salvere will advise you about this.
- You or your Nominee must take advice on becoming an employer from Salvere, as any employment, insurance, pension and tax issues will be the responsibility of the employer. You or your Nominee will be required to adhere to all aspects of employment law.
- You will be required to provide evidence of how you have spent the money for audit purposes. You will need to keep a record of all income and expenditure including receipts, invoices, timesheets, payslips and bank statements. Salvere can help you to manage this
- The bank account will be audited by Salvere and us and therefore it is important that you / Salvere submit all receipts and invoices for related expenditure.
- Salvere may make direct healthcare payments directly to you or your Nominee however the CCG will need to approve this.
- See Section 6. Employing your own Staff

√	**A 'cash budget' (third party arrangement) held and managed by SOLO or Your Life Your Way**

A cash budget is where the Clinical Commissioning Group pays the allocated budget to an organisation called Your Life Your Way, SOLO Support Services, who hold the money for you and help you decide what you and your child need. After you have agreed this with us, Your Life Your Way, SOLO Support Services will then buy and pay for the care and support you have chosen. Please note – Your Life Your Way, SOLO Support Services will employ your Personal Assistants if you choose to have a cash budget.

- The account is held and managed by Your Life Your Life or SOLO Support Services on your behalf
- Your Life Your Way or SOLO Support Services will buy the care and support you have chosen and take on the employment responsibilities
- You or your Nominee will need to sign an agreement with Your Life Your Way / SOLO Support Services; this sets out the services they will provide to you and the charges they will deduct from your Personal Health Budget for these services. Your Life Your Way / SOLO Support Services will advise you about this.
- You can request the balance of your bank account during working hours, Monday-Friday
- The bank account will be audited by Your Life Your Way / SOLO Support Services and us and therefore it is important that you / SOLO Support Services / Your Life Your Way submit all receipts and invoices for related expenditure.

√	**A Notional budget**

A Notional Budget enables you to be involved in planning your child's care. The Clinical Commissioning Group will pay your service provider directly for any services that your child has been assessed as needing. Please note - you cannot employ your own Personal Assistants if you choose to have a notional budget.

- The Clinical Commissioning Group will purchase and arrange the care and support from the provider(s) you have chosen
- The Clinical Commissioning Group will fund the care and support directly
- You will be involved in planning your childs' care and support including developing your childs' care plan.
-

6. General Rules about How to Use the Money

The Personal Health Budget enables you to buy the care, support or service that is detailed and agreed in your childs' care plan.

The money cannot be spent on illegal services or activities, alcohol, tobacco, gambling or debt repayment.

You cannot use your Personal Health Budget to pay for primary or general medical services, for example GP services, vaccinations, dental charges, or optical appliances and hospital care.

If funds are used in this way the CCG may cease your Personal Health Budget and recover the inappropriately spent monies from you or your Nominee as appropriate.

Using a Care Agency

If you wish to use a care agency to provide a regulated activity you must purchase care from a provider who is registered with the Care Quality Commission, who regulate the standards of care agencies nationally. There is a list of registered providers available, please see www.cqc.org.uk for more information. Salvere / SOLO Support Services / Your Life Your Way or your child's named health professional can also advise you about choosing a care agency.

If you choose to purchase a service through a care agency then please be advised that the contract and agreed price is a private arrangement between you or your Nominee and the care agency. Should the care agency increase its prices in the future above the agreed personal health budget amount, or require you to give a period of notice, we recommend that you request a review of your child's care plan and budget by contacting your childs' named health professional. It may be more cost effective for the CCG to commission the service directly from your preferred care agency and the CCG will provide you with the option of a notional budget to ensure value for money.

Employing your own staff

You may also use your Personal Health Budget to purchase a service from any willing trained provider. This may include employing a Personal Assistant. If a provider you choose requires training to enable them to carry out their role effectively, training must be undertaken to ensure that your child receives a high quality service. Salvere can support you to access training as an employer and for your child's Personal Assistant(s).

We strongly recommend that a DBS check (Disclosure and Barring Service) is completed as part of the employment process. If you choose to employ your own staff you will have some legal responsibilities as an employer. These include but are not limited to providing:

- A statement of employment particulars including: providing a written contract; highlighting the location of the work; remuneration; period of notice etc. It is a legal requirement to have a written contract of employment between you and your member of staff

- Deducting Tax and National Insurance Contributions

- Adhering to Minimum Wage, Statutory Sick Pay and Maternity Entitlements and Responsibilities, Paternity leave and pay, Annual leave and pay, Adoption, Redundancy, Equal Opportunities, Unions and Health and Safety policies.

- You are legally required to take out Employers and Public Liability Insurance.

You will be responsible for all the employer responsibilities. Guidance can be obtained online at: www.direct.gov.uk: '*Employing a professional carer or personal assistant'* or www.hmrc.gov.uk

We recommend that you consult Salvere, who support people using direct healthcare payments for information and advice about becoming an employer. You cannot ordinarily employ family members or anyone who lives with you or the spouse / partner of a relative / anyone living in the same house as you*.

This will only be agreed if, the CCG is satisfied that to secure a service from that person is necessary to meet the child's needs or promote the welfare of the child.
This will be detailed here if agreed by us.

The CCG has agreed that the following family members (detailed above*) are employed by you or your Nominee: Full Name: _____Not Applicable_____ Relationship _____ Reason _____

Representatives and Nominees and their relatives and partners cannot be employed to avoid any conflict of interest.

7. Record Keeping and Audit

You are required to keep basic records.

Your bank account will be audited through Salvere, Your Life Your Way or SOLO Support Services. Salvere, Your Life Your Way and SOLO Support Services are only able to make payments that are agreed in your childs' care plan. The records will be subject to audit arrangements and Salvere, Your Life Your Way and SOLO Support Services will be audited annually (as a minimum).

The balance of the bank account will be reviewed regularly and any money that has not been allocated to your childs' care or support excluding your contingency funds will be returned to the Clinical Commissioning Group (unless a prior agreement has been made with your named health professional).

8. Review, Changed Needs, Contingency and Emergency Arrangements

The arrangements agreed within your child's care plan will be reviewed within the first 12 weeks and then at least annually. The review will determine if your childs' health needs and personal outcomes have been met or have changed, and to establish what has worked well or not worked well for you and your child.

The Clinical Commissioning Group will arrange a review earlier if we become aware that your childs' health needs have changed and/or if the Personal Health Budget is insufficient to secure the services. You can also ask for a review if your childs' needs have changed during this period of time - you may request an earlier review of your childs' needs by contacting your childs' named health professional.

You are required to make contingency arrangements within your childs' care plan, which may include having a contingency fund. In crisis situations the Clinical Commissioning Group may, in the absence of alternative support, step in and help on an interim basis.

Primary care services, including access to your childs' GP and emergency services, such as Accident and Emergency, will always be available to your child regardless of having a Personal Health Budget. These services are not included in your budget.

If your child's needs change or something is not working, you or your Nominee, must contact your childs' named health professional. If your child goes into hospital, you must inform us so that we can consider whether an adjustment to the personal health budget is needed for services which are not provided while your child is in hospital.

9. Comments, Complaints and Compliments

You have a right to comment, complain or compliment through the Clinical Commissioning Group's complaints procedure about any action, decision or apparent failing of the Clinical Commissioning Group.

Contact the Customer Care Team:

by telephone: 0151 247 7000

by email: Southport and formbyccg.complaints@nhs.net

by post: NHS Southport and Formby CCG

3rd Floor Merton House,
Stanley Road,

Bootle.
L20 3DL.

10. Ending the Agreement

Either you or we may end this agreement by giving one months' notice in writing to the other party.

We may end this agreement with immediate effect if, after investigation, it is found:

- You are using the money illegally or for any purpose which is not permitted in this Agreement or in the child's care plan
- You are not using the money in your childs' best interests or as agreed with us
- You are found to be acting in a way that is not in the childs' best interests

Wherever possible, we will work with you to find a resolution to the issues before ending the agreement.

At the point of ending the agreement, any funds paid to you by the Clinical Commissioning Group which covers the period after the termination date, must be paid back in full.

Following a review if we decide to reduce the amount of or stop making the direct healthcare payment you or your Nominee may ask us to reconsider this decision, and you may provide evidence or relevant information to inform the reconsideration. We will inform you or your Nominee in writing of the decision following the reconsideration and state the reasons for the decision.

If this agreement ends for any reason and your child continues to have health needs, the funding for your health needs will be provided by the CCG as part of the NHS in the usual way.

11. Data Protection and Use of Data

We may share information that we hold or become aware of with other statutory agencies for the prevention of fraud and abuse.

12. Signatures

This is where all parties are signing up to this agreement. This means that we will all work to what has been agreed in this document.

1st Party:

Us – Signature on behalf of the Clinical Commissioning Group:

Signature: _____

Date: _____

2nd Party:

You / The Representative– The person receiving the Personal Health Budget on behalf of a child for who you have parental responsibility

Signature: _____

Date: _____

3rd Party:

Nominee – the person receiving and managing the Personal Health Budget on behalf of the above named Representative

Signature: _Not Applicable_____

Date: _____

13. Annex A
SOLO Support Services & Your Life Your Way

SOLO Support Services & Your Life Your Way are the CCGs approved provider for a personal health budget deployed as a 'cash budget' (third party arrangement). SOLO Support Services & Your Life Your Way are Care Quality Commission (CQC) registered care agencies.

SOLO Support Services & Your Life Your Way work with families to build care plans and hold your personal health budget for you. SOLO & Your Life Your Way buy and pay for the care and support you have chosen. Please note – SOLO & Your Life Your Way will employ your Personal Assistants if you choose to have a 'cash budget' (third party arrangement). SOLO & Your Life Your Way will deduct their charges for their services from your Personal Health Budget. These charges have been agreed between yourself and SOLO Support Services & Your Life Your Way as part of your care plan.

Salvere

Salvere are the CCGs approved provider for making direct healthcare payments for personal health budgets. Salvere are a Community Interest Company who support and assist families to organise, buy and manage their care, including building your childs' own care plan using a direct healthcare payment.

Salvere will help you to manage all of your responsibilities as an employer and help you to employ personal assistants, arrange payroll, pay HMRC, provide staff handbooks, contracts of employment, risk assessment, help you make decisions about disclosure barring service checks, and ensure appropriate training and competency checks are in place and ensure clinical tasks are delegated safely.

Salvere will hold your Personal Health Budget in a bank account, which will be opened in your name / your child's name / your Nominee's name and managed by you or your nominee. Salvere will deduct their charges for their services from your Personal Health Budget. These charges have been agreed between yourself and Salvere as part of your childs' care plan.

Appendix 7

Close Family Members

Who is a close family member?

A person's close family members are described in the regulations as:

a. the spouse or civil partner of the person receiving care

b. someone who lives with the person as if their spouse or civil partner

c. their parent or parent-in-law

d. their son or daughter

e. son- in- law or daughter- in- law

f. stepson or stepdaughter

g. brother or sister

h. aunt or uncle

i. grandparent, or

j. the spouse or civil partners of (c)- (i), or someone who lives with them as if their spouse or civil partner

Appendix 8

Regulatory Bodies

Which are the statutory regulatory bodies?

- The General Chiropractic Council (GCC) regulates chiropractors.
- The General Dental Council (GDC) regulates dentists, dental nurses, dental technicians, dental hygienists, dental therapists, clinical dental technicians and orthodontic therapists.
- The General Medical Council (GMC) regulates doctors.
- The General Optical Council (GOC) regulates optometrists, dispensing opticians, student opticians and dispensing opticians, specialist practitioners and optical businesses.
- The General Osteopathic Council (GOsC) regulates osteopaths.
- The Health and Care Professions Council (HCPC) regulates the members of 15 health professions: arts therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dietitians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists/orthotists, radiographers, speech and language therapists, and social workers in England.
- The Nursing and Midwifery Council (NMC) regulates nurses and midwives.
- The Royal Pharmaceutical Society of Great Britain (RPSGB) regulates pharmacists, pharmacy technicians and pharmacy premises in Great Britain in England, Wales and Scotland.

Appendix 9

Timescales for Appealing Personal Health Budgets Decisions

1.0 Timescales:

1.1 The appeal must be made within 4 weeks of receiving the CCG's response to the PHB request. Appeals can be made by email, letter, by phone, either direct to the CCG, or via the CSU.

1.2 On receipt of an appeal, the CCG will respond within 10 working days confirming that a meeting will be convened.

1.3 The meeting should take place within 25 working days of the appeal being received.

1.4 The response of the panel will be confirmed to the service user in a letter within 28 working days of acknowledgement the original request meeting. The reasons for the decision will be set out in the decision letter, (together with an information leaflet on the NHS Complaints Procedure if the patient or their representative is not satisfied with the decision).

1.5 In the event of any timescales being exceeded, it is the responsibility of the CCG to keep the patient or their representative informed of reasons and progress.

1.6 Once the review is complete the CCG will inform the patient or their representative of its decision in writing, setting out the reasons for its decision within 28 working days of acknowledgement of the original request. If a patient or their representative is not satisfied that can pursue the matter via the local NHS complaints process.

1.7 If the internal process cannot resolve the concerns of the individual and/or their representative then the appellant can use the NHS Complaints Procedure.